DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 409, 410, 411, 413, 414, 415, and 424

[CMS-1503-FC]

RINs 0938-AP79

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period addresses changes to the physician fee schedule and other Medicare Part B payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. It finalizes the calendar year (CY) 2010 interim relative value units (RVUs) and issues interim RVUs for new and revised procedure codes for CY 2011. It also addresses, implements, or discusses certain provisions of both the Affordable Care Act (ACA) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). In addition, this final rule with comment period discusses payments under the Ambulance Fee Schedule (AFS), the Ambulatory Surgical Center (ASC) payment system, and the Clinical Laboratory Fee Schedule (CLFS), payments to end-stage renal disease (ESRD) facilities, and payments for Part B drugs. Finally, this final rule with comment period also includes a discussion regarding the Chiropractic Services Demonstration program, the Competitive Bidding Program for durable medical equipment, prosthetics, orthotics,

and supplies (CBP DMEPOS), and provider and supplier enrollment issues associated with air ambulances.

DATES: Effective date: These regulations are effective on January 1, 2011.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on January 3, 2011.

ADDRESSES: In commenting, please refer to file code CMS-1503-FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the instructions for "submitting a comment."

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1503-FC,

P.O. Box 8013,

Baltimore, MD 21244-8013.

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

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1503-FC,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

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

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201

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

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-9994 in advance to schedule your arrival with one of our staff members.

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

FOR FURTHER INFORMATION CONTACT:

Sara Vitolo, (410) 786–5714, for issues related to malpractice RVUs.

Erin Smith, (410) 786-0763, for issues related to end-stage renal disease-related services for home dialysis.

Michael Moore, (410) 786-6830, for issues related to geographic practice cost indices.

Ken Marsalek, (410) 786–4502, for issues related to the physician practice information survey, the multiple procedure payment reduction, and payment for the technical component of pathology services.

Regina Walker-Wren, (410) 786–9160, for issues related to outpatient mental health add-on provision and increased payment for certified nurse-midwife services.

Elizabeth Truong, (410) 786–6005, or Sara Vitolo, (410) 786–5714, for issues related to potentially misvalued services.

Elizabeth Truong, (410) 786–6005, for issues related to the sustainable growth rate or anesthesia or physician fee schedule conversion factors.

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

Pamela West, (410) 786-2302, for issues related to payment for diabetes self-management training programs and kidney disease education services.

Ryan Howe, (410) 786–3355, for issues related to direct practice expense inputs and telehealth services.

Sara Vitolo, (410) 786-5714, for issues related to pulmonary rehabilitation services, application of skin substitutes, canalith repositioning, intranasal/oral immunization, and the refinement panel.

Roberta Epps, (410)786 -4503, for issues related to portable x-ray and bone density tests.

Chava Sheffield, (410) 786-2298, for issues related to equipment utilization rate assumption for advanced imaging services.

Chava Sheffield, (410) 786-2298, or Larry Chan, (410) 786-6864, for issues related the physician fee schedule practice expense methodology.

Stephanie Frilling, (410) 786-4507, or Erin Smith, (410) 786-0763, for issues related to the incentive payment programs for primary care and general surgery services, and payment for the annual wellness visit and preventive services.

Cheryl Gilbreath, (410)786-5919, for issues related to payment for covered outpatient drugs and biologicals.

Roechel Kujawa, (410)786-9111, for issues related to ambulance services.

Glenn McGuirk, (410) 786-5723, for clinical laboratory issues.

Randall Ricktor, (410) 786-4632, for Federally Qualified Health Center Issues.

Pauline Lapin, (410)786-6883, for issues related to the chiropractic services demonstration BN issue.

Troy Barsky, (410)786-8873, or Kristin Bohl, (410)786-8680, for issues related to physician self-referral.

Troy Barsky, (410)786-8873, or Fred Grabau (410)786-0206, for issues related to timely filing rules.

Henry Richter, (410)786-4562, or Lisa Hubbard, (410)786-5472, for issues related to renal dialysis provisions and payments for end-stage renal disease facilities.

Diane Stern, (410)786-1133, for issues related to the physician quality reporting initiative and incentives for e-prescribing.

Sheila Roman, 410-786-6004, or Pamela Cheetham, 410-786-2259, for issues related to the Physician Resource Use Feedback Program and value-based purchasing.

Joel Kaiser, (410)786-4499, for issues related to the DME provisions.

Sandra Bastinelli, (410)786-3630, for issues related to provider and supplier enrollment issues.

Rebecca Cole, (410) 786-4497, for issues related to physician payment not identified above.

SUPPLEMENTARY INFORMATION:

Comment Subject Areas: We will consider comments on the following subject areas discussed in this final rule with comment period that are received by the date and time indicated in the DATES section of this final rule with comment period:

(1) The interim final work, practice expense, and malpractice RVUs (including the direct practice expense (PE) inputs and the equipment utilization rate assumption, and the applicability of a multiple procedure payment reduction (MPPR)), for new and revised CY 2011 HCPCS codes. These codes and their CY 2011 interim final RVUs are listed in Addendum C to this final rule with comment period.

(2) The physician self-referral designated health services codes listed in Tables 98 and 99.

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

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

implemented PFS amount and not at a transition rate for that year. Consistent with this policy, all new CY 2011 CPT codes will not be paid based on transitional PE RVUs in CY 2011. Instead, we will pay these services based on the fully implemented PE RVUs in CY 2011. Additionally, existing CPT codes for which the global period has changed in CY 2011 will not be subject to the PPIS PE RVU transition. We believe that changing the global period of a code results in the CPT code describing a different service to which the previous PE RVUs would no longer be relevant when the code is reported for a service furnished in CY 2011. The five CY 2011 existing CPT codes with global period changes from CY 2010 to CY 2011 are: 11043 (Debridement, muscle, and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less); 11044 (Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less); 57155 (Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy); 97597 (Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 square centimeters or less); and 97598 (Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instructions(s) for ongoing care, per session, total wound(s) surface area; each additional 20 square centimeters, or part thereof (List separately in addition to code

for primary procedure)).

c. Allocation of PE to Services

To establish PE RVUs for specific services, it is necessary to establish the direct and indirect PE associated with each service.

(i) Direct costs. The relative relationship between the direct cost portions of the PE RVUs for any two services is determined by the relative relationship between the sum of the direct cost resources (that is, the clinical staff, equipment, and supplies) typically required to provide the services. The costs of these resources are calculated from the refined direct PE inputs in our PE database. For example, if one service has a direct cost sum of $400 from our PE database and another service has a direct cost sum of $200, the direct portion of the PE RVUs of the first service would be twice as much as the direct portion of the PE RVUs for the second service.

(ii) Indirect costs. Section II.A.2.b. of this final rule with comment period describes the current data sources for specialty-specific indirect costs used in our PE calculations. We allocate the indirect costs to the code level on the basis of the direct costs specifically associated with a code and the greater of either the clinical labor costs or the physician work RVUs. We also incorporate the survey data described earlier in the PE/HR discussion. The general approach to developing the indirect portion of the PE RVUs is described below.

- For a given service, we use the direct portion of the PE RVUs calculated as described above and the average percentage that direct costs represent of total costs (based on survey data) across the specialties that perform

the service to determine an initial indirect allocator. For example, if the direct portion of the PE RVUs for a given service were 2.00 and direct costs, on average, represented 25 percent of total costs for the specialties that performed the service, the initial indirect allocator would be 6.00 since 2.00 is 25 percent of 8.00.

- We then add the greater of the work RVUs or clinical labor portion of the direct portion of the PE RVUs to this initial indirect allocator. In our example, if this service had work RVUs of 4.00 and the clinical labor portion of the direct PE RVUs was 1.50, we would add 6.00 plus 4.00 (since the 4.00 work RVUs are greater than the 1.50 clinical labor portion) to get an indirect allocator of 10.00. In the absence of any further use of the survey data, the relative relationship between the indirect cost portions of the PE RVUs for any two services would be determined by the relative relationship between these indirect cost allocators. For example, if one service had an indirect cost allocator of 10.00 and another service had an indirect cost allocator of 5.00, the indirect portion of the PE RVUs of the first service would be twice as great as the indirect portion of the PE RVUs for the second service.

- We next incorporate the specialty-specific indirect PE/HR data into the calculation. As a relatively extreme example for the sake of simplicity, assume in our example above that, based on the survey data, the average indirect cost of the specialties performing the first service with an allocator of 10.00 was half of the average indirect cost of the specialties performing the second service with an

indirect allocator of 5.00. In this case, the indirect portion of the PE RVUs of the first service would be equal to that of the second service.

d. Facility and Nonfacility Costs

For procedures that can be furnished in a physician's office, as well as in a hospital or facility setting, we establish two PE RVUs: facility and nonfacility. The methodology for calculating PE RVUs is the same for both the facility and nonfacility RVUs, but is applied independently to yield two separate PE RVUs. Because Medicare makes a separate payment to the facility for its costs of furnishing a service, the facility PE RVUs are generally lower than the nonfacility PE RVUs.

e. Services with Technical Components (TCs) and Professional Components (PCs)

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

f. Alternative Data Sources and Public Comments on Final Rule for 2010

In the CY 2010 PFS final rule with comment period (74 FR 61749 through 61750), we discussed the Medicare Payment Advisory Commission's (MedPAC's) comment that in the future, "CMS should consider alternatives to collecting specialty-specific cost data or options to decrease the reliance on such data." We agreed with MedPAC that it would be appropriate to consider the future of the PE RVUs moving forward. We sought comments from other stakeholders on the issues raised by MedPAC for the future. In particular, we requested public comments regarding MedPAC's suggestion that we consider alternatives for collecting specialty-specific cost data or options to decrease the reliance on such data. We noted MedPAC's comment that, "CMS should consider if Medicare or provider groups should sponsor future data collection efforts, if participation should be voluntary (such as surveys) or mandatory (such as cost reports), and whether a nationally representative sample of practitioners would be sufficient for either a survey or cost reports." MedPAC also stated that one option for decreasing the reliance on specialty-specific cost data would be the elimination of the use of indirect PE/HR data in the last step of establishing the indirect cost portion of the PE RVUs as described previously.

Almost all of the commenters on the CY 2010 PFS final rule with comment period that addressed this issue expressed a general willingness to work with CMS on methodological improvements or future data collection efforts. Although no commenters detailed a comprehensive overall alternative methodology, several commenters did provide suggestions regarding future data collection efforts and specific aspects of the current methodology.

The commenters on the CY 2010 PFS final rule with comment period that addressed the issue of surveys supported the use of surveys if they yielded accurate PE information. The few commenters that addressed the issue of cost reports were opposed to physician cost reports. The commenters varied with respect to their opinions regarding whether data collection efforts should be led by organized medicine, individual specialty societies, or CMS. Several commenters that addressed the issue of voluntary versus mandatory data collection efforts supported voluntary data collection efforts and opposed mandatory data collection efforts.

Some commenters recommended no changes to the methodology or PE data in the near future. Other commenters indicated that the methodology and data changes needed to be made for CY 2011. Although most commenters did not directly address the use of the indirect PE/HR data, those that did predominately opposed the elimination of the use of these data.

Many commenters addressed specifics of the PE methodology (as further described in section II.A.2.c. of this final rule with comment period). Some were opposed to the scaling factor applied in the development of the direct PE portion of the PE RVUs so that in the aggregate the direct portion of the PE RVUs do not exceed the proportion indicated by the survey data (See Step 4 in g.(ii) below). Several of these commenters advocated the elimination of this direct scaling factor, while others indicated that the issue should be examined more closely.

A few commenters recommended that physician work not be used as an allocator in the development of the indirect portion of the PE RVUs as described earlier in this section. A few indicated that physician time, but not physician work, should be

used in the allocation. Other commenters suggested that indirect costs should be allocated solely on the basis of direct costs.

We note that many of the issues raised by commenters on the CY 2010 PFS final rule with comment period are similar to issues raised in the development of the original resource-based PE methodology and in subsequent revisions to the methodology, including the adoption of the bottom-up methodology. While we did not propose a broad methodological change or broad data collection effort in the CY 2011 PFS proposed rule, we invited comments on our summary of the issues raised by the commenters on the CY 2010 PFS final rule with comment period, as discussed in the CY 2011 PFS proposed rule (75 FR 40050). The complete public comments on the CY 2010 PFS final rule with comment period are available for public review at www.regulations.gov by entering "CMS-1413-FC" in the search box on the main page.

Comment: A number of commenters believe the PPIS data are flawed and, therefore, should not be used to set the PE RVUs for all or certain categories of PFS services. Other commenters supported the adoption of the PPIS data and, whether ultimately favoring the adoption of the PPIS data or not, many commenters stated that the 4-year transition adopted by CMS is important to physicians and Medicare beneficiaries to ensure access to care. The commenters explained that the transition gives physician specialty societies the opportunity to collect new and more detailed data where appropriate for refinement and CMS the opportunity to more carefully analyze the new data and its appropriateness. Although once again the commenters did not provide specific recommendations on alternatives to a comprehensive survey of practice expenses

or options to decrease the PFS reliance on specialty-specific cost data, the commenters offered the following suggestions regarding future practice expense data collection.

- Select a reputable company with experience in health care market research.
- Base changes on a comprehensive data source with adequate participation rates.
- Have data independently reviewed in order to ensure accuracy.
- Make data publicly available in time to allow for review and comment by stakeholders.

Several commenters emphasized the administrative complexity and burden if CMS were to require all physicians to submit cost reports. One commenter supported a limited study of practice costs estimated by cost reports to determine if the current PE RVUs were appropriately paying physicians for the physician's office costs of services. The commenter believes that cost reports would be more accurate than the PPIS methodology. Finally, several commenters indicated a willingness to engage CMS in more detailed discussion about potential refinements to the current PE/HR data.

Response: We appreciate the commenters' recommendations regarding factors we should consider in developing future practice expense data collection efforts in order to improve the accuracy of the information. While we are continuing the transition that was adopted in the CY 2010 PFS final rule with comment period (74 FR 61751) under the CY 2011 PFS to full implementation of the PPIS data for the CY 2013 PFS PE RVUs, we continue to remain interested in the thoughts of stakeholders regarding the MedPAC comment that "CMS should consider alternatives to collecting specialty-specific cost data or options to decrease the reliance on such data." More specifically, we encourage stakeholders to contact us at any time if they encounter additional information to share,

develop further ideas or analyses that could inform our ongoing consideration of physicians' practice expenses, or otherwise would like to discuss this topic further as part of an open dialogue with us. While to date, no stakeholders have presented a comprehensive overall alternative methodology, we remain interested in potential novel or refined approaches. We also continue to welcome more limited suggestions for improvements to our current PE methodology or future practice expense information collection activities.

g. PE RVU Methodology

For a more detailed description of the PE RVU methodology, we refer readers to the CY 2010 PFS final rule with comment period with comment period (74 FR 61745 through 61746).

(1) Setup File

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

(2) Calculate the Direct Cost PE RVUs

Sum the costs of each direct input.

Step 1: Sum the direct costs of the inputs for each service.

Apply a scaling adjustment to the direct inputs.

Step 2: Calculate the current aggregate pool of direct PE costs. This is the product of the current aggregate PE (aggregate direct and indirect) RVUs, the CF, and the average direct PE percentage from the survey data.

Step 3: Calculate the aggregate pool of direct costs. This is the sum of the product of the direct costs for each service from Step 1 and the utilization data for that service.

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

Step 5: Convert the results of Step 4 to an RVU scale for each service. To do this, divide the results of Step 4 by the CF. Note that the actual value of the CF used in this calculation does not influence the final direct cost PE RVUs, as long as the same CF is used in Step 2 and Step 5. Different CFs will result in different direct PE scaling factors, but this has no effect on the final direct cost PE RVUs since changes in the CFs and changes in the associated direct scaling factors offset one another.

(3) Create the Indirect Cost PE RVUs

Create indirect allocators.

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

Step 7: Calculate direct and indirect PE percentages at the service level by taking a weighted average of the results of Step 6 for the specialties that furnish the service. Note that for services with TCs and PCs, the direct and indirect percentages for a given service do not vary by the PC, TC, and global components.

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

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

There are two situations where this formula is modified:

- If the service is a global service (that is, a service with global, professional, and technical components), then the indirect allocator is: indirect percentage (direct PE RVUs/direct percentage) + clinical PE RVUs + work RVUs.
- If the clinical labor PE RVUs exceed the work RVUs (and the service is not a global service), then the indirect allocator is: indirect percentage (direct PE RVUs/direct percentage) + clinical PE RVUs.

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

For presentation purposes in the examples in the Table 2, the formulas were divided into two parts for each service.

- The first part does not vary by service and is the indirect

percentage (direct PE RVUs/direct percentage).

- The second part is either the work RVUs, clinical PE RVUs, or both depending on whether the service is a global service and whether the clinical PE RVUs exceed the work RVUs (as described earlier in this step).

Apply a scaling adjustment to the indirect allocators.

Step 9: Calculate the current aggregate pool of indirect PE RVUs by multiplying the current aggregate pool of PE RVUs by the average indirect PE percentage from the survey data.

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

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

Calculate the indirect practice cost index.

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

Step 13: Using the specialty-specific indirect PE/HR data, calculate specialty-specific aggregate pools of indirect PE for all PFS services for that specialty by adding the product of the indirect PE/HR for the specialty, the

physician time for the service, and the specialty's utilization for the service across all services performed by the specialty.

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

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

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

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

(4) Calculate the Final PE RVUs

Step 18: Add the direct PE RVUs from Step 6 to the indirect PE RVUs from Step 17 and apply the final PE budget neutrality (BN) adjustment, MEI rebasing adjustment, and multiple procedure payment reduction (MPPR) adjustment.

The final PE BN adjustment is calculated by comparing the results of Step 18 (prior to the MEI rebasing and MPPR adjustments) to the current pool of PE RVUs. This final BN adjustment is required primarily because certain specialties are excluded from the PE RVU calculation for ratesetting purposes, but all specialties are included for purposes of calculating the final BN adjustment. (See "Specialties excluded from ratesetting calculation" below in this section.)

As discussed in section II.E.5. of this final rule with comment period, we are rebasing and revising the Medicare Economic Index (MEI) for CY 2011. As discussed in section II.C.4. of this final rule with comment period, section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) specifies that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. There is inherent duplication in the PE associated with those services which are frequently furnished together, so reducing PFS payment for the second and subsequent services to account for the efficiencies in multiple service sessions may be appropriate. Consistent with this provision of the ACA, we are adopting a limited expansion of the current MPPR policy for imaging services for CY 2011 and a new MPPR policy for therapy services.

(5) Setup File Information

- Specialties excluded from ratesetting calculation: For the purposes of calculating the PE RVUs, we exclude certain specialties, such as certain nonphysician practitioners paid at a percentage of the PFS and low-volume

specialties, from the calculation. These specialties are included for the purposes of calculating the BN adjustment. They are displayed in Table 1.

TABLE 1: Specialties Excluded from Ratesetting Calculation

Specialty Code	Specialty Description
42	Certified nurse midwife
49	Ambulatory surgical center
50	Nurse practitioner
51	Medical supply company with certified orthotist
52	Medical supply company with certified prosthetist
53	Medical supply company with certified prosthetist-orthotist
54	Medical supply company not included in 51, 52, or 53.
55	Individual certified orthotist
56	Individual certified prosthestist
57	Individual certified prosthetist-orthotist
58	Individuals not included in 55, 56, or 57
59	Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc.
60	Public health or welfare agencies
61	Voluntary health or charitable agencies
73	Mass immunization roster biller
74	Radiation therapy centers
87	All other suppliers (e.g., drug and department stores)
88	Unknown supplier/provider specialty
89	Certified clinical nurse specialist
95	Competitive Acquisition Program (CAP) Vendor
96	Optician
A0	Hospital
A1	SNF
A2	Intermediate care nursing facility
A3	Nursing facility, other
A4	HHA
A5	Pharmacy
A6	Medical supply company with respiratory therapist
A7	Department store
1	Supplier of oxygen and/or oxygen related equipment
2	Pedorthic personnel
3	Medical supply company with pedorthic personnel

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

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

- Identify professional and technical services not identified under the usual TC and 26 modifiers: Flag the services that are PC and TC services, but do not use TC and 26 modifiers (for example, electrocardiograms). This flag associates the PC and TC with the associated global code for use in creating the indirect PE RVUs. For example, the professional service, CPT code 93010 (Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only), is associated with the global service, CPT code 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report).

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

- Work RVUs: The setup file contains the work RVUs from this final rule with comment period.

(6) Equipment Cost Per Minute

The equipment cost per minute is calculated as:

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

Where:

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

usage = equipment utilization assumption; 0.75 for certain expensive diagnostic imaging equipment (see 74 FR 61753 through 61755 and section II.A.3. of this final rule with comment period) and 0.5 for others.

price = price of the particular piece of equipment.

interest rate = 0.11.

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

maintenance = factor for maintenance; 0.05.

Note: The use of any particular conversion factor (CF) in Table 2 to illustrate the PE calculation has no effect on the resulting RVUs.

TABLE 2: Calculation of PE RVUs under Methodology for Selected Codes

	Step	Source	Formula	99213 Office visit, est Nonfacility	33533 CABG, arterial, single facility	71020 Chest x-ray Nonfacility	71020-TC Chest x-ray Nonfacility	71020-26 Chest x-ray Nonfacility	93000 ECG, complete Nonfacility	93005 ECG, tracing Nonfacility	93010 ECG, report Nonfacility
(1) Labor cost (lab)	Step 1	AMA		13.32	77.52	5.74	5.74	0.00	6.12	6.12	0.00
(2) Supply cost (sup)	Step 1	AMA		2.98	7.34	3.39	3.39	0.00	1.19	1.19	0.00
(3) Equipment cost (eqp)	Step 1	AMA		0.19	0.65	8.17	8.17	0.00	0.12	0.12	0.00
(4) Direct cost (dir)	Step 1		=(1)+(2)+(3)	16.50	85.51	17.31	17.31	0.00	7.43	7.43	0.00
(5) Direct adjustment (dir adj)	Steps 2-4	See footnote*		0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
(6) Adjusted labor	Steps 2-4	=Lab * Dir adj	=(1)*(5)	6.68	38.87	2.88	2.88	0.00	3.07	3.07	0.00
(7) Adjusted supplies	Steps 2-4	= Sup * Dir adj	=(2)*(5)	1.50	3.68	1.70	1.70	0.00	0.60	0.60	0.00
(8) Adjusted equipment	Steps 2-4	= Eqp * Dir adj	=(3)*(5)	0.10	0.33	4.10	4.10	0.00	0.06	0.06	0.00
(9) Adjusted direct	Steps 2-4		=(6)+(7)+(8)	8.27	42.87	8.68	8.68	0.00	3.73	3.73	0.00
(10) Conversion factor (CF)	Step 5	PFS		36.87	36.87	36.87	36.87	36.87	36.87	36.87	36.87
(11) Adj labor cost converted	Step 5	=(Lab * Dir adj)/CF	=(6)/(10)	0.18	1.05	0.08	0.08	0.00	0.08	0.08	0.00
(12) Adj supply cost converted	Step 5	=(Sup * Dir adj)/CF	=(7)/(10)	0.04	0.10	0.05	0.05	0.00	0.02	0.02	0.00
(13) Adj equipment cost converted	Step 5	=(Eqp * Dir adj)/CF	=(8)/(10)	0.00	0.01	0.11	0.11	0.00	0.00	0.00	0.00
(14) Adj. direct cost converted	Step 5		=(11)+(12)+(13)	0.22	1.16	0.24	0.24	0.00	0.10	0.10	0.00
(15) Work RVUs	Setup File	PFS		0.97	33.75	0.22	0.00	0.22	0.17	0.00	0.17
(16) Dir pct	Steps 6,7	Surveys		0.26	0.18	0.29	0.29	0.29	0.29	0.29	0.29
(17) Ind pct	Steps 6,7	Surveys		0.74	0.82	0.71	0.71	0.71	0.71	0.71	0.71
(18) Ind alloc formula (1st part)	Step 8	See Step 8		((14)/(16)) * (17)	((14)/(16)) * (17)	((14)/(16)) * (17)	((14)/(16)) * (17)	((14)/(16)) * (17)	((14)/(16)) * (17)	((14)/(16)) * (17)	((14)/(16)) * (17)
(19) Ind alloc (1st part)	Step 8		See (18)	0.65	5.29	0.58	0.58	0.00	0.25	0.25	0.00
(20) Ind alloc formulas (2nd part)	Step 8	See Step 8		(15)	(15)	(15)+(11)	(11)	(15)	(15)+(11)	(11)	(15)
(21) Ind alloc (2nd part)	Step 8		See (20)	0.97	33.75	0.30	0.08	0.22	0.25	0.08	0.17
(22) Indirect allocator (1st + 2nd)	Step 8		=(19)+(21)	1.62	39.04	0.88	0.66	0.22	0.50	0.33	0.17
(23) Indirect adjustment (ind adj)	Steps 9-11	See footnote**		0.37	0.37	0.37	0.37	0.37	0.37	0.37	0.37
(24) Adjusted indirect allocator	Steps 9-11	=Ind alloc * ind adj		0.60	14.47	0.33	0.24	0.08	0.19	0.12	0.06
(25) Ind. practice cost index (IPCI)	Steps 12-16	See Steps 12 - 16		1.11	0.83	0.90	0.90	0.90	0.92	0.92	0.92

	Step	Source	Formula	99213 Office visit, est Nonfacility	33533 CABG, arterial, single facility	71020 Chest x-ray Nonfacility	71020-TC Chest x-ray Nonfacility	71020-26 Chest x-ray Nonfacility	93000 ECG, complete Nonfacility	93005 ECG, tracing Nonfacility	93010 ECG, report Nonfacility
(26) Adjusted indirect	Step 17	= Adj ind alloc * IPCI	=(24) * (25)	0.67	12.04	0.29	0.22	0.07	0.17	0.11	0.06
(27) MEI rebasing adjustment	Step 18	PFS		1.18	1.18	1.18	1.18	1.18	1.18	1.18	1.18
(28) MPPR adjustments	Step 18	PFS		1.01	1.01	1.01	1.01	1.01	1.01	1.01	1.01
(29) PE RVU	Step 18	=(Adj dir + Adj ind) * budn * MEI adj * MPPR adj	=((14)+(26)) * budn * (27) * (28)	1.06	15.68	0.63	0.54	0.09	0.32	0.25	0.07

Note: PE RVUs in Table 2, row 29, may not match the values in Addendum B due to rounding.
* The direct adj = [current pe rvus * CF * avg dir pct]/[sum direct inputs] = [Step 2]/[Step 3]
** The indirect adj = [current pe rvus * avg ind pct]/[sum of ind allocators] = [Step 9]/[Step 10]

3. PE Revisions for CY 2011

a. Equipment Utilization Rate

As part of the PE methodology associated with the allocation of equipment costs for calculating PE RVUs, we currently use an equipment utilization rate assumption of 50 percent for most equipment, with the exception of expensive diagnostic imaging equipment (which is equipment priced at over $1 million, for example, computed tomography (CT) and magnetic resonance imaging (MRI) scanners), for which we adopted a 90 percent utilization rate assumption and provided for a 4-year transition beginning in CY 2010 (74 FR 61755). Therefore, CY 2010 is the first transitional payment year. Payment is made in CY 2010 for the diagnostic services listed in Table 3 (those that include expensive diagnostic imaging equipment in their PE inputs) of the CY 2011 PFS proposed rule (75 FR 40054) based on 25 percent of the new PE RVUs and 75 percent of the prior PE RVUs for those services.

Section 1848(b)(4)(C) of the Act (as added by section 3135(a) of the ACA) requires that with respect to fee schedules established for CY 2011 and subsequent years, in the methodology for determining PE RVUs for expensive diagnostic imaging equipment under the CY 2010 PFS final rule with comment period, the Secretary shall use a 75 percent assumption instead of the utilization rates otherwise established in that rule. The provision also requires that the reduced expenditures attributable to this change in the utilization rate for CY 2011 and subsequent years shall not be taken into account when applying the budget neutrality limitation on annual adjustments described in section 1848(c)(2)(B)(ii)(II) of the Act.

As a result, the 75 percent equipment utilization rate assumption will be applied to

expensive diagnostic imaging equipment in a non-budget neutral manner for CY 2011, and the resulting changes to PE RVUs will not be transitioned over a period of years. We will apply the 75 percent utilization rate assumption in CY 2011 to all of the services to which we currently apply the transitional 90 percent equipment utilization rate assumption in CY 2010. These services are listed in a file on the CMS Web site that is posted under downloads for the CY 2010 PFS final rule with comment period at http://www.cms.gov/physicianfeesched/downloads/CODES_SUBJECT_TO_90PCT_USAGE_RATE.zip. These codes are also displayed in Table 3 at the end of this section.

Comment: Several commenters argued that the 75 percent utilization rate assumption should not be applied because of the imprecise data on which the policy was based. The commenters explained that based on an independent survey, actual equipment utilization rates are close to 50 percent. In addition, the commenters postulated that rural imaging centers would be adversely affected by the change due to lower equipment utilization rates than non-rural centers. The commenters requested that CMS base equipment utilization rate assumptions on actual utilization data rather than assumptions.

Several other commenters supported the implementation of the 75 percent utilization rate assumption, and MedPAC recommended that CMS explore increasing the equipment utilization rate assumption for diagnostic imaging equipment that costs less than $1 million. Finally, several commenters clarified that certain procedures were not subject to the provision, including nuclear cardiology services and therapeutic interventional radiology.

Response: Section 1848(b)(4)(C) of the Act (as added by section 3135(a) of the ACA) requires that with respect to fee schedules established for CY 2011 and subsequent

years, in the methodology for determining PE RVUs for expensive diagnostic imaging equipment under the CY 2010 PFS final rule with comment period, the Secretary shall use a 75 percent assumption instead of the utilization rates otherwise established in that rule. We acknowledge that further data regarding actual equipment utilization in the physician's office setting may be informative, but our use of such data to set the equipment utilization rate assumption for expensive diagnostic imaging equipment at a value other than 75 percent would require a statutory change.

We did not propose to expand the 75 percent equipment utilization rate assumption for CY 2011 to other procedures beyond those that use CT and MRI scanners as listed in Table 4 of the CY 2011 PFS proposed rule (75 FR 40055) and Table 3 at the end of this section. Any future changes in equipment utilization rate assumptions, including any expansion of the 75 percent equipment utilization rate assumption to additional expensive diagnostic imaging equipment, would be made through the annual PFS notice and comment rulemaking cycle. Furthermore, any changes in equipment utilization rate assumptions for less costly diagnostic imaging equipment (less than $1 million) or for therapeutic imaging or other equipment would not be subject to the statutory provision that specifies a 75 percent assumption. We note that we are constantly reassessing our methodology for developing the PE RVUs and would propose any changes to the equipment utilization rate assumptions for these types of equipment through the annual PFS rulemaking cycle if we determine such changes could be appropriate.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal without modification. The 75 percent equipment utilization rate

assumption will be applied to expensive diagnostic imaging equipment in a non-budget neutral manner for CY 2011, and the changes to the PE RVUs will not be transitioned over a period of years. We will apply the 75 percent utilization rate assumption in CY 2011 to all of the services to which we currently apply the transitional 90 percent utilization rate assumption in CY 2010. The CY 2011 codes are displayed in Table 3 at the end of this section that lists all the codes to which the 75 percent equipment utilization rate assumption applies for CY 2011. In addition, the codes subject to this policy are posted under the downloads for the CY 2011 PFS final rule with comment period on the CMS Web site at http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage.

Additionally, for CY 2011, we proposed to expand the list of services to which the higher equipment utilization rate assumption applies to include all other diagnostic imaging services that utilize similar expensive CT and MRI scanners. The additional 24 CPT codes (listed in Table 4 of the CY 2011 PFS proposed rule (75 FR 40055)) to which we proposed to apply the 75 percent equipment utilization rate assumption also have expensive diagnostic imaging equipment (priced at over $1 million) included in their PE inputs. These services are predominantly diagnostic computed tomographic angiography (CTA) and magnetic resonance angiography (MRA) procedures that include similar expensive CT and MRI scanners in their direct PE inputs. We indicated in the CY 2010 PFS final rule with comment period (74 FR 61754) that we were persuaded by PPIS data on angiography that the extrapolation of MRI and CT data (and their higher equipment utilization rate) may be inappropriate. However, this reference was limited to those procedures that include an angiography room in the direct PE inputs, such as CPT code

93510 (Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous). In contrast, CTA and MRA procedures include a CT room or MRI room, respectively, in the direct PE inputs, and the PPIS data confirm that a higher assumed utilization rate than 50 percent would be appropriate. The PPIS angiography room data that reflected a 56 percent equipment utilization rate would not specifically apply to CTA and MRA procedures. Thus, on further review, we believe it is appropriate to include CTA and MRA procedures in the list of procedures for which we assume a 75 percent equipment utilization rate, and we proposed to do so beginning in CY 2011.

Consistent with section 1848(c)(2)(B)(v)(III) of the Act (as amended by section 3135 of the ACA), the reduced expenditures attributable to this change in the utilization rate assumption applicable to CY 2011 shall not be taken into account when applying the budget neutrality limitation on annual adjustments described in section 1848(c)(2)(B)(ii)(II) of the Act.

As provided in the CY 2010 PFS final rule with comment period (74 FR 61751), CY 2011 is the second year of the 4-year transition to the PE RVUs calculated using the PPIS data. We note that the reductions in the PE RVUs for expensive diagnostic imaging equipment attributable to the change to an equipment utilization rate assumption of 75 percent for CY 2011 are not subject to the transition.

Comment: Several commenters urged CMS not to finalize the proposed expansion of the list of procedures to which the 75 percent equipment utilization rate assumption would apply, pending further evaluation of equipment utilization data. While noting the statutory requirement of section 1848(b)(4)(C) of the Act (as added by section

3135(a) of the ACA), the commenters believe that CMS is not required to add additional services to the policy for CY 2011. Other commenters, including MedPAC, supported the proposed increase in the equipment utilization rate assumption from 50 percent to 75 percent for the 24 additional services that use diagnostic imaging equipment priced at over $1 million.

Response: No commenters presented a rationale for not including the proposed 24 additional services to the 75 percent equipment utilization rate assumption, when the proposed additions use the same diagnostic CT or MRI imaging equipment as the current codes to which the policy applies. We note that the 90 percent equipment utilization rate assumption that we finalized in the CY 2010 PFS final rule with comment period (74 FR 61755) applies to CT and MRI scanners when used as diagnostic imaging equipment, one of these two pieces of equipment is listed as a direct PE input for the proposed MRA and CTA services, and no commenters recommended that we remove the CT or MRI equipment inputs from the additional codes. Therefore, we continue to believe that it is appropriate to apply the 75 percent equipment utilization rate assumption beginning in CY 2011 to MRA and CTA procedures, as we proposed.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to include CTA and MRA procedures in the 75 percent equipment utilization rate assumption policy because they include expensive CT and MRI scanners that cost more than $1 million as direct PE inputs for these diagnostic imaging procedures. We are modifying our proposal, however, and will not include CPT code 77079 (Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)) because, upon further analysis for this final

rule with comment period, we noted that the procedure does not include a CT room in its direct PE inputs.

For CY 2011, we are also adding to the 75 percent equipment utilization rate assumption policy three new CY 2011 CPT codes for diagnostic imaging procedures that include a CT room in their direct PE inputs, specifically CPT codes 74176 (Computed tomography, abdomen and pelvis; without contrast material); 74177 (Computed tomography, abdomen and pelvis; with contrast material); and 74178 (Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions). As new codes for CY 2011, the work, PE, and malpractice RVUs for these CPT codes that are displayed in Addendum C to this final rule with comment period are interim final values that are open to comment. Similarly, the assignment of the 75 percent equipment utilization rate assumption to these CPT codes, which contributes to the development of their PE RVUs, is being made on an interim final basis. We refer readers to section V.C. of this final rule with comment period for further discussion of the establishment of interim final RVUs for CY 2011 new and revised codes.

As a result of the CY 2011 changes, the 75 percent equipment utilization rate assumption will be applied to all diagnostic imaging procedures with nationally established rates under the PFS in CY 2011 and which include a CT or MRI scanner in their direct PE, consistent with the statutory requirement of section 1848(b)(4)(C) of the Act (as added by section 3135(a) of the ACA).

Consistent with section 1848(c)(2)(B)(v)(III) of the Act (as amended by section 3135 of the ACA), the reduced expenditures attributable to the change in the utilization

rate assumption applicable to CY 2011 (from the CY 2011 transitional rate for the 90 percent equipment utilization rate assumption for expensive diagnostic imaging equipment costing over $1 million (CT and MRI scanners) that would have applied under the final policy established in the CY 2010 PFS final rule with comment period to the 75 percent rate required under section 1848(b)(4)(C) of the Act) shall not be taken into account when applying the budget neutrality limitation on annual adjustments described in section 1848(c)(2)(B)(ii)(II) of the Act.

Table 3 below lists the codes to which the 75 percent equipment utilization rate assumption applies for CY 2011. The codes subject to this policy are also posted under the downloads for the CY 2011 PFS final rule with comment period on the CMS Web site at http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage.

Table 3: FINAL CPT CODES SUBJECT TO 75 PERCENT EQUIPMENT UTILIZATION RATE ASSUMPTION IN CY 2011

CPT Code	Short Descriptor
70336	Mri, temporomandibular joint(s)
70450	Ct head/brain w/o dye
70460	Ct head/brain w/ dye
70470	Ct head/brain w/o & w/ dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/ dye
70482	Ct orbit/ear/fossa w/o & w/ dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/ dye
70488	Ct maxillofacial w/o & w/ dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/ dye
70492	Ct soft tissue neck w/o & w/ dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/ dye
70543	Mri orbit/face/neck w/o & w/dye
70544	Mr angiography head w/o dye

CPT Code	Short Descriptor
70545	Mr angiography head w/dye
70546	Mr angiography head w/o & w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiography neck w/o & w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70554	Fmri brain by tech
71250	Ct thorax w/o dye
71260	Ct thorax w/ dye
71270	Ct thorax w/o & w/ dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/ dye
71552	Mri chest w/o & w/ dye
71555	Mri angio chest w/ or w/o dye
72125	CT neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spone w/o & w/dye
72191	Ct angiography, pelv w/o & w/ dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/ dye
72194	Ct pelvis w/o & w/ dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/ dye
72197	Mri pelvis w/o &w/ dye

CPT Code	Short Descriptor
72198	Mri angio pelvis w/ or w/o dye
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct upper extremity w/o & w/dye
73206	Ct angio upper extr w/o & w/dye
73218	Mri upper extr w/o dye
73219	Mri upper extr w/dye
73220	Mri upper extremity w/o & w/dye
73221	Mri joint upper extr w/o dye
73222	Mri joint upper extr w/dye
73223	Mri joint upper extr w/o & w/dye
73225	Mr angio upr extr w/o & w/dye
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lower extremity w/o & w/dye
73706	Ct angio lower ext w/o & w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lower ext w/ & w/o dye
73721	Mri joint of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint of lwr extr w/o & w/dye
73725	Mr angio lower ext w or w/o dye
74150	Ct abdomen w/o dye
74160	Ct abdomen w/ dye
74170	Ct abdomen w/o & w/ dye
74175	Ct angio abdom w/o & w/dye
74176	Ct abd & pelvis w/o contrast
74177	Ct abdomen&pelvis w/contrast
74178	Ct abd & pelv 1+ section/regns
74181	Mri abdomen w/o dye
74182	Mri abdomen w/ dye
74183	Mri abdomen w/o and w/ dye
74185	Mri angio, abdom w/ or w/o dye
74261	Ct colonography, w/o dye
74262	Ct colonography, w/ dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
75561	Cardiac mri for morph w/dye
75563	Cardiac mri w/stress img & dye
75565	Card mri vel flw map add-on
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image

CPT Code	Short Descriptor
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75635	Ct angio abdominal arteries
76380	CAT scan follow up study
77058	Mri, one breast
77059	Mri, broth breasts
77078	Ct bone density, axial
77084	Magnetic image, bone marrow

b. HCPCS Code-Specific PE Issues

In this section, we discuss other specific CY 2011 proposals and changes related to direct PE inputs. The changes that follow were proposed in the CY 2011 PFS proposed rule and included in the proposed CY 2011 direct PE database, which is available on the CMS Web site under the downloads for the CY 2011 PFS proposed rule at http://www.cms.gov/PhysicianFeeSched/. The final direct PE database for CY 2011 is available under the downloads for the CY 2011 PFS final rule with comment period at the same location.

(1) Biohazard Bags

We identified 22 codes for which the supply item "biohazard bag" (SM004) is currently considered a direct PE input. The item is already properly accounted for in the indirect PE because it is not attributable to an individual patient service. Therefore, we proposed to remove the biohazard bag from the CY 2011 direct PE database and noted that the changes in direct PE inputs for the associated services were reflected in the proposed CY 2011 direct PE database.

We did not receive any public comments on our proposal to remove biohazard bags as a supply input. Therefore, we are finalizing our CY 2011 proposal to remove the

supply item as a direct PE input for the associated services. This change is reflected in the final CY 2011 direct PE database.

(2) PE Inputs for Professional Component (PC) Only and Technical Component (TC) Only Codes Summing to Global Only Codes

In the case of certain diagnostic tests, different but related CPT codes are used to describe global, professional, and technical components of a service. These codes are unlike the majority of other diagnostic test CPT codes where modifiers may be used in billing a single CPT code in order to differentiate professional and technical components. When different but related CPT codes are used to report the components of these services, the different CPT codes are referred to as "global only," "professional component (PC) only," and "technical component (TC) only" codes. Medicare payment systems are programmed to ensure that the PE RVUs for global only codes equal the sum of the PE RVUs for the PC and TC only codes. However, it came to our attention that the direct PE inputs for certain global only codes do not reflect the appropriate summation of their related TC only and PC only component code PE inputs as they appear in the direct PE database. While the PFS payment calculations have been programmed to apply the correct PE RVUs for the global only code based on a summation of component code PE RVUs, the direct PE database has reflected incorrect inputs that are overridden by the payment system. Therefore, we proposed to correct the direct PE inputs for the global only codes so that the inputs reflect the appropriate summing of the PE inputs for the associated PC only and TC only codes. The proposed CY 2011 direct PE database included PE corrections to the 14 CPT codes listed in Table 4.

TABLE 4: Groups of Related CPT Codes with Proposed Changes to PE Inputs so that Inputs for Professional Component (PC) Only and Technical Component (TC) Only Codes Sum to Global Only Codes

CPT Code	Long Descriptor
93224	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation
93225	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; recording (includes connection, recording, disconnection)
93226	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; scanning analysis with report
93230	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; including recording, microprocessor-based analysis with report, physician review and interpretation
93231	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; recording (includes connection, recording, and disconnection
93232	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; microprocessor-based analysis with report
93268	Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission, physician review and interpretation
93270	Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; recording (includes connection, recording, and disconnection)
93271	Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmissions, and analysis
93720	Plethysmography, total body; with interpretation and report
93721	Plethysmography, total body; tracing only, without interpretation and report
93784	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report
93786	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only
93788	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report

Comment: A number of commenters expressed support for CMS' proposal to ensure that the direct PE inputs for certain global only codes reflect the appropriate summation of their related TC only and PC only component code PE inputs as they

appear in the direct PE database. One commenter questioned why the prior clinical labor time for the global only codes in the PE database did not match the direct PE inputs that must have been used in CY 2010 to generate the PE RVUs, given that the PE RVUs for the global only codes were the sum of the PE RVUs for the component codes.

Response: We appreciate the commenters' support for the proposal, and we are finalizing our correction of the direct PE inputs for the global only codes so that the inputs reflect the appropriate summing of the PE inputs for the associated PC only and TC only codes. In response to the commenter who questioned why prior clinical labor time for the global only codes in the PE database did not match the direct PE inputs that must have been used to generate the PE RVUs for payment, we note that Medicare payment systems are programmed to ensure that the PE RVUs for global only codes equal the sum of the PE RVUs for the PC and TC only codes. Therefore, rather than relying upon the direct PE inputs for the global only codes to determine the PE RVUs, which would have not resulted in values that equaled the summation of the component code PE RUVs, our PFS system was programmed so that the PE RVUs for the global only codes were set as the sum of the PE RVUS for the component codes. We expect the corrections to the inputs as incorporated in the direct PE database to alleviate any confusion caused by the prior inclusion of inputs associated with the global only codes that were not actually used to generate the PE RVUs.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to correct the direct PE inputs for the global only codes so that the inputs reflect the appropriate summing of the PE inputs for the associated PC only and TC only codes. The final CY 2011 direct PE database includes PE corrections to the 14

CPT codes listed in Table 4.

(3) Equipment Time Inputs for Certain Diagnostic Tests

In the CY 2011 PFS proposed rule (75 FR 40056), we stated that we had recently identified equipment time PE inputs that we believed were incorrect for four CPT codes associated with certain diagnostic tests (each is displayed in Table 4):

- CPT code 93225 is the TC only code that includes the connection, recording, and disconnection of the holter monitor (CMS Equipment Code EQ127) used in 24-hour continuous electrocardiographic rhythm derived monitoring. The CY 2010 equipment time input for the holter monitor is 42 minutes, which parallels the intra-service clinical labor input time for the CPT code. However, we believed that the equipment time should reflect the 24 hours of continuous monitoring in which the device is used exclusively by the patient. Therefore, we proposed to change the monitor equipment time for CPT code 93225 to 1440 minutes, the number of minutes in 24 hours.

- CPT code 93226 is the TC only code that includes the scanning analysis with report. We believed that the number of minutes the monitor (CMS Equipment Code EQ127) is used in this service should parallel the intra-service clinical labor input time of 52 minutes during which the monitor is in use, instead of the CY 2010 equipment time of 1440 minutes, because this code does not represent 24 hours of device use. Therefore, we proposed to change the monitor equipment time for CPT code 93226 to 52 minutes.

- CPT 93224 is the global only code that includes the connection, recording, and disconnection of the monitor (CMS Equipment Code EQ127) and the scanning analysis with report, as well as the physician review and interpretation. We proposed direct PE

inputs for CPT code 93224 to include 1492 total minutes of monitor time (which represents the total monitor time we proposed for CPT codes 93225 and 93226).

- CPT code 93788 is the TC only code that describes the scanning analysis with report for ambulatory blood pressure monitoring. We believed that the equipment time input for the blood pressure monitor should parallel the 10 minutes of clinical labor input for the CPT code since that is the time during which the monitor is in use. In CY 2010, the equipment time input for the monitor is 1440 minutes, which is appropriate only for CPT code 93786, the code that describes the 24 hours of ambulatory blood pressure monitoring recording. Therefore, we proposed to correct the equipment time input for the ambulatory blood pressure monitor in CPT code 93788 to 10 minutes.

- CPT code 93784 is the global only code that includes the recording, the scanning analysis with report, and the physician interpretation and report for ambulatory blood pressure monitoring. We proposed to establish the direct PE inputs for CPT code 93784 to include 1450 total minutes of time for the ambulatory blood pressure monitor (which represents the proposed total amount of monitor time included in CPT codes 93786 and 93788).

The proposed CY 2011 direct PE database reflected these changes.

Comment: Several commenters pointed out that the prior assignment of the 1440 minutes of holter monitor equipment time to CPT code 93226 stemmed from discussions between CMS and provider groups that resulted in PE policies initially implemented in CY 2007 (72 FR 18910). The commenters recommended that CMS retain the 1440 minutes of holter monitor equipment for CPT code 93326, consistent with current policy, rather than reassign the 1440 minutes of holter monitor equipment time as proposed to

CPT code 93226.

Response: We agree with the commenters that it would be most appropriate to maintain our established policy for the equipment times associated with CPT codes 93225 and 93226, based upon further description of the direct practice expenses experienced by the current providers that typically furnish these services to Medicare beneficiaries. Therefore, we are not adopting the equipment time changes that we proposed for CPT codes 93225 and 93226. However, we are revising the direct PE inputs for CPT code 93224, a global only code, to include the total equipment time for the holter monitor that is incorporated in component codes CPT codes 93225 and 93226, as discussed in section II.A.3.b.(2). of this final rule with comment period. The PE inputs for CPT code 93224 did not previously correctly reflect the summation of the direct PE inputs for the component codes.

Comment: One commenter supported the proposed changes to the direct PE inputs for CPT codes 93784 through 93788. However, the commenter was confused about why 1440 minutes of equipment time were assigned to CPT code 93786, which the commenter stated is used only for the technical component of scanning the data rather than recording the data.

Response: As we stated in our proposal, we believe that the direct PE inputs for CPT code 93786 are currently correct because the code describes the recording of the data. We believe that the commenter may have inadvertently referred to CPT code 93786 instead of CPT code 93788, which is the technical component code that describes the scanning rather than the recording of the data. We proposed to remove the 1440 minutes associated with the scanning analysis from the inputs for CPT code 93788, not CPT code

93786.

After consideration of the public comments we received, we are finalizing our CY 2011 proposals to change the ambulatory blood pressure monitor equipment times included as direct PE inputs for CPT codes 938784 and 93788, while maintaining the current equipment time direct PE input for CPT code 93786. However, we are not finalizing our proposals to change the holter monitor equipment times included as direct PE inputs for CPT codes 93225 and 93226, but instead will maintain the inputs for CPT codes 93225 and 93226 as they were for CY 2010. We are also revising the direct PE inputs for CPT code 93224 to include the total equipment time for the holter monitor that is incorporated in CPT codes 93225 and 93226. The equipment times in the final CY 2011 direct PE database reflect these decisions.

(4) Cobalt-57 Flood Source

Stakeholders requested that CMS reevaluate the useful life of the Cobalt-57 flood source (CMS Equipment Code ER001), given their estimate of approximately 271 days for the source's half-life. The CY 2010 useful life input in the CY 2010 direct PE database for the Colbalt-57 flood source is 5 years. Using publicly available catalogs, we found that the Cobalt-57 flood source is marketed with a useful life of 2 years. Therefore, we proposed to change the useful life input from the current 5 years to 2 years. The Cobalt-57 flood source was included with the revised useful life input for 96 HCPCS codes in the proposed CY 2011 direct PE database.

Comment: One commenter supported the proposal to change the useful life input from 5 years to 2 years for the Cobalt-57 flood source.

Response: We appreciate the commenter's support for our proposal.

After consideration of the public comment we received, we are finalizing our CY 2011 proposal to change the useful life input in the direct PE database for the Cobalt-57 flood source from 5 years to 2 years. This change is included in the final CY 2011 direct PE database.

(5) Venom Immunotherapy

One stakeholder provided updated price information for the venoms used for the five venom immunology CPT codes, specifically 95145(Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom); 95146 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms); 95147 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms); 95148 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms); 95149 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms).

In the CY 2004 PFS final rule with comment period (68 FR 63206), we adopted a pricing methodology that utilizes the average price of a 1 milliliter dose of venom and adds that price per dose as direct PE inputs for CPT codes 95145 and 95146. When a patient requires three stinging insect venoms, as for CPT code 95147, the price input for a 3-vespid mix is used. This 3-vespid mix price is also used to value CPT codes 95148

(four venoms) and 96149 (five venoms), with the single venom price added once to CPT code 97148 and twice to CPT code 97149.

As requested by the stakeholder, we updated the price inputs for the 1-milliliter dose of venom to $16.67 and for the 3-vespid mix to $30.22 in the proposed CY 2011 direct PE database.

Comment: One commenter supported the proposal to update the price inputs for the venoms used for venom immunotherapy.

Response: We appreciate the information provided by stakeholders regarding the price inputs for venom immunotherapy supplies, consistent with our interest in utilizing accurate market prices as the direct PE inputs for these items.

After consideration of the public comment we received, we are finalizing our CY 2011 proposals to update the price inputs for the 1-milliliter dose of venom to $16.67 and for the 3-vespid mix to $30.22 in the CY 2011 direct PE database. These changes are included in the final CY 2011 direct PE database.

(6) Equipment Redundancy

Stakeholders recently brought to our attention that the ECG, 3-channel (with SpO2, NIBP, temp, resp) (CMS Equipment Code EQ011) incorporates all of the functionality of the pulse oximeter with printer (CMS Equipment Code EQ211). Therefore, in HCPCS codes where CMS Equipment Code EQ011 is present, CMS Equipment Code EQ211 is redundant. On this basis, we proposed to remove the pulse oximeter with printer (CMS Equipment Code EQ211) as an input for the 118 codes that also contain the ECG, 3-channel (with SpO2, NIBP, temp, resp) (CMS Equipment Code EQ011). We made these adjustments in the proposed CY 2011 direct PE database.

We received no public comments regarding this proposal to address the pulse oximeter equipment redundancy. Therefore we are finalizing our CY 2011 proposal without modification. We have made these adjustments in the final CY 2011 direct PE database.

(7) Equipment Duplication

We recently identified a number of CPT codes with duplicate equipment inputs in the PE database. We proposed to remove the duplicate equipment items and modified the proposed CY 2011 direct PE database accordingly as detailed in Table 5.

TABLE 5: CPT Codes with Proposed Removal of Duplicate Equipment Items in the Direct PE Database

CPT Code		CMS Equipment Code for Duplicate Equipment	Description of Equipment
19302	P-mastectomy w/ln removal	EF014	light, surgical
19361	Breast reconstr w/lat flap	ED005	camera, digital system, 12 megapixel (medical grade)
		EF031	table, power
		EQ168	light, exam
44157	Colectomy w/ileoanal anast	EF031	table, power
		EQ168	light, exam
44158	Colectomy w/neo-rectum pouch	EF031	table, power
		EQ168	light, exam
56440	Surgery for vulva lesion	EF031	table, power
		EQ170	light, fiberoptic headlight w-source
57296	Revise vag graft, open abd	EF031	table, power
		EQ170	light, fiberoptic headlight w-source
58263	Vag hyst w/t/o & vag repair	EF031	table, power
59610	Vbac delivery	EF031	table, power
67228	Treatment of retinal lesion	EL005	lane, exam (oph)
		EQ230	slit lamp (Haag-Streit), dedicated to laser use
76813	Ob us nuchal meas, 1 gest	ED024	film processor, dry, laser
77371	Srs, multisource	EQ211	pulse oximeter w-printer
93540	Injection, cardiac cath	ED018	computer workstation, cardiac cath monitoring
		EL011	room, angiography
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)
		EQ032	IV infusion pump
		EQ088	contrast media warmer
		EQ211	pulse oximeter w-printer
93542	Injection for heart x-rays	ED018	computer workstation, cardiac cath monitoring
		EL011	room, angiography

CPT Code		CMS Equipment Code for Duplicate Equipment	Description of Equipment
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)
		EQ032	IV infusion pump
		EQ088	contrast media warmer
		EQ211	pulse oximeter w-printer

Comment: One commenter pointed out that the equipment duplication issue for CPT codes 93540 and 93542 is irrelevant because these codes would no longer be reported for Medicare in CY 2011. The commenter stated that the codes are being replaced by a new set of diagnostic cardiac catheterization CPT codes.

Response: We agree with the commenter's assessment that our proposal for these codes is not relevant for CY 2011 because these codes are being deleted.

Comment: One commenter reviewed the duplicate inputs and offered a correction regarding CPT code 19302 (Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy). The commenter pointed out that one of the line-items erroneously duplicated (light, surgical, EF014) for that code should have originally been applied to CPT code 19304 (Mastectomy, subcutaneous).

Response: We appreciate the commenter bringing this error to our attention and we agree with the commenter's assessment.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to remove the duplicate equipment items from the CY 2011 direct PE database as detailed in Table 5, with modification to transfer the duplicate surgical light input from CPT code 19302 to CPT code 19304. These changes are reflected in the final CY 2011 direct PE database.

(8) Establishing Overall Direct PE Supply Price Inputs Based on Unit Prices and Quantities

In the CY 2011 PFS proposed rule (75 FR 40057), we stated that we had identified minor errors in total price inputs for a number of supply items due to mathematical mistakes in multiplying the item unit price and the quantity used in particular CPT codes for the associated services. We proposed to modify the direct PE database to appropriately include the overall supply price input for a supply item as the product of the unit price and the quantity of the supply item used in the CPT code. Most of the overall supply price input changes were small, and we adjusted the proposed CY 2011 direct PE database accordingly. The CPT and Level II HCPCS codes and associated supplies for nonfacility and facility settings that were subject to these corrections are displayed in Tables 6 and 7, respectively.

Table 6: Overall Supply Price Calculation Corrections for Nonfacility Settings

CPT/ HCPCS Code	Short Descriptor	CMS Supply Code with Overall Price Corrections	Description of Supply
11952	Therapy for contour defects	SC029	needle, 18-27g
11954	Therapy for contour defects	SC029	needle, 18-27g
15820	Revision of lower eyelid	SA082	pack, ophthalmology visit (w-dilation)
15821	Revision of lower eyelid	SA082	pack, ophthalmology visit (w-dilation)
15822	Revision of upper eyelid	SA082	pack, ophthalmology visit (w-dilation)
17311	Mohs, 1 stage, h/n/hf/g	SG078	tape, surgical occlusive 1in (Blenderm)
17312	Mohs addl stage	SG078	tape, surgical occlusive 1in (Blenderm)
17313	Mohs, 1 stage, t/a/l	SG078	tape, surgical occlusive 1in (Blenderm)
17314	Mohs, addl stage, t/a/l	SG078	tape, surgical occlusive 1in (Blenderm)
21011	Exc face les sc < 2 cm	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)
21013	Exc face tum deep < 2 cm	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)
21073	Mnpj of tmj w/anesth	SG079	tape, surgical paper 1in (Micropore)
21076	Prepare face/oral prosthesis	SL047	dental stone powder
21081	Prepare face/oral prosthesis	SK024	film, dental
21310	Treatment of nose fracture	SB034	mask, surgical, with face shield
23075	Exc shoulder les sc < 3 cm	SG056	gauze, sterile 4in x 4in (10 pack uou)
		SH021	bupivacaine 0.25% inj (Marcaine)
24075	Exc arm/elbow les sc < 3 cm	SG056	gauze, sterile 4in x 4in (10 pack uou)
		SH021	bupivacaine 0.25% inj (Marcaine)
25075	Exc forearm les sc < 3 cm	SG056	gauze, sterile 4in x 4in (10 pack uou)

CPT/ HCPCS Code	Short Descriptor	CMS Supply Code with Overall Price Corrections	Description of Supply
		SH021	bupivacaine 0.25% inj (Marcaine)
26115	Exc hand les sc < 1.5 cm	SG056	gauze, sterile 4in x 4in (10 pack uou)
		SH021	bupivacaine 0.25% inj (Marcaine)
27327	Exc thigh/knee les sc < 3 cm	SG056	gauze, sterile 4in x 4in (10 pack uou)
27618	Exc leg/ankle tum < 3 cm	SG056	gauze, sterile 4in x 4in (10 pack uou)
28039	Exc foot/toe tum sc > 1.5 cm	SG056	gauze, sterile 4in x 4in (10 pack uou)
28043	Exc foot/toe tum sc < 1.5 cm	SG056	gauze, sterile 4in x 4in (10 pack uou)
28045	Exc foot/toe tum deep <1.5cm	SG056	gauze, sterile 4in x 4in (10 pack uou)
28306	Incision of metatarsal	SA048	pack, minimum multi-specialty visit
28307	Incision of metatarsal	SA048	pack, minimum multi-specialty visit
28310	Revision of big toe	SA048	pack, minimum multi-specialty visit
28312	Revision of toe	SA048	pack, minimum multi-specialty visit
28313	Repair deformity of toe	SA048	pack, minimum multi-specialty visit
28315	Removal of sesamoid bone	SA048	pack, minimum multi-specialty visit
28340	Resect enlarged toe tissue	SA048	pack, minimum multi-specialty visit
28344	Repair extra toe(s)	SA048	pack, minimum multi-specialty visit
28345	Repair webbed toe(s)	SA048	pack, minimum multi-specialty visit
28496	Treat big toe fracture	SA048	pack, minimum multi-specialty visit
28755	Fusion of big toe joint	SA048	pack, minimum multi-specialty visit
28820	Amputation of toe	SA048	pack, minimum multi-specialty visit
28890	High energy eswt, plantar f	SC051	syringe 10-12ml
29870	Knee arthroscopy, dx	SG079	tape, surgical paper 1in (Micropore)
32553	Ins mark thor for rt perq	SB034	mask, surgical, with face shield
36475	Endovenous rf, 1st vein	SC074	iv pressure infusor bag
36592	Collect blood from picc	SG050	gauze, non-sterile 2in x 2in
41530	Tongue base vol reduction	SD009	canister, suction
41805	Removal foreign body, gum	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)
41806	Removal foreign body,jawbone	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)
42107	Excision lesion, mouth roof	SD009	canister, suction
46505	Chemodenervation anal musc	SD009	canister, suction
49411	Ins mark abd/pel for rt perq	SB034	mask, surgical, with face shield
49440	Place gastrostomy tube perc	SK089	x-ray developer solution
49441	Place duod/jej tube perc	SK089	x-ray developer solution
49442	Place cecostomy tube perc	SK089	x-ray developer solution
49446	Change g-tube to g-j perc	SK089	x-ray developer solution
49450	Replace g/c tube perc	SK089	x-ray developer solution
49451	Replace duod/jej tube perc	SK089	x-ray developer solution
49452	Replace g-j tube perc	SK089	x-ray developer solution
49460	Fix g/colon tube w/device	SK089	x-ray developer solution
49465	Fluoro exam of g/colon tube	SK089	x-ray developer solution
50382	Change ureter stent, percut	SB034	mask, surgical, with face shield
50384	Remove ureter stent, percut	SB034	mask, surgical, with face shield
50385	Change stent via transureth	SB034	mask, surgical, with face shield
50386	Remove stent via transureth	SB034	mask, surgical, with face shield
50387	Change ext/int ureter stent	SB034	mask, surgical, with face shield
50389	Remove renal tube w/fluoro	SB034	mask, surgical, with face shield
51100	Drain bladder by needle	SH047	lidocaine 1%-2% inj (Xylocaine)
51101	Drain bladder by trocar/cath	SH047	lidocaine 1%-2% inj (Xylocaine)
51727	Cystometrogram w/up	SC051	syringe 10-12ml
51728	Cystometrogram w/vp	SC051	syringe 10-12ml

CPT/ HCPCS Code	Short Descriptor	CMS Supply Code with Overall Price Corrections	Description of Supply
51729	Cystometrogram w/vp&up	SC051	syringe 10-12ml
52649	Prostate laser enucleation	SA048	pack, minimum multi-specialty visit
53855	Insert prost urethral stent	SB024	gloves, sterile
59300	Episiotomy or vaginal repair	SG062	packing, gauze plain 0.25-0.50in (5 yd uou)
59812	Treatment of miscarriage	SA052	pack, post-op incision care (staple)
64490	Inj paravert f jnt c/t 1 lev	SK025	film, dry, radiographic, 8in x 10in
64493	Inj paravert f jnt l/s 1 lev	SH021	bupivacaine 0.25% inj (Marcaine)
		SK025	film, dry, radiographic, 8in x 10in
65272	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation)
65286	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation)
66250	Follow-up surgery of eye	SA082	pack, ophthalmology visit (w-dilation)
67031	Laser surgery, eye strands	SA082	pack, ophthalmology visit (w-dilation)
67105	Repair detached retina	SA082	pack, ophthalmology visit (w-dilation)
67110	Repair detached retina	SA082	pack, ophthalmology visit (w-dilation)
67120	Remove eye implant material	SA082	pack, ophthalmology visit (w-dilation)
67228	Treatment of retinal lesion	SA082	pack, ophthalmology visit (w-dilation)
67901	Repair eyelid defect	SA048	pack, minimum multi-specialty visit
75571	Ct hrt w/o dye w/ca test	SJ019	electrode adhesive disk
75572	Ct hrt w/3d image	SJ019	electrode adhesive disk
75573	Ct hrt w/3d image, congen	SJ019	electrode adhesive disk
75574	Ct angio hrt w/3d image	SJ019	electrode adhesive disk
75960	Transcath iv stent rs&i	SK034	film, x-ray 14in x 17in
76821	Middle cerebral artery echo	SM013	disinfectant, surface (Envirocide, Sanizide)
77371	Srs, multisource	SG079	tape, surgical paper 1in (Micropore)
77372	Srs, linear based	SG079	tape, surgical paper 1in (Micropore)
77373	Sbrt delivery	SG079	tape, surgical paper 1in (Micropore)
78452	Ht muscle image spect, mult	SC051	syringe 10-12ml
		SK092	x-ray fixer solution
78454	Ht musc image, planar, mult	SK092	x-ray fixer solution
88125	Forensic cytopathology	SL026	clearing agent (Histo-clear)
88355	Analysis, skeletal muscle	SK073	skin marking ink (tattoo)
		SL061	embedding paraffin
		SL078	histology freezing spray (Freeze-It)
		SL201	stain, eosin
88356	Analysis, nerve	SB023	gloves, non-sterile, nitrile
		SK073	skin marking ink (tattoo)
		SL061	embedding paraffin
		SL078	histology freezing spray (Freeze-It)
		SL108	Pipette
		SL201	stain, eosin
88365	Insitu hybridization (fish)	SF004	blade, microtome
		SL179	1.0N NaOH
		SL183	slide, organosilane coated
		SL189	ethanol, 100%
		SL190	ethanol, 70%
		SL194	Hemo-De
		SM016	eye shield, splash protection
88367	Insitu hybridization, auto	SC057	syringe 5-6ml
		SF004	blade, microtome
		SL030	cover slip, glass

CPT/ HCPCS Code	Short Descriptor	CMS Supply Code with Overall Price Corrections	Description of Supply
		SL085	label for microscope slides
		SL178	0.2N HCL
		SL179	1.0N NaOH
		SL181	pipette tips, sterile
		SL183	slide, organosilane coated
		SL189	ethanol, 100%
		SL190	ethanol, 70%
		SL191	ethanol, 85%
		SL194	Hemo-De
		SM016	eye shield, splash protection
88368	Insitu hybridization, manual	SF004	blade, microtome
		SL179	1.0N NaOH
		SL183	slide, organosilane coated
		SL189	ethanol, 100%
		SL190	ethanol, 70%
		SL194	Hemo-De
		SM016	eye shield, splash protection
88385	Eval molecul probes, 51-250	SL207	air, filtered, compressed
		SL218	DNA, Versagene, blood kit
		SL220	ethanol, 200%
		SL225	gas, nitogen, ultra-high purity (compressed), grade 5.0
88386	Eval molecul probes, 251-500	SL207	air, filtered, compressed
		SL218	DNA, Versagene, blood kit
		SL220	ethanol, 200%
		SL225	gas, nitogen, ultra-high purity (compressed), grade 5.0
90470	Immune admin H1N1 im/nasal	SB036	paper, exam table
91065	Breath hydrogen test	(blank)	Sivrite-4
91132	Electrogastrography	SD062	electrode, surface
91133	Electrogastrography w/test	SD062	electrode, surface
92550	Tympanometry & reflex thresh	SK059	paper, recording (per sheet)
92597	Oral speech device eval	SB022	gloves, non-sterile
92610	Evaluate swallowing function	SB022	gloves, non-sterile
92626	Eval aud rehab status	SK008	audiology scoring forms
92627	Eval aud status rehab add-on	SK008	audiology scoring forms
92640	Aud brainstem implt programg	SK068	Razor
95004	Percut allergy skin tests	SC023	multi-tine device
95024	Id allergy test, drug/bug	SA048	pack, minimum multi-specialty visit
		SG050	gauze, non-sterile 2in x 2in
95027	Id allergy titrate-airborne	SA048	pack, minimum multi-specialty visit
		SC052	syringe 1ml
95044	Allergy patch tests	SK087	water, distilled
95052	Photo patch test	SK087	water, distilled
95148	Antigen therapy services	SH009	antigen, venom
95805	Multiple sleep latency test	SK094	x-ray marking pencil
96040	Genetic counseling, 30 min	SK062	patient education booklet
96102	Psycho testing by technician	SK057	paper, laser printing (each sheet)
96360	Hydration iv infusion, init	SC018	iv infusion set
		SC051	syringe 10-12ml

CPT/ HCPCS Code	Short Descriptor	CMS Supply Code with Overall Price Corrections	Description of Supply
		SG050	gauze, non-sterile 2in x 2in
96365	Ther/proph/diag iv inf, init	SC018	iv infusion set
		SC051	syringe 10-12ml
		SG050	gauze, non-sterile 2in x 2in
96366	Ther/proph/diag iv inf addon	SB022	gloves, non-sterile
96367	Tx/proph/dg addl seq iv inf	SB022	gloves, non-sterile
96369	Sc ther infusion, up to 1 hr	SC013	infusion pump cassette-reservoir
96371	Sc ther infusion, reset pump	SC013	infusion pump cassette-reservoir
96372	Ther/proph/diag inj, sc/im	SB022	gloves, non-sterile
96374	Ther/proph/diag inj, iv push	SB022	gloves, non-sterile
		SC051	syringe 10-12ml
		SG050	gauze, non-sterile 2in x 2in
96375	Tx/pro/dx inj new drug addon	SB022	gloves, non-sterile
		SC051	syringe 10-12ml
96401	Chemo, anti-neopl, sq/im	SC051	syringe 10-12ml
		SG050	gauze, non-sterile 2in x 2in
96402	Chemo hormon antineopl sq/im	SC051	syringe 10-12ml
		SG050	gauze, non-sterile 2in x 2in
96409	Chemo, iv push, sngl drug	SC018	iv infusion set
		SC051	syringe 10-12ml
96411	Chemo, iv push, addl drug	SC018	iv infusion set
		SC051	syringe 10-12ml
96413	Chemo, iv infusion, 1 hr	SC018	iv infusion set
		SC051	syringe 10-12ml
96417	Chemo iv infus each addl seq	SC018	iv infusion set
96445	Chemotherapy, intracavitary	SC018	iv infusion set
		SH069	sodium chloride 0.9% irrigation (500-1000ml uou)
96542	Chemotherapy injection	SC018	iv infusion set
99366	Team conf w/pat by hc pro	SK062	patient education booklet
G0270	MNT subs tx for change dx	SK057	paper, laser printing (each sheet)
		SK062	patient education booklet
G0271	Group MNT 2 or more 30 mins	SK057	paper, laser printing (each sheet)

Table 7: Overall Supply Price Calculation Corrections for Facility Settings

CPT/ HCPCS Code	Short Descriptor	CMS Supply Code with Overall Price Corrections	Description of Supply
15738	Muscle-skin graft, leg	SG017	bandage, Kling, non-sterile 2in
15820	Revision of lower eyelid	SA082	pack, ophthalmology visit (w-dilation)
15821	Revision of lower eyelid	SA082	pack, ophthalmology visit (w-dilation)
15822	Revision of upper eyelid	SA082	pack, ophthalmology visit (w-dilation)
19303	Mast, simple, complete	SB006	drape, non-sterile, sheet 40in x 60in
20900	Removal of bone for graft	SA054	pack, post-op incision care (suture)
21011	Exc face les sc < 2 cm	SA048	pack, minimum multi-specialty visit
21013	Exc face tum deep < 2 cm	SA048	pack, minimum multi-specialty visit
21193	Reconst lwr jaw w/o graft	SJ061	tongue depressor

CPT/ HCPCS Code	Short Descriptor	CMS Supply Code with Overall Price Corrections	Description of Supply
21194	Reconst lwr jaw w/graft	SJ061	tongue depressor
21240	Reconstruction of jaw joint	SJ061	tongue depressor
21366	Treat cheek bone fracture	SJ061	tongue depressor
21435	Treat craniofacial fracture	SJ061	tongue depressor
21555	Exc neck les sc < 3 cm	SA048	pack, minimum multi-specialty visit
21930	Exc back les sc < 3 cm	SA048	pack, minimum multi-specialty visit
22902	Exc abd les sc < 3 cm	SA048	pack, minimum multi-specialty visit
23075	Exc shoulder les sc < 3 cm	SA048	pack, minimum multi-specialty visit
24075	Exc arm/elbow les sc < 3 cm	SA048	pack, minimum multi-specialty visit
25075	Exc forearm les sc < 3 cm	SA048	pack, minimum multi-specialty visit
26115	Exc hand les sc < 1.5 cm	SA048	pack, minimum multi-specialty visit
27047	Exc hip/pelvis les sc < 3 cm	SA048	pack, minimum multi-specialty visit
27327	Exc thigh/knee les sc < 3 cm	SA048	pack, minimum multi-specialty visit
27618	Exc leg/ankle tum < 3 cm	SA048	pack, minimum multi-specialty visit
28307	Incision of metatarsal	SA048	pack, minimum multi-specialty visit
28340	Resect enlarged toe tissue	SA048	pack, minimum multi-specialty visit
28345	Repair webbed toe(s)	SA048	pack, minimum multi-specialty visit
28820	Amputation of toe	SA048	pack, minimum multi-specialty visit
33516	Cabg, vein, six or more	SA052	pack, post-op incision care (staple)
34510	Transposition of vein valve	SA054	pack, post-op incision care (suture)
35013	Repair artery rupture, arm	SA048	pack, minimum multi-specialty visit
41150	Tongue, mouth, jaw surgery	SA048	pack, minimum multi-specialty visit
41153	Tongue, mouth, neck surgery	SA048	pack, minimum multi-specialty visit
41155	Tongue, jaw, & neck surgery	SA048	pack, minimum multi-specialty visit
41805	Removal foreign body, gum	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)
41806	Removal foreign body, jawbone	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)
42160	Treatment mouth roof lesion	SD122	suction tip, Yankauer
51925	Hysterectomy/bladder repair	SB006	drape, non-sterile, sheet 40in x 60in
56620	Partial removal of vulva	SA048	pack, minimum multi-specialty visit
57284	Repair paravag defect, open	SA051	pack, pelvic exam
		SB006	drape, non-sterile, sheet 40in x 60in
57285	Repair paravag defect, vag	SA051	pack, pelvic exam
		SB006	drape, non-sterile, sheet 40in x 60in
57423	Repair paravag defect, lap	SA051	pack, pelvic exam
		SB006	drape, non-sterile, sheet 40in x 60in
58660	Laparoscopy, lysis	SB006	drape, non-sterile, sheet 40in x 60in
58662	Laparoscopy, excise lesions	SJ046	silver nitrate applicator
58670	Laparoscopy, tubal cautery	SJ046	silver nitrate applicator
58940	Removal of ovary(s)	SA052	pack, post-op incision care (staple)
58952	Resect ovarian malignancy	SB006	drape, non-sterile, sheet 40in x 60in
64632	N block inj, common digit	SA048	pack, minimum multi-specialty visit
65112	Remove eye/revise socket	SA050	pack, ophthalmology visit (no dilation)
65114	Remove eye/revise socket	SA050	pack, ophthalmology visit (no dilation)
65235	Remove foreign body from eye	SA082	pack, ophthalmology visit (w-dilation)
65265	Remove foreign body from eye	SA082	pack, ophthalmology visit (w-dilation)
65272	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation)
65273	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation)
65280	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation)

CPT/ HCPCS Code	Short Descriptor	CMS Supply Code with Overall Price Corrections	Description of Supply
65285	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation)
65286	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation)
65290	Repair of eye socket wound	SA082	pack, ophthalmology visit (w-dilation)
65770	Revise cornea with implant	SA050	pack, ophthalmology visit (no dilation)
65850	Incision of eye	SA082	pack, ophthalmology visit (w-dilation)
65865	Incise inner eye adhesions	SA082	pack, ophthalmology visit (w-dilation)
65870	Incise inner eye adhesions	SA082	pack, ophthalmology visit (w-dilation)
66180	Implant eye shunt	SA082	pack, ophthalmology visit (w-dilation)
66185	Revise eye shunt	SA082	pack, ophthalmology visit (w-dilation)
66220	Repair eye lesion	SA082	pack, ophthalmology visit (w-dilation)
66250	Follow-up surgery of eye	SA082	pack, ophthalmology visit (w-dilation)
66500	Incision of iris	SA082	pack, ophthalmology visit (w-dilation)
66600	Remove iris and lesion	SA082	pack, ophthalmology visit (w-dilation)
66605	Removal of iris	SA082	pack, ophthalmology visit (w-dilation)
66625	Removal of iris	SA082	pack, ophthalmology visit (w-dilation)
66630	Removal of iris	SA082	pack, ophthalmology visit (w-dilation)
66635	Removal of iris	SA082	pack, ophthalmology visit (w-dilation)
66682	Repair iris & ciliary body	SA082	pack, ophthalmology visit (w-dilation)
66820	Incision, secondary cataract	SA082	pack, ophthalmology visit (w-dilation)
66850	Removal of lens material	SA082	pack, ophthalmology visit (w-dilation)
66852	Removal of lens material	SA082	pack, ophthalmology visit (w-dilation)
66930	Extraction of lens	SA082	pack, ophthalmology visit (w-dilation)
66940	Extraction of lens	SA082	pack, ophthalmology visit (w-dilation)
66983	Cataract surg w/iol, 1 stage	SA082	pack, ophthalmology visit (w-dilation)
67015	Release of eye fluid	SA082	pack, ophthalmology visit (w-dilation)
67031	Laser surgery, eye strands	SA082	pack, ophthalmology visit (w-dilation)
67036	Removal of inner eye fluid	SA082	pack, ophthalmology visit (w-dilation)
67040	Laser treatment of retina	SA082	pack, ophthalmology visit (w-dilation)
67105	Repair detached retina	SA082	pack, ophthalmology visit (w-dilation)
67107	Repair detached retina	SA082	pack, ophthalmology visit (w-dilation)
67110	Repair detached retina	SA082	pack, ophthalmology visit (w-dilation)
67115	Release encircling material	SA082	pack, ophthalmology visit (w-dilation)
67120	Remove eye implant material	SA082	pack, ophthalmology visit (w-dilation)
67228	Treatment of retinal lesion	SA082	pack, ophthalmology visit (w-dilation)
67400	Explore/biopsy eye socket	SA082	pack, ophthalmology visit (w-dilation)
67412	Explore/treat eye socket	SA082	pack, ophthalmology visit (w-dilation)
67440	Explore/drain eye socket	SA082	pack, ophthalmology visit (w-dilation)
67908	Repair eyelid defect	SG008	applicator, cotton-tipped, non-sterile 6in
88356	Analysis, nerve	SL108	Pipette

Comment: Several commenters agreed that the overall supply price inputs should be equal to the product of the supply price and the quantity associated with each code. Some commenters pointed out that for many of the supply items displayed in Tables 6 and 7, the overall supply prices remained incorrect in the proposed CY 2011 direct PE

database. The commenters speculated that an underlying programming error may have led to incorrect calculations.

Response: In constructing the proposed CY 2011 direct PE database posted on the CMS web site, we inadvertently retained a display column of data that reflected our previous calculation error, despite our correct calculation of the values for PFS ratesetting purposes. We have corrected the underlying process error that led to the incorrect display. We have modified the direct PE database for the CY 2011 PFS final rule with comment period to appropriately display the overall supply price input for a supply item as the product of the unit price and the quantity of the supply item used in the CPT code.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to modify the direct PE database to include the overall supply price input for a supply item as the product of the unit price and the quantity of the supply item used in the CPT code. We have modified the display column within the publicly available database to reflect the proper calculation. These changes are reflected in the final CY 2011 direct PE database.

c. AMA RUC Recommendations in CY 2010 for Changes to Direct PE Inputs

In a March 2010 letter, the AMA RUC made specific PE recommendations that we considered in the CY 2011 PFS proposed rule (75 FR 40062 through 40063). The proposed changes that follow were included in the proposed CY 2011 direct PE database, which is available on the CMS Web site under the downloads for the CY 2011 PFS proposed rule at http://www.cms.gov/PhysicianFeeSched/. The final direct PE database for CY 2011 is available under the downloads for the CY 2011 PFS final rule with comment period at the same location.

(1) Electrogastrography and Esophageal Function Test

We proposed to accept the AMA RUC recommendations for the CY 2011 PE inputs for the following CPT codes: 91132 (Electrogastrography, diagnostic, transcutaneous); 91133 (Electrogastrography, diagnostic, transcutaneous; with provocative testing); 91038 (Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)). For CPT code 91038, we assumed a useful life of 5 years for the equipment item "ZEPHR impedance /pH reflux monitoring system with data recorder, software, monitor, workstation and cart," based on its entry in the AHA's publication, "Estimated Useful Lives of Depreciable Hospital Assets," which we use as a standard reference. The proposed CY 2011 direct PE database was changed accordingly.

(2) 64-Slice CT Scanner and Software

The AMA RUC submitted an updated recommendation regarding the correct pricing of the 64-slice CT scanner and its accompanying software. Based on the documentation accompanying the recommendation, we accepted this recommendation and proposed to update the price input for the 64-slice scanner and software. This affected the following four CPT codes that use either the scanner, the software, or both: 75571 (computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium); 75572 (Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)); 75573 (Computed tomography, heart, with contrast material, for evaluation

of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)); and 75574 (Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post processing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structure, if performed)). The proposed CY 2011 direct PE database was modified accordingly.

(3) Breath Hydrogen Test

The AMA RUC provided recommendations regarding the PE inputs for CPT code 91065 (breath hydrogen test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit). We accepted the recommendations with two modifications. We folded the two pieces of equipment listed as "quinGas Table-Top Support Stand, 3 Tank" and "Drying Tube, Patient Sample" into the "BreathTrackerDigital SC Instrument" and summed their inputs into one equipment line-item, since these equipment items are used together specifically for the service in question. We increased the useful life input of the "BreathTrackerDigital SC Instrument" from 7 to 8 years based on our use of the American Hospital Association (AHA)'s publication entitled, "Estimated Useful Lives of Depreciable Hospital Assets" as a standard reference. Additionally, because the AMA RUC did not include equipment times in their recommendations for this CPT code, we used 53 minutes as the total time for all equipment items based on the total intra-service period for the clinical labor, consistent with our general policy for establishing equipment times. These modifications were reflected in the proposed CY 2011 direct PE database.

(4) Radiographic Fluoroscopic Room

A recent AMA RUC review of services that include the radiographic fluoroscopic room (CMS Equipment Code EL014) as a direct PE input revealed that the use of the item is no longer typical for certain services in which it is specified within the current direct cost inputs. The AMA RUC recommended to CMS that the radiographic fluoroscopic room be deleted from CPT codes 64420 (Injection, anesthetic agent; intercostal nerve, single); 64421 (Injection, anesthetic agent; intercostal nerves, multiple, regional block); and 64620 (Destruction by neurolytic agent, intercostal nerve). We accepted these recommendations and, therefore, these changes were included in the proposed CY 2011 direct PE database.

Comment: Several commenters generally expressed support for our acceptance of these AMA RUC-recommended direct PE inputs with the stated refinements. The AMA RUC expressed appreciation for CMS' acceptance of the committee's recommendations.

Response: We appreciate the assistance of stakeholders in our efforts to utilize the most accurate direct PE inputs for PFS services. We also appreciate the judicious work of the AMA RUC in providing these recommendations in time for us to respond to them and include our proposals in the CY 2011 proposed rule.

Comment: One commenter expressed concern about these recommendations on the basis of the flawed professional composition of the AMA RUC. The commenter stated that without fair representation by all specialties, including nonphysician practitioners who may bill Part B directly under the PFS, CMS' reliance on the AMA RUC as representing the professional views and knowledge of all healthcare specialties for purposes of establishing the direct PE inputs for services paid under the PFS is deeply

flawed.

Response: As we have stated previously (69 FR 66243), because the AMA RUC is an independent committee, we are not in a position to set the requirements for AMA RUC membership. Concerned stakeholders should communicate directly with the AMA RUC regarding its professional composition. We note that we alone are responsible for all decisions about the direct PE inputs for purposes of PFS payment so, while the AMA RUC provides us with recommendations for new and revised CPT codes in the context of what we believe is its broad expertise, we ultimately remain responsible for determining the direct PE inputs for all new or revised services.

After consideration of the public comments we received, we are finalizing our CY 2011 proposals to accept the AMA RUC recommendations, with certain changes described above, regarding the direct PE inputs for electrogastrography and esophageal function tests, the 64-slice CT scanner and software, the breath hydrogen test, and certain procedures that no longer require a radiographic fluoroscopic room. These decisions are reflected in the final CY 2011 direct PE database.

(5) Cystometrogram

The AMA RUC recently identified a rank order anomaly regarding CPT code 51726 (Complex cystometrogram (ie, calibrated electronic equipment)). Currently, this procedure has higher PE RVUs, despite being less resource-intensive than the three CPT codes for which it serves as the base: 51727 (Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique); 51728 (Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (that is, bladder voiding pressure), any

technique); and 51729 (Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (that is, bladder voiding pressure) and urethral pressure profile studies (that is, urethral closure pressure profile), any technique).

Since the AMA RUC's general view is that CPT codes with a 0-day global period do not have pre-service time associated with the code, the AMA RUC recommended removing the nonfacility pre-service clinical labor time from the PE inputs for 51726. Additionally, the AMA RUC recommended that the nonfacility clinical intra-service staff time for CPT code 51276 be reduced from the 118 minutes of intra-service clinical labor time currently assigned to the code to 85 minutes of intra-service clinical labor time. These changes would resolve the rank order anomaly and bring the PE inputs for CPT code 51726 into alignment with the other three codes. Finally, and for the reasons stated above, the AMA RUC recommended that CMS remove the 23 minutes of pre-service nonfacility clinical labor time from CPT code 51725 (Simple cystometrogram (CMG) (for example, spinal manometer)). We agreed with the AMA RUC recommendations, proposed to accept these recommendations for CY 2011 and, therefore, changed the direct PE inputs for CPT codes 51725 and 51726 in the nonfacility setting in the proposed CY 2011 direct PE database.

Comment: Some commenters argued that the rank order anomaly resulted from clinical labor inputs that were too low in the more complex codes, rather than too high in the base codes. These commenters stated that the AMA RUC and CMS had addressed the wrong "end" of the rank order anomaly in making the changes to the clinical labor minutes assigned to CPT codes 51725 and 51726. Several commenters on the CY 2010 PFS final rule with comment period, where new CY 2011 CPT code 51727, 51728, and

51729 were assigned interim direct PE inputs, also argued that CPT codes 51727, 51728, and 51729 should have additional clinical labor inputs, including a greater number of minutes during the intra-service period and minutes during the pre-service period.

Response: We have reviewed the direct PE inputs for all five CPT codes in this series and continue to agree with the AMA RUC's recommendations regarding changes for CY 2011. Specifically, we believe the pre-service nonfacility clinical labor time for the 0-day global period CPT codes 51725 and 51726 should be removed and the intra-service clinical labor time for CPT code 51726 should also be reduced, consistent with the usual treatment of other 0-day global codes. We believe the AMA RUC provided recommendations to us regarding the direct PE inputs for these four cystometrogram services that accurately reflect the costs of the resources (that is, the clinical labor, equipment, and supplies) typically required to furnish these services to Medicare beneficiaries.

Comment: Several commenters requested that CMS change the supply inputs included in the direct PE database for the complex cystometrogram services. For example, the commenters requested that single dual sensor catheters replace the single sensor catheters currently included as direct PE inputs for these codes. The commenters stated that both the catheters and their price inputs are outdated. In other cases, the commenters explained that certain supplies in the database were not those typically used by certain physician specialties in performing the services.

Response: We rely on our review of recommendations received from the AMA RUC in order to make changes to the clinical labor, supply, and equipment inputs for CPT codes within the direct PE database. We have no reason to believe that the supplies

used in the complex cystometrogram procedures described by CPT codes 51727, 51728, and 51729 are outdated because these were new codes for CY 2010 and the AMA RUC recently addressed their direct PE inputs when initially recommending values for the services. We believe the AMA RUC's extensive expertise and broad perspective generally allows it to accurately identify the direct PE inputs for new and revised CPT codes. We encourage stakeholders who believe that enhancements in technology or changes in medical practice have resulted in changes in the supplies or equipment typically used in furnishing a particular service to address these concerns with the AMA RUC.

As we discuss further in section II.A.3.e. of this final rule with comment period with respect to our proposal regarding updating supply and equipment price inputs, we welcome public requests for updates to supply price and equipment price and useful life inputs associated with existing codes through the process we are adopting beginning in CY 2011.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to accept the recommendations of the AMA RUC regarding the revised direct PE inputs for CPT codes 51725 and 52726. The final direct PE inputs are included in the final CY 2011 direct PE database.

d. Referral of Existing CPT Codes for AMA RUC Review

As part of our review of high cost supplies, we conducted a clinical review of the procedures associated with high cost supplies to confirm that those supplies currently are used in the typical case described by the CPT codes. While we confirmed that most high cost supplies could be used in the procedures for which they are currently direct PE

inputs, we noted that one of the high cost supplies, fiducial screws (CMS Supply Code SD073) with a current price of $558, is included as a direct PE input for two CPT codes, specifically 77301 (Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications) and 77011 (Computed tomography guidance for stereotactic localization). The documentation used in the current pricing of the supply item describes a kit that includes instructions, skull screws, a drill bit, and a collar for the TALON® System manufactured by Best nomos. Best nomos' literature describes the insertion of the screws into the patient's skull to ensure accurate set-up. When CPT codes 77301 and 77011 were established in CY 2002 and CY 2003, respectively, we accepted the AMA RUC recommendations to include fiducial screws in the PE for these services. Upon further review, while we understand why this supply may still be considered a typical PE input for CPT code 77011, we do not now believe that fiducial screws, as described in the Best nomos literature, would typically be used in CPT code 77301, where the most common clinical scenario would be treatment of prostate cancer.

Therefore, in order to ensure that CPT codes 77301 and 77011 are appropriately valued for CY 2011 through the inclusion or exclusion of fiducial screws in their PE, in the CY 2011 PFS proposed rule (75 FR 40063), we asked the AMA RUC to review these CPT codes with respect to the inclusion of fiducial screws in their PE. We requested that the AMA RUC make recommendations to us regarding whether this supply should be included in the PE or removed from the PE for CPT codes 77301 and 77011 in a timeframe that would allow us to adopt interim values for these codes for CY 2011, should the AMA RUC recommend a change. Were the AMA RUC to continue to

recommend the inclusion of fiducial screws in the PE for CPT code 77301 and/or 77011 for CY 2011, we requested that the AMA RUC provide us with a detailed rationale for the inclusion of this specialized supply in the PE for the typical case reported under the relevant CPT code. We also requested that the AMA RUC furnish updated pricing information for the screws if they were to continue to recommend the screws as a PE input for one or both of these CPT codes in CY 2011.

Comment: The AMA RUC recommended that CMS remove the fiducial screws as a direct PE input from both CPT codes 77011 and 77301. Several commenters also agreed that the fiducial screws would not typically be used with CPT code 77301. Additionally, multiple commenters pointed out that the fiducial screws may now be reported using HCPCS supply code A4648 (Tissue marker, implantable, any type, each) when the markers are implanted.

Response: We appreciate the responsiveness of the AMA RUC to our request and the interest of the other commenters in this issue.

After consideration of the public comments we received and the AMA RUC recommendation following publication of the CY 2011 PFS proposed rule, for CY 2011, we are accepting the AMA RUC's recommendation and removing fiducial screws from the direct PE database as inputs for CPT codes 77011 and 77301. Because the direct PE inputs for these codes are being revised on an interim final basis for CY 2011, the changes are subject to public comment on this final rule with comment period.

e. Updating Equipment and Supply Price Inputs for Existing Codes

Historically, we have periodically received requests to change the PE price inputs for supplies and equipment in the PE database. In the past, we have considered these

requests on an ad hoc basis and updated the price inputs as part of quarterly or annual updates if we believed them to be appropriate. In the CY 2011 PFS proposed rule (75 FR 49963), we proposed to establish a regular and more transparent process for considering public requests for changes to PE database price inputs for supplies and equipment used in existing codes.

We proposed to act on public requests to update equipment and supply price inputs annually through rulemaking by following a regular and consistent process as discussed in the following paragraphs. We proposed to use the annual PFS proposed rule released in the summer and the final rule with comment period released on or about November 1 each year as the vehicle for making these changes.

We would accept requests for updating the price inputs for supplies and equipment on an ongoing basis; requests must be received no later than December 31 of each calendar year to be considered for inclusion in the next proposed rule. In that next proposed rule, we would present our review of submitted requests to update price inputs for specific equipment or supplies and our proposals for the subsequent calendar year. We would then finalize changes in the final rule with comment period for the upcoming calendar year. Our review of the issues and consideration of public comments may result in the following outcomes that would be presented in the final rule with comment period:

- Updating the equipment or supply price inputs, as requested.
- Updating the equipment or supply price inputs, with modifications.
- Rejecting the new price inputs.
- Declining to act on the request pending a recommendation from the AMA RUC.

To facilitate our review and preparation of issues for the proposed rule, at a minimum, we would expect that requesters would provide the following information:

- Name and contact information for the requestor.
- The name of the item exactly as it appears in the direct PE database under downloads for the most recent PFS final rule with comment period, available on the CMS Web site at http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage.

In order to best evaluate the requests in the context of our goal of utilizing accurate market prices for these items as direct PE inputs, we also would expect requestors to provide multiple invoices from different suppliers/manufacturers. In some cases, multiple sources may not be available, whereupon a detailed explanation should be provided to support the request. When furnishing invoices, requestors should take into consideration the following parameters:

++ May be either print or electronic but should be on supplier and/or manufacturer stationery (for example, letterhead, billing statement, etc.)

++ Should be for the typical, common, and customary version of the supply or equipment that is used to furnish the services.

++ Price should be net of typical rebates and/or any discounts available, including information regarding the magnitude and rationale for such rebates or discounts.

++ If multiple items are presented on the same invoice, relevant item(s) should be clearly identified.

We solicited public comments on this process, including the information that requestors should furnish to facilitate our full analysis in preparation for the next calendar year's rulemaking cycle.

Comment: Several commenters supported establishing a regular and more transparent process for considering public requests for changes to the direct PE price inputs for supplies and equipment used in existing codes. However, other commenters were concerned that the process might prevent CMS from making timely corrections to the database that are brought to the attention of the agency by specialty societies or other stakeholders. These commenters suggested creating an expedited process whereby mistakes could be corrected.

Response: We appreciate the broad support for the proposal. We believe that this process, though regular, would not limit our ability to correct technical errors that are discovered by the agency or brought to our attention by stakeholders. On these occasions, we would continue to correct errors and issue correction notices to final rules when appropriate. The regular process for updating supply and equipment prices is intended to reflect significant changes in the market prices of supplies and equipment that are used in the direct PE database. It would not substitute for the timely correction of technical errors.

Comment: Some commenters were concerned that the proposed process would necessitate a 12- to 24- month delay between CMS' acknowledgement of a price update and the resulting change in PE RVU calculations. The commenters pointed out that the current ad hoc process has historically resulted in a fairly timely response from the agency in most circumstances and were concerned that the formalization of the process

might result in unnecessary delays. One commenter suggested creating a process for quarterly updates to the supply and equipment price inputs.

Response: We understand that some commenters are concerned about the timelines for price updates. However, we believe that the value of the transparency of the proposed process outweighs its potential for slowing the previous ad hoc process. Additionally, it is important to acknowledge that in most previous cases, price input updates would not have been immediately effective since such updates have always required CMS' review, concurrence, and processing through the rate setting methodology prior to any change in Medicare payment rates. Additionally, many stakeholders already provide public comments to CMS regarding specific issues addressed in our the annual rate setting for the PFS through the notice and comment rulemaking process, Therefore, we believe that the annual process offers both an economic use of stakeholders' resources, as well as the best opportunity for broad public input into proposed price changes. These are qualities any accelerated alternative, such as quarterly updates, would lack.

We believe that an annual update process most effectively promotes both timeliness and transparency, while also allowing for public comment and input regarding our proposals before the adoption of pricing changes that could have a significant effect on payment for services under the PFS.

Comment: Some commenters asserted that it may be more difficult to obtain invoices for some supplies that are not frequently used and there should be acceptable alternative sources of information, including price lists or other information from the manufacturer. One commenter suggested that in the case of items that are not used in

high volumes in physicians' office, volume or other discounts are unlikely for physicians' practices.

Response: Even though the direct PE inputs should reflect the resource costs required for typical cases, we understand that there may be circumstances in which updated invoices or invoices that reflect volume or other discounts may be difficult to obtain. As stated in our proposal, we will consider a detailed written explanation in support of requests submitted without the documentation usually required.

Comment: One commenter urged that the updating of supply and equipment prices be only for "like" items and not for "newer technology" items. The commenter requested that CMS refer the initial review of new supply and equipment inputs to the AMA RUC Practice Expense Subcommittee for review and recommendation back to CMS. Other commenters made specific requests for additions, deletions, or substitutions of supply and equipment items associated with particular codes.

Response: We appreciate the opportunity to clarify that this regular and consistent process would only apply to the price inputs for supply and equipment items. As part of our review of equipment price inputs, we will also consider updates to the useful life of equipment insofar as that information is supported by similar documentation. However, we will continue to encourage stakeholders who believe that there should be additions, deletions, or substitutions of direct PE inputs associated with particular codes to address these concerns through the AMA RUC, including when a stakeholder believes that enhanced technology has replaced older technology in the typical case of a particular service. We believe the AMA RUC recommendations are an

efficient and effective mechanism to inform our review of changes to the clinical labor, supply, and equipment inputs within the direct PE database.

Comment: One commenter was concerned about the potential for CMS to reject the requested price input outright and suggested that CMS be required to explain its rejection of the request for an updated price input.

Response: We appreciate the concerns of the commenter and consider this perspective as providing additional support for instituting such a regular and transparent process. As we stated in the CY2011 proposed rule (75 FR 40063), we would present our review of submitted requests to update price inputs for specific equipment or supplies and our proposals for the subsequent calendar year in the annual proposed rule. This process would provide CMS an annual opportunity to explain our review and decisions regarding public requests for changes in direct PE price inputs.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to act on public requests to update equipment and supply price inputs annually through rulemaking by following a regular and consistent process as discussed in the preceding paragraphs. We will use the annual PFS proposed rule released in the summer and the final rule with comment period released on or about November 1 each year as the vehicle for making these changes. In order to make the most effective use of the rulemaking process and be responsive to the concerns of stakeholders that we consider the most recent evidence available, we ask that requests for updates to supply price inputs or equipment price or useful life inputs be submitted as comments to the PFS final rule with comment period each year, subject to the deadline for public comments applicable to that rule. Alternatively, stakeholders may submit requests to CMS on an

ongoing basis throughout a given calendar year to CMS PE_Price_Input_Update@cms.hhs.gov. Requests received by the end of a calendar year will be considered in rulemaking during the following year. For example, requests received by December 31, 2010 will be considered in conjunction with the CY 2012 PFS rulemaking cycle. We refer readers to the description earlier in this section of the minimum information we are requesting that stakeholders provide in order to facilitate our review and preparation of issues for the proposed rule.

In the CY 2012 PFS proposed rule, scheduled to be released in the summer of CY 2011, we will present a review of any timely requests we receive to update supply price inputs or equipment price or useful life inputs. After reviewing the issues and responding to the public comments, we will finalize our decision as one of the outcomes listed below for each request in the final rule with comment period for CY 2012.

- Updating the equipment or supply price inputs, as requested.
- Updating the equipment or supply price inputs, with modifications.
- Rejecting the new price inputs.
- Declining to act on the request pending a recommendation from the AMA RUC.

f. Other Issues

We received other public comments on matters related to direct PE inputs that were not the subject of proposals in the CY 2011 PFS proposed rule. We thank the commenters for sharing their views and suggestions. Because we did not make any proposals regarding these matters, we do not generally summarize or respond to such comments in this final rule with comment period. However, we are summarizing and

responding to several of the public comments in order to reiterate or clarify certain information.

Comment: Several commenters stated that the clinical labor minutes for CPT code 37210 (Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure) are inconsistent with recommendations forwarded to CMS by the AMA RUC for CY 2007 and accepted by CMS in the CY 2007 PFS final rule with comment period (71 FR 69643). The commenters indicated that 10 minutes of clinical labor time were erroneously not attributed to this CPT code in the proposed CY 2011 direct PE database.

Response: We agree with the commenters' assessment and appreciate being informed of the error. The 10 minutes of clinical labor time missing from the direct PE inputs for CPT code 37210 have been incorporated and this change is reflected in the final CY 2011 direct PE database.

Comment: Several commenters expressed concerns regarding the current direct PE inputs for various services. One commenter submitted extensive information regarding a perceived disparity between the equipment inputs for echocardiography services and those for other ultrasound services. Another commenter requested that CMS ask the AMA RUC to establish nonfacility RVUs for the placement or insertion of high dose rate brachytherapy catheters/applicators because it is common practice, especially in gynecology, for physicians to perform such procedures in their offices or in freestanding clinics. One commenter stated that the proposed PE RVUs do not provide sufficient

payment to cover the cost of prothrombin time (PT)/international normalized ratio (INR) home monitoring services and recommended that CMS alter the direct PE inputs for those services. Another commenter requested that CMS alter direct PE inputs for holter monitoring based on changes to the language in CPT code descriptors from the current "24 hours" to "up to 48 hours," even when the AMA RUC did not recommend such changes.

Response: We did not propose CY 2011 changes to the direct PE inputs for any of those services referenced by the commenters and, therefore, their direct PE inputs have already been finalized in a prior year's PFS rulemaking. As we have previously stated in this section, we encourage stakeholders who believe a change is required in the direct PE inputs associated with a particular service in the typical case that is furnished in the facility or nonfacility setting to address these concerns with the AMA RUC with respect to codes that have been reviewed by the AMA RUC. The direct PE inputs for existing services paid under the PFS have all been adopted through rulemaking that has allowed for public notice and comment, so their current direct PE inputs are final unless we would make a proposal to change them in a future year. In most cases, we like to receive and review recommendations from the AMA RUC for new and revised codes or other codes for which another review has been conducted in order to assist us in determining whether we should make changes to the clinical labor, supply, and equipment inputs within the direct PE database and, if so, what revisions should be made.

Additionally, throughout the year we meet with parties who want to share their views on topics of interest to them. These discussions may provide us with information regarding changes in medical practice and afford opportunities for the public to bring to

our attention issues they believe we should consider for future rulemaking. Thus, we encourage stakeholders to contact us at any time if there are topics related to the direct PE inputs for physicians' services that they would like to discuss.

B. Malpractice Relative Value Units (RVUs)

1. Background

Section 1848(c) of the Act requires that each service paid under the PFS be comprised of three components: work, PE, and malpractice. From 1992 to 1999, malpractice RVUs were charge-based, using weighted specialty-specific malpractice expense percentages and 1991 average allowed charges. Malpractice RVUs for new codes after 1991 were extrapolated from similar existing codes or as a percentage of the corresponding work RVU. Section 4505(f) of the BBA required us to implement resource-based malpractice RVUs for services furnished beginning in 2000. Therefore, initial implementation of resource-based malpractice RVUs occurred in 2000.

The statute also requires that we review, and if necessary adjust, RVUs no less often than every 5 years. The first review and update of resource-based malpractice RVUs was addressed in the CY 2005 PFS final rule with comment period (69 FR 66263). Minor modifications to the methodology were addressed in the CY 2006 PFS final rule with comment period (70 FR 70153). In the CY 2010 PFS final rule with comment period, we implemented the second review and update of malpractice RVUs. For a discussion of the second review and update of malpractice RVUs see the CY 2010 PFS proposed rule (74 FR 33537) and final rule with comment period (74 FR 61758).

2. Malpractice RVUs for New and Revised Services Effective Before the Next 5-Year Review

Currently, malpractice RVUs for new and revised codes effective before the next 5-Year Review (for example, effective CY 2011 through CY 2014) are determined by a

direct crosswalk to a similar "source" code or a modified crosswalk to account for differences in work RVUs between the new/revised code and the source code. For the modified crosswalk approach, we adjust the malpractice RVUs for the new/revised code to reflect the difference in work RVUs between the source code and the AMA RUC's recommended work value (or the work value we are applying as an interim final value under the PFS) for the new code. For example, if the interim final work RVUs for the new/revised code are 10 percent higher than the work RVUs for the source code, the malpractice RVUs for the new/revised code would be increased by 10 percent over the source code RVUs. This approach presumes the same risk factor for the new/revised code and source code but uses the work RVUs for the new/revised code to adjust for risk-of-service. The assigned malpractice RVUs for new/revised codes effective between updates remain in place until the next 5-Year Review.

For CY 2011, we explained that we will continue our current approach for determining malpractice RVUs for new/revised codes that become effective before the next 5-Year Review and update. Under this approach we crosswalk the new/revised code to the RVUs of a similar source code and adjust for differences in work (or, if greater, the clinical labor portion of the fully implemented PE RVUs) between the source code and the new/revised code. Additionally, we stated that we would publish a list of new/revised codes and the analytic crosswalk(s) used for determining their malpractice RVUs in the CY 2011 final rule with comment period, which we have not previously done. We also explained that the CY 2011 malpractice RVUs for new/revised codes would be implemented as interim final values in the CY 2011 PFS final rule with comment period,

where they would be subject to public comment, and finalized in the CY 2012 PFS final rule with comment period.

Comment: Several commenters supported the continuation of our current approach to determining malpractice RVUs for new/revised codes that become effective before the next 5-Year Review and update. The commenters stated that publication of the new/revised codes and the analytic crosswalk(s) used for determining their malpractice RVUs in the final rule is a move toward greater transparency. A few commenters requested that CMS provide the rationale used for selecting crosswalks for new/revised codes and subject the rationale to public comment.

Response: For purposes of determining malpractice RVUs for the CY 2011 new/revised codes, we accepted all source code recommendations submitted by the AMA RUC. We understand that the AMA RUC-recommended source codes for new/revised codes were based on the expected similar specialty mix of practitioners furnishing the source code and the new/revised code. In other words, the medical specialties furnishing a source code were expected to be similar to the specialty mix furnishing the new/revised code. In adopting all of the AMA RUC's source code recommendations for CY 2011, we agree with its assessment of these similarities in each new/revised code case. If we were to disagree with the AMA RUC's malpractice source code recommendations in a future year for any new/revised codes, we would provide the rationale for both our difference of opinion and the alternative source code we select for purposes of establishing the interim final malpractice RVUs.

After consideration of the public comments we received, we are continuing our current approach of assigning the interim final malpractice RVUs for new/revised codes

based on the methodology described earlier in this section. We adjusted the malpractice RVUs of the CY 2011 new/revised codes for differences in work RVUs (or, if greater, the clinical labor portion of the fully implemented PE RVUs) between the source code and the new/revised code to reflect the specific risk-of-service for the new/revised code. The source code crosswalks for the CY 2011 new/revised codes are being adopted on an interim final basis and are subject to public comment on this CY 2011 final rule with comment period, as are the CY 2011 malpractice RVUs of the new/revised codes that are listed in Addendum C to this final rule with comment period. The malpractice RVUs for the CY 2011 new/revised codes will be finalized in the CY 2012 PFS final rule with comment period, where we will also respond to the public comments received on the values that are included in this CY 2011 final rule with comment period.

Table 8 lists the CY 2011 new/revised codes and their respective source codes for determining the interim final CY 2011 malpractice RVUs. We are also posting this crosswalk on the CMS Web site under the downloads for the CY 2011 PFS final rule with comment period at:

http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage.

Table 8: Source Codes for CY 2011 New/Revised Codes Used to Set the Malpractice RVUs

CY 2011 New/ Revised CPT Code	CY 2011 New/Revised CPT Code Short Descriptor	CPT Code Crosswalk for Malpractice RVUs
11042	Deb subq tissue 20 sq cm/<	11042
11043	Deb musc/fascia 20 sq cm/<	11043
11044	Deb bone 20 sq cm/<	11044
11045	Deb subq tissue add-on	15003
11046	Deb musc/fascia add-on	15361
11047	Deb bone add-on	15361
11900	Injection into skin lesions	11900
11901	Added skin lesions injection	11901
12001	Repair superficial wound(s)	12001
12002	Repair superficial wound(s)	12002

CY 2011 New/ Revised CPT Code	CY 2011 New/Revised CPT Code Short Descriptor	CPT Code Crosswalk for Malpractice RVUs
12004	Repair superficial wound(s)	12004
12005	Repair superficial wound(s)	12005
12006	Repair superficial wound(s)	12006
12007	Repair superficial wound(s)	12007
12011	Repair superficial wound(s)	12011
12013	Repair superficial wound(s)	12013
12014	Repair superficial wound(s)	12014
12015	Repair superficial wound(s)	12015
12016	Repair superficial wound(s)	12016
12017	Repair superficial wound(s)	12017
12018	Repair superficial wound(s)	12018
15823	Revision of upper eyelid	15823
19357	Breast reconstruction	19357
22551	Neck spine fuse&remove addl	22856
22552	Addl neck spine fusion	22614
23430	Repair biceps tendon	23430
29540	Strapping of ankle and/or ft	29540
29550	Strapping of toes	29550
29914	Hip arthro w/femoroplasty	29866
29915	Hip arthro acetabuloplasty	29806
29916	Hip arthro w/labral repair	29806
30901	Control of nosebleed	30901
31295	Sinus endo w/balloon dil	31525
31296	Sinus endo w/balloon dil	31535
31297	Sinus endo w/balloon dil	31240
31634	Bronch w/balloon occlusion	31629
33620	Apply r&l pulm art bands	33660
33621	Transthor cath for stent	33320
33622	Redo compl cardiac anomaly	33783
36410	Non-routine bl draw > 3 yrs	36410
37220	Iliac revasc	35473
37221	Iliac revasc w/stent	37205
37222	Iliac revasc add-on	35473
37223	Iliac revasc w/stent add-on	37206
37224	Fem/popl revas w/tla	35474
37225	Fem/popl revas w/ather	35493
37226	Fem/popl revasc w/stent	37205
37227	Fem/popl revasc stnt & ather	35493
37228	Tib/per revasc w/tla	35470
37229	Tib/per revasc w/ather	35495
37230	Tib/per revasc w/stent	37205
37231	Tib/per revasc stent & ather	37205
37232	Tib/per revasc add-on	35470
37233	Tibper revasc w/ather add-on	35495
37234	Revsc opn/prq tib/pero stent	37206
37235	Tib/per revasc stnt & ather	37206
38900	Io map of sent lymph node	19126
43283	Lap esoph lengthening	44121
43327	Esoph fundoplasty lap	43280
43328	Esoph fundoplasty thor	33660
43332	Transab esoph hiat hern rpr	43281

CY 2011 New/ Revised CPT Code	CY 2011 New/Revised CPT Code Short Descriptor	CPT Code Crosswalk for Malpractice RVUs
43333	Transab esoph hiat hern rpr	43282
43334	Transthor diaphrag hern rpr	43281
43335	Transthor diaphrag hern rpr	43282
43336	Thorabd diaphr hern repair	43112
43337	Thorabd diaphr hern repair	43112
43338	Esoph lengthening	32602
43753	Tx gastro intub w/asp	99281
43754	Dx gastr intub w/asp spec	91037
43755	Dx gastr intub w/asp specs	91037
43756	Dx duod intub w/asp spec	89100
43757	Dx duod intub w/asp specs	89100
47490	Incision of gallbladder	49442
49327	Lap ins device for rt	49435
49412	Ins device for rt guide open	15171
49418	Insert tun ip cath perc	36558
49421	Ins tun ip cath for dial opn	49421
51736	Urine flow measurement	51736
51741	Electro-uroflowmetry first	51741
52281	Cystoscopy and treatment	52281
52332	Cystoscopy and treatment	52332
53860	Transurethral rf treatment	57522
55866	Laparo radical prostatectomy	55866
57155	Insert uteri tandems/ovoids	57155
57156	Ins vag brachytx device	57155
59400	Obstetrical care	59400
59409	Obstetrical care	59409
59410	Obstetrical care	59410
59412	Antepartum manipulation	59412
59414	Deliver placenta	59414
59425	Antepartum care only	59425
59426	Antepartum care only	59426
59430	Care after delivery	59430
59510	Cesarean delivery	59510
59514	Cesarean delivery only	59514
59515	Cesarean delivery	59515
59610	Vbac delivery	59610
59612	Vbac delivery only	59612
59614	Vbac care after delivery	59614
59618	Attempted vbac delivery	59618
59620	Attempted vbac delivery only	59620
59622	Attempted vbac after care	59622
61781	Scan proc cranial intra	61797
61782	Scan proc cranial extra	63086
61783	Scan proc spinal	61797
61885	Insrt/redo neurostim 1 array	61885
64415	N block inj brachial plexus	64415
64445	N block inj sciatic sng	64445
64447	N block inj fem single	64447
64479	Inj foramen epidural c/t	64479
64480	Inj foramen epidural add-on	64480
64483	Inj foramen epidural l/s	64483

CY 2011 New/ Revised CPT Code	CY 2011 New/Revised CPT Code Short Descriptor	CPT Code Crosswalk for Malpractice RVUs
64484	Inj foramen epidural add-on	64484
64566	Neuroeltrd stim post tibial	51736
64568	Inc for vagus n elect impl	63664
64569	Revise/repl vagus n eltrd	63047
64570	Remove vagus n eltrd	61535
64611	Chemodenerv saliv glands	64653
65778	Cover eye w/membrane	65430
65779	Cover eye w/membrane stent	65600
66174	Translum dil eye canal	67121
66175	Trnslum dil eye canal w/stnt	67570
66761	Revision of iris	66761
67028	Injection eye drug	67028
69801	Incise inner ear	69801
71250	Ct thorax w/o dye	71250
72125	Ct neck spine w/o dye	72125
72128	Ct chest spine w/o dye	72128
72131	Ct lumbar spine w/o dye	72131
73080	X-ray exam of elbow	73080
73200	Ct upper extremity w/o dye	73200
73510	X-ray exam of hip	73510
73610	X-ray exam of ankle	73610
73630	X-ray exam of foot	73630
73700	Ct lower extremity w/o dye	73700
74176	Ct angio abd & pelvis	74150
74177	Ct angio abd&pelv w/contrast	74160
74178	Ct angio abd & pelv 1+ regns	74170
76881	Us xtr non-vasc complete	76885
76882	Us xtr non-vasc lmtd	73630
77427	Radiation tx management x5	77427
88120	Cytp urne 3-5 probes ea spec	88365
88121	Cytp urine 3-5 probes cmptr	88365
88172	Cytp dx eval fna 1st ea site	88172
88177	Cytp c/v auto thin lyr addl	88172
88300	Surgical path gross	88300
88302	Tissue exam by pathologist	88302
88304	Tissue exam by pathologist	88304
88305	Tissue exam by pathologist	88305
88307	Tissue exam by pathologist	88307
88363	Xm archive tissue molec anal	85396
90460	Imadm any route 1st vac/tox	90471
90461	Inadm any route addl vac/tox	90472
90870	Electroconvulsive therapy	90870
90935	Hemodialysis one evaluation	90935
90937	Hemodialysis repeated eval	90937
90945	Dialysis one evaluation	90945
90947	Dialysis repeated eval	90947
91010	Esophagus motility study	91010
91013	Esophgl motil w/stim/perfus	91010
91117	Colon motility 6 hr study	43235
92081	Visual field examination(s)	92081
92082	Visual field examination(s)	92082

CY 2011 New/ Revised CPT Code	CY 2011 New/Revised CPT Code Short Descriptor	CPT Code Crosswalk for Malpractice RVUs
92132	Cmptr ophth dx img ant segmt	92020
92133	Cmptr ophth img optic nerve	92083
92134	Cptr ophth dx img post segmt	92083
92228	Remote retinal imaging mgmt	92250
92285	Eye photography	92285
92504	Ear microscopy examination	92504
92507	Speech/hearing therapy	92507
92508	Speech/hearing therapy	92508
92606	Non-speech device service	92606
92607	Ex for speech device rx 1hr	92607
92608	Ex for speech device rx addl	92608
92609	Use of speech device service	92609
93040	Rhythm ecg with report	93040
93042	Rhythm ecg report	93042
93224	Ecg monit/reprt up to 48 hrs	93224
93227	Ecg monit/reprt up to 48 hrs	93227
93268	Ecg record/review	93268
93272	Ecg/review interpret only	93272
93451	Right heart cath	33210
93452	Left hrt cath w/ventrclgrphy	33967
93453	R&l hrt cath w/ventriclgrphy	33213
93454	Coronary artery angio s&i	33967
93455	Coronary art/grft angio s&i	93619
93456	R hrt coronary artery angio	33216
93457	R hrt art/grft angio	33240
93458	L hrt artery/ventricle angio	33213
93459	L hrt art/grft angio	33240
93460	R&l hrt art/ventricle angio	33240
93461	R&l hrt art/ventricle angio	33208
93462	L hrt cath trnsptl puncture	33210
93463	Drug admin & hemodynmic meas	36140
93464	Exercise w/hemodynamic meas	36140
93563	Inject congenital card cath	93975
93564	Inject hrt congntl art/grft	93975
93565	Inject l ventr/atrial angio	93975
93566	Inject r ventr/atrial angio	93975
93567	Inject suprvlv aortography	93975
93568	Inject pulm art hrt cath	93975
93652	Ablate heart dysrhythm focus	93652
93922	Upr/l xtremity art 2 levels	93922
93923	Upr/lxtr art stdy 3+ lvls	93923
93924	Lwr xtr vasc stdy bilat	93924
95800	Slp stdy unattended	95819
95801	Slp stdy unatnd w/anal	95819
95803	Actigraphy testing	95819
95805	Multiple sleep latency test	95805
95806	Sleep study unatt&resp efft	95806
95807	Sleep study attended	95807
95808	Polysomnography 1-3	95808
95810	Polysomnography 4 or more	95810
95811	Polysomnography w/cpap	95811

CY 2011 New/ Revised CPT Code	CY 2011 New/Revised CPT Code Short Descriptor	CPT Code Crosswalk for Malpractice RVUs
95950	Ambulatory eeg monitoring	95950
95953	Eeg monitoring/computer	95953
95956	Eeg monitor technol attended	95956
96105	Assessment of aphasia	96125
96446	Chemotx admn prtl cavity	96413
97597	Rmvl devital tis 20 cm/<	97597
97598	Rmvl devital tis addl 20 cm<	97598
99224	Subsequent observation care	99231
99225	Subsequent observation care	99232
99226	Subsequent observation care	99233

3. Revised Malpractice RVUs for Selected Disc Arthroplasty Services

As discussed in the CY 2010 PFS proposed rule (74 FR 33539), we assign malpractice RVUs to each service based upon a weighted average of the risk factors of all specialties that furnish the service. For the CY 2010 review of malpractice RVUs, we used CY 2008 Medicare payment data on allowed services to establish the frequency of a service by specialty. CPT code 22856 (Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical) had zero allowed services for CY 2008. Therefore, our contractor initially set the level of services to 1, and assigned a risk factor according to the average risk factor for all services that do not explicitly have a separate technical or professional component. We proposed to adopt our contractor's initial malpractice RVUs for CPT code 22856 in the CY 2010 proposed rule. Application of the average physician risk factor would have resulted in a significant decrease in malpractice RVUs for CPT code 22856 in CY 2010.

Several commenters on the CY 2010 PFS proposed rule expressed concern regarding the proposed malpractice RVUs for CPT code 22856, which represented a proposed reduction of more than 77 percent. The commenters stated that this service is

predominantly furnished by neurosurgeons and orthopedic surgeons. Given the high risk factors associated with these specialty types and the changes in malpractice RVUs for comparable services, the commenters stated that a reduction in the malpractice RVUs of this magnitude for CPT code 22856 could not be correct.

After consideration of the public comments, for CY 2010, we set the risk factor for CPT code 22856 as the weighted average risk factor of six comparable procedures mentioned by the commenters: CPT code 22554 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2); CPT code 22558 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar); CPT code 22857 (Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar); CPT code 22845 (Anterior instrumentation; 2 to 3 vertebral segments (list separately in addition to code for primary procedure)); CPT code 63075 (Discectomy, anterior, with decompression of spinal cord and/ or nerve root(s), including osteophytectomy; cervical, single interspace); and CPT code 20931 (Allograft for spine surgery only; structural (list separately in addition to code for primary procedure)). The weighted average risk factor for these services is 8.4.

Since publication of the CY 2010 PFS final rule with comment period, stakeholders have mentioned that we made significant changes to the malpractice RVUs for CPT code 22856 in CY 2010. The commenters also brought to our attention that other services are clinically similar to CPT code 22856 and have similar work RVUs and, therefore, some stakeholders believe these services should all have similar malpractice

RVUs. Services mentioned by the stakeholders that are clinically similar to CPT code 22856 include CPT code 22857; CPT code 22861 (Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical); CPT code 22862 (Revision including replacement of total disc arthroplasty (artificial disc) anterior approach, lumbar); CPT code 22864 (Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical); and CPT code 22865 (Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar).

After further review of this issue, for CY 2011 we proposed to apply the same risk factor used for CPT code 22856 to certain other services within this family of services (CPT codes 22857 through 22865) for which there were no allowed services in CY 2008. CPT codes 22861 and 22864 had zero allowed services in CY 2008 and our contractor initially set their malpractice RVUs in the same way as it did for CPT code 22856. Therefore, for CY 2011 we proposed to assign the weighted average risk factor used for CPT code 22856 (that is, the weighted average of the risk factors for CPT codes 20931, 22554, 22558, 22845, 22857, and 63075) to CPT codes 22861 and 22864. However, CPT codes 22857, 22862, and 22865 are low volume services (allowed services under 100). Our policy for low volume services is to apply the risk factor of the dominant specialty as indicated by our claims data. Thus, for CY 2011 we proposed to continue to apply our policy for low volume services to CPT codes 22857, 22862, and 22865.

Comment: A few commenters expressed support for the proposed changes in malpractice RVUs for disc arthroplasty services that are similar to CPT code 22856. One commenter urged CMS to finalize the proposal in the CY 2011 PFS final rule.

Response: We appreciate the commenters' support for our proposal.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to apply the same risk factor used for CPT code 22856 to CPT codes 22861 and 22864 for purposes of setting the malpractice RVUs for these codes prior to the next 5-Year Review of malpractice RVUs.

C. Potentially Misvalued Services Under the Physician Fee Schedule

1. Valuing Services Under the PFS

As discussed in section I. of this final rule with comment period, in order to value services under the PFS, section 1848(c) of the Act requires the Secretary to determine relative values for physicians' services based on three components: the work, practice expense (PE), and malpractice components. Section 1848(c)(1)(A) of the Act defines the work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Additionally, the statute provides that the work component shall include activities that occur before and after direct patient contact. Furthermore, the statute specifies that with respect to surgical procedures, the valuation of the work component for the code would reflect a "global" concept in which pre-operative and post-operative physicians' services related to the procedure would also be included.

In addition, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." As discussed in detail in sections I.A.2. and I.A.3. of this final rule with comment period, the statute also defines the PE and malpractice components and provides specific guidance in the calculation of the RVUs for each of these components. Section 1848(c)(1)(B) of the Act defines the PE component as "the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses."

Section 1848(c)(2)(C)(ii) of the Act specifies that the "Secretary shall determine a number of practice expense relative value units for the services for years beginning with 1999 based on the relative practice expense resources involved in furnishing the service." Furthermore, section 1848(c)(2)(B) of the Act directs the Secretary to conduct a periodic review, not less often than every 5 years, of the RVUs established under the PFS. Finally, on March 23, 2010, the ACA was enacted, further requiring the Secretary to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of those services identified as being potentially misvalued. Section 3134(a) of the ACA added a new section 1848(c)(2)(K) of the Act which requires the Secretary to periodically identify potentially misvalued services using certain criteria, and to review and make appropriate adjustments to the relative values for those services. Section 3134(a) of the ACA also added a new section 1848(c)(2)(L) of the Act which requires the Secretary to develop a validation process to validate the RVUs of potentially misvalued codes under the PFS and make appropriate adjustments.

As discussed in section I.A.1. of this final rule with comment period, we establish physician work RVUs for new and revised codes based on our review of recommendations received from the AMA RUC. The AMA RUC also provides recommendations to CMS on the values for codes that have been identified as potentially misvalued. To respond to concerns expressed by MedPAC, the Congress, and other stakeholders regarding accurate valuation of services under the PFS, the AMA RUC created the Five-Year Review Identification Workgroup in 2006. In addition to providing recommendations to CMS for work RVUs, the AMA RUC's Practice Expense Subcommittee reviews direct PE (clinical labor, medical supplies, and medical

equipment) for individual services and examines the many broad methodological issues relating to the development of PE RVUs.

In accordance with section 1848(c) of the Act, we determine appropriate adjustments to the RVUs, taking into account the recommendations provided by the AMA RUC and MedPAC, and publish the explanation for the basis of these adjustments in the PFS proposed and final rules. We note that section 1848(c)(2)(A)(ii) of the Act authorizes the use of extrapolation and other techniques to determine the RVUs for physicians' services for which specific data are not available, in addition to taking into account the results of consultations with organizations representing physicians.

2. Identifying, Reviewing, and Validating the RVUs of Potentially Misvalued Services under the PFS

a. Background

In its March 2006 Report to Congress, MedPAC noted that "misvalued services can distort the price signals for physicians' services as well as for other health care services that physicians order, such as hospital services." In that same report MedPAC postulated that physicians' services under the PFS can become misvalued over time for a number of reasons: "For example, when a new service is added to the physician fee schedule, it may be assigned a relatively high value because of the time, technical skill, and psychological stress that are required to perform it. Over time, skill, and stress involved may decline as physicians become more familiar with the service and more efficient at providing it. The amount of physician work needed to furnish an existing service may decrease when new technologies are incorporated. Services can also become overvalued when practice expenses decline. This can happen when the costs of

equipment and supplies fall, or when equipment is used more frequently, reducing its cost per use. Likewise, services can become undervalued when physician work increases or practice expenses rise." In the ensuing years since MedPAC's 2006 report, additional groups of potentially misvalued services have been identified by Congress, CMS, MedPAC, the AMA RUC, and other stakeholders.

In recent years CMS and the AMA RUC have taken increasingly significant steps to address potentially misvalued codes. As MedPAC noted in its March 2009 Report to Congress, in the intervening years since MedPAC made the initial recommendations, "CMS and the AMA RUC have taken several steps to improve the review process." Most recently, section 1848(c)(2)(K)(ii) of the Act (as added by section 3134 of the ACA) directed the Secretary to specifically examine potentially misvalued services in seven categories as follows:

(1) Codes and families of codes for which there has been the fastest growth.

(2) Codes or families of codes that have experienced substantial changes in practice expenses.

(3) Codes that are recently established for new technologies or services.

(4) Multiple codes that are frequently billed in conjunction with furnishing a single service.

(5) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

(6) Codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes').

(7) Other codes determined to be appropriate by the Secretary.

Section 1848(c)(2)(K)(iii) of the Act (as added by section 3134 of the ACA) also specifies that the Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services. In addition, the Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment of potentially misvalued services. This section authorizes the use of analytic contractors to identify and analyze potentially misvalued codes, conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of potentially misvalued services. Finally, section 1848(c)(2)(K)(iii)(V) of the Act (as added by section 3134 of the ACA) specifies that the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the physician fee schedule.

b. Progress in Identifying and Reviewing Potentially Misvalued Codes

Over the last several years, CMS, in conjunction with the AMA RUC, has identified and reviewed numerous potentially misvalued codes in all seven of the categories specified in section 1848(c)(2)(K)(ii) (as added by section 3134 of the ACA), and we plan to continue our work examining potentially misvalued codes in these areas over the upcoming years, consistent with the new legislative mandate on this issue. In the current process, the AMA RUC reviews potentially misvalued codes that are identified either by CMS or through its own processes and recommends revised work RVUs and/or direct PE inputs for those codes to CMS. CMS then assesses the recommended revised work RVUs and/or direct PE inputs and, in accordance with

section 1848(c) of the Act, we determine if the recommendations constitute appropriate adjustments to the RVUs under the PFS. Since CY 2009, CMS and the AMA RUC have identified over 700 potentially misvalued codes.

For example, in regards to the first category (codes and families of codes for which there has been the fastest growth), for CY 2009 CMS identified over 100 potentially misvalued codes for which an analysis of the utilization data showed an annual growth in allowed services of 10 percent (or more) for 3 consecutive years (73 FR 38586). Each of these codes had allowed charges of $1 million or more in CY 2007. We published this list in the CY 2009 PFS proposed rule (73 FR 38586 through 38589) and requested that the AMA RUC immediately begin a review of the codes on this list. Meanwhile, in parallel with CMS' efforts, the AMA RUC also initiated processes to identify and review potentially misvalued codes on an ongoing basis using certain screens, including screens for "CMS fastest growing procedures" and "high volume growth." Both of these AMA RUC screens are applicable to the first category of potentially misvalued codes specified in the ACA. We plan to continue to analyze Medicare claims data over future years to identify additional services that exhibit rapid growth and high Medicare expenditures for referral to the AMA RUC for review as potentially misvalued codes.

Pertaining to the second category specified in section 1848(c)(2)(K)(ii) of the Act (as added by section 3134 of the ACA) (codes or families of codes that have experienced substantial changes in practice expenses), in CY 2009 we requested that the AMA RUC continue its review of direct PE inputs, focusing particularly on high-volume codes where the PE payments are increasing significantly under the transition to the new PE

methodology (73 FR 38589). The AMA RUC has responded by sending CMS recommendations for revised direct PE inputs for codes identified for PE review on an ongoing basis.

Additionally in CY 2009, we began an initiative to review and update the prices for high-cost supplies in order to ensure the accuracy and completeness of the direct PE inputs. We discuss our most recent efforts in refining the process to update the prices of high-cost supplies in section II.C.5. of this final rule with comment period.

For the third category of potentially misvalued codes identified in section 1848(c)(2)(K)(ii) (as added by section 3134 of the ACA) (codes that are recently established for new technologies or services), the AMA RUC routinely identifies such codes through a screen based on 3 years of Medicare claims data, and sends CMS recommendations for revised work RVUs and/or direct PE inputs for these codes on an ongoing basis. The AMA RUC may determine that a code for a new service requires reevaluation or does not require reevaluation, or it may conclude, on a case-by-case basis, that more than 3 years of claims data are necessary before the code can be reviewed. In that case, it would determine the appropriate future timeframe for review.

We also note that in its June 2008 Report to Congress entitled "Reforming the Health Care System" and in the context of a discussion about primary care, MedPAC acknowledges,"…. Efficiency can improve more easily for other types of services, such as procedures, with advances in technology, technique, and other factors. Ideally, when such efficiency gains are achieved, the fee schedule's relative value units (RVUs) for the affected services should decline accordingly, while budget neutrality would raise the RVUs for the fee schedule's primary care services." (page 27). Section II.C.5. of this

final rule with comment period includes a discussion regarding periodic updates to the costs of high-cost supplies. This discussion is highly relevant to new technology services, where growth in volume of a service as it diffuses into clinical practice may lead to a decrease in the cost of expensive supplies. We also expect that other efficiencies in physician work and PE may be achieved after an initial period of relative inefficiency that reflects the "learning curve." We plan to pay particular attention to the work values and direct PE inputs for these new services and the AMA RUC's periodic review process to ensure that any efficiencies are captured under the PFS over time, recognizing that the appropriate timing for revaluing these services needs to be considered on a case-by-case basis depending on the growth rate in service volume.

We have also addressed the fourth category (multiple codes that are frequently billed in conjunction with furnishing a single service) in rulemaking prior to the enactment of the ACA. As discussed in the CY 2009 PFS proposed rule (73 FR 38586), we have a longstanding policy of reducing payment for multiple surgical procedures performed on the same patient, by the same physician, on the same day. Over the ensuing years, the multiple procedure payment reduction (MPPR) policy has been extended to a number of nuclear diagnostic and diagnostic imaging procedures. We continue our work to recognize efficiencies in this area with a new CY 2011 policy to expand the MPPR policy to additional combinations of imaging services and to therapy services for CY 2011 as described in section II.C.4. of this final rule with comment period.

We note the AMA RUC has also established a screen to identify services performed by the same physician on the same date of service 95 percent of the time or

more. Over the past 2 years, the CPT Editorial Panel has established new bundled codes to describe a comprehensive service for certain combinations of these existing services that are commonly furnished together, and the AMA RUC has recommended work values and direct PE inputs to CMS for these comprehensive service codes that recognize the associated efficiencies. We look forward to working with the AMA RUC in this joint effort to examine codes commonly reported together and more appropriately value common combinations services.

We address the fifth category of potentially misvalued codes (codes with low relative values, particularly those that are often billed multiple times for a single treatment) in section II.C.3.b. of this final rule with comment period. That is, we have provided a list of services with low work RVUs that are commonly reported with multiple units in a single encounter and requested that the AMA RUC review these codes that we have identified as potentially misvalued.

The sixth category (codes which have not been subject to review since the implementation of the RBRVS (the so-called "Harvard-valued codes")) also continues to be addressed by CMS and the AMA RUC on an ongoing basis. As we noted in the CY 2009 PFS proposed rule (73 FR 38589), there were at that time approximately 2,900 codes, representing $5 billion in annual spending, that were originally valued using Harvard data and had not subsequently been evaluated by the AMA RUC. Consequently, in CY 2009, we requested that the AMA RUC engage in an ongoing effort to review the remaining Harvard-valued codes, focusing first on the high-volume, low-intensity codes (73 FR 38589). In response to our request, the AMA RUC initially conducted an analysis of Harvard-valued services with utilization above 10,000 services per year, which

resulted in a list of 296 distinct services (73 FR 69883). The AMA RUC, in its public comment on the CY 2009 proposed rule, stated that it believes it would be effective to limit any review to these 296 services and also noted that of the 296 services identified, 23 had already been identified by another screen and were in the process of being reviewed (73 FR 69883). To date, the AMA RUC has reviewed and submitted to CMS recommendations for revised work RVUs and/or direct PE inputs for a number of Harvard-valued codes, prioritizing those codes with utilization of over 1 million services. The AMA RUC and CMS intend to continue our ongoing assessment of Harvard-valued codes, next targeting codes with utilization of over 100,000 services.

Finally, the seventh category of potentially misvalued codes in section 1848(c)(2)(K)(ii) (as added by section 3134 of the ACA) is all other codes determined to be appropriate by the Secretary. In this category, CMS has previously proposed policies and requested that the AMA RUC review codes for which there have been shifts in the site-of-service (site-of-service anomalies), as well as codes that qualify as "23-hour stay" outpatient services. The policies for valuation of both the site-of-service anomaly codes and the "23-hour stay" codes are developed further in sections II.C.3.d. and e., respectively, of this final rule with comment period. For CY 2011, we have also identified codes with low work RVUs but that are high volume based on claims data as another category of potentially misvalued codes and referred these codes to the AMA RUC for review, as discussed in section II.C.3.b. of this final rule with comment period. In addition, for CY 2011 we have newly targeted key codes that the AMA RUC uses as reference services for valuing other services, termed "multispecialty points of comparison" services, and referred these to the AMA RUC for review as potentially

misvalued codes as described in section II.C.3.a. of this final rule with comment period. Finally, we note the AMA RUC has also established screens to identify potentially misvalued codes in additional categories, including codes with a high intra-service work per unit of time (IWPUT) and codes representing services that had been surveyed by one specialty, but are now performed by a different specialty. We will continue to review AMA RUC recommendations for revised work RVUs and/or direct PE inputs for codes that fall into these categories.

As a result of the combined efforts of CMS and the AMA RUC to address potentially misvalued codes, for CY 2009 the AMA RUC recommended revised work values and/or PE inputs for 204 misvalued services (73 FR 69883). For CY 2010, an additional 113 codes were identified as misvalued and the AMA RUC provided new recommendations for revised work RVUs and/or PE inputs to CMS as discussed in the CY 2010 PFS final rule with comment period (74 FR 61778). Upon review of the AMA RUC-recommended work RVUs, CMS accepted the majority of the values as appropriate adjustments to the RVUs under the PFS, in accordance with section 1848(c) of the Act. However, for a number of codes, mainly the site-of-service anomaly codes, we indicated that although we would accept the AMA RUC valuations for these codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services (73 FR 69883 and 74 FR 61776 through 61778, respectively). In the CY 2010 PFS final rule with comment period, we requested that the AMA RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). In that same rule, we also stated that we would continue to examine these codes and consider whether it would be appropriate

to propose additional changes in future rulemaking. We discuss our CY 2011 proposals with respect to these codes in section II.C.3.d. of this final rule with comment period.

c. Validating RVUs of Potentially Misvalued Codes

In addition to identifying and reviewing potentially misvalued codes, section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a formal process to validate relative value units under the PFS. The validation process may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work. The Secretary is directed to validate a sampling of the work RVUs of codes identified through any of the seven categories of potentially misvalued codes specified by section 1848(c)(2)(K)(ii) of the Act (as added by section 3134 of the ACA). Furthermore, the Secretary may conduct the validation using methods similar to those used to review potentially misvalued codes, including conducting surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the validation of RVUs of services. Currently, while CMS does assess the AMA RUC- recommended work RVUs to determine if the recommendations constitute appropriate adjustments to the RVUs under the PFS, we intend to establish a more extensive validation process of RVUs in the future in accordance with the requirements of section 1848(c)(2)(L) of the Act (as added by section 3134 of the ACA). Therefore, in the CY 2011 PFS proposed rule (75 FR 40068), we solicited public comments on possible approaches and methodologies that we should consider for a validation process. We were interested in public comments regarding approaches,

including the use of time and motion studies, to validate estimates of physician time and intensity that are factored into the work RVUs for services with rapid growth in Medicare expenditures, one of the categories that the statute specifically directs CMS to examine. We indicated that we plan to discuss the validation process in a future PFS rule once we have considered the matter further in conjunction with any public comments and other input from stakeholders that we receive.

Comment: Some commenters were skeptical that there could be viable alternative methods to the existing AMA RUC code review process for validating physician time and intensity that would preserve the appropriate relativity of specific physician's services under the current payment system. These commenters generally urged CMS to rely solely on the AMA RUC to provide valuations for services under the PFS. A number of commenters expressed the belief that since CMS has reviewed the AMA RUC recommendations for codes and generally accepted these valuations in the past, these actions constitute a "CMS validation process." The commenters asserted that this current "CMS validation process" more than meets the requirement of section 1848(c)(2)(L) of the Act (as added by section 3134 of the ACA).

In addition, a number of commenters opposed the approach of using time and motion studies to validate estimates of physician time and intensity, stating that properly conducted time and motion studies are extraordinarily expensive and, given the thousands of codes paid under the PFS, it would be unlikely that all codes could be studied. The commenters generally opposed applying different methodologies to valuing different services under the PFS and supported using a consistent methodology for all codes. Some commenters observed that it would be extremely difficult for CMS to establish a

process by which to validate a sample of work RVUs under the PFS because of the relative nature of the system. Specifically, one commenter noted that the "advantages of a relative system are considerable – they allow scaling based on available funds and make it far easier for a payer such as Medicare to set rates for multiple services with a single adjustment to the conversion factor. However, one disadvantage of a relative system is that it cannot be externally validated unless all components are included in the validation. Services cannot be examined for absolute accuracy, only for relative precision. If we identify some component of the calculation used to generate the RVU that is incorrect, it is impossible to know whether this is a systemic error or an issue with an individual code. If it is a systemic error, then it does not invalidate the relative value system, which merely must operate on an even playing field." That is, many commenters believe that as long as appropriate relativity is maintained in the work RVUs for services valued under the PFS, the specific methodology for valuing services is less important. Accordingly, many commenters expressed support for the AMA RUC's use of "magnitude estimation" to develop the recommended value for a service and urged CMS to accept the AMA RUC's recommendations as the most informed and best estimation of the true value of physician work for a service.

In contrast, some commenters declared that "the flaws inherent in the RUC system are the lack of accountability and transparency." These commenters believe that the AMA RUC's composition as a professional panel puts cognitive services at a disadvantage and suggested that "the composition of the RUC needs to be modified to more accurately reflect the desired workforce composition. At present primary care specialties are under-represented which we [the commenters] believe contributes to the

overvaluation of procedural codes and undervaluation of cognitive codes." Similarly, other commenters noted that while certified registered nurse anesthetists (CRNAs) furnished approximately 32 million anesthesia services in the United States annually and can bill Medicare directly for their services, "the AMA RUC excludes CRNAs from directly participating in its deliberations because CRNAs are not physicians." These commenters noted that "without fair representation by all specialties that bill Part B directly, CMS' reliance on the AMA-RUC as representing the professional views and knowledge of all healthcare specialties is deeply flawed." The commenters also advised that "while the RUC relies on persuasion and brokering deals, RVUs need to be validated empirically." In general, these commenters believe that since section 1848(c)(2)(L) of the Act (as added by section 3134 of the ACA) expressly specifies that CMS has the authority to conduct surveys and studies and collect data, CMS should develop a process that uses empirical evidence as the basis for validation of work RVUs.

Response: We agree with the commenters that the work before us to develop a formal validation process as specified by section 1848(c)(2)(L) of the Act (as added by section 3134 of the ACA) will be a challenging but worthwhile effort to ensure accurate valuation of physician work under the PFS. While we have reviewed AMA RUC recommendations for codes and frequently accepted these valuations in the past, we disagree with the commenters' assertion that these actions constitute a formal CMS validation process as envisioned by section 1848(c)(2)(L) of the Act (as added by section 3134 of the ACA). Section 1848(c)(2)(L) of the Act (as added by section 3134 of the ACA) clearly specifies a new requirement that "the Secretary shall establish a process to validate relative value units under the fee schedule." While we solicited comments on the

possibility of using time and motion studies to support a future validation process, we understand that these studies would require significant resources and we remain open to suggestions for other approaches to developing a validation process.

In response to the commenters who raised the issue of the AMA RUC's most commonly used approach for valuing codes, referred to as "magnitude estimation," we note that the AMA RUC does not rely on a single consistent methodology to value codes. Based on our historical and current review of the AMA RUC recommendation summaries which accompany the work RVU recommendations for each code newly valued or revalued by the AMA RUC each year, we have noticed that the AMA RUC appears to use a variety of methodologies in its valuation process. For some codes, the AMA RUC uses magnitude estimation in conjunction with survey data from surveys conducted by the specialty societies to support the values. For other codes, the AMA RUC uses magnitude estimation to override the results of the survey data, recommending to CMS a value that is not based on survey data, but rather, justified in terms of its appropriate relativity within the system to other similar services. The AMA RUC may also elect to use a crosswalk approach in valuing a code by applying a work value from a currently valued code to the code under review based on the clinical similarity of the procedures or explicit considerations of pre-, intra-, and post-service time. In some instances, we note that the AMA RUC has asserted that it uses the building block methodology to value the code, a methodology we have historically supported (74 FR 61777). Since the AMA RUC uses a variety of methodologies for valuing codes, not just magnitude estimation supported by survey data, or our recommended methodology of valuation based on building blocks, we foresee that validation of the work RVUs will be complex, perhaps

requiring an initial study of the all the possible valuation methodologies currently being employed by the AMA RUC so that we can better understand how relativity between services under the PFS has developed and been maintained over the years.

As we have stated previously (69 FR 66243), because the AMA RUC is an independent committee, we are not in a position to set the requirements for AMA RUC membership regarding primary care specialties or other types of practitioners. Concerned stakeholders should communicate directly with the AMA RUC regarding its professional composition. We note that we alone are responsible for all decisions about establishing the RVUs for purposes of PFS payment so, while the AMA RUC provides us with recommendations regarding the work and direct PE inputs for new and revised CPT codes in the context of its broad expertise, we determine the interim final RVUs for all new or revised services. Additionally, the interim RVUs are subject to public comment and we respond to those comments in a final rule when we adopt the final RVUs for the new and revised CPT codes. We believe that the formal validation process will further complement the ongoing work of the AMA RUC to provide recommendations to us regarding the valuation of PFS services.

Comment: While a number of commenters strongly opposed CMS' plans to develop a formal validation process, many other commenters expressed support for the development and establishment of a system-wide validation process of the work RVUs under the PFS. The commenters commended CMS for seeking new approaches to validation, as well as being open to suggestions from the public on this process. A number of commenters submitted technical advice and offered their time and expertise as resources for CMS to draw upon in any examination of possible approaches to

developing a formal validation process.

Furthermore, MedPAC advised that a formal validation process should include validating the fee schedule's estimates of physician time. MedPAC noted that "Contract research for CMS and the Assistant Secretary for Planning and Evaluation has shown that some of the time estimates are likely too high. In addition, the Government Accountability Office has found that the fee schedule does not adequately account for efficiencies occurring when a physician furnishes multiple services for the same patient on the same day." Finally, MedPAC suggested that CMS should consider alternative approaches, "such as collecting data on a recurring basis from a cohort of practices and other facilities where physicians and nonphysician clinical practitioners work."

Some commenters noted that "involving RUC experts, those who are most intimately acquainted with and possess the deepest level of expertise and experience makes the most sense" and stated that these individuals "are also those best equipped to provide insights and guidance to help shape an independent validation system." A number of commenters asked CMS to confirm that stakeholders would be given the opportunity to comment on any specific proposals for a validation process that CMS plans to implement.

Response: We thank the many commenters who generously offered to help and provided technical suggestions, including the use of statistical modeling and possible sources of data that we should consider in developing a validation process. We will review MedPAC's suggestions to examine physician time in the formal validation process. We will also consider the commenters' recommendation that we include the AMA RUC and other professional groups who also have a stake in ensuring appropriate

payment for practitioners' services. As we stated previously, we intend to establish a more extensive validation process of RVUs in the future in accordance with the requirements of section 1848(c)(2)(L) of the Act (as added by section 3134 of the ACA). We note that MedPAC, in providing comments to the CY 2011 PFS proposed rule, "strongly supports efforts to improve the accuracy of the fee schedule's RVUs." We plan to discuss the validation process in more detail in a future PFS rule once we have considered the matter further in conjunction with the public comments that we have received in response to our solicitation in the CY 2011 proposed rule as well as other input from stakeholders. Moreover, we note that any proposals we would make on the formal validation process would be subject to public comment, and we would consider those comments before finalizing any policies.

3. CY 2011 Identification and Review of Potentially Misvalued Services

In this section, we discuss codes that may be potentially misvalued according to five different criteria:

- Codes on the multi-specialty points of comparison list;
- Codes with low work RVUs commonly billed in multiple units per single encounter;
- Codes with high volume and low work RVUs;
- Codes with site-of-service anomalies; and
- Codes that qualify as "23-hour stay" outpatient services.

a. Codes on the Multispecialty Points of Comparison List

The AMA RUC uses a scale referred to as the multispecialty points of comparison (MPC) to evaluate the reasonableness of a specialty society's recommended RVU value

for a service. The MPC list contains reference codes of established comparison services that are used in the valuation of new codes. The current MPC list consists of 316 codes which the AMA RUC may use to compare and contrast the relativity of codes under review to existing relative values. Since the AMA RUC may use the values on the MPC list as a basis for relativity when determining the values for new, revised, and newly reviewed codes (including potentially misvalued codes), it is essential that the services on the MPC list be appropriately valued since any codes misvalued on the MPC list could contribute to the misvaluing of other codes under review. While we believe that the entire MPC list should be assessed to ensure that services are paid appropriately under the PFS, we prioritized the review of the MPC list, ranking the codes by allowed service units and charges based on CY 2009 claims data. We proposed to refer the codes in Table 9 to the AMA RUC for review in CY 2011.

TABLE 9: Codes on the MPC List Referred for AMA RUC Review

CPT Code	Short Descriptor
66984	Cataract surg w/iol, 1 stage
97110	Therapeutic exercises
43239	Upper GI endoscopy, biopsy
20610	Drain/inject, joint/bursa
78815	Pet image w/ct, skull-thigh
45385	Lesion removal colonoscopy
45380	Colonoscopy and biopsy
11721	Debride nail, 6 or more
17000	Destruct premalg lesion
92980	Insert intracoronary stent
74160	Ct abdomen w/dye
71020	Chest x-ray
11100	Biopsy, skin lesion
66821	After cataract laser surgery
52000	Cystoscopy
92083	Visual field examination(s)
73721	Mri jnt of lwr extre w/o dye

CPT Code	Short Descriptor
93010	Electrocardiogram report
77334	Radiation treatment aid(s)
92250	Eye exam with photos
95810	Polysomnography, 4 or more
77003	Fluoroguide for spine inject
11056	Trim skin lesions, 2 to 4
76700	Us exam, abdom, complete
77290	Set radiation therapy field
77300	Radiation therapy dose plan
43235	Uppr gi endoscopy, diagnosis
71275	Ct angiography, chest
95900	Motor nerve conduction test
31231	Nasal endoscopy, dx
95165	Antigen therapy services
94060	Evaluation of wheezing
31575	Diagnostic laryngoscopy

Comment: While some commenters agreed with CMS that the entire MPC list should be assessed to ensure that services are paid appropriately under the PFS, and supported the proposal that the AMA RUC review the services listed in Table 9, a number of other commenters expressed surprise that CMS seemed to be suggesting that any code on the MPC list could be classified as potentially misvalued. Many commenters noted that the MPC list of codes is considered the "gold standard" within the PFS and it is used to help judge the appropriate relativity of procedures across specialties. A number of commenters assured CMS that the codes on the MPC list have been thoroughly vetted and, therefore, these commenters took issue with CMS for implying that the codes could somehow be considered potentially misvalued. Specifically, one commenter noted, "[t]he assumption of the specialties, the RUC and CMS has been that these services are appropriately valued and well established." Another commenter expressed the concern as follows: "[c]hallenging the rank order of the MPC list

essentially negates 20 years of RUC work. Obtaining new data to validate the old data inevitably leads to the problem of what should be done if the data yield different results. Is there any reason to believe that a newer survey is a more accurate survey, or that the data analysis and subsequent opinion of the current or future RUCs will be more valid than that of previous RUCs? Admittedly data collection methods have become more refined in the past 20 years, but that neither means nor implies that relativity amongst physician services has changed." Some commenters reminded CMS that the AMA RUC is already planning to review some codes on the MPC list in the coming year, while other commenters noted that some of the codes on the MPC list have been reviewed by the AMA RUC within the past 6 years. Some commenters did not believe that some of the well-established services on the MPC list would need another review and that the resources required to re-review such services could be better used elsewhere. Furthermore, some commenters believe that if a code has been surveyed as part of the potentially misvalued services initiative during the last 5 years and it is identified again using a different screen, that it need not be resurveyed again.

Finally, several commenters noted that while reviewing all the codes on the MPC list would "be a substantial undertaking for the RUC, properly valuing these services will help restore equity in the physician payment system." The commenters further suggested that CMS should specify to the AMA RUC what it considers good survey methodology, including the use of peer review and time studies.

Response: We note that the vast majority of commenters, whether they supported or opposed our proposal, acknowledged the significant and central role that the MPC list plays in the valuation of services under the PFS. Because it is currently the "gold

standard" to which other codes, across specialties, are compared, we agree with the commenters who suggested that codes on this list should be vetted, though we disagree that we should assume this has been done or occurs automatically and systematically. We also acknowledge that the AMA RUC recently has reviewed some of the codes and is planning to review more codes on the MPC list. Our proposal suggested prioritizing the review of the codes by ranking them according to utilization which, in our view, would potentially provide the most immediate benefit to the system.

If a code on the MPC list has not been reviewed recently - certainly more recently than 6 years ago - we believe that the code is vulnerable to being potentially misvalued and that the misvaluation of an MPC code could disproportionately affect the correct valuation of other related services under the PFS. Given the rapid changes in medical practice, we have no reason to believe that the relativity of the MPC codes would not have changed over the past 20 years and we would expect that more recent survey data would more accurately reflect the physician work in current medical practice. If the codes are resurveyed and newer more accurate data are available, we would support using the most recent available data to value physician work under the PFS, which is consistent with our general policy to use the most current data whenever possible and practicable to update the PFS.

Given the evolving review process of the AMA RUC over the past several years, CMS' strong interest in ensuring current and appropriate physician work values for PFS services, and the increased emphasis on revaluing established services that are potentially misvalued, we are requesting that the AMA RUC provide a current and comprehensive recommendation on the appropriate physician work value, including describing and

affirming the methodology for the recommended work value, for all of the codes listed in Table 9. To the extent the AMA RUC chooses to limit its work in reexamining MPC codes that have recently been evaluated, consistent with our usual practice, we will consider the context when we evaluate the AMA RUC's recommendation for the value of the code.

Although valuation is ultimately our responsibility, the AMA RUC and CMS remain partners in ensuring the appropriate valuation of physician work for services under the PFS and we believe our proposal serves to enhance this process. Accordingly, after consideration of the public comments we received, we are finalizing our CY 2011 proposal and we look forward to receiving the AMA RUC's recommendations for the codes listed in Table 9.

b. Codes with Low Work RVUs Commonly Billed in Multiple Units Per Single Encounter

Consistent with section 1848(c)(2)(K)(ii) of the Act (as added by section 3134 of the ACA) which identifies categories of potentially misvalued codes for our review, we believe services with low work RVUs that are commonly billed with multiple units in a single encounter are an additional appropriate category for identifying potentially misvalued codes. An example of a high multiple/low work RVU service is CPT code 95004 (Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests). For purposes of compiling a list of the high multiple/low work RVU services, we defined a high multiple service as one that is commonly performed in multiples of 5 or more per day. Then, we selected from high multiple services with work RVUs of less

than or equal to 0.5 RVUs. We note that in selecting 5 per day as the minimum threshold for the number of common services performed in a multiple service encounter, we intended to establish a meaningful threshold which, in conjunction with the threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

In the CY 2011 PFS proposed rule (75 FR 40069), we requested that the AMA RUC review the codes in Table 10.

TABLE 10: Codes with Low Work RVUs that are Commonly Billed in Multiple Units Referred for AMA RUC Review

CPT Code	Short Descriptor
95904	Sense nerve conduction test
17003	Destruct premalg les, 2-14
95004	Percut allergy skin tests
11101	Biopsy, skin add-on
95024	Id allergy test, drug/bug
76000	Fluoroscope examination
95144	Antigen therapy services
95010	Percut allergy titrate test
88300	Surgical path, gross
95027	Id allergy titrate-airborne
95015	Id allergy titrate-drug/bug
95148	Antigen therapy services

c. Codes with High Volume and Low Work RVUs

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we requested that the AMA RUC review these codes in the CY 2011 PFS proposed rule (75 FR 40069).

TABLE 11: Codes with Low Work RVUs that are High Volume Referred for AMA RUC Review

CPT Code	Short Descriptor
71010	Chest x-ray
73510	X-ray exam of hip
97035	Ultrasound therapy
88313	Special stains group 2
73630	X-ray exam of foot
72100	X-ray exam of lower spine
73030	X-ray exam of shoulder
73562	X-ray exam of knee, 3
73560	X-ray exam of knee, 1 or 2
94010	Breathing capacity test
77052	Comp screen mammogram add-on
88304	Tissue exam by pathologist
73564	X-ray exam, knee, 4 or more
72170	X-ray exam of pelvis
74000	X-ray exam of abdomen
73610	X-ray exam of ankle
11719	Trim nail(s)
73620	X-ray exam of foot
92567	Tympanometry
73110	X-ray exam of wrist
73130	X-ray exam of hand
93701	Bioimpedance, cv analysis
72040	X-ray exam of neck spine
92543	Caloric vestibular test

Comment: A number of commenters agreed with CMS' proposal for the AMA RUC to review codes with low work RVUs that are commonly billed with multiple units, and codes with high volume and low work RVUs. Other commenters did not support these proposals based on a belief that just because a code has low work RVUs, the conclusion should not necessarily be drawn that the code is potentially misvalued.

Response: While we do not believe that low work RVUs automatically indicate that the code is misvalued, we believe that some codes in this category may be vulnerable to being potentially misvalued because they have not been subject to review recently, there are particular challenges associated with establishing appropriate low work RVUs for services, and these services would not likely be subject to AMA RUC revaluation without CMS' recommendation. Accordingly, after consideration of the public comments we are received, we are finalizing our CY 2011 proposal and we look forward to receiving the AMA RUC's recommendation for the codes listed in Tables 10 and 11.

d. Codes with Site-of-Service-Anomalies

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were furnished in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work furnished, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has

shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the "building blocks" of the code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remained concerned that in the AMA RUC's recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the AMA RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomaly concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the "starting value") and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).
- Next, we examined the AMA RUC-recommended changes to the building blocks of the code.
- We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We noted in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site-of-service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We noted that the RVU values associated with the incremental time change were calculated using the intensity associated with the particular pre-, intra-, or post-period. For the intensity of the intra-service period, we utilized the original IWPUT associated with the code. The AMA RUC generally recommended allowing only half of a hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes had half of a hospital discharge day management service value accounted in the valuation. Finally, we noted that while we eliminated the RVUs associated with all

inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we allowed for the possibility that in some cases, some part of the work which had been furnished in the inpatient setting may continue to be furnished even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (eg, for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12:

Pre-Service Time	Median Intra-Service Time	Immediate Post -Service Time	99231	99232	99238	99211	99212	99213	Original IWPUT
75 min	120 min	43 min	1 visit (0.76 RVUs)	1 visit (1.39 RVUs)	1 visit (1.28 RVUs)	2 visits (0.36 RVUs)	2 visits (0.96 RVUs)	2 visits (1.94 RVUs)	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table 13 shows the building blocks that were recommended for CY 2009 by the AMA RUC after its review of the code for site-of-service anomalies.

TABLE 13:

Pre-Service Time	Median Intra-Service Time	Immediate Post-Service Time	99231	99232	99238	99211	99212	99213	Revised IWPUT
85min	90min	30min					2 visits	2 visits	0.0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code 99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IWPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14:

Pre-Service Time	Median Intra-Service Time	Immediate Post-Service Time	99231	99232	99238	99211	99212	99213
0.22 RVUs	-0.44 RVUs	0.38 RVUs	-0.76 RVUs	-1.39 RVUs	-0.64 RVUs	-0.36 RVUs		

In the final step, the RVUs associated with the changes to the building blocks recommended by the AMA RUC (Table 14) were deducted from or added to the starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building block value of 8.08 RVUs (11.07+0.22-0.44+0.38-0.76-1.39-0.64-0.36=8.08).

The methodology discussed above was applied to each of the site-of-service anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15: CY 2009 Site-of-Service Anomaly Codes[1]

CPT Code	Short Descriptor	CY 2008 RVUs ("Starting Value")	RUC Recommended Value for CY 2009	CY 2011 Reverse Building Block Value
21025	Excision of bone, lower jaw	11.07	9.87	8.09
23415	Release of shoulder ligament	10.09	9.07	10.63
25116	Remove wrist/forearm lesion	7.38	7.38	7.21
42440	Excise submaxillary gland	7.05	7.05	6.52
52341	Cysto w/ureter stricture tx	6.11	5.35	5.62
52342	Cysto w/up stricture tx	6.61	5.85	6.20
52343	Cysto w/renal stricture tx	7.31	6.55	5.90
52344	Cysto/uretero, stricture tx	7.81	7.05	5.58
52345	Cysto/uretero w/up stricture	8.31	7.55	5.76
52346	Cystouretero w/renal strict	9.34	8.58	6.05
52400	Cystouretero w/congen repr	10.06	8.66	7.00
52500	Revision of bladder neck	9.39	7.99	8.72
52640	Relieve bladder contracture	6.89	4.73	5.01
53445	Insert uro/ves nck sphincter	15.21	15.21	11.72
54410	Remove/replace penis prosth	16.48	15.00	14.00
54530	Removal of testis	9.31	8.35	8.88
57287	Revise/remove sling repair	11.49	10.97	10.20
62263	Epidural lysis mult sessions	6.41	6.41	6.99
62350	Implant spinal canal cath	8.04	6.00	0.41
62355	Remove spinal canal catheter	6.60	4.35	-0.43
62360	Insert spine infusion device	3.68	4.28	-3.14
62361	Implant spine infusion pump	6.59	5.60	-0.92
62362	Implant spine infusion pump	8.58	6.05	-0.51
62365	Remove spine infusion device	6.57	4.60	-0.35
63650	Implant neuroelectrodes	7.57	7.15	4.25
63685	Insrt/redo spine n generator	7.87	6.00	4.80
64708	Revise arm/leg nerve	6.22	6.22	6.17
64831	Repair of digit nerve	10.23	9.00	8.87
65285	Repair of eye wound	14.43	14.43	13.52

[1]We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16: CY 2010 Site-of-Service Anomaly Codes[2]

CPT Code	Short Descriptor	CY 2009 RVUs ("Starting Value")	RUC Recommended Value for CY 2010	CY 2011 Reverse Building Block Value
28120	Part removal of ankle/heel	5.64	8.08	6.03
28122	Partial removal of foot bone	7.56	7.56	6.79
28725	Fusion of foot bones	11.97	11.97	12.41
28730	Fusion of foot bones	12.21	12.21	10.06
36825	Artery-vein autograft	10.00	15	13.12
42415	Excise parotid gland/lesion	17.99	17.99	15.17
42420	Excise parotid gland/lesion	20.87	20.87	17.80
49507	Prp i/hern init block >5 yr	9.97	9.97	9.37
49521	Rerepair ing hernia, blocked	12.36	12.36	11.59
49587	Rpr umbil hern, block > 5 yr	7.96	7.96	7.19
61885	Insrt/redo neurostim 1 array	7.37	7.57	3.22

[2]We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that was somewhat lower than the AMA RUC-recommended value. While our results suggested that the majority of the codes with site-of-service anomalies continue to be overvalued under the AMA RUC's most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is, the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these

inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IWPUT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IWPUT is counterintuitive to the IWPUT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produced aberrant results, and where clinical review indicated a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We noted the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is furnished. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section

1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We noted that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, in the CY 2011 PFS proposed rule (75 FR 40072), we requested that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produced an aberrant result that is clearly not a reflection of physician work for the service, we requested that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produced a result that is consistent with the physician work for the service, we encouraged the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we hoped to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011. Furthermore, we indicated that if the recommendations that we received from the AMA

RUC were not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produced a result that CMS medical advisors believe is consistent with the work for the service, we proposed to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produced a negative work value, we suggested that the AMA RUC review and revise the building blocks of the code so that a new valuation could be determined based on the building block methodology. For such codes, if the revised recommendations that we hoped to receive from the AMA RUC were still not consistent with the building block methodology upon revision, because we could not pay for these services based on negative work RVUs, we proposed to modify the AMA RUC-recommended values for these codes as CMS determined to be clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urged the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) of the Act (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

Comment: While several commenters supported CMS' recommendation to use the reverse building block methodology to value physician work for codes identified as having site-of-service anomalies, the majority of commenters strongly opposed the reverse building block methodology, expressing concern that the methodology produced very low or negative work RVUs for a number of the codes listed in Tables 14 and 15. Several letter writing campaigns by groups of providers and beneficiaries affected by some of the codes listed in Tables 14 and 15 produced scores of comments expressing confusion and alarm that CMS appeared to be on the verge of finalizing negative work RVUs. Some commenters noted that the values calculated by the application of the reverse building block methodology would result in rank order anomalies across the PFS.

Many commenters reiterated CMS' observation that some of the codes were originally Harvard-valued, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code, and an attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology would produce aberrant (that is, very low or negative) results. Some commenters disagreed with CMS' statement that if the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it would be reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time, or intensity, or both. These commenters believe that that this assumption is fundamentally wrong and that the reverse actually may be true. One commenter noted, "When a procedure migrates from the inpatient to the outpatient setting, the physician work and practice expense actually increase. The result is more office visits, more utilization of office staff, more

consumption of office supplies, and no decrease in legal liability to the physician (and in some instances increased legal liability as functions formerly performed by hospital staff are now done by physician office staff)."

A number of commenters asserted that any mathematical or computational methodology used to value physician work is simply absurd. Many commenters stated their preference for the AMA RUC's established valuation process which the commenters believe is based on specialty society survey data. Other commenters asserted that the AMA RUC's use of magnitude estimation is the only methodology that makes sense in assigning physician work values to individual services because the PFS is a relative system and maintaining appropriate relativity between the services is paramount in valuing physician work.

Response: We acknowledge that commenters overwhelmingly objected to the proposed reverse building block methodology because, in some cases, it produced very low or negative physician work values. While we explained in the proposed rule (75 FR 40071 through 40072) the possible reasons why negative values could be generated in the application of the reverse building block methodology, the commenters generally disregarded this explanation and summarily dismissed the methodology as invalid based on the reasoning that negative work values are absurd. Responding to the commenters who were concerned that CMS was preparing to implement negative work RVUs imminently, we assure the commenters that at no time was this a possibility, as we made clear in the CY 2011 PFS proposed rule (75 FR 40072) where we acknowledge that we could not pay for services based on negative work RUVs. As we stated in the proposed rule, in cases where the reverse building block methodology produced a

negative work value, we suggested that the AMA RUC review and revise the building blocks of the code so that a new valuation could be determined based on the building block methodology. We further proposed that if we did not believe the AMA RUC recommended values were consistent with the building block methodology, we would modify the recommended values as we determined to be clinically appropriate and adopt the modified RVUs on an interim final basis for CY 2011.

The AMA RUC has not provided revised work recommendations to us for these codes for CY 2011. Therefore, in light of the strong public opposition to the reverse building block methodology and since we remain convinced that the values for the codes with site-of-service anomalies listed in Tables 14 and 15 continue to be misvalued based on our clinical review of the building blocks for those services as recommended previously by the AMA RUC, we believe that the most appropriate action is to continue to await the further AMA RUC review of these codes that we requested in the CY 2011 PFS proposed rule (75 FR 40072). However, after consideration of the public comments we received, we are modifying our CY 2011 proposal and we will not apply the reverse building block methodology to value any of these codes for CY 2011 as we proposed. We are requesting that the AMA RUC reconsider its previously recommended values that have been applied on an interim basis in CYs 2009 and 2010, as applicable, and revise the work RVUs to better reflect the intensity of the services and the revised physician times and post-procedure visits included in the valuation of these codes. As we stated in the CY 2011 PFS proposed rule (75 FR 40072), we suggest that the AMA RUC review and revise the building blocks of the codes so that a new valuation can be determined based on the building block methodology. Until we receive the revised values from the

AMA RUC for CY 2012 and can make a determination regarding them, we will continue to accept the existing AMA RUC-recommended work RVUs listed in Tables 14 and 15 on an interim basis for CY 2011. We would follow our usual method of reviewing the AMA RUC recommendations in the context of the associated valuation methodologies it used for CY 2012 and would either accept the recommendations for these codes or provide alternative work values that would be adopted on an interim final basis for CY 2012 and open to public comment on the CY 2012 PFS final rule with comment period.

e. Codes with "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight

in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the hospital for less than 24 hours, which often means the patient may indeed stay overnight in the hospital. On occasion, the patient may stay longer than a single night in the hospital; however, in both cases, the patient is considered for Medicare purposes to be a hospital outpatient, not an inpatient, and our claims data support that the typical 23-hour stay service is billed as an outpatient service. Accordingly, we believe that the valuation of the codes that fall into the 23-hour stay category should not reflect work that is typically associated with an inpatient service. For example, inpatient E/M visit codes such as CPT codes 99231 (Level 1 subsequent hospital care, per day); 99232 (Level 2 subsequent hospital care, per day); and 99233 (Level 3 subsequent hospital care, per day), should not be included at the full value in the valuation of 23-hour stay services.

Currently, the valuation of 23-hour stay services is conducted in a nonuniform manner by the AMA RUC. The AMA RUC has indicated that it currently includes a half hospital discharge day management service and no hospital inpatient visits for outpatient services with expected hospital stays of 23 hours or less. In contrast, for those outpatient services where the AMA RUC believes that the recovery period could be longer than 23 hours, the AMA RUC stated in its comment on the CY 2010 PFS proposed rule that it currently includes a full hospital discharge day management service and one or more inpatient E/M visits in the code's value. However, we note the typical 23-hour stay service is billed as an outpatient service and so long as the typical case continues to be

billed as an outpatient service, we believe the code should not incorporate physician work values for services that are typically associated with an inpatient service. In the CY 2010 PFS proposed rule and final rule with comment period (74 FR 33556 and 74 FR 61777, respectively), we stated that we believed the use of inpatient E/M visit codes for services rendered in the post-service period for outpatient 23-hour stay procedures would result in overpayment for pre- and post-service work that would not be furnished. Accordingly, we proposed in the CY 2010 proposed rule (74 FR 33556 through 33557) not to allow any additional inpatient E/M service to be billed for care furnished during the post-procedure period when care is furnished for an outpatient service requiring less than a 24-hour hospital stay.

However, we find it is plausible that while the patient receiving the 23-hour stay service remains a hospital outpatient, the patient would typically be cared for by the physician furnishing the procedure during that post-procedure period. While we do not believe that post-procedure hospital "visits" would be at the inpatient level since the typical case is an outpatient who would be ready to be discharged from the hospital in 23 hours or less, we agree that the intra-service time of the inpatient hospital visit may be included in the valuation for the 23-hour stay code.

Accordingly, for CY 2011 we modified our proposed CY 2010 approach and suggested that in the future, when the AMA RUC reviews new and potentially misvalued codes that are identified as 23-hour stay services, the AMA RUC would apply the following methodology:

- Begin with the starting RVU value of the 23-hour stay code under review and decrease the hospital discharge day management service from one day to a half day.

- Deduct the RVUs of inpatient hospital visits from the starting RVU value.
- Reallocate the time associated with the intra-service portion of the inpatient hospital visits to the immediate post-service time of the 23-hour stay code under review.

Example: A 23-hour stay code is currently valued at 15 RVUs and has 1 hospital discharge day management service and 1 level 3 subsequent hospital care visit incorporated in this value.

- Applying step (1): 15 - 0.64* = 14.36
- Applying step (2): 14.36 – 2** = 12.36
- Applying step (3): 12.36 + (30 minutes x 0.0224)*** = 13.032 RVUs

* Value associated with 1/2 hospital discharge day management service.
** Value associated with an inpatient hospital visit, CPT code 99233.
*** Value associated with the reallocated intra-service time multiplied by the post-service intensity of the 23-hour stay code.

Finally, we note that since work relative value units are established by the Secretary in the context of relativity to other codes in the system, the recommended methodology for the evaluation of 23-hour stay codes is best applied within the context of relativity. We appreciate that the AMA RUC has the ability to assess the 23-hour stay code after application of the recommended methodology to ensure appropriate relativity of this code and other codes within the system. We strongly encourage the AMA RUC to apply the recommended methodology to ensure the consistent and appropriate valuation of the physician work for these services.

Comment: A number of commenters asserted that if a service is performed in the hospital and the patient stays overnight, the work of the physician is typically the same regardless of whether the hospital designates the patient receiving the services as an

inpatient or outpatient. Other commenters supported CMS' position in that it is appropriate for physicians' services related to the post-procedure care of the patient to be recognized and the intra-service time of the inpatient hospital visit should be included in the valuation for the 23-hour stay code. Some commenters noted that recent issues associated with hospital observation care may also be impacting CPT observation care codes, and these commenters "request that any changes in the 23+ hour stay policy be deferred until after the RUC conducts its consideration of hospital observation services in February 2011."

Response: While some commenters advocated for a deferral on the issue of valuing 23-hour stay services, we note that a number of commenters supported CMS' proposed approach. As we stated in the CY 2010 PFS proposed rule (74 FR 33557) and affirmed in the CY 2011 PFS proposed rule (75 FR 40072), we believe these services, for a typical patient, would be considered for Medicare purposes to be hospital outpatient services, not inpatient services, and our claims data support that the typical 23-hour stay service is billed as an outpatient service. Furthermore, since the typical patient commonly remains in the hospital for less than 24 hours, even if the stay extends overnight, and discharge from the hospital is therefore imminent, we believe the acuity of the typical patient is less than that of a typical inpatient who is admitted to the hospital, resulting in less intensity for the physician work to care for the hospital outpatient immediately following a 23-hour stay procedure. Accordingly, we believe that the valuation of the codes that fall into the 23-hour stay category should not reflect physician work that is typically associated with an inpatient service. Furthermore, we do not believe that it would be more beneficial to suspend valuing 23-hour services in the

manner we discussed in the proposed rule until after the AMA RUC's review of hospital observation care services. Even if the AMA RUC were to provide future recommendations to us for valuing surgical procedures in which hospital observation care services were substituted for hospital inpatient care visits, we believe that we should treat the valuation of the physician time in the same manner as discussed previously, that is, by valuing the intra-service time of the hospital observation care service in the immediate post-service time of the 23-hour stay code being valued.

Accordingly, in light of the support from the commenters, we are finalizing our proposed approach to valuing 23-hour stay services by allowing the intra-service portion of the subsequent hospital care visits (or observation care visits in the future if the AMA RUC were to recommend them instead as building blocks for outpatient surgical services) furnished to outpatients in the hospital post-procedure to be allocated to the immediate post-service time of the procedure to account for the physician work in these cases. We encourage the AMA RUC to apply this methodology itself in the recommendations it provides to us for valuing 23-hour stay codes, in order to ensure the consistent and appropriate valuation of the physician work for these services.

4. Expanding the Multiple Procedure Payment Reduction (MPPR) Policy to Additional Nonsurgical Services

a. Background

Medicare has a longstanding policy to reduce payment by 50 percent for the second and subsequent surgical procedures furnished to the same patient by the same physician on the same day, largely based on the presence of efficiencies in the practice expense (PE) and pre- and post-surgical physician work. Effective January 1, 1995, the

MPPR policy, with the same percentage reduction, was extended to nuclear medicine diagnostic procedures (CPT codes 78306, 78320, 78802, 78803, 78806, and 78807). In the CY 1995 PFS final rule with comment period (59 FR 63410), we indicated that we would consider applying the policy to other diagnostic tests in the future.

Consistent with recommendations of MedPAC in its March 2005 Report to Congress on Medicare Payment Policy, under the CY 2006 PFS, the MPPR policy was extended to the technical component (TC) of certain diagnostic imaging procedures performed on contiguous areas of the body in a single session (70 FR 70261). The reduction recognizes that, for the second and subsequent imaging procedures, there are some efficiencies in clinical labor, supplies, and equipment time. In particular, certain clinical labor activities and supplies are not duplicated for subsequent procedures and, because equipment time and indirect costs are allocated based on clinical labor time; those would also be reduced accordingly.

The imaging MPPR policy currently applies to computed tomography (CT) and computed tomographic angiography (CTA), magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA), and ultrasound services within 11 families of codes based on imaging modality and body region. When we adopted the policy in CY 2007, we stated that we believed efficiencies were most likely to occur when contiguous body areas are the focus of the imaging because the patient and equipment have already been prepared for the second and subsequent procedures, potentially yielding resource savings in areas such as clerical time, technical preparation, and supplies (70 FR 45850). Therefore, the MPPR policy currently applies only to procedures involving contiguous body areas within a family of codes, not across families,

and to those procedures that are furnished in a single session. Additionally, while the MPPR policy applies to TC-only services and to the TC of global services, it does not apply to professional component (PC) services.

Under the current imaging MPPR policy, full payment is made for the TC of the highest-paid procedure, and payment is reduced by 25 percent of the TC for each additional procedure when an MPPR scenario applies. We had originally planned to phase in the MPPR policy over a 2-year period, with a 25 percent reduction in CY 2006 and a 50 percent reduction in CY 2007 (70 FR 70263). However, the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171) capped the PFS payment amount for most imaging procedures at the amount paid under the hospital outpatient prospective payment system (OPPS). In view of the DRA, we determined that it would be prudent to retain the MPPR at 25 percent while we continued to examine the appropriate payment levels (71 FR 69659). The DRA also exempted reduced expenditures attributable to the MPPR policy from the PFS budget neutrality provision. Most recently, effective July 1, 2010, section 3135(b) of the ACA increased the MPPR on the TC of imaging services under the policy established in the CY 2006 PFS final rule with comment period from 25 to 50 percent and exempted the reduced expenditures attributable to this further change from the PFS budget neutrality provision.

In the July 2009 GAO report entitled, "Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved when Services are Provided Together," the GAO recommended that we take further steps to ensure that fees for services paid under the PFS reflect efficiencies that occur when services are furnished by the same physician on the same beneficiary on the same day. The GAO recommended the following: (1)

expanding the existing MPPR policy to the PC to reflect efficiencies in physician work for certain imaging services; and (2) expanding the MPPR to reflect PE efficiencies that occur when certain nonsurgical, nonimaging services are furnished together. The GAO also encouraged us to focus on service pairs that have the most impact on Medicare spending.

In the March 2010 report, MedPAC noted its concerns about mispricing of services under the PFS. MedPAC indicated that it would explore whether expanding the unit of payment through packaging or bundling would improve payment accuracy and encourage more efficient use of services.

In the CYs 2009 and 2010 PFS proposed rules (73 FR 38586 and 74 FR 33554, respectively), we stated that we planned to analyze nonsurgical services commonly furnished together (for example, 60 to 75 percent of the time) to assess whether an expansion of the MPPR policy could be warranted. MedPAC encouraged us to consider duplicative physician work, as well as PE, in any expansion of the MPPR policy.

b. CY 2011 Expansion of the Imaging Technical Component MPPR Policy to Additional Combinations of Imaging Services

Over the past 2 years, the AMA RUC has examined several services billed 90 percent or more of the time together as part of the potentially misvalued service initiative and, in several cases, created one code to describe the complete service, with a value that reflects the expected efficiencies. Notwithstanding the bundling work of the RUC, there may be additional imaging and other diagnostic services that are furnished together less than 90 percent of the time where we could still expect efficiencies in the TC, and in

some cases in the PC, resulting in potential overpayment for these services under current policy when furnished together.

Section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) specifies that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service, and review and make appropriate adjustments to their relative values. As a first step in applying this provision, we proposed a limited expansion of the current imaging MPPR policy for CY 2011. We will continue to review other possible expansions of the MPPR policy to the TC and/or PC of imaging procedures or other diagnostic tests for the future. Any further changes will be addressed in future rulemaking.

In a related policy for hospital outpatient payment of imaging services, in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68559 through 68569), the OPPS adopted a policy to pay for two or more CT and CTA, MRI and MRA, or ultrasound procedures furnished in the same session through a single composite ambulatory payment classification (APC) group. These composite APC payments were based on the 11 families of codes subject to the MPPR under the PFS that were collapsed into 3 imaging families for the OPPS according to their modality – 1 for ultrasound, 1 for CT and CTA, and 1 for MRI and MRA services.

At that time, we stated our belief that the contiguous body area concept that was incorporated in the PFS imaging families was not necessary for potential efficiencies to be achieved in an imaging session. We provided examples to illustrate that we would not expect second and subsequent imaging services of the same modality involving noncontiguous body areas to require duplicate facility resources (comparable to the TC

under the PFS) for clinical labor activities such as greeting the patient, providing education and obtaining consent, retrieving prior exams, setting up an intravenous infusion, and preparing and cleaning the room, any more than second and subsequent imaging procedures of the same modality involving contiguous body areas. While we noted that multiple imaging claims under the OPPS are generally within the same imaging modality and involve contiguous body areas the vast majority of the time, we estimated that the collapsed 3 families, as opposed to the 11 PFS families, would add 12 percent additional claims to those eligible for a single composite APC payment under the OPPS based on the provision of 2 or more imaging services in a single session, allowing us to capture additional claims with efficiencies.

Taking into consideration the OPPS policy that was adopted in the CY 2009 OPPS/ASC final rule with comment period, for CY 2011 under the PFS, we proposed to apply the MPPR regardless of family, that is, the policy would apply to multiple imaging services furnished within the same family of codes or across families. This proposal would simplify the current imaging MPPR policy in a way that is consistent with the standard PFS MPPR policy for surgical procedures that does not group procedures by body region. Therefore, the MPPR would apply to CT and CTA, MRI and MRA, and ultrasound procedures services furnished to the same patient in the same session, regardless of the imaging modality, and not limited to contiguous body areas.

Because of the different pieces of equipment used for CT/CTA, MRI/MRA, and ultrasound procedures, it would be unlikely that a single practitioner would furnish more than one imaging procedure involving 2 different modalities to one patient in a single session where the proposed MPPR policy would apply. On the other hand, while most

multiple procedures furnished with a single modality in one session would involve procedures currently assigned to one of the 11 imaging families, it would not be uncommon for more than one imaging procedure of the same modality to be furnished across families and, like the scenario for hospital outpatient imaging services, we would expect efficiencies to occur in these cases. Therefore, we believe that an expansion of the current imaging MPPR policy to account for efficiencies in such situations would allow us to pay more appropriately for these multiple imaging procedure sessions, consistent with our ongoing efforts to address misvalued services.

The expansion of the imaging MPPR policy to include all of the current codes in a single family to which the standard 50 percent reduction for second and subsequent procedures would apply would reduce payment for 20 percent more services than the current MPPR policy under the PFS. Thus, in CY 2011, we would capture additional efficiencies and pay more appropriately in these cases. We note that section 1848(c)(2)B)(v)(VI) (as added by section 3135(b) of the ACA)) specifies that reduced expenditures attributable to the increase in the imaging MPPR from 25 to 50 percent in CY 2011 are excluded from the PFS budget neutrality adjustment. However, the reduced payment for code combinations that would newly be subject to the imaging MPPR policy under this proposal would be made in a budget neutral manner under the PFS, as these new combinations are not included under section 1848(b)(4)(D) (as added by section 3135(b) of the ACA), which addresses "single-session imaging to consecutive body parts" under the established imaging MPPR policy.

We also proposed to add the CY 2010 codes displayed in Table 17 of the CY 2011 PFS proposed rule (75 FR 40075) to the list of imaging services subject to the

MPPR policy in CY 2011. These four codes (CPT codes 75771 through 75774) were newly created for CY 2010 and are similar to codes currently in imaging family 2, titled CT and CTA (Chest/Thorax/Abdomen/Pelvis).

We further note that new CY 2010 CPT codes 74261 (Computed tomography (CT) colonography, diagnostic, including image postprocessing; without contrast material) and 74262 (Computed tomography (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed) were added to the CY 2010 MPPR policy through the July 2010 PFS quarterly update, with a retroactive effective date of January 1, 2010. These codes replaced CPT code 0067T (Computed tomographic (CT) colonography (that is, virtual colonoscopy); diagnostic) in CY 2010, which was on the list of procedures subject to the imaging MPPR policy prior to CY 2010.

As discussed earlier in this section, reduced expenditures attributable to the increase in the MPPR for multiple imaging procedures to consecutive body parts (that is, those previously designated in the same family of codes) are exempt from the budget neutrality provision of the PFS. However, the reduced expenditures attributable to the MPPR for combinations of multiple imaging procedures that we proposed for CY 2011 (the MPPR for multiple imaging procedures not involving consecutive body parts) would be subject to budget neutrality adjustment under the PFS. We note that this formulation for whether reduced expenditures are exempt from budget neutrality applies both to procedures currently subject to the imaging MPPR and to new codes that would be subject to the policy in CY 2011 and in future years. To the extent that imaging procedures described by the new codes are furnished in combination with other

procedures that are subject to the imaging MPPR on consecutive body areas, the reduced expenditures attributable to the MPPR for these combinations would be exempt from the PFS budget neutrality adjustment.

Comment: With one exception, the commenters uniformly opposed the proposal to consolidate the imaging families for application of the imaging MPPR and urged CMS not to finalize the proposal. The exception was MedPAC, which supported the policy as reasonable and consistent with the hospital OPPS policy on multiple imaging and the PFS MPPR policy for multiple surgical procedures, neither of which are limited to procedures involving contiguous body areas.

Many commenters pointed out that the AMA RUC has worked to resolve any duplication in the direct PE inputs for services commonly furnished together over the past few years. The commenters stated that new bundled services were implemented in CY 2010 and speculated that additional ones would be implemented in the future and, therefore, concluded that a general MPPR to adjust PFS payment when imaging services are commonly furnished together is not necessary. The commenters argued that any duplication in the PE should be resolved at the code pair level. The AMA RUC urged CMS to continue to work within the established processes and offered for its Practice Expense Subcommittee to review specific code pairs about which CMS was concerned regarding potential PE duplication and recommend a course of action that would be fair and consistent.

Response: The imaging MPPR is not intended to supersede the AMA RUC process that values services described by CPT codes. We encourage the AMA RUC to continue examining code pairs for PE duplication based upon the typical case and

appropriately valuing new comprehensive codes for bundled services that are established by the CPT Editorial Panel. However, we believe that it is necessary to address the PE duplication immediately for imaging code pairs that have not been recently reviewed or bundled into single comprehensive codes. We note that as more code combinations are bundled into a single complete service reported by one CPT code, they would no longer be subject to the MPPR. For example, there are new CY 2011 codes to describe abdominal and pelvic CT scans furnished together, specifically CPT codes 74176 (Computed tomography, abdomen and pelvis; without contrast material); 74177 (Computed tomography, abdomen and pelvis; with contrast material); and 74178 (Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions). We are accepting the AMA RUC recommendations for the direct PE inputs for these codes for CY 2011 and, therefore, their TCs are valued accordingly. Whereas prior to CY 2011, the 50 percent imaging MPPR would have applied to the TC of the second service when an abdominal and pelvic CT were furnished in the same imaging session, this will no longer be the case in CY 2011. Instead, the TC payment for the comprehensive code will reflect the valuing of the specific services furnished in combination with one another. Thus, we believe our current and proposed MPPR formulations are consistent with the AMA RUC's work to review code pairs for potential PE duplication and to appropriately value comprehensive codes for a bundle of component services.

Comment: Numerous commenters opposed applying the MPPR to noncontiguous body area imaging services using the same modality and to combinations of imaging services involving different modalities. Many commenters indicated that there is no

major duplication in clinical labor activities when two studies of noncontiguous body areas using a single imaging modality are furnished in the same session and even less duplication when imaging services are furnished in a separate session on the same day using different modalities. The commenters argued that the duplication in clinical labor activities that occurs in the pre- and post-operative periods for multiple surgical procedures does not apply to imaging services.

More specifically, several commenters observed that the minimal duplicate costs of a few minutes of technician time do not justify a 50 percent payment reduction in the TC for the second service. Some commenters also believe that the imaging MPPPR creates an incentive for physicians to order separate procedures on different days, thereby discouraging efficiencies. In addition, the commenters contended that the imaging MPPR is detrimental to patient care, access, and convenience.

One commenter asserted that it is not appropriate to compare the OPPS composite ambulatory payment classification (APC) groups to office-based imaging as a justification for expanding the imaging MPPR under the PFS. The commenter cited an analysis of OPPS payment demonstrating that CMS pays hospitals for the second imaging study at nearly 100 percent of the amount paid for a single study, concluding that not until the third study would the payment be reduced from the sum of what would otherwise be paid under the OPPS if the studies were performed alone.

Another commenter agreed that the current PFS imaging families could be further collapsed to eliminate the contiguous body area concept but opposed applying the MPPR across modalities. The commenter suggested establishing three families to parallel the modality-based APC groups used under the OPPS, that is, CT/CTA, MRI/MRA, and

ultrasound. Another commenter noted that highly specialized clinics often treat complex conditions and perform multiple imaging services on noncontiguous body areas primarily for good patient care. As an example of a situation when complex imaging services are used to diagnose and treat significant medical conditions, the commenter indicated that a CT of the chest may be furnished, resulting in a diagnosis of lung cancer. In addition, the same commenter noted that appropriate treatment of the patient's neurological signs and symptoms also requires a CT of the head, because primary lung tumors account for 50 percent of all metastatic brain tumors. The commenter explained that these medically necessary combinations of imaging services are often performed in a single imaging session. Results of the initial imaging service, contended the commenter, could change the course of treatment for the patient and it would be prudent not to delay or complicate a patient's treatment plan. The commenter also pointed out that it is a convenience to the patient to have same day access for all imaging services.

Another commenter acknowledged that while some efficiencies are gained in certain situations and settings when multiple imaging services are furnished together, the expanded MPPR policy would not appropriately pay for the additional studies required for the majority of patients with significant medical conditions. The commenter explained that highly organized clinics treating these complex patients often structure patient encounters so that there are intervening consultations with multiple providers and additional tests in between imaging services.

Response: While most multiple procedures furnished with a single modality in 1 session would involve procedures currently assigned to 1 of the 11 imaging families, it would not be uncommon for more than 1 imaging procedure of the same modality to be

furnished across families, and we would expect efficiencies to occur in these cases. As noted by MedPAC, the proposed PFS MPPR expansion to eliminate the concept of contiguous body areas as the basis for a payment reduction due to efficiencies is consistent with the established hospital OPPS policy on multiple imaging and the PFS MPPR policy for multiple surgical procedures, neither of which is limited to procedures involving contiguous body areas. While we acknowledge that the OPPS composite imaging APCs utilize a different payment methodology than an MPPR to reflect the level of efficiencies when multiple imaging services are furnished together, consideration of the specific body areas imaged is not an aspect of the OPPS policy. The OPPS methodology continues to distinguish among services using different imaging modalities in part because of the statutory requirement that APCs be clinically homogenous. This same limitation would not apply to an MPPR. Despite the differences in their payment methodologies, both the OPPS and the PFS strive to recognize the efficiencies in the TCs when multiple imaging services are furnished together. We continue to believe that there are significant efficiencies in the TCs when multiple imaging procedures of the same modality are furnished on noncontiguous body areas in the same imaging a session, and believe that an expanded imaging MPPR under the PFS is an important policy refinement to pay more appropriately for the comprehensive imaging service under such circumstances.

Because most of the combinations of imaging services furnished in one session that are not now subject to the imaging MPPR occur within one modality, we believe it would be unnecessarily complex to continue separate families (even if fewer than 11) for different imaging modalities to address the limited circumstances when imaging services

furnished with more than one modality are performed in a single imaging session. Even in these unusual cases, we would expect certain efficiencies in the TCs, such as the establishment of venous access only one time. Finally, the more general proposed policy would provide a streamlined basis for our further consideration of other possible expansions of an MPPR policy to the TC and/or PC of imaging procedures or other diagnostic tests in the future.

Consistent with our current expectations for provider ordering practices under the established imaging MPPR policy for single modality, contiguous body area imaging studies, under an expanded MPPR we would not expect providers to order multiple imaging procedures of different modalities or for noncontiguous body areas on different days or order different imaging sessions on the same day simply to garner increased payment unless it were medically reasonable and necessary that the studies be furnished on different days or in different sessions on the same day. However, where it is medically necessary to have intervening consultations among multiple providers or other diagnostic tests furnished to a patient between imaging services on the same day to which the MPPR would otherwise apply, such cases would constitute separate imaging sessions and the MPPR would not apply.

Comment: Many commenters addressed CMS' assertion that because of the different pieces of equipment used for CT/CTA, MRI/ MRA, and ultrasound procedures it would be unlikely that a single practitioner would furnish more than one imaging procedure involving two different modalities to one patient in a single session where the proposed MPPR policy would apply. While most commenters agreed with this statement, the commenters questioned why CMS would implement the proposal if this

were the case. When procedures are furnished across modalities, the commenters believe them to be separate and distinct procedures with little or no overlap and argue that efficiencies cannot be achieved. The commenters asserted that CMS offered no data to support its expectation that efficiencies would occur when different imaging modalities are furnished at the same time. Many commenters requested a more rigorous analysis, validated evidence to support the proposed expansion, and an opportunity for stakeholders to comment on the analysis.

A number of the commenters agreed that specialized staff with different expertise and certification is often needed to furnish services within the different imaging modalities. When multiple imaging is necessary, the commenters explained that two appointments are created, and the patient is checked in twice, prepared and instructed twice, educated on each study independently, transported from one room to another, and furnished separate supplies such as contrast and IV tubing, following which the two rooms are cleaned.

Response: We agree with the majority of commenters that in most cases a practitioner would not furnish more than one imaging procedure involving two different modalities to one patient in a single session. While there may be some instances where the MPPR applies to two different modalities used in a single session, the MPPR would not apply in most cases because this clinical scenario is uncommon. In response to the commenters who questioned why we proposed to apply an MPPR across modalities, we believe that if, in the unusual case, more than one imaging service of different modalities were furnished to a patient in a single session, there would be some efficiencies in the TC, such as greeting the patient only one time and setting up one intravenous line. We

acknowledge that the application of a general MPPR policy to numerous imaging service combinations may result in an overestimate of the efficiencies in some cases and an underestimate in others, but this can be true for any service paid under the PFS, and we believe it is important to establish a general policy to pay appropriately for the TCs of combinations of imaging services upon which we may consider building in the future. We do not believe that it is administratively efficient or necessary for appropriate payment to maintain modality-specific imaging families given the uncommon occurrences of pairs of imaging services involving different modalities furnished by one practitioner on the same day to a single patient that we observe in our claims data.

Comment: Several commenters generally opposed the inclusion of nondiagnostic radiation oncology imaging procedures in any future expansion of the MPPR policy, given the clinical differences between radiation oncology and diagnostic imaging. In addition, one commenter noted that cardiologists commonly provide echocardiography services and peripheral vascular ultrasound tests. While both types of services use ultrasound technology that resembles the technology used in the ultrasound procedures currently subject to the imaging MPPR, the commenter reported that these services are furnished using a different machine and different staff who have different expertise so the imaging MPPR policy.

Response: We did not propose to expand the existing contiguous body area MPPR policy, which currently includes only nonobstetrical chest, abdominal, and pelvic ultrasound services, to include peripheral vascular ultrasound services or echocardiography services in CY 2011. While we explained in the CY 2011 PFS proposed rule (75 FR 40074) that we would continue to review other possible expansions

of the MPPR policy to the TC and/or PC of imaging procedures or other diagnostic tests for the future, we have not proposed to do so at this time. Further changes to include services such as nondiagnostic radiation oncology imaging services or echocardiography or peripheral vascular ultrasound services would be addressed in future rulemaking.

Comment: A few commenters reported that it is often difficult for imaging providers to understand when an encounter begins and ends and, therefore, urged CMS to better define a single session. They explained that it is not always easy to identify when the use of the -59 modifier (Distinct procedural services), denoting a separate session under the current imaging MPPR policy, is appropriate. This ambiguity leaves the responsibility for determining whether imaging services are furnished in a separate session to the judgment of the imaging technologist, leading to inconsistent determinations and, therefore, variable payment for the same services furnished in similar clinical scenarios. One commenter specifically requested further parameters of a separate encounter be defined to include the same exam room, a specific timeframe, or a specific action. Another commenter noted that distinguishing separate sessions is a particular challenge for ultrasound imaging.

Response: In the CY 2006 PFS final rule with comment period (70 FR 70262), we indicated that a single imaging session is one encounter where a patient could receive one or more radiological studies. If a patient has a separate encounter on the same day for a medically necessary reason and receives a second imaging service, this would represent a separate session. Physicians would report the -59 modifier to indicate multiple sessions and the MPPR would not apply. This same policy would continue in CY 2011 under the consolidation of the imaging families to expand the imaging MPPR

under the PFS. We believe that providers' 5 years of previous experience with this policy should allow them to continue to appropriately distinguish separate imaging sessions by reporting the -59 modifier, even under the expanded MPPR policy. We may provide further subregulatory guidance to providers on this issue in the future in view of our CY 2011 expanded imaging MPPR policy if specific issues arise that we believe warrant further clarification regarding the characteristics of separate imaging sessions.

After consideration of the public comments we received, we are finalizing our proposal, without modification, to apply the 50 percent imaging MPPR to all of the ultrasound, CT, CTA, MRI, and MRA services to which the current contiguous body area and modality-specific policy applies, regardless of the specific combinations of imaging services furnished to the patient in a single session. We believe this proposal is consistent with our overall strategy to pay more appropriately for services that are commonly furnished together, consistent with section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) that instructs the Secretary to identify multiple codes that are frequently billed in conjunction with furnishing a single service, and review and make appropriate adjustments to their relative values.

As stated earlier in this section, expenditures attributable to the increase in the MPPR for multiple imaging procedures to consecutive body parts (that is, those previously designated in the same family of codes) are exempt from the budget neutrality provision of the PFS. However, the reduced expenditures attributable to the MPPR for new combinations of multiple imaging procedures that we are finalizing for CY 2011 (the MPPR for multiple imaging procedures not involving consecutive body parts) would be subject to budget neutrality adjustment under the PFS. We note that this formulation for

whether reduced expenditures are exempt from budget neutrality applies both to procedures currently subject to the imaging MPPR and to new codes that are subject to the policy in CY 2011 and in future years. To the extent that imaging procedures described by the new codes are furnished in combination with other procedures that are subject to the imaging MPPR on consecutive body areas, the reduced expenditures attributable to the MPPR for these combinations would be exempt from the PFS budget neutrality adjustment.

The complete list of codes subject to the CY 2011 MPPR policy for diagnostic imaging services is included in Addendum F to this final rule with comment period and the CY 2011 code additions to the MPPR policy are listed in Table 17. The codes being added to the policy are those we proposed, as well as new CY 2011 codes or newly covered codes that are clinically similar to the imaging codes subject to the MPPR in CY 2010. The new codes include CPT codes 74176 (Computed tomography, abdomen and pelvis; without contrast material); 74177 (Computed tomography, abdomen and pelvis; with contrast material(s)); and 74178 (Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions). The newly covered codes are CPT codes 72159 (Magnetic resonance angiography, spinal canal and contents, with or without contrast material) and73225 (Magnetic resonance angiography, upper extremity, with or without contrast material). These codes are being added on an interim final basis and are open to public comment on this final rule with comment period. The complete list of CPT codes newly added to the diagnostic imaging MPPR for CY 2011 is displayed in Table 17 below.

TABLE 17: CPT Code Additions to the Diagnostic Imaging MPPR Policy for CY 2011

CPT Code	Short Descriptor	Subject to Comment in CY 2011 PFS Final Rule
72159	Mr angio spine w/o & w/ dye	Yes
73225	Mr angio upr extr w/o & w/ dye	Yes
74176	Ct abd & pelvis w/o contrast	Yes
74177	Ct abdomen & pelvis w/ contrast	Yes
74178	Ct abd & pelv 1+ section/regns	Yes
75571	Ct hrt w/o dye w/ca test	No
75572	Ct hrt w/3d image	No
75573	Ct hrt w/3d image, congen	No
75574	Ct angio hrt w/3d image	No

c. CY 2011 Expansion of the MPPR Policy to Therapy Services

In the July 2009 GAO report entitled, "Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved when Services are Provided Together," the GAO found efficiencies when multiple physical therapy services were furnished in one session and concluded that an MPPR policy could be appropriate for these services. In the report, the GAO noted that officials from the AMA RUC explained that time spent on pre-service and post-service therapy activities is spread across the number of services in a typical session in order to avoid duplication of the PE for the services. Nevertheless, the GAO found that there was duplication of certain activities in the intra-service period, and provided the example of time spent testing range of motion or muscle flexibility that was duplicated in commonly observed code pairs.

In the typical clinical scenario for therapy services, we believe that therapy services are misvalued for PFS payment when multiple services are furnished to a patient in a single session because duplicate clinical labor and supplies are included in the PE of

the services furnished. We believe this duplication should be accounted for under the PFS, as we currently account for efficiencies in multiple surgical and multiple diagnostic imaging procedures furnished in a single session. Over the past 2 years, the AMA RUC has examined several services billed 90 percent or more of the time together as part of its potentially misvalued service initiative and, in several cases, created one code to describe the complete service, with a value that reflects the expected efficiencies. Notwithstanding the AMA RUC's analyses, in most cases it has not created one code to describe a complete therapy service, in part because many of the core therapy CPT codes are timed codes based on increments of treatment time.

Therefore, in the CY 2011 PFS proposed rule (75 FR 40075), we proposed a further step to implement section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) that specifies that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. For CY 2011 we proposed an MPPR policy for the HCPCS codes listed in Table 18, specifically the separately payable "always therapy" services that are only paid by Medicare when furnished under a therapy plan of care. These services are designated "always therapy" services regardless of who furnishes them and always require therapy modifiers to be reported, specifically -GP (Services rendered under outpatient physical therapy plan of care); -GO (Services rendered under outpatient occupational therapy plan of care); or -GN (Services rendered under outpatient speech-language pathology plan of care). The therapy codes are available in a file on the CMS Web site at: http://www.cms.gov/TherapyServices/. We excluded both contractor-priced and bundled codes from Table 18 because, under our proposal, an MPPR would not be applicable for

"always therapy" services furnished in combination with these codes. In the case of bundled codes that are not separately paid, there are no explicit efficiencies in the direct PE to be reflected in payment for the second and subsequent therapy services furnished to the patient on the same day. In the case of contractor-priced codes, there is no nationally established pricing that could be uniformly adjusted to reflect the expected efficiencies when multiple therapy services are furnished.

TABLE 18: Separately Payable "Always Therapy" Services Proposed as Subject to the CY 2011 MPPR Policy*

CPT/HCPCS Code	Short Descriptor
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx, 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
96125	Cognitive test by hc pro
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy

CPT/HCPCS Code	Short Descriptor
97036	Hydrotherapy
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/o for orthotic/prosth use
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers

*Excludes contractor-priced and bundled codes.

We did not propose an MPPR policy for "sometimes therapy" services, specifically those services that may be furnished under a therapy plan of care or otherwise by physicians or NPPs as medical services. We believe that the care patterns are different for the latter group of services that may sometimes be furnished as therapy services, and we noted that they are less commonly furnished with multiple services in a single session than the "always therapy" services. In the discussion that follows, our reference to therapy services means those HCPCS codes designated annually as "always therapy" services by CMS.

Based on CY 2009 PFS claims data, we identified over 500 therapy service code pairs billed for the same patient in a single session. We then reviewed a sample of the most common therapy code pairs, specifically those high volume code pairs with more than 250,000 combined services per year, to examine the potential for duplication in the PE. These code pairs represented more than half of the occurrences of therapy services billed together. While we acknowledged that the PE inputs per service for some therapy services were included in the direct PE database based on one-half of the total PE inputs required for two services furnished in a single session, which would account for some duplication, this was not the case for all combinations of therapy services. Of the high volume therapy services examined, approximately one-fourth of the code pairs were not valued based on two services. In addition, we noted that the CY 2009 PFS claims data for services paid under the PFS (excluding services furnished in facility settings that were paid at PFS rates) show that when multiple therapy services are billed on a claim for the same date of service, the median number is four services per day. Therefore, even for those clinical labor times that may reflect the allocation of total time across two units of therapy services, we believe that some elements of the current PE inputs are duplicated based on current patterns of therapy service delivery where most multiple service claims involve delivery of more than two services in a session.

In the CY 2011 proposed rule (75 FR 40076), we stated that duplicate labor activities currently included in the PE for the service period for these high volume pairs of therapy services are as follows: clean room/equipment; education/instruction/counseling/coordinating home care; greet patient/provide gowning; obtain measurements, for example, ROM/strength/edema; and post-treatment patient

assistance. The most common duplicate supply item included in the PE was the multispecialty visit pack. Examples of duplicated and unduplicated labor activities and supplies for two sample therapy code pairs and our estimates of potential clinically appropriate time and quantity reductions for multiple service sessions (which were also included in our proposed rule) are displayed in Table 19. We note that CY 2009 PFS claims data for these sample code pairs include over 3.4 million pairs of CPT codes 97112 (Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and /or proprioception for sitting and/or standing activities) and 97110 (Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility) furnished by the same practitioner on the same day and over 500,000 pairs of CPT codes 97001 (Physical therapy evaluation) and 97140 (Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes).

TABLE 19: Examples of Duplicate PE Inputs for Therapy Services that Should be Accounted for When Multiple Services are Furnished in One Session

Example 1: CPT code 97112 (Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and /or proprioception for sitting and/or standing activities) and CPT code 97110 (Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility)

Staff Description	Labor Task Description	Time Period	Code A 97112 Labor Task Time	Code B 97110 Labor Task Time	Total Minute Reduction
Physical Therapy Aide	Clean room/equipment	Service Period, Post-Service	1	1	1
Physical Therapy Assistant	Education/instruction/ counseling/coord home care	Service Period, Post-Service	2.5	2.5	2.5
Physical Therapy Aide	Greet patient/provide gowning	Service Period, Pre-Service	1.5	1.5	1.5
Physical Therapy Assistant	Obtain measurements, eg, ROM/strength/edema	Service Period, Pre-Service	1.5	1.5	1.5
Physical Therapy Assistant	Obtain vital signs	Service Period, Pre-Service	1	1	1
Physical Therapy Assistant	Phone calls between visits with patient, family	Post-Service Period	1	1	1
Physical Therapy Aide	Post treatment patient assistance	Service Period, Post-Service	1	1	1
Physical Therapy Assistant	Review/read documentation, plan of care, treatment goals	Pre-Service Period	1.5	1.5	1.5
Physical Therapy Aide	Verify/Coordinate availability of resources/equip	Pre-Service Period	1.5	1.5	1.5

Supply Description	Price	Code A 97112 Quantity	Code B 97110 Quantity	Code B 97110 Quantity Reduction
pack, minimum multi-specialty visit	$1.14	0.5	0.5	0
Thera-bands (6in width)	$0.06	1.5	1.5	1.5

Example 2: CPT code 97001 (Physical therapy evaluation) and CPT Code 97140 (Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes)

Staff Description	Labor Task Description	Time Period	Code A 97001 Labor Task Time	Code B 97140 Labor Task Time	Total Minute Reduction
Physical Therapy Aide	Clean room/equipment	Service Period, Post-Service	3	1	1
Physical Therapy Assistant	Education/instruction/ counseling/coord home care	Service Period, Post-Service	2	1	1
Physical Therapy Aide	Greet patient/provide gowning	Service Period, Pre-Service	3	1.5	1.5
Physical Therapy Assistant	Obtain measurements, eg, ROM/strength/edema	Service Period, Pre-Service	8	1.5	1.5
Physical Therapy Assistant	Obtain vital signs	Service Period, Pre-Service	3	1	1
Physical Therapy Assistant	Phone calls between visits with patient, family	Post-Service Period	2	1	1
Physical Therapy Assistant	Review/read documentation, plan of care, treatment goals	Pre-Service Period	1	.5	.5
Physical Therapy Aide	Verify/Coordinate availability of resources/equip	Pre-Service Period	3	1.5	1.5
Physical Therapy Aide	Prep and position patient	Service Period, Pre-Service	2	0	0
Physical Therapy Aide	Prepare room, equipment, supplies	Service Period, Pre-Service	2	0	0
Physical Therapy Aide	Post treatment assistance	Service Period, Post-Service	0	1	0

Supply Description	Price	Code A 97001 Quantity	Code B 97140 Quantity	Code B 97140 Quantity Reduction
pack, minimum multi-specialty visit	$1.14	1	0.5	0.5
lotion, message, unscented	$0.158	0	0.5	0

In the CY 2011 PFS proposed rule (75 FR 40078), we did not remove minutes for clinical labor tasks that were not duplicated. For example, for CPT code pair 97001 and 97140 the following tasks were not duplicated: post treatment patient assistance; prep

and position patient; and prepare room, equipment, and supplies. In addition, we did not remove any supply items that would be required for only one of the separate services because these would not be duplicated in the PE applicable to the combination of services. We estimated no reduction for equipment time, even though efficiencies would be expected for equipment that is used in both services when they are furnished together. Finally, a corresponding reduction to the indirect expenses would be appropriate since indirect costs are allocated partially based on direct costs. For five high volume therapy code pairs that each occur over 2 million times in PFS claims for multiple therapy services and account for almost half of such claims, we estimated that the resulting reduction in the PE for the lower paying code would range from 28 to 56 percent.

As we summarized in the CY 2011 PFS proposed rule (75 FR 40078), given the duplicative clinical labor activities and supplies as shown in the code combination examples, we believe it would be appropriate to extend the MPPR policy that is currently applied to surgical services and the TC of imaging services, to the PE component of certain therapy services. Specifically, we proposed to apply a 50 percent payment reduction to the PE component of the second and subsequent therapy services for multiple "always therapy" services furnished to a single patient in a single day. Because we believed it would be difficult to determine the precise beginning and end of therapy sessions and we did not believe that beneficiaries would typically have more than one therapy session furnished in a single day, we proposed to apply the 50 percent MPPR policy to the PE component of subsequent therapy services furnished to the same patient on the same day, rather than limiting the proposed policy to services furnished in the same session.

We noted that many therapy services are time-based CPT codes, so multiple units of a single code may be billed for a single session that lasts for a longer period of time than one unit of the code. The proposed MPPR policy would apply to multiple units of the same therapy service, as well as to multiple different services, when furnished to the same patient on the same day. Therefore, we proposed that full payment would be made for the service or unit with the highest PE and payment would be made at 50 percent of the PE component for the second and subsequent procedures or units of the same service.

We proposed that the work and malpractice components of the therapy service payment would not be reduced. For therapy services furnished by an individual or group practice or "incident to" a physician's service, the MPPR would apply to all "always therapy" services furnished to a patient on the same day, regardless of whether the services are furnished in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology. The MPPR policy would apply to both those services paid under the PFS that are furnished in the office setting and those services paid at the PFS rates that are furnished by outpatient hospitals, home health agencies, comprehensive outpatient rehabilitation facilities (CORFs), and other entities that are paid by Medicare for outpatient therapy services. Table 20 provides a sample calculation of the current and proposed CY 2011 payment for multiple therapy services furnished in on the same day. For those services paid under the PFS, the PFS budget neutrality provision would apply so that the estimated reduced expenditures for therapy services would be redistributed to increase payment for other PFS services.

TABLE 20: Sample Payment Calculation for Multiple Therapy Services Furnished to a Single Patient on the Same Day

	Procedure 1 Unit 1	Procedure 1 Unit 2	Procedure 2	Current Total Payment	Proposed CY 2011 Total Payment	Proposed Payment Calculation
Work	$7.00	$7.00	$11.00	$25.00	$25.00	no reduction
PE	$10.00	$10.00	$8.00	$28.00	$19.00	$10 + (0.5 x $10) + (0.5 x $8)
Malpractice	$1.00	$1.00	$1.00	$3.00	$3.00	no reduction
Total	$18.00	$18.00	$20.00	$56.00	$47.00	$18 + $7 + (0.5 x $10) + $1 + $11 + (0.5 x $8) + $1

In the CY 2011 PFS proposed rule (75 FR 40078), we stated that we believe the proposed therapy MPPR policy would provide more appropriate payment for therapy services that are commonly furnished together by taking into account the duplicative clinical labor activities and supplies in the PE that are not furnished more than once in the single therapy session. This approach is consistent with the statutory requirement for the Secretary to identify, review and adjust the relative values of potentially misvalued services under the PFS as specified by section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA). We also believe this proposed policy is responsive to continued concerns about significant growth in therapy spending and to MedPAC and GAO recommendations regarding the expansion of MPPR policies under the PFS to account for additional efficiencies. We observed that paying more appropriately for therapy services based on PE relative values that are adjusted for the clinical scenario under which the services are furnished would result in reduced therapy expenditures, and beneficiaries would be able to receive more medically necessary outpatient therapy services before reaching the therapy cap. For a further discussion of potential alternatives to the therapy caps, we refer readers to section III.A.2. of this final rule with comment period.

Comment: Many commenters opposed application of the proposed MPPR policy to therapy services. The commenters characterized the proposal as drastic, arbitrary, and unfair, resulting in across-the-board cuts based on flawed assumptions that would lead to therapy underpayments that would jeopardize access to necessary care and harm patients. The commenters requested that CMS withdraw the proposal, study the issue further, and share the analyses with the public.

In contrast, MedPAC supported the general direction of the proposed policy, but suggested that CMS better justify how a 50 percent reduction would capture the duplicate inputs related to multiple therapy services performed in a single session. MedPAC also recommended that CMS request that the AMA RUC review the values of all outpatient therapy codes to ensure that the practice expenses are not duplicated, regardless of whether or not the current values of those codes assume that two services are furnished during a single visit.

Numerous commenters requested a detailed justification for the proposed policy's 50 percent reduction, including an explanation of the methodology used to calculate the new payments that would result. These commenters asked CMS to work with stakeholders to finalize a policy that would not adversely impact access to care, particularly in rural and other underserved areas. The commenters further urged consideration of other payment methods and alternatives to the therapy caps that would preserve and improve access to therapy services. The commenters stated that between 80 to 90 percent of physical therapy services furnished in private practices would potentially be subject to the MPPR, concluding that the policy would result in payment decreases of 19.2 percent and 17.8 percent for physical therapy services in facilities and offices,

respectively, notably more than the CMS' impact estimate of 11 percent for the proposed rule.

The commenters provided analyses to show that the duplication of supplies is very limited and argued that a more thorough analysis of duplication based on expert clinical review would result in considerably lower estimates of duplication. For example, the AMA RUC explained that for a typical single session combination of 2 units of CPT code 97110 (Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility) and one unit of 97140 (Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes), a $12 PE payment reduction from the MPPR would be applied to adjust for $3.60 in potentially duplicated costs.

Before implementing an MPPR, the commenters urged CMS to take time to ensure that individual services were valued correctly based upon the resources needed to deliver them. The commenters advised CMS to conduct a more thorough analysis, taking into consideration the fact that the direct PE inputs for therapy services were already reduced to avoid duplication. The commenters alleged that CMS provided incorrect examples of duplication in the proposed rule examples by overestimating the duplication compared to the standard time allocated by the AMA RUC for certain activities. The commenters explained that PE for therapy services was valued by the AMA RUC based upon three units of service, not two units of service as stated by CMS in the proposed rule. Three units of service are typical, and the commenters contended that no duplication of PE exists when the typical three units of service are delivered using typical

time allotments for clinical labor activities. The commenters submitted multiple examples of combinations of therapy services, using the most frequently billed therapy codes and providing valuations for each of the components of PE, such as pre-service and post-service physical therapy assistant activities. The commenters pointed out that in the case of single unit therapy claims, or claims with one therapeutic procedure and one modality, there would currently be underpayment based on how therapy services are valued. The commenters further argued that it would not be fair to apply the MPPR to all subsequent services when some of the code combinations are already undervalued.

Many commenters observed that the AMA RUC has worked in good faith to resolve any duplication in the PE inputs over the past few years and pointed out that CMS has historically accepted over 90 percent of the AMA RUC's recommendations. In April 2010, some commenters reported that the AMA RUC reviewed high volume therapy code pairs that included the most frequently billed therapy CPT code 97110, and the commenters conveyed the AMA RUC's conclusion that there is no duplication in the work or PE inputs for the most frequently reported therapy codes.

The commenters pointed out that single comprehensive codes for certain bundles of component services were implemented in CY 2010, and that additional ones would be created in the future. Therefore, the commenters disagreed with CMS' reasoning for proposing a general MPPR that is not code pair-specific in the context of these ongoing efforts of the CPT Editorial Panel and the AMA RUC to revise the coding and values for services that are commonly furnished together. Instead, the commenters urged CMS to continue to work within the established processes and resolve duplication, where it exists, at the code pair level rather than with payment.

Response: We appreciate the detailed information provided by the commenters regarding the historical AMA RUC process to value the therapy codes and the additional examples of the practice expenses as they apply to the many combinations of therapy services that may be reported. We understand that the AMA RUC valued many of the therapy services based on certain assumptions about the typical combinations of services furnished in a therapy session. However, as the commenters pointed out, there are numerous combinations of therapy services observed in the PFS claims data that we posted on the CMS web site under supporting files for the CY 2011 PFS proposed rule that are commonly furnished in the physician's office setting. In the context of this large number of commonly observed combinations, we do not believe that our usual PFS methodology of valuing the typical service adequately accounts for the duplication in PE that occurs in the many possible therapy service combinations. Although they are frequent, they do not represent the typical case used by the AMA RUC in valuing the individual component services and, thus, do not fully account for duplications in PE. We proposed the therapy MPPR in order to pay more appropriately for therapy services in general by adjusting for the duplicate payment for the PE that may occur when combinations of therapy services are furnished together.

We agree with the commenters that, when considering all claims for therapy services paid under the PFS, the median number of services is three. Thus, that number may have been appropriate for the AMA RUC to use in valuing therapy services. However, the median number of four services that we presented in the CY 2011 PFS proposed rule was based upon all claims for multiple therapy services, and did not include claims for a single therapy service. It was the multiple service claims that we

examined for purposes of the MPPR analysis, and it is these claims to which the MPPR would apply. Therefore, we continue to believe that the median number of four is the appropriate reference point when evaluating an MPPR. We note further that when the AMA RUC valued certain therapy services based on the assumption that a combination of three types of therapy services would be furnished to the patient, then in the case of multiple service claims where the median number of services is four, some PE duplication would clearly occur for the typical multiple service case with more than three services.

Although we continue to believe that 50 percent would generally be an appropriate level for an MPPR for the PE component of payment for therapy services, consistent with the current PFS MPPR policies for imaging and surgical services and our PE overlap analysis of certain therapy code combinations for the CY 2011 PFS proposed rule, we acknowledge there are particular challenges associated with establishing an MPPR for therapy services to account for the duplication in PE. For example, the current coding structure for therapy services relies upon timed units in many cases, and as a result, the number of commonly observed combinations is very large. The PE overlaps vary depending upon the specific combinations of services furnished to the patient, which may include evaluation services, therapeutic procedures, and therapeutic modalities. The common occurrence of such a great variety of multiple therapy code combinations contrasts with the relatively lesser number of combinations and/or frequency of combinations of surgical procedures or diagnostic imaging procedures to which the established PFS MPPR policies apply.

As the commenters pointed out, the direct PE inputs for certain therapy services

were systematically established based upon a standard AMA RUC methodology of three therapy services furnished in a session that included two therapeutic procedures and one therapeutic modality and that assigned certain PE inputs solely to the two therapeutic procedures. However, the scenarios utilized by the AMA RUC in this process are an incomplete representation of the usual combinations of services reported when therapy services are furnished in a practitioner's office. For example, the most common combination of CPT codes for therapy services in CY 2009 PFS claims data consisted of an average of 3.5 services which were comprised of some combination of one or more units of a single therapeutic procedure CPT code and one or more units of a single modality CPT code, rather than 3 total units of the services. The second most common combination was a therapeutic procedure CPT code alone, with an average of 2.8 units, while the AMA RUC relied upon 2 therapeutic procedures in a session for its assignment of certain PE inputs. Other commonly observed combinations of codes included 3.4 to 4.6 therapy services, with different numbers of therapeutic procedures and therapeutic modalities furnished to the patient than were assumed by the AMA RUC under the scenarios that were the basis for establishing the PE inputs for certain therapy CPT codes. Therefore, despite the AMA RUC's consideration of multiple services for valuation, the therapy code combinations as actually reported by practitioners would typically have some additional duplication in their PE. Thus, while the current PFS values for therapy services may reflect some efficiencies in the PE for certain code combinations based on the AMA RUC approach to valuation (to the extent we accepted the AMA RUC recommendations), the actual efficiencies are not fully recognized in the PE inputs for the most commonly reported therapy code combinations, nor are they

necessarily recognized in the many other common code combinations that were not considered by the AMA RUC as the typical case.

Based on our review of the scenarios submitted by the commenters, we continue to believe that there is significant overlap in the PE when many combinations of therapy services are furnished together and that this overlap has not been adequately accounted for in the direct PE inputs that the AMA RUC has recommended to us for the component services. We believe the overlaps remain substantial and they can be potentially higher than 50 percent for some combinations while lower for others. Our analysis of five high volume therapy code pairs as noted in the CY 2011 PFS proposed rule (75 FR 40078) suggested a reduction in the PE for the lower paying code of 28 to 56 percent to account for PE duplication.

In response to the commenters who projected that the impact on physician's office payment for physical therapy services would be greater than the 11 percent reduction we modeled for the proposed rule (75 FR 40232), we note that an additional element of our analysis was the continued transition to setting the PE RVUs based on the PPIS data. The PPIS transition is expected to significantly increase payment for the PE component of therapy services in CY 2011. While we acknowledge that the estimated change in PE RVUs due to the proposed therapy MPPR alone would result in a payment decrease for the specialty of physical and occupational therapy of somewhat more than 11 percent, it is the combined consideration of all factors affecting the CY 2011 PE RVUs that resulted in the 11 percent decrease for physical and occupational therapists in the proposed rule specialty impact table (75 FR 40232). We note further that the estimated impact of all the PE RVU changes for physical and occupational therapy based upon our proposals for

CY 2011 if there were no remaining transition to the new PE RVUs using the PPIS data would be –7 percent.

Any MPPR policy, such as the MPPR that currently applies to surgical services and imaging procedures, is a relatively blunt payment policy tool that improves the overall accuracy of payment when combinations of services are furnished together but is not, by its nature, a specific policy that precisely values each code combination. A general MPPR is not unlike the well-established PFS pricing methodology that relies on the typical case, where we readily acknowledge that the clinician's resources used to furnish a specific service to a specific patient on a specific day may be more or less than those used in the typical case. Similarly, while we believe that an MPPR would generally improve the accuracy of PFS payment when multiple therapy services are furnished to a single patient in a single session, we understand that for a specific combination of services for a given patient, the resources required may be more or less than those recognized for payment under the MPPR policy. In view of the requirements of section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) which specify that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service and make RVU adjustments, we continue to believe it would be appropriate to expand the current PFS MPPR policies to address those scenarios where we conclude that combinations of services commonly furnished together are systematically overvalued.

We believe the more specific valuation of common code combinations is best conducted with input from the AMA RUC as it evaluates single new comprehensive codes for a bundle of component services when those new codes are established by the

CPT Editorial Panel. In such cases where a single code is used to report a comprehensive service, an MPPR would no longer apply, which would be appropriate because the potential for PE duplication would have been explicitly considered in determining the PE inputs for the comprehensive service. As we stated earlier in this section concerning the MPPR for imaging services, the MPPR is not intended to supersede the AMA RUC process. We encourage the AMA RUC to reexamine the values and direct PE inputs for therapy services, including code pairs, for duplication in the PE, and to recommend therapy services to the CPT Editorial Panel for consideration of bundling into comprehensive codes. However, we believe it is appropriate to use an MPPR to address the PE duplication that is currently present within the PFS RVUs for the therapy codes when more than one service is furnished to a patient.

After consideration of the public comments we received, we are adopting, with modifications, our proposal to establish a MPPR policy for "always therapy" services for CY 2011. However, given the complexities involved in establishing an MPPR for the very large number of therapy codes and combinations, rather than the proposed 50 percent payment reduction to the PE component of the second and subsequent "always therapy" services billed by the same practitioner or facility on the same date of service for the same patient, we are adopting a 25 percent MPPR for “always therapy” services furnished in CY 2011. We continue to believe that a 50 percent MPPR for therapy services may be appropriate in light of our analysis of five high volume therapy code pairs that each occur over 2 million times in PFS claims for multiple therapy services and account for almost half of such claims, and for which we estimated that the resulting reduction in the PE for the lower paying code would range from 28 to 56 percent.

However, we believe a 25 percent MPPR represents an appropriate and conservative first step toward eliminating payment for duplicative PE when multiple "always therapy" services are furnished to the same patient by the same therapy provider on the same date of service. We note that a 25 percent MPPR represents half the proposed reduction, and is slightly less than the lower range of the reduction suggested by our analysis of high volume code pairs. During CY 2011 and future years, we will continue to refine our analyses and consider whether further modifications to the policy would be appropriate, including the possible adoption of a 50 percent MPPR or a different payment percentage reduction. Any further changes to the MPPR for therapy services will be addressed in future rulemaking, including the possible adoption of any alternative percentage payment reduction to the 25 percent MPPR that will be in place for CY 2011. We will also closely follow the work of the CPT Editorial Panel and the AMA RUC with respect to the coding and valuation for therapy services over the next few years as we assess the potential merits of further changes to the MPPR policy. We note that the typical reductions in total PFS payment for high utilization therapy code combinations due to the MPPR alone would fall within the range of 7 to 9 percent under our final policy, but this decrease will be mitigated by the continued transition to use of the PPIS data. As displayed in Table 101 of this final rule with comment period, we estimate that the CY 2011 impact on the PE RVUs of the new therapy MPPR and continued PPIS transition is a reduction in PFS payment to physical and occupational therapists of approximately -3 percent.

The final list of CY 2011 CPT codes for "always therapy" services that are subject to the therapy MPPR is displayed in Table 21 at the end of this section.

Comment: Some commenters pointed out that CMS' analysis was based only on data from physicians and private practice therapists, which the commenters opposed as unrepresentative of the typical therapy session because the data represent only 35 percent of outpatient therapy services paid under Medicare. The commenters objected that no data from skilled nursing facilities (SNFs), rehabilitation agencies, CORFs, and hospital outpatient departments were considered in the analysis. The commenters reported that application of the MPPR policy on a per-day basis would be inconsistent with the delivery of therapy services in provider settings where multiple sessions of the same or different disciplines of therapy on the same day are commonly furnished to "captive" patients and would unfairly reduce payment for the resources used to provide these services. The commenters believe there is no duplication in the PE in such circumstances. Some commenters suggested that reductions should not be applied when there is a break in services into more than one session in the same day.

Response: With respect to payment under the PFS, according to section 1848(c)(1)(B) of the Act, the term "practice expense component" means the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses. Under section 1848(c)(2)(C)(ii) of the Act, we are required to determine PE RVUs based on the relative practice expense resources involved in furnishing services. We develop these resource-based PE RVUs by looking at the direct and indirect physician practice resources involved in furnishing each service. To establish the direct PE inputs for services paid under the PFS, we consider the typical clinical scenario in which those services are delivered and paid by Medicare. In the case

of therapy services that are paid under the PFS, the scenarios we consider are office-based (not institutional) because these therapy services are the only ones that are actually paid under the PFS (section 1848 of the Act) and subject to all of the provisions of the PFS, including budget neutrality under section 1848(c)(2)(B)(ii)(II) of the Act. Section 1834(k)(3) of the Act then requires that we pay for all outpatient therapy services at the applicable PFS amount. Therefore, our analyses and policy development regarding the therapy MPPR were based solely on claims for office-based therapy services and, given the applicable statutory payment provisions; we do not believe it would have been appropriate for us to consider institutional patterns of care in setting PFS rates for therapy services.

We are required to establish the values for services paid under the PFS (office-based services) so that therapy services are valued appropriately in the context of all other services paid under the PFS, and that means ensuring that therapy services are appropriately valued for the office setting. In the case of other services paid under the PFS that may be furnished in both facility and nonfacility settings, we generally establish separate but related facility and nonfacility values to differentially value the services when furnished in each of the two types of settings. However, therapy services are only paid under the PFS when furnished in the office setting, so we establish the PFS values for therapy services based on patterns of care in the office setting. This approach ensures equitable and relative treatment of all services paid under the PFS with respect to the statutory provisions that apply to the PFS, including year-to-year budget neutrality. In contrast to other services paid under the PFS, the statute then specifies that we pay for therapy services furnished in facility settings at the applicable PFS amount (which, as

discussed above, is established based upon our resource-based methodology for services furnished in nonfacility settings). Although the statutory payment scheme for therapy services differs from most other services, we note that this treatment ensures that Medicare payment is the same across all settings for outpatient Part B therapy services.

We acknowledge the commenters' point that multiple therapy sessions furnished to one patient by one provider (one National Provider Identifier (NPI)) in a single day are more common in facility settings than in the office setting. However, we continue to believe that in these situations there would be some overlaps in the PE, including patient education and obtaining measurements, that would be appropriately accounted for through the therapy MPPR. Furthermore, given the nature of therapy services and the associated coding, we believe it would be very challenging to determine the medical necessity of multiple therapy sessions on one date of service or the precise beginning and ending of therapy sessions if we were to exclude from the MPPR those therapy services furnished by the same provider to a single patient on the same day but in different sessions, although we acknowledge that this modification would be consistent with our established policy for the imaging MPPR.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to apply the therapy MPPR when multiple therapy services are billed on the same date of service for the same patient by the same practitioner or facility under the same NPI, regardless of whether those therapy services are furnished in separate sessions.

Comment: Many commenters objected to applying the MPPR across therapy disciplines because the commenters argued that physical therapy, occupational therapy,

and speech-language pathology (SLP) are separate and distinct interventions furnished independently by individually licensed professionals, each of which is certified to provide unique and specialized services that do not cross discipline or service lines. Several commenters explained that each discipline involves entirely different skills, equipment, supplies, and treatment goals, and separate disciplines are often located in different treatment settings. Individual plans of care, explained the commenters, are separately maintained for each therapy discipline and contain specific goals and treatments. Some commenters compared the proposal to claiming that services furnished to a single patient on the same day by a cardiologist and internal medicine specialist contain duplicative PE inputs. The same commenters described administrative contact with the patient in this scenario as distinct and separate, observing that greeting and gowning the patient, cleaning, and assistant activities are furnished independently by the second or subsequent discipline, and cannot be shared.

The large majority of commenters argued that the proposal did not make logical distinctions between therapy treatments or specialties or even properly distinguish between the skills of rehabilitation practitioners. While physical therapists and occupational therapists report the same CPT codes, the commenters noted that the codes do not represent the same service and the plan and approach to treatments differ depending on the discipline.

Response: We recognize that the therapy disciplines are separately qualified professionals who address specific impairments using separate and unique skills. However, in the office setting which is the basis for our valuing therapy services for payment under the PFS as discussed previously, although we believe it would be

uncommon for services to be furnished to a single patient by different therapy disciplines and billed by a single provider (one NPI) on the same date of service, we continue to believe that there would be some overlap in the PE in this circumstance. The PE overlaps that we would anticipate include greeting the patient, obtaining vital signs, and post-visit phone calls. We do not agree with the commenters that we should accept such multiple discipline cases from the therapy MPPR that would otherwise apply.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to apply the therapy MPPR to all therapy services across the disciplines billed on the same date of service for the same patient by the same practitioner or facility under the same NPI.

Comment: Several commenters pointed out that, unlike other therapy services, many SLP services contain therapist work in their PE because SLPs have no assistants. These commenters requested that the therapy MPPR not be implemented, or at least be delayed, until the AMA RUC completes its plan to recommend moving SLP work from PE to work. In addition to bundled codes, the commenters also requested that add-on codes, such as CPT code 92608 (Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)), be exempted from the therapy MPPR, since the PE inputs for add-on codes explicitly take into consideration the PE inputs for a base code that is always reported. The commenters reported that the major SLP codes include a wide variety of service types and are essentially bundled already, meaning that SLP practitioners rarely bill two different services on the same day for the same patient. The commenters expressed concern

because SLP services are furnished and valued differently than physical and occupational therapy, yet the proposed rule contained no SLP examples to justify including SLP codes in the MPPR or to estimate the impact on SLP services.

Response: We note that most of the SLP codes will have been valued with therapist work in the work component of the SLP service RVUs by CY 2011, although we do not see the continued valuation of therapist work in the PE as an impediment to application of the MPPR to SLP services. Since many single SLP codes represent multiple component services that are reported using a single comprehensive code, the impact of the therapy MPPR on PFS payment for SLP services would be minimal. For those services that may occasionally be billed with more than one SLP code for a session, we see no basis for treating SLP services differently than other therapy services because we believe there would also be PE duplication in these cases.

However, we agree with the commenters that add-on codes should not be subject to the MPPR for therapy services because their PE inputs already consider that the add-on code is always furnished along with a primary service.

Therefore, after consideration of the public comments we received, we are removing add-on therapy CPT code 92608 from the list of "always therapy" services that we proposed for application of the therapy MPPR policy. In addition, we are removing CPT code 97010 (Application of a modality to 1 or more areas; hot or cold pack) which is a bundled code that was inadvertently included on the proposed list. These changes are reflected in the final list of codes subject to the therapy MPPR policy that is displayed in Table 21 at the end of this section. This policy parallels our treatment of the MPPR for surgical services, where surgical add-on codes are not subject to the surgical MPPR.

Comment: Some commenters characterized the proposed therapy MPPR as contrary to the objectives of the ACA, which the commenters believe was designed to shift care to the most effective and efficient delivery setting to ensure beneficiary access to cost-effective, high quality and coordinated care. Because therapy services do not involve expensive drugs or testing, yet they assist patients in avoiding or reducing other medical costs, many commenters believe that physical therapy is the most efficient and cost-effective treatment to return patients to independent function. The commenters contended that growing Medicare expenditures for the treatment of common musculoskeletal problems could easily be controlled by earlier access of patients to physical therapy services.

The commenters were concerned that lower therapy payments would exacerbate the shortage of therapists, lead to restricted access to therapy services, especially in rural areas, and result in patients who are more prone to injuries and functioning at a lower level. Undertreated functional impairments, argued the commenters, would lead to increased spending for medication and medical costs associated with decreased mobility, pain and falls, increased emergency room services, longer inpatient stays, quicker returns to the hospital setting, and earlier placement in nursing homes.

In addition, some commenters were concerned that the MPPR would provide an incentive to schedule patients in a manner that would be inefficient, inappropriate, and inconvenient for patients. The commenters noted that research proves therapy is more effective for many elderly patients with several visits on the same day, separated by rest. The commenters indicated that patients in rural communities prefer multiple therapy service visits to minimize lengthy commutes.

Response: Through the CY 2011 proposed rule and its associated public comment period, we have invited public involvement in the process of policy development regarding an MPPR for therapy services. We believe the therapy MPPR policy is fully consistent with section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) which specifies that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service, and review and make appropriate adjustments to their relative values. Therefore, we do not agree with the commenters that the MPPR policy undermines the goals of the ACA but, instead, we believe the policy fulfills one of our statutory obligations by valuing more appropriately combinations of therapy services furnished to patients and paid under the PFS. We have no reason to believe that appropriately valuing services for payment under the PFS by reducing payment for duplication in the resource-based PE payment for the component services would contribute to therapist workforce shortages or limit patients' access to medically reasonable and necessary therapy services.

With respect to the ordering and scheduling of therapy services for Medicare beneficiaries, we require that Medicare-covered services be appropriate to patient needs and that a physician certifies each patient's plan of care. We would not expect the adoption of an MPPR for therapy services to result in therapy services being furnished on separate days by one provider so that the provider may garner increased therapy payment unless this pattern of care is the most clinically appropriate for the patient. We agree with the commenters that this unprofessional behavioral response on the part of practitioners would be inefficient and inappropriate and could result in patient compliance problems with the plan of care. We will continue to monitor access to care

and patterns of delivery for therapy services, with particular attention focused on identifying any changes in the delivery of same day therapy services that may be inappropriate.

Comment: Several commenters noted that CMS has contracted with Computer Sciences Corporation (CSC) and RTI International to develop outpatient therapy payment alternatives and urged CMS to place a high priority on the development of an alternative payment approach for therapy services rather than applying the proposed MPPR. Many commenters supported bundled per-session codes that would vary based on the severity of the patient and the complexity of evaluation and treatment services, and some commenters believe this payment approach would be more equitable than the proposed MPPR. The commenters argued for a scientific approach to the development of alternatives to the current payment system, which the commenters believe contrasts with the analysis presented by CMS to support the MPPR. However, most commenters encouraged further study and development before implementation of any alternatives. Many commenters pledged to work with CMS in the future to further develop a bundled service approach based on episodes of care.

Response: We appreciate the effort and useful information contributed by stakeholders to the discussion and development of alternatives to the therapy caps and we refer readers to section III.A.2. of this final rule with comment period for a further discussion of the public comments and our responses on this issue. We look forward to the continued cooperation of stakeholders as we continue our work in this area over the coming years. However, we do not believe short-term alternative payment options for therapy services are sufficiently developed to warrant immediate implementation, and the

commenters on the CY 2011 PFS proposed rule generally shared that view. In contrast, we believe that we can implement an appropriate MPPR for therapy services beginning in CY 2011 that would immediately provide more appropriate payment for the PE component of therapy services when multiple therapy services are furnished to one patient on one date of service by one provider. Paying more appropriately for therapy services in CY 2011 will allow patients to receive more medically necessary therapy services before reaching the therapy cap. To the extent that the therapy MPPR encourages the future bundling of therapy codes into a single comprehensive service that would be specifically valued, we support the exploration of that concept to capture the specific efficiencies associated with certain combinations of therapy services.

Comment: Several commenters asserted that the therapy MPPR proposal violated the Administrative Procedure Act (APA), alleging the proposal was arbitrary and capricious. In addition, some commenters argued that CMS did not provide sufficient information regarding the data and analysis used to develop the policy to allow the informed public input from qualified providers of therapy services.

Response: Consistent with the requirements of the APA, a full description of our analysis and the rationale we used as the basis for the proposed therapy MPPR policy was presented in the proposed rule, the public comments on our proposal have been reviewed, and our responses are provided in this final rule with comment period. Although many commenters requested that we share more data to support the proposed policy, several commenters demonstrated that they have their own access to Medicare data by submitting reports to us along with their comments in order to support their views or to refute the examples we presented in the proposed rule. We note further that we posted therapy

utilization data on the CMS web site after publication of the proposed rule to provide additional information regarding the specific combinations and utilization of therapy services on PFS claims. The information was posted under downloads for the CY 2011 PFS proposed rule at: http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage. Therefore, we believe the final MPPR for therapy services is being adopted in compliance with the notice and comment rulemaking process under the APA.

In summary, after consideration of the public comments we received, we are adopting our CY 2011 proposal to apply an MPPR to the PE component of Medicare payment for the second and subsequent outpatient "always therapy" services, with a modification to apply a 25 percent reduction for CY 2011 rather than the 50 percent reduction we had proposed. Specifically, beginning in CY 2011 we are adopting an MPPR for "always therapy" services under which a 25 percent reduction will be applied to the PE component of payment for the second and subsequent "always therapy" service(s) (those displayed in Table 21) that are furnished to a single patient by a single provider on one date of service in all settings where outpatient therapy services are paid under Part B. This policy applies to office-based therapy services paid under the PFS as well as to institutional therapy services paid under Part B at the PFS rates. We note that the MPPR would apply only when multiple therapy services are billed on the same date of service for one patient by the same practitioner or facility under the same NPI. This policy does not apply to add-on, bundled, or contractor-priced "always therapy" codes. It does, however, apply to all "always therapy" services furnished on a single date of

service by the same provider to a single patient, including "always therapy" services furnished in different sessions or in different therapy disciplines.

For those therapy services paid under the PFS, we are required to make a budget neutrality adjustment under section 1848(c)(2)(B)(ii)(II) of the Act. As a result, the estimated reduced expenditures for therapy services due to the 25 percent MPPR will be redistributed to increased CY 2011 payments for other PFS services. We refer readers to XI.A.2. of this final rule with comment period for further discussion of the impact of this policy. The final list of CY 2011 "always therapy" CPT codes subject to the MPPR policy for therapy services is displayed in Table 21.

Table 21: "Always Therapy" Services Subject To The CY 2011 MPPR Policy*

CPT Code	Short Descriptor
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx, 1hr
92609	Use of speech device service
96125	Cognitive test by hc pro
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy

CPT Code	Short Descriptor
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/o for orthotic/prosth use
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers

*Excludes contractor-priced, bundled, and add-on "always therapy" codes.

5. High Cost Supplies

a. Background

MedPAC and the AMA RUC have long recommended that CMS establish a frequent price update process for high-cost supplies that are direct PE inputs in the PE database for services paid under the PFS because of their speculation that prices for these items may decrease over time as competition increases and new technologies disseminate into medical practice. MedPAC in particular has perennially noted that it is important for CMS to update the prices of high-priced supplies on a regular basis as inaccurate prices can distort PE RVUs over time, contributing to the misvaluation of established services

under the PFS.

Most of the current prices for high-cost supplies included in the direct PE database are from 2004 or earlier. There are currently 62 unique supplies with prices of $150 or more in the proposed CY 2011 PE database, which is available on the CMS Web site under the supporting data files for the CY 2011 PFS proposed rule at http://www.cms.gov/PhysicianFeeSched/. Finally, we note that we do not actually pay the supply prices included in the PE database but, instead, use them to develop the PE RVUs according to our standard PE methodology as described in section II.A.2. of this final rule with comment period. Payment for a procedure that uses a supply is based upon the PE RVUs that result from the PE methodology, and supplies are among the direct PE inputs for procedures. Therefore, it is the relativity of high-cost supply prices to prices for other PE items (equipment, low-cost supplies, and clinical labor) that is important.

Accordingly, in the CY 2009 PFS proposed rule (73 FR 38582), we proposed a process to update the prices for high-cost supplies priced at $150 or more that are included in the PE inputs for procedures paid under the PFS PE methodology. The CY 2009 proposed rule described a publicly transparent process in which CMS would publish a list of the high-cost supplies in the PFS proposed rule (65 supplies were included in the CY 2009 PFS proposed rule), and specialty societies or other relevant organizations would provide acceptable documentation supporting the pricing for the supplies during the 60-day public comment period. Furthermore, in that same proposed rule (73 FR 38582), we provided guidance on what constitutes valid, reliable documentation that reflects the typical price of the high-cost item in the marketplace. We

outlined examples of acceptable documentation, such as a detailed description (including system components), sources, and current pricing information, confirmed by copies of catalog pages, invoices, and quotes from manufacturers, vendors, or distributors. We indicated that documentation that does not include specific pricing information such as phone numbers and addresses of manufacturers, vendors, or distributors or Web site links without pricing information would not be acceptable. We also noted that if acceptable documentation was not received within the proposed rule's 60-day public comment period, we would use prices from the Internet, retail vendors, and supply catalogs to determine the appropriate cost, and that we would use the lowest price identified by these sources (73 FR 38582). Finally, we solicited public comments on alternatives that could be used to update pricing information in the absence of acceptable documentation provided by specialty societies or other interested organizations.

In the CY 2009 PFS final rule with comment period (73 FR 69882), we indicated that we received many comments on the proposed process and, while some commenters expressed support, others believed the proposed process was flawed and burdensome. Moreover, although we received some data in response to our request for information on the 65 high-cost supplies with prices of $150 or more, much of what we received was not complete or did not represent typical market prices. In particular, we expressed concern that the submitted data often represented manufacturer list prices for the premier models of many supplies, while we believed there were less expensive alternatives. Therefore, we were unable to determine the most appropriate, typical supply prices for our PFS payment methodology that prices the typical service described by a HCPCS code. Rather than finalizing the proposed process for updating high-cost supplies and revising the

prices for the 65 supplies based on inadequate pricing information, we stated in the CY 2009 PFS final rule with comment period (73 FR 69882) that we would research the possibility of using an independent contractor to assist us in obtaining accurate pricing information. Furthermore, we informed the public that we planned to study the limitations of available pricing data and determine how to revise our proposed process to elicit better data.

In the CY 2010 PFS proposed rule and final rule with comment period (74 FR 33554 and 61776, respectively), we stated that we were continuing to examine ways to obtain accurate pricing information for high-cost supplies. We noted again in the CY 2010 PFS proposed rule that we would depend upon the cooperation of the medical community to obtain typical prices in the marketplace, and we provided stakeholders with another opportunity to submit public comments on the process. In the CY 2010 PFS final rule with comment period, we acknowledged commenters' general support for an initiative to ensure accurate pricing of high-cost supplies. In general, the commenters strongly preferred a transparent and public process, and we stated that we would consider this perspective as we explore the best way to ensure that accurate supply pricing information is used in the PFS payment methodology.

b. Future Updates to the Prices of High-Cost Supplies

In working towards refining a process to update the prices of high-cost supplies and consistent with our intention expressed in the CY 2009 PFS final rule with comment period (73 FR 69882), we contracted with an independent contractor during CY 2009 to help us study the availability of accurate pricing information. We requested that the independent contractor, L&M Policy Research, research pricing information for the 65

high-cost supplies listed in the CY 2009 proposed rule (73 FR 38583 through 38585) and determine what, if any, pricing information reflecting typical market prices could be obtained for these high-cost supplies.

We first requested that the contractor explore publicly available sources to obtain typical market prices for these supplies. The contractor utilized supply vendor catalogs and web sites and directly contacted vendors, manufacturers, group purchasing organizations (GPOs), and any other suppliers that the contractor identified in their research in order to identify prices for each of the supplies. Where more than one version of a supply item appeared to match a description of a high-cost supply and/or more than one possible vendor or manufacturer was identified, the contractor attempted to obtain prices from the multiple sources.

Upon review of the high-cost supply list, the contractor refined the list to 62 unique high-cost items with prices of $150 or more for the study. The original list only consisted of 64 items but included one item inadvertently listed twice (CMS Supply Code SD207 (suture device for vessel closure (Perclose A-T)) and one item (CMS Supply Code SH079 (collagen implant)) that was deleted from the PE database after CY 2007 because it was no longer used as an input for any codes. While the contractor was able to obtain prices for 37 of the 62 unique supplies, the contractor was unable to obtain pricing information for the remaining 25 supplies. Documentation of these prices, a requirement we discussed in the CY 2009 PFS proposed rule (73 FR 38582), was only obtained for 25 of the 36 supplies with new pricing information. For the remainder, while the contractor was given price quotes over the phone, the sales agents or customer service representatives declined to provide any form of written documentation, in some cases

because company policies restricted providing pricing documentation to prospective customers without an account. Moreover, information on typical discounts was obtained for only seven products, and only one discount was documented. In the case of these products, companies disclosed the maximum available discounts, ranging from 18 percent to 45 percent. Relative to prices currently included in the PE database, the contractor found higher prices for the majority of the medical supplies that were researched, specifically 23 supplies with higher prices, 8 with lower prices, and 3 with the same price. The high-cost supplies studied by the contractor and their current database prices are displayed in Table 22.

TABLE 22: High-Cost Supplies with Prices of $150 or Greater in the PFS Direct PE Database that were Studied by the CMS Contractor

CMS Supply Code	Supply Description	Current Database Unit Price	Associated CPT Codes
	stent, ureteral, wguidewire, 3cm flexible tip	$235	52332
	probe, cryoablation, renal	$1,175	50593
	catheter, intradiscal (spineCATH)	$1,380	22526, 22527
	probe, cryoablation (Visica ICE 30 or 40)	$1,589	19105
	kit, capsule, ESO, endoscopy w-application supplies (ESO)	$450	91111
	catheter, balloon, lacrimal	$306	68816
	catheter, CVA, system, tunneled w-port, dual (LifeSite)	$1,750	36566
	stent, vascular, deployment system, Cordis SMART	$1,645	37205, 37206
	agent, embolic, 2 ml uou	$258	37210
	tube, jejunostomy	$98	49441, 49446, 49451, 49452
SA005	kit, capsule endoscopy w-application supplies (M2A)	$450	91110

CMS Supply Code	Supply Description	Current Database Unit Price	Associated CPT Codes
SA010	kit, CVA catheter, tunneled, without portpump	$308	36557, 36558, 36581
SA011	kit, CVA catheter, tunneled, with subcut port	$495	36560, 36561, 36563, 36582, 36583
SA015	kit, for percutaneous thrombolytic device (Trerotola)	$488	36870, 37184, 37186, 37187, 37188
SA020	kit, loop snare (Microvena)	$275	36595, 37203
SA022	kit, percutaneous neuro test stimulation	$305	63610, 64561
SA024	kit, photopheresis procedure	$858	36522
SA025	kit, PICC with subcut port	$586	36570, 36571, 36585
SA036	kit, transurethral microwave thermotherapy	$1,149	53850
SA037	kit, transurethral needle ablation (TUNA)	$1,050	53852
SA038	kit, transurethral waterinduced thermotherapy	$650	53853
SA039	kit, vertebroplasty (LP2, CDO)	$696	22520, 22521
SA074	kit, endovascular laser treatment	$519	36478
SA075	kit, hysteroscopic tubal implant for sterilization	$1,245	58565
SA077	kit, pleural catheter insertion	$329	32550, 96440
SA087	tray, RTS applicator (Mammosite)	$2,550	19296
SA091	tray, scoop, fast track system	$750	31730
SA092	kit, gene, MLL fusion	$1,395	88385
SA093	kit, priming, random	$463 (6 pack)	88385, 88386
SC085	tubing set, plasma exchange	$173	36514
SD018	catheter, balloon, thermal ablation (Thermachoice)	$727	58353

CMS Supply Code	Supply Description	Current Database Unit Price	Associated CPT Codes
SD019	catheter, balloon, ureteral-GI (strictures)	$166	43456, 45303, 45340, 45386, 46604
SD020	catheter, CVA, tunneled, dual (Tesio)	$355	36565
SD023	catheter, enteroclysis	$183	74251, 74260, 89100, 89105, 89130, 89132, 89135, 89136, 89140, 89141
SD058	electrode, grid	$475	95829
SD072	eyelid weight implant, gold	$218	67912
SD073	fiducial screws (set of 4)	$558 (set of 4)	77011, 77301
SD094	mammotome probe	$200	19103
SD109	probe, radiofrequency, 3 array (StarBurstSDE)	$1,995	20982, 32998, 41530, 50592
SD151	catheter, balloon, low profile PTA	$432	35470, 35471, 35474
SD152	catheter, balloon, PTA	$244	35472, 35473, 35475, 35476, G0392, G0393
SD154	catheter, microcatheter (selective 3rd order)	$338	36217, 36247, 36481, 37183, 37210
SD155	catheter, RF endovenous occlusion	$725	36475

CMS Supply Code	Supply Description	Current Database Unit Price	Associated CPT Codes
SD175	guidewire, steerable (Transcend)	$180	36217, 36247, 36481, 37183, 37205, 37206, 37210, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460
SD177	hysteroscope, ablation device	$1,146	58563
SD185	plasma antibody adsorption column (Prosorba)	$1,150	36515
SD186	Plasma LDL adsorption column (Liposorber)	$1,380	36516
SD189	plate, surgical, mini-compression, 4 hole	$226	21208
SD191	plate, surgical, reconstruction, left, 5 x 16 hole	$719	21125, 21127, 21215
SD193	plate, surgical, rigid comminuted fracture	$389	21461, 21462
SD204	sensor, pH capsule (Bravo)	$225	91035
SD205	sheath, endoscope ultrasound balloon	$154	31620
SD207	suture device for vessel closure (Perclose A–T)	$225	35470, 35471, 35472, 35473, 35474, 35475, 37184, 37187, 37188, 37205, G0392
SD215	probe, endometrial cryoablation (Her Option)	$1,250	58356

CMS Supply Code	Supply Description	Current Database Unit Price	Associated CPT Codes
SD216	catheter, balloon, esophageal or rectal (graded distention test)	$165	91040, 91120
SD218	stent, ureteral, without guidewire	$162	50382, 50384, 50385
SF028	laser tip (single use)	$290	30117, 52214, 52224, 52317
SF029	laser tip, bare (single use)	$150	46917, 46924
SF030	laser tip, diffuser fiber	$850	52647, 52648
SL055	DNA stain kit (per test)	$150 (10 pack)	88358
SL209	array kit, Genosensor	$2,121	88386
SL225	gas, nitogen, ultra-high purity (compressed) grade 5.0	$190	88385, 88386

Next, we directed the contractor to access the United States General Services Administration (GSA) medical supply schedule to augment the results obtained through review of vendor materials and direct contact with vendors, manufacturers, and GPOs. We note that the GSA establishes long-term government-wide contracts with commercial firms for many products, negotiating contracts and determining prices to be fair and reasonable prior to placing them on schedule. Included on the schedule are thousands of medical supplies at prices that, in most cases, are established through competition. The GSA schedule is an open solicitation and a business of any size, if it is stable and financially sound, can request to be included on the schedule. GSA's vendors usually are nationwide vendors with substantial non-government sales, and products on the schedule must be manufactured in the U.S. or in a nation with a trade agreement with the United

States. Submissions for the schedule are received 365 days per year, vendor contracts can be of varying lengths, and vendors can add or delete products from the schedule. Depending on the aggregate cost estimate associated with the vendor's supply items, the time to achieve inclusion on the schedule can vary from as short as several months to as long as 2 years. The GSA has delegated authority to the Department of Veterans Affairs (VA) to procure medical supplies under the VA Federal Supply Schedules Program.

Using the GSA general search engine under the category "Laboratory, Scientific, & Medical" available at https://www.gsaadvantage.gov/advgsa/advantage/main/start_page.do, the contractor obtained nine prices for items similar to the high-cost supplies in the PE database and that are displayed in Table 20 from the publicly available information on the Internet, including pricing for one product for which its prior work did not yield an updated price. We believe that additional items that are similar to the high-cost supplies in the PE database and that may be used with the same procedures may be on the GSA schedule but we are still working through the crosswalk between our supplies and the way the supplies are presented on the GSA schedule. In the proposed rule (75 FR 40081), we stated that examples of high-cost supplies in the PE database that the contractor located on the GSA schedule include: (1) kit, capsule, ESO, endoscopy w-application supplies (ESO), priced at $450 in the PE database and $444 on the GSA schedule; and (2) tube, jejunostomy, priced at $195 the PE database and $60 to $83 on the GSA schedule, depending on the characteristics of the tube. We note that the price of the "jejunostomy" tube that we included in the proposed rule was incorrect. The actual price of that supply item in the PE database is $97.50, a lower value that is still substantially higher than the price range

on the GSA schedule.

Since the GSA medical supply schedule is a source for pricing information that is public and transparent and reflects the best government contract price for a product, we believe it is a desirable resource for us to use in a refined process for updating the prices of high-cost supplies. For historical context, CMS has previously proposed to use VA prices that result from the competitive marketplace as comparison points to limit the Medicare prices for oxygen and certain items of durable medical equipment and prosthetic devices (62 FR 38100 through 38107, and 64 FR 44227 through 44231) in 1997 and 1999, respectively. These prior proposals were based on our determination that the Medicare payment amounts for these items as durable medical equipment or prosthetics (not as physicians' services) were not inherently reasonable. We noted, however, that our current interest in the GSA schedule for pricing high-cost supplies for payment of physicians' services is not based on considerations of inherent reasonableness, and we do not actually pay the prices in the PE database for supplies under the PFS.

We further noted that public commenters on pricing high-cost supplies have consistently requested that we ensure that the pricing information used to update the prices is provided publicly. The commenters have observed that this transparency would enable stakeholders to evaluate and provide feedback to the agency on pricing accuracy (74 FR 61776). We also acknowledged that our past attempts over several years to identify typical market prices for the high-cost supplies have been inhibited by the limited availability of public data that meet the documentation requirements we have previously established. Individual vendors do not always publish their product prices or

provide typical discounts. Moreover, discounts may vary depending on suppliers and the volume of supplies purchased. In the CY 2011 PFS proposed rule (75 FR 40082), we explained that our understanding of the GSA medical supply schedule is that the publicly listed fair and reasonable prices on the schedule generally do not include volume and or certain other discounts that may be subsequently negotiated by the buyer. Consequently, we would consider the prices available on the GSA schedule to represent the "individual item ceiling" price for a single item purchase, which we believe would be appropriate to estimate the high-cost supply prices for physicians' office purchases. We solicited public comments regarding the high-cost supplies in the direct PE database for the CY 2011 PFS proposed rule, available on the CMS Web site as noted earlier in this section, and the corresponding supplies or alternative items that could be used for the same function that are currently on the GSA supply schedule. We encouraged commenters to provide a detailed analysis of the current relationships between the items in the PE database and those on the GSA schedule.

In the CY 2011 PFS proposed rule (75 FR 40082), we described a refined process for regularly updating prices for high-cost supplies under the PFS and solicit comments on how we could improve on this process. The process could occur every 2 years beginning as soon as CY 2013, although we noted that we would propose the refined process through rulemaking before revising the prices for any high-cost supply item based on the GSA schedule. We could also consider establishing a different price update period depending on whether a high-cost supply was a new supply in the PE database or had been in use for some time, in which case we might expect that the price would have stabilized and, therefore, could be updated less frequently. In general, we would expect

that the periodicity of updating prices for high-cost supplies that we eventually adopted would balance the associated administrative burden with the rate of price changes, to ensure that the associated procedures remain appropriately valued, rather than increasingly misvalued, over time.

We envisioned that we would base high-cost supply price inputs on the publicly available price listed on the GSA medical supply schedule. Since the medical community would have several years to examine the GSA medical supply schedule before the refined process would be adopted, and we had found no apparent limitations on vendors placing products on the GSA schedule, beyond the schedule's interest in competitive, best value procurements, stakeholders would have the opportunity to ensure that any high-cost direct PE input for a PFS service that may currently be missing from the GSA medical supply schedule would be included before CMS needs to access the publicly available price for the item. If a supply price were not publicly available on the GSA medical supply schedule by the time CMS needs to access the price, we would propose to reduce the current price input for the supply by a percentage that would be based on the relationship between GSA prices at that time and the existing PE database prices for similar supplies (currently an average 23 percent reduction). We believe that this refined process would be desirable because it is consistent with commenters' repeated requests for the updating methodology to be transparent and predictable.

Moreover, the VA (with responsibility delegated by the GSA) determines whether prices are fair and reasonable by comparing the prices and discounts that a company offers the government with the prices and discounts that the company offers to commercial customers. Therefore, using the GSA medical supply schedule as a source

for publicly available prices would also better account for product-specific market dynamics than the alternative of an across-the-board percentage reduction for supplies not on the GSA schedule based on general price trends for the high-cost supplies on the schedule. That is, if the market price of a particular supply were not to drop according to broad trends for other high-cost supplies, suppliers would have the opportunity to provide their price to the public on the GSA schedule in order to preclude any reduction in Medicare payment for procedures associated with that supply.

Finally, we reiterated our interest in receiving detailed public comments on the refined process discussed above, including all aspects of the price update methodology that we have presented. Moreover, we believe a similar approach could potentially be appropriate to update the prices for other supplies in the PE database that would not fall under our definition of high-cost supplies, and we welcomed further public comments on that possible extension. We also invited further suggestions for alternative approaches to updating high-cost supply prices, specifically those that would result in a predictable, public, and transparent methodology that would ensure that the prices in the PE database reflect typical market prices. These principles are particularly important in order to ensure that the services that utilize the high-cost supplies when provided in the physician's office are appropriately valued under the PFS and continue to be appropriately valued over time.

Comment: Many commenters agreed with the need for a frequent, transparent price update process for high-cost supplies based on publicly available sources of pricing information. MedPAC supported CMS' description of the process update the prices of high-cost cost supplies presented in the CY 2011 PFS proposed rule: "As an initial step, it

is reasonable to use the GSA schedule as a source for the prices of high-cost supply items and to reduce the prices of items not on the GSA schedule by the average difference between the GSA prices and the prices in CMS' PE database for similar supplies."

Response: We appreciate the general affirmation by many stakeholders of the significance of accurate pricing of high-cost supplies relative to other PE items (equipment, low-cost supplies, and clinical labor). We also value MedPAC's support for the update process that we described for the prices of high-cost supplies.

Comment: Many commenters asserted that because the medical supply prices on the GSA schedule reflect the best price for government entities, these prices are not representative of typical prices available to practitioners caring for Medicare beneficiaries. The commenters suggested that physicians in private practices do not have the requisite purchasing power to negotiate such large discounts on their own and that the sales environments for the government and private markets are vastly different. Therefore, the commenters argued, because the GSA schedule is a streamlined buying process that the government uses to buy products and services through registered vendors at pre-negotiated prices, the schedule does not provide an accurate reflection of prices faced by any physician practice. Some commenters also observed that the prices on this schedule have historically been used only by manufacturers and suppliers in the context of providing these high-cost supplies to the VA alone, and do not reflect prices to other non-governmental entities.

Response: We appreciate the differences in the purchasing power of the federal government and individual practitioners. However, we have reason to believe that prices on the GSA schedule do not reflect the full volume discounts available to large

purchasers like the Federal government. In fact, while the GSA has delegated the authority to the VA to procure medical supplies under the VA Federal Supply Schedules Program, we understand that the prices that appear on the schedule do not reflect the prices the VA itself would usually pay for a medical supply. Instead, the VA determines the schedule prices to be fair and reasonable prior to placing them on the schedule, and uses that schedule price as a starting point for its own negotiations with supply vendors for specific purchases.

While several commenters explained how vendors provide the VA itself with discounts that are greater than those offered to other buyers, and a few additional commenters made uncorroborated claims that prices on the GSA supply schedule reflect discounts unavailable to other providers, we received no evidence that the prices contained on the schedule are atypical of medical supply prices in the private marketplace. We agree that the prices on the GSA schedule may reflect some discounting, but we do not believe that the prices reflect the full discounting available to the VA itself for many purchases. Instead, we believe that the discounting on the GSA schedule reflects what the VA has deemed reasonable for other government buyers in the context of prices and discounts that a vendor offers to commercial customers.

We also believe that typical practitioners receive discounts from vendors' listed prices for supply items for a variety of reasons, although we acknowledge that the basis for the discounts reflected on the GSA schedule may differ from the basis for the discounts that are available to typical practitioners. Therefore, we do not necessarily agree with the premise underlying many commenters' concerns that the usefulness of the GSA schedule as a source for PFS high-cost supply prices is necessarily undermined

solely because large government buyers benefit from some exclusive discounts.

We believe that in a relative payment system, maintaining the relativity of discounting among the prices for supply items may be more significant than any concern associated with the reasons different buyers receive particular discounts. At the moment, we have no reason to believe that the prices on the GSA schedule are atypical of the non-government market, despite broad assertions by the commenters that the government may receive discounts for different reasons than those available to private purchasers. As we consider this high-cost supply update process for the future, we would be interested in receiving further public comments that substantiate the claims that medical supply prices on the GSA schedule are not representative of actual prices paid by typical practitioners caring for Medicare patients.

Comment: Some commenters expressed concern that pricing high-cost supplies based on the GSA supply schedule could result in loss of appropriate relativity in PE RVUs because pricing for other supplies would be determined using other methodologies.

Response: As stated earlier in this section, we do not actually pay the supply prices included in the PE database but instead use them to develop the PE RVUs according to our standard PE methodology as described in section II.A.2. of this final rule with comment period. However, we believe that inaccuracies in the prices for high-cost supplies that are specific to a very few PFS services may disproportionately distort physician payment by leading to inaccurate PE RVUs for services using those high-cost supplies. We believe that neglecting to incorporate any discounts or typical reductions in the market price for a high-cost supply that is sold to a practitioner for use in a specific

service would result in a greater likelihood that the service would be misvalued under a relative payment system than would similar imprecision in the prices for lower-cost supplies that are commonly used in many services and where price changes are typically less extreme. Finally, we note that we also remain interested in the possibility of using the GSA supply schedule for all PFS supply and equipment price inputs, as we stated in the CY 2011 PFS proposed rule (75 FR 40082).

Comment: One commenter suggested that using the GSA schedule for supply price inputs might allow a single supplier furnishing a small volume of a product at a divergent price to distort the PE RVU calculations. On the other hand, MedPAC stated that the current CMS' process of "using price information voluntarily submitted by specialty societies, individual practitioners, suppliers, and product developers might not result in objective and accurate prices because each group has a financial stake in the process."

Another commenter recommended that if CMS were to use the GSA schedule prices as high-cost inputs, then CMS should guarantee that physicians may purchase supplies at the GSA schedule prices. The commenter claimed that failure to do so would result in inherently unfair, lower PE RVUs for certain procedures, which could ultimately create an access to care problem for Medicare beneficiaries.

Response: We believe that our current system of accepting voluntarily submitted invoices for supply and equipment price direct PE inputs may be problematic for high-cost supplies because the prices for such supplies may be particularly susceptible to distortions that significantly influence the PE RVUs that we use for payment of the associated services. We also believe that any attempt to account for these distortions and

more appropriately value the services must be transparent to the stakeholders. Because the prices on the GSA supply schedule are developed based on the interaction between parties that have competing financial interests (the VA and supply vendors), we believe that these prices are more likely to be representative of competitive market prices than are prices that are voluntarily submitted by individuals with financial stakes in the PFS payment process. We agree that distortions – whether price overstatements or understatements - in the values of the direct PE inputs, resulting in misvalued services, have the potential to create financial incentives for practitioners that are detrimental to ensuring access to medically necessary and reasonable care for Medicare beneficiaries. Based in part on prior analysis by MedPAC, we believe that the greater risk of misvalued PE RVUs results from overvaluing high-cost supplies since we believe that prices for these items may generally decrease over time as competition increases.

As we discussed in our response to a previous comment, we do not actually use the prices in the PE database for supplies but instead those prices are the basis for the PE RVUs for the associated services developed under the budget neutral PFS. Therefore, we do not agree with the commenter that we should guarantee that physicians may purchase supplies at the GSA schedule prices. Where our goal is for the high-cost supply prices we use for PFS ratesetting to reflect typical market prices for these items, especially in a relative sense, for many reasons different supplies may not be available to individual practitioners purchasing them at the prices in the PE database. The PFS is not a payment system that reimburses health care practitioners based on their individual costs, and the price available to an individual practitioner for a supply item may be high or lower than the price in the PE database that is used for setting the PFS PE RVUs for the associated

procedure.

Comment: One commenter claimed that no U.S. manufacturer sells cryoablation probes through the GSA supply schedule and, therefore, asserted that the pricing process for high-cost supplies described in the CY 2011 PFS proposed rule would be inappropriate for that particular supply. Other commenters reported difficulty locating particular medical supplies on the GSA supply schedule.

Response: While we recognize that not all high-cost supplies are currently on the GSA supply schedule, as we stated in the CY 2011 PFS proposed rule (75 FR 40082), we believe that since we have provided the medical community several years to examine the GSA medical supply schedule before its use could be adopted under the PFS, stakeholders would have the opportunity to ensure that any high-cost direct PE input for a PFS service that may currently be missing from the GSA medical supply schedule would be included before CMS needs to access the publicly available price for the item. Furthermore, we have found that the use of multiple clinically related search terms under the GSA schedule search engine improves our ability to locate supply items that are related to those that we currently include in the direct PE database for the PFS. We believe that the mistaken assumption that certain supplies are unavailable on the GSA supply schedule, resulting from some commenters' inconclusive searches, may have influenced many commenters' responses to the process we discussed in the CY 2011 PFS proposed rule.

Prior to adopting use of the GSA supply schedule to update the prices for high-cost supplies under the PFS, we believe it would be appropriate to work with interested stakeholders to consider developing a crosswalk between supply items

included the direct PE database and the GSA supply schedule.

Comment: One commenter contended that implementation of a process to update high-cost supply prices based on the GSA schedule would disadvantage all medical device companies that have chosen to provide devices directly to the armed services or facilities for the treatment of veterans. A few commenters speculated that many supply vendors would resist placing their products on the GSA schedule for a variety of reasons, including avoiding any unnecessary regulatory burden or the scrutiny of GSA audits.

Response: We have no reason to believe that vendors who sell directly to the VA at discounts must incorporate negotiated discounted prices on the GSA schedule, so we do not believe that utilizing publicly available prices as direct PE inputs would have a disproportionately unfair impact on suppliers who sell directly to the VA. At the same time, we also understand that not every medical supply vendor would choose to place their products on the GSA schedule. That is why we stated in the proposed rule (75 FR 40082) that if a supply price were not publicly available on the GSA medical supply schedule by the time CMS needs to access the price, we would consider proposing to reduce the current price input in the PE database for the supply by a percentage that would be based on the relationship between GSA prices at that time and the existing PE database prices for similar supplies. Vendors would need to balance their concerns about placing their products on the GSA supply schedule with the alternative pricing policy that would apply.

Comment: Several commenters objected to a reduction of supply price inputs based on the relationship between GSA prices at the time the prices are being updated and the existing PE database prices for similar supplies. Many of the commenters stated

that the 23 percent reduction presented as an example in the CY 2011 PFS proposed rule (75 FR 40082) was based on a very small sample of items and appeared arbitrary. One commenter contended that the percentage reduction would need to be validated for application to current pricing and argued that it would be inappropriate for use on an item-specific basis.

Additional commenters, including the AMA RUC, pointed out the discrepancy between the price of the "jejunostomy tube" supply item listed in the chart of high-cost supplies and in the direct PE database. These commenters were concerned that this discrepancy may have led CMS to incorrectly calculate the average difference between GSA prices and current prices in the direct PE database. One commenter reasoned that it would be unfair for CMS to change the price inputs for innovative medical devices by relying on "speculation that prices for these items may decrease over time as competition increases and new technologies disseminate into medical practice."

Response: We appreciate the commenters' concerns regarding the example of the 23 percent reduction mentioned in the CY 2011 PFS proposed rule. We provided that sample percentage as an example based on a current analysis of a small sample of supplies. We appreciate commenters correctly pointing out that we displayed an outdated price input for the supply item "jejunostomy tube" in the CY 2011 PFS proposed rule (75 FR 40080 through 40081). As we explained in the proposed rule, we are still working through the crosswalk between our supplies and the way the supplies are presented on the GSA schedule. We included the 23 percent figure as a rough guide based on a comparison of current GSA schedule and PE database prices for a small sample of high-cost supply items.

Prior to implementing any price update based on GSA supply schedule prices, we would conduct a thorough analysis of the validity of the GSA pricing data in question. We believe that using such data for price comparisons, validated, and expanded to include all applicable supply items, may be more likely to approximate typical prices for these supplies than any available alternative – especially failing to update the high-cost supply price inputs with the necessary frequency. In cases where the prices for certain high-cost supplies do not follow the broad trends for other high-cost supplies, suppliers would have the opportunity to provide their price to the public on the GSA schedule in order to preclude any reduction in Medicare payment for procedures associated with that supply.

Comment: Some commenters asserted that CMS should conduct independent market research similar in kind to the research CMS claims that the VA conducts in placing supply items and their associated prices on the GSA schedule. Another commenter recommended that CMS use a particular market research contractor to price these supplies.

Response: As we stated in the CY 2011 PFS proposed rule (75 FR 40079), we contracted with an independent contractor during CY 2009 to help us study the availability of accurate pricing information for high-cost supplies. We believe such research needs to be conducted with transparency, including using publicly available sources and contacting supply vendors directly. The contractor reported tremendous difficulty in identifying typical market prices using these methods. We have no reason to believe that a different contractor using similar methods would have greater success in acquiring market pricing information without utilizing a methodology that would be

burdensome to practitioners or supply vendors or other stakeholders. Because the supply vendors in contact with the VA generally have a financial incentive to cooperate with their market research directly, we believe that the VA's methodology in this case would yield more accurate information than information derived from market researchers who do not have such cooperation, like the contractor working previously on behalf of CMS.

Comment: Several commenters, including the AMA RUC, recommended that CMS consider creating HCPCS codes to be reported by rendering physicians for high-cost supplies when used for the care of a patient during procedure. The supplies could then be removed from the direct PE database and appropriate pricing for these supply HCPCS codes could be determined by CMS on an annual basis. One commenter requested that CMS explore whether such a methodology would be budget neutral under the PFS, since the commenter did not support an approach that would reduce PFS payments for cognitive services.

Response: We appreciate the commenters' suggestions, but we believe creating separately reportable HCPCS codes for high-cost supplies and paying separately for these items would merely shift the pricing challenge rather than resolve it, and could compound the problem of misvaluing services by explicitly paying for high-cost supplies at the expense of other low-cost supplies, equipment, and clinical labor included in the PE component of PFS payment. We do not understand how this suggestion would help CMS price the supply items accurately, nor how it would lead to more appropriate payment for high-cost supplies under the relativity of the budget neutral PFS. This approach would be required to be budget neutral under the PFS and, to the extent that our current PE methodology pays less than the direct PE database cost for a supply item, payment for

individual high-cost supplies at prices we establish could redistribute dollars from other PFS services to payment for these supply items if we were to pay more for them separately. Finally, unbundling payment for high-cost supplies from the associated procedures would be contrary to the current public policy interest in increasing the size of the payment bundles used for Medicare payment to encourage efficiencies in the delivery of services.

Comment: Several commenters expressed a readiness to provide any additional information that may help CMS in pricing high-cost supplies, in lieu of using the GSA schedule prices for that purpose.

Response: We appreciate commenters' offers of assistance regarding the pricing of direct PE inputs. However, based on the public comments from stakeholders that we received on the process we proposed in the CY 2009 PFS proposed rule and the experience of the CMS' contractor who attempted to acquire market pricing for supply items directly from supply vendors, we believe that use of the GSA schedule would have greater potential to provide us systematically and transparently with typical market prices for high-cost supply items that could be updated with an appropriate periodicity.

Comment: Some commenters expressed concern that CMS had not presented any information about how prices for Medicare PE purposes would actually be developed from the GSA supply schedule and had not specified how the Agency would do so nor whether (or when) CMS intended to make to make the approach available for public comment.

Response: We appreciate the commenters' concerns regarding the practical implementation of a high-cost supply price update process based on prices on the GSA

supply schedule. In the CY 2011 PFS proposed rule (75 FR 40082), our discussion was intended to encourage broad stakeholder comment, including consideration of potential alternatives to the process presented. Prior to implementing a high-cost supply update methodology, such as the use of prices on the GSA schedule that was the focus of our proposed rule discussion, we would expect to use annual rulemaking in order to propose a more detailed process that would be subject to modification based upon our consideration of the public comments.

In summary, we appreciate the many public comments we received on our discussion of a process that would use GSA schedule prices to update the prices for high-cost supplies utilized for developing PE RVUs under the PFS. In the context of our explicit responsibility to review and adjust the PFS values for potentially misvalued services under section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA), we believe it is especially important to soon establish a periodic and transparent process to update the cost of high-cost supplies to reflect typical market prices so that these supply items are appropriately considered in our ratesetting methodology. While public commenters expressed some concerns regarding our discussion of use of the GSA supply schedule prices in such a process, at this point we remain optimistic that this approach has significant potential to be used under the PFS and, based on our several year history of work in this area, we do not see other viable alternatives at this point. We will continue to study the issue of how to update the prices for high-cost supplies over the upcoming months, and we encourage stakeholders to also further consider the process we discussed in CY 2011 rulemaking and provide their additional thoughts and perspectives to us on an ongoing basis.

D. Geographic Practice Cost Indices (GPCIs)

1. Background

Section 1848(e)(1)(A) of the Act requires us to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (that is, work, PE, and malpractice). While requiring that the PE and malpractice GPCIs reflect the full relative cost differences, section 1848(e)(1)(A)(iii) of the Act requires that the physician work GPCIs reflect only one-quarter of the relative cost differences compared to the national average. In addition, section 1848(e)(1)(G) of the Act sets a permanent 1.5 work GPCI floor in Alaska for services furnished beginning January 1, 2009. Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, adjust the GPCIs not less often than every 3 years. This section also specifies that if more than 1 year has elapsed since the last GPCI revision, we must phase in the adjustment over 2 years, applying only one-half of any adjustment in each year. As discussed in the CY 2009 PFS final rule with comment period (73 FR 69740), the CY 2009 adjustment to the GPCIs reflected the fully implemented fifth comprehensive GPCI update. CY 2010 would have typically included no adjustments to the GPCIs. However, section 3102(a) of the ACA amended section 1848(e)(1)(E) of the Act to extend the 1.0 work GPCI floor for services furnished through December 31, 2010. Additionally, section 3102(b) of the ACA added a new subparagraph (H) to section 1848(e)(1) of the Act, which specifies that for CY 2010 and CY 2011, the employee compensation and rent portions of the PE GPCI must reflect only one-half of the relative cost differences for each locality compared to the national average. The new subparagraph also includes a "hold harmless" provision for CY 2010

and CY 2011 for any PFS locality that would otherwise receive a reduction to its PE GPCI resulting from the limited recognition of cost differences. Additionally, section 1848(e)(1)(I) of the Act (as added by section 10324(c) of the ACA) established a 1.0 PE GPCI floor for services furnished in frontier States effective January 1, 2011. In May 2010, we provided our Medicare contractors with an updated CY 2010 payment file that included the 1.0 work GPCI floor and the PE GPCIs calculated according to the methodology required by section 1848(e)(1)(H) of the Act (as added by section 3102(b) of the ACA) for CY 2010, to be used for payment of services furnished on or after January 1, 2010.

For the CY 2011 PFS proposed rule, we completed the sixth review of the GPCIs and proposed new GPCIs. We noted that section 1848(e)(1)(E) of the Act (as amended by section 3102(a) of the ACA) extends the 1.0 work GPCI floor only through December 31, 2010. Under current statute, the 1.0 work GPCI floor will expire on January 1, 2011. Therefore, the CY 2011 physician work GPCIs, and summarized geographic adjustment factors (GAFs), do not reflect the 1.0 work floor. However, section 1848(e)(1)(G) of the Act (as amended by section 134(b) of the MIPPA) set a permanent 1.5 work GPCI floor in Alaska for services furnished beginning January 1, 2009 and, as noted above, section 1848(e)(1)(I) of the Act (as added by section 10324(c) of the ACA) provides for a permanent 1.0 PE GPCI floor for frontier States effective January 1, 2011. Therefore, as required by the statute, the 1.5 work GPCI floor for Alaska and the 1.0 PE GPCI floor for frontier States will be in effect for CY 2011. In addition to the limited recognition of certain cost differences for the PE GPCIs, section 1848(e)(1)(H) of the Act (as added by section 3102 (b) of the ACA) also requires us to

complete an analysis of the data sources used and cost share weights assigned to the PE GPCIs. Implementation of the ACA provisions related to the CY 2011 PE GPCIs is discussed in more detail in the GPCI update section below.

2. GPCI Update

As discussed in the CY 2011 PFS proposed rule (75 FR 40083), the updated GPCI values were developed by Acumen, LLC (Acumen) under contract to CMS. As mentioned above, there are three GPCI components (physician work, PE, and malpractice), and all GPCIs are developed through comparison to a national average for each component. Additionally, each of the three GPCIs relies on its own data source(s) and methodology for calculating its value as described below.

a. Physician Work GPCIs

The physician work GPCIs are designed to capture the relative cost of physician labor by Medicare PFS locality. Previously, the physician work GPCIs were developed using the median hourly earnings from the 2000 Census of workers in seven professional specialty occupation categories which we used as a proxy for physicians' wages and calculated to reflect one-quarter of the relative cost differences for each locality compared to the national average. Physicians' wages are not included in the occupation categories because Medicare payments are a key determinant of physicians' earnings. Including physicians' wages in the physician work GPCIs would, in effect, have made the indices dependent upon Medicare payments.

The physician work GPCIs were updated in CYs 2001, 2003, 2005, and 2008 using professional earnings data from the 2000 Census. However, wage and earnings data are no longer available from the Census long form and the 2000 data are outdated.

Therefore, for the proposed sixth GPCI update, we used the 2006 through 2008 Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) data as a replacement for the 2000 Census data. The use of BLS OES data as a replacement for the 2000 Census data is discussed in more detail in the update of the PE GPCIs section. As noted above, the 1.0 work GPCI floor is set to expire under current statute on December 31, 2010. Therefore, the CY 2011 proposed physician work GPCIs reflected the removal of this floor.

b. Practice Expense GPCIs

(1) The Affordable Care Act Requirements for PE GPCIs

(A) General Methodology for the CY 2011 GPCIs

The ACA added a new subparagraph (H) to section 1848(e)(1) of the Act which revised the methodology for calculating the PE GPCIs for CY 2010 and CY 2011 so that the employee compensation and rent portions of the PE GPCIs reflect only one-half of the relative cost differences for each locality compared to the national average. Additionally, under section 1848(e)(1)(H)(iii) of the Act (as added by section 3102(b) of the ACA), each PFS locality is held harmless so that the PE GPCI will not be reduced as a result of the change in methodology for PE GPCIs. In accordance with section 1848(e)(1)(H)(ii) of the Act (as added by section 3102(b) of the ACA), the employee compensation and rent components of the proposed CY 2011 PE GPCIs were calculated to reflect one-half of the cost differences for each PFS locality relative to the national average cost. Additionally, as required by the statute, physicians' services furnished in each PFS locality would be adjusted by the higher of the locality's PE GPCI calculated with the limited recognition of employee compensation and rent cost differences or the

PE GPCI calculated without the limited recognition of cost differences.

(B) Phase-In of PE GPCIs

Section 1848(e)(1)(C) of the Act requires us to phase in GPCI adjustments over 2 years if there was more than 1 year between GPCI adjustments. In accordance with the statute, we proposed to phase in the updated PE GPCIs using one-half of the CY 2010 values and one-half of the fully implemented values (as described in this section). To apply the phase-in and hold harmless provisions of the Act, we calculated transitional PE GPCIs based on two scenarios. Under the first scenario, we calculated transitional CY 2011 PE GPCIs using the full recognition of employee compensation and rent cost differences for each locality as compared to the national average. As discussed below, the first scenario reflects the "hold harmless" transitional PE GPCI value that would apply to any PFS locality receiving a reduction to its PE GPCI resulting from the application of the limited recognition of PE cost differences. The CY 2011 transitional PE GPCI values with full recognition of cost differences were calculated using one-half of the CY 2010 PE GPCI values with full recognition of cost differences and one-half of the updated PE GPCIs with full recognition of cost differences. The first scenario represents the transitional PE GPCI values prior to the limited recognition of cost differences (the pre-ACA CY 2011 transitional values). In other words, this scenario does not include the effects of sections 1848(e)(1)(H)(i) and (ii) of the Act (as added by section 3102(b) of the ACA).

For the second scenario, we calculated transitional CY 2011 PE GPCIs with the limited recognition of cost differences for the employee compensation and rent components (as required by sections 1848(e)(1)(H)(i) and (ii) of the Act (as added by

section 3102(b) of the ACA)). The CY 2011 transitional PE GPCI values with the limited recognition of cost differences were calculated using one-half of the CY 2010 PE GPCIs with the limited cost differences and one-half of the updated PE GPCIs with the limited cost differences. The hold harmless provision under section 1848(e)(1)(H)(iii) of the Act (as added by section 3102(b) of the ACA) was applied by selecting the greater of the CY 2011 transitional PE GPCI value calculated with the limited recognition of cost differences or the CY 2011 transitional PE GCPI value calculated with full recognition of cost differences (the pre-ACA CY 2011 transitional values). The phase-in of the CY 2011 PE GPCIs and application of the hold harmless provision are illustrated in Table 23 below.

Table 23: Phase-In of the CY 2011 PE GPCIs

	CY 2010	**Updated GPCIs**	**CY 2011 (Transitional Year)**	**Hold Harmless**
File 1 PE GPCI Without 3102(b) of ACA	Without ACA	Without ACA (Updated Data)	(1/2 of 2010)+ (1/2 Updated GPCI)	Greater of File 1 Transitional Value or File 2 Transitional Value
File 2 PE GPCI With 3102(b) of ACA	With ACA	With ACA (Updated Data)	(1/2 of 2010 w/ ACA)+ (1/2 Updated GPCI w/ ACA)	

(C) Data Analysis

Section 1848(e)(1)(H)(iv) of the Act (as added by section 3102(b) of the ACA) also requires the Secretary to "analyze current methods of establishing practice expense adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the cost of operating a medical practice in different fee schedule areas." Section 1848(e)(1)(H)(iv) of the Act (as added by section 3102(b) of the

ACA) requires that such analysis shall include an evaluation of the following:

- The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and non-physician staff wages, in different fee schedule areas.

- The office expense portion of the practice expense geographic adjustment, including the extent to which types of office expenses are determined in local markets instead of national markets.

- The weights assigned to each area of the categories within the practice expense geographic adjustment.

This section also requires the Secretary to make appropriate adjustments to the PE GPCIs no later than by January 1, 2012. To begin to implement this statutory requirement based on our initial analysis, we proposed to implement changes in PE data sources and cost share weights discussed herein effective beginning in CY 2011.

In accordance with section 1848(e)(1)(H)(iv) of the Act (as added by section 3102(b) of the ACA), we initially analyzed the current methods and data sources used in the establishment of the PE GPCIs. With respect to the method used, we began with a review of the GAO's March 2005 Report entitled, "MEDICARE PHYSICIAN FEES: Geographic Adjustment Indices Are Valid in Design, but Data and Methods Need Refinement"(GAO-05-119). While we have raised concerns in the past about some of the GAO's GPCI recommendations, we noted that with respect to the PE GPCIs, the GAO did not indicate any significant issues with the methods underlying the PE GPCIs. Rather, the report focused on some of the data sources used in the method. For example, the GAO stated that the wage data used for the PE GPCIs are not current. Similarly,

upon our reexamination of public comments we had received on the PE GPCIs for previous updates, we noted that the commenters predominately focused on either the data sources used in the method or raised issues such as incentivizing the provision of care in different geographic areas. However, the latter issue (incentivizing the provision of care) is outside the scope of the statutory requirement that the PE GPCIs reflect the relative costs of the mix of goods and services comprising practice expenses in the different fee schedule areas relative to the national average.

One key component of the PE GPCI method that our analysis identified involved the office expense portion of the PE GPCIs and the cost share weight assigned to this component. Most significantly, we proposed that the weight for the office rent component be revised from 12.209 percent to 8.410 percent to reflect our more detailed breakout of the types of office expenses that are determined in local markets instead of national markets. For example, for previous GPCI updates, we used the office expenses cost category as the cost share weight for office rent and, therefore, all individual components previously included in the office expenses category were adjusted for local area cost differences by the GPCIs. As discussed in section II.E. of this final rule with comment period, we proposed to disaggregate the broader office expenses component into 9 new cost categories as part of the proposed CY 2011 MEI rebasing. The disaggregation of the office expenses category indicates that the fixed capital cost category, for which the consumer price index (CPI) for owner's equivalent rent is the price proxy, is the office expense category applicable to the office rent component of the PE GPCI. Therefore, the fixed cost capital cost category is the only component of office expenses that we proposed to adjust for local area cost differences beginning in CY 2011.

We proposed to assign other newly defined components of the office expenses category (for example, utilities, chemicals, paper, rubber and plastics, telephone, postage, and moveable capital) to the medical equipment, supplies, and other miscellaneous expenses cost component of the PE GPCIs. As discussed later in this section, the medical equipment, supplies, and other miscellaneous expenses component of the PE GPCIs is assumed to have a national market and, therefore, this component is not adjusted for local area cost differences.

The proposed expense categories for the PE GPCIs, along with their respective cost share weights, are primarily derived from the 2006 American Medical Association (AMA) Physician Practice Information Survey (PPIS) for self-employed physicians and selected self-employed non-medical doctor specialties. The PPIS is the most comprehensive, multispecialty, contemporaneous, and consistently collected PE data source available. It was developed by medical organizations and captures the costs of operating a medical practice, including office rents and nonphysician staff wages. Moreover, we also examined the feasibility of using the American Community Survey (ACS) and the Bureau of Labor and Statistics (BLS) Occupational Employment Statistics (OES) data for the employee compensation component of the PE GPCI. For previous updates, the employee compensation component was based on the 2000 Decennial Census long form data. Since the Census data are significantly outdated and the 2010 Census no longer includes occupational wage data, we believe the ACS or BLS OES data might be viable alternatives. While the ACS 3-year public use microsample (PUMS) is currently available, it reflects only about 3 percent of households and the data exhibit significant variation due to the small sample. In particular, the ACS PUMS has fewer

than 10 observations of pharmacists in the Manhattan, Beaumont Texas, and Southern Maine localities. Therefore, we believe it would be premature to use the ACS data for determining GPCI values. The 2006, 2007, and 2008 panels from the BLS OES represent a larger sample than the ACS PUMS and more recent data than the 2000 Census. As such, we proposed to use the BLS OES data for updating the GPCIs. We look forward to exploring the use of the full ACS data when they become available. Additionally, we explored other sources of rent data (including commercial rental data and survey data) for use in calculating the PE GPCIs. We could not identify a reliable alternative rental data source available on a national basis with coverage of nonmetropolitan areas.

We do not believe there is a national data source better than the Housing and Urban Development (HUD) data for determining the relative cost differences in office rents. Therefore, based on our review of the available data sources, we proposed to use the 2010 apartment rental data produced by HUD at the 50th percentile as a proxy for the relative cost difference in physician office rents.

In the proposed rule (75 FR 40085), we indicated that we believe our analysis of the current methods of establishing PE GPCIs and our evaluation of data that fairly and reliably establish distinctions in the cost of operating a medical practice in the different fee schedule areas meet the statutory requirements of section 1848(e)(1)(H)(iv) of the Act (as added by section 3102(b) of the ACA). A more detailed discussion of our analysis of current methods of establishing PE GPCIs and evaluation of data sources is included in Acumen's draft report. Acumen's draft report and associated analysis of the sixth GPCI update, including the PE GPCIs, was posted on the CMS Web site after display of the

CY 2011 PFS proposed rule. The draft report may be accessed from the PFS website at: http://www.cms.gov/PhysicianFeeSched/ under the "Downloads" section of the CY 2011 PFS proposed rule web page. Acumen's final report and associated analysis of the sixth GPCI update will be posted on the CMS website after publication of the CY 2011 PFS final rule with comment.

(D) Determining the PE GPCI Cost Share Weights

To determine the cost share weights for the CY 2011 GPCIs, we proposed to use the proposed 2006-based Medicare Economic Index (MEI) as discussed in section II.E. of this final rule with comment period. The proposed MEI was rebased and revised to reflect the weighted-average annual price change for various inputs needed to provide physicians' services. As discussed in detail in that section, the proposed expense categories in the MEI, along with their respective weights, were primarily derived from data collected in the 2006 AMA PPIS for self-employed physicians and selected self-employed non-medical doctor specialties.

For the cost share weight for the PE GPCIs, we used the 2006-based MEI weight for the PE category of 51.734 percent minus the professional liability insurance category weight of 4.295 percent. Therefore, we proposed a cost share weight for the PE GPCIs of 47.439 percent. For the employee compensation portion of the PE GPCIs, we used the nonphysician employee compensation category weight of 19.153 percent. The fixed capital category weight of 8.410, for which the CPI for owner's equivalent rent is the price proxy, was used for the office rent component. To determine the medical equipment, supplies, and other miscellaneous expenses component, we removed professional liability (4.295 percent), nonphysician employee compensation

(19.153 percent), and fixed capital (8.410 percent) from the PE category weight (51.734 percent). Therefore, we proposed a cost share weight for the medical equipment, supplies, and other miscellaneous expenses component of 19.876 percent.

Furthermore, the physician compensation cost category and its weight of 48.266 percent reflected the proposed work GPCI cost share weight and the professional liability insurance weight of 4.295 percent was used for the malpractice GPCI cost share weight. In the proposed rule (75 FR 40085), we stated that we believe our analysis and evaluation of the weights assigned to each of the categories within the PE GPCIs meets the statutory requirements of section 1848(e)(1)(H)(iv) of the Act (as added by section 3102(b) of the ACA).

The proposed cost share weights for the CY 2011 GPCIs are displayed in Table 24 below.

Table 24: Cost Share Weights for CY 2011 GPCI Update

Expense Category	Current Cost Share Weight	Proposed Cost Share Weight
Physician Work	52.466%	48.266%
Practice Expense	43.669%	47.439%
- Employee Compensation	18.654%	19.153%
- Office Rent	12.209%	8.410%
- Equipment, Supplies, Other	12.806%	19.876%
Malpractice Insurance	3.865%	4.295%
Total	100%	100%

(E) PE GPCI Floor for Frontier States

Section 10324(c) of the ACA added a new subparagraph (I) under section 1848(e)(1) of the Act to establish a 1.0 PE GPCI floor for physicians' services furnished in frontier States. In accordance with section 1848(e)(1)(I) of the Act (as added by section 10324(c) of the ACA), beginning in CY 2011, we applied a 1.0 PE GPCI floor for

physicians' services furnished in States determined to be frontier States. The statute requires us to define any State as a frontier State if at least 50 percent of the State's counties are determined to be frontier counties, which the statute defines as counties that have a population density less than 6 persons per square mile. However, section 1848(e)(1)(I) of the Act (as added by section 10324(c) of the ACA) also specifies that this provision shall not apply to States receiving a non-labor related share adjustment under section 1886(d)(5)(H) of the Act (which excludes Alaska and Hawaii from qualifying as a frontier State).

Consistent with the proposed FY 2011 hospital inpatient prospective payment system (IPPS) 1.0 wage index floor for frontier States (as required by section 10324(a) of the ACA) (75 FR 30920 through 30921), we proposed to identify frontier counties by analyzing population data and county definitions based upon the most recent annual population estimates published by the U.S. Census Bureau. We divided each county's population total by each county's reported land area (according to the decennial census) in square miles to establish population density. We also proposed to update this analysis from time to time, such as upon publication of a subsequent decennial census, and if necessary, add or remove qualifying States from the list of frontier States based on the updated analysis.

For a State that qualifies as a frontier State, in accordance with section 1848(e)(1)(I) of the Act (as added by section 10324(c) of the ACA), we proposed that physicians' services furnished within that State would receive the higher of the applicable PE GPCI value calculated according to the standard CY 2011 methodology or a minimum value of 1.00. Furthermore, in accordance with section 1848(e)(1)(I) of the

Act (as added by section 10324(c) of the ACA), the frontier State PE GPCI floor is not subject to budget neutrality and would only be extended to physicians' services furnished within a frontier State.

For determining the proposed CY 2011 PFS PE GPCI values, the frontier States are the following: Montana; Wyoming; North Dakota; Nevada; and South Dakota (as reflected in Table 25).

Table 25: Frontier States Under Section 1848(e)(1)(I) of the Act (as added by Section 10324(c) of the ACA)

State	Total Counties	Frontier Counties	Percent Frontier Counties
Montana	56	45	80%
Wyoming	23	17	74%
North Dakota	53	36	68%
Nevada	17	11	65%
South Dakota	66	34	52%

(2) Summary of the CY 2011 PE GPCIs

The PE GPCIs include three components: employee compensation, office rent, and medical equipment, supplies and miscellaneous expenses as discussed below:

- Employee Compensation: We used the 2006 through 2008 BLS OES data to determine the proposed employee compensation component of the PE GPCIs. The proposed employee compensation component accounted for 40.4 percent of the total PE GPCIs.

- Office Rents: Consistent with the previous GPCI update, we used the most recent residential apartment rental data produced by HUD (2010) at the 50^{th} percentile as a proxy for the relative cost differences in physician office rents. The proposed office rent component accounted for 17.7 percent of the PE GPCIs.

- Medical Equipment, Supplies, and other Miscellaneous Expenses: We assumed

that items such as medical equipment and supplies have a national market and that input prices do not vary among geographic areas. As discussed in previous GPCI updates in the CY 2005 and CY 2008 PFS proposed rules, specifically the fourth GPCI update (69 FR 47503) and fifth GPCI update (72 FR 38138), respectively, some price differences may exist, but we believe these differences are more likely to be based on volume discounts rather than on geographic market differences. For example, large physicians' practices may utilize more medical equipment and supplies and therefore may or may not receive volume discounts on some of these items. To the extent that such discounting may exist, it is a function of purchasing volume and not geographic location. The proposed medical equipment, supplies, and miscellaneous expenses component was factored into the PE GPCIs with a component index of 1.000. The proposed medical equipment, supplies, and other miscellaneous expense component accounted for 41.9 percent of the PE GPCIs.

c. Malpractice GPCIs

The malpractice GPCIs are calculated based on insurer rate filings of premium data for $1 million to $3 million mature claims-made policies (policies for claims made rather than services furnished during the policy term). The CY 2011 malpractice GPCI update reflects 2006 and 2007 premium data.

d. Public Comments and CMS Responses on the Proposed 6th GPCI Update

We received many public comments regarding the CY 2011 proposed GPCIs. Summaries of the comments and our responses follow.

Comment: Many commenters requested that CMS delay implementation of the changes in underlying PE GPCI data and cost share weights until complete findings and

recommendations from the Institute of Medicine's study of geographic adjustment factors for physician payment, the Secretary's Medicare Geographic Payment Summit, and the MEI technical advisory panel have been developed and considered. A few commenters acknowledged that the BLS OES data is the best data source for updating the GPCIs for CY 2011 but expressed concern that it provides data for MSAs and rest of state areas and not counties. The commenters believe that collecting data at the MSA level distorts the accuracy of the input costs and requested that CMS delay the update until the full ACS data can be evaluated and compared with the BLS OES data. A few commenters requested that CMS delay the GPCI update for CY 2011 as was done in the CY 2004 PFS final rule with comment period for the 4th GPCI update.

Additionally, several commenters stated that a more comprehensive analysis and evaluation of the PE GPCI is required by the ACA, further noting that section 1848(e)(1)(H)(v) of the Act (as added by section 3102(b) of the ACA) allows CMS until January 1, 2012 to implement the findings from the analysis of PE data. To that end, several commenters requested a more comprehensive analysis of the occupational groups used to determine the employee wage component of the PE GPCI to reflect the "true costs" incurred by physician groups in the delivery of health care to Medicare beneficiaries. The commenters cited pharmaceutical, accounting, legal, computer science, and management professionals as examples of the types of nonphysician labor costs that should be included in the determination of the employee compensation index. Several commenters also stated that HUD rental data does not reflect the "actual costs" of physician office rent and therefore should be replaced by another data source.

Response: Section 1848(e)(1)(C) of the Act requires us to review and update the

GPCIs at least every 3 years. When updating the GPCIs we believe we should use the best data that are currently available. As mentioned by the commenters, the BLS OES data are more timely data than the 2000 census data (which has been used for previous GPCI updates). We believe that the BLS OES data, which are currently available, are an appropriate and relevant data source for updating the work GPCIs and employee compensation component of the PE GPCIs. Also because of the timeliness of the data, we believe that using the BLS OES data would result in a more accurate reflection of the geographic practice cost differences among PFS localities than not updating the GPCIs for CY 2011.

While we believe it is appropriate to finalize updated GPCIs for CY 2011 using the most current data, we also acknowledge that there is much ongoing analysis that may inform future GPCI changes. Therefore, as discussed below, we are not using the revised cost share weights for the CY 2011 GPCIs that would apply under the revised and rebased MEI for CY 2011. We will address the GPCI cost share weights once again in the CY 2012 PFS proposed rule, and we may make additional proposals that would further modify the GPCI data and/or methods for CY 2012.

Additionally, we will review the complete findings and recommendations from the Institute of Medicine's study of geographic adjustment factors for physician payment, the Secretary's Medicare Geographic Payment Summit, and the MEI technical advisory panel, and we will continue to study the issues as required by section 1848(e)(1)(H)(iv) of the Act (as added by section 3102(b) of the ACA). We will once again consider the GPCIs for CY 2012 in the context of our annual PFS rulemaking beginning in CY 2011 based on the information available at that time. The CY 2011 GPCIs arising from the 6th

GPCI update reflect our initial review and response to the currently available GPCI data, methods, and cost share weights. Once the full ACS data are available, we will reassess the occupational groups used to determine the employee compensation component of the PE GPCI and continue to explore the use of commercial rent data as part of our ongoing analysis of the GPCIs. We anticipate that further information, including our review of the full ACS data, may lead to proposed additional refinements to the GPCIs for future years. We have addressed the CY 2011 GPCI cost share weights in response to other public comments received on the CY 2011 PFS proposed rule that are summarized later in this section.

With regard to the commenters who expressed concern that the BLS OES data are not collected at the county level, we note that the 2000 Decennial Census data are only available at the county level for approximately 10 percent of counties. For previous updates, the GAFs for more than 90 percent of counties were developed based on MSAs or larger geographic areas (for example, data for all rural areas in a State were combined and used to proxy values for each rural county in a State). Therefore, using BLS OES data and disaggregating data to the county level is not a significant departure from previous GPCI updates.

Moreover, we acknowledge that in the CY 2004 PFS proposed and final rules (68 FR 49042 and 68 FR 63213 respectively), we updated only the malpractice GPCI because the special tabulation of census data used for the physician work GPCI and employee compensation portion of the PE GPCI was not yet available. We explained that no acceptable data sources could be found to update the work GPCIs and the employee compensation portion of the practice expense GPCIs. Therefore, we made no

changes to the work GPCIs and PE GPCIs for CY 2004. However, in view of the statutory requirement to update the GPCIs at least every 3 years, we do not believe it would be appropriate to finalize an update only for malpractice GPCIs for CY 2011, while delaying the update of the work GPCI and PE GPCI, when we currently have appropriate updated data available to us for this purpose. As discussed previously, we will review the GPCIs as part of the CY 2012 PFS rulemaking cycle (beginning in CY 2011) based on the information available at that time, and we may propose changes to the GPCIs prior to the next 3-year GPCI update.

Comment: Several commenters stated that the use of HUD rental data is not an appropriate proxy for determining the office rent index and suggested that CMS use data on actual physician office rents instead. Additionally, one commenter questioned CMS' analysis of the Medical Group Management Association's (MGMA's) survey data on rent. The commenter raised questions as to why CMS rejected the use of MGMA rental data due to insufficiency in sample size and representation, despite admitting that the physician response rate on the MGMA survey was typical for surveys of business.

Response: As we have previously explained in the CY 2005 and CY 2008 final rules with comment period (69 FR 66262 and 72 FR 66245 respectively), we recognize that apartment rents may not be a perfect proxy for measuring the relative cost differences in physician office rents. However, we believe the HUD rental data are the most comprehensive and valid indicator that is available of the real estate rental market in all areas of the country. We continue to believe that HUD rental data remain the best data source for determining the relative cost differences in physicians' office rent among all areas of the country. The data are regularly updated and available nationally, and

retain consistency area-to-area and year-to-year. We would welcome any alternative rental data source that is available nationally with sufficient representation among PFS localities.

With regard to our review of MGMA survey data, we have concerns with both the sample size and representativeness of the MGMA data. For example, the responses represent only about 2,250 physician practices nationwide and have disproportionate sample sizes by State, suggesting very uneven response rates geographically. In addition, we also have concerns that the MGMA data have the potential for response bias. The MGMA's substantial reliance on its membership base suggests a nonrandom selection into the respondent group. Some evidence for such issues in the MGMA data arises from the very different sample sizes by State. For example, in the MGMA data, 10 States have fewer than 10 observations each, and California, New York, and New Jersey have fewer than 10 observations per locality. Therefore, we continue to believe the MGMA survey data would not be a sufficient rental data source for all PFS localities.

Comment: One commenter expressed concern that the BLS OES wage data may result in the undervaluation of physician earnings because the data exclude incomes of self-employed professionals.

Response: The GPCIs are not an absolute measure of physician earnings; rather, they are a measure of the relative cost differences for each of the three PFS components. We have no evidence to suggest that self-employment income would have different geographic variation than non-self-employed income. Absent such evidence, we would expect that including wage data from self-employed professionals would result in a geographic distribution of professional wages similar to the BLS OES data source.

Comment: Many commenters stated that implementing PE GPCI changes in CY 2011 would reduce payment to urban areas and, therefore, would violate the "hold harmless" provision as required by the ACA.

Response: Section 1848(e)(1)(H) of the Act (as added by section 3102 (b) of the ACA) requires that we apply a limited recognition of cost differences for the rent component and employee compensation component of the PE GPCI as compared to the national average. This section also includes a "hold harmless" provision for CY 2010 and CY 2011 for any PFS locality that would receive a reduction to its PE GPCI resulting from the limited recognition of PE cost differences. For CY 2010 and CY 2011, we applied the limited recognition of PE cost differences and "hold harmless provision" in accordance with the statutory requirement, which is specific only to the limited recognition of rent and employee wage cost differences. In other words, the "hold harmless"(non-budget neutral) provision under section 1848(e)(1)(H)(iii) of the Act (as added by section 3102 (b) of the ACA) does not apply to the effects of updated data incorporated into the GPCIs as a result of our normal GPCI update process. As discussed earlier in this section, the proposed GPCI update reflected our preliminary review based on the best information currently available. We anticipate that further information may lead to proposed additional refinements to the GPCIs in future years.

Comment: One commenter recommended that CMS track the "hold harmless" transitional GPCIs to determine whether certain regions of the country are underpaid as a result of the application of the limited recognition of PE cost differences.

Response: The "hold harmless" provision under section 1848(e)(1)(H)(iii) of the Act (as added by section 3102(b) of ACA) was applied by selecting the greater of the

CY 2011 transitional PE GPCI value calculated with the limited recognition of cost differences or the CY 2011 transitional PE GCPI value calculated with full recognition of cost differences. Therefore, no locality is "underpaid" by the application of the limited recognition of PE cost differences.

Comment: One commenter requested that CMS consider applying a 1.0 GPCI floor to non-frontier States that serve significant rural populations. The commenter was not specific as to which GPCI (work, PE, or malpractice) the floor should be applied.

Response: As discussed previously in this section, section 1848(e)(1)(I) of the Act (as added by section 10324(c) of the ACA) established a permanent 1.0 PE GPCI floor only for frontier States, and section 3102(a) of the ACA amended section 1848(e)(1)(E) of the Act to extend the 1.0 work GPCI floor for services furnished only through December 31, 2010. We do not otherwise have the authority to establish GPCI floors that do not consider the differences in physicians' resource costs among localities.

Comment: A few commenters requested that CMS release underlying data sources, including county level GPCI values and budget neutrality estimates, which would allow interested parties to replicate GPCI calculations.

Response: We strive to be as transparent as possible in all of our proposals. To that end, we have made numerous files available on the CMS Web site under the downloads for the CY 2011 PFS proposed rule to assist in the public's review of the CY 2011 proposal. These files include: the preliminary contractor's report on data for the 6th GPCI update; the CY 2010 through CY 2012 GPCIs, both as proposed (including the ACA provisions) and without the ACA provisions to permit isolation of the impacts of the updated data; and web links to the publicly available source data and copies of data

files that are not otherwise publicly available, for example county and locality-specific RVUs from Medicare claims data and malpractice insurance premium data. In combination, this information allows the public to apply our methodology to replicate our calculations for the proposed GPCIs.

Comment: Many commenters expressed concern about the proposed cost share weights for the rent component and medical equipment, supplies, and other miscellaneous component of the PE GPCI. The commenters stated that the proposed cost share weights would unjustifiably shift Medicare payment away from urban localities to rural localities. Several commenters suggested that portions of the "all other services" component of the office expenses cost category, (which includes maintenance services, storage, security and janitorial services, office equipment, information technology systems, and medical record systems) and the stand-alone "other professional services" cost category (which includes accounting services, legal services, office management services, continuing education, professional association memberships, journals, and professional care expenses) are wage-related and, therefore, should be adjusted for locality cost differences. Additionally, a few commenters stated that the cost share weight attributed to the rent component of the PE GPCI should vary by region because one national cost share weight for rent penalizes areas where office rent is a higher portion of practice expenses.

Response: Although we typically update the GPCI cost share weights concurrently with the most recent MEI revision and rebasing, the commenters raised many points regarding the reallocation of labor-related costs from the medical equipment and supplies and miscellaneous component to the employee compensation component of

the PE GPCI. After consideration of the public comments we received on this issue, we will continue to use the current GPCI cost share weights for CY 2011. We have asked the Institute of Medicine to evaluate the accuracy of the geographic adjustment factors used for Medicare physician payment. The Institute of Medicine will prepare two reports for Congress and the Secretary of the Department of Health and Human Services. The first report, expected in spring 2011, will include an evaluation of the accuracy of geographic adjustment factors, and the methodology and data used to calculate them. The second report, expected in spring 2012, will evaluate the effects of the adjustment factors on the distribution of the health care workforce, quality of care, population health, and the ability to provide efficient, high-value care. For more information on the Institute of Medicine's study on Medicare geographic adjustment factors, we refer readers to the Institute of Medicine Web site: http://iom.edu/Activities/HealthServices/GeographicAdjustments.aspx.

We will explore further the options that were raised to us by the commenters and the recommendations in the forthcoming Institute of Medicine report(s). We will also continue our analysis of the cost share weights attributed to the PE GPCI as required by section 1848(e)(1)(H)(iv) of the Act (as added by section 3102(b) of the ACA), including the possibility of assigning cost share weights to the rent component of the PE GPCI that vary among fee schedule areas. We will address the GPCI cost share weights again in the CY 2012 PFS proposed rule.

Comment: MedPAC suggested an alternative method for calculating the PE GPCI. This alternative PE GPCI method would account for variations in the cost share of equipment and supplies across services.

Response: We appreciate MedPAC's suggestion of an alternative method that would vary the portion of PE that is geographically adjusted for locality differences based on the characteristics of individual services, rather than applying a uniform percentage across all PFS services. We recommend that MedPAC continue to analyze this or other alternative geographic adjustment methods, including their administrative feasibility.

Comment: A few commenters stated that the "range of disparity" between the highest and lowest paid PFS localities is too large and contradicts data studies showing little to no distinction in physician practice expenses throughout the nation. For example, the commenters stated that the AMA's analysis of its own PPIS data concluded that "expenses did not differ significantly by either metro location or Census region." One commenter requested an explanation of the discrepancy between the AMA's findings of no measurable practice expense distinctions and CMS' findings that continue to show substantial distinctions in physician practice expenses among the Medicare payment localities. Another commenter stated that a 2007 survey conducted by the journal, Medical Economics, indicated that the average practice expenses are highest in the Midwestern States (which is contrary to the proposed CY 2011 GPCIs).

Response: We have reviewed the studies referenced by the commenters and compared their findings with the GPCI values calculated for the CY 2011 PFS proposed rule. As mentioned by the commenters, both the AMA and Medical Economics studies aggregated per-physician expenses at the Census region level. The AMA PPIS analysis showed the Northeast as having the lowest per-physician expenses, followed by the Midwest then the West, with the South identified as having the highest expenses. Although there is about a 20 percent difference in total expenses between the Northeast

and South, the study noted that the difference was not significant after controlling for practice setting and physician specialty. The Medical Economics survey findings showed about a 30 percent difference in costs, with the East showing the lowest expenses and the Midwest with the highest. Both studies demonstrated that rural areas have the highest per-physician expenses and highly populated areas the lowest.

To compare the variation of PE GPCI values calculated for the CY 2011 PFS proposed rule to the AMA and Medical Economics studies, we used PE RVUs to create weighted averages of the PE GPCIs by Census region. Additionally, because the AMA and Medical Economics data reported total per-physician practice expenses, whereas the GPCI is a cost index, we produced indices for each source to create comparable measures of variation. We then normalized each index to the lowest cost area from each data source. Consequently, the index values show the percent difference in costs relative to the lowest cost area. For example, the AMA study shows the Northeast as having the lowest per-physician expenses, thus establishing an index value of 1.00 for that area. For the AMA study, the Midwest index value is 1.07 which signifies that costs in the Midwest are 7 percent above the Northeast AMA values. The PE GPCI data indicate that the Midwest has the lowest costs; and the South, with an index value of 1.01, has costs that are 1 percent above the Midwest GPCI values. When aggregated to the Census region, the PE GPCIs showed less variation in costs than the comparison data sources (AMA PPIS and Medical Economics). Using the PE GPCI data to calculate Census region indices produced only a 16 percent difference in costs between the most costly and least costly areas, equating to roughly half the variation found in the Medical Economics survey and about 75 percent of the variation found in the PPIS study. Table 26 compares

the results on the disparity in costs by Census region.

Table 26: Census Region Cost Indices by Data Source

	AMA	Medical Economics	PE GPCI Data	PE GPCI Components		
				Rent	Wages	Office Supplies
Midwest	1.07	1.29	1.00	1.00	1.04	1.00
South	1.21	1.20	1.01	1.12	1.00	1.00
West	1.11	1.06	1.14	1.47	1.17	1.00
Northeast	1.00	1.00	1.16	1.55	1.18	1.00

Additionally, the conceptual approaches to the GPCIs and the data sources noted by the commenters are sufficiently different to make comparisons extremely difficult. The different rank ordering in the costs by regions, as shown in Table E4, may also reflect the different strategies used to measure costs. Specifically, the AMA and Medical Economics studies ordered areas based on total physicians' expenses, whereas the GPCIs are intended to provide a local cost index that is then applied to each PFS component; work, practice expense, and malpractice expense. Based on our review of the AMA PPIS and Medical Economics studies, a key factor in explaining differences with the proposed GPCI values is differences in practice patterns across the different areas. Specifically, rural practitioners tend to see more patients, incurring higher expenses. However, as noted in the Medical Economics study, higher patient loads result in higher payment. To place this in the context of Medicare PFS payment, seeing more patients produces more billed services, allowed charges, and payments. Therefore, the greater number of patients seen by rural physicians is accounted for in total RVUs to the physician, rather than through the GPCI values.

Moreover, the very low cost ranking of the Northeast in both the AMA PPIS and

Medical Economics datasets suggests a possible influence of economies of scale. The GPCIs are designed to capture differences in the prices of inputs facing physicians in each region. The input prices are used to create GPCI values as a measure of the relative cost differences in operating a medical practice in one locality versus another. It is likely that the AMA and Medical Economics studies are capturing differences in the production of services, distinct from the input prices. In particular, the geographic differences may reflect differences in economies of scale in more and less urbanized areas. More rural practitioners are less likely to work in large practices, leading to higher per-physician costs, all else being equal. For example, a two-physician practice may need the same number of front office staff as a one-physician practice. When this expense is measured on a per-physician basis, the single physician pays twice as much for front office support. This type of variation can occur within localities and may reflect the practitioner's choice to work in a small or large physician practice. Nevertheless, there is no mechanism within the existing GPCI approach to account for the influence of economies of scale, despite its potentially significant impact on the effective per-unit costs of providing care.

Comment: Several commenters recommended that CMS use data from a reliable survey of physicians' practices, such as the AMA PPIS or the MGMA survey, to develop the office rent index and employee compensation index.

Response: Because of the limited sample sizes of the AMA PPIS (n=2,137) and MGMA studies (n=2,246), we do not believe that it would be possible to calculate reliable indices for all Medicare PFS localities based upon these data. As mentioned previously, in the MGMA data, 10 States have fewer than 10 observations each, and California, New York, and New Jersey have fewer than 10 observations per locality.

In light of the comments received suggesting the use of survey data to determine GPCI values and the typical response rates for existing physician surveys, we are continuing to consider the possibility of establishing a physician cost report and requiring a sufficiently large sample of physicians in each locality to report data on actual costs incurred. However, we believe that a physician cost report could take years to develop and implement, and could be prohibitively expensive. We also have some concerns about the administrative burden this approach would place on physician's office staff. Therefore, we are requesting specific public comments regarding the potential benefits to be gained from establishing a physician cost report and whether this approach is appropriate to achieve potentially greater precision in measuring the relative cost differences in physicians' practices among PFS localities. We are also requesting public comments on the potential administrative burden of requiring physicians to routinely complete and submit a cost report and whether this requirement should be mandatory for all physician practices. Additionally, we have asked the Institute of Medicine to look at the use of survey data in the context of their geographic adjustment analysis. It is also our understanding that MedPAC is considering the issue of data sources used to determine geographic payment adjustments under the PFS.

Comment: One commenter stated that all geographic adjustment factors should be eliminated from the Medicare PFS "except for those designed to achieve a specific public policy goal, for example, to encourage physicians to practice in underserved areas." The commenter requested that CMS utilize the most broadly applicable methodology allowed by law to reduce geographic payment disparity.

Response: We are required by section 1848(b)(1)(C) and (e)(1)(A) of the Act to

develop and apply separate GPCIs to adjust for resource cost differences among localities compared to the national average for each of the three PFS components: work, practice expense, and malpractice expense. The purpose of the GPCIs is not to reduce geographic payment disparity; rather, the GPCIs distribute PFS payments among areas in order to adjust for area cost differences. In general the data show that urban areas usually are higher cost, while rural areas are lower cost. However, there are several provisions currently in place that have the effect of reducing geographic payment disparities. For example, the statute requires that only one-quarter of area cost differences in physician work be recognized, and we assign a 1.0 index to the medical equipment, supplies, and miscellaneous component of the PE GPCI because we believe there is a national market for these items. In addition, 34 States and 2 territories are "Statewide" payment localities wherein all physicians, whether urban or rural, are paid the same. Moreover, many geographic areas are designated as Health Professional Shortage Areas (HPSAs). Physicians in these areas may be eligible for a 10 percent HPSA bonus payment in addition to the amount paid under the Medicare PFS for services they furnish. Beginning in CY 2011, general surgeons furnishing major surgical procedures in these areas may be eligible for the HPSA surgical incentive payment program (HSIP) that also pays 10 percent in addition to the amount paid under the PFS as discussed in section VI.S.2. of this final rule with comment period. For complete information on the HPSA bonus payment program and a list of eligible areas for both programs by zip code, we refer readers to the CMS Web site at: http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp. All of these factors mentioned above have the effect of reducing geographic payment disparities under the

Medicare PFS.

Comment: One commenter encouraged CMS to follow the GAOs recommendations, as outlined in the GAO's March 2005 Report (GAO-05-119), for improving underlying GPCI data and methods by taking the following actions:

- Transition from Census Bureau's Decennial Census data to the annual ACS for earning and wage data.
- Include physician assistant wage data to improve the measurement of the PE GPCI.
- Consider the feasibility of using a commercial rent index or a residential rent index directly based on ACS data for determining the rent component of the PE GPCI.
- Collect malpractice premium data from all States, accounting for at least half of the malpractice business in a State.
- Standardize collection of malpractice premium data, for example by using data from Physician Insurer's Association of America.

Response: As previously discussed, the full ACS data were not available in time for the 6th GPCI update. We intend to explore the use of ACS data for determining the work GPCI and the employee compensation component of the PE GPCI, as well as evaluate its possible use as an office rent index once the data are fully available. We also intend to continue exploring the potential use of commercial rent data as part of our ongoing review and refinement of the GPCIs.

Additionally, we have considered the use of physician assistant wages in calculating the employee compensation index. However, since physician assistants can furnish medical services and bill the Medicare program directly, their wages are

influenced by Medicare PFS payment. Therefore, we have some concern that a circular effect could occur if we included physician assistants among the occupational groups comprising the employee compensation component, similar to our concern with including physicians' salaries in the determination of the work GPCI.

With regard to the collection of malpractice premium data, the CY 2011 malpractice GPCI update reflects 2006 and 2007 premium data which were also used for the CY 2010 update to the malpractice RVUs. As compared to previous malpractice RVU updates, we substantially increased the number of States from which we were able to collect rate filings. We were able to collect malpractice premium data from every State except for Mississippi and Puerto Rico. Premium data were selected from at least two companies in each State, with more selected if necessary to reach 50 percent of the market share in that State. To ensure consistency across States we collected premium data from State Departments of Insurance. For States where we were not able to collect rate fillings, we used premium information from the Medical Liability Monitor Survey data from 2005 through 2008.

e. Summary of Final CY 2011 GPCIs

After consideration of the public comments received on the GPCIs, we are finalizing the 6th GPCI update using the most current data, with modifications; we are not finalizing the proposal to change the GPCI cost share weights for CY 2011. Instead, we are continuing to use the current GPCI cost share weights for determining the PE GPCI values and locality GAFs in CY 2011, and we will address the cost share weights again in the CY 2012 PFS proposed rule. As a result, the cost share weight for the physician work GPCI (as a percentage of the total) will be 52.5 percent (current and for CY 2011) rather

than 48.3 percent (as proposed), and the cost share weight for the PE GPCI will be 43.7 percent (current and for CY 2011) rather than 47.4 percent (as proposed) with only a slight difference in the employee compensation component (18.7 percent rather than 19.2 percent as proposed). However, the cost share weight for the office rent component of the PE GPCI will be 12.2 percent (current and for CY 2011) rather than 8.4 percent (as proposed), and the medical equipment, supplies, and other miscellaneous expenses component will be 12.8 percent (current and for CY 2011) rather than 19.9 percent (as proposed). Moreover, the cost share weight for the malpractice GPCI will be 3.9 percent (current and for CY 2011) rather than 4.3 percent (as proposed).

Additionally, we will review the complete findings and recommendations from the Institute of Medicine's study of geographic adjustment factors for physician payment, the Secretary's Medicare Geographic Payment Summit, and the MEI technical advisory panel, and continue to study the issues as required by section 1848(e)(1)(H)(iv) of the Act (as added by section 3102(b) of the ACA). We will once again consider the GPCIs for CY 2012 in the context of our annual PFS rulemaking beginning in CY 2011 based on the information available at that time.

We are using the 2006 through 2008 panels from the BLS OES data for updating the work GPCIs and the employee compensation component of the PE GPCIs. We are also using the 2010 apartment rental data produced by HUD at the 50th percentile as a proxy for the relative cost difference in physicians' office rents and 2006 and 2007 malpractice premium data for determining the malpractice GPCIs.

As required by section 1848(e)(1)(H)(ii) and (iii) of the Act (as added by section 3102(b) of the ACA), the CY 2011 GPCIs reflect only one-half of the relative cost

differences for the employee compensation and rent portions of the PE GPCI, and the "hold harmless" provision ensures that no locality receives a payment reduction resulting from the limited recognition of PE cost differences. For CY 2011, the "hold harmless" provision was applied by selecting the greater of the CY 2011 transitional PE GPCI value calculated with the limited recognition of cost differences or the CY 2011 transitional PE GPCI value calculated with full recognition of cost differences.

In accordance with section 1848(e)(1)(I) of the Act (as added by section 10324(c) of the ACA), and consistent with the final FY 2011 hospital IPPS (75 FR 5160 through 5161), we applied a 1.0 PE GPCI floor for services furnished in frontier States. The frontier States are the following: Montana; Wyoming; North Dakota; Nevada; and South Dakota. As we indicated above in this section, section 1848(e)(1)(E) of the Act (as amended by section 3102(a) of the ACA) extended the 1.0 work GPCI floor only through December 31, 2010. Therefore, the CY 2011 physician work GPCIs and summarized GAFs do not reflect the 1.0 work floor. However, the permanent 1.5 work GPCI floor for Alaska (as established by section 134(b) of the MIPPA) will remain in effect for CY 2011.

We are finalizing the CY 2011 GPCIs shown in Addendum E. The GPCIs have been budget neutralized to ensure that nationwide, total RVUs are not impacted by changes in locality GPCIs. The 1.0 PE GPCI floor for frontier States and the PE GPCI "hold harmless" provision were applied to the budget neutralized GPCIs.

Typically when we complete a review and update of the GPCIs, the values shown represent the first year of the 2-year GPCI update transition. Although the CY 2011 GPCIs have been set on that basis, we note that we will be assessing the results of the

various studies regarding the GPCIs and cost share weights (once they are completed), and exploring the use of the full ACS data. Based on these assessments, we may make additional proposals that would further modify the GPCIs for CY 2012, which would result in changes to the CY 2012 GPCIs shown in Addendum E to this final rule with comment period. Therefore, the final CY 2011 GPCIs may not reflect a true mid-point "phase-in" to the updated GPCIs, although, as noted above, they have been set for CY 2011 on that basis. The CY 2011 updated GAFs and GPCIs may be found in Addenda D and E of this final rule with comment period.

3. Payment Localities

The current PFS locality structure was developed and implemented in 1997. There are currently 89 localities; 34 localities are Statewide areas. There are 52 localities in the other 18 States, with 10 States having 2 localities, 2 States having 3 localities, 1 State having 4 localities, and 3 States having 5 or more localities. The District of Columbia, Maryland, and Virginia suburbs, Puerto Rico, and the Virgin Islands are additional localities that make up the remainder of the total of 89 localities. The development of the current locality structure is described in detail in the CY 1997 PFS proposed rule (61 FR 34615) and the subsequent final rule with comment period (61 FR 59494).

As we have previously noted in the CYs 2008 and 2009 proposed rules (72 FR 38139 and 73 FR 38513), any changes to the locality configuration must be made in a budget neutral manner within a State and can lead to significant redistributions in payments. For many years, we have not considered making changes to localities without the support of a State medical association in order to demonstrate consensus for the

change among the professionals whose payments would be affected (with some increasing and some decreasing). However, we have recognized that, over time, changes in demographics or local economic conditions may lead us to conduct a more comprehensive examination of existing payment localities.

For the past several years, we have been involved in discussions with physician groups and their representatives about recent shifts in relative demographics and economic conditions, most notably within the current California payment locality structure. We explained in the CY 2008 PFS final rule with comment period that we intended to conduct a thorough analysis of potential approaches to reconfiguring localities and would address this issue again in future rulemaking. For more information, we refer readers to the CY 2008 PFS proposed rule (72 FR 38139) and subsequent final rule with comment period (72 FR 66245).

As a follow-up to the CY 2008 PFS final rule with comment period, we contracted with Acumen to conduct a preliminary study of several options for revising the payment localities on a nationwide basis. The contractor's interim report was posted on the CMS Web site on August 21, 2008, and we requested comments from the public. The report entitled, "Review of Alternative GPCI Payment Locality Structures," remains accessible from the CMS PFS Web page under the heading "Interim Study of Alternative Payment Localities under the PFS." The report may also be accessed directly from the following link:

http://www.cms.hhs.gov/PhysicianFeeSched/10_Interim_Study.asp#TopOfPage.

We accepted public comments on the interim report through November 3, 2008. The alternative locality configurations discussed in the report are described briefly below in

this section.

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

This option uses the Office of Management and Budget (OMB's) Metropolitan Statistical Area (MSA) designations for the payment locality configuration. MSAs would be considered as urban CBSAs. Micropolitan Areas (as defined by OMB) and rural areas would be considered as non-urban (rest of State) CBSAs. This approach would be consistent with the IPPS pre-reclassification CBSA assignments and with the geographic payment adjustments used in other Medicare payment systems. This option would increase the number of PFS localities from 89 to 439.

Option 2: Separate High-Cost Counties from Existing Localities (Separate Counties)

Under this approach, higher cost counties are removed from their existing locality structure and they would each be placed into their own locality. This option would increase the number of PFS localities from 89 to 214, using a 5 percent GAF differential to separate high-cost counties.

Option 3: Separate MSAs from Statewide Localities (Separate MSAs)

This option begins with statewide localities and creates separate localities for higher cost MSAs (rather than removing higher cost counties from their existing locality as described in Option 2). This option would increase the number of PFS localities from 89 to 130, using a 5 percent GAF differential to separate high-cost MSAs.

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

This option creates tiers of counties (within each State) that may or may not be contiguous but share similar practice costs. This option would increase the number of PFS localities from 89 to 140, using a 5 percent GAF differential to group similar counties into statewide tiers.

As discussed in Acumen's interim report, all four studied alternative locality configurations would increase the number of localities and separate higher cost areas from rural "rest of state" areas. As a result, payments to urban areas would increase, while rural areas would see a decrease in payment because they would no longer be grouped with higher cost "urbanized" areas. A number of public commenters on the draft report expressed support for Option 3 (separate MSAs from Statewide localities) because the commenters believed this alternative would improve payment accuracy over the current locality configuration and could mitigate possible payment reductions to rural areas as compared to Option 1 (CMS CBSAs). Therefore, Acumen is conducting a more in-depth analysis of the dollar impacts that would result from the application of Option 3. For a detailed discussion of the public comments on the contractor's interim locality study report, we refer readers to the CY 2010 PFS proposed rule (74 FR 33534) and subsequent final rule with comment period (74 FR 61757).

We note that the discussion of PFS payment localities and our preliminary study of alternative payment locality configurations in the CY 2011 PFS proposed rule was intended for informational purposes only. We did not make any proposals regarding the PFS locality configurations for CY 2011 and, therefore, public comments on the PFS locality configurations are not within scope of the CY 2011 PFS proposed rule. We thank the commenters for sharing their views and suggestions; however, we are not

summarizing or responding to 'out of scope' comments in this final rule with comment period.

E. PFS Update for CY 2010: Rebasing and Revising of the Medicare Economic Index (MEI)

1. Background

The Medicare Economic Index (MEI) was originally required by section 1842(b)(3) of the Act, which states that prevailing charge levels beginning after June 30, 1973 may not exceed the level from the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by year-to-year economic changes. We continued to use the MEI as part of the statutory update formula (specified under section 1848 of the Act) when the physician fee schedule was implemented in 1992 (56 FR 59511).

Beginning July 1, 1975, and continuing through today, the MEI has served these purposes by reflecting the weighted-average annual price change for various inputs needed to furnish physicians' services. As such, the index is necessarily a fixed-weight input price index, with an adjustment for the change in economy-wide, private nonfarm business multifactor productivity. The MEI is comprised of two broad categories: (1) physician's own time; and (2) physician's practice expense (PE).

The MEI was first published on June 16, 1975 (40 FR 25446), and became effective for services furnished beginning July 1, 1975. The original MEI had a base period of 1971. The structure of the original MEI remained essentially unchanged from its original until the CY 1993 final rule (57 FR 55896) in which we finalized a comprehensive rebasing and revision process with a 1989 base year. The new index was

based in part on the recommendations of a Congressionally-mandated meeting of experts held in March 1987. The MEI was again rebased in the CY 1999 final rule (63 FR 58845), which moved the cost structure of the index from a 1989 base to a 1996 base. The methodology for the productivity adjustment was revised in the CY 2003 final rule (67 FR 80019) to reflect the percentage change in the 10-year moving average of economy-wide private nonfarm business multifactor productivity (previously the index was adjusted by a measure of labor productivity). The current form of the MEI was detailed in the CY 2004 PFS final rule (68 FR 63239) which updated the cost structure of the index from a base year of 1996 to 2000.

We proposed to rebase and revise the MEI and incorporate it into the CY 2011 PFS update. The terms "rebasing" and "revising", while often used interchangeably, actually denote different activities. Rebasing refers to moving the base year for the structure of costs of an input price index, while revising relates to other types of changes such as changing data sources, cost categories, or price proxies used in the price index. As is always the case with a rebasing and revising exercise, we have used the most recently available, relevant, and appropriate information to develop the proposed MEI cost category weights and price proxies. In the following sections of this final rule with comment period, we detail our proposals and respond to comments regarding the updated cost weights for the MEI expense categories, our rationale for selecting the price proxies in the MEI, and the results of the rebasing and revising of the MEI.

2. Use of More Current Data

The MEI was last rebased and revised in 2003 in the CY 2004 PFS final rule with comment period (68 FR 63239). The current base year for the MEI is 2000, which means

that the cost weights in the index reflect physicians' expenses in 2000. However, we believe it is desirable to periodically rebase and revise the index so that the expense shares and their associated price proxies reflect more current conditions. For the CY 2011 PFS update, we are finalizing the proposal to rebase and revise the MEI to reflect appropriate physicians' expenses in 2006.

Compared to the 2000-based MEI, we proposed to make several changes to the MEI cost structure. First, we proposed to exclude the Pharmaceutical cost category as pharmaceuticals are neither paid for under the PFS nor are they included in the definition of "physicians' services" for purposes of calculating the physician update via the SGR system (for more details see the CY 2010 PFS final rule with comment period (74 FR 61961 through 61962)). We also proposed to exclude the expenses associated with separately billable supplies since these items are not paid for under the PFS. Our primary data source, the 2006 Physician Practice Information Survey (PPIS), collected data on these costs enabling us to accurately remove them from the index. In addition, we proposed to include nine new cost categories that disaggregate the costs under the broader Office Expenses cost category. The 2000-based MEI did not break these expenses into individual cost categories. As a result of comments received, which are described more fully below in this section, we are modifying this proposal to instead include ten detailed cost categories. As indicated in the CY 2011 PFS proposed rule, we proposed to continue to adjust the MEI for economy-wide multifactor productivity based on changes in the 10-year moving average of private nonfarm business multifactor productivity. After considering the comments received, we are finalizing our proposal to continue to adjust the MEI for economy-wide multifactor productivity based on changes

in the 10-year moving average of private nonfarm business multifactor productivity.

3. Rebasing and Revising Expense Categories in the MEI

The MEI is used in conjunction with the SGR system to update the PFS and represents the price component of that update. The proposed expense categories in the index, along with their respective weights, are primarily derived from data collected in the 2006 AMA PPIS for self-employed physicians and selected self-employed non-medical doctor specialties. As noted, in addition to data on medical doctors, we included data from several non-medical doctor specialties in the MEI cost weight calculations (including optometrists, oral surgeons, podiatrists, and chiropractors) consistent with the definition of the term "physician" in section 1861(r) of the Act. In summary, the term "physician" when used in connection with the performance of functions or actions an individual is legally authorized to perform means the following: (1) a doctor of medicine or osteopathy; (2) a doctor of dental surgery or of dental medicine; (3) a doctor of podiatric medicine; (4) a doctor of optometry; or (5) a chiropractor. For a complete definition, please see section 1861(r) of the Act. We weighted the expense data from the above-referenced specialties with the self-employed physician expense data using physician counts by specialty, the same methodology used in the AMA PPIS.

The AMA PPIS data were used to determine the expenditure weights in the MEI for all of the major cost categories including total expenses, physicians' earnings, physicians' benefits, employed physician payroll, nonphysician compensation, office expenses, professional liability insurance (PLI), medical equipment, medical supplies, and other professional expenses. We are finalizing our proposal to further disaggregate

both non-physician compensation and office expenses into subcategories reflecting more detailed expenses. We used several data sources for further disaggregation of expenses including: data from the 2002 Bureau of Economic Analysis (BEA) Benchmark Input-Output table (I/O), the 2006 Bureau of the Census Current Population Survey (CPS), the 2006 Bureau of Labor Statistics (BLS) Occupational Employment Survey (OES), the 2006 Employment Cost for Employee Compensation Survey (ECEC), and the 2006 Internal Revenue Service (IRS) Statistics of Income (SOI) data. The development of each of the cost categories using these sources is described in detail below.

a. Developing the Weights for Use in the MEI

Developing a rebased and revised MEI requires selecting a base year and determining the appropriate expense categories. We proposed to rebase the MEI to CY 2006. We choose CY 2006 as the base year as: 1) this is the most recent year for which comprehensive physician expense data are available; and (2) we believe these data represent an accurate proxy for the physician expense distribution in CY2011.

Table 27 lists the set of mutually exclusive and exhaustive cost categories that make up the final rebased and revised MEI, including the addition of the All Other Products category we are adopting in response to public comments.

TABLE 27: Final 2006 MEI Cost Categories, Weights, and Price Proxies Compared to the 2000 MEI Cost Categories and Weights

Cost Category	Final 2006-Cost Weights (1, 2)	2000 Cost Weights	2006 Price Proxies
Total	**100.00**	**100.000**	
Physician's Compensation (Own Time)(3)	48.266	52.466	
Wages and Salaries	43.880	42.730	AHE Total Nonfarm Private for Production & Nonsupervisory Employees(5)
Benefits (3)(4)	4.386	9.735	ECI-Benefits Total Nonfarm Private(6)

Cost Category	Final 2006-Cost Weights (1, 2)	2000 Cost Weights	2006 Price Proxies
Physician's Practice Expense	51.734	47.534	
Nonphysician Employee Compensation	19.153	18.654	
Nonphysician Employee Wages and Salaries	13.752	13.809	
Prof/Tech Wages	6.006	5.887	ECI-Wages/Salaries: Private Professional &Technical
Managerial Wages	1.446	3.333	ECI-Wages/Salaries: Private Managerial
Clerical Wages	4.466	3.892	ECI-Wages/Salaries: Private Clerical
Services Wages	1.834	0.696	ECI-Wages/Salaries: Private Service
Nonphysician Employee Benefits (4)	5.401	4.845	ECI-Ben: Private Blend
Office Expenses	20.035	12.209	
Utilities	1.266	-	CPI Fuel & Utilities (7)
Chemicals	0.723	-	PPI for Other Basic Organic Chemical Manufacturing (8)
Paper	0.657	-	PPI for Converted Paper
Rubber & Plastics	0.598	-	PPI for Rubber and Plastics
Telephone	1.501	-	CPI for Telephone Services
Postage	0.898	-	CPI for Postage
All Other Services	3.582	-	ECI Compensation Services Occupations
All Other Products	0.500		CPI-U All Items Less Food and Energy
Fixed Capital	8.957	-	CPI for Owner's Equivalent Rent
Moveable Capital	1.353	-	PPI for Machinery and Equipment
PLI	4.295	3.865	CMS-Prof. Liab. Phys. Premiums
Medical Equipment	1.978	2.055	PPI-Medical Instruments & Equip.
Pharmaceuticals and Medical Materials and Supplies	1.760-	4.320	
Pharmaceuticals	-	2.309	
Medical Materials and Supplies	1.760	2.011	PPI Surg. Appliances and Supplies/CPI(U) Med Supplies
Other Professional Expenses	4.513	-	CPI-U All Items Less Food and Energy
Other Expenses	-	6.433	

(1) Due to rounding, weights may not sum to 100.000 percent.
(2) Sources: 2006 Physician Practice Information Survey (PPIS), Center for Health Policy Research, American Medical Association; 2006 Employment Cost for Employee Compensation, U.S. Department of Labor, Bureau of Labor Statistics; 2006 Occupational Employment Statistics (OES), BLS; U.S. Department of Commerce, Bureau of Economic Analysis 2002 Benchmark Input Output Tables, and U.S. Department of Commerce, Bureau of the Census, 2006 Current Population Survey.
(3) Includes employed physician payroll.
(4) Includes paid leave.
(5) Average Hourly Earnings (AHE)
(6) Employment Cost Index (ECI)

(7) Consumer Price Index (CPI)
(8) Producer Price Index (PPI)

The development of each of the cost categories in the final 2006 MEI is described, in detail, as follows.

b. Physician's Own Time

The component of the MEI that reflects the physician's own time is represented by the net income portion of business receipts. The proposed 2006 cost weight associated with the physician's own time (otherwise referred to as the Physician Compensation cost weight) is based on 2006 AMA PPIS data for mean physician net income (physician compensation) for self-employed physicians and for the selected self-employed specialties referenced previously in this rule.

We proposed to continue to add employed physician compensation to self-employed physician compensation in order to calculate an aggregate Physician Compensation cost weight. By including the compensation of employed physicians in the Physician Compensation expense category, these expenses will be adjusted by the appropriate price proxies for a physician's own time. The proposed 2006 Physician Compensation cost weight is 48.266 percent as compared to a 52.466 percent share in the 2000-based MEI. We split the Physician Compensation component into two subcategories: Wages & Salaries; and Benefits. For self-employed physician's compensation, the ratios for Wages & Salaries and Benefits were calculated using data from the PPIS. Self-employed physician wages & salaries accounted for 92.2 percent of physician compensation while physician benefits accounted for the remaining 7.8 percent. For employed physician payroll, the distribution for wages & salaries and benefits for 2006 was 85.8 percent and 14.2 percent, respectively. This ratio was determined by calculating a weighted average

of available SOI data for partnerships, corporations, and S-corporations specific to physicians and outpatient care centers. Based on these methods, the proposed 2006 Physician Wages & Salaries cost weight was 43.880 percent and the proposed 2006 Physician Benefits cost weight was 4.386 percent.

c. Physician's Practice Expenses

To determine the remaining individual Practice Expenses cost weights, we used mean expense data from the 2006 PPIS survey expressed as a percentage of total expenses. The detailed explanations for the derivation of the individual weights under Practice Expenses are listed below.

(1) Nonphysician Employee Compensation

The cost weight for Nonphysician Employee Compensation was developed using the 2006 AMA PPIS mean expenses for these costs. We further divided this cost share into Wages & Salaries and Benefits using 2006 BLS Employer Costs for Employee Compensation (ECEC) data for the Health Care and Social Assistance (private industry) category. Although this survey does not contain data only for offices of physicians, data are available to help determine the shares associated with wages & salaries and benefits for private industry health care and social assistance services (which include offices of physicians, hospitals, nursing homes, and offices of dentists). We believe these data provide a reasonable estimate of the split between wages and benefits for employees in physicians' offices. Data for 2006 in the ECEC for Health Care and Social Assistance indicate that wages and benefits are 71.8 percent and 28.2 percent of compensation, respectively. The 2000-based MEI included a wage and benefit split of 74.0 percent and 26.0 percent of compensation.

We proposed to use 2006 Current Population Survey (CPS) data and 2006 BLS Occupational Employment Statistics (OES) data to develop cost weights for wages for nonphysician occupational groups. These are the same data sources that were used in the 2000-based MEI. We determined total annual earnings for offices of physicians using employment data from the CPS and mean annual earnings from the OES. To arrive at a distribution for these separate categories, we determined annual earnings for each of the four categories (which are Professional & Technical workers, Managers, Clerical workers, and Service workers), using the Standard Occupational Classification (SOC) system. We then determined the overall share of the total for each. The resulting proposed distribution, as well as the distribution from the 2000-based MEI, are presented in Table 28.

TABLE 28: Percent Distribution of Nonphysician Payroll Expense by Occupational Group: 2006 and 2000

BLS Occupational Group	2006 Expenditure Shares	2000 Expenditure Shares
Total	100.000	100.000
Professional & Technical Workers	43.671	42.635
Managers	10.517	24.138
Clerical Workers	32.477	28.187
Service Workers	13.336	5.040

Values may not sum to 100 due to rounding.

The decrease in the Managers expenditure share is directly related to a decrease in the total number of employees in Management occupations in physicians' offices, in particular, "Medical and health service managers." The decrease in expenditure share may also be due, in part, to the methods used in this rebasing. That is, for the 2006-based MEI, we are using data limited to "Offices of physicians." In the 2000-based version of the index, the only data that were available to inform these estimates were inclusive of

physician offices and clinics ("Offices of physicians and clinics"). An examination of 2006 CPS and OES data comparing "Outpatient care centers" to "Offices of physicians" indicates that there is a higher share of management occupations in the "Outpatient care centers" than in "Offices of physicians".

The increase in the Service Workers expenditures share is attributable to a substantive increase in the number of employees in service occupations, particularly, "Medical assistants and other health care support occupations".

(2) Office Expenses

The aggregate Office Expenses cost weight was derived using the 2006 AMA PPIS and was calculated as the mean office expenses expressed as a percentage of mean total expenses. This calculation resulted in a 20.035 percent share of total costs in 2006 compared to a 12.209 percent share in the 2000-based index. The Office Expenses cost weight used in the 2000-based MEI was based on the AMA 1997 Socioeconomic Monitoring System (SMS) survey, which defined office expenses as rent, mortgage interest, depreciation on medical buildings, utilities, and telephones. The AMA expanded the office expense question in the 2006 PPIS survey to include additional expenses, described in more detail below in this section.

As a result, and in order to provide for a higher level of precision in assigning appropriate price proxies to underlying costs, we proposed to further disaggregate the Office Expenses cost category into 9 detailed cost categories using the BEA 2002-Benchmark I/O data for Offices of Physicians, Dentists, and Other Health Practitioners (North American Industrial Classification System (NAICS) 621A00). In response to comments, and as described more fully below, we are finalizing those nine

categories, as well as adding a tenth detailed cost category.

The proposed Office Expenses cost categories and associated cost weights were developed by matching the BEA I/O data as closely as possible to the 2006 AMA PPIS survey, which defined office expenses as "office (non-medical) equipment and office (nonmedical) supplies, as well as rent, mortgage, interest, maintenance, refrigeration, storage, security, janitorial, depreciation on medical buildings used in your practice, utilities, or other office computer systems (including information management systems/electronic medical record systems) and telephone." In most instances, the proposed underlying detailed cost categories and associated cost weights were chosen to be consistent with the NAICS 3-digit classification. BEA I/O expense data is published on a NAICS-basis. Some of the proposed underlying detailed cost categories such as All Other Services include various 3-digit NAICS codes for service related industries. Similar methods are used in the other legislatively-required market baskets developed by CMS. After we categorized the BEA I/O data, we calculated the relative share for each category as a percentage of the total office expenses categories within the I/O data. We then aged the 2002 weights forward to 2006 to derive the 2006 detailed Office Expense cost weights as a percent of total Office Expenses. The methodology we used to age the data forward was to apply the annual price changes from each respective price proxy to the appropriate cost categories. We repeated this practice for each year of the interval from 2002 to 2006. We then applied the resulting 2006 distributions to the aggregate 2006 AMA Office Expenses weight of 20.035 percent to yield the detailed 2006 Office Expenses' weights as a percent of total expenses.

In response to public comments that are detailed in the subsequent sections of this

rule, we conducted an additional review of the BEA I/O data used to disaggregate the Office Expense cost category, comparing the I/O's detailed categories with the questions on the AMA PPIS survey. This review led to small revisions to the underlying Office Expense cost weights and resulted in the inclusion of one additional cost weight in that category: All Other Products. These products, which were previously assumed to be captured in the Other Professional Expenses category (as measured by the AMA PPIS survey), include a variety of miscellaneous products, such as miscellaneous wood and building products, that we believe respondents included in Office Expenses as maintenance expense. Table 27 provides the revised MEI weights.

We believe the introduction of these new, more detailed categories for the 2006-based index allow for an increased level of precision while maintaining appropriate levels of aggregation in the index. The individual price proxies are described in more detail in section II.E.4.of this final rule.

The following is a description of the types of expenses included in each of the detailed Office Expense cost categories.

- Utilities: The Utilities cost weight includes expenses classified in the fuel, oil and gas, water and sewage, and electricity industries. These types of industries are classified in NAICS and include NAICS 2211 (Electric power generation, transmission, and distribution), 2212 (Natural gas distribution), and 2213 (Water, sewage, and other systems). The cost weight for utilities is 1.266 percent.

- Chemicals: The Chemicals cost weight includes expenses classified in the NAICS 325 (Chemical manufacturing), excluding pharmaceuticals and biologicals. This would include, but is not limited to, expenses such as soap and cleaning compounds, as

well as photocopier toners and laser printer toners. The cost weight for chemicals is 0.723 percent.

- Paper: The Paper cost weight includes expenses classified in NAICS 322 (paper manufacturing) and NAICS 323 (printing and related support activities). This would include expenses associated with items such as paper, paperboard, sanitary paper products, and printing. The cost weight for paper is 0.657 percent.

- Rubber and Plastics: The Rubber and Plastics cost weight includes expenses classified in NAICS 326 (Plastics and Rubber Products Manufacturing). This would include, but is not limited to expenses associated with plastic bags, plastic trash cans, and plastic plumbing fixtures. The cost weight for Rubber and Plastics is 0.598 percent.

- Telephone: The Telephone cost weight includes expenses classified in NAICS 517 (Telecommunications) and NAICS 518 (Internet service providers), and NAICS 515 (Cable and other subscription programming). Telephone service, which is one component of the Telecommunications expenses, accounts for the majority of the expenditures in this cost category. The cost weight for Telephone services is 1.501 percent.

- Postage: The Postage cost weight includes expenses classified in NAICS 491 (Postal services) and NAICS 492 (Courier services). The cost weight for Postage is 0.898 percent.

- All Other Services: The All Other Services cost weight includes other service expenses including, but not limited to, nonresidential maintenance and repair, machinery repair, janitorial, and security services. This cost weight does not include expenses associated with professional services such as accounting, billing, legal, and marketing

which are included in the Other Professional Expenses cost weight derived using the AMA PPIS survey. The cost weight for All Other Services is 3.582 percent.

- All Other Products: The All Other Products cost weight, which we are adding based upon our further review in response to public comments, includes other miscellaneous expenses, including but not limited to, a variety of miscellaneous building products (such as wood and concrete). The cost weight for All Other Products is 0.500 percent.

- Fixed Capital: The Fixed Capital cost weight includes expenses for building leases, mortgage interest, and depreciation on medical buildings. The cost weight for Fixed Capital is 8.957 percent.

- Moveable Capital: The Moveable Capital cost weight includes expenses and depreciation costs for non-medical equipment including but not limited to, computer equipment and software and the rental and leasing of industrial machinery equipment. The cost weight for Moveable Capital is 1.353 percent.

(3) Professional Liability Insurance (PLI) Expense

The proposed weight for PLI expense was derived from the 2006 AMA survey and was calculated as the mean PLI expense expressed as a percentage of mean total expenses. This calculation resulted in a 4.295-percent share of total costs in 2006 compared to a 3.865-percent share in the 2000-based index. The increase in the weight for PLI reflects the current prices of premiums, as well as an update to the level of coverage purchased by physicians in 2006 compared to 2000.

(4) Medical Equipment Expenses

The proposed weight for Medical Equipment was calculated using the 2006 AMA PPIS mean expense data expressed as a percentage of mean total expenses. This calculation resulted in a 1.978-percent share of total costs in 2006 compared to a 2.055-percent share in the 2000-based index. By definition, this category includes the expenses related to depreciation, maintenance contracts, and the leases or rental of medical equipment used in diagnosis or treatment of patients. The category would also include the tax-deductible portion of the purchase price or replacement value of medical equipment, if not leased.

(5) Medical Supplies Expenses

The proposed weight for Medical Supplies was calculated using the 2006 AMA PPIS mean expense data expressed as a percentage of mean total expenses. This calculation resulted in a 1.760-percent share of total costs in 2006 compared to a 2.011-percent share in the 2000-based index. By definition, this category includes the expenses related to medical supplies such as sterile gloves, needles, bandages, specimen containers, and catheters. Additionally, we proposed to exclude the expenses related to separately billable supplies as these expenses are not paid for under the PFS. The Medical Supply cost category does not include expenses related to drugs.

(6) Other Professional Expenses

The proposed weight for Other Professional expenses was calculated using the 2006 AMA PPIS mean expense data expressed as a percentage of mean total expenses. This calculation resulted in a 4.513-percent share of total costs in 2006. By definition, this category includes the expenses related to tax-deductible expenses for any other professional expenses not reported in another category from the PPIS. These expenses

would include fees related to legal, marketing, accounting, billing, office management services, professional association memberships, maintenance of certification or licensure, journals and continuing education, professional car upkeep and depreciation, and any other general expenses or other professional expenses not reported elsewhere on the PPIS.

In summary, we are finalizing the proposed 2006-based MEI cost categories and respective cost weights for all categories except for the underlying detailed Office Expense cost categories and cost weights. In response to public comments, we reexamined the BEA I/O data and compared it again with the specific types of costs sought by the AMA PPIS survey question on Office Expenses. Although we are finalizing the proposed Office Expense cost weight of 20.035 percent, our re-evaluation resulted in slight changes to the underlying detail of the Office Expense cost categories and cost weights. Specifically, we are finalizing the nine proposed detailed cost categories and adding one additional detailed cost category, All Other Products. The final detailed cost categories and cost weights for the underlying Office Expense cost categories are shown in Table 27.

Table 29 shows a comparison of the proposed MEI Office Expense cost categories and weights to the final MEI Office Expense cost categories and weights. In addition to adding the subcategory All Other Products, the final Office Expenses' category weights were updated in response to public comments to reflect the removal of automobile-related expenses, which were in effect being double-counted, from the Movable Capital category. Further examination of the AMA's PPIS questions showed that automobile costs, such as those associated with leasing and depreciation, were

captured in the question related to other professional expenses and are, thus accounted for in Other Professional Expenses (with a final cost weight of 4.513 percent). Notably, that cost weight is not impacted as, again, those costs were captured there in the survey.

Table 29: Comparison of Proposed Office Expense Cost Categories and Cost Weights to the Final Office Expense Cost Categories and Cost Weights

Cost Categories	2006 Final Weight	2006 Proposed Weight
Office Expenses	20.035%	20.035%
Utilities	1.266%	1.139%
Chemicals	0.723%	0.679%
Paper	0.657%	0.616%
Rubber & Plastics	0.598%	0.563%
Telephone	1.501%	1.415%
Postage	0.898%	0.661%
All Other Services	3.582%	4.718%
All Other Products	0.500	-----
Fixed Capital	8.957%	8.410%
Moveable Capital	1.353%	1.834%

4. Selection of Price Proxies for Use in the MEI

After the 2006 cost weights for the rebased and revised MEI were developed, we reviewed all of the price proxies to evaluate their appropriateness. As was the case in the development of the 2000-based MEI (68 FR 63239), most of the proxy measures we considered are based on BLS data and are grouped into one of the following five categories:

- Producer Price Indices (PPIs): PPIs measure price changes for goods sold in markets other than retail markets. These fixed-weight indexes are a measure of price change at the intermediate or final stage of production. They are the preferred proxies for physician purchases as these prices appropriately reflect the product's first commercial transaction.

- Consumer Price Indices (CPIs): CPIs measure changes in the prices of final goods and services bought by consumers. Like the PPIs, they are fixed-weight indexes. Since they may not represent the price changes faced by producers, CPIs are used if there are no appropriate PPIs or if the particular expenditure category is likely to contain purchases made at the final point of sale.

- Average Hourly Earnings (AHEs): AHEs are available for production and nonsupervisory workers for specific industries, as well as for the nonfarm business economy. They are calculated by dividing gross payrolls for wages & salaries by total hours. The series reflects shifts in employment mix and, thus, is representative of actual changes in hourly earnings for industries or for the nonfarm business economy.

- ECIs for Wages & Salaries: These ECIs measure the rate of change in employee wage rates per hour worked. These fixed-weight indexes are not affected by employment shifts among industries or occupations and thus, measure only the pure rate of change in wages.

- ECIs for Employee Benefits: These ECIs measure the rate of change in employer costs of employee benefits, such as the employer's share of Social Security taxes, pension and other retirement plans, insurance benefits (life, health, disability, and accident), and paid leave. Like ECIs for wages & salaries, the ECIs for employee benefits are not affected by employment shifts among industries or occupations.

When choosing wage and price proxies for each expense category, we evaluate the strengths and weaknesses of each proxy variable using the following four criteria:

- Relevance: The price proxy should appropriately represent price changes for specific goods or services within the expense category. Relevance may encompass

judgments about relative efficiency of the market generating the price and wage increases.

- Reliability: If the potential proxy demonstrates a high sampling variability, or inexplicable erratic patterns over time, its viability as an appropriate price proxy is greatly diminished. Notably, low sampling variability can conflict with relevance -- since the more specifically a price variable is defined (in terms of service, commodity, or geographic area), the higher the possibility of high sampling variability. A well-established time series is also preferred.

- Timeliness of actual published data: For greater granularity and the need to be as timely as possible, we prefer monthly and quarterly data to annual data.

- Public availability: For transparency, we prefer to use data sources that are publicly available.

The BLS price proxy categories previously described meet the criteria of relevance, reliability, timeliness, and public availability. Below we discuss the price and wage proxies for the rebased and revised MEI (as shown in Table E4), along with a summary of the public comments we received on our proposals and our responses to those comments.

a. Cost (Expense) Categories in the MEI

(1) Physician's Own Time (Physician Compensation)

For the revised and rebased MEI, we proposed to continue to use the AHE for production and non-supervisory employees for the private nonfarm economy as the proxy for the Physician Wages & Salaries component (BLS series code: CEU0500000008).

The AHE for the private nonfarm economy reflects general earnings including the impacts of supply, demand, and economy-wide productivity for the average worker in the economy. As such, use of this proxy is consistent with the original intent of the Congress for the change in the MEI to follow reflect changes in expenses of practice and general earnings levels.[1] The current 2000-based MEI uses the ECI for Total Benefits (BLS series code: CIU2030000000000I) for total private industry as the price proxy for Physician Benefits. We proposed to continue using the same proxy for the 2006-based MEI and received no public comment on this particular aspect of the index. This means that both the wage and benefit proxies for physician earnings are derived from the private nonfarm business sector and are computed on a per-hour basis.

(2) Nonphysician Employee Compensation

For the 2006-based MEI, we proposed to use the same ECI private series for each occupational group as in the 2000-based MEI. In particular, we proposed to use the ECI for Professional and Technical Workers, the ECI for Managerial Services, the ECI for Administrative Support Services, and the ECI for Service Occupations.

As described in the CY 2008 PFS proposed rule (72 FR 38190), as a result of the discontinuation of the White Collar Benefit ECI for private workers, we proposed to continue to use a composite ECI benefit index. We are continuing to use the composite ECI for non-physician employees in the proposed rebased and revised MEI; however, we proposed to rebase the weights within that blend in order to reflect the more recent 2006 data. Table 30 lists the four ECI series and corresponding weights used to construct the 2006 composite benefit index.

[1] U.S. Senate, Committee on Finance, Social Security Amendments of 1972. "Report of the Committee on Finance United States Senate to Accompany H.R. 1," September 26, 1972, p. 191.

TABLE 30: CMS Composite Price Index for Nonphysician Employee Benefits

ECI series	2006 Weight
Benefits, Private, Professional & Related	44%
Benefits, Private, Management, Business, Financial	11%
Benefits, Private, Office & Administrative Support	32%
Benefits, Private, Service Occupations	13%

(3) Utilities

For the 2006-based MEI, we proposed to use the CPI for Fuel and Utilities (BLS series code #CUUR0000SAH2) to measure the price growth of this cost category. This cost category was not broken out separately in the 2000-based MEI.

(4) Chemicals

For the 2006-based MEI, we proposed to use the PPI for Other Basic Organic Chemical Manufacturing (BLS series code #PCU32519-32519) to measure the price changes of this cost category. We are using this industry-based PPI because BEA's 2002 benchmark I/O data show that the majority of the office of physicians' chemical expenses are attributable to Other Basic Organic Chemical Manufacturing (NAICS 32519). This cost category was not broken out separately in the 2000-based MEI.

(5) Paper

For the 2006-based MEI, we proposed to use the PPI for Converted Paper and Paperboard (BLS series code #WPU0915) to measure the price growth of this cost category. This cost category was not broken out separately in the 2000-based MEI.

(6) Rubber and Plastics

For the 2006-based MEI, we proposed to use the PPI for Rubber and Plastic Products (BLS series code #WPU07) to measure the price growth of this cost category. This cost category was not broken out separately in the 2000-based MEI.

(7) Telephone

For the 2006-based MEI, we proposed to use the CPI for Telephone Services (BLS series code #CUUR0000SEED) to measure the price growth of this cost category. This cost category was not broken out separately in the 2000-based MEI.

(8) Postage

For the 2006-based MEI, we proposed to use the CPI for Postage (BLS series code #CUUR0000SEEC01) to measure the price growth of this cost category. This cost category was not broken out separately in the 2000-based MEI.

(9) All Other Services

For the 2006-based MEI, we proposed to use the ECI for Compensation for Service Occupations (private industry) (BLS series code #CIU2010000300000I) to measure the price growth of this cost category. This cost category was not broken out separately in the 2000-based MEI.

(10) All Other Products

As noted previously, we are adding this category in this final rule with comment period in response to public comments. This category includes a variety of miscellaneous expenses such as miscellaneous building products; thus, we will use the CPI-U for All Items Less Food and Energy as a proxy for price changes. This cost category was not broken out separately in the 2000-based MEI.

(11) Fixed Capital

For the 2006-based MEI, we proposed to use the CPI for Owner's Equivalent Rent (BLS series code #CUUS0000SEHC) to measure the price growth of this cost category. This price index represents about 50 percent of the CPI for Housing, which was used in the 2000-based MEI to proxy total Office Expenses.

(12) Moveable Capital

For the 2006-based MEI, we proposed to use the PPI for Machinery and Equipment (series code #WPU11) to measure the price growth of this cost category. This cost category was not broken out separately in the 2000-based MEI.

(13) Professional Liability Insurance (PLI)

Each year, we solicit PLI premium data for physicians from a sample of commercial carriers. This information is not collected through a survey form, but instead is requested directly from, and provided by (on a voluntary basis), several national commercial carriers. As we require for our other price proxies, the professional liability price proxy is intended to reflect the pure price change associated with this particular cost category. Thus, it does not include changes in the mix or level of liability coverage. To accomplish this result, we obtain premium information from a sample of commercial carriers for a fixed level of coverage, currently $1 million per occurrence and a $3 million annual limit. This information is collected for every State by physician specialty and risk class. Finally, the State-level, physician-specialty data are aggregated by effective premium date to compute a national total, using counts of physicians by State and specialty as provided in the AMA publication, Physician Characteristics and Distribution in the U.S.

The resulting data provide a quarterly time series, indexed to a base year consistent with the MEI, and reflect the national trend in the average professional liability premium for a given level of coverage, generally $1 million/$3 million of claims-made mature policies. From this series, quarterly and annual percent changes in PLI are estimated for inclusion in the MEI.

The most comprehensive data on professional liability costs are held by the State insurance commissioners, but these data are available only with a substantial time lag and hence, the data currently incorporated into the MEI are much timelier. We believe that, given the limited data available on professional liability premiums, the information and methodology described above produces an adequate proxy of the PLI price trends facing physicians.

(14) Medical Equipment

The Medical Equipment cost category includes depreciation, leases, and rent on medical equipment. We proposed to use the PPI for Medical Instruments and Equipment (BLS series code: WPU156201) as the price proxy for this category, consistent with the price proxy used in the 2000-based MEI and other CMS input price indexes.

(15) Medical Materials and Supplies

As was used in the 2000-based MEI, we proposed to use a blended index comprised of a 50/50 blend of the PPI Surgical Appliances (BLS series code: WPU156301) and the CPI-U for Medical Equipment and Supplies (BLS series code: CUUR0000SEMG). We believe physicians purchase the types of supplies contained within these proxies, including such items as bandages, dressings, catheters, intravenous (I.V.) equipment, syringes, and other general disposable medical supplies, via wholesale

purchase, as well as at the retail level. Consequently, we proposed to combine the two aforementioned indexes to reflect those modes of purchase.

(16) Other Professional Expenses

This category includes the residual subcategory of other professional expenses such as accounting services, legal services, office management services, continuing education, professional association memberships, journals, professional car expenses, and other general expenses and other professional expenses not captured elsewhere. Given this heterogeneous mix of goods and services, we are finalizing our proposal to use the CPI-U for All Items Less Food and Energy. In summary, we are finalizing the proposed 2006-based MEI price proxies with one modification. Since an additional cost category, All Other Products, was added to the office expense disaggregation, we are also finalizing the decision to use the CPI for All Items Less Food and Energy as the price proxy for that category.

(b) Productivity Adjustment to the MEI

The MEI has been adjusted for changes in productivity since its inception. In the CY 2003 PFS final rule (67 FR 80019), we implemented a change in the way the MEI was adjusted to account for those changes in productivity. The MEI used for the 2003 physician payment update incorporated changes in the 10-year moving average of private nonfarm business multifactor productivity that were applied to the entire index. Previously, the index incorporated changes in productivity by adjusting the labor portions of the index by changes in the 10-year moving average of economy-wide private nonfarm business labor productivity.

We proposed to continue to use the current method for adjusting the full MEI for multifactor productivity in the rebased and revised MEI, and are finalizing that proposal.

As described in the CY 2003 PFS final rule, we believe this adjustment is appropriate because it explicitly reflects the productivity gains associated with all inputs (both labor and non-labor). We believe that using the 10-year moving average percent change in private nonfarm business multifactor productivity is appropriate for deriving a stable measure that helps alleviate the influence that a peak (or a trough) of a business cycle may have on the measure. The adjustment will be based on the latest available historical e private nonfarm business multifactor productivity data as measured and published by BLS.

5. Results of Rebasing

Table 31 illustrates the results of updating the MEI cost weights for Physician Compensation, Practice Expenses (excluding PLI), and PLI from a 2000-based cost distribution to a 2006-based cost distribution, including all the proposed and finalized revisions as specified in this final rule.

TABLE 31: Percent Distribution of Selected Physician Expenses used to Calibrate RVUs: CYs 2006 and 2000

	CY 2006 Weight	CY 2000 Weight
Physician Compensation (Own Time)	48.266%	52.466%
Practice Expenses (less PLI)	47.439%	43.669%
PLI	4.295%	3.865%

The rebased and revised MEI has several differences as compared to the 2000-based MEI; these changes have been discussed in detail in prior sections of this rule. Table E8 shows the average calendar year percent change for CY 2004 to CY 2011 for both the 2000- and 2006-based MEIs. The 2006-based MEI annual percent changes differ from the 2000-based MEI annual percent changes by 0.0 to 0.8 percentage point. For CYs 2007 through 2011, the annual percent change in the rebased and revised MEI

was within 0.3 percentage point of the percent change in the 2000-based MEI. In the earlier years, there were larger differences between the annual percent change in the rebased and revised MEI and the 2000-based MEI. The majority of these differences can be attributed to the lower benefit cost weight, as measured by the 2006 AMA data, and the exclusion of the Pharmaceuticals cost category. The remaining differences are attributable to the higher cost weight for PLI, as measured by the 2006 AMA data.

TABLE 32: Annual Percent Changes in the 2000-based and Revised 2006-based MEI

Update Year [A]	Final 2006-based MEI	Current 2000-based MEI
CY 2004	2.3	2.6
CY 2005	1.8	2.6
CY 2006	1.8	2.4
CY 2007	1.6	1.9
CY 2008	1.9	1.8
CY 2009	1.6	1.6
CY 2010	1.5	1.2
CY 2011[B]	0.4	0.3
Average Change for CYs 2004- 2011	1.6	1.8

[A] Update year based on historical data through the second quarter of the prior calendar year. For example, the 2010 update is based on historical data through the second quarter 2009.

[B] Based on historical data through the 2nd quarter 2010.

As shown in Table 33, the percent change of the rebased and revised MEI for the CY 2011 PFS final rule is an increase of 0.4 percent, one tenth of a percentage point higher than the 2000-based MEI for the same period. The proposed rule included an estimated increase of 0.3 percent for 2011 based on projected data from IHS Global Insight, Inc. The 0.4 percent increase was calculated based on historical data through the second quarter of 2010, including revised data from the BLS on the 10-year moving average of BLS private nonfarm business multifactor productivity published on October 6, 2010 (http://www.bls.gov/news.release/pdf/prod3.pdf). The 0.1 percentage

point difference in the MEI update factor from the 0.3-percent estimate indicated in the proposed rule to our current figure of 0.4 percent is primarily related to the incorporation of more recent historical data for private nonfarm business multifactor productivity.

TABLE 33: Annual Percent Change in the 2000-based and Revised 2006-based MEI for CY 2011

	2006-Based MEI	2000-Based MEI
CY 2011	0.4	0.3

TABLE 34: Annual Percent Change in the Revised and Rebased MEI CY 2011, All Categories[1]

Cost Categories	2006 Weight [2]	CY 2011 Percent Change
MEI Total, productivity adjusted	100.000%	0.4
Productivity: 10-year moving average of MFP	N/A	1.2
MEI Total, without productivity adjustment	100.000%	1.6
Physician Compensation (Own Time) [3]	48.266%	2.4
Wages and Salaries	43.880%	2.5
Benefits	4.386%	1.7
Physician's Practice Expenses	51.734%	0.7
Nonphysician Employee Compensation	19.153%	1.5
Nonphysician Employee Wages	13.752%	1.4
Prof/Tech Wages	6.006%	1.2
Managerial Wages	1.446%	1.2
Clerical Wages	4.466%	1.7
Services Wages	1.834%	1.7
Nonphysician Employee Benefits	5.401%	1.6
Other Practice Expenses	26.308%	0.1
Office Expenses	20.035%	0.6
Utilities	1.266%	-3.1
Chemicals	0.723%	-2.5
Paper	0.657%	-0.3
Rubber & Plastics	0.598%	-0.3
Telephone	1.501%	0.8
Postage	0.898%	4.7
All Other Services	3.582%	1.8
All Other Products	0.500%	1.4
Fixed Capital	8.957%	0.6
Moveable Capital	1.353%	0.1

Cost Categories	2006 Weight [2]	CY 2011 Percent Change
PLI [4]	4.295%	-2.9
Medical Equipment	1.978%	0.5
Medical Materials and Supplies	1.760%	0.4
Other Professional Expenses	4.513%	1.4

[1] The estimates are based upon the latest available Bureau of Labor Statistics data on the 10-year moving average of BLS private nonfarm business multifactor productivity published on October 6, 2010 (http://www.bls.gov/news.release/pdf/prod3.pdf)

[2] The weights shown for the MEI components are the 2006 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for CY 2006. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2006 weight. The sum of these products (weights multiplied by the price index levels) yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.

[3] 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 (BLS) Website at http://stats.bls.gov.

[4] Derived from a CMS survey of several major commercial insurers.

[N/A] Productivity is factored into the MEI as a subtraction from the total index growth rate; therefore, no explicit weight exists for productivity in the MEI.

6. Medicare Economic Index Technical Advisory Panel

In the CY 2011 PFS proposed rule, we notified the public of our intent to convene a Medicare Economic Index Technical Advisory Panel (MEI TAP) to study all aspects of the MEI including its cost categories, their associated cost weights and price proxies, and the adjustment of the index by an economy-wide measure of multi-factor productivity. We will be convening the MEI TAP. More details regarding this issue can be found in the next section of this rule.

7. Summary of Comments and the Associated Responses

a. Timing of Rebasing and Revising the MEI

Comment: Many commenters support the rebasing and revising of the MEI using CY 2006 as a base year and the incorporation of practice cost changes reflected in the 2006 AMA PPIS. Many of these commenters also indicated their support for the upcoming MEI technical advisory panel, but stressed that CMS should not delay moving

forward with rebasing and revising the MEI for CY 2011. Several people wrote that they believe that the rebasing, along with the addition of new product categories, will result in a more accurate distribution of expenses among physician compensation, practice expense, and professional liability. The commenters believe that the proposal to rebase to 2006 will make the MEI more representative of current conditions in the health care marketplace and, in particular, more reflective of the higher burden of practice expenses in relation to physician compensation in modern physician practices. The commenters agree that the use of more current data and the expansion of the categories used in determining the MEI update are a technical improvement over the 2000-based MEI and urge CMS to proceed accordingly.

Response: We agree with the commenters that the 2006-based MEI reflects a more current estimate of the cost distribution associated with furnishing physicians' services. Therefore we are finalizing our proposals (with minor modifications described above) to rebase and revise the MEI, and are proceeding with implementation of the 2006-based MEI for CY 2011.

Comment: Many commenters indicated CMS should postpone implementation of the rebased and revised MEI until the MEI technical advisory panel can conduct a comprehensive review of all aspects of the index. These commenters believe that it is premature to finalize proposals that will significantly change the MEI prior to receiving recommendations from the technical advisory panel and therefore strongly support convening the technical advisory panel first and rebasing and revising the MEI afterwards.

Response: We agree with the commenters that the MEI technical advisory panel

should move forward (discussed in more detail below). However, we do not find any compelling technical reason to postpone finalizing the proposed changes to the index. We believe rebasing and revising the index for CY 2011 to reapportion the work, practice expense, and malpractice weights will allow the MEI to appropriately reflect more recent data. For these reasons we disagree with the commenters that support delaying the rebasing of the MEI until the technical panel has had a chance to convene and make further recommendations. Should we concur with recommendations from the technical advisory panel that would result in technical improvements to the MEI, we would propose any changes in a future rulemaking exercise.

Comment: One commenter questioned the need for changes in the MEI in 2011, particularly since there is no statutory timeframe for these changes and the most recent changes in practice expenses from the PPIS survey are in the first year of a 4-year phase-in.

Response: The current MEI reflects the physician practice cost structure for 2000. Based on both our own analysis and supporting public comments, it is evident that this cost structure has changed from 2000 to 2006. Accordingly, we believe it is technically appropriate to update to a more recent base year for use in CY 2011.

Comment: A commenter suggested that when rebasing is done in the future, CMS should propose phasing in the changes, perhaps over 2 years, in order to mitigate negative consequences.

Response: We do not believe it would be appropriate to phase in changes to the MEI associated with rebasing and revising the index. These periodic efforts are done to ensure that the MEI is reflecting the latest available information and echoes current cost

distributions associated with furnishing physicians' services. Our approach is consistent across all of the Medicare market baskets in this regard and is likewise consistent with how technical improvements are incorporated into other published price indexes, such as the CPI or PPI.

Comment: Some commenters asked CMS to delay rebasing the MEI until the summit on geographic practice costs and the IOM studies have been completed.

Response: We believe that it is technically appropriate to update the MEI to reflect the more current cost structure as determined by using the 2006 AMA PPIS data. We note that the MEI is constructed independent of the GPCIs. While the GPCI weights have historically been linked to the MEI cost weights, we do not believe it would be appropriate to postpone rebasing the MEI in anticipation of the summit's or the IOM's findings.

b. PPIS Data

Comment: Many commenters stated they, like CMS, are unaware of another more robust or more current source of available data on physician practice costs than the PPIS. Other commenters noted that CMS and the AMA have supported using PPIS data to update the practice expense per hour (PE/HR) calculations beginning in CY 2010. The commenters believe that if the data were sufficient to adjust PE/HR, then they are sufficient to update the MEI. Other commenters indicate they support periodic updates to the index, recognizing the difficulties associated with updating the MEI's cost categories and weights on an annual basis.

Response: We agree with the commenters that the PPIS is the most up-to-date and comprehensive data source available on physician practice costs. We also believe

that the estimates derived from the PPIS are current, valid, and appropriate for use in rebasing and revising the MEI. Likewise, we concur that a variety of data-related issues would make updating the MEI on an annual basis difficult and believe that periodic revisions such as the one we are adopting in this final rule with comment period are more appropriate.

Comment: A few commenters expressed general concerns over using data from the PPIS. One commenter specifically notes that the MEI changes are allegedly being proposed to reflect changes in medical practice based on research using PE data. The commenter has reviewed some of the research, including the research process and questioned the research data itself. Their concerns over the raw data source include issues related to sample design, sample geographic distribution, and sample size sufficiency. They questioned the choice of the data collection firm used by AMA.

Response: We conducted an extensive review of the PPIS data and continue to believe it appropriately reflects the cost distributions of physicians. We note that we rely upon the physician community to complete the AMA surveys as accurately as possible since unlike other provider types (such as hospitals and skilled nursing facilities) physicians are not required to submit annual Medicare cost report data.

Comment: Some commenters indicated that CMS did not make clear why the rebased MEI would be based on PPIS data from 2006. Several expressed concerns that the use of 4-year old data is questionable as data this old would not reflect physician expenses in 2011 (and that more up-to-date data on physician costs is surely available).

Response: As stated in the CY 2011 PFS proposed rule (75 FR 40088), we chose to rebase the MEI to 2006 in order to incorporate the 2006 AMA PPIS data. We believe

the 2006 AMA PPIS data is the most up-to-date, complete, statistically valid data source available. We welcome any recommendations for more up-to-date data sources available on physician expenses. We would also note that the 2006 data from the PPIS are used to provide the cost structure that is used in the MEI. The increase in the CY 2011 MEI ultimately reflects the input price inflation, adjusted for productivity, that physicians face based on a 2006 distribution of costs. It does not, nor is it intended to, reflect physician input cost levels for 2011.

Comment: Some commenters noted that in the interest of transparency, CMS should publish on its website all data from the PPIS that were used in rebasing the MEI.

Response: We understand the commenter's request for transparency. Unfortunately, we are unable to publish the detailed micro level data from the AMA PPIS survey as it is proprietary information. We would suggest the commenter contact the AMA with their request.

c. Office Expenses

Comment: Several commenters appreciated the intent of the new subcategories found in Office Expenses to include more medical office-specific data and believe it will improve the index.

Response: We agree with the commenters and believe that having greater detail under the Office Expense cost category in the MEI provides a technical improvement.

Comment: Several commenters questioned the CMS proposal to create detailed categories under the broader Office Expense cost category. Some of the commenters had specific concerns about the particular subcategories. Examples included the following:

- The Chemicals and Rubber & Plastics categories (all derived from the BEA) might not be relevant (or meaningful) to today's physicians' practice.

- Computers, computer expenses, billing, and scheduling technology and electronic medical records are high-cost, non-optional office expenses for medical practices that are not adequately captured and would represent more appropriate categories.

- CMS references data on the Office Expenses' components derived from the BEA, but the agency provided no rationale to justify the changes in Office Expenses, nor did it provide a detailed accounting methodology or solicit advice on new inputs to the index.

Response: We proposed to disaggregate the Office Expense cost category into more detailed cost categories as a result of a change to the question in the 2006 AMA PPIS survey that captured these types of costs. In addition, in rulemaking for the CY 2008 Physician Fee Schedule, we received a comment from the industry about our use of the CPI for Housing to proxy Office Expenses (72 FR 66376). At that time, we notified the public of our intent to explore the feasibility of breaking the Office Expenses category into more descriptive cost categories during the next rebasing.

In order to appropriately represent the information collected by the PPIS and to increase the level of precision of our price proxies, we proposed to disaggregate the Office Expense cost category and its associated weight into more detailed components and to proxy those costs with the most technically appropriate price proxies. Moreover, we believe it would be technically inappropriate to proxy the Office Expense cost category, which now includes a much broader range of expenses, by one price proxy,

namely the CPI for Housing. For these reasons, we developed our proposals and solicited public comments.

We disagree with the commenters' assertion that the Chemicals and Rubber & Plastics categories are not relevant to today's physician practice (and note that the commenters did not provide additional information or data to support the claim that the proposed categories are not relevant). The information we relied on came directly from the BEAs' Benchmark I/O files for Offices of Physicians, Dentists, and Other Health Practitioners. The Chemicals cost category includes expenses for items such as soaps and cleaning compounds, as well as photocopier toners and laser printer toners. The Rubber and Plastics category includes expenses for items such as plastic plumbing fixtures, plastic bags, and plastic trash cans. Although we will continue to explore further additional disaggregation of expenses, we believe that the aforementioned costs are associated with, and relevant to, furnishing physicians' services.

As indicated previously, and in response to the comment, we conducted an additional review of the BEA I/O data used to disaggregate the Office Expense cost category, comparing the detailed underlying expenses with the questions on the AMA PPIS survey. This review led us to make small revisions to the underlying Office Expense cost weights, including the addition of another cost weight for the new subcategory, All Other Products. These products were initially assumed to be captured in Other Professional Expenses as measured by the AMA PPIS survey, but were determined to have been reported as Office Expenses. All Other Products would include a variety of miscellaneous products such as miscellaneous wood and apparel products. Table E4 provides the revised MEI weights. Also, as part of this additional analysis on the Office

Expense categories, we determined that automobile-related expenses were captured in the PPIS question associated with Other Professional Expenses (and that its associated weight reflected respondents including those costs when answering that question). As a result, we removed automobile-related NAICS-based industry spending from the BEA I/O data that was being used to distribute expenses across the various Office Expense subcategories. As this spending was included in the Movable Capital subcategory for the proposed rule, the weight associated with that subcategory will be 1.353 rather than the 1.834 we proposed.

We disagree with the commenters' statements that the MEI does not adequately capture high-level or high-cost technology expenses (and briefly note that Movable Capital includes only non-medical movable equipment). The Office Expense cost weight (20.035 percent) was calculated using the 2006 PPIS data, which specifically requested health information technology equipment and other nonmedical office equipment to be included in the Office Expense category as follows:

> Provide [your] share (dollar amount) of the specialty or department level's share (dollar amount) of the practice's total (dollar amount) for] 2006 office expenses, including office (non-medical) equipment and office (non-medical) supplies, as well as rent, mortgage interest, maintenance, refrigeration, storage, security, janitorial, depreciation on medical buildings used in your practice, utilities, or other office computer systems (including information management systems/electronic medical record systems) and telephone.

Given that the expenses related to information management systems and electronic medical record systems were included as "office expenses" in the 2006 PPIS, the 20.035 percent weight would include these costs. Unfortunately, given the data limitations, it remains difficult to determine a percentage associated specifically with

computer equipment, computer-related depreciation, and computer-related leasing. For this rebasing, the costs we classified as Moveable Capital are comprised of the expenses paid by Office of Physicians industry to the following industries based on NAICS classification:

33329A	Other industrial machinery manufacturing
33331A	Vending, commercial, industrial, and office machinery manufacturing
333414	Heating equipment, except warm air furnaces
333415	Air conditioning, refrigeration, and warm air heating equipment manufacturing
33399A	Other general purpose machinery manufacturing
33411A	Computer terminals and other computer peripheral equipment manufacturing
334210	Telephone apparatus manufacturing
334220	Broadcast and wireless communications equipment
334290	Other communications equipment manufacturing
334300	Audio and video equipment manufacturing
334418	Printed circuit assembly (electronic assembly) manufacturing
334613	Magnetic and optical recording media manufacturing
335120	Lighting fixture manufacturing
337110	Wood kitchen cabinet and countertop manufacturing
337215	Showcase, partition, shelving, and locker manufacturing
532400	Commercial and industrial machinery and equipment rental and leasing

We believe technology-related expense are captured in the MEI and that the PPI for Machinery and Equipment is an appropriate price proxy to estimate price changes. However, we will actively monitor the data moving forward to ensure these types of expenses are adequately reflected in the MEI.

Finally, we would note that the descriptions of the methodologies used to construct the subcategories under Office Expenses were both detailed and consistent with those provided in the recent proposed rules relating to the rebasing of other CMS market baskets. However, in response to the comment we hope the additional information provided here is helpful.

Comment: One commenter found it most problematic that the CMS proposal related to Office Expenses would reduce the weight of rent within physician practice expenses. Currently, rent comprises 12.2 percent of the practice expense GPCI. Under the proposed rule, rent would be reduced to 8.4 percent. The commenter also noted that their attempt to validate the proposal, using BEA 2002 Benchmark I/O use files for NAICS 621A00 as described in the proposed rule were not successful.

Response: We proposed to disaggregate the Office Expense cost weight in the 2006-based MEI in order to recognize and take advantage of the expansion of the AMA PPIS survey question to include additional expenses not included in the 2000-based survey. Consistent with the methodology used for other CMS market baskets, we relied upon the BEA I/O data to disaggregate the Office Expense cost category, which we described in the proposed rule. This methodology required a series of calculations including classifying costs as office expenses consistent with AMA PPIS survey. As noted elsewhere, and based on public comment, we have refined our methodology, as well as added additional detail in this final rule which we believe will be helpful in validating our estimates. The new methodology has resulted in a cost weight of 8.957 percent for Fixed Capital. Comments related to weights specifically associated with the PE GPCIs are found in section II.D. of this final rule with comment period.

Comment: A commenter stated that it appeared that utility costs have been included twice in the MEI calculation. The HUD data used by CMS as a source for the rent data includes utilities. However, utilities have been included a second time as a new component of the "Office Expense" category of "Other Practice Expenses" and it does not appear that the "Fixed Capital" (rent) component has been scaled down as a result. This

error should be corrected, a new proposed rule published, and a new comment period opened.

Response: We disagree with the commenter's assertions that utilities expenses in the MEI are double counted. The Utilities cost weight in the MEI was derived using the BEA I/O data for NAICS 621A (Offices of Physicians, Offices of Dentist, and Offices of Other Practitioners). The BEA I/O data provide information regarding physicians' purchases from other industries. Expenses classified in the Utilities cost weight, such as NAICS 22110 (Electric power generation, transmission, and distribution), were not included in the Fixed Capital cost weight; therefore, we did not include utility costs twice in the MEI calculation. The HUD data referenced by the commenter is used in conjunction with the GPCI rent update and is independent of the development of the cost weight for Utilities in the MEI.

d. Purpose of the MEI

Comment: Several commenters requested that CMS address the problem that the "market basket" of inputs, whose prices are measured in the MEI, is outdated and, despite periodic rebasing, has not been comprehensively revised since it was originally developed in 1973. They indicated that the MEI does not reflect the inputs involved in 21st century medical practice and claim that the costs associated with complying with an array of government-imposed regulatory requirements, including increasing staffing levels, costs related to Medicare prescription drug plans and formulary compliance, compliance with rules governing referrals and interactions with other providers, and others, are not accounted for in the index. They also indicate that the MEI has not been adjusted for modern practice costs such as computers, copiers, and new medical

technology.

Response: We disagree with the commenters' statement that the MEI only measures changes in specific types of practice costs that existed in 1973. Since 1973, the MEI has been rebased four times. For each of those updates, the MEI methodology and data sources were thoroughly reviewed and evaluated to ensure that the index accurately reflected the cost distributions encountered by physicians. The revisions have included changes to the structure of the index, the price proxies used, the data sources used to develop the weights, the productivity adjustment, and, as proposed in the CY 2011 PFS proposed rule, disaggregating categories within the Office Expenses category into more detail.

We also note that the MEI is a price index, not a cost index. Changes in physician costs are a function of changes in prices and changes in quantities. Examples of changes in quantities include purchasing more moveable equipment (such as health information technology), hiring additional office staff, or changing the mix of staff. The MEI was established in accordance with section 1842(b)(3) of the Act, which states the growth of prevailing charge levels is to be limited to growth in an "appropriate economic index". The relevant Senate Finance Committee report[2] provides slightly more detail on such an index, stating that:

> [I]t is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to appropriate economic indexes so that the program will not merely recognize whatever increases in charges are established in a locality but would limit recognition of charge increases to rates that economic data indicate would be fair to all concerned and follow rather than lead any inflationary trends.

[2] U.S. Senate, Committee on Finance, Social Security Amendments of 1972. "Report of the Committee on Finance United States Senate to Accompany H.R. 1," September 26, 1972, p. 190.

Thus, in accordance with Congressional intent that the index reflect and follow inflationary trends, and since its inception in 1973, the MEI has been constructed as a fixed-weight price index that measures the inflationary trends of goods and services associated with furnishing physicians' services. The data sources that are used to construct the weights have been updated regularly to include the modern inputs required by physicians in running their respective practices. The MEI then appropriately apportions the various costs into their respective categories and calculates the associated weights. It is this distribution of costs, and not the level of costs, that the MEI appropriately incorporates. Based on this distribution, the MEI measures the weighted input price inflation, adjusted by productivity, faced by physicians. The MEI is then incorporated into the SGR formula to derive the final PFS update. Having an accurate and contemporary distribution of input costs is critical to producing an accurate measure of price inflation and is the major reason we are moving forward to rebase and revise the MEI for CY 2011.

Finally, to date, we have not received any proposals from the public on how the MEI should be revised and still meet its statutory requirements. We will continue to evaluate the validity and relevance of the index to ensure that it meets statutory requirements while adequately reflecting the evolution of the expense distribution associated with furnishing physicians' services.

Comment: A commenter asserted that the time gap between the two surveys, the PPIS and the SMS, may not be directly comparable, but a comparison of the two indicates that medical practice costs increased 79 percent from 2000 to 2006. However,

the MEI only increased 18 percent from 2000 to 2006. The commenter notes that every other available measure of physician expense growth shows faster growth than the MEI.

Response: The MEI is strictly a fixed-weight price index expressly designed to measure the change in price of a fixed basket of goods. Changes in physician costs are a function of changes in prices and changes in quantities. As other commenters have noted to CMS, and CMS agrees, cost increases are only reflected in the MEI's weights to the extent the relative cost of an input changes over time. Comparing the MEI (reflecting price changes) to other cost metrics (that reflect both price changes, as well as changes in volume and mix) is inappropriate given the MEI's definition and purpose.

Comment: A commenter noted that the proposed revisions to the MEI do not do anything to improve the adequacy of the MEI. The commenter also noted that in the proposed rule, CMS estimated the 2011 MEI at just 0.3 percent, and the addition of the new components that CMS has proposed based on BEA data does nothing to increase it.

Response: The rebased and revised MEI is intended to more accurately reflect the cost structure of furnishing physicians' services, as well as measure the input price inflation encountered by physicians. Accordingly, we disagree with the commenter and believe that the 2006-based MEI offers numerous technical improvements. These improvements include updating the base year to reflect more current cost distributions, updating price proxies, and adding more detailed cost categories.

Comment: A commenter stated that the MEI is used to annually update medical practice costs in the SGR calculation. Virtually all physician groups signed on to a January 2009 letter arguing that the MEI's price inputs as currently structured do not

accurately reflect current medical practice costs. No action has been taken to remedy the situation.

Response: We disagree with the commenter's claim the MEI annually updates the medical practice cost in the SGR. The purpose of the MEI in the SGR is to measure price increases related to the furnishing of physician services. It is not intended to measure cost increases, but rather to reflect the cost structure associated with furnishing physicians' services, and then subsequently measure the weighted price increases associated with that cost structure. We would also like to note that the MEI is currently part of the statutorily prescribed formula for physician payment updates and that revisions to the MEI are adopted through the notice and comment rulemaking process.

e. Technical Panel

Comment: Many commenters expressed their support for the convening of a Medicare Economic Index Technical Advisory Panel (MEI TAP).

Response: We agree that the MEI TAP should be convened and will be moving forward accordingly. This process includes announcing the panel's creation through an official CMS communication such as a **Federal Register** announcement. This announcement will provide details on the expected number of panel members, provide an opportunity for the public to nominate members, and inform the public of the objectives and scope of the panel's activities.

We will be asking this group of independent experts to evaluate only technical aspects of the MEI, including the index's inputs, input weights, price-measurement proxies, and the productivity adjustment.

Any formal recommendations made by the MEI TAP will be carefully considered

by CMS. Suggested modifications that we believe would result in technical improvements to the MEI would appear in subsequent PFS proposed rules and be subject to public comment and the overall rulemaking process.

Comment: Several commenters provided many suggestions on technical issues that they believe should be considered by the technical advisory panel. The commenters generally requested that the panel perform a thorough review of all aspects and elements of the MEI.

Response: We appreciate the constructive comments on potential topics for the MEI technical advisory panel, which will be asked to fully evaluate the index. As noted above, the panel will be evaluating all technical aspects of the MEI including the cost categories, their associated weights and price proxies, and the productivity adjustment.

Comment: A commenter stated that any recommendations that are made by the panel should be published with an opportunity for comment before they are finalized.

Response: Any substantive recommendations from the technical advisory panel that CMS believes will result in technical improvements to the MEI will be subject to the rulemaking process, including giving the opportunity to the public to review and comment.

Comment: Some commenters request that CMS reach out to the medical community to ensure that the panel's work is accurate and complete. Others indicated that pending the recommendations of the technical advisory panel, CMS should: (1) include physicians and other stakeholders in the MEI revision process, so that the impact of any recommended changes can be studied prior to implementation; and (2) clearly state their rationale for proposed changes.

Response: As mentioned previously, we will be reaching out to the public for suggestions as to the composition of an independent expert panel that will assist us in ensuring that the MEI is constructed accurately and completely, and fulfills its purpose to appropriately reflect the inflationary pressures faced by physicians in furnishing services. CMS will also present to the public any future proposed revisions to the MEI through notice and comment rulemaking, during which we will clearly state the rationale for any proposed changes and consider public comment before finalizing changes to the index.

Comment: One commenter believes that one of the possible options for resolving the SGR problem involves replacing the SGR update formula with the MEI. The commenter noted that input from the MEI technical panel should better position the MEI as a viable alternative to the SGR update formula.

Response: We welcome any technical comments the public has on the composition of the MEI, including the inputs, input weights, price-measurement proxies, and productivity adjustment. Any recommendations from the MEI TAP will be evaluated and considered for possible future rulemaking. However, we note that replacement of, or adjustments to, the SGR is outside the scope of the MEI TAP.

f. Other

Comment: Several commenters agreed with CMS' proposal to remove pharmaceuticals and separately billable medical supplies, since these are not paid under the PFS. Even though this change lessens the weight given to the practice expense component of the index, it made sense to the commenters given the separate line-item payments for these goods. Further, incident-to drugs are now paid based on average sales

price (ASP) and, since last-year's changes, are no longer a factor in the SGR formula and the determination of the PFS conversion factor.

Response: We agree with the commenters on the appropriateness of removing drugs and separately billable supplies from the MEI since they are not paid under the PFS and are no longer included as costs in the SGR formula.

Comment: A commenter disagreed with the continued use of the AHE wage data for the total nonfarm business economy as a price proxy for physician income rather than using BLS data specific to all professional and technical workers.

Response: We disagree with the commenter's suggestion. We believe that the use of the average hourly earnings data for the total nonfarm business economy, which captures skill mix shifts in the labor force, is the most appropriate index for use as the price proxy for physician income in the MEI. The AHE for the nonfarm business economy reflects general earnings including the impacts of supply, demand, and economy-wide productivity for the average worker in the economy. Its use is consistent with the Congress's original intent that the index be based on changes in expenses of practice and general earnings levels.[3] It is also consistent with our use of the BLS private nonfarm business multifactor productivity measure to adjust the index as economy-wide wage increases reflect economy-wide productivity increases. Therefore, we are finalizing our proposal to continue to use average hourly earnings for the total private nonfarm economy as a price proxy for physician income in the 2006-based MEI.

Comment: A commenter stated that although CMS has expanded the designation of the data underlying some of the GPCI and MEI constructs over the designations of

[3] U.S. Senate, Committee on Finance, Social Security Amendments of 1972, "Report of the Committee on Finance United States Senate to Accompany H.R. 1," September 26, 1972, p. 191.

previous years, the descriptions used are sometimes either inconsistent or contradictory. For example, CMS noted that "for the proposed sixth GPCI update, we used the 2006 through 2008 Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) data as a replacement for the 2000 Census data." (75 FR 40083). In contrast, CMS used "2006 Occupational Employment Statistics (OES), BLS" for the proposed 2006 MEI expense weights. (75 FR 40089, note (2)). The commenter believes it is impossible to discern from the proposed rule whether inconsistent data sets were used or whether there is simply a misprint.

Response: Because the MEI and GPCIs serve different purposes and are not interdependent, we may use data from different years and, in some instances, different sources. Both the MEI and the GPCI use the OES. However, because the MEI is based to 2006 it is appropriate to use the 2006 BLS Occupational Employment Statistics data to disaggregate the nonphysician wages cost weight into more detailed occupational cost weights.

For the proposed sixth GPCI update, CMS proposed to use OES data for 2006 through 2008. The rationale for choosing this data for the proposed GPCI update was provided in the CY 2011 PFS proposed rule (75 FR 40084).

8. Adjustments to the RVU Shares to Match the Proposed Rebased MEI Weights

As described in the previous section, CMS proposed to rebase the MEI for CY 2011 based on the most current data and establish new weights for physician work, PE, and malpractice under the MEI. As stated in the previous section, the MEI was rebased to a CY 1996 base year beginning with the CY 1999 MEI (63 FR 58845), and to a CY 2000 base year beginning with the CY 2004 MEI (68 FR 63239). For both the

CY 1999 and CY 2004 rebasing, we made adjustments to ensure that estimates of aggregate PFS payments for work, PE, and malpractice were in proportion to the weights for these categories in the rebased MEI (63 FR 58829 and 69 FR 1095).

Consistent with past practice when the MEI has been rebased, we proposed to make adjustments to ensure that estimates of aggregate CY 2011 PFS payments for work, PE, and malpractice are in proportion to the weights for these categories in the rebased CY 2011 MEI.

As explained in the CY 2011 PFS proposed rule (75 FR 40095), to match the proportions for work, PE, and malpractice in the rebased CY 2011 MEI would necessitate increasing the proportion of aggregate CY 2011 PFS payments for PE and malpractice and decreasing the proportion for work. This could be accomplished by applying adjustments directly to the work, PE, and malpractice RVUs. However, as stated in the proposed rule (75 FR 40095), we are cognizant of the public comments made during prior rulemaking on issues related to scaling the work RVUs. Many commenters have indicated a preference for the work RVUs to remain stable over time and for any necessary adjustments that would otherwise be made broadly to the work RVUs to be accomplished in an alternative manner. For example, in past 5-Year Reviews of the work RVUs, many commenters cited stability in the work RVUs, among other reasons, in their requests that any required budget neutrality adjustments not be made directly to the work RVUs. Given these prior comments, for CY 2011, we proposed to make the necessary MEI rebasing adjustments without adjusting the work RVUs. Instead, we proposed to increase the PE RVUs and the malpractice RVUs. Furthermore, as noted in the proposed rule (75 FR 40096), section 1848(c)(2)(B)(ii)(II) of the Act requires that changes to

RVUs cannot cause the amount of expenditures for a year to differ by more than $20 million from what expenditures would have been in the absence of the changes. Therefore, as required by section 1848(c)(2)(B)(ii) of the Act, we proposed to make an adjustment to the CY 2011 conversion factor to ensure that the adjustments to the PE RVUs and the malpractice RVUs would not cause an increase in CY 2011 PFS expenditures.

Comment: A number of commenters expressed support for the use of the most current and accurate data as inputs to "formulas used by the Agency, whether the formula for the SGR, for practice expense inputs, malpractice expense inputs, or in this case to calculating the Medicare Economic Index." These commenters supported the proposal to rebase and revise the MEI using the AMA PPIS data and the corresponding adjustments to the work, PE, and MP RVUs. Some commenters noted particularly that since the AMA PPIS has been deemed appropriate for the purpose of the PE RVU update process begun in CY 2010, using this same data source to inform the MEI costs and weights in CY 2011 is also appropriate because it will ensure that all of the major cost-based components of the fee schedule methodology will now be tied to cost data collected in the same year (2006). Furthermore, a number of commenters supported the proposed policy to adjust the RVU shares on the basis that the changes appear to have a modest positive impact on many of the services that were negatively affected by the implementation of the AMA PPIS data in CY 2010. These services were typically ones that are more heavily weighted to PE than work. In contrast, numerous commenters expressed dissatisfaction with the proposed policy on the premise that it "penalizes health care work that is not technology-intensive," that is, services that are typically more

heavily weighted to physician work than PE, "when in fact it is the technology-intensive health expenses that are actually driving up costs." A few of these commenters suggested that CMS insulate certain services that are work-intensive from the effects of the MEI rebasing.

Response: We believe that using the most current and accurate data whenever practicable to update the PFS is a key principle for the payment system. We agree with the commenters that using the AMA PPIS data to rebase and revise the MEI in CY 2011 promotes consistency within the PFS. In using the AMA PPIS information to rebase and revise the MEI, the result is that the most current data drive the work RVU share down compared to the PE RVU and malpractice RVU shares. Since the PFS is both resource-based, relative, and budget neutral, if the data show that physicians' resources (that is, costs) have shifted proportionately more to PE and malpractice, the proportion for work must come down. We have tried to accommodate the preferences of previous commenters to preserve the stability of work RVUs by proposing to make the necessary MEI rebasing adjustments without adjusting the work RVUs. However, given the PFS budget neutrality requirement, we cannot implement some commenters' suggestion to insulate certain services that are work-intensive from the effects of the MEI rebasing without violating the inherent relativity of the system. That is, in order to insulate certain services from the effects of the MEI rebasing while adjusting the RVU shares to match the proportions for work, PE, and malpractice in the rebased MEI in a budget neutral manner as discussed previously, the individual work RVUs for those certain services would need to be increased. However, if we were to increase the work RVUs for those certain services, the services would no longer be appropriately valued relative to the other

services under the PFS.

Comment: Of the many commenters who supported CMS' proposal to adjust the RVU shares to match the proportions for work, PE, and malpractice in the rebased CY 2011 MEI, the vast majority also favored adjusting the RVU shares upward for PE and malpractice while making a corresponding adjustment to the conversion factor for budget neutrality without modifying the RVUs for work. These commenters stated that stability in the work RVUs was desirable. However, some commenters also expressed concern that CMS proposed an additional downward adjustment to the conversion factor when, under current law, the effect of the SGR update formula in December of 2010 and CY 2011 would reduce PFS payments significantly. These commenters generally opposed the MEI rebasing and the adjustment to the RVUs to match the MEI weights; however, if CMS were to proceed with the policy, the commenters suggested that, at the very least the adjustments be phased in over 2 or 4 years. A few commenters suggested replacing the SGR update formula entirely with the MEI.

Response: We are sympathetic to the commenters' concern that an additional downward adjustment to the conversion factor on top of the negative effect of the statutory SGR-based update is inopportune. However, as we explained in the proposed rule (75 FR 40095) and discussed previously in this section, rather than applying adjustments directly to the work, PE, and malpractice RVUs in order to match the rebased MEI weights for those categories, we believe that it is appropriate for the work RVUs to remain stable over time. The only way we can make the adjustments without affecting the work RVUs is to also make an adjustment to the conversion factor. We note that we did not receive a public comment suggesting that we make the downward

adjustment to the work RVUs instead of the conversion factor in order to meet the requirements of section 1848(c)(2)(B)(ii) of the Act for budget neutrality. In response to the commenters that suggested replacing the SGR update with the MEI, we assume the commenters are making a general suggestion for a change in the current law, which is outside the purview of CMS.

Comment: Many commenters addressed CMS' proposal to convene a technical advisory panel to review all aspects of the MEI. In light of this proposal, the majority of commenters urged CMS to delay implementation of the MEI rebasing and any other MEI changes, including the proposed adjustment to the RVU shares, until the advice of the technical advisory panel is reviewed by CMS and recommendations for change, if any, are considered. Additionally, while the commenters generally supported convening an MEI technical advisory panel, some commenters, including MedPAC, advised that CMS should go ahead and implement the rebased and revised MEI and the proposed adjustment to the RVU shares in CY 2011. These commenters noted that if the recommendations of the advisory panel indicated that the MEI should be adjusted, CMS could propose future changes accordingly.

Response: We acknowledge the overwhelming support from commenters for the MEI technical advisory panel and refer readers to section II.E.6 of this final rule with comment period for a more detailed discussion of our plans to convene the panel. We note that a more detailed summary of the public comments and our responses is included in that section.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to make MEI rebasing adjustments to the PFS work and PE RVUs and

to adjust the conversion factor to maintain budget neutrality. In light of the substantial support in general for us to make adjustments to match the proportions of the work, PE, and malpractice RVU shares to the categories in the revised and rebased CY 2011 MEI and our decision, as described in section II.E.5 of this final rule, to proceed with rebasing the MEI for CY 2011, we are finalizing our proposal to adjust the RVU shares for CY 2011 to align the RVU shares with the rebased MEI weights. Specifically, we will not be making an adjustment directly to the work RVUs. Instead, we are increasing the PE RVUs by an adjustment factor of 1.181 and the malpractice RVUs by an adjustment factor of 1.358. The RVUs in Addendum B to this final rule with comment period reflect the application of these adjustment factors. We note that an application of the 1.358 adjustment factor to the malpractice RVUs for services with malpractice RVUs of 0.01 will, due to rounding, result in malpractice RVUs of 0.01.

Furthermore, section 1848(c)(2)(B)(ii)(II) of the Act requires that changes to RVUs cannot cause the amount of expenditures for a year to differ by more than $20 million from what expenditures would have been in the absence of the changes. Therefore, as required by section 1848(c)(2)(B)(ii) of the Act, we are making an adjustment of 0.9181 to the CY 2011 conversion factor to ensure that the 1.181 adjustment to the PE RVUs and the 1.358 adjustment to the malpractice RVUs do not cause an increase in CY 2011 PFS expenditures.

F. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate

1. Medicare Sustainable Growth Rate (SGR)

The SGR is an annual growth rate that applies to physicians' services paid by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the PFS update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR for a year (beginning with CY 2001) is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services;

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries;

(3) The estimated projected growth in real GDP per capita; and

(4) The estimated change in expenditures due to changes in statute or regulations.

In general, section 1848(f)(3) of the Act requires us to publish SGRs for 3 different time periods, no later than November 1 of each year, using the best data available as of September 1 of each year. Under section 1848(f)(3)(C)(i) of the Act, the SGR is estimated and subsequently revised twice (beginning with the FY and CY 2000 SGRs) based on later data. (The Act also provides for adjustments to be made to the SGRs for FY 1998 and FY 1999. See the February 28, 2003 **Federal Register**

(68 FR 9567) for a discussion of these SGRs.) Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the preliminary estimate. In this final rule with comment, we are making our preliminary estimate of the CY 2011 SGR, a revision to the CY 2010 SGR, and our final revision to the CY 2009 SGR.

2. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services covered by the SGR. The statute indicates that "the term physicians' services includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee."

We published a definition of physicians' services for use in the SGR in the November 1, 2001 **Federal Register** (66 FR 55316). We defined physicians' services to include many of the medical and other health services listed in section 1861(s) of the Act. As discussed in the CY 2010 PFS final rule with comment period (74 FR 61961), the statute provides the Secretary with clear discretion to decide whether physician-administered drugs should be included or excluded from the definition of "physicians' services." Accordingly, we removed physician-administered drugs from the definition of "physicians' services" in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and the levels of allowed expenditures and actual expenditures beginning with CY 2010, and for all subsequent years. Furthermore, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of

"physicians' services," we removed physician-administered drugs from the calculation of allowed and actual expenditures for all prior years.

Additionally, payment was made under the PFS for several new benefit categories in CY 2010 including pulmonary rehabilitation (PR), cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), and kidney disease education (KDE) services. We note further that section 101 of the MIPPA added a new benefit category for "additional preventive services" effective January 1, 2009. Although we neglected to identify and add these additional benefit categories when describing the scope of physicians' services for purposes of the SGR in course of rulemaking for CY 2010 and CY 2009, respectively, we did include payments for these services in calculating target and actual PFS expenditures beginning in CY 2009 for additional preventive services and beginning in CY 2010 for PR, CR, ICR, and KDE services.

Section 4103 of the ACA added a new benefit category for "personalized prevention plan services" (which include the annual wellness visit). Payment for these services will be made under the PFS, and payments for these services will be included in calculating target and actual PFS expenditures, beginning January 1, 2011.

Thus, for purposes of determining allowed expenditures, actual expenditures for all years, and SGRs beginning with CY 2010 and for all subsequent years, we are specifying that physicians' services include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers (and those paid through intermediaries where specified) or the equivalent services processed by the Medicare Administrative Contractors (MACs):

- Physicians' services.

- Services and supplies furnished incident to physicians' services, except for the expenditures for drugs and biologicals which are not usually self-administered by the patient.
- Outpatient physical therapy services and outpatient occupational therapy services.
- Services of PAs, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, NPs, and certified nurse specialists.
- Screening tests for prostate cancer, colorectal cancer, and glaucoma.
- Screening mammography, screening pap smears, and screening pelvic exams.
- Diabetes outpatient self-management training (DSMT) services.
- MNT services.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests (including outpatient diagnostic laboratory tests paid through intermediaries).
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Bone mass measurements.
- An initial preventive physical exam.
- Cardiovascular screening blood tests.
- Diabetes screening tests.
- Telehealth services.

- Physician work and resources to establish and document the need for a power mobility device.
- Additional preventive services.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.
- Intensive cardiac rehabilitation.
- Kidney disease education services.
- Personalized prevention plan services.

3. Preliminary Estimate of the SGR for 2011

Our preliminary estimate of the CY 2011 SGR is -13.4 percent. We first estimated the CY 2011 SGR in March 2010, and we made the estimate available to the MedPAC and on our Web site. Table 35 shows the March 2010 estimate and our current estimates of the factors included in the CY 2011 SGR. The majority of the difference between the March estimate and our current estimate of the CY 2011 SGR is explained by adjustments to reflect several intervening legislative changes that occurred after our March estimate was prepared.

TABLE 35: CY 2011 SGR Calculation

Statutory Factors	March Estimate	Current Estimate
Fees	0.2 percent (1.002)	0.2 percent (1.002)
Enrollment	3.1 percent (1.031)	2.4 percent (1.024)
Real Per Capita GDP	0.8 percent (1.008)	0.7 percent (1.007)
Law and Regulation	-4.4 percent (0.956)	-16.2 percent (0.838)
Total	-0.4 percent (0.996)	-13.4 percent (0.866)

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, 1.002 x 1.024 x 1.007 x 0.838 = 0.866). A more detailed explanation of each figure is provided in section II.F.6.a. of this final rule with comment period.

4. Revised Sustainable Growth Rate for CY 2010

Our current estimate of the CY 2010 SGR is 8.3 percent. Table 36 shows our preliminary estimate of the CY 2010 SGR that was published in the CY 2010 PFS final rule with comment period (74 FR 61965) and our current estimate. The majority of the difference between the preliminary estimate and our current estimate of the CY 2010 SGR is explained by adjustments to reflect several intervening legislative changes that have occurred since publication of the CY 2010 final rule with comment period.

TABLE 36: CY 2010 SGR Calculation

Statutory Factors	Estimate from CY 2010 Final Rule	Current Estimate
Fees	0.9 percent (1.009)	0.9 percent (1.009)
Enrollment	1.2 percent (1.012)	1.6 percent (1.016)
Real Per Capita GDP	0.7 percent (1.007)	0.7 percent (1.007)
Law and Regulation	-11.3 percent (0.887)	4.9 percent (1.049)
Total	-8.8 percent (0.912)	8.3 percent (1.083)

Note: A more detailed explanation of each figure is provided in section II.F.6.b. of this final rule with comment period.

5. Final Sustainable Growth Rate for CY 2009

The SGR for CY 2009 is 6.4 percent. Table 37 shows our preliminary estimate of the CY 2009 SGR from the CY 2009 PFS final rule with comment period (73 FR 69904), our revised estimate from the CY 2010 PFS final rule with comment period (74 FR 61966), and the final figures determined using the best available data as of September 1, 2010.

TABLE 37: CY 2009 SGR Calculation

Statutory Factors	Estimate from CY 2009 Final Rule	Estimate from CY 2010 Final Rule	Final
Fees	2.1 percent (1.021)	1.8 percent (1.018)	1.8 percent (1.018)
Enrollment	-0.2 percent (0.998)	-0.8 percent (0.992)	-0.6 percent (0.994)
Real Per Capita GDP	1.2 percent (1.012)	0.9 percent (1.009)	1.0 percent (1.010)
Law and Regulation	4.2 percent (1.042)	4.1 percent (1.041)	4.1 percent (1.041)
Total	7.4 percent (1.074)	6.1 percent (1.061)	6.4 percent (1.064)

Note: A more detailed explanation of each figure is provided in section II.F.6.b. of this final rule with comment period.

6. Calculation of CYs 2011, 2010, and 2009 Sustainable Growth Rates

a. Detail on the CY 2011 SGR

All of the figures used to determine the CY 2011 SGR are estimates that will be revised based on subsequent data. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and allowed expenditures and incorporated into subsequent PFS updates.

(1) Factor 1--Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2011

This factor is calculated as a weighted-average of the CY 2011 changes in fees for the different types of services included in the definition of physicians' services for the SGR. Medical and other health services paid using the PFS are estimated to account for approximately 89.4 percent of total allowed charges included in the SGR in CY 2011 and are updated using the MEI. The MEI for CY 2011 is 0.4 percent. Diagnostic laboratory tests are estimated to represent approximately 10.6 percent of Medicare allowed charges included in the SGR for CY 2011. Medicare payments for these tests are updated by the Consumer Price Index for Urban Areas (CPI-U), which is 1.1 percent for CY 2011.

However, section 3401 of the ACA reduces the CPI-U update applied to clinical laboratory tests by a productivity adjustment, but does not allow this adjustment to cause the update to be negative. The applicable productivity adjustment for CY 2011 is 1.2 percent. Adjusting the CPI-U update by the productivity adjustment results in a -0.1 percent (1.1 percent – 1.2 percent) update for CY 2011. However, since section 3401 of the ACA does not allow the productivity adjustment to result in a negative CLFS update, the result is that the CLFS update for CY 2011 is 0.0 percent. Additionally, section 3401 of the ACA reduces the update applied to clinical laboratory tests by 1.75 percent for CYs 2011 through 2015. Therefore, for CY 2011, diagnostic laboratory tests will receive an update of -1.75 percent. Additionally, as discussed in the CY 2010 PFS final rule with comment period (74 FR 61961), we removed physician-administered drugs from the definition of "physicians' services" in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and the levels of allowed expenditures and actual expenditures beginning with CY 2010, and for all subsequent years. Therefore, drugs represent 0.0 percent of Medicare allowed charges included in the SGR in CY 2011.

Table 38 shows the weighted-average of the MEI and laboratory price changes for CY 2010.

TABLE 38: Weighted-Average of the MEI and Laboratory Price Changes for CY 2011

	Weight	Update
Physician	0.894	0.4
Laboratory	0.106	-1.8
Weighted-average	1.000	0.2

We estimate that the weighted-average increase in fees for physicians' services in CY 2011 under the SGR (before applying any legislative adjustments) will be 0.2 percent.

(2) Factor 2--The Percentage Change in the Average Number of Part B Enrollees from CY 2010 to CY 2011

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from CY 2010 to CY 2011. Services provided to Medicare Advantage (MA) plan enrollees are outside the scope of the SGR and are excluded from this estimate. We estimate that the average number of Medicare Part B fee-for-service enrollees will increase by 2.4 percent from CY 2010 to CY 2011. Table 39 illustrates how this figure was determined.

TABLE 39: Average Number of Medicare Part B Fee-For-Service Enrollees from CY 2010 to CY 2011 (excluding beneficiaries enrolled in MA plans)

	2010	2011
Overall	43.932 million	45.010 million
Medicare Advantage (MA)	11.683 million	11.998 million
Net	32.249 million	33.012 million
Percent Increase		2.4 percent

An important factor affecting fee-for-service enrollment is beneficiary enrollment in MA plans. Because it is difficult to estimate the size of the MA enrollee population before the start of a CY, at this time we do not know how actual enrollment in MA plans will compare to current estimates. For this reason, the estimate may change substantially as actual Medicare fee-for-service enrollment for CY 2011 becomes known.

(3) Factor 3--Estimated Real Gross Domestic Product Per Capita Growth in 2011

We estimate that the growth in real GDP per capita from CY 2010 to CY 2011 will be 0.7 percent (based on the 10-year average GDP over the 10 years of 2002 through 2011). Our past experience indicates that there have also been changes in estimates of real per capita GDP growth made before the year begins and the actual change in GDP computed after the year is complete. Thus, it is possible that this figure will change as actual information on economic performance becomes available to us in CY 2011.

(4) Factor 4--Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2011 Compared With CY 2010

The statutory and regulatory provisions that will affect expenditures in CY 2011 relative to CY 2010 are estimated to have an impact on expenditures of -16.2 percent. These include the Department of Defense Appropriations Act (DODAA), the Temporary Extension Act (TEA), and the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (PACMBPRA) which provided for physician updates. Furthermore, the ACA contained provisions regarding the policy on equipment utilization for imaging services, the multiple procedure payment reduction policy for imaging services, and the annual wellness visit providing personalized prevention plan services.

b. Detail on the CY 2010 SGR

A more detailed discussion of our revised estimates of the four elements of the CY 2010 SGR follows.

(1) Factor 1--Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2010

This factor was calculated as a weighted-average of the CY 2010 changes in fees that apply for the different types of services included in the definition of physicians' services for the SGR in CY 2010.

We estimate that services paid using the PFS account for approximately 91.1 percent of total allowed charges included in the SGR in CY 2010. These services were updated using the CY 2010 MEI of 1.2 percent. We estimate that diagnostic laboratory tests represent approximately 8.9 percent of total allowed charges included in the SGR in CY 2010. Medicare payments for these tests are updated by the CPI-U, which is -1.4 percent for CY 2010. However, section 145 of the MIPPA, as modified by section 3401 of the ACA, reduced the update applied to clinical laboratory tests by 0.5 percent for CY 2009 and CY 2010. Therefore, for CY 2010, diagnostic laboratory tests received an update of -1.9 percent. Since we removed physician-administered drugs from the definition of "physicians' services" for purposes of computing the SGR and the levels of allowed expenditures and actual expenditures beginning with CY 2010, and for all subsequent years, drugs represent 0.0 percent of Medicare allowed charges included in the SGR in CY 2010.

Table 40 shows the weighted-average of the MEI, laboratory, and drug price changes for CY 2010.

TABLE 40: Weighted-Average of the MEI, Laboratory, and Drug Price Changes for CY 2010

	Weight	Update
Physician	0.911	1.2
Laboratory	0.089	-1.9
Drugs	0.000	0.0
Weighted-average	1.000	0.9

After considering the elements described in Table 40, we estimate that the weighted-average increase in fees for physicians' services in CY 2010 under the SGR (before applying any legislative adjustments) will be 0.9 percent. Our estimate of this factor in the CY 2010 PFS final rule with comment period was 0.9 percent (74 FR 61966).

(2) Factor 2--The Percentage Change in the Average Number of Part B Enrollees from CY 2009 to CY 2010

We estimate that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in Medicare Advantage plans) increased by 1.6 percent in CY 2010. Table 41 illustrates how we determined this figure.

TABLE 41: Average Number of Medicare Part B Fee-For-Service Enrollees from CY 2009 to CY 2010 (excluding beneficiaries enrolled in MA plans)

	2009	2010
Overall	42.846 million	43.932 million
Medicare Advantage (MA)	11.098 million	11.683 million
Net	31.748 million	32.249 million
Percent Increase		1.6 percent

Our estimate of the 1.6 percent change in the number of fee-for-service enrollees, net of Medicare Advantage enrollment for CY 2010 compared to CY 2009, is a larger change than our original estimate of 1.2 percent in the CY 2010 PFS final rule with comment period (74 FR 61967). While our current projection based on data from 8 months of CY 2010 differs from our original estimate of 1.2 percent when we had no actual data, it is still possible that our final estimate of this figure will be different once we have complete information on CY 2010 fee-for-service enrollment.

(3) Factor 3--Estimated Real Gross Domestic Product Per Capita Growth in CY 2010

We estimate that the growth in real GDP per capita will be 0.7 percent for CY 2010 (based on the 10-year average GDP over the 10 years of CY 2001 through CY 2010). Our past experience indicates that there have also been differences between our estimates of real per capita GDP growth made prior to the year's end and the actual change in this factor. Thus, it is possible that this figure will change further as complete actual information on CY 2010 economic performance becomes available to us in CY 2011.

(4) Factor 4--Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2010 Compared With CY 2009

The statutory and regulatory provisions that will affect expenditures in CY 2010 relative to CY 2009 are estimated to have an impact on expenditures of 4.9 percent. These include the DODAA, TEA, and PACMBPRA which provided for physician updates. Also included are the MIPPA provisions regarding the physician update, Physician Quality Reporting Initiative (PQRI) and e-prescribing bonuses, the work GPCIs, and payment provisions related to certain pathology services. Additionally, the ACA contained provisions regarding the work GPCIs, the policy on equipment utilization for imaging services, coverage of preventive services, and a physician enrollment requirement.

c. Detail on the CY 2009 SGR

A more detailed discussion of our final revised estimates of the four elements of the CY 2009 SGR follows.

(1) Factor 1--Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2009

This factor was calculated as a weighted-average of the CY 2009 changes in fees that apply for the different types of services included in the definition of physicians' services for the SGR in CY 2009. As we stated in the CY 2010 PFS final rule with comment period (74 FR 61965), although we removed drugs from the calculation of allowed and actual expenditures under sections 1848(d)(3)(C) and 1848(d)(4) of the Act retrospectively to the 1996/1997 base year, we determined that we were only authorized to remove drugs from the calculation of the SGR beginning with CY 2010. Therefore, we did not remove drugs from the SGR calculations for previous years, including CY 2009. Consistent with this determination, the revisions to our estimate of the CY 2009 SGR will be limited to revisions to reflect later data available as of September 1, 2010, that were not available when we published our previous estimates.

Services paid using the PFS accounted for approximately 82.3 percent of total Medicare-allowed charges included in the SGR for CY 2009 and are updated using the MEI. The MEI for CY 2009 was 1.6 percent. Diagnostic laboratory tests represented approximately 8.0 percent of total CY 2009 Medicare allowed charges included in the SGR and were updated by the CPI-U, which was 5.0 percent for CY 2009. However, section 145 of the MIPPA, as modified by section 3401 of the ACA, reduced the update applied to clinical laboratory tests by 0.5 percent for CYs 2009 and 2010. Therefore, for CY 2009, diagnostic laboratory tests received an update of 4.5 percent. Drugs represented approximately 9.7 percent of total Medicare-allowed charges included in the SGR for CY 2009. We estimate a weighted-average change in fees for drugs included in

the SGR of 1.6 percent for CY 2009. Table 42 shows the weighted-average of the MEI, laboratory, and drug price changes for CY 2009.

TABLE 42: Weighted-Average of the MEI, Laboratory, and Drug Price Changes for CY 2009

	Weight	Update
Physician	0.823	1.6
Laboratory	0.080	4.5
Drugs	0.097	1.6
Weighted-average	1.000	1.8

After considering the elements described in Table 42, we estimate that the weighted-average increase in fees for physicians' services in CY 2009 under the SGR (before applying any legislative adjustments) was 1.8 percent. This figure is a final one based on complete data for CY 2009.

(2) Factor 2--The Percentage Change in the Average Number of Part B Enrollees from CY 2008 to CY 2009

We estimate the change in the number of fee-for-service enrollees (excluding beneficiaries enrolled in MA plans) from CY 2009 to CY 2010 was -0.6 percent. Our calculation of this factor is based on complete data from CY 2009. Table 43 illustrates the calculation of this factor.

TABLE 43: Average Number of Medicare Part B from CY 2008 to CY 2009 (Excluding Beneficiaries Enrolled in MA plans)

	2008	2009
Overall	41.958 million	42.846 million
Medicare Advantage (MA)	10.008 million	11.098 million
Net	31.950 million	31.748 million
Percent Change		-0.6 percent

(3) Factor 3--Estimated Real Gross Domestic Product Per Capita Growth in CY 2009

We estimate that the growth in real per capita GDP was 1.0 percent in CY 2009 (based on the 10-year average GDP over the 10 years of CY 2000 through CY 2009). This figure is a final one based on complete data for CY 2009.

(4) Factor 4--Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2009 Compared With CY 2008

Our final estimate for the net impact on expenditures from the statutory and regulatory provisions that affect expenditures in CY 2009 relative to CY 2008 is 4.1 percent. These include the DRA provision regarding payments for imaging services, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110-173) (MMSEA) provision regarding the PQRI bonuses payable in CY 2009, and the MIPPA provisions regarding the physician update, mental health services, and the change in application of budget neutrality to the CF.

G. The Update Adjustment Factor (UAF)

Section 1848(d) of the Act provides that the PFS update is equal to the product of the MEI and the UAF. The UAF is applied to make actual and target expenditures (referred to in the statute as "allowed expenditures") equal. As discussed previously, allowed expenditures are equal to actual expenditures in a base period updated each year by the SGR. The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

1. Calculation under Current Law

Under section 1848(d)(4)(B) of the Act, the UAF for a year beginning with CY 2001 is equal to the sum of the following--

- Prior Year Adjustment Component. An amount determined by--

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for those services for that year;

+ Dividing that difference by the amount of the actual expenditures for those services for that year; and

+ Multiplying that quotient by 0.75.

- Cumulative Adjustment Component. An amount determined by--

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for those services during that period;

+ Dividing that difference by actual expenditures for those services for the prior year as increased by the SGR for the year for which the UAF is to be determined; and

+ Multiplying that quotient by 0.33.

Section 1848(d)(4)(E) of the Act requires the Secretary to recalculate allowed expenditures consistent with section 1848(f)(3) of the Act. As discussed previously, section 1848(f)(3) specifies that the SGR (and, in turn, allowed expenditures) for the upcoming CY (CY 2011 in this case), the current CY (that is, CY 2010) and the preceding CY (that is, CY 2009) are to be determined on the basis of the best data available as of September 1 of the current year. Allowed expenditures for a year generally are estimated initially and subsequently revised twice. The second revision

occurs after the CY has ended (that is, we are making the second revision to CY 2009 allowed expenditures in this final rule with comment).

Table 44 shows the historical SGRs corresponding to each period through CY 2011.

TABLE 44: Annual and Cumulative Allowed and Actual Expenditures for Physicians' Services from April 1, 1996 through the End of the Current Calendar Year

Period	Annual Allowed Expenditures ($ in billions)	Annual Actual Expenditures ($ in billions)	Cumulative Allowed Expenditures ($ in billions)	Cumulative Actual Expenditures ($ in billions)	FY/CY SGR
4/1/96-3/31/97	$46.8[1]	$46.8	$46.8	$46.8	N/A
4/1/97-3/31/98	$48.3	$47.0	$95.2	$93.9	FY 1998=3.2%
4/1/98-3/31/99	$50.4	$47.8	$145.6	$141.7	FY 1999=4.2%
1/1/99-3/31/99	$12.7	$12.4	[2]	$141.7	FY 1999=4.2%
4/1/99-12/31/99	$40.3	$37.0	[3]	$178.8	FY 2000=6.9%
1/1/99-12/31/99	$53.0	$49.5	$185.8	$178.8	FY 1999/2000
1/1/00-12/31/00	$56.8	$54.1	$242.7	$232.9	CY 2000=7.3%
1/1/01-12/31/01	$59.4	$61.2	$302.1	$294.2	CY 2001=4.5%
1/1/02-12/31/02	$64.3	$64.6	$366.4	$358.7	CY 2002=8.3%
1/1/03-12/31/03	$69.0	$70.2	$435.4	$429.0	CY 2003=7.3%
1/1/04-12/31/04	$73.6	$78.3	$509.0	$507.2	CY 2004=6.6%
1/1/05-12/31/05	$76.7	$83.5	$585.7	$590.7	CY 2005=4.2%
1/1/06-12/31/06	$77.8	$84.6	$663.5	$675.3	CY 2006=1.5%
1/1/07-12/31/07	$80.5	$84.5	$744.0	$759.8	CY 2007=3.5%
1/1/08-12/31/08	$84.2	$86.7	$828.2	$846.4	CY 2008=4.5%
1/1/09-12/31/09	$89.6	$90.6	$917.8	$937.0	CY 2009=6.4%
1/1/10-12/31/10	$97.0	$92.9	$1,014.7	$1,029.9	CY 2010=8.3%
1/1/11-12/31/11	$84.0	NA	$1,098.7	NA	CY 2011=-13.4%

[1] Allowed expenditures in the first year (April 1, 1996-March 31, 1997) are equal to actual expenditures. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on our Web site at the following address: http://www.cms.hhs.gov/SustainableGRatesConFact/. We expect to update the web site with the most current information later this month.

[2] Allowed expenditures for the first quarter of 1999 are based on the FY 1999 SGR.

[3] Allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR.

Consistent with section 1848(d)(4)(E) of the Act, Table 44 includes our second revision of allowed expenditures for CY 2009, a recalculation of allowed expenditures for CY 2010, and our initial estimate of allowed expenditures for CY 2011. To determine the UAF for CY 2011, the statute requires that we use allowed and actual expenditures from April 1, 1996 through December 31, 2010 and the CY 2011 SGR.

Consistent with section 1848(d)(4)(E) of the Act, we will be making revisions to the CY 2010 and CY 2011 SGRs and CY 2010 and CY 2011 allowed expenditures. Because we have incomplete actual expenditure data for CY 2010, we are using an estimate for this period. Any difference between current estimates and final figures will be taken into account in determining the UAF for future years.

We are using figures from Table 44 in the following statutory formula:

$$UAF_{11} = \frac{Target_{10} - Actual_{10}}{Actual_{10}} \times 0.75 + \frac{Target_{4/96-12/10} - Actual_{4/96-12/10}}{Actual_{10} \times SGR_{11}} \times 0.33$$

UAF_{11} = Update Adjustment Factor for CY 2011 = -2.9 percent

$Target_{10}$ = Allowed Expenditures for CY 2010 = $97.0 billion

$Actual_{10}$ = Estimated Actual Expenditures for CY 2010 = $92.9 billion

$Target_{4/96-12/10}$ = Allowed Expenditures from 4/1/1996 - 12/31/2010 = $1,014.7 billion

$Actual_{4/96-12/10}$ = Estimated Actual Expenditures from 4/1/1996 - 12/31/2010 = $1,029.9 billion

SGR_{11} = -13.4 percent (0.866)

$$\frac{\$97.0 - \$92.9}{\$92.9} \times 0.75 + \frac{\$1{,}014.7 - \$1{,}029.9}{\$92.9 \times 0.866} \times 0.33 = -2.9\%$$

Section 1848(d)(4)(D) of the Act indicates that the UAF determined under section 1848(d)(4)(B) of the Act for a year may not be less than -0.07 or greater than 0.03. Since -0.029 is between -0.07 and 0.03, the UAF for CY 2010 will be -0.029.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1.0 should be added to the UAF determined under section 1848(d)(4)(B) of the Act. Thus, adding 1.0 to -0.029 makes the UAF equal to 0.971.

H. Physician and Anesthesia Fee Schedule Conversion Factors for CY 2011

The CY 2011 PFS CF is $25.5217. The CY 2011 national average anesthesia CF is $15.8085.

1. Physician Fee Schedule Update and Conversion Factor

a. CY 2011 PFS Update

The formula for calculating the PFS update is set forth in section 1848(d)(4)(A) of the Act. In general, the PFS update is determined by multiplying the CF for the previous year by the percentage increase in the MEI times the UAF, which is calculated as specified under section 1848(d)(4)(B) of the Act.

b. CY 2011 PFS Conversion Factor

Generally, the PFS CF for a year is calculated in accordance with section 1848(d)(1)(A) of the Act by multiplying the previous year's CF by the PFS update.

We note section 101 of the MIEA-TRHCA provided a 1-year increase in the CY 2008 CF and specified that the CF for CY 2009 must be computed as if the 1-year increase had never applied. Section 101 of the MMSEA provided a 6-month increase in the CY 2009 CF, from January 1, 2009, through June 30, 2009, and specified that the CF for the remaining portion of CY 2009 and the CFs for CY 2010 and subsequent years must be computed as if the 6-month increase had never applied. Section 131 of the MIPPA extended the increase in the CY 2009 CF that applied during the first half of the year to the entire year, provided for a 1.1 percent increase to the CY 2010 CF, and

specified that the CFs for CY 2011 and subsequent years must be computed as if the increases for CYs 2008, 2009, and 2010 had never applied. Section 1011(a) of the DODAA and section 5 of the TEA specified a zero percent update for CY 2010, effective January 1, 2010 through May 31, 2010. Subsequently, section 101(a)(2) of the PACMBPRA provided for a 2.2 percent update to the CF, effective from June 1, 2010 to November 30, 2010. Therefore, under current law, the CF in effect in December 2010 is $28.3868.

In addition, when calculating the PFS CF for a year, section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ more than $20 million from what it would have been in the absence of these changes. If this threshold is exceeded, we must make adjustments to preserve budget neutrality. We estimate that CY 2011 RVU changes would result in a decrease in Medicare physician expenditures of more than $20 million. Accordingly, we are increasing the CF by 1.0045 to offset this estimated decrease in Medicare physician expenditures due to the CY 2011 RVU changes. Furthermore, as discussed in section II.E.6 of this final rule with comment period, we are decreasing the CF by 0.9181 in order to offset the increase in Medicare physician payments due to the CY 2011 rescaling of the RVUs so that the proportions of total payments for the work, PE, and malpractice RVUs match the proportions in the final revised and rebased MEI for CY 2011. Accordingly, we calculate the CY 2011 PFS CF to be $25.5217. This final rule with comment period announces a reduction to payment rates for physicians' services in CY 2011 under the SGR formula. These payment rates are currently scheduled to be reduced under the SGR system on December 1, 2010, and then again on January 1, 2011.

The total reduction in MPFS rates between November 2010 and January 2011 under the SGR system will be 24.9 percent. By law, we are required to make these reductions in accordance with section 1848(d) and (f) of the Act, and these reductions can only be averted by an Act of Congress. While Congress has provided temporary relief from these reductions every year since 2003, a long-term solution is critical. We are committed to permanently reforming the Medicare payment formula.

We illustrate the calculation of the CY 2011 PFS CF in Table 45.

TABLE 45: Calculation of the CY 2011 PFS CF

December 2010 Conversion Factor		$28.3868
CY 2011 Medicare Economic Index	0.4 percent (1.0040)	
CY 2011 Update Adjustment Factor	-2.9 percent (0.9710)	
CY 2011 RVU Budget Neutrality Adjustment	0.5 percent (1.0045)	
CY 2011 Rescaling to Match MEI Weights Budget Neutrality Adjustment	-8.2 percent (0.9181)	
CY 2011 Conversion Factor		**$25.5217**

We note payment for services under the PFS will be calculated as follows:

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

2. Anesthesia Conversion Factor

We calculate the anesthesia CF as indicated in Table 45. Anesthesia services do not have RVUs like other PFS services. Therefore, we account for any necessary RVU adjustments through an adjustment to the anesthesia CF to simulate changes to RVUs. More specifically, if there is an adjustment to the work, PE, or malpractice RVUs, these adjustments are applied to the respective shares of the anesthesia CF as these shares are proxies for the work, PE, and malpractice RVUs for anesthesia services. Furthermore, as discussed in section II.E.6 of this final rule with comment

period, we are rescaling the RVUs so that the proportions of total payments for the work, PE, and malpractice RVUs match the proportions in the final revised and rebased MEI for CY 2011. Accordingly, we are adjusting the anesthesia CF to reflect the RVUs adjustments being made to all other physician fee schedule services to match the revised and rebased MEI weights.

As explained previously, in order to calculate the CY 2011 PFS CF, the statute requires us to calculate the CFs for CYs 2009, 2010, and 2011 as if the various legislative changes to the CFs for those years had not occurred. Accordingly, under current law, the anesthesia CF in effect in December 2010 is $16.6058. We illustrate the calculation of the CY 2011 anesthesia CF in Table 46.

TABLE 46: Calculation of the CY 2011 Anesthesia Conversion Factor

December 2010 Anesthesia Conversion Factor		$16.6058
CY 2011 Medicare Economic Index	0.4 percent (1.0040)	
CY 2011 Update Adjustment Factor	-2.9 percent (0.9710)	
CY 2011 Anesthesia Adjustment	-2.3 percent (0.97651)	
CY 2011 Anesthesia Conversion Factor		$15.8085

III. Code-Specific Issues for the PFS

A. Therapy Services

1. Outpatient Therapy Caps for CY 2011

Section 1833(g) of the Act applies an annual, per beneficiary combined cap on expenses incurred for outpatient physical therapy and speech-language pathology services under Medicare Part B. A similar separate cap for outpatient occupational therapy services under Medicare Part B also applies. The caps apply to expenses incurred for therapy services furnished in outpatient settings, other than in an outpatient hospital setting which is described under section 1833(a)(8)(B) of the Act. The caps were in effect during 1999, from September 1, 2003 through December 7, 2003, and continuously beginning January 1, 2006. The caps are a permanent provision, that is, there is no end date specified in the statute for therapy caps. Beginning January 1, 2006, the DRA provided for exceptions to the therapy caps until December 31, 2006. The exceptions process for therapy caps has been extended through December 31, 2009 pursuant to three subsequent amendments (in MEIA-TRHCA, MMSEA, and MIPPA).

Section 1833(g)(5) of the Act (as amended by section 3103 of the ACA) extended the exceptions process for therapy caps through December 31, 2010. The annual change in the therapy cap is computed by multiplying the cap amount for CY 2010, which is $1,860, by the MEI for CY 2011, and rounding to the nearest $10. This amount is added to the CY 2010 cap to obtain the CY 2011 cap. Since the MEI for CY 2011 is 0.4 percent, the therapy cap amount for CY 2011 is $1870.

The agency's authority to provide for exceptions to therapy caps (independent of the outpatient hospital exception) will expire on December 31, 2010, unless the Congress

acts to extend it. If the current exceptions process expires, the caps will be applicable in accordance with the statute, except for services furnished and billed by outpatient hospital departments.

Comment: The commenters unanimously requested repeal of the therapy caps, while characterizing caps as arbitrary and medically unfounded and the combination of cap amounts for PT and SLP services as groundless. A number of commenters argued that therapy caps restrict provision of medically necessary services to beneficiaries. Several commenters reported that patients are discharged for care prior to recovery due to payment restrictions and this leads to increased medical costs for Medicare.

Response: Therapy caps are mandated by statute. We have no authority to repeal the caps, or to restructure the grouping of therapy disciplines to which the caps apply. However, we understand the concerns of the commenters, and we are actively exploring alternatives to therapy caps to inform the discussions about approaches to identify and pay for those therapy services that are necessary for patients to attain the best outcomes with the most efficient use of resources.

2. Alternatives to Therapy Caps

a. Background

In section 4541 of the Balanced Budget Act of 1997 (Pub. L. 105-33) (BBA), the Congress enacted the financial limitations on outpatient therapy services (the "therapy caps" discussed above for physical therapy, occupational therapy, and speech-language pathology). At the same time, the Congress requested that the Secretary submit a Report to Congress that included recommendations on the establishment of a revised coverage policy for outpatient physical therapy services and outpatient occupational therapy

services under the statute. The Balanced Budget Refinement Act of 1999 (Pub. L. 106-113) (BBRA) placed the first of a series of moratoria on implementation of the limits. In addition, it required focused medical review of claims and revised the report requirements in section 4541(d)(2) of the BBA to request a report that included recommendations on the following: (A) The establishment of a mechanism for assuring appropriate utilization of outpatient physical therapy services, outpatient occupational therapy services, and speech-language pathology services; and (B) the establishment of an alternative payment policy for such services based on classification of individuals by diagnostic category, functional status, prior use of services (in both inpatient and outpatient settings), and such other criteria as the Secretary determines appropriate, in place of the limits. In 1999, therapy services were not defined, but services documented as therapy were billed and reported when furnished by a variety of individuals in many different settings. These services were not identified in a way that would allow analysis of utilization or development of alternative payment policies. Since that time, we have clarified the definition of therapy services and applied the qualifications of therapists consistently to outpatient settings, which have facilitated analysis of therapy services.

We have studied therapy services with the assistance of a number of contractors over the past 11 years. Reports of these projects are available on the CMS Web site at http://www.cms.gov/TherapyServices/. On November 9, 2004, we delivered the Report to Congress, Number 137953, "Medicare Financial Limitations on Outpatient Therapy Services" that referenced two utilization analyses. We periodically updated the utilization analyses and posted other contracted reports on the CMS web site in order to further respond to the requirements of the BBRA. Subsequent reports highlighted the

expected effects of limiting services in various ways and presented plans to collect data about patient condition using available tools. The general belief was that if patient condition could be reliably described, that approach would ensure appropriate payment for appropriately utilized services.

Over the past decade, significant progress has been made in identifying the outpatient therapy services that are billed to Medicare, the demographics of the beneficiaries who utilize those services, the types of services, the HCPCS codes used to bill the services, the allowed and paid amounts of the services, and the settings, geographic locations, and provider or supplier types where services are furnished.

Some of the information that is necessary to ensure appropriate utilization and develop objective and equitable payment alternatives to therapy caps based on patient condition has proven difficult to develop. The influence of prior use of inpatient services on outpatient use of therapy services was not accessible due to systems issues and differences in the policies, billing, and reporting practices for inpatient and outpatient therapy services. The weakness of the ICD-9-CM diagnostic codes in describing the condition of the rehabilitation patient obscured analyses of claims to assess the need for therapy services. The primary diagnosis on the claim is a poor predictor for the type and duration of therapy services required, which complicates assignment of patient cohorts for analysis. Although changes to the guidance in the Medicare Benefit Policy Manual (Pub. 100-02) on documentation of therapy services in 2005 improved the consistency of records and facilitated chart review, it became increasingly obvious that neither claims analysis nor chart review could serve as a reliable and valid method to determine a patient's need for services or to form the basis for equitable payment. We concluded that

in order to develop alternative payment approaches to the therapy caps, we needed a method to identify patients with similar risk-adjusted conditions (cohorts) and then we would identify the therapy services that are necessary for the patients to attain the best outcomes with the most efficient use of resources.

While we studied therapy utilization, a number of proprietary tools were developed by researchers in the professional community to assess the outcomes of therapy. Some tool sponsors collected sufficient information to predict with good reliability the amount or length of treatment that would result in the best expected outcomes. We encouraged the use of these proprietary tools in manual instructions, but proprietary tools do not serve our purposes because modification of proprietary tools may only be done by the tool sponsor. There now are some versions of the tools in the public domain and they are being utilized widely to identify patient conditions and, by some insurers, to pay for efficient and effective treatment. Examples of such tools include the National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association and Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO).

In 2006, Focus on Therapeutic Outcomes, Inc. delivered to CMS a report titled, "Pay for Performance for Physical Therapy and Occupational Therapy," which is also available on the CMS Web site at http://www.cms.gov/TherapyServices. The purpose of this project was to simulate a pay-for-performance implementation, designed to align financial incentives with the achievement of better clinical outcomes from services that were delivered efficiently. The project, funded by HHS/CMS Grant 18-P-93066/9-01, demonstrated the predictive validity of the risk-adjusted pay-for-performance model and

the feasibility of reducing payments without affecting services to beneficiaries who need them.

b. Current Activities

The Tax Relief and Health Care Act of 2006 (TRHCA) extended the therapy cap exceptions process through December 31, 2007 and provided funds used for two CMS projects related to developing alternative payment approaches for therapy services that are based on beneficiary needs. A 5-year project titled "Development of Outpatient Therapy Alternatives" (DOTPA), awarded to RTI International, was initiated in order to develop a comprehensive and uniform therapy-related data collection instrument, assess its feasibility, and determine the subset of the measures that we could routinely and reliably collect in support of payment alternatives. While DOTPA will identify measurement items relevant to payment, the project will not deliver a standardized measurement tool. We may either develop a tool or allow other tools to be used for payment purposes when they include those items that identify the following: (1) beneficiary need; and (2) outcomes (that is effectiveness of therapy services). In addition to therapy caps, the DOTPA project considers our interest in value-based purchasing by identifying components of value, including beneficiary need and the effectiveness of therapy services. The DOTPA project reports are available on the contractor's Web site at http://optherapy.rti.org/. The data collection design and instrument development have been completed, and a Paperwork Reduction Act (PRA) package was submitted for approval of the data collection forms by the Office of Management and Budget (OMB). The **Federal Register** notice for the second round of public comment on this package was published on April 23, 2010 (75 FR 21296). The PRA package has been approved;

the contractor is recruiting potential participants in the data collection, developing training materials for participants, and updating the project web site. We did not seek public comments on the DOTPA project in the proposed rule.

The TRCHA also funded the 2-year project contracted to Computer Sciences Corporation (CSC) entitled "Short Term Alternatives for Therapy Services" (STATS). STATS has provided recommendations regarding alternative payment approaches to therapy caps that could be considered before completion of the DOTPA project. The STATS project draws upon the analytical and clinical expertise of contractors and stakeholders to consider policies, measurement tools, and claims data that are currently available to provide further information about patient condition and the outcomes of therapy services. The final report, received September 13, 2010, included recommended actions we could take within 2 or 3 calendar years to replace the current cap limits on therapy services with a policy that pays appropriately for necessary therapy services.

c. Potential Short-Term Approaches to Therapy Caps

On June 30, 2009, we received a draft of the CSC report titled "STATS Outpatient Therapy Practice Guidelines," a summary of expert workgroup discussions, and several short-term payment alternatives for consideration. CSC discussed options based on the assumption that short-term policy changes should facilitate the development of adequate function and/or outcomes reporting tools. In the long-term, CSC recommended that payment be based on function or quality measurements that adequately perform risk adjustment for episode-based payment purposes.

Based on the draft report, additional stakeholder input, and subsequent communications with the contractor, in the CY 2011 PFS proposed rule

(75 FR 40097 through 40099) we discussed several potential alternatives to the therapy caps that could lead to more appropriate payment for medically necessary and effective therapy services that are furnished efficiently. We solicited public comments on the proposed rule regarding all aspects of these alternatives, including the potential associated benefits or problems, clinical concerns, practitioner administrative burden, consistency with other Medicare and private payer payment policies, and claims processing considerations. We did not propose either short-term or long-term payment alternatives to the therapy caps. However, we referred readers to section II.C.4.(c) of the proposed rule for our CY 2011 proposal to expand the MPPR policy to "always therapy" services furnished in a single session in order to pay more appropriately for therapy services, taking into consideration the expected efficiencies when services are furnished together. While we did not propose the adoption of an MPPR policy for therapy services specifically as an alternative to the therapy caps, we acknowledged that by paying more appropriately for combinations of therapy services that are commonly furnished in a single session, practitioners would be able to furnish more medically necessary therapy services to a given beneficiary before surpassing the caps. We noted that the proposed MPPR policy would have the potential to reduce the number of beneficiaries impacted by the therapy caps in a given year.

Comment: Many commenters stated that use of the financial cap on therapy services as a rationale for the proposed MPPR was unacceptable and not a sound basis for such a significant policy proposal. Quite a few commenters contrasted the cap alternatives research with the MPPR which, in the commenters' opinion, did not reflect a similar level of analysis. Instead of implementing the proposed MPPR, a large majority

of the commenters urged CMS to place a high priority in resources and funding for research to identify alternatives to the cap that would ensure patients receive medically necessary therapy services.

While the commenters agreed that more therapy could be furnished to a beneficiary before surpassing the caps if the payments were reduced, the commenters believe that other, more serious access problems would result from arbitrary payment reductions under an MPPR. Many commenters were concerned that the proposed MPPR policy might restrict access to therapy services for patients with more severe problems, especially neurological problems and complex medical conditions. Less payment, explained the commenters, would force therapists to spend less time with patients, incentivize cutting corners, and encourage greater fraud and abuse. The commenters argued that the shortage of therapists, particularly physical therapists, would be exacerbated and access to therapy services would be severely jeopardized.

Response: We appreciate the effort and resources contributed by stakeholders to the discussion and development of alternatives to therapy caps. We look forward to the continued cooperation of stakeholders as we continue our work in this area over the coming years. We refer readers to section II.C.4.(c) of this final rule with comment period for a detailed discussion of the public comments and our responses regarding the proposed therapy MPPR.

The three specific short-term options that we discussed in the CY 2011 PFS proposed rule would not have required statutory changes when CSC originally delivered them. In CY 2011, some would require extension of the therapy cap exceptions process. Some would require moderate reporting changes that would yield more detailed

information about patient function and progress to inform future payment approaches and facilitate the medical review of services above the therapy caps at the present time. Others require new coding and bundled per-session payment that would be a first step toward episode-based payment. They are not necessarily independent of each other.

Under each of these alternatives, administrative simplification with respect to current policies, such as HCPCS code edits and "ICD-9-CM to HCPCS code" crosswalk edits that serve to limit utilization without regard to the patient's clinical presentation, could be pursued in the context of these options.

The first option would modify the current therapy caps exceptions process to capture additional clinical information regarding therapy patient severity and complexity in order to facilitate medical review. This approach would complement the DOTPA project, which is identifying items to measure patient condition and outcomes. We believe the first option may have the greatest potential for rapid implementation that could yield useful information in the short-term. In the CY 2011 PFS proposed rule (75 FR 40097), we indicated that we were especially interested in detailed public comments on this option that could inform a potential proposal to adopt such an alternative through future rulemaking. The second option would involve introducing additional claims edits regarding medical necessity, in order to reduce overutilization. The third option would be to adopt a per-session bundled payment that would vary based on patient characteristics and the complexity of evaluation and treatment services furnished in the session. Each option would require significant provider and contractor education, and all would necessitate major claims processing systems changes. Moreover, some of the options may affect beneficiaries by changing the type or amount

of services covered by Medicare or the beneficiary's cost sharing obligations.

Comment: Many commenters agreed that a long term solution to the therapy caps is desirable. Generally, the commenters supported an evidence-based payment system grounded in accurate, comprehensive analysis of the clinical characteristics of the wide range of therapy patients in diverse settings and the concept of bundled payment for episodes of care based on clinical characteristics of patients. Many commenters urged CMS to place a high priority in resources and funding for research to identify alternatives to the cap that would ensure patients receive medically necessary therapy services. The commenters asserted that such research would be a key factor in identifying clinically appropriate ways to control spending. Those who commented on this issue commended CMS for proposing alternatives that reflect in-depth analytical work, expressing appreciation to CMS and its contractor for the opportunity to participate on task forces and pledging continued assistance in trials of alternatives. The commenters also commend CMS for recommending better clinical information be included in payment decisions.

MedPAC and some other commenters supported all three alternatives as reasonable steps consistent with the end goals of value for purchases based on the care needs of beneficiaries. Many commenters supported the first option or the third option, and very few supported the second option. Regardless of the alternative chosen, commenters consistently recommended further study and analysis, with a national demonstration or pilot project to test any alternative prior to implementation.

Response: We continue to believe that the advice and assistance of stakeholders, including clinicians and practice administrators, are essential to the development of policies that are appropriate, realistic, and effective in allowing necessary therapy care while limiting overutilization. We appreciate the time and effort provided by the

dedicated professionals involved in the STATS workgroups and DOTPA technical advisory panels.

Comment: A commenter suggested that diagnoses cannot be used to predict medical necessity. The same commenter argued that if the patient were assessed using self-reported functional status measures that are risk-adjusted using many variables, it would be possible to predict outcomes, identify ineffective treatment, and reduce gaming without relying on clinician-generated estimates known to be biased and fraught with poor reliability and validity.

Several other commenters stated that clinicians' judgment is essential to accurate outcomes assessment, and these commenters provided examples of clinical judgments believed essential to appropriate care planning.

Response: None of the alternatives discussed in the proposed rule would require a measurement tool scored by either a clinician or the patient. We note the disagreement among the commenters on this point.

Comment: While generally supportive of the development of alternatives to therapy caps, many commenters expressed concern that there were insufficient data and details of the options discussed in the proposed rule to develop a rational payment system based on the options at this time. Several commenters suggested that sophisticated multivariate statistical methods with a long list of clinically appropriate risk-adjustment variables would be required. Another commenter recommended using risk-adjustment models built on large aggregate datasets to develop efficiency and effectiveness projections on which payments could be based.

Response: We agree that the alternatives presented were not fully developed and

that statistically sound methods of evaluation of the fully developed alternatives would be appropriate. We made no specific proposal to adopt an alternative beginning in CY 2011, but instead presented three potential options in order to gather additional public input on the overall concepts and the details to inform our future developmental work in this area. We will continue to review and consider all the information provided to us and acknowledge that, in the context of any future proposal, we would need to provide further detail as part of notice and comment rulemaking in order for the public to provide meaningful comment prior to the adoption of changes to therapy payment.

Comment: Many commenters complained that therapy payments have decreased relative to inflation over the past 10 years. The commenters described the practitioner's struggle to provide appropriate care and noted their fear of alternatives that could result in fewer resources with which to treat beneficiaries. Some commenters stated that Medicaid payments also decreased, leaving them with less flexibility to provide covered services to Medicare beneficiaries. Several commenters warned that those who bill therapy services will find "creative" ways to manage patients in the future, leading to reduced quality of care, or that therapists will be laid off, leading to access problems for beneficiaries.

Some commenters recommended that CMS take time to consider the potential alternatives to therapy caps from all angles related to cost, including the costs of different health outcomes. Several commenters reported that outpatient physical therapy saves Medicare spending by preventing more expensive procedures and surgeries.

Response: Achieving appropriate payment for quality services that quickly lead to good health outcomes is among the major goals of our payment policy. It is also our goal to limit overutilization of services, and to discourage the provision of services that

are not medically reasonable and necessary or represent an abuse of Medicare funds. To that end, we will continue to develop policies aimed at paying for those therapy services that meet patients' needs. The clear challenge is to identify those needs and the services required.

Comment: One commenter was concerned that underlying therapy utilization data are flawed due to inconsistent coverage and payment policies that also negatively affect good clinical practice by restricting the therapist's clinical judgment. The commenter provided detailed examples to illustrate inconsistencies in forms and billing rules between Part A and B providers and suppliers which in the aggregate, the commenter argued, impede CMS' ability to analyze claims data for comparison purposes. Differences due to National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) policies and most particularly local coverage determinations (LCDs) were also identified by the commenter as creating significant variations among contractors. The commenter was particularly concerned about requirements for specific ICD-9-CM and CPT code combinations, which limit therapy diagnoses or require specific diagnoses as primary.

Response: We develop national and local policies and guidelines as needed to interpret statutory requirements and to limit, whenever possible, abusive behaviors while encouraging high quality care and good outcomes for beneficiaries. Since no one method is entirely effective in curbing incorrect or fraudulent billing practices, a number of approaches have been adopted. We attempt to coordinate these policies and we recognize that it is sometimes difficult for providers and suppliers to stay informed about changes, especially when they treat beneficiaries whose services are impacted by different

payment policies. We will continue to work cooperatively with interested stakeholders, as we did with the STATS project, to identify and resolve concerns or conflicts regarding our policies. We intend that any claims data collected in a pilot study would be unencumbered by conflicts that have been identified.

Comment: Many commenters stated that the options are identified as alternatives to the cap exceptions process, which expires December 31, 2010.

Response: The short-term alternatives discussed are potential alternatives to the therapy caps, and while it may be possible to implement some as modifications to the exceptions process, we recognize that Congress would have to act to extend the authority for a therapy cap exceptions process or to otherwise provide for certain alternatives to therapy caps.

Option (1): Revise therapy caps exceptions process by requiring the reporting of new patient function-related Level II HCPCS codes and severity modifiers.

This option would require that clinicians submit beneficiary function-related nonpayable HCPCS codes to replace the -KX modifier (Specific required documentation on file). Codes would not be submitted on every claim, but at episode onset and at periodic intervals (for example, progress report intervals of 12 sessions or 30 days--whichever is less). Codes would be submitted for all patients in order for the claims to be paid and not only those claims approaching or surpassing the therapy caps. The current -KX modifier is not useful to identify claims exceeding therapy caps, because it is used for services both before and after the caps are exceeded, and it must be used on the entire claim for facilities. New codes also would not identify claims above the cap, but they would perform the same function as the current -KX modifier to signal that

documentation in the medical record supported medical necessity that should lead to an exception to the therapy caps. The codes would also provide more information for medical review.

Six Level II HCPCS G-codes representing functions addressed in the plan of care and 5 (or 7) modifiers representing severity/complexity would be utilized to report information on the claim. Examples of six new function-related G-codes:

- GXXXU--Impairments to body functions and/or structures--current.
- GXXXV--Impairments to body functions and/or structures--goal.
- GXXXW--Activity limitations and/or participation restrictions--current.
- GXXXX--Activity limitations and/or participation restrictions--goal.
- GXXXY--Environmental barriers--current.
- GXXXZ--Environmental barriers--goal.

Two potential severity/complexity scales have been suggested that would require the adoption of 5 or 7 new severity modifiers, respectively. Under one scenario, modifiers based on the International Classification of Function would identify severity as follows:

- None (0 to 4 percent).
- MILD (5 to 24 percent).
- MODERATE (25 to 49 percent).
- SEVERE (50 to 95 percent).
- COMPLETE (96 to 100 percent).

Alternatively, a proportional severity/complexity scale would use 7 modifiers to describe impairments, limitations, or barriers--

- 0 percent;
- 1 to 19 percent;
- 20 to 39 percent;
- 40 to 59 percent;
- 50 to 79 percent;
- 80 to 99 percent; or
- 100 percent.

Implementation of this general approach might require 6 months to 2 years to modify claims processing for the current therapy caps and exceptions processing of claims, and to develop, pilot test, and refine coding before applying the approach nationally. While therapists initially would need to learn the new codes and update their billing systems, ultimately their reporting burden might be reduced because the -KX modifier would not be required on each claim line for patients with expenditures approaching or exceeding the therapy caps. This option could potentially result in a small reduction in outpatient therapy expenditures due to increased Medicare contractor scrutiny of episodes where functional severity scores did not change over time, or to other atypical reporting patterns associated with the new codes.

In the long-term, these codes and modifiers could be mapped to reliable and validated measurement tools (either currently available tools in the public domain or newly developed tools from items on the DOTPA instrument or the Continuity Assessment Record and Evaluation (CARE) tool). If statistically robust patient condition information were collected from claims data, it may be possible to develop Medicare payment approaches for outpatient therapy services that could pay appropriately and

similarly for efficient and effective services furnished to beneficiaries with similar conditions who have good potential to benefit from the services furnished. At a minimum, the new codes could allow contractors to more easily identify and limit the claims for beneficiaries who show no improvement over reasonable periods of time.

Comment: Most commenters supported the concept of Option (1) although often not without concerns about the details of implementation. The commenters generally endorsed the concept of describing patients' goals in terms of activity participation and environmental barriers, in addition to impairments based on the World Health Organization's (WHO's) International Classification of Functioning, Disability and Health (ICF). Some supported Option (1) as the best of the three options as it could begin providing a national overview of functional status and severity of patients which would be essential if CMS were to pursue future episode-based payment. The majority of commenters agreed with the concept of developing an infrastructure to work toward payment reform based on episodes of care, patient characteristics, functional status, rehabilitation complexity, severity, and outcomes. Many commenters supported Option (1) as the first step in a plan to move toward Option (3) that would introduce per-session codes to bundle payment, as described in detail below, and ultimately episode-based payments, although a few suggested the severity codes could be used, after adequate testing and definition, to inform appropriate payment. Some commenters recommended developing Option (1) and suggested that further development should include: definition of terms (including the ICD-10 diagnosis codes in 2013), input from therapists, field testing, and data analysis to ensure that payment appropriately reflects patient complexity and risk before application of the codes to individual therapy disciplines.

The commenters in favor of this option supported the use of ICF language in descriptions, but consistently preferred a 7-point rating scale for severity over the 5-point scale based on the ICF. Several commenters also noted that sufficient training would be required for contractors and providers of service under this option.

Response: We appreciate the perspectives of the commenters who see Option (1) as a first step in the process of exploring alternatives to the therapy caps that could move toward payment based on the needs of beneficiaries.

Comment: Many commenters opposed this option as burdensome, easy to "game," and lacking the potential for saving money. The commenters in opposition to the option claimed it could require a great deal of research to establish, validate and value codes, and then pilot test, refine, establish inter-tester reliability, and modify the claims processing process, which could take 2 years. Instead, the same commenters recommended the use of valid and reliable measurement tools currently in the public domain and in use by clinicians. One commenter requested that CMS not use clinician-graded single item assessment scales of patient severity or complexity, unless such methodology possessed published reliability and validity on the selection and grading processes because there are more psychometrically sound published scales available that include a risk adjustment process to predict treatment success and number of visits and are less vulnerable to gaming. If scales were used, several commenters recommended that they must be sensitive and cardinal so each change would represent an equal increment.

Response: We recognize that Option (1) is not yet fully developed and would require further study. As we consider this option further, we will also assess the

feasibility of using currently available validated measurement scales in the public domain. The issues of "gaming" and savings remain of interest in relationship to this and the other options.

Comment: Several commenters voiced serious concerns about the concept of using function-related codes and severity modifiers on the claim to monitor patient improvement. The commenters were alarmed that contractors would deny services when improvement was insufficiently demonstrated, or when the beneficiary's goal was to prevent deterioration of function. Several commenters were concerned that a contractor's attention to function and severity modifiers might cause the contractor to unduly limit the therapy sessions a patient needed to maintain or increase functionality.

A few commenters interpreted the statute to require only that a service be medically necessary to treat the underlying illness or condition, and not to require that the service lead to improvement. According to the commenters, a service required to maintain current function is medically necessary but the focus on identifying improvement would prevent those patients with progressive diseases from receiving therapy to prevent further decline in function when there is little probability of meeting an undefined improvement standard. A few commenters provided citations of court cases that rejected Medicare policies and practices that denied therapy services based on arbitrary rules of thumb without consideration of the patient's individual condition. Therefore, the same commenters recommended that CMS omit reference to improvement standards in any proposal related to Option (1).

Response: The policies for Medicare Part B outpatient therapy services require payment for therapy services that require the skills of a therapist. In contrast, "Unskilled

services are palliative procedures that are repetitive or reinforce previously learned skills, or maintain function after a maintenance program has been developed. . . . services related to activities for the general good and welfare of patients, for example, general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute therapy services for Medicare purposes" (Medicare Benefit Policy Manual, Pub. 100-02, chapter 15, section 220.2.A.). We note that when the goal of therapy is to halt degeneration of function due to disease, therapy is not palliative or related to general welfare, but may be an active treatment with measurable outcomes. For that reason, we do not anticipate that function-related codes and severity modifiers would be used exclusively as a proxy for the determination of medical necessity.

The Medicare policy goes on to state, ". . . services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function. . . ." (Pub. 100-02, chapter 15, section 220.2.A.). Further details concerning maintenance therapy and examples of covered services to patients with degenerative neurological diseases are found in Pub. 100-02, chapter 15, section 220.2.D.

Option (2): Enhance existing therapy caps exceptions process by applying medical necessity edits when per-beneficiary expenditures reach a predetermined value.

The existing automatic process for exceptions, and the revised exceptions process described in Option (1) above, pay practitioners indefinitely for services if they attest on the claim by appending a specific modifier to therapy HCPCS codes that the services

being furnished are medically necessary and that supporting documentation is included in the medical record. Unless the local contractor uses claims edits or does post-payment review, these processes do not identify or limit unusually high annual per-beneficiary utilization. High utilization is not limited to beneficiaries with multiple or complex conditions. We would use existing therapy utilization data to develop annual per-beneficiary medical necessity payment edits, such as limits to the number of services per-session, per-episode, or per-diagnostic grouping, for exceptions to the therapy caps which would be set at benchmark payment levels that only a small percentage of beneficiaries would surpass in a single year. Once these levels were reached, additional claims would be denied and practitioners would need to appeal those denials if they wished to challenge Medicare's nonpayment.

This alternative would require 1 to 2 years to implement as an expansion of existing policy, and its effects would be anticipated by analysis of the current utilization of therapy services. Additional practitioner burden would be incurred in the small number of cases exceeding the per beneficiary expenditure edits if the practitioner chose to appeal the medical necessity denial.

Comment: Few commenters preferred Option (2) over the other two. In addition, the commenters stated that they were familiar with this approach because other insurers use a similar system of edits, so the adoption of Option (2) for Medicare patients would 'not represent an additional administrative burden. The commenters who favored this option reported that it would be the easiest for CMS to implement and would be the only option likely to save money in the very short-term. Some commenters who favored this option would still prefer the use of existing measurement tools to gather data about

therapy services. One commenter pointed out that limits per-diagnosis should be based on reasonable data that reflect good patient outcomes.

Most of the commenters who supported Option (2) also noted that this option could influence therapy utilization and possibly outcomes, creating flawed data that were not representative of needed services. The commenters were concerned that future payment policy decisions might later be based on those flawed data.

Response: We agree that Option (2) has the benefit of being relatively easy to implement and we appreciate the perspective of some commenters on the low anticipated burden. We also recognize that a database of limited services would not be appropriate to use for estimating the full cost of medically necessary services.

Comment: Some commenters took a neutral position on this option, finding that it could be part of a viable alternative to therapy caps but only after considerable study and development. MedPAC noted that Option (2) would implement more meaningful therapy caps in the interim, while longer-term solutions were being developed and tested. At the same time, MedPAC supported CMS' efforts to identify medically unnecessary care and to implement payment systems that ensure that the program obtains value for its purchases. Other commenters were concerned that the benchmark levels for edits be realistic and not arbitrary. The commenters requested that CMS consider a method to deal with outliers without forcing denials and appeals.

Response: Option (2) could be used in combination with other options. We recognize the description we provided was not specific about the edit levels and that further deliberation would be appropriate before edits could be implemented.

Comment: The majority of commenters opposed Option (2). Although some

commenters agreed that edits for medically unlikely services are useful and appropriate, they expressed concerns about this approach because edits can often be arbitrary, are not based on patient needs, and may improperly limit necessary services. Some commenters asserted that individuals with degenerative conditions may require shorter sessions over longer periods of time to address functional loss and slow deterioration and to maximize health outcomes. The commenters also opposed edits that would fail to address the affects of cognitive impairment on treatment. Several commenters cited the existing ICD-9-CPT code crosswalks, LCDs, NCCI edits, and MUEs as examples of similar edits that commenters often found to be clinically inappropriate. The commenters argued that current edits and policies based on unsupported information led to denials and appeals that were costly to therapists and CMS. The commenters urged CMS to avoid edits that lack clinical relevance or a scientific basis and create anomalies in claims data.

Response: Option (2) was developed with input from therapy professionals based on their review of therapy utilization data. If this option were to be implemented, we would, at a minimum, review the advice and recommendations of stakeholders, along with any available utilization data to inform our decisions regarding the edit levels.

Comment: A few commenters criticized Option (2) as scientifically flawed. One commenter reported that use of a combined effectiveness (that is, functional status change) and efficiency (that is, number of treatment visits) algorithm in a value-based payment process is one of the few methods where one could determine if the patient needs more or less treatment to reach optimal risk-adjusted gains in functional status. The same commenter referenced numerous research efforts that have analyzed functional status outcomes in rehabilitation using sophisticated risk-adjustment methods and

requested that CMS use these as a basis for a new payment policy.

Other commenters asserted that currently available utilization data are inadequate to develop predetermined edit values, citing studies of therapy utilization under contract to CMS and studies performed by industry that demonstrate why ICD-9 coding, lack of function/severity data, and lack of a definition for "episode" are problematic.

Response: Current therapy utilization data reveal that one percent of beneficiaries who receive services incur costs that proportionately far exceed those of the other 99 percent of beneficiaries. However, we are also aware that without some knowledge of the condition of the beneficiary, it is impossible to determine which, if any, of those services were medically necessary. While it would be desirable to analyze more detailed utilization data that include patient function/severity outcomes for setting edit values, those data are not available to us in the short-term. We believe that the existing limited utilization data, albeit not fully descriptive of patients, could inform potential future edit values for therapy services.

Comment: If CMS plans to move forward with edits, many commenters strongly requested that professional organizations be consulted to determine whether such edits are clinically appropriate and realistic. Some commenters specifically urged CMS to await the results of the DOTPA pilot in the hope of capturing meaningful clinical differences between patients before applying edits. Before such edits could reliably be applied to payment, other commenters recommended that CMS design, test, and evaluate additional data on functional status and barriers to participation. Many commenters indicated that more data are needed; especially thresholds based on episodes, condition groupings, and similar criteria that could trigger medical review, but not support denial.

To that end, some commenters stated that it might be possible to support this approach under Option (2), but after Option (1) was implemented.

Response: We understand the commitment of stakeholders to the development of alternatives to the therapy caps based on clinically appropriate policies. We will consider the potential benefit of Option (1) to develop data on which to base the edits required under Option (2) as we further contemplate alternatives to the therapy caps.

Comment: A few commenters opposed Option (2) edits because the edits would virtually eliminate the exceptions process mandated by law and replace it with denial of claims at a predetermined value, which may be inconsistent with the statutory requirement for an exceptions process. The same commenters stated that there would be no basis for edits until Option (1) was implemented to provide more detailed claims-based information. Several commenters reported research showing 10 percent of Part B patients in nursing facilities have highly complex problems, with multidisciplinary needs and inconsistent patterns of therapy service use. The commenters were concerned that denials would interfere with treatment of these complex patients with special needs.

Response: Option (2) would require an existing exception to the therapy caps, which would be enhanced to allow limited billing and payment for medically necessary services that exceed the caps. The option could not be used if the exceptions process were not extended. However, the Deficit Reduction Act of 2005 that established exceptions to the caps for medically necessary therapy services also required implementation of clinically appropriate code edits in order to identify and eliminate improper payments for therapy services. CMS currently applies NCCI and MUE edits to therapy services that fail to meet a reasonable assumption of medical necessity. We view

implementation of Option (2) as consistent with our current authority to create edits to control inappropriate billings.

Benchmark levels for Option (2) would be based on existing therapy utilization data and limits would be set at levels that a high percentage of beneficiaries would not exceed. While it may be helpful to have more data related to patient condition as described in Option (1) before implementing Option (2), we do not consider such information vital to the development of limits that affect a very small percentage of beneficiaries whose service payments would so far exceed average payments that they would be likely to include inappropriate billings and would be unlikely to interfere with the delivery of medically necessary services.

Comment: If the option of implementing edits were pursued, several commenters indicated that the edits should be variable based on clinical criteria, result in medical review instead of denials, and reflect issues of multidisciplinary care, care coordination, and clinical issues.

Response: If Option (2) were to be further developed, we would consider the commenters' suggestions prior to finalizing a plan for implementation, along with any new information available from additional research studies, OIG reports, or other sources.

Option (3): Introduce per-session "Evaluation/Assessment and Intervention" (E&I) codes to bundle payment for groups of current therapy HCPCS codes into a single per-session payment.

As discussed in section II.C.4.(c) of this final rule with comment period, multiple therapy services are often furnished in a single session, and we proposed to expand the MPPR policy to "always therapy" services in CY 2011 in order to take into consideration

the efficiencies that occur when multiple services (the typical therapy scenario) are furnished in one session to a beneficiary. Furthermore, we note that section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) regarding potentially misvalued codes under the PFS specifies that the Secretary may make appropriate coding changes, which may include consolidation of individual services into bundled codes for payment under the PFS, as part of her review and adjustment of the relative values for services identified as potentially misvalued.

This option would require that practitioners submit a single new Level II HCPCS code to represent all the therapy services currently reported and paid separately for an outpatient therapy session. Payment for the HCPCS code would be based on patient characteristics (as identified through prior CMS contractor analyses) and the complexity of the evaluation/assessment and intervention services furnished during the session. The new coding requirements would not necessarily disrupt the current exceptions process or the revised exceptions process described in Option (1) above. Approximately 12 E&I codes would be needed for each discipline, taking into consideration the basic algorithm shown in Table 47.

Table 47: Evaluation/Assessment & Intervention Level II HCPCS Codes

		Evaluation/Assessment Complexity		
		Minimal	**Moderate**	**Significant**
Intervention Level	None	E&I Code #1	E&I Code #2	E&I Code #3
	Minimal	E&I Code #4	E&I Code #5	E&I Code #6
	Moderate	E&I Code #7	E&I Code #8	E&I Code #9
	Significant	E&I Code #10	E&I Code #11	E&I Code #12

We would need to develop and test operational definitions for each E&I code so that practitioners would be able to properly report services and appropriate relative values

could be established for each per-session code. We believe that a pilot study might reveal that the different practice patterns for the three therapy professions (physical therapy, occupational therapy, and speech-language pathology) could necessitate separate relative value determinations for each E&I code by type of therapy service furnished. As a result, up to 36 total new Level II HCPCS codes could be needed (12 per discipline).

We anticipate that the definitions of E&I codes 1 through 3 and 7 through 12 would describe services that may only be furnished by a "clinician" (therapist, physician, or non-physician practitioner). E&I codes 1 through 3 would be reported for sessions that consisted only of evaluations. In addition, the definitions of E&I codes 4 through 6 would describe services that could be furnished by or under the permissible supervision of all qualified outpatient therapy professionals. Based upon historical therapy utilization patterns, the vast majority of E&I codes submitted would likely fall in the 4 through 9 code range. We would expect the RVUs under the PFS for all E&I codes to take into consideration the efficiencies when multiple services (those that would be currently reported under multiple CPT codes) are furnished.

This option would require 2 to 4 years to add new codes and conduct a short-term pilot study to refine coding and value the 12 new HCPCS codes (or 36 if they are specific to each therapy discipline). There would be significant initial practitioner administrative burden to learn new codes and update billing systems. However, ultimately, with elimination of the practitioner's reporting of 76 different codes and many of the associated claims processing edits, the administrative burden of reporting therapy services to Medicare would be minimized.

This bundled approach to reporting and payment could result in more appropriate

valuation of therapy services that reflects efficiencies when individually reported services are furnished in the same session. As a result, it could lead to reduced therapy expenditures, as well as a reduction in the number of beneficiaries affected by the therapy caps in a given year.

Comment: The vast majority of commenters concurred that provider payments should be influenced by underlying beneficiary characteristics. Most commenters agreed that following research and development, an episode-based payment alternative would be the most feasible payment model for outpatient therapy services in the long-term, and some recommended it be developed in a performance-based model. The commenters generally supported this option as a foundation to those goals, but recommended expert therapist input into the process and further study to determine how such an approach might affect different therapy types and settings. Several commenters noted that it would be critical to ensure clear nomenclature, the availability of an appropriate reporting methodology, and adequate payment for these codes that reflects the resources used to provide these services.

To assure appropriate payment for needed services, the commenters agreed that the outcomes resulting from provider interventions must be incorporated in payment models. The commenters believe that experience gained in a transparent development process could be carried over into future payment system reform. Therefore, the majority of commenters who supported Option (3) also requested that there be a transparent process of development and testing in which expert therapists from various settings were included. Many also argued that Option (3) should be developed only after Option (1) had been implemented and function and severity data had been collected to inform the

development of Option (3).

Response: We appreciate the support of commenters for Option (3) and their interest in moving toward long-term goals by implementing short-term approaches as an incremental step. We agree that the information presented in the proposed rule was limited regarding Option (3) and that further study would be necessary before a bundled per-session payment approach could be implemented. We will consider the commenters' recommendations to develop an episode-based payment alternative in the future.

Comment: The concept of moving toward per-session codes that would be based on the severity of the patient and intensity of therapist clinical judgment and work involved in the provision of the therapy service was welcomed by many commenters. Those commenters who encouraged CMS to use this option to reduce the administrative burden of counting minutes and eliminate NCCI edits and MUEs anticipated corresponding improvement in the effective and efficient delivery of clinical interventions. The commenters urged CMS to ensure compliance of policies related to Option (3) with other payment policies, such as the delivery of medically necessary care driven by the development of an appropriate functional goal-based plan of care.

Response: While a per-session payment methodology could result in modification of current policies regarding counting treatment time, it would not necessarily result in deleting claims edits. If we were to adopt such a methodology, we would assess the current claims processing edits and determine whether they continued to be appropriate and/or implement new edits to address potential issues under the revised payment approach.

Comment: Some commenters suggested a modified definition of severity. The

commenters recommended two separate severity tables of "severity or complexity," one for evaluation and the other for intervention. For each table separately, severity/complexity of clinical presentation would be rated as low, moderate, or high. In all cases, the commenters believe CMS should identify the factors to be used to determine severity for both evaluations and interventions. The commenters urged that CMS defer to professional standards of practice and state law with respect to the provision of services in each category. Other commenters recommended modifiers for complex patients and comprehensive multidisciplinary rehabilitation settings to facilitate application of special policies for those circumstances.

Response: The tables presented in the proposed rule were illustrative of the potential Level II per-session HCPCS codes, and these codes would require further development prior to implementation. We appreciate the commenters' suggestions and will consider them as we weigh this option.

Comment: Some commenters who supported the general premise of Option (3) and some commenters who opposed it were not optimistic that per-session payment could be developed in a reliable and valid manner in the short-term.

Response: This alternative was developed as a short-term action that would start the process toward bundled payments for therapy episodes. The work completed by expert therapist advisors to the STATS workgroups laid a foundation that could facilitate development of the initial per-session HCPCS codes, which could reasonably be based on utilization data that demonstrated which services were historically billed together most of the time. We have analyzed data regarding common therapy code combinations. While a per-session payment approach could have a significant impact on payment for therapy

services, we would not expect that developing and valuing per-session E&I codes would be a particularly lengthy or complex process. We note that over the past several years, the CPT Editorial Panel has bundled multiple services into a single code numerous times in different medical specialty areas and the AMA RUC has then valued the new comprehensive service by taking into account the expected efficiencies in the physician work and/or practice expense.

Comment: Rather than consign the code definition and valuation processes integral to Option (3) to the CPT Editorial Panel and AMC RUC processes, which have little transparency, several commenters recommended that CMS develop Level II HCPCS codes for this purpose and allow for continued stakeholder input as to their valuation. Some commenters expressed appreciation for being included in the STATS process and suggested it as a model for future transparency in developing payment policies.

Response: We appreciate the confidence stakeholders expressed regarding our capacity to develop HCPCS codes and values using a transparent process that includes input from stakeholders. If we were to move toward per-session payment in the future, we would need to consider the most appropriate approach to the development and valuation of new codes to describe those services. In the meantime, we note that if the CPT Editorial Panel were to develop new codes for comprehensive therapy services, as they have developed new CY 2011 comprehensive codes for cardiac catheterization and lower extremity endovascular revascularization services that bundle services that are commonly furnished together, we would consider those therapy codes for adoption under the PFS and would value them if we recognized them for PFS payment.

Comment: Due to the nature of certain services when assessment and

intervention are inseparable, some commenters asserted that interventions should not be included in this model but should be separately identified. The commenters provided the examples of active wound care management and prosthetic/orthotic management.

Response: The details of therapy E&I codes have not been proposed or finalized. We appreciate the perspective of the commenters and will keep it in mind if we were to pursue the creation of per-session therapy codes in the future.

Comment: While some commenters stated that Option (3) has the potential to simplify and increase consistency in coding for therapy services, several commenters who opposed this option and Option (1) mentioned that providers would learn to "game the system" and that all patients would be documented as severe on initial intake.

Response: We too are concerned about approaches where providers could learn to game the system. The commenters who criticized this option generally preferred the edits in Option (2).

Restriction on utilization of certain codes sometimes increases the risk of billing different codes, billing more of the same codes, or increasing patient visits, resulting in the same or greater cost to the Medicare program. The edits described in Option (2) would prevent high payments for individual beneficiaries, but might have little or no effect on the payments to providers or suppliers who increase the number of beneficiaries treated. Generally, we apply a number of different methods concurrently to reduce risk.

At times, it may be difficult to know whether the clinical judgment and objective measurements have been accurately reported or documented in the record and whether the service furnished is appropriately represented by the billed HCPCS code. Providers focused on billing inappropriately may also document inappropriately. In the long term,

we hope to incentivize honest and ethical providers and suppliers of services to furnish effective and efficient, high quality services. Possible fraudulent activity may be identified by aberrant billing patterns, and the new codes could facilitate the identification of such patterns.

Several commenters expanded on the options presented as alternatives to the therapy caps or recommended options of their own. A few presented their own analyses of utilization to support their recommendations.

Comment: Several commenters recommended incorporation of currently and publicly available validated tools to inform the collection of patient-specific information and move toward performance-based payment. A few commenters suggested that the study "Pay-for-Performance for Outpatient Physical Therapy and Occupational Therapy" that Focus On Therapeutic Outcomes (FOTO) completed in 2006 under Grant #18-P-93066-/0-01 might be a good template from which to start a process to replace caps and ultimately develop a value-based purchasing process. The commenters suggested the FOTO predictive model could be used, after pilot testing, to develop a reimbursement process where care is based on need and payment is based on results.

Response: We recognize the importance of demonstrating the application of a value-based purchasing approach to physical and occupational therapy services. We posted the FOTO study on the CMS Web site at: http://www.cms.gov/TherapyServices/downloads/P4PFinalReport06-01-06.pdf.

We are aware that research continues on the functional status indicator and that other measurement tools are also available in the public domain. The STATS discussions resulted in some improvements in the feasibility of matching outcomes data to claims.

However, there are a number of problems that would have to be resolved before any of the currently available versions of therapy outcomes tools could be incorporated into payment policy. The FOTO study did not address value-based purchasing for speech-language pathology services and there remain questions about applying the FOTO functional status indicator, or any self-reported measure, to certain cognitively impaired patients or to the Medicare population without further refinement.

As we continue to explore various options, we would be interested in the feasibility of using historical research, existing electronic input systems, and registry information to provide a conceptual framework for alternative payment systems.

Comment: Although CMS did not discuss the option of establishing therapy payments based on episodes in the discussion of short-term options, many commenters encouraged CMS to pursue that goal. Using data obtained from the severity/complexity codes described in Option (1), DOTPA, and other data initiatives, several commenters urged CMS to undertake research to develop a new episodic prospective payment system for Part B therapy services. Some commenters described the details of a plan to base therapy episode payment on groups based on patient clinical characteristics, considering mean episode costs, adjusting for high and low outliers or interrupted episodes, setting a default payment for unmapped episode groups, and also adjusting for local wage indices and providing an annual market basket payment rate update.

The opportunity for CMS to define sessions and episodes more clearly and the potential to support the overall goal of payment reform was eagerly anticipated by several commenters. The commenters applauded CMS for recognizing the potential opportunity to gather these data on episodes for payment of therapy services furnished in the

institutional setting.

Episode-based payment was recommended as an alternative to the proposed therapy MPPR by numerous commenters. The commenters explained that the fundamental problem with fee-for-service payment is the incentive to over utilize therapy services in the outpatient setting and limit institutional providers from using resources flexibly. The commenters described analysis of a large database of Medicare beneficiaries as the basis for a methodology for grouping diagnosis codes to create episodes of care on which therapy payment would be based. The commenters noted that adjustment would be needed to payments for complex patients and readmissions. The same commenters supported episode payments for separate therapy disciplines based on a patient's medical diagnosis and goals. A critical goal for these commenters was to identify and account for differences in the conditions and needs of patients in skilled nursing facilities as opposed to other outpatient therapy settings.

Response: We did not discuss development of episode-based payments as an option in the CY 2011 PFS proposed rule because we recognize that substantially more research would be necessary to define the episodes and determine what resources would be needed for different groups or categories of patients before the episodes could be incorporated into a payment system, particularly one that also addressed quality, efficiency, and good health outcomes. However, the absence of discussion in our proposed rule of an episode-based payment methodology as a short-term therapy cap alternatives option should not be interpreted as our reluctance to pursue the definition of episodes or the refinement of the concept of episode-based payments.

Comment: A number of commenters supported testing variables they believe to

be important in making a clinical judgment concerning a patient's severity, including: general type of patient (orthopedic, neurological, medical, etc.); impairment (body part treated); intake functional status; patient age; symptom acuity; surgical history; payer; gender; level of fear-avoidance of physical activities; and number of co-morbid conditions. Other commenters urged inclusion of clinical judgment of severity based on medical condition, physical impairments resulting from these conditions, patient function, and ability to participate in activities of daily living.

Response: As we progress in the analysis of payment alternatives to the therapy caps, we appreciate the information on variables believed to be critical by stakeholders who have conducted related research and/or furnished therapy services to a wide array of patients in different clinical settings. We welcome their expert contributions and collaboration with us on this important issue.

In conclusion, we emphasize that we continue to be committed to developing alternatives to the therapy caps that would provide appropriate payment for medically necessary and effective therapy services furnished to Medicare beneficiaries based on patient needs, rather than the current therapy caps which establish financial limitations on Medicare payment for therapy services in some outpatient settings regardless of medical necessity. The Congress has repeatedly intervened to allow exceptions to these caps for certain time periods, and the current exceptions are automatically processed based on a practitioner's attestation that medical necessity is documented in the chart for an individual patient. We believe that, ultimately, payment for therapy services should incentivize the most effective and efficient care, consistent with Medicare's focus on value in its purchasing.

The STATS contractor has worked closely with a broad variety of clinicians, administrators, scientists, researchers, and other contractors to develop the three alternatives presented in this discussion in CY 2011 rulemaking for the PFS. We are grateful for all public comments on the proposed rule from interested stakeholders, including individual therapists from both facility and nonfacility outpatient settings paid under Medicare Part B.

We are committed to finding alternatives to the current therapy cap limitations on expenditures for outpatient therapy services that will ensure that beneficiaries continue to receive those medically necessary therapy services that maximize their health outcomes. We continue to dedicate our resources to identifying alternatives that would encourage the most efficient and cost-effective treatments. We believe motivated therapists, with attention to the most cost-effective practices, can incorporate practice efficiencies that benefit patients by achieving the best possible results at the lowest cost. Our STATS and DOTPA projects, which are currently engaged in data collection and analysis to inform short-term and long-term alternatives to the therapy caps, respectively, lay the foundation for future payment alternatives for outpatient therapy services. We are optimistic that the STATS project has identified short-term, feasible alternatives that may be tested in the future. The DOTPA project will create a tool and test its use to collect patient condition information that could then be applied to identify patient need for therapy services. Together, these projects may provide the basis for a long-term plan to reshape Medicare's payment policy for outpatient therapy services to align with the value-based purchasing principles that are now guiding principles of the Medicare program.

B. Diabetes Self-Management Training (DSMT) Services (HCPCS Codes G0108 and G0109)

1. Background

Section 1861(s)(2)(S) of the Act provides for coverage of DSMT in outpatient settings without limiting this coverage to hospital outpatient departments. DSMT services consist of educational and training services furnished to an individual with diabetes by a certified provider in an outpatient setting.

Section 1861(qq)(2)(A) of the Act stipulates that training must be furnished by a "certified provider" which is a physician or other individual or entity that also provides other items or services for which payment may be made under Medicare. This program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management. DSMT services are reported under HCPCS codes G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) and G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes).

2. Payment for DSMT Services

In accordance with section 1848(j)(3), Medicare payment for outpatient DSMT services is made under the PFS as specified in §414.1 through §414.48. When we created HCPCS codes G0108 and G0109, the only direct costs included in the PE were registered nurse labor. Section 410.144(a)(4)(a) states that the DSMT team includes at least a registered dietitian and a certified diabetes educator. We initially did not establish work

RVUs for DSMT services because we believed training would typically be performed by individuals other than a physician, such as a registered nurse (65 FR 83130). However, since that time, we have received requests from a number of stakeholders, including the American Association of Clinical Endocrinologists (AACE), the American Association of Diabetes Educators (AADE), and the Juvenile Diabetes Research Foundation, to include physician work in valuing DSMT services that is similar to the physician work that has been included in medical nutrition therapy (MNT) services since CY 2007 and kidney disease education (KDE) services since CY 2010. The stakeholders argued that because physicians coordinate DSMT programs, provide patient instruction, and communicate with referring physicians, physician work should be included in the RVUs for DSMT services. The stakeholders also requested that we reconsider the direct PE inputs for DMST services and include clinical labor for diabetes educators at a higher hourly rate instead of registered nurse labor. In addition, they stated that the supplies and equipment in the PE for DSMT services should be the same as for KDE services, with additional direct PE inputs for a diabetes educator curriculum, data tracking software, and DSMT program accreditation.

For CY 2011, we proposed the following:

- To assign physician work RVUs to DSMT services that are comparable, as adjusted for the service times of the HCPCS codes, to the work RVUs for MNT services. The rationale for the proposed work RVUs for the DSMT HCPCS G-codes was based on the similarity of DSMT services to MNT services in the individual (CPT code 97803) and group (CPT code 97804) setting.

- That HCPCS G0108 for 30 minutes of individual DSMT services would be crosswalked to CPT code 97803 (Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes) for purposes of assigning work RVUs, with the physician work RVUs for CPT code 97803 multiplied by two to account for the greater time associated with HCPCS code G0108 (that is, 30 minutes).

- That HCPCS G0109 for 30 minutes of group DSMT services would be crosswalked to CPT code 97804 (Medical nutrition therapy; group (2 or more individuals(s)), each 30 minutes) for purposes of assigning work RVUs.

- To modify the PE inputs for DSMT services to reflect the current equipment and supplies for the KDE HCPCS G-codes implemented in the CY 2010 PFS final rule with comment period (74 FR 61901) (that is, HCPCS codes G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour) and G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour)), based on the similarity in the equipment and supplies necessary for DSMT and KDE services. We made adjustments to some of the equipment times for the 30 minute DSMT individual and group services as compared to the one hour individual and group KDE services.

- To include a diabetes educator curriculum and data tracking software in the PE inputs for DSMT services, while noting that we did not include the DSMT program accreditation costs because it is our general practice not to include these costs in the PE inputs.

- To utilize the same approach for clinical labor as we adopted for MNT services when we provided physician work RVUs for those services in CY 2007 (71 FR 69645), rather than changing the current labor type for DSMT services. Specifically, we removed all of the clinical labor from the group DSMT code and most of the clinical labor from the individual DSMT code, given that we proposed work RVUs for both DSMT HCPCS codes for CY 2011.

In the CY 2011 PFS proposed rule (75 FR 40100), we stated our belief that these proposals would value DSMT services more consistently with other similar services that are paid under the PFS. As a result of our proposed CY 2011 changes, the proposed work RVUs for HCPCS codes G0108 and G0109 were 0.90 and 0.25, respectively. As described above, we also proposed to modify the direct PE inputs for these codes for CY 2011.

Comment: Numerous commenters specifically supported the establishment of work RVUs for the DSMT services based on the work RVUs of the similar MNT services, CPT codes 97803 for 15 minutes of individual MNT services and 97804 for 30 minutes of group MNT services. Some commenters explained that addition of work RVUs would lead to higher payment rates for DSMT services, resulting in a significant positive impact on diabetes education practices and increased patient access to care for DSMT services. Several commenters suggested that this change would appropriately recognize the active role many physicians contribute to ensuring that their patients have access to DSMT services and providing care coordination and communication with the multidisciplinary DSMT team members. One commenter concurred with the proposal to update the direct PE inputs for the DSMT HCPCS codes based on those assigned to the

HCPCS codes for KDE services.

Response: We appreciate the commenters' support for our proposal to establish work RVUs and to update the direct PE inputs for the DSMT services.

In conducting our review of the public comments on this issue for this final rule with comment period, we examined newly available PFS claims data for same day billings from one provider for a single Medicare beneficiary. In response to that analysis and in accordance with our PFS methodology which values services as delivered to the typical patient, we note that we have made minor adjustments to some of the direct PE inputs for supplies and equipment times for both HCPCS G-codes for DSMT services, G0108 and G0109, under our final CY 2011 policy. We made these refinements after a review of our PFS utilization data indicated that 2 units of HCPCS code G0108 (a total of 60 minutes) were typically billed together on the same day for the same patient, instead of the one unit of HCPCS code G0108 (30 minutes) which was used as the assumption for the typical session at the time of our CY 2011 proposal. As a result, we have assigned half of the amount of the direct inputs for supplies and equipment time in HCPCS code G0420 (60 minutes individual KDE services) to HCPCS code G0108 (30 minutes individual DSMT services). Regarding the direct PE inputs for HCPCS code G0109, we continue to believe that there is a similarity among the group and individual DSMT and KDE services and the education practices when these services are delivered, as reflected in their PFS utilization patterns. For this reason, we have made minor modifications to the PE inputs for HCPCS code G0109 (30 minutes of group DSMT services) to reflect half of each input for HCPCS code G0421 (60 minutes of group KDE services) that parallel the modifications we made for the individual DSMT HCPCS code described

previously. We further note that these refinements to the direct PE inputs for DSMT services are based on the final adjustments that were made to the direct PE inputs for HCPCS codes G0420 and G0421 for KDE services, discussed in section V. B.2.e. of this final rule with comment period, because our approach to establishing the direct PE inputs for the DMST HCPCS G-codes is based on the inputs for KDE services.

As a result, the modifications we made to the supplies and equipment inputs for the DSMT HCPCS G-codes, G0108 and G0109, equal half of the same supply and equipment times in the one hour HCPCS G-codes for KDE services, G0420 and G0421.

In addition, because the $200 price of the diabetes educator curriculum does not meet the $500 floor we established for inclusion in the equipment database, we have bundled the diabetes educator curriculum price with the $500 data tracking software one because the patient's curriculum information is typically recorded in the tracking software. The equipment descriptor for the data tracking software was modified to read: Diabetes education data tracking software, includes curriculum. Accordingly, we changed the price input from $500 to $700 and assigned the bundled equipment a total of 4 minutes. In this way, we are including the cost of the curriculum in the direct PE inputs for DSMT services as we proposed for CY 2011, while remaining consistent with the established $500 floor on inclusion of equipment in the PE database.

After consideration of the public comments we received, we are finalizing the proposed work RVUs and direct PE input for DSMT services, with modification to make the PE adjustments described previously. The final CY 2011 direct PE database that lists the direct PE inputs is available on the CMS Web site under the downloads for the CY 2011 PFS final rule with comment period at:

http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage. The final CY 2011 RVUs for HCPCS codes G0108 and G0109 are displayed in Addendum B to this final rule with comment period.

C. End-Stage Renal Disease Related Services for Home Dialysis (CPT codes 90963, 90964, 90965, and 90966)

1. End-Stage Renal Disease Home Dialysis Monthly Capitation Payment Services (CPT codes 90963, 90964, 90965, and 90966)

In the CY 2004 PFS final rule with comment period (68 FR 63216), we established new Level II HCPCS G-codes for end-stage renal disease (ESRD) monthly capitation payment (MCP) services. For center-based patients, payment for the G-codes varied based on the age of the beneficiary and the number of face-to-face visits furnished each month (for example, 1 visit, 2-3 visits and 4 or more visits). Under the MCP methodology, the lowest payment applied when a physician provided one visit per month; a higher payment was provided for two to three visits per month. To receive the highest payment, a physician would have to provide at least four ESRD-related visits per month. However, payment for home dialysis MCP services only varied by the age of beneficiary. Although we did not initially specify a frequency of required visits for home dialysis MCP services, we stated that we "expect physicians to provide clinically appropriate care to manage the home dialysis patient" (68 FR 63219).

Effective January 1, 2009, the CPT Editorial Panel created new CPT codes to replace the G-codes for monthly ESRD-related services, and we accepted the new codes for use under the PFS in CY 2009. The CPT codes for monthly ESRD-related services for home dialysis patients include the following, as displayed in Table 32 of the CY 2011

PFS proposed rule (75 FR 40101) and reprinted as Table 48 below: 90963, 90964, 90965, and 90966. In addition, the clinical vignettes used for the valuation of CPT codes 90963, 90964, 90965, and 90966 include scheduled (and unscheduled) examinations of the ESRD patient.

Given that we pay for a physician (or nonphysician practitioner (NPP)) to evaluate the ESRD patient over the course of an entire month under the MCP, we believe that it is clinically appropriate for the physician (or NPP) to have at least one in-person, face-to-face encounter with the patient per month. As such, for CY 2011 we proposed to require the MCP physician (or NPP) to furnish at least one in-person patient visit per month for home dialysis MCP services (as described by CPT codes 90963 through 90966). The proposed requirement would be effective for home dialysis MCP services beginning January 1, 2011. As stated in the CY 2011 PFS proposed rule (75 FR 40100), we believe this requirement reflects appropriate, high quality medical care for ESRD patients being dialyzed at home and generally would be consistent with the current standards of medical practice.

Comment: Many commenters stated that a monthly visit embodies the standard of care for home dialysis patients. However, many of the same commenters also stated that it may not always be feasible to furnish a face-to-face visit every month for home dialysis patients due to extenuating circumstances. A number of commenters explained that, in contrast to patients who dialyze in a dialysis center, home dialysis patients would need to travel to the doctor's office (or the physician would need to visit the patient's home) which would be an undue burden on both the physician and the patient. To that end, several commenters urged CMS to provide flexibility in cases where a patient does

not show up for their scheduled appointment and for those that cannot travel due to significant geographic distance between the patient and the nephrologist. For example, some specialty societies stated that pediatric home dialysis patients may experience exceptional circumstances due to the scarcity of pediatric nephrologists and remote geographic locations, making the monthly face-to-face visit requirement harder to fulfill. In these circumstances, one commenter requested that CMS consider allowing the MCP physician to furnish at least 1 visit every 3 months and allowing the other monthly visits to be furnished as a telehealth service. Additionally, several commenters explained that the monthly management of a home dialysis patient involves many tasks (in addition to face-to-face visits) including: reviewing lab tests, treatment data and the dialysis prescription; monitoring the patient's vascular access; and overseeing quality improvement activities (as well as incurring the practice expense associated with managing the patient's care). The commenters stated that the MCP physician should not be "penalized" if the patient chooses not to attend the monthly visit. Moreover, many of the commenters who agreed that monthly visits are optimal care did not support a monthly visit requirement for the home dialysis MCP service. The commenters stated that the frequency of face-to-face visits should remain at the discretion of the nephrologist and patient. Several of the commenters who did not support a policy change also stated that requiring a monthly visit could create disincentives for providing beneficiaries with home dialysis therapy in circumstances where it may be difficult for the MCP physician to furnish a visit every month. The commenters explained that nephrologists may not want to encourage home dialysis therapy if they will not get paid as a result of a patient "opting out" of a scheduled visit.

Response: We continue to believe that furnishing monthly face-to-face visits is an important component of high quality medical care for ESRD patients being dialyzed at home and generally would be consistent with the current standards of medical practice. However, we also acknowledge that extenuating circumstances may arise that make it difficult for the MCP physician (or NPP) to furnish a visit to a home dialysis patient every month. Therefore, we will allow Medicare contractors the discretion to waive the requirement for a monthly face-to- face visit for the home dialysis MCP service on a case-by-case basis, for example, when the MCP physician's (or NPP's) notes indicate that the MCP physician (or NPP) actively and adequately managed the care of the home dialysis patient throughout the month. Additionally, as we explained in the CY 2004 PFS final rule with comment period (68 FR 63219 through 63220), we also believe that the use of other practitioners working with the MCP physician (or NPP) to furnish the required monthly visit for the home dialysis MCP service could help alleviate scheduling issues and problems related to geographic distance.

With regard to the comment on furnishing the proposed required visit for the home dialysis MCP as a telehealth service, we note that any interested parties may submit requests to add services to the list of Medicare telehealth services. Requests submitted before the end of CY 2010 will be considered for the CY 2012 PFS proposed rule. Requestors should be advised that each request to add a service to the list of Medicare telehealth services must include any supporting documentation the requestor wishes us to consider as we review the request. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to directly mail these

requests, we refer readers to section IV.B. of this final rule with comment period and the CMS web site at: http://www.cms.hhs.gov/telehealth.

Comment: Several commenters stated that the conditions for coverage for dialysis facilities require a monthly interaction between a clinician representing the facility and the home dialysis patient. The commenters believe that the conditions for coverage for dialysis facilities permit flexibility in the monthly visit requirement if the patient chooses to opt out of the monthly visit and requested that CMS align the proposed visit requirement for the home dialysis MCP service with the "flexibility" permitted under the conditions for coverage for dialysis facilities.

Response: With regard to conditions for coverage for dialysis facilities, §494.90(b)(4) of the regulations specifies that the dialysis facility must ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant providing ESRD care at least monthly. Section 494.100 requires "a dialysis facility that is certified to provide service to home patients to ensure that home dialysis services are at least equivalent to those provided to in-facility patients and meet all applicable conditions of this part." In addition, the interpretive guidance for part 494 entitled "Conditions for Coverage for ESRD Facilities" specifies that a monthly visit is required for each home patient by a physician, an advanced practice registered nurse, or a physician assistant. The visit may be conducted in the dialysis facility, at the physician's office, or in the patient's home. The guidelines state that "any patient may choose not to be seen by a physician every month" but also specify that if there is a pattern of a patient consistently missing physician and or practitioner visits, the lack of medical oversight should be addressed with the patient in the plan of care.

The requirement for at least one monthly visit with a clinician associated with the dialysis facility is a condition for coverage for the dialysis facility for purposes of participating in the Medicare program and not a direct factor in determining the payment amount for the dialysis facility. In other words, the clinician visit is not a component of the facility's composite rate. However, as mentioned in the background section, the clinical vignettes used for the valuation of the home dialysis MCP service under the PFS include scheduled (and unscheduled) examinations of the ESRD patient. Given that physician or NPP visits are a factor in determining the PFS payment amount for the home MCP service that is furnished to the typical Medicare beneficiary, we do not believe that the monthly visit requirement for the home dialysis MCP service is analogous to the visit requirement under the conditions for coverage for dialysis facilities that has no implications for setting payment rates under the PFS. Therefore, we do not agree that the visit requirement for the home dialysis MCP service necessarily should be "aligned" with the conditions for coverage for dialysis facilities.

Comment: One commenter suggested that CMS consider structuring the home dialysis MCP similar to the center-based MCP. Under this approach, the commenter suggested that a higher payment amount could be made for home dialysis MCP services with at least one in person, face-to-face visit per month.

Response: We will consider the commenter's suggestion as we continue to develop and refine Medicare payment policy for physicians and practitioners managing patients on dialysis. In the event we decide to make changes in the payment amount(s) for the home dialysis MCP services, we would do so in a future proposed rule where the public would have the opportunity to provide comments as afforded by the rulemaking

process.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, with modification. We will require the MCP physician (or NPP) to furnish at least one in-person patient visit per month for home dialysis MCP services (as described by CPT codes 90963 through 90966). However, Medicare contractors will have the discretion to waive the monthly visit requirement for the home dialysis MCP service on a case-by-case basis.

2. Daily and Monthly ESRD-Related Services (CPT Codes 90951 through 90970)

In CY 2008, the AMA RUC submitted recommendations for valuing the new CY 2009 CPT codes displayed in Table 48 that replaced the MCP HCPCS G-codes for monthly ESRD-related services. We accepted these codes for use under the PFS.

TABLE 48: MCP Codes Recognized Under the PFS

MCP Code	Long Descriptor
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month
90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month
90953	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month
90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month
90955	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month

MCP Code	Long Descriptor
90956	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month
90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month
90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month
90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face physician visits per month
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face physician visits per month
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older

There are four additional CPT codes for ESRD-related services that are reported on a per-day basis. These daily CPT codes are: 90967 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age); 90968 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age); 90969

(End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age); and 90970 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older).

For the MCP codes displayed in Table 32 of the CY 2011 PFS proposed rule, the AMA RUC initially recommended 36 minutes of clinical labor time for the pre-service period. They also recommended an additional 6 minutes in the post-period for CPT codes 90960, 90961, 90962, and 90966. For the four codes describing daily services (CPT codes 90967 through 90970), the AMA RUC recommended including 1.2 minutes of clinical labor per day, which is the prorated amount of pre-service clinical labor included in the monthly codes. The AMA RUC also recommended that CPT codes 90952 and 90953 be contractor-priced.

In the CY 2009 PFS final rule with comment period (73 FR 69898), we asked the AMA RUC to reconsider their recommended PE inputs in the interest of making certain that they accurately reflected the typical direct PE resources required for these services. In addition, we asked the AMA RUC to review the physician times for CPT codes 90960 and 90961 that are used in the calculation of the PE RVUs. We accepted the work values for the new CPT codes for ESRD-related services that were recommended by the AMA RUC.

Since CY 2009, we have continued to calculate the PE RVUs for the entire series of MCP codes displayed in Table 32 of the CY 2011 PFS proposed rule (75 FR 40101) by using the direct PE inputs from the predecessor HCPCS G-codes, except for CPT codes 90952 and 90953 which are contractor-priced. We have also continued to use the

physician time associated with the predecessor HCPCS G-codes for CPT codes 90960 and 90961 for purposes of calculating the PE RVUs.

In CY 2009, the AMA RUC submitted new recommendations for CPT codes 90951 and 90954 through 90970. For each of the MCP codes (CPT code 90951 and CPT codes 90954 through 90966), the AMA RUC recommended an increased pre-service clinical staff time of 60 minutes. For each of the daily dialysis service codes (CPT codes 90967 through 90970), the AMA RUC recommended an increased clinical labor time of two minutes, which is the prorated amount of clinical labor included in the monthly codes. The AMA RUC also recommended an additional 38 minutes of physician time for CPT codes 90960 and 90961. This resulted in a total physician time of 128 minutes and 113 minutes, respectively, for these codes. The AMA RUC continued to recommend that CPT codes 90952 and 90953 be contractor-priced.

For CY 2011, we proposed to accept these AMA RUC recommendations as more accurate reflections of the typical direct PE resources required for these services. Therefore, we proposed to develop the PE RVUs for CPT code 90951 and CPT codes 90954 through 90970 using the direct PE inputs as recommended by the AMA RUC and reflected in the proposed CY 2011 PE database, which is available on the CMS Web site under the supporting data files for the CY 2011 PFS proposed rule at: http://www.cms.gov/PhysicianFeeSched/. We also proposed to use the AMA RUC-recommended physician times for CPT codes 90960 and 90961. Consistent with the AMA RUC's recommendations, we proposed to continue to contractor-price CPT codes 90952 and 90953.

We did not receive public comment on our proposal to accept these AMA RUC

recommendations as more accurate reflections of the typical direct PE resources required for these services. Therefore, we are finalizing our CY 2011 proposal to develop the PE RVUs for CPT code 90951 and CPT codes 90954 through 90970 using the direct PE inputs as recommended by the AMA RUC and reflected in the CY 2011 direct PE database, which is available on the CMS Web site under the supporting data files for the CY 2011 PFS final rule with comment period at: http://www.cms.gov/PhysicianFeeSched/. We will also use the AMA RUC-recommended physician times for CPT codes 90960 and 90961. Consistent with the AMA RUC's recommendations, we will continue to contractor-price CPT codes 90952 and 90953.

D. Portable X-Ray Set-Up (HCPCS code Q0092)

When a portable x-ray is furnished to a single patient, as many as four component HCPCS codes may be billed and paid for the service, including the portable x-ray transportation (HCPCS code R0070 (Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen)); the portable x-ray set-up (HCPCS code Q0092 (Set-up of portable x-ray equipment)); and the professional and technical components of the x-ray service itself (CPT 70000 series). Currently, the direct PE database contains x-ray equipment in both the radiology codes in the 70000 series of CPT and HCPCS code Q0092, the code for the set-up of a portable x-ray. In the technical component of the x-ray service is the direct PE input of a radiology room which contains x-ray equipment for the various radiology codes in the 70000 series of CPT. In addition, portable x-ray equipment is included as a direct PE input for HCPCS code Q0092. Thus, x-ray equipment currently is recognized within the

direct PE values for two of the HCPCS codes that would be reported for the portable x-ray service, resulting in an overvaluation of the comprehensive portable x-ray service.

Therefore, for CY 2011 we proposed to remove portable x-ray equipment as a direct PE input for HCPCS code Q0092, in order to pay more appropriately for the x-ray equipment used to furnish a portable x-ray service. We believe the resulting payment for the comprehensive portable x-ray service would more appropriately reflect the resources used to furnish portable x-ray services by providing payment for the x-ray equipment solely through payment for the technical component of the x-ray service that is furnished.

Comment: Several commenters opposed the removal of portable x-ray equipment as a direct PE input for HCPCS code Q0092. The commenters believe the elimination of the equipment from HCPCS code Q0092 is inconsistent with longstanding CMS payment policy recognizing the unique and additional costs incurred by portable x-ray suppliers in furnishing services that involve special equipment requiring extra assembly and disassembly time. In addition, the commenters believe that the proposed equipment elimination conflicts with the statutory mandate of section 1848(c) of the Act that CMS calculate the PFS RVUs based on the actual resources used in furnishing a service because equipment is a legitimate direct PE component of the set-up component service (HCPCS code Q0092).

Response: We agree that x-ray equipment is used to furnish a portable x-ray service and the equipment set-up is reported with HCPCS code Q0092. However, because the portable x-ray set-up service would always be reported along with the technical component of the x-ray service (CPT 70000 series) that already includes x-ray equipment as a direct PE input, to include x-ray equipment again in the PE of the set-up

code would clearly be duplicative. Only one item of equipment, that is, a single x-ray machine, is used in furnishing the portable x-ray service. We are, therefore, eliminating the portable x-ray equipment from HCPCS code Q0092 and, instead, recognizing the cost of such equipment in the direct PE for the technical component of the x-ray service.

Comment: According to several commenters, because CMS has not undertaken a review of all combinations of services paid under the PFS that together might comprise a "comprehensive service" to identify potentially duplicative direct PE inputs when the services are furnished together, CMS should refrain from applying the proposed policy to suppliers of portable x-ray services.

Response: While it would require an extensive analysis to review all combinations of PFS services that may be furnished together and identify potentially duplicative PE inputs, the PFS has several longstanding policies that were adopted to provide appropriate payment when certain services are furnished together. For example, existing multiple procedure payment reduction policies reduce payment for the second and subsequent surgical procedures or technical components of imaging services when furnished to the same patient by the same physician on the same day, based partly on the presence of efficiencies in the PE under such circumstances. Furthermore, as discussed in section II.C.4. of this final rule with comment period, we are adopting a new multiple procedure payment reduction policy for CY 2011 for therapy services because of the duplication in the PE when therapy services are furnished together. Finally, we note that for those CPT codes that are designated as add-on codes to primary services, we ensure that the direct PE inputs do not duplicate inputs in the primary services. Given our ongoing efforts to more appropriately value services furnished together, we believe that

HCPCS code Q0092 essentially functions as an "add-on" code to the primary service that it generally accompanies, which is the technical component of an x-ray service. Therefore, we believe it is fully consistent with our ongoing efforts to recognize efficiencies through payment policy when multiple services are furnished together to remove the duplicative x-ray equipment from the direct PE inputs for HCPCS code Q0092.

Comment: A few commenters believe that elimination of x-ray equipment in HCPCS code Q0092 would have a negative impact on the financial status of portable x-ray suppliers who are typically small business owners. According to the commenters, CMS should heed the statutory mandates of the Regulatory Flexibility Act (RFA) which require mitigation of such adverse effects.

Response: We note that the RFA requires only that we analyze regulatory options for small businesses that include a justification for the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities. The CY 2011 PFS proposed rule included a regulatory impact analysis (75 FR 40230 through 40245), as does section XI.A. of this final rule with comment period. As a specialty, the aggregate impact on portable x-ray suppliers from the PFS changes proposed for CY 2011 was an increase of 8 percent in the proposed rule (75 FR 40232), and it is an increase of 6 percent for CY 2011 as displayed in Table 101 of this final rule with comment period. Therefore, the combined effect of all final PFS policies for CY 2011 will not adversely impact portable x-ray suppliers.

After consideration of the public comments we received, we are finalizing our

CY 2011 proposal to remove portable x-ray equipment as a direct PE input for HCPCS code Q0092.

E. Pulmonary Rehabilitation Services (HCPCS Code G0424)

In the CY 2010 PFS proposed rule (74 FR 33614), we proposed to create new HCPCS G-code G0424 (Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per session, per day) to describe the services of a pulmonary rehabilitation (PR) program as specified in section 144(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Using CPT code 93797 (Cardiac rehab without telemetry) as a reference code, we proposed to assign 0.18 work RVUs and 0.01 malpractice RVUs to G0424. To establish PE RVUs, we reviewed the PE inputs of similar services, particularly those of the respiratory therapy HCPCS codes G0237 (Therapeutic procedures to increase strength or endurance or respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)) and G0238 (Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)), as well as the cardiac rehabilitation codes, CPT codes 93797 and 93798 (Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)). In the CY 2010 PFS final rule with comment period (74 FR 61886), we finalized our proposal with modifications to the code descriptor and PE inputs, as recommended by some commenters.

Based on commenters' recommendations from the CY 2010 PFS final rule with comment period and further information furnished by stakeholders, for CY 2011 we proposed to increase the work RVUs for HCPCS code G0424 to 0.28 for CY 2011 to be

comparable to the work RVUs for cardiac rehabilitation with monitoring (CPT code 93798) in view of the monitoring required for HCPCS code G0424.

We also proposed to increase the clinical labor time for the respiratory therapist from 15 minutes to 30 minutes and to crosswalk the PE equipment inputs for HCPCS code G0424 to those for respiratory treatment services (HCPCS code G0238), which include a 1-channel ECG and a pulse oximeter. We retained the treadmill currently assigned to HCPCS code G0424 and adjusted the equipment time to 45 minutes. While several public commenters recommended this equipment, these commenters also requested a full 60 minutes of respiratory therapist time be included in the PE for HCPCS code G0424, comparable to the 15 minutes of respiratory therapist time included in the one-on-one codes for 15 minutes of respiratory treatment services (HCPCS codes G0237 and G0238). However, because pulmonary rehabilitation services reported under HCPCS code G0424 can be furnished either individually or in groups, we believe that 30 minutes of respiratory therapist time would be more appropriate for valuing the typical pulmonary rehabilitation service.

Comment: Many commenters applauded CMS for its proposal to increase the work RVUs for HCPCS code G0424 to 0.28. While the commenters supported the increase in work RVUs in the short term, they believe that an accurate, independent assessment of the work value associated with physician's office-based pulmonary rehabilitation is the only reasonable way to determine actual physician work. The commenters stated that continuing to rely on work values related to cardiac rehabilitation is flawed, noting that the clinical characteristics of the cardiac rehabilitation patient are different from the pulmonary rehabilitation patient. Due to the expected frequency and

duration of acute events, the commenters explained that the pulmonary rehabilitation patient would require greater physician involvement.

Response: Until we gain more data and experience on the use of this code to report pulmonary rehabilitation services furnished to Medicare beneficiaries under the new comprehensive benefit, we believe using the work RVUs for cardiac rehabilitation with monitoring (CPT code 93798) as a crosswalk is appropriate for this service. We further note that the crosswalk methodology is commonly used by the AMA RUC in recommending work RVUs to us for new or revised codes.

Comment: A number of commenters generally supported the increase in the clinical labor time for a respiratory therapist from 15 minutes to 30 minutes. While the commenters generally agreed with CMS' reasoning for not increasing the respiratory therapist time to 60 minutes, the commenters noted that in the physician's office setting, pulmonary therapy items and services are routinely provided one-on-one, face-to-face, requiring 60 minutes of individualized therapy services by a respiratory therapist. Some commenters believe that the proposal to increase the respiratory therapist time to only 30 minutes would place physicians at an economic disadvantage in the provision of pulmonary rehabilitation items and services when furnished in an office setting due to the limited amount of office space available to treat more than one patient in the same time period. One commenter suggested that the respiratory therapist time be increased to 45 minutes or that CMS consider the development of a HCPCS code for the provision of pulmonary rehabilitation items and services to patients on a one-on-one, face-to-face per 15 minute basis to ensure that physicians can provide this service in the office setting. Another commenter believed that HCPCS code G0424 is undervalued at 0.46 PE RVUs

in comparison to the PE RVUs for other PFS services that are conceptually similar but do not include a treadmill, arm ergometer, monitoring devices, or emergency carts.

Response: Payment for services under the PFS is resource-based, and individual services are valued based upon the resources needed to provide the typical service. As we noted in the CY 2011 PFS proposed rule (75 FR 40103), pulmonary rehabilitation services reported under HCPCS code G0424 can be furnished either individually or in groups and we continue to believe that 30 minutes of respiratory therapist time is appropriate for valuing the typical pulmonary rehabilitation service. We believe that pulmonary rehabilitation in the physician's office is most commonly furnished to a group of patients, rather than one-on-one for 60 minutes of respiratory therapist time. Regarding the commenter who was concerned that the PE for HCPCS code G0424 was undervalued in comparison to similar services that do not use the equipment necessary for HCPCS code G0424, we note that we have utilized the standard PFS PE methodology to develop the PE RVUs for HCPCS code G0424 based on the direct PE inputs we consider to be appropriate.

Comment: One commenter suggested that the valuing of HCPCS code G0424 is flawed and does not fully account for the inclusion of all professionals who are involved in the pulmonary rehabilitation program, specifically physical therapists. In addition, the commenter referenced the CY 2010 PFS final rule with comment (74 FR 61884) where CMS stated and recognized that physical therapists provide pulmonary rehabilitation services. The commenter believes that by only basing the value on services performed by respiratory therapists, CMS has miscalculated the payment for the comprehensive, multidisciplinary pulmonary rehabilitation program and recommended that CMS create a

separate HCPCS code with a higher value that could be used to delineate those patients who require individualized physical therapy within the pulmonary rehabilitation program.

Response: Like all services paid under the PFS, pulmonary rehabilitation is valued based on the staff type who would typically perform this service, a respiratory therapist. Because the items and services furnished by a pulmonary rehabilitation program are individualized, we expect that evaluations and individualized treatments would be conducted by one or more members of the multidisciplinary team of the pulmonary rehabilitation program with the appropriate expertise. Therefore, individualized treatment by a physical therapist would be furnished when required by the patient as part of the pulmonary rehabilitation plan of care. However, we do not believe individualized treatment would be typical and, therefore, we do not believe the creation of a separate HCPCS code with a higher value is necessary to recognize those cases that require individualized physical therapy as part of a pulmonary rehabilitation program.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to increase the work RVUs for HCPCS code G0424 to 0.28 for CY 2011 to be comparable to the work RVUs for cardiac rehabilitation with monitoring (CPT code 93798). In addition, we are finalizing our CY 2011 proposal to increase the clinical labor time for the respiratory therapist from 15 minutes to 30 minutes and to crosswalk the PE equipment inputs for HCPCS code G0424 to those for respiratory treatment services (HCPCS code G0238), which include a 1-channel ECG and a pulse oximeter.

F. Application of Tissue Cultured Skin Substitutes to Lower Extremities (HCPCS Codes G0440 and G0441)

There are currently two biological products, Apligraf and Dermagraft, which are FDA-approved for the treatment of diabetic foot ulcers. While commonly used by podiatrists for this purpose, these products are also used by other specialists in the treatment of other clinical conditions, such as burns.

Many Medicare contractors have established local coverage determinations specifying the circumstances under which these services are covered. In the case of diabetic foot ulcers, clinical studies of Apligraf application were based on up to 5 treatments over a 12-week period. In contrast, Dermagraft was applied weekly, up to 8 treatments over a 12-week period.

The skin substitute CPT codes were reviewed and new codes were last created by the CPT Editorial Panel for CY 2006. There are currently 2 skin repair CPT codes that describe Apligraf application, one primary code, CPT code 15340 (Tissue cultured allogeneic skin substitute; first 25 sq cm or less) and one add-on code, CPT code 15341 (Tissue cultured allogeneic skin substitute; each additional 25 sq cm, or part thereof (List separately in addition to code for primary procedure)) and 4 codes that describe Dermagraft application, two initial codes based on body area, CPT codes 15360 (Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children) and 15365 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children) and two add-on codes, CPT codes 15361 (Tissue cultured allogeneic dermal substitute, trunk,

arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)) and 15366 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)).

In the CY 2011 PFS proposed rule (75 FR 40103), we noted that several stakeholders had expressed concern about the appropriateness and equity of the coding and payment for these services, given their similar uses and the office resources required when the products are applied repeatedly over a number of weeks for treatment of lower extremity ulcers. They were concerned that current coding, with the associated payment policies and relative values, does not provide for appropriate payment for the services based on how they are furnished. In addition, some stakeholders believe that the current coding and payment provides a financial incentive for the selection of one tissue cultured product over another, rather than facilitating clinical decision-making based solely on the most clinically appropriate product for the patient's case. For example, the Dermagraft and Apligraf application codes have 90-day and 10-day global periods, respectively, and their current values include several follow-up office visits. When patients are treated periodically with repeated applications of the products over several weeks, the patients may be seen in follow-up by the physician. However, those encounters would not be evaluation and management visits but, instead, would be procedural encounters that would typically be valued differently under the PFS than the follow-up office visits currently included in the values for the Dermagraft and Apligraf application codes.

Furthermore, while different stakeholders indicated that debridement and site preparation are variably performed when these products are applied, the CPT codes for Dermagraft application allow separate reporting of these preparation services when they are performed, while the Apligraf application codes bundle these services. Since CY 2006, the PFS has accepted the AMA RUC work and PE recommendations for the Dermagraft and Apligraf application codes and has paid accordingly.

With respect to Medicare payment policy, some Medicare contractors allow the use of modifier -58 (Staged or related procedure or service by the same physician during the postoperative period) to be reported with the skin substitute application codes and provide full payment for the service each time it is performed, even if the subsequent application(s) is within the global period of the service. Other contractors do not allow the use of modifier -58 and, therefore, provide a single payment for a series of applications over 90 days or 10 days, as applicable to the particular code reported for the product's initial application.

Because of the current inconsistencies in valuing similar skin substitute application services and the common clinical scenarios for their use for Medicare beneficiaries, in the CY 2011 PFS proposed rule (75 FR 40103), we stated that we believe it would be appropriate to temporarily create Level II HCPCS G-codes to report application of tissue cultured skin substitutes applied to the lower extremities in order to provide appropriate and consistent payment for the services as they are commonly furnished. Therefore, we proposed to create two new HCPCS G-codes for CY 2011, GXXX1 (Application of tissue cultured allogeneic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; first 25

sq cm or less) and GXXX2 (Application of tissue cultured allogeneic skin or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; each additional 25 sq cm), that would be recognized for payment under the PFS for the application of Apligraf or Dermagraft to the lower limb. These codes would not allow separate reporting of CPT codes for site preparation or debridement. We emphasized that we would expect that the use of these HCPCS G-codes for payment under Medicare would be temporary, while stakeholders work through the usual channels to establish appropriate coding for these services that reflects the current common clinical scenarios in which the skin substitutes are applied. Furthermore, we stated that we would expect to receive recommendations from the AMA RUC for appropriate work values and direct practice expense inputs for the applicable codes, according to the usual process for new or revised codes.

Under the PFS, as a temporary measure, the HCPCS G-codes would be assigned a 0-day global period so payment would be made each a time a covered service was furnished. We proposed to base payment on the physician work relative values and the direct PE inputs for the existing CPT codes for Apligraf application, with adjustments for the global period differences because the HCPCS G-codes and the Apligraf application CPT codes. These CPT codes resemble the new HCPCS G-codes in terms of wound size description and the inclusion of site preparation and debridement in their current values so we believe they appropriately represent the physician work involved in the proposed HPCPCS G-codes. However, we proposed to adjust the work RVUs of the Apligraf application codes to derive the HCPCS G-code proposed CY 2011 work values by extracting the values for any office visits and discharge day management services

because the HCPCS G-codes have a 0-day global period. In addition, we proposed to adjust the direct PE inputs of the Apligraf application codes to develop the proposed CY 2011 direct PE inputs of the HPCPS G-codes that have a 0-day global period.

Our crosswalks and adjustments resulted in proposed CY 2011 work RVUs of 2.22 for HPCPCS code GXXX1 and 0.50 for HCPCPS GXXX2. The proposed direct PE inputs for HCPCS codes GXXX1 and GXXX2 are included in the direct PE database for the CY 2011 proposed rule that is posted on the CMS Web site at: http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp.

We noted that many Medicare contractors currently have local coverage policies that specify the circumstances under which Medicare covers the application of skin substitutes. The local coverage policies may include diagnostic or prior treatment requirements, as well as frequency limitations on the number and periodicity of treatments. We stated our expectation that these policies would be updated in the context of the temporary new HCPCS G-codes that we proposed for use in CY 2011 to report the application of tissue cultured allogeneic skin or dermal substitutes. We proposed to establish the HCPCS G-codes for temporary use in CY 2011 in order to improve the consistency and resource-based nature of PFS payments for skin substitute application services that require similar resources. However, we noted our continued interest in ensuring that skin substitutes are properly utilized for Medicare beneficiaries who will benefit from that treatment. We indicated that we would continue to monitor the utilization of these services and plan to identify any concerning trends in utilization that contractors may want to examine further through medical review or other approaches.

Comment: While acknowledging concerns with the existing CPT codes for the

application of skin substitutes, several commenters opposed the proposed HCPCS G-codes because the commenters believe that CMS should wait for new codes to be created by the CPT Editorial Panel and the associated recommendations to be developed by the AMA RUC for physician work and direct PE inputs for any new codes. The commenters argued that CMS' proposal to create new temporary codes would circumvent or otherwise influence the well-established processes already underway to address issues identified by the stakeholders. Several commenters pointed out that CMS' proposal would not treat the application of skin substitutes that are not tissue cultured similarly to the procedures for the application of Apligraf and Dermagraft. Because these commenters argued that inconsistencies in coding and payment for the other products would continue, several commenters recommended that CMS await a more comprehensive solution from the CPT Editorial Panel.

On the other hand, a number of commenters supported the proposal to establish the two new HCPCS G-codes, and a few of these commenters recommended no changes to the proposed HCPCS code descriptors. However, one commenter who generally supported the proposal recommended that CMS expand the proposed HCPCS code descriptors to incorporate the application of a broader range of skin substitutes that were not tissue cultured, specifically to include the application of biologically active skin substitutes.

Another commenter requested that CMS clarify the meaning of "dermal substitute." This commenter also requested that CMS delete the words "for use on lower limb" and allow the new codes to be used for application of tissue cultured skin or dermal substitutes on locations other than the lower limb. Consistent with this perspective, the

commenter further recommended that CMS not recognize the existing CPT codes for application of Apligraf and Dermagraft on other areas of the body. The commenter argued that, as proposed, the HCPCS G-codes would lead to confusion and the potential for fraudulent billing because both a HCPCS G-code and a CPT code could describe the application of the same product to the lower extremities. The commenter believes that CMS should only recognize the proposed G-codes under the PFS for the application of tissue cultured skin or dermal substitutes to any body site, to allow for consistency in reporting and payment of these services.

Several commenters requested that CMS provide guidance on the proper use of the current CPT codes and new HCPCS G-codes for reporting the application of skin substitutes. Other commenters were concerned that the temporary HCPCS G-codes could create confusion, disrupt physician's office billing policies, and otherwise burden coding staff and advised CMS to not finalize the proposal.

Response: We appreciate the perspectives of stakeholders and we share the commenters' desire for appropriate and consistent payment that is resource-based for the application of skin substitutes as these services are commonly furnished for appropriate clinical indications. We appreciate and value the work of the CPT Editorial Panel in evaluating the complexities and nuances in this area and look forward to reviewing any new codes created for CY 2012 or later years and the AMA RUC recommendations for the physician work and direct PE inputs for those new codes. We note that there are no new codes for CY 2011 that describe the application of skin substitutes and, therefore, new codes would not be available before CY 2012 at the earliest.

In proposing to create two temporary HCPCS G-codes for CY 2011, we sought a

fair and balanced temporary alternative to provide appropriate and equitable payment for the application of tissue cultured skin or dermal substitutes to the lower extremities. While we understand from stakeholders that the work of the CPT Editorial Panel is ongoing in this area, our proposal was specifically to establish temporary HCPCS G-codes that would allow for more appropriate reporting and payment under certain scenarios in the short term while a more comprehensive solution is being developed and refined by expert advisors. Because our proposal was so limited in scope and temporary, clearly it was not our intention to circumvent or unduly influence the CPT Editorial Panel or the AMA RUC as these groups proceed in their comprehensive work to establish new codes and values for the application of skin substitutes. We would also not expect that the characteristics of the temporary HCPCS G-codes, in terms of terminology in the code descriptors, global periods, work values, or direct PE inputs, should shape or otherwise affect the ongoing work of stakeholders who are developing a complete approach to coding for the application of skin substitutes. We acknowledge that new CPT codes and their AMA RUC-recommended values and direct PE inputs arising from these processes may appropriately differ in one or multiple characteristics from the temporary HCPCS G-codes.

With regard to the commenters who were concerned about the limited scope of our proposal and suggested that we not proceed or that we broaden the scope of the proposed code descriptors to address inequities and inconsistencies that the commenters believe would persist under our proposal, we believe that the limited proposal continues to be the most appropriate temporary approach for CY 2011. First, it was not our intention to comprehensively address the issue of coding revisions for the application of

skin substitutes because we are aware of the ongoing work of the CPT Editorial Panel in this area and would not want to undermine its deliberative process. Moreover, based on the public comments we received, we have reason to believe that a revised coding structure for the application of skin substitutes will be available soon. Second, the HCPCS G-codes that we proposed had a 0-day global period based on the FDA-approved indications and regimens for the application of the tissue cultured products to which the codes would apply, and we are not certain to what extent a 0-day global period would be appropriate for the application of other skin substitutes. Third, while several commenters provided suggestions regarding alternative language that could be used in the HCPCS G-code descriptors, it is unclear which skin substitutes products would be incorporated under the revised terms. Some of the suggested alternatives would use phrases such as "biologically active" that, as far as we know, are not fully defined in the medical community and are not currently used in the CPT code descriptors that describe the application of skin substitutes. Because of our uncertainty in this regard, we would be hesitant to make such significant revisions to the HCPCS G-code descriptors without the opportunity for public notice and comment, which would allow stakeholders the opportunity to provide input about revised code descriptors and the appropriateness of the values for the HCPCS G-codes. In contrast, our proposal relied upon the use of terms in the HCPCS G-code descriptors that are already included in the descriptors for established CPT codes and, therefore, we do not believe we would be setting a precedent that would affect the current work of the CPT Editorial Panel on this issue. Finally, we do not see a need to further clarify terms, such as "dermal substitute," in the HCPCS G-code descriptors because these are currently used in the CPT code descriptors and the same

definitions would apply to the G-codes.

Furthermore, we believe it would continue to be appropriate to recognize the existing CPT codes for the application of tissue cultured skin or dermal substitutes to areas of the body other than the lower extremities. We established the 0-day global period, the physician work values, and the direct PE inputs for the proposed HCPCS G-codes based on the specific clinical scenarios where Apligraf or Dermagraft would be applied to treat lower extremity ulcers. We do not necessarily believe that the same global periods and values would be appropriate for the application of these products to other body areas under different clinical scenarios. The usual coding guidance that providers should report the most specific HCPCS code that describes the service furnished would apply in the case of the application of Apligraf or Dermagraft. If one of these products were applied to the lower extremities, we would expect the HCPCS G-codes to be reported, rather than the CPT codes, as the HCPCS G-codes are more specific to application in that body area.

Finally, because it is our common practice to create one or more new HCPCS G-codes for payment under the PFS each year, we believe that physicians' offices are experienced in integrating new codes into the reporting of services furnished and paid under the PFS. Not only are local coverage determinations commonly applicable to the application of skin substitutes, we also understand that there are a subset of physicians who regularly apply tissue cultured skin or dermal substitutes to lower extremities to treat ulcers. In this context, we believe that our national educational efforts, in addition to education by local contractors, will quickly disseminate information to the relevant practitioners about these new HCPCS G-codes and their appropriate use in CY 2011.

After consideration of the public comments we received, we are finalizing our proposal, with editorial modification, to create two new HCPCS G-codes for reporting the application of tissue cultured skin substitutes and dermal substitutes to the lower extremities in CY 2011. For internal consistency, we are changing the descriptors of HCPCS codes GXXX1 and GXXX2 from the proposed language to both refer to "skin substitute or dermal substitute." HCPCS code GXXX2 as proposed read "Application of tissue cultured allogeneic skin or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; each additional 25 sq cm." The final codes are HCPCS code G0440 (Application of tissue cultured allogeneic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; first 25 sq cm or less) and HCPCS code G0441 (Application of tissue cultured allogeneic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; each additional 25 sq cm) that will be recognized for payment under the PFS in CY 2011.

Comment: A number of commenters supported the assignment of a 0-day global period to the application of tissue cultured skin or dermal substitutes. Many expressed the view that assigning a 0-day global period to the codes would allow the products to be prescribed and administered based on their clinical value, without concern for payment differences between products. The commenters who did not support the 0-day global period were those who believe that the proposal would further payment inequities between products used similarly. For example, one commenter reasoned that, insofar as a patient is likely to require multiple administrations of a skin substitute product during a 90-day period, providers would have a significant incentive to use the products whose

application would be reported under the proposed codes rather than a product whose application procedure continues to have a 90-day global period.

Another commenter addressed the bundling of site preparation and debridement into the proposed HCPCS codes GXXX1 and GXXX2. The commenter argued that the proposed values for the new codes HCPCS G-codes would not be sufficient to account for this work. The commenter recommended that the proposed values should be adjusted upward or separate payment should be allowed for site preparation and/or debridement.

In reviewing CMS' proposed methodology for setting the physician work values for the HCPCS G-codes, one commenter contended that CMS should finalize a total of 2.86 works RVUs for GXXX1 instead of the proposed 2.22 work RVUs. The commenter claimed that the work RVUs for GXXX1 should be crosswalked from CPT code 15340 less only the physician work for the two post-procedure visits in CPT code 15340 which are not included in HCPCS code GXXX1.

Another commenter recommended that CMS review the proposed PE inputs for the new HCPCS G-codes. Specifically, the commenter explained that the only difference in clinical labor time between CPT code 15340 and HCPCS code GXXX1 should be an adjustment to account for the difference in the global period (10 days for CPT code 15340 and 0 days for HCPCS code GXXX1). The commenter also stated that HCPCS code GXXX1 should include all the pre-service clinical staff time in CPT code 15340, yet did not for the proposed rule. The commenter was unclear on whether the post-service clinical labor time was properly adjusted to account for the change in global period from CPT code 15340 to HCPCS code GXXX1.

Response: We agree with the commenters that a 0-day global period is the most

appropriate for the application of tissue cultured skin substitutes or dermal substitutes to the lower limb for purposes of the temporary HCPCS G-codes, pending a comprehensive change in coding established by the CPT Editorial Panel. As discussed in the previous response, we sought a fair and balanced temporary solution to provide appropriate and consistent payment for the application of tissue cultured skin substitutes or dermal substitutes to the lower limb. The commenters who did not support the 0-day global period were those who were more broadly against the creation of the new HCPCS G-codes codes because of potential payment imbalances between products that would be included in the new codes and those that would not be. No commenters asserted that the 0-day global period would be inappropriate for the codes to which we proposed to apply that period.

The proposed physician work values for HCPSC G-codes G0440 and G0441 (proposed as HCPCS codes GXXX1 and GXXX2, respectively) were crosswalked, with adjustment for the different global periods, from CPT codes 15340 and 15341. CPT codes 15340 and 15341 currently include site preparation and debridement and, as such, the additional reporting of a separate CPT code for these activities, if performed on the same site as the skin substitute application procedure, is not permitted. We believe that the values for both the current CPT codes and the HCPCS G-codes are clinically appropriate for the services they describe, with payment for site preparation and debridement bundled if furnished.

In response to a commenter's concern, we reviewed the proposed valuation of the physician work for HCPCS codes G0440 and G0441 to ensure consistency with our proposed methodology, and we continue to believe that the appropriate work value for

HCPCS code G0440 is 2.22 RVUs as we proposed. HCPCS code G0440 was crosswalked to CPT code 15340, with adjustments to account for the 0-day global period of the HCPCS G-code. CPT code 15340, with a 10-day global period, is currently valued to include two CPT code 99212 (level 2 established patient office or other outpatient visit) post-operative visits (0.48 RVUs each, 0.96 RVUs total) and half of one CPT code 99238 (Hospital discharge day management; 30 minutes or less) visit (1.28 RVUs each, 0.64 RVUs total). CPT code 15340 has a current total physician work value of 3.82 RVUs. To adjust for the 0-day global period for the minor procedure described by HCPCS code G0440, we believe it would be appropriate to deduct the value of both the two post-operative office visits and the discharge day visit. In the case of post-operative office visits, these may be separately reported and paid if medically reasonable and necessary. In addition, we also do not believe that a half discharge day visit should be a building block based on the clinical characteristics of the procedure described by HCPCS code G0440. When we make these adjustments to the work value of 3.82 RVUs for CPT code 15340, 2.22 work RVUs, the value we proposed for HCPCS code G0440, remain.

We also reviewed the proposed PE inputs included in the direct PE database for the CY 2011 PFS proposed rule. Like the physician work values, to determine the PE inputs we crosswalked HCPCS code G0440 from CPT code 15340 and HCPCS code G0441 from CPT code 15341. As one commenter observed, the difference in the values should reflect the shift from a 10-day global period to a 0-day global period. However, for PE inputs, the change in global period typically affects both the pre- and post- service PE inputs. To establish the the post-operative clinical labor time for HCPCS code G0440, we subtracted out the time associated with the two CPT code 99212 visits that

were removed (32 minutes total) and the half discharge day visit (19 minutes total) that was eliminated, bringing the post-operative clinical labor time down from 54 minutes to three minutes. For the pre-service activities, while 0-day global period procedures generally have 0 minutes of pre-service clinical labor time allocated to them, we believe that 5 minutes in the nonfacility setting and 10 minutes in the facility setting reflect more appropriate pre-service clinical labor times in the instance of HCPCS code G0440. These revised pre- and post- service clinical labor times were reflected in the proposed CY 2011 direct PE database for HCPCS code G0440.

While we valued the physician work and clinical labor time PE inputs according to the crosswalk methodology as described in the CY 2011 PFS proposed rule (75 FR 40103 through 40104), upon review of the new CY 2011 HCPCS G-codes for this final rule with comment period, we noticed that we had not applied the proposed methodology to the PE inputs for equipment and supplies. Therefore, consistent with our proposal, we have adjusted the supply and equipment PE inputs for HCPCS codes G0440 and G0441 in the final CY 2011 PE database to reflect the shift to a 0-day global period from a 10-day global period for these HCPCS codes. As the equipment and supply PE inputs for the 10-day global period CPT codes reflect those necessary for multiple visits to the provider, the equipment and supply inputs for the new HCPCS G-codes codes should reflect more appropriate values for codes with a 0-day global period.

After consideration of the public comments we received, we are finalizing our proposal to value HCPCS codes G0440 and G0441 as 0-day global procedures into which site preparation and debridement are bundled. As we proposed, under our final policy we have crosswalked the physician work RVUs and direct PE inputs from CPT codes 15340

and 15341 to HCPCS codes G0440 and G0441, respectively, with adjustments. We have adjusted the work RVUs and the direct PE inputs (clinical labor, equipment, and supplies) to reflect the shift from a 10-day global period to a 0-day global period for the new HCPCS G-codes.

Comment: Several commenters were concerned about the use of the -58 modifier for 10-day and 90-day global surgical procedures for the application of skin substitutes when repeated application of a product within the global period is the typical case. The commenters were largely supportive of eliminating the use of the -58 modifier for the two new HCPCS codes which, the commenters remarked, has been the source of some confusion and has been interpreted inconsistently by Medicare contractors. The commenters explained that the change to a 0-day global period would result in no need for the -58 modifier to be reported with the HCPCS G-codes. Several commenters recommended that CMS provide guidance on use of the -58 modifier with the existing CPT codes for the application of skin substitutes, most of which have 90-day global period and all of which would continue to be recognized for payment under the PFS.

Response: Assignment of a 0-day global period for the two HCPCS G-codes eliminates the need for use of the -58 modifier with these two new codes. We recognize that the -58 modifier may continue to be used in conjunction with the other CPT codes with 10-day or 90-day global periods for the application of skin substitutes. Specific determinations of the appropriate use of the -58 modifier will continue to be the responsibility of individual Medicare contractors.

In summary, after consideration of the public comments we received, we are finalizing our CY 2011 proposal, with modification to adjust the supply and equipment

direct PE inputs, as well as editorial modification to the code descriptors for consistency, to create two new HCPCS G-codes for CY 2011, G0440 (Application of tissue cultured allogeneic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; first 25 sq cm or less) and G0441 (Application of tissue cultured allogeneic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; each additional 25 sq cm), that will be recognized for payment under the PFS for the application of products described by the codes to the lower limb. These codes do not allow separate reporting of CPT codes for site preparation or debridement. Providers reporting the application of tissue cultured allogeneic skin substitute or dermal substitutes to the lower limb for payment under the PFS in CY 2011 should report HCPCS code G0440, along with HCPCS code G0441 if applicable based on wound size, and not CPT code 15340, 15341, 15360, 16361, 15365, or 15366.

Under the PFS, as a temporary measure, the HCPCS G-codes are assigned a 0-day global period so payment is made each a time a covered service is furnished. As proposed, we are basing payment on the physician work relative values and the direct PE inputs for the existing CPT codes 15340 and 15341 for Apligraf application, with adjustments for the global period differences between the HCPCS G-codes and the Apligraf application CPT codes. However, as we proposed, we have adjusted the work RVUs of the Apligraf application codes to derive the final CY 2011 HCPCS G-code work values by extracting the values for any office visits and discharge day management services because the HCPCS G-codes have a 0-day global period. In addition, with modifications of our proposed PE equipment and supply inputs to be fully consistent with

our crosswalk proposal, we have adjusted the direct PE inputs of the Apligraf application codes to develop the final CY 2011 direct PE inputs for the HPCPS G-codes that have a 0-day global period.

Our crosswalks and adjustments result in CY 2011 final work RVUs of 2.22 for HCPCS code G0440 and 0.50 for HCPCS G0441. The final direct PE inputs for HCPCS codes G0440 and G0442 are included in the direct PE database for the CY 2011 PFS final rule with comment period rule.

G. Canalith Repositioning (CPT code 95992)

For CY 2009, CPT created a new code for canalith repositioning, specifically CPT code 95992 (Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day). This service may be furnished by both physicians and therapists. Although we accepted the AMA RUC-recommended work RVUs and PE inputs, we initially bundled this procedure on an interim basis in the CY 2009 PFS final rule with comment period (73 FR 69896), indicating that we believed it would be paid through the E/M service that it would accompany. Subsequently, in view of concerns from therapists who cannot furnish E/M services, we clarified that therapists could report one of the generally defined therapy CPT codes when canalith repositioning was furnished. In the CY 2010 PFS final rule with comment period (74 FR 61766), we changed the code's status under the PFS to "not recognized for payment under Medicare," consistent with our expectation that another payable code would be reported when the service was furnished.

Based on further information from stakeholders regarding the distinct and separate nature of this procedure from an E/M service and their request that we recognize this CPT code for payment, similar to our separate payment for most other procedures commonly

furnished in association with an E/M service, we proposed to recognize CPT code 95992 for payment under the CY 2011 PFS, consistent with our typical treatment of most other codes for minor procedures. In doing so, we proposed to change the code's status to "A" and utilize the CY 2009 RUC recommendations for work RVUs (0.75) and PE inputs for establishing its payment in CY 2011. (That is, status "A" means Active code. These codes are separately payable under the PFS if covered.) Because canalith repositioning (CPT code 95992) can be furnished by physicians or therapists as a therapy service under a therapy plan of care or by physicians as physicians' services outside of a therapy plan of care, we would add CPT code 95992 to the "sometimes therapy" list on the therapy code abstract file.

Comment: Many commenters supported CMS' proposal to acknowledge the distinct and separate nature of CPT code 95992 from an E/M service by recognizing CPT code 95992 for separate payment and agreed with the proposed use of the AMA RUC-recommended values for work RVUs (0.75) and PE inputs for establishing payment in CY 2011.

Response: We appreciate the commenters' support for our proposal.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to recognize CPT code 95992 for payment under the PFS. As a result, the code's status has been changed to "A" in Addendum B to this final rule with comment period and the CY 2009 AMA RUC recommendations for work RVUs (0.75) and PE inputs will be used for establishing its payment in CY 2011. (That is, status "A" means Active code. These codes are separately payable under the PFS if covered.) CPT code 95992 has also been added to the "sometimes therapy" list on the therapy code abstract

file.

H. Intranasal/Oral Immunization Codes (CPT codes 90467, 90468, 90473, and 90474)

To ensure that the PE RVUs are consistent between the intranasal/oral and injectable immunization administration CPT codes that describe services that utilize similar PE resources, we proposed to crosswalk the PE values for CPT code 90471 (Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)) to CPT codes 90467 (Immunization administration younger than age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day) and 90473 (Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)) .

Similarly, we also proposed to crosswalk the PE values for CPT code 90472 (Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)) to CPT codes 90468 (Immunization administration younger than age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; each additional administration (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)) and 90474 (Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)).

Comment: Many commenters expressed support for the proposal. One

commenter questioned why the PE values are currently different and several other commenters urged CMS to utilize the AMA RUC recommendations and the resource-based methodology to develop PE RVUs for these services in CY 2011, rather than crosswalk the PE RVUs.

Response: We appreciate the support from the commenters for our proposal. We would note that, even with the same direct PE inputs, somewhat different PE RVUs for the various CPT codes may result from our PE methodology that relies upon the historical specialty mix, as reflected in the most recent PFS utilization data, of providers who furnished the services to allocate the indirect PE. Therefore, because we believe it is especially important to have consistent PE values for payment of these similar services under the PFS, we are unable to utilize the AMA RUC direct PE input recommendations and the resource-based methodology to develop PE RVUs for these services. While in general we value services under the PFS with reference to the direct PE inputs recommended by the AMA RUC and our standard resource-based approach to establishing PE RVUs, we note that we also commonly use crosswalks to other similar codes to establish the values for services in certain circumstances. In this instance, we believe a crosswalk is particularly appropriate in order to maintain appropriate relativity between similar services and avoid the potential for non-clinically-based bias in favor of one vaccine administration technique over another.

Comment: A few commenters questioned why the CY 2011 proposed rule referenced "physician" counseling when identifying CPT codes 90467 and 90468 and requested clarification that nurse practitioners (NPs) and physician assistants (PAs) also be included within the scope of this proposal.

Response: We would like to clarify that the reference to "physician" counseling noted by the commenters is part of the official CPT code descriptors for CPT codes 90467 and 90468. Consistent with our usual interpretation of CPT codes that include the term physician in the code descriptor, for Medicare payment purposes this specificity does not exclude NPs or PAs from providing counseling to the patient/family that is within the NP's or PA's scope of practice.

Comment: Several commenters recommended modifying the proposal by crosswalking the PE RVUs for CPT code 90466 (Immunization administration younger than age 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; each addition injection (single or combination vaccine/toxoid) per day (List separately in addition to code for primary procedure)) to CPT code 90468 to achieve parity and reflect the additional clinical time and other practice expenses expended to provide immunizations to young children.

Response: For CY 2011, the CPT Editorial Panel revised the reporting of immunization administration services for the pediatric population. As a result, CPT codes 90466 and 90468 have been deleted and replaced with CPT code 90461 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health professional; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)). In addition, CPT codes 90465 (Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination

vaccine/toxoid), per day) and 90467 were deleted and replaced with CPT code 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component).

We agree with the commenters who believe that consistency in the PE RVUs across CPT codes with different code descriptors reflecting immunization services to different populations or using different routes of administration is desirable. As a matter of longstanding policy (69 FR 66307), we have crosswalked the nonfacility PE value from CPT code 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular) [predecessor CPT codes 90782 and 90772] to the PE values for CPT code 90471 and to the HCPCS G-codes for administration of specific vaccines. We will continue this crosswalk for CY 2011 and, as we proposed, also crosswalk the nonfacility PE value of CPT code 90471 to CPT code 90473. The PE value for CPT code 90472 is based on the direct PE inputs for that code, according to the usual PFS methodology. We will crosswalk the nonfacility PE value of CPT code 90472 to CPT code 90474 for CY 2011 as we proposed. Finally, we are modifying our CY 2011 proposal and crosswalking the nonfacility PE RVUs for CPT codes 90472 and 90474 to new CPT code 90461 (replacement code for CPT codes 90466 and 90468) for CY 2011. In addition, we will crosswalk the nonfacility PE RVUs for CPT codes 90471 and 90473 to new CPT code 90460 (replacement code for CPT codes 90465 and 90467).

After consideration of the public comments we received and the CY 2011 changes in codes for pediatric immunization services by the CPT Editorial Panel, we are finalizing

our CY 2011 proposals, with the following modifications. In summary, for CY 2011 we will--

- Crosswalk the nonfacility PE RVUs for CPT codes 90472 and 90474 to new CPT code 90461; and
- Crosswalk the nonfacility PE RVUs for CPT codes 90471 to 90473 to new CPT code 90460.

I. Refinement Panel Process

As discussed in the 1993 PFS final rule with comment period (57 FR 55938), we adopted a refinement panel process to assist us in reviewing the public comments on interim physician work RVUs for CPT codes with an interim final status in each year and developing final work values for the subsequent year. We decided that the panel would be comprised of a multispecialty group of physicians who would review and discuss the work involved in each procedure under review, and then each individual would individually rate the work of the procedure. We believed that establishing the panel with a multispecialty group would balance the interests of those who commented on the work RVUs against the budgetary and redistributive effects that could occur if we accepted extensive increases in work RVUs across a broad range of services. Historically, the refinement panel has based its recommendation to change a work value or to retain the interim value has hinged solely on the outcome of a statistical test on the ratings (an F-test).

Depending on the number and range of codes that public commenters, typically specialty societies, request be subject to refinement, we establish refinement panels with representatives from 4 groups of physicians: clinicians representing the specialty most

identified with the procedures in question; physicians with practices in related specialties; primary care physicians; and contractor medical directors (CMDs). Typically the refinement panels meet in the summer prior to the promulgation of the final rule finalizing the RVUs for the codes. Typical panels have included 8 to 10 physicians across the 4 groups. Over time, the statistical test used to evaluate the RVU ratings of individual panel members have become less reliable as the physicians in each group have tended to select a previously discussed value, rather than independently evaluating the work. In addition, the resulting RVUs have occasionally exhibited rank order anomalies (that is, a more complex procedure is assigned lower RVUs than a less complex procedure).

Recently, section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) authorized the Secretary to review potentially misvalued codes and make appropriate adjustments to the relative values. In addition, MedPAC has encouraged CMS to critically review the values assigned to the services under the PFS. MedPAC has stated its belief that CMS has historically relied too heavily on specialty societies to identify services that are misvalued by accepting a high proportion of the recommendations of the AMA RUC.

We believe the refinement panel process continues to provide stakeholders with a meaningful opportunity to review and discuss of the interim work RVUs with a clinically diverse group of experts which then provides informed recommendations to CMS. Therefore, in the CY 2011 proposed rule (75 FR 40105), we indicated that we would like to continue the refinement process, including the established composition that includes representatives from the 4 groups of physicians, but with administrative modification and

clarification. Specifically, for refinement panels beginning in CY 2011 (that is, for those codes with CY 2011 interim values that would be subject to refinement during CY 2011), we proposed to eliminate the use of the F-test and instead base revised RVUs on the median work value of the panel members' ratings. We believe this approach will simplify the refinement process administratively, while resulting in a final panel recommendation that reflects the summary opinion of the panel members based on a commonly used measure of central tendency that is not significantly affected by outlier values. In addition, we clarified that we have the final authority to set the RVUs and, therefore, may make adjustments to the work RVUs resulting from refinement if policy concerns warrant their modification.

Comment: Most commenters expressed support for the proposal to eliminate the F-test, including the increased transparency of the refinement panel process that the commenters believe would result from this change. Many commenters, including the AMA RUC, agreed with the use of the median work value of the panel members' ratings and believe the median would provide a clearer view of the central tendency of the estimates provided by the survey respondents. On the other hand, several commenters believe the current process is effective and eliminates the effects of agreement between the panel members' ratings.

The AMA RUC recommended that CMS be mindful when assigning individuals to the refinement panel to ensure that all members, including CMDs, are not from the same specialties that were involved in the public comment originating the issue under review. Another commenter cautioned CMS that the refinement panels need to be balanced and should ensure that there is at least one representative on the panel who has

direct experience with the procedure or service under review.

Response: We appreciate the support of the commenters regarding our proposal to use the median work value of the panel members' ratings and will move forward to finalize our proposal for refinement panels beginning in CY 2011 (refinement of CY 2011 new/revised codes with interim values).

When identifying individuals for the refinement panel, including CMDs, we attempt to select individuals from each of the different specialties with an interest in the codes being refined, not just the specialty or specialties responsible for the public comment originating the request for refinement. We also take steps to ensure that the panel members have direct experience and knowledge of the procedure or service under review. We will certainly continue our efforts in this regard. However, we note that in recent years the number of physicians who are available to participate in the refinement panel has been limited at times, and some specialty societies have had difficulty obtaining representation for the panel.

Comment: Several commenters urged CMS to use a methodology that would allow the AMA RUC-recommended value to prevail when appropriately supported by the pertinent specialty societies and when the value is strongly supported by the rank order and resources of the procedure, since the PFS final rule with comment period is the first opportunity for the public to see the RVUs for the coming calendar year. These commenters also believe a full and fair review process is warranted prior to the publication of these values in the final rule with comment period.

Response: We note that PFS payments for services are resource-based. When reviewing the AMA RUC recommendations, our decisions to value services are based on

the resources needed to perform the typical service and, therefore, these decision are based upon a thorough review of the AMA RUC recommendations in the context of the specific new or revised codes. In those cases where we reject the AMA RUC recommendations, we publish our rationale in the PFS final rule with comment period where we first make the values public. These values are published as interim final values that are subject to public comment. The public comment period serves as the opportunity for public review and we see no other alternative to this timing, given the timeframes in which the new or revised CPT codes and the AMA RUC recommendations regarding their values are available to us and in which the new or revised CPT codes must be incorporated into the PFS for payment.

Comment: Several commenters expressed concerns about the proposal to allow CMS to have the final authority to set the work RVUs if policy concerns warrant modifications to the values derived from the refinement process. These commenters opposed this proposal and recommended that the decisions of the refinement panels remain unchanged by CMS. The commenters believe a major strength of the current process is that is gives stakeholders a strong incentive to participate, knowing that the outcomes of the process will not be overturned by CMS.

Response: Although we appreciate the concerns raised by the commenters, by law, we retain the final responsibility and authority to set the RVUs and, therefore, may make adjustments to the work RVUs resulting from refinement if policy concerns (such as a rank order anomaly) warrant their modifications.

Comment: One commenter urged CMS to make the refinement process transparent and open to the public.

Response: We believe our proposal would make the refinement process more transparent, as noted by some commenters. We further believe that representation from specialty societies as part of the AMA RUC process for valuing the codes allows the input of physicians who have direct experience with the procedure or service under review.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to eliminate the use of the F-test for the refinement panels and, instead, we will base the revised RVUs on the median work value of the panel members' ratings. In addition, we note that CMS retains the final authority to set the RVUs and, therefore, make adjustments to the work RVUs resulting from refinement if policy concerns warrant their modification.

J. Remote Cardiac Monitoring Services (CPT codes 93012, 93229, 93268, and 93271)

In the CY 2011 PFS proposed rule (75 FR 40105), we reiterated our concerns about the issue of developing PE RVUs for services that are utilized 24 hours a day, 7 days a week (24/7), such as those that require certain centralized monitoring system equipment and which have been discussed in earlier PFS rulemaking cycles, most recently in the CY 2010 PFS final rule with comment period (74 FR 61755). We stated that the PE equipment methodology was developed for equipment that is in use during standard physician's office business hours and not equipment that is used in furnishing such continuous services, and that we would conduct further analysis of this issue. We indicated that services that were contractor-priced in CY 2009 remained contractor-priced in CY 2010 and that any proposed changes would be communicated through future rulemaking.

In the CY 2011 PFS proposed rule (75 FR 40105), we explained that since publication of the CY 2010 PFS final rule with comment period, we focused our additional analysis on 4 of the CPT codes that commenters have brought to our attention because they involve concurrent, remote, 24/7 attended monitoring of multiple patients from a central location: CPT code 93012 (Telephonic transmission of post-symptom electrocardiogram rhythm strip(s); 24-hour attended monitoring, per 30 day period of time; tracing only); CPT code 93229 (Wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed transmission of daily and emergent data reports); CPT code 93268 (Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission, physician review and interpretation); and CPT 93271 code (Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmissions, and analysis).

We pointed out that of these four codes, CPT code 93229 is currently contractor-priced in CY 2010, meaning that the local Medicare contractors determine payment rates for the service within the PFS geographic areas in their jurisdiction. The three services that are currently nationally-priced on the PFS are in the first year of a

4-year transition to lower payment rates based on the use of the PPIS data adopted in the CY 2010 PFS final rule with comment period. We refer readers to section II.A.2. of this final rule with comment period for a description of the general PFS PE methodology that is the basis for the following discussion of approaches to establishing PE RVUs for these four CPT codes.

In the CY 2011 PFS proposed rule, we explained that we examined several alternative methods for developing PE RVUS upon which PFS payment rates for these four CPT codes could be based. Each of these services involves transmission of information from multiple patients who wear individual monitoring devices that transmit patient-specific information to centralized equipment that is simultaneously in use for multiple patients. We stated that we believed it would be most consistent with the principles underlying the PFS PE methodology to classify the centralized monitoring equipment as an indirect cost since it is servicing multiple patients at the same time. We explained that after classifying this equipment as an indirect cost, we used our standard methodology to calculate an indirect practice cost index value for each code based on the PE/HR survey data of the historical mix of specialties providing these services. We went on to state that establishing payment rates for these codes based on this approach would result in decreases in the payment rates for these services, including the typical contractor's price for CPT code 93229. For the three services that are nationally priced, these decreases would be relative to the lower payment rates based on the use of the PPIS data after the 4-year transition.

In the CY 2011 PFS proposed rule, we acknowledged that we had also received PE/HR data from the Remote Cardiac Services Provider Group (RCSPG), a group of

Independent Diagnostic Testing Facility (IDTF) suppliers of these types of services. We explained that for sensitivity analysis purposes, we substituted these data for the PE/HR data of the specialties performing these services, while continuing to treat the centralized monitoring equipment as an indirect cost. We stated that we found that establishing payment rates for these codes based on the approach of using the submitted RCSPG PE/HR data would again result in decreases in the payment rates for these services, including the typical contractor's price for CPT code 93229. As in the prior alternative, the decreases for the nationally priced codes would be relative to the payment rates reflecting the 4-year transition to the PPIS data.

We indicated that although we believed that it would be most consistent with the principles underlying the PE methodology to classify the centralized monitoring equipment as an indirect cost, we also performed a sensitivity analysis of the payment rates if the centralized monitoring equipment were classified as a direct cost. In this simulation, we assumed that the centralized monitoring equipment was in year-round use, 7 days per week for 24 hours per day. We found that establishing payment rates for these codes based on the approach of classifying the centralized monitoring equipment as a direct cost would again result in decreases in the payment rates for the nationally priced services relative to their payment rates after the 4-year transition to the use of the PPIS data, as well as to the typical current contractor's price for CPT code 93229.

Finally, we explained that we considered proposing contractor-pricing for all four of these services for CY 2011 but were cognizant of past public comments on this issue that had requested that all of these services be priced nationally on the PFS, including the one service (CPT code 93229) that is currently contractor-priced.

In the CY 2011 PFS proposed rule, we also considered that the services currently priced nationally on the PFS were scheduled to receive lower payment rates under the 4-year transition to the PPIS data and that the contractor's price for CPT 93229 was recently reduced in the area where the majority of the billings for this service currently occur.

We concluded that after taking all these factors into consideration, we were not proposing CY 2011 methodological or direct cost input changes for CPT codes 93012, 93268, or 93271 - the services that are nationally priced under the PFS. We proposed to continue contractor-pricing for CPT 93229 for CY 2011. We solicited public comments on this issue, including responses to our analysis of alternative approaches to establishing PE RVUs for 24/7 services, and further discussion of the issues we identified in our alternative pricing methodologies. In addition, while we had focused the 24/7 services analysis up until that point in time on developing the PE RVUS for remote cardiac monitoring services, we observed that there may be 24/7 services in other areas of medicine, either currently paid under the PFS or in development for the future. Therefore, we also solicited public comments on these current or emerging 24/7 services, including descriptions of the similarities or differences between these other services and remote cardiac monitoring services, particularly with respect to the issues we identified in our analysis of alternative approaches to establishing PE RVUs for remote cardiac monitoring services under the PFS.

Comment: Several commenters expressed concerns regarding CMS' discussion of PFS payment for remote cardiac monitoring, which included no proposal of changes for CY 2011. The commenters pointed out the benefits of 24/7 remote monitoring services

for cardiac and other specialty services and argued that these types of services can differ in complexity and frequency from one another and from traditional medical services. In general, the commenters expressed interest in CMS accurately capturing the cost components for all of these services, primarily arguing for the consideration of these costs as direct costs.

One commenter explained that the current methodology for assigning PE RVUs does not work for remote cardiac providers whose businesses are structured differently from physicians' practices and, as a result, the RVUs assigned to the services do not reflect their proper relative cost. Although CMS focused its analysis on services characterized by concurrent, remote, 24/7 attended monitoring of multiple patients from a single location, the commenter addressed cardiac event monitoring, pacemaker monitoring, Holter monitoring, International Normalized Ratio (INR) monitoring, and a number of new monitoring technologies such as cardiac telemetry under the umbrella term of remote cardiac monitoring. The commenter asserted that the IDTF providers of remote cardiac monitoring services operate on a 24/7 basis because the services that they furnish require round-the-clock service and are, therefore, structured very differently from physicians' offices and other IDTFs. The commenter argued that CMS should utilize PE/HR data submitted by RCSPG, a group of IDTF suppliers of these types of services, to the entire ranging of cardiac monitoring services furnished by these providers. Alternatively, the commenter indicated that CMS could use the all physician indirect percentage, use an indirect practice cost index (IPCI) of one, and add equipment costs to the PE formula for allocating indirect costs in setting the PE RVUs for cardiac monitoring services. Finally, the commenter requested that if CMS did not adopt one of

the previous two suggestions, then CMS should temporarily suspend the phase-in of the use of PPIS data for cardiac monitoring services. Several other commenters also requested that CMS suspend the PPIS transition for remote cardiac monitoring services.

Several commenters disagreed with CMS regarding the appropriateness of treating the centralized monitoring equipment as an indirect cost, arguing that the equipment is used specifically for patients that are receiving a specific service and, therefore, represents a direct cost like other medical equipment. The commenters contended that the centralized equipment is inherently different from other indirect practice expenses that are used to run a practice and are not tied directly to any one particular service. One commenter speculated that considering the cardiac monitoring equipment as an indirect expense would dilute the payment for this cardiac telemetry by distributing it to many people who are not providing it. Another commenter expressed concern that an indirect cost approach does not appropriately account for the significant differences in remote monitoring services and thus cannot accurately capture the cost components of each.

With respect to the remote cardiac monitoring service described by CPT code 93229 which is contractor-priced, one commenter made several specific requests, namely that CMS: (1) nationally price CPT code 93229 rather than contractor-price the service; (2) consider the centralized monitoring equipment associated with CPT code 93229 as a direct cost; (3) adjust the equipment utilization assumption for the centralized monitoring equipment from 100 percent to 50 percent; (4) use new direct cost inputs (for example, the cost of the monitoring device worn by patient) supplied by the commenter; (5) incorporate a new PE/HR, based on the cardiac monitoring industry-wide RCSPG PE/HR

data applied to all cardiac monitoring services, based on data from two telemetry providers for CPT code 93229 that yields a PE/HR of $243.22 that would be applied to CPT code 93229, or based on data for telemetry and cardiac event monitoring (CEM) which results in a PE/HR of $214.79 that would be applied to telemetry and CEM services; and (6) apply an additional indirect allocation in the CMS PE methodology based on the equipment direct costs as previously recommended by one telemetry provider. The commenter provided equipment inputs and the associated prices and further recommended that CMS should continue to apply the clinical labor and supply input items associated with this services as recommended by the AMA RUC.

Response: We appreciate the continuing interest of the commenters in the pricing of cardiac monitoring services under the PFS. After further review of this issue, while we continue to recognize there are some unique aspects to the services, we do not agree with the commenters that the PE for cardiac monitoring services cannot be appropriately valued using the PFS PE methodology. After our review, we believe that we can appropriately identify and price the direct cost inputs for these services. Furthermore, we note that the PPIS data for allocating indirect costs is from a multispecialty, nationally representative PE survey of both physicians and NPPS and, as the most comprehensive source of PE information available to date, appropriate for use for cardiac monitoring services. Therefore, we disagree that we should suspend the PE transition to the PPIS data or otherwise change our established methodology for setting the PE RVUs furnished by a subset of providers in a certain specialty area.

We continue to believe that it is more appropriate to classify the costs associated with the centralized monitoring equipment, including the hardware and software,

workstation, webserver, and call recording system, as indirect costs since it is difficult to allocate those costs to services furnished to individual patients in a manner that adequately reflects the number of patients being tested. This would be true for CPT code 93229 which has not previously been nationally priced. We believe that the ability to appropriately allocate costs to individual services is a key concept that should guide our adoption of the direct PE inputs for services paid under the PFS. Having drawn this conclusion, we plan to review the direct PE inputs for other nationally priced services that include centralized monitoring equipment under the PFS and, if we find that we have not consistently treated that equipment as an indirect cost, we may propose changes to the direct PE inputs for existing codes in a future PFS rulemaking cycle.

We agree with several commenters that it would be appropriate at this time to nationally price CPT code 93229, especially in light of our conclusion regarding how the centralized monitoring system should be treated under the PFS PE methodology and the fact that the commenters have provided current prices and associated documentation for the direct PE inputs used in the typical case. Therefore, we are accepting the AMA RUC recommendations originally made for CY 2009 (73 FR 69896) for clinical labor and supplies for CPT code 93229 and are utilizing these direct PE inputs for CY 2011. With respect to the equipment inputs provided to us by one commenter who currently furnishes the majority of services described by CPT code 93229, under our final CY 2011 policy the only piece of equipment that would be appropriately treated as a direct PE input is the cardiac telemetry monitoring device worn by the patient. The other equipment items, including the monitoring system software and hardware, workstation, webserver, and call recording system are indirect practice costs. Therefore, we are accepting the commenter's

submission of $21,575 as the price for this device in the typical case, and applying a 50 percent utilization rate and useful life of 3 years as recommended by the commenter.

We do not believe it would be appropriate to deviate from our standard PFS PE methodology to adopt a PE/HR that is specific to CPT code 93229 or any other set of cardiac monitoring codes based on data from two telemetry providers, from a subset of services provided by certain specialty cardiac monitoring providers, or from a certain group of specialty providers that overall furnish only a portion of cardiac monitoring services, nor to change our established indirect PE allocation methodology. We believe the current PE methodology appropriately captures the relative costs of these services in setting their PE RVUs, based on the conclusion we have drawn following our assessment of the centralized monitoring system that is especially characteristic of services such as CPT code 93229. We note that these direct PE inputs are included in the final CY 2011 direct PE database that is posted on the CMS Web site under downloads for this CY 2011 PFS final rule with comment period at: http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage. We further note that the CY 2011 payment for CPT code 93229 (without considering the negative PFS update that will apply for CY 2011 under current law) is close to the current typical contractor's price for the service in CY 2010.

After consideration of the public comments we received, we are establishing a national price for CPT code 93229 based on nationally set RVUs, instead of maintaining the code as contractor-priced as we proposed. We are adopting the AMA RUC's recommendations for the clinical labor and supply inputs, and utilizing price, utilization, and useful life information provided by the commenters as equipment inputs for the

cardiac telemetry monitoring device worn by the patient. The final CY 2011 RVUs for CPT code 93229 are displayed in Addendum B to this final rule with comment period. While we are making no changes to the direct PE inputs for other remote cardiac monitoring CPT codes for CY 2011, we will consider in the future whether changes could be appropriate if we conclude that these services utilize a centralized monitoring system that would most appropriately be treated an indirect cost.

Comment: While most of the commenters addressed remote cardiac monitoring services specifically discussed in the CY 2011 PFS proposed rule, several commenters addressed other types of emerging 24/7 services. One commenter described a pilot program that utilizes telehealth to monitor certain health status indicators for cardiac patients. This monitoring occurs during the day and night and includes an assessment by a nurse. The commenter stated that the initial results of the pilot show a lower rate of hospital readmissions for participants. The commenter asserted that there is currently no payment for this service, and urged CMS to consider funding for these types of programs.

Outside of cardiac monitoring, another commenter noted that there are many types of remote monitoring services that provide important benefits, especially for chronically ill patients. The commenter explained that these may include health status monitoring services, activity and sensor monitoring services, and medication dispensing and monitoring services. The commenter asserted that the resource requirements for these types of services can differ in complexity and frequency and may involve varied resources, including equipment and other fees; training and coaching; data collection, monitoring and documentation; and personal emergency response. As such, the commenter recommended that CMS' PE methodology for remote monitoring services be

as transparent and flexible as possible to allow for these differences, and to accurately capture the cost components for each. Therefore, the commenter, concluded that a direct cost approach would be the most appropriate approach in most cases.

Response: We thank the commenters for providing information on other current and emerging 24/7 services. We will consider appropriate payment for other 24/7 services under the PFS as specific codes for such services are created by the CPT Editorial Panel. Regarding direct PE inputs for other remote monitoring services, we acknowledge diversity in the direct and indirect costs to providers for furnishing various monitoring services—and all services—and believe that our current PE methodology, as discussed earlier in this section, is able to yield appropriate values across this wide range. As stated earlier in the context of remote cardiac monitoring, we believe that the ability to appropriately allocate costs to the services furnished to individual patients is a key concept that should guide our adoption of the direct PE inputs for services paid under the PFS, including remote monitoring and other 24/7 services.

We look forward to continuing a dialogue with stakeholders involved in developing and furnishing 24/7 services as medical practice evolves in order to ensure that the PFS pays appropriately for those 24/7 services that are covered by Medicare and paid as physicians' services.

IV. Medicare Telehealth Services For The Physician Fee Schedule

A. Billing and Payment for Telehealth Services

1. History

Prior to January 1, 1999, Medicare coverage for services delivered via a telecommunications system was limited to services that did not require a face-to-face encounter under the traditional model of medical care. Examples of these services included interpretation of an x-ray or electrocardiogram or electroencephalogram tracing, and cardiac pacemaker analysis.

Section 4206 of the BBA provided for coverage of, and payment for, consultation services delivered via a telecommunications system to Medicare beneficiaries residing in rural health professional shortage areas (HPSAs) as defined by the Public Health Service Act. Additionally, the BBA required that a Medicare practitioner (telepresenter) be with the patient at the time of a teleconsultation. Further, the BBA specified that payment for a teleconsultation had to be shared between the consulting practitioner and the referring practitioner and could not exceed the fee schedule payment which would have been made to the consultant for the service provided. The BBA prohibited payment for any telephone line charges or facility fees associated with the teleconsultation. We implemented this provision in the CY 1999 PFS final rule with comment period (63 FR 58814).

Effective October 1, 2001, section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement Protection Act of 2000 (Pub. L. 106-554) (BIPA) added a new section 1834(m) to the Act which significantly expanded Medicare telehealth services. Section 1834(m)(4)(F)(i) of the Act defines Medicare telehealth services to include

consultations, office visits, office psychiatry services, and any additional service specified by the Secretary, when delivered via a telecommunications system. We first implemented this provision in the CY 2002 PFS final rule with comment period (66 FR 55246). Section 1834(m)(4)(F)(ii) of the Act required the Secretary to establish a process that provides for annual updates to the list of Medicare telehealth services. We established this process in the CY 2003 PFS final rule with comment period (67 FR 79988).

As specified in regulations at §410.78(b), we generally require that a telehealth service be furnished via an interactive telecommunications system. Under §410.78(a)(3), an interactive telecommunications system is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and the practitioner at the distant site. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system. An interactive telecommunications system is generally required as a condition of payment; however, section 1834(m)(1)of the statute does allow the use of asynchronous "store-and-forward" technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. As specified in regulations at §410.78(a)(1), store and forward means the asynchronous transmission of medical information from an originating site to be reviewed at a later time by the practitioner at the distant site.

Medicare telehealth services may be provided to an eligible telehealth individual notwithstanding the fact that the individual practitioner providing the telehealth service is

not at the same location as the beneficiary. An eligible telehealth individual means an individual enrolled under Part B who receives a telehealth service furnished at an originating site. As specified in BIPA, originating sites are limited under section 1834(m)(3)(C) of the statute to specified medical facilities located in specific geographic areas. The initial list of telehealth originating sites included the office of a practitioner, a critical access hospital (CAH), a rural health clinic (RHC), a federally qualified health center (FQHC) and a hospital. More recently, section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110-275) (MIPPA) expanded the list of telehealth originating sites to include hospital-based renal dialysis centers, skilled nursing facilities (SNFs), and community mental health centers (CMHCs). In order to serve as a telehealth originating site, these sites must be located in an area designated as a rural HPSA, in a county that is not in a metropolitan statistical area (MSA), or must be an entity that participate in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary as of December 31, 2000. Finally, section 1834(m) of the statute does not require the eligible telehealth individual to be presented by a practitioner at the originating site.

2. Current Telehealth Billing and Payment Policies

As noted above, Medicare telehealth services can only be furnished to an eligible telehealth beneficiary in an originating site. An originating site is defined as one of the specified sites where an eligible telehealth individual is located at the time the service is being furnished via a telecommunications system. In general, originating sites must be located in a rural HPSA or in a county outside of an MSA. The originating sites authorized by the statute are as follows:

- Offices of a physician or practitioner
- Hospitals
- CAHs
- RHCs
- FQHCs
- Hospital-Based Or Critical Access Hospital-Based Renal Dialysis Centers (including Satellites)
- SNFs
- CMHCs

Currently approved Medicare telehealth services include the following:

- Initial inpatient consultations
- Follow-up inpatient consultations
- Office or other outpatient visits
- Individual psychotherapy
- Pharmacologic management
- Psychiatric diagnostic interview examination
- End Stage Renal Disease (ESRD) related services
- Individual medical nutrition therapy (MNT)
- Neurobehavioral status exam
- Individual health and behavior assessment and intervention (HBAI).

In general, the practitioner at the distant site may be any of the following, provided that the practitioner is licensed under State law to furnish the service being furnished via a telecommunications system:

- Physician
- Physician assistant (PA)
- Nurse practitioner (NP)
- Clinical nurse specialist (CNS)
- Nurse midwife
- Clinical psychologist
- Clinical social worker
- Registered dietitian or nutrition professional.

Practitioners furnishing Medicare telehealth services are located at a distant site, and they submit claims for telehealth services to the Medicare contractors that process claims for the service area where their distant site is located. Section 1834(m)(2)(A) of the Act requires that a practitioner who furnishes a telehealth service to an eligible telehealth individual be paid an amount equal to the amount that the practitioner would have been paid if the service had been furnished without the use of a telecommunications system. Distant site practitioners must submit the appropriate HCPCS procedure code for a covered professional telehealth service, appended with the -GT (Via interactive audio and video telecommunications system) or –GQ (Via asynchronous telecommunications system) modifier. By reporting the –GT or –GQ modifier with a covered telehealth procedure code, the distant site practitioner certifies that the beneficiary was present at a telehealth originating site when the telehealth service was furnished. The usual Medicare deductible and coinsurance policies apply to the telehealth services reported by distant site practitioners.

Section 1834(m)(2)(B) of the Act provides for payment of a facility fee to the originating site. To be paid the originating site facility fee, the provider or supplier where the eligible telehealth individual is located must submit a claim with HCPCS code Q3014 (Telehealth originating site facility fee), and the provider or supplier is paid according to the applicable payment methodology for that facility or location. The usual Medicare deductible and coinsurance policies apply to HCPCS code Q3014. By submitting HCPCS code Q3014, the originating site authenticates that it is located in either a rural HPSA or non-MSA county or is an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary as of December 31, 2000 as specified in section 1834(m)(4)(C)(i)(III) of the Act.

As described above, certain professional services that are commonly furnished remotely using telecommunications technology, but that do not require the patient to be present in-person with the practitioner when they are furnished, are covered and paid in the same way as services delivered without the use of telecommunications technology when the practitioner is in-person at the medical facility furnishing care to the patient. Such services typically involve circumstances where a practitioner is able to visualize some aspect of the patient's condition without the patient being present and without the interposition of a third person's judgment. Visualization by the practitioner can be possible by means of x-rays, electrocardiogram or electroencephalogram tracings, tissue samples, etc. For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram tracing that has been transmitted via telephone (that is, electronically, rather than by means of a verbal description) is a covered physician's service. These remote services are not Medicare telehealth services

as defined under section 1834(m) of the Act. Rather, these remote services that utilize telecommunications technology are considered physicians' services in the same way as services that are furnished in-person without the use of telecommunications technology; they are paid under the same conditions as in-person physicians' services (with no requirements regarding permissible originating sites), and should be reported in the same way (that is, without the –GT or –GQ modifier appended).

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

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

- Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. We also look for similarities in the telecommunications system used to deliver the proposed service, for example, the use of interactive audio and video equipment.

- Category 2: Services that are not similar to the current list of telehealth services. Our review of these requests includes an assessment of whether the use of a telecommunications system to deliver the service produces similar diagnostic findings or therapeutic interventions as compared with the in-person delivery of the same service.

Requestors should submit evidence showing that the use of a telecommunications system does not affect the diagnosis or treatment plan as compared to in-person delivery of the requested service.

Since establishing the process to add or remove services from the list of approved telehealth services, we have added the following to the list of Medicare telehealth services: individual HBAI services; psychiatric diagnostic interview examination; ESRD services with 2 to 3 visits per month and 4 or more visits per month (although we require at least 1 visit a month to be furnished in-person by a physician, CNS, NP, or PA in order to examine the vascular access site); individual MNT; neurobehavioral status exam; and initial and follow-up inpatient telehealth consultations for beneficiaries in hospitals and skilled nursing facilities (SNFs).

Requests to add services to the list of Medicare telehealth services must be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. For example, requests submitted before the end of CY 2010 are considered for the CY 2012 proposed rule. Each request for adding a service to the list of Medicare telehealth services must include any supporting documentation the requester wishes us to consider as we review the request. Because we use the annual PFS rulemaking process as a vehicle for making changes to the list of Medicare telehealth services, requestors should be advised that any information submitted is subject to public disclosure for this purpose. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, we refer readers to the CMS Web site at www.cms.gov/telehealth/.

C. Submitted Requests for Addition to the List of Telehealth Services for CY 2011

We received requests in CY 2009 to add the following services as Medicare telehealth services effective for CY 2011: (1) individual kidney disease education (KDE) services; (2) individual diabetes self-management training (DSMT) services; (3) group KDE, DSMT, MNT, and HBAI services; (4) initial, subsequent, and discharge day management hospital care services; (5) initial, subsequent, discharge day management, and other nursing facility care services; (6) neuropsychological testing services; (7) speech-language pathology services; and (8) home wound care services. The following presents a discussion of these requests, including our proposed additions to the CY 2011 telehealth list.

1. Individual KDE Services

The American Society of Nephrology, Dialysis Patient Citizens, AMGEN, and Kidney Care Partners submitted requests to add individual KDE services, reported by HCPCS code G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour), to the list of approved telehealth services for CY 2011 on a category 1 basis.

Individual KDE services, covered under the new Medicare KDE benefit effective for services furnished beginning in CY 2010, are defined as face-to-face educational services provided to a patient with stage IV chronic kidney disease (CKD). We believe the interaction between a practitioner and a beneficiary receiving individual KDE services is similar to the education, assessment, and counseling elements of individual MNT services, reported by HCPCS code G0270 (Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in

diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes); CPT code 97802 (Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes); and CPT code 97803 (Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes), all services that are currently on the telehealth list.

Therefore, we proposed to add HCPCS code G0420 to the list of telehealth services for CY 2011 on a category 1 basis and to revise our regulations at §410.78(b) and §414.65(a)(1) to include individual KDE as a Medicare telehealth service.

Comment: Several commenters expressed support for CMS' proposal to add KDE services to the list of Medicare telehealth services for CY 2011. One commenter stated that the proposal would provide patients at risk for developing chronic kidney disease and ESRD with access to educational services that may help in controlling the progression of disease. Another commenter suggested that delivery of KDE services through telehealth would provide beneficiaries with the flexibility to interact with practitioners in a manner tailored to their needs, thus facilitating a more patient-centered approach. Another commenter noted that greater flexibility in the provision of KDE services is particularly important in rural areas where individuals do not have as much access to dialysis centers.

Response: We agree with the commenters that adding KDE services to the list of Medicare telehealth services may be valuable to Medicare beneficiaries, especially insofar as it helps provide greater access to the services for beneficiaries in rural or other isolated areas.

Comment: One commenter who supported the proposal also encouraged the

CMS to maintain its existing policy regarding the qualified providers for KDE services in order to appropriately ensure the quality and content conveyed to patients in educational sessions and remain concordant with the intent of MIPPA.

Response: We note that the addition of KDE to the list of Medicare telehealth services does not alter the qualifications for providers of KDE services as specified in §410.48 of the regulations.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to add HCPCS code G0420 to the list of telehealth services for CY 2011 on a category 1 basis and to revise our regulations at §410.78(b) and §414.65(a)(1) to include individual KDE as a Medicare telehealth service.

2. Individual DSMT Services

The Tahoe Forest Health System and the Marshfield Clinic submitted requests to add individual DSMT services, reported by HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes), to the list of telehealth services for CY 2011 on a category 1 basis. In the CY 2009 PFS final rule with comment period (73 FR 69743), we stated that we believe individual DSMT services are not analogous to individual MNT services because of the element of skill-based training that is encompassed within individual DSMT services that is not an aspect of individual MNT services (or any other services currently approved for telehealth). Due to the statutory requirement that DSMT services include teaching beneficiaries the skills necessary for the self-administration of injectable drugs, we have stated our belief that DSMT, whether provided to an individual or a group, must be evaluated as a category 2 service as specified in the CY 2009 PFS proposed rule (73 FR 38516). Prior to CY 2011

rulemaking, we had considered several previous requests to add DSMT to the list of Medicare telehealth services. We had not added individual DSMT to the list of telehealth services because we believe that skill-based training, such as teaching patients how to inject insulin, would be difficult to accomplish effectively without the physical presence of the teaching practitioner (70 FR 45787 and 70157, and 73 FR 38516 and 69743).

In considering the new request to add individual DSMT services to the list of telehealth services in CY 2011, we took into account requestors' argument that individual DSMT services are highly similar to individual MNT services and that injection training constitutes just a small proportion of DSMT services. Except for the component of individual DSMT services that involves instruction in self-administration of injectable drugs for eligible beneficiaries, we agreed with the requestors that individual DSMT services are similar to individual MNT services, which are currently on the list of Medicare telehealth services. We note that Medicare coverage of DSMT services was initially authorized in the BBA. After more than a decade of Medicare coverage, the most recent information shows that DSMT continues to be significantly underutilized in the context of the eligible population of Medicare beneficiaries. While we are uncertain to what extent geographic barriers to care contribute to this underutilization, given the morbidity associated with poorly managed diabetes and the growing evidence-base regarding effective DSMT services, we believe it is very important to facilitate Medicare beneficiary access to these underutilized services. While we were previously concerned about treating the components of DSMT services differently in the context of considering DSMT services for the telehealth list, in the CY 2011 PFS proposed rule (75 FR 40108), we stated our belief that our concern regarding the skill-based injection training

component of DSMT services could be addressed by imposing a requirement that a minimum portion of the training be furnished in-person. We noted that for beneficiaries who meet the coverage criteria, Medicare covers 10 hours of DSMT services in the year following the initial training, as described in the Medicare Benefit Policy Manual (Pub. 100-02, Chapter 15, Section 300.3). Taking into consideration the initial year coverage of DSMT services, for CY 2011 we proposed that a minimum of 1 hour of instruction in injection training must be furnished in-person during the year following the initial DSMT service. Imposing this condition would allow us to expand access to DSMT services by adding individual DSMT services to the list of telehealth services, while ensuring effective injection training for beneficiaries.

Therefore, we proposed to add HCPCS code G0108 to the list of telehealth services beginning in CY 2011. We also proposed that, as a condition of payment for individual DSMT services furnished as telehealth services to an eligible telehealth individual, a minimum of 1 hour of in-person instruction in the self-administration of injectable drugs must be furnished to the individual during the year following the initial DSMT service. The injection training may be furnished through either individual or group DSMT services. By reporting the –GT or –GQ modifier with HCPCS code G0108 as a telehealth service, the distant site practitioner would certify that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training during the year following the initial DSMT service. Consistent with this proposal, we proposed to revise our regulations at §410.78(b) and §414.65(a)(1) to include individual DSMT services as a Medicare telehealth service, with the exception of 1 hour of in-person instruction in self-administration of injectable drugs which must be

furnished to the eligible telehealth individual as individual or group DSMT services during the year following the initial DSMT service.

Comment: A number of commenters expressed support for CMS' proposal to add DSMT services to the list of Medicare telehealth services. One commenter requested that CMS clarify that this proposal would permit NPs and PAs in all patient care settings to provide and bill for DSMT services furnished through telehealth technologies.

Response: As we stated in the CY 2011 PFS proposed rule (75 FR 40109), our proposal is consistent with the statutory requirements of section 1834(m)(1) of the Act and as provided in §410.141(e) that individual DSMT services may be furnished by a physician, individual, or entity that furnishes other services for which direct Medicare payment may be made and that submits necessary documentation to, and is accredited by, an accreditation organization approved by us as described in the Benefit Policy Manual (Pub. 100–04, chapter 15, section 300.2). However, consistent with the statutory requirements of section 1834(m)(1) of the Act and as provided in §410.78(b)(1) and (b)(2) of our regulations, Medicare telehealth services, including individual DSMT furnished as a telehealth service, can only be furnished by a licensed physician, PA, NP, CNS, certified nurse-midwife, clinical psychologist, clinical social worker, or registered dietitian or nutrition professional. Additionally, the site of the beneficiary must conform with the statutory requirements of telehealth originating sites from section 1834(m)(3)(C) of the Act and described in section IV.A. 2. of this final rule with comment period.

Comment: One commenter requested that pharmacists be added to the list of eligible Medicare telehealth distant site practitioners. The commenter stated that since pharmacists are already providing valuable DSMT services to patients in-person, these

practitioners should not be excluded from providing those same valuable services via telehealth.

Response: Under section 1834(m) of the Act, payment is made for a Medicare telehealth service furnished by a physician or practitioner in a distant site. For purposes of Medicare telehealth services, the physician or practitioner must either be a physician as defined in section 1861(r) of the Act or another practitioner as defined in section 1842(b)(18)(C) of the Act. Because pharmacists do not fall within these statutory definitions, we do not have the authority to make payment to pharmacists as eligible distant site practitioners for Medicare telehealth services.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to add HCPCS code G0108 to the list of telehealth services beginning in CY 2011. As a condition of payment for individual DSMT services furnished as telehealth services to an eligible telehealth individual, a minimum of 1 hour of in-person instruction in the self-administration of injectable drugs must be furnished to the individual during the year following the initial DSMT service. The injection training may be furnished through either individual or group DSMT services. By reporting the -GT or –GQ modifier with HCPCS code G0108 as a telehealth service, the distant site practitioner certifies that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training during the year following the initial DSMT service. Consistent with this final policy, we are revising our regulations at §410.78(b) and §414.65(a)(1) to include individual DSMT services as a Medicare telehealth service, with the exception of 1 hour of in-person instruction in self-administration of injectable drugs which must be furnished to the eligible telehealth

individual as individual or group DSMT services during the year following the initial DSMT service.

We note that, as specified in §410.141(e), individual DSMT services may be furnished by a physician, individual, or entity that furnishes other services for which direct Medicare payment may be made and that submits necessary documentation to, and is accredited by, an accreditation organization approved by CMS. However, consistent with the statutory requirements of section 1834(m)(1) of the Act and as provided in §410.78(b)(1) and (b)(2) of our regulations, Medicare telehealth services, including individual DSMT furnished as a telehealth service, can only be furnished by a licensed physician, PA, NP, CNS, certified nurse-midwife, clinical psychologist, clinical social worker, or registered dietitian or nutrition professional.

3. Group KDE, MNT, DSMT, and HBAI Services

The American Society of Nephrology, Dialysis Patient Citizens, AMGEN, Tahoe Forest Health Systems, Kidney Care Partners, the American Telemedicine Association, and the Marshfield Clinic submitted requests to add one or more of the following group services to the telehealth list for CY 2011:

- Group KDE services, reported by HCPCS code G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour);
- Group MNT services, reported by CPT code 97804 (Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes);
- Group DSMT services, reported by HCPCS code G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes); and/or

- Group HBAI services, reported by CPT code 96153 (Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)) and 96154 (Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)).

When furnished as individual services, HBAI and MNT services are currently on the list of Medicare telehealth services. Furthermore, we proposed to add individual KDE and DSMT services to the list of Medicare telehealth services beginning in CY 2011 as described above.

In the CY 2007 and CY 2010 PFS rulemaking cycles (70 FR 45787 and 70157, and 74 FR 33543 and 61764), we stated that we did not believe that group services could be appropriately delivered through telehealth. In the CY 2011 PFS proposed rule (75 FR 40109), we observed that currently there are no group services approved as Medicare telehealth services and that there is a different interactive dynamic between the practitioner and his or her patients in group services as compared to individual services. We previously had considered requests to add various group services to the list of Medicare telehealth services on a category 2 basis because we had believed that, especially given the interactive dynamic between practitioners and their patients, group services were not similar to other services on the list of Medicare telehealth services. Therefore, we had maintained that it was necessary to evaluate the addition of group services by comparing diagnostic findings or therapeutic interventions when services are furnished via telehealth versus when services are furnished in-person.

In the CY 2011 proposed rule (75 FR 40109), we stated that we continue to believe that the group dynamic may be a critical and defining element for certain

services, and that this characteristic precludes many group services from being considered on a category 1 basis for addition to the list of Medicare telehealth services. For example, we believe that due to the therapeutic nature of the group dynamic that is integral to group psychotherapy, group psychotherapy is fundamentally different from other Medicare telehealth services and, therefore, could not be considered on a category 1 basis for addition to the telehealth services list. For the same reason, in the absence of evidence to the contrary, we do not believe group psychotherapy services could be appropriately delivered through telehealth.

However, upon further consideration, with regard to the particular group education and training services for which we received requests for addition to the Medicare telehealth services list, for CY 2011 we concluded that we believe the group dynamic is not central to the core education and training components of these particular services, specifically DSMT, MNT, KDE, and HBAI services. We believe that these group services are sufficiently similar to the individual, related services that are already on the telehealth services list or were proposed for addition beginning in CY 2011. Specifically, we believe that for these group services, which consist principally of an information exchange for the purpose of education and training, the roles of, and interactions between, the patients and the practitioner are sufficiently similar to the related individual education and training services that the services can be furnished appropriately as a telehealth service.

Therefore, we proposed to add HCPCS code G0421 for group KDE services, CPT code 97804 for group MNT services, HCPCS code G0109 for group DSMT services, and CPT codes 96153 and 96154 for group HBAI services to the Medicare telehealth services

list on a category 1 basis for CY 2011. Furthermore, because the concerns we raised above regarding adequate injection training with the addition of individual DSMT are also present for group DSMT, we proposed to require the same minimum of 1 hour of in-person instruction for injection training within the year following the initial DSMT service for any beneficiary that receives DSMT services via telehealth. By reporting the –GT or –GQ modifier with HCPCS code G0109, the distant site practitioner would certify that the beneficiary has received or will receive 1 hour of in-person instruction in self-administration of injectable drugs which must be furnished to the eligible telehealth individual as individual or group DSMT services during the year following the initial DSMT service. Consistent with this proposal to add these group education and training services, we also proposed to revise our regulations at §410.78(b) and §414.65(a)(1) to include group KDE, MNT, DSMT, and HBAI services as Medicare telehealth services, with the exception of 1 hour of in-person instruction in self-administration of injectable drugs which must be furnished to the eligible telehealth individual as individual or group DSMT services in the year following the initial DSMT service.

Comment: Many commenters agreed with CMS' proposal to add group KDE, MNT, DSMT, and HBAI to the list of Medicare telehealth services for CY 2011. Some commenters commended CMS' willingness to expand the list of Medicare telehealth services and explained that the additions would facilitate beneficiary access to care.

Many commenters also urged CMS to make further additions to the list of Medicare telehealth services beyond those proposed for CY 2011.

Response: We believe adding these group services to the list of Medicare telehealth services will facilitate beneficiary access to care, and we appreciate the

commenters' shared interest in that goal.

The process for requesting additional services to be added the list of Medicare telehealth services is described in section IV.B. of this final rule with comment period. Requests for additions for CY 2012 must be received by the end of CY 2010. Further information is available about the process on the CMS web site at: http://www.cms.gov/telehealth/.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to add HCPCS code G0421 for group KDE services, CPT code 97804 for group MNT services, HCPCS code G0109 for group DSMT services, and CPT codes 96153 and 96154 for group HBAI services to the Medicare telehealth services list on a category 1 basis. Furthermore, because we have the same concerns for group DSMT services that we raised above regarding adequate injection training for individual DSMT services, we are requiring the same minimum of 1 hour of in-person instruction for injection training within the year following the initial DSMT service for any beneficiary that receives DSMT services via telehealth. By reporting the –GT or -GQ modifier with HCPCS code G0109, the distant site practitioner would certify that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training during the year following the initial DSMT service. Consistent with the addition of these group education and training services, we are also revising our regulations at §410.78(b) and §414.65(a)(1) to include group KDE, MNT, DSMT, and HBAI services as Medicare telehealth services, with the exception of 1 hour of in-person instruction for injection training within the year following the initial DSMT service.

As described above for individual DSMT services, we note that group DSMT services may be furnished by a physician, individual, or entity that furnishes other services for which direct Medicare payment may be made and that submits necessary documentation to, and is accredited by, an accreditation organization approved by CMS, as specified in §410.141(e) for DSMT services. However, consistent with the statutory requirements of section 1834(m)(1) of the Act and as provided in §410.78(b)(1) and (b)(2) of our regulations, Medicare telehealth services, including group DSMT furnished as a telehealth service, can only be furnished by a licensed physician, PA, NP, CNS, certified nurse-midwife, clinical psychologist, clinical social worker, or registered dietitian or nutrition professional.

4. Initial, Subsequent, and Discharge Day Management Hospital Care Services

The University of Louisville School of Medicine, the American Telemedicine Association, and Mille Lacs Health System submitted various requests to add initial hospital care services (reported by CPT codes 99221 (Level 1 initial hospital care), 99222 (Level 2 initial hospital care), and 99223 (Level 3 initial hospital care)); subsequent hospital care services (reported by CPT codes 99231 (Level 1 subsequent hospital care), 99232 (Level 2 subsequent hospital care), and 99233 (Level 3 subsequent hospital care)); and/or hospital discharge day management services (reported by CPT codes 99238 (Hospital discharge day management; 30 minutes or less) and 99239 (Hospital discharge day management; more than 30 minutes) to the Medicare telehealth services list beginning in CY 2011, generally on a category 1 basis. Some of the requestors also recommended that we limit the delivery of these services through telehealth to the provision of services to patients with a psychiatric diagnosis or to those treated in a

psychiatric hospital or licensed psychiatric bed.

We appreciate the recommendations of the requestors to substantially expand the list of Medicare telehealth services. The requestors submitted a number of studies regarding the outcomes of telehealth services in caring for patients with psychiatric diagnoses. However, we note that the CPT codes for hospital care services are used to report care for hospitalized patients with a variety of diagnoses, including psychiatric diagnoses. In the CY 2011 PFS proposed rule (75 FR 40110), we stated our belief that it would be not be appropriate to add services to the telehealth list only for certain diagnoses because the service described by a HCPCS code is essentially the same service, regardless of the patient's diagnosis. When evaluating the addition of services for telehealth on a category 1 basis, our focus is on the roles of, and interactions among, the beneficiary, the physician or practitioner, and the telepresenter (if applicable), which generally are similar across diagnoses for services that may be reported with the same HCPCS codes. Even in the unique case of certain ESRD services, we limited additions to the list of Medicare telehealth services based on the appropriateness of certain specific codes, taking into consideration the full service descriptions (69 FR 47511). Therefore, we continue to believe that it is most appropriate to consider additions to the list of telehealth services based on the overall suitability of the services described by the relevant HCPCS codes to delivery through telehealth.

In the CY 2005, CY 2008, and CY 2009 PFS rulemakings (69 FR 47510 and 66276, 72 FR 38144 and 66250, and 73 FR 38517 and 69745, respectively), we did not add initial, subsequent, or discharge day management hospital care services to the list of approved telehealth services because of our concern regarding the use of telehealth for

the ongoing evaluation and management (E/M) for the generally high acuity of hospital inpatients. While we continue to have some concern in this area, we also share the requestors' interest in improving access for hospitalized patients to care furnished by treating practitioners. Therefore, we reevaluated these services in the context of the CY 2011 requests, including considering the possibility that these services could be added on a category 1 basis based on their resemblance to services currently on the telehealth list, such as initial and follow-up inpatient telehealth consultations. The following presents a discussion of our review for the CY 2011 proposed rule of the subcategories of hospital care services included in these requests.

Currently, one of the three codes for an initial hospital care service (specifically CPT codes 99221, 99222, or 99223) is reported for the first hospital inpatient E/M visit to the patient by the admitting or a consulting practitioner when that visit is furnished in-person. In addition, we note that currently there are several HCPCS G-codes on the Medicare telehealth services list that may be reported for initial and follow-up inpatient consultations through telehealth, specifically HCPCS codes G0406 (Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth); G0407 (Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth); G0408 (Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth); G0425 (Initial inpatient telehealth consultation, typically 30 minutes communicating with the patient via telehealth); G0426 (Initial inpatient telehealth consultation, typically 50 minutes communicating with the patient via telehealth); and G0427 (Initial inpatient

telehealth consultation, typically 70 minutes or more communicating with the patient via telehealth).

While initial inpatient consultation services are currently on the list of approved telehealth services, there are no services on the current list of telehealth services that resemble initial hospital care for an acutely ill patient by the admitting practitioner who has ongoing responsibility for the patient's treatment during the hospital course. Therefore, we were unable to consider initial hospital care services on a category 1 basis for the telehealth list for CY 2011.

We reviewed the documentation submitted in support of adding the initial hospital care codes to the Medicare telehealth services list as category 2 requests. Most of the studies provided by the requestors were specific to the treatment of patients with particular diagnoses. Additionally, the studies were not specific to initial hospital care visits by admitting practitioners. Finally, most of the studies concluded that more research was required in order to establish medical equivalence between telehealth and in-person services. Therefore, we received no information that provides robust support for the addition of initial hospital care services to the approved telehealth list on a category 2 basis. The initial hospital care codes describe the first visit to the hospitalized patient by the admitting practitioner who may or may not have seen the patient in the decision-making phase regarding hospitalization. We believe it is critical that the initial hospital visit by the admitting practitioner be conducted in-person to ensure that the practitioner with ongoing treatment responsibility comprehensively assesses the patient's condition upon admission to the hospital through a thorough in-person examination.

Therefore, we did not propose to add initial hospital care services to the Medicare telehealth services list for CY 2011.

We again considered adding subsequent hospital care services reported by CPT codes 99231 through 99233 to the telehealth list for CY 2011 on a category 1 basis. In the CY 2005 and CY 2008 PFS proposed rules (69 FR 47511 and 72 FR 38155), we stated that the potential acuity of patients in the hospital setting precludes consideration of subsequent hospital visits as similar to existing telehealth services. However, as stated earlier, we also note that HCPCS codes for initial and follow-up inpatient consultation services are on the list of telehealth services. These E/M services are furnished to high acuity hospitalized patients, although not by the admitting practitioner himself or herself. However, in light of the increasingly prevalent care model that entails multidisciplinary team care for patients with complex medical illnesses that involve multiple body systems, consulting practitioners may often play a key, intensive, and ongoing role in caring for hospitalized patients. Therefore, we believe that subsequent hospital care visits by a patient's admitting practitioner may sufficiently resemble follow-up inpatient consultation services to consider these subsequent hospital care services on a category 1 basis for the telehealth list. While we still believe the potential acuity of hospital inpatients is greater than those patients likely to receive currently approved Medicare telehealth services, we also believe that it would be appropriate to permit some subsequent hospital care services to be furnished through telehealth in order to ensure that hospitalized patients have frequent encounters with their admitting practitioner. However, we also continue to believe that the majority of these visits should be in-person to facilitate the

comprehensive, coordinated, and personal care that medically volatile, acutely ill patients require on an ongoing basis.

Therefore, for CY 2011 we proposed that subsequent hospital care services, specifically CPT codes 99231, 99232, and 99233, be added to the list of telehealth services on a category 1 basis for CY 2011, but with some limitations on the frequency with which these services may be furnished through telehealth. Because of our concerns regarding the potential acuity of hospital inpatients, we proposed to limit the provision of subsequent hospital care services through telehealth to once every 3 days. We were confident that admitting practitioners would continue to make appropriate in-person visits to all patients who need such care during their hospitalization. Consulting practitioners should continue to use the inpatient telehealth consultation HCPCS G-codes, specifically G0406, G0407, G0408, G0425, G0426, or G0427 when reporting consultations furnished to inpatients via telehealth.

Consistent with this proposal, we proposed to revise §410.78(b) and §414.65(a)(1) to include subsequent hospital care services as Medicare telehealth services, with the limitation of one telehealth subsequent hospital care service every 3 days.

We also considered adding hospital discharge day management services to the list of telehealth services. These services, reported by CPT codes 99238 and 99239, include the final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms. These services are furnished when a practitioner deems it medically reasonable and necessary to assess a patient's readiness for discharge and to

prepare a patient for discharge from an acute care environment to a less intensive setting. There are no services on the current list of telehealth services that resemble such preparation of a patient for discharge. We believe it is especially important that, if a practitioner furnishes a discharge day management service, the service be furnished in-person in order to allow the practitioner to comprehensively assess the patient's status in preparation for discharge so that the patient will have a higher likelihood of making a successful transition to the less intensive setting. Therefore, we did not consider hospital discharge day management services for addition to the Medicare telehealth services list on a category 1 basis.

We reviewed the documentation submitted by requestors in support of adding these codes to the Medicare telehealth services list on a category 2 basis. Most of the submitted studies were specific to the treatment of patients with specific diagnoses and were not specific to discharge services. Additionally, most of the studies concluded that more research was required in order to establish medical equivalence between telehealth and in-person services. The submitted documentation did not provide the necessary evidence to alter our previous conclusion that hospital discharge day management services should be provided in-person in light of the acuity of hospitalized patients, their typically complex post-hospitalization care needs, and the importance of patient education by the admitting practitioner who had ongoing responsibility for the patient's treatment during the hospital stay. Therefore, we did not propose to add hospital discharge day management services to the list of telehealth services for CY 2011.

Comment: Many commenters expressed support for all of CMS' proposed additions to the list of Medicare telehealth services, including subsequent hospital care

services. One commenter urged CMS to focus on adding services where research demonstrates that technology can facilitate medically equivalent services and improve beneficiary access to providers, and to carefully monitor implementation of any new telehealth services to ensure that patients' experience of the care is positive and that patient outcomes are not compromised. The commenter encouraged CMS' continued attention to the evidence and the role of patient needs as CMS evaluates telehealth requests. The commenter cited CMS' decision not to propose the addition of hospital discharge day management services as a Medicare telehealth service as an example of the agency applying appropriate rigor to best reflect patient needs and preferences.

Response: We appreciate the support for our proposed additions, as well as our consideration and decisions regarding requested additions to telehealth services that we did not propose to add to the list of telehealth services for CY 2011.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to add subsequent hospital care services, specifically CPT codes 99231, 99232, and 99233, to the list of telehealth services on a category 1 basis for CY 2011, but with the limitation of one subsequent hospital care service furnished through telehealth every 3 days. We are revising §410.78(b) and §414.65(a)(1) accordingly to include subsequent hospital care services as Medicare telehealth services, with the limitation of one telehealth subsequent hospital care service every 3 days. We are also finalizing our decision not to add initial or discharge day management hospital care services to the list of Medicare telehealth services.

5. Initial, Subsequent, Discharge Day Management, and Other Nursing Facility Care Services

The American Telemedicine Association and the Marshfield Clinic submitted requests to add nursing facility care codes, covering the spectrum of initial (reported by CPT codes 99304 (Level 1 initial nursing facility care), 99305 (Level 2 initial nursing facility care) and 99306 (Level 3 initial nursing facility care)); subsequent (reported by CPT codes 99307 (Level 1 subsequent nursing facility care), 99308 (Level 2 subsequent nursing facility care), 99309 (Level 3 subsequent nursing facility care), and 99310 (Level 4 subsequent nursing facility care)); discharge day management (reported by CPT codes 99315 (Nursing facility discharge day management; 30 minutes or less) and 99316 (Nursing facility discharge day management; more than 30 minutes)); and other (reported by CPT code 99318 (Evaluation and management of a patient involving an annual nursing facility assessment)) services, to the Medicare telehealth services list beginning in CY 2011. The commenters requesting the addition of these services expressed concerns regarding limited access to care if we did not allow these services to be furnished through telehealth, and requested that CMS acknowledge the recent Congressional inclusion of nursing facilities as telehealth originating sites by adding these codes to the list of Medicare telehealth services.

In the CY 2010 PFS proposed and final rules (74 FR 33544 and 74 FR 61762), we discussed concerns about potential disparities in patient acuity between nursing facility services and the current list of Medicare telehealth services. We also declined to add HCPCS codes to the Medicare telehealth services list that are used exclusively to describe Federally-mandated nursing facility visits. As discussed in the CY 2010 PFS

proposed rule (74 FR 33543), the long-term care regulations at §483.40(c) require that residents of SNFs receive initial and periodic personal visits. These regulations ensure that at least a minimal degree of personal contact between a practitioner and a SNF resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay. We continue to believe that these Federally-mandated visits should be conducted in-person, and not as Medicare telehealth services. Therefore, in the CY 2010 PFS final rule with comment period, we revised §410.78 to preclude physicians and other practitioners from furnishing the physician visits required under §483.40(c) through telehealth.

We reviewed the use of telehealth for each of the subcategories of nursing facility services included in the requests for CY 2011. We identified the E/M services that fulfill Federal requirements for personal visits under §483.40(c), and we did not propose for CY 2011 to add any HCPCS codes to the Medicare telehealth services list that are used exclusively to describe these Federally-mandated visits. These codes include the CPT codes for initial nursing facility care (CPT codes 99304 through 99306) that are used to report the initial E/M visit that fulfills Federally-mandated requirements under §483.40(c) and other nursing facility service (CPT code 99318) that is only payable by Medicare if the visit is substituted for a Federally-mandated visit under §483.40(c).

The nursing facility discharge day management services reported under CPT code 99315 and 99316 are E/M visits that prepare a nursing facility resident for discharge from the facility. There are no Medicare requirements that such a service be furnished. If a practitioner chooses to furnish this service, we continue to believe that an in-person visit is most appropriate in order to ensure the resident is prepared for discharge from the

nursing facility. These services are furnished when a practitioner deems it medically reasonable and necessary to assess a patient's readiness for and to prepare a patient being discharged from the monitored nursing facility environment to another typically less intensive setting. There are no services on the current list of telehealth services that resemble such preparation of a patient for discharge. As in the case of hospital discharge day management services, we believe it is especially important that, if a practitioner furnishes a nursing facility discharge day management service, the service be furnished in-person. The practitioner must be able to comprehensively assess the patient's status in preparation for discharge so that the patient will have a higher likelihood of making a successful transition from the nursing facility to another setting. Therefore, we did not consider nursing facility discharge day management services for addition to the Medicare telehealth services list on a category 1 basis for CY 2011. When we considered the addition of these services under category 2, we had no evidence that nursing facility discharge services furnished through telehealth are equivalent to in-person discharge services. Therefore, we did not propose to add nursing facility discharge day management services to the CY 2011 telehealth list.

Subsequent nursing facility services, reported by CPT codes 99307 through 99310, may be used to report either a Federally-mandated periodic visit under §483.40(c) or another E/M visit, prior to or after the initial nursing facility care visit, as long as the subsequent nursing facility care visit is medically reasonable and necessary for the resident's care. While we continue to believe that many SNF residents have complex medical care needs, we believe that it is appropriate to consider the addition of these codes to the telehealth list on a category 1 basis. As we state above in the context of our

discussion of subsequent hospital care services, the HCPCS codes for initial and follow-up inpatient consultation services for nursing facility patients are on the list of Medicare telehealth services, and subsequent nursing facility services are similar to those services. These E/M services are furnished to high acuity, complex SNF patients, although not by the admitting practitioner himself or herself. Therefore, we believe that subsequent nursing facility visits by a patient's admitting practitioner sufficiently resemble follow-up inpatient consultation services to consider them on a category 1 basis for the telehealth list. We concluded for CY 2011 that it would be appropriate to permit some subsequent nursing facility care services to be furnished through telehealth to ensure that complex nursing facility patients have frequent encounters with their admitting practitioner, although we continue to believe that the Federally-mandated visits should be in-person to facilitate the comprehensive, coordinated, and personal care that these complex patients require on an ongoing basis.

Therefore, we proposed that subsequent nursing facility care services, specifically CPT codes 99307, 99308, 99309 and 99310, be added to the list of Medicare telehealth services on a category 1 basis beginning in CY 2011, with some limitations on furnishing these services through telehealth. Because of our concerns regarding the potential acuity and complexity of SNF inpatients, we proposed to limit the provision of subsequent nursing facility care services furnished through telehealth to once every 30 days. We were especially interested in public comments, including any evidence regarding patterns of high quality care and clinical outcomes, regarding this proposal to limit the provision of subsequent nursing facility care services furnished through telehealth to once every 30 days. We remain committed to ensuring that SNF inpatients receive appropriate

in-person visits and that Medicare pays only for medically reasonable and necessary care. Currently and continuing in CY 2011, an unlimited number of initial and follow-up consultation services may be furnished through telehealth to these patients, so we believe that only a limited number of subsequent nursing facility care services by the admitting practitioner would be appropriate for SNF inpatients. Finally, we specified that subsequent nursing facility care services reported for a Federally-mandated periodic visit under §483.40(c) may not be furnished through telehealth. In light of this CY 2011 proposal, we were confident that admitting practitioners would continue to make appropriate in-person visits to all patients who need such care during their SNF stay.

Consistent with our proposal, we proposed to revise §410.78(b) and §414.65(a)(1) to include subsequent nursing facility care services as Medicare telehealth services, with the limitation of one telehealth subsequent nursing facility care service every 30 days. Federally-mandated periodic visits may not be furnished through telehealth, as specified currently in §410.78(e)(2).

Comment: One commenter recommended that CMS limit the use of telehealth for subsequent nursing facility care services to CPT codes 99307 and 99308, the lower two levels of care. The commenter stated that the subsequent nursing facility care services described by CPT codes 99309 and 99310, the higher two levels of care, require a detailed to comprehensive history and examination, along with moderate to complex decision making that warrant an in-person visit with the physician. The same commenter disagreed with the limitation of one telehealth subsequent nursing facility care service every 30 days and suggested that unless and until evidence of overutilization is obtained, the limit could hinder access to appropriate care under the telehealth benefit. The

commenter agreed with the CMS policy that all Federally-mandated visits as defined by the long-term care regulations §483.40(c) should be conducted in-person and not as Medicare telehealth services.

Response: We appreciate the response to our specific request for public comment regarding the addition of subsequent nursing facility care services to the list of Medicare telehealth services with the limitation of one telehealth subsequent nursing facility care service every 30 days. As we stated in the proposed rule (75 FR 40112), we remain committed to ensuring that SNF inpatients receive appropriate in-person visits and that Medicare pays only for medically reasonable and necessary care. We received no new evidence from the commenter regarding patterns of high quality care and clinical outcomes in terms of our proposal to limit the provision of subsequent nursing facility care services furnished through telehealth to once every 30 days. Because we want to ensure that nursing facility patients with complex medical conditions have appropriately frequent medically reasonable and necessary encounters with their admitting practitioner, we continue to believe that it would be appropriate to permit the full range of subsequent nursing facility care services to be furnished through telehealth. At the same time, because of our concerns regarding the potential acuity and complexity of SNF inpatients, we want to ensure that these patients continue to receive in-person visits as appropriate to manage their care. We are adding these services as Medicare telehealth services with the limitation as we proposed, and we remain confident that admitting practitioners will continue to make appropriate in-person visits to all patients who need such care during their SNF stay.

After consideration of the public comments we received, we are finalizing our

CY 2011 proposal to add subsequent nursing facility care services, specifically CPT codes 99307, 99308, 99309 and 99310, to the list of Medicare telehealth services on a category 1 basis beginning in CY 2011, with limits to the provision of subsequent nursing facility care services furnished through telehealth to once every 30 days. We are revising §410.78(b) and §414.65(a)(1) to include subsequent nursing facility care services as Medicare telehealth services, with the limitation of one telehealth subsequent nursing facility care service every 30 days. Federally-mandated periodic visits may not be furnished through telehealth, as specified currently in §410.78(e)(2).

6. Neuropsychological Testing Services

The American Telemedicine Association submitted a request to add neuropsychological testing services, described by CPT codes 96119 (Neuropsychological testing (for example, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report); and 96119 (Neuropsychological testing (for example, Halstead-Reitan Neuropsychological Battery, Wechsler Memory scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face), to the list of telehealth services for CY 2011 based on their similarity to other telehealth services.

In the CY 2008 PFS final rule with comment period (72 FR 66251), we stated that we have received conflicting comments and data regarding the appropriateness of furnishing neuropsychological testing via telehealth. While we appreciate the recent request for addition of these same services to the Medicare telehealth services list, we did

not believe that these services are similar to services currently on the Medicare telehealth services list and, therefore, we concluded that they would not be appropriate for consideration or addition under category 1 for CY 2011. In the CY 2011 request for the addition of the these services, we received no information to indicate that the diagnostic findings of neuropsychological testing through telehealth are similar to those based upon in-person testing, and therefore that testing through telehealth does not affect the patient's diagnosis. Consequently, we did not propose to add neuropsychological testing services to the list of approved Medicare telehealth services for CY 2011.

We received no public comments regarding our discussion of the request to add neuropsychological testing to the list of Medicare telehealth services. Therefore, we are finalizing our decision not to add neuropsychological testing to the list of Medicare telehealth services for CY2011.

7. Speech-Language Pathology Services

The Marshfield Clinic submitted a request to add various speech-language pathology services to the list of approved telehealth services for CY 2011. Speech-language pathologists are not permitted under section 1842(b)(18)(C) of the Act to furnish and receive payment for Medicare telehealth services. Therefore, we did not propose to add any speech-language pathology services to the list of Medicare telehealth services for CY 2011. For further discussion of these services in the context of telehealth, we refer readers to the CY 2005 and CY 2007 PFS proposed and final rules with comment period (69 FR 47512 and 66276, and 71 FR 48995 and 69657).

Comment: One commenter stated that research has proven that audiology procedures offered via telehealth services have great potential. The commenter also

stated that CMS should use its broad discretion in implementing programs to expand the list of available telehealth services to include audiology.

Response: It is not within our administrative authority to pay speech language pathologists and audiologists for services furnished via telehealth. The statute authorizes the Secretary to pay for telehealth services only when furnished by a physician or a practitioner as those terms are defined in section 1834(m)(4)(D) and (E) of the Act.

After consideration of the public comment we received, we are finalizing our decision not to add various speech-language pathology services to the list of approved telehealth services for CY 2011.

8. Home Wound Care Services

Wound Care Associates, LLC, submitted a request to add wound care in the home setting to the list of Medicare telehealth services. A patient's home is not permitted under current statute to serve as an originating site for Medicare telehealth services. Therefore, we did not propose to add home wound care services to the list of Medicare telehealth services for CY 2011.

We received no public comments regarding our discussion of the request to add wound care in the home setting to the list of Medicare telehealth services. Therefore, we are finalizing our decision not to add wound care in the home setting to the list of Medicare telehealth services for CY2011.

9. Other Issues

We received other public comments on matters related to Medicare telehealth services that were not the subject of proposals in the CY 2011 PFS proposed rule. We thank the commenters for sharing their views and suggestions. Because we did not make

any proposals regarding these matters, we do not generally summarize or respond to such comments in this final rule with comment period. However, we are summarizing and responding to the following comments in order to reiterate certain information.

Comment: One commenter requested an explanation of the acceptable time and format to request or recommend changes to the criteria set in 2003 by which CMS considers specific services for Medicare coverage when furnished through telehealth.

Response: As we discussed in the CY 2010 PFS final rule with comment period (74 FR 61766), our established criteria and process for reviewing requests to add to the list of approved Medicare telehealth services were subject to full notice and comment procedures in the CY 2003 PFS proposed and final rules. Since we did not make any proposals relating to the criteria or process for CY 2011, any potential revisions to the process for adding or deleting services from the list of approved Medicare telehealth services are outside the scope of this CY 2011 final rule with comment period.

Throughout the year, we regularly meet with parties who want to share their views on topics of interest to them. These discussions may provide us with information regarding changes in medical practice and afford opportunities for the public to bring to our attention issues they believe we should consider for future rulemaking. Thus, we encourage stakeholders to contact us at any time if there are topics related to physician payment policy that they would like to discuss.

Comment: One commenter requested an explanation regarding how the payment rates for telehealth consultations are set in a manner that is consistent with section 1834(m)(2)(A) of the Act that requires Medicare to pay a practitioner who furnishes a

telehealth service an amount equal to the amount that the practitioner would have been paid if the service had been furnished without the use of a telecommunications system.

Response: As we stated in the CY 2009 PFS final rule with comment period (73 FR 69745), we established the RVUs for follow-up inpatient telehealth consultations at the same level as the RVUs established for subsequent hospital care (as described by CPT codes 99231 through 99233). For CY 2010, we established the RVUs for initial inpatient telehealth consultations at the same level as the RVUs for initial hospital care (as described by CPT codes 99221 through 99223) (75 FR 61775). We believe this is appropriate because a physician or practitioner furnishing a telehealth service is paid an amount equal to the amount that would have been paid if the service had been furnished without the use of a telecommunication system. Since physicians and practitioners furnishing follow-up inpatient consultations in an in-person encounter must continue to utilize subsequent hospital care codes (as described by CPT codes 99231 through 99233) and those furnishing initial inpatient consultations in an in-person encounter must generally utilize initial hospital care codes (as described by CPT codes 99221 through 99223), we believe it is appropriate that the RVUs for the subsequent and initial telehealth HCPCS G-codes are set at the same level as the subsequent and initial hospital care codes, respectively.

D. Summary of CY 2011 Telehealth Policies

In summary, we are finalizing our proposals to add the following requested services to the list of Medicare telehealth services for CY 2011:

- Individual and group KDE services (HCPCS codes G0420 and G0421, respectively);

- Individual and group DSMT services, with a minimum of 1 hour of in-person instruction to be furnished in the year following the initial DSMT service to ensure effective injection training (HCPCS codes G0108 and G0109, respectively);
- Group MNT and HBAI services (CPT codes 97804, and 96153 and 96154, respectively);
- Subsequent hospital care services, with the limitation for the patient's admitting practitioner of one telehealth visit every 3 days (CPT codes 99231, 99232, and 99233); and
- Subsequent nursing facility care services, with the limitation for the patient's admitting practitioner of one telehealth visit every 30 days (CPT codes 99307, 99308, 99309, and 99310).

Furthermore, we are revising §410.78(b) and §414.65(a)(1) accordingly. Specifically, we are adding individual and group KDE services, individual and group DSMT services, group MNT services, group HBAI services, and subsequent hospital care and nursing facility care services to the list of telehealth services for which payment will be made at the applicable PFS payment amount for the service of the practitioner. In addition, we have reordered the listing of services in these two sections and removed "initial and follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals and SNFs" in §410.78(b) because these are described by the more general term "professional consultations" that is in the same section. Finally, we are continuing to specify that the physician visits required under §483.40(c) may not be furnished as telehealth services.

E. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2011 is 0.4 percent. Therefore, for CY 2011, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or $24.10. The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown in Table 49.

TABLE 49: The Medicare Telehealth Originating Site Facility Fee and MEI Increase by the Applicable Time Period

Facility Fee	MEI Increase	Period
$20.00	N/A	10/01/2001 – 12/31/2002
$20.60	3.0%	01/01/2003 – 12/31/2003
$21.20	2.9%	01/01/2004 – 12/31/2004
$21.86	3.1%	01/01/2005 – 12/31/2005
$22.47	2.8%	01/01/2006 – 12/31/2006
$22.94	2.1%	01/01/2007 – 12/31/2007
$23.35	1.8%	01/01/2008 – 12/31/2008
$23.72	1.6%	01/01/2009 – 12/31/2009
$24.00	1.2%	01/01/2010 – 12/31/2010
$24.10	0.4%	01/01/2011 – 12/31/2011

V. Addressing Interim Final Relative Value Units from CY 2010 and Establishing Interim Relative Value Units for CY 2011

A. Background

In accordance with section 1848(c) of the Act, CMS determines work, PE, and malpractice RVUs for each service paid under the PFS. On an annual basis, the AMA RUC provides CMS with recommendations regarding physician work values for new, revised, and potentially misvalued codes. Over the last several years, CMS, in conjunction with the AMA RUC, has identified and reviewed numerous potentially misvalued CPT codes. In 2006, the AMA RUC established the Five-Year Review Identification Workgroup to identify potentially misvalued services using the following screens: "New Technology;" "Site-of-Service Anomalies;" " High Volume Growth;" "CMS Fastest Growing;" "High Intra-Service Work per Unit Time (IWPUT);" "Services Surveyed by One Specialty—Now Performed by a Different Specialty;" "Harvard-Valued, Utilization over 1 Million;" "Harvard Valued, Utilization over 100,000;" and "Codes Reported Together/Bundled CPT Services." In addition to providing recommendations to CMS for work RVUs, the AMA RUC's Practice Expense Subcommittee reviews and then the AMA RUC recommends direct PE inputs (clinical labor, medical supplies, and medical equipment) for individual services. To guide the establishment of malpractice RVUs for new and revised codes before the next 5-Year Review of Malpractice, the AMA RUC also provides crosswalk recommendations, that is, "source" codes with a similar specialty mix of practitioners furnishing the source code and the new/revised code. CMS reviews the AMA RUC recommendations on a code-by-code basis. For AMA RUC recommendations regarding physician work RVUs,

we determine whether we agree with the recommended work RVUs for a service (that is, we agree the valuation is accurate), or, if we disagree, we determine an alternative value that better reflects our estimate of the physician work for the service. Because of the timing of the CPT Editorial Panel decisions, AMA RUC recommendations, and our rulemaking cycle, we publish these work RVUs in the PFS final rule with comment period as interim final values, subject to public comment. Similarly, we assess the AMA RUC's recommendations for direct PE inputs and malpractice crosswalks, and establish PE and malpractice interim final values, which are also subject to comment. We note that, with respect to interim final PE RVUs, the main aspect of our valuation that is open for public comment for a new, revised, or potentially misvalued code is the direct PE inputs and not the other elements of the PE valuation methodology, such as the indirect cost allocation methodology, that also contribute to establishing the PE RVUs for a code. The public comment period on the PFS final rule with comment period remains open for 60 days after the rule is issued.

If we receive public comments on the interim final work RVUs for a specific code indicating that refinement of the interim final work value is warranted based on sufficient information from the commenters concerning the clinical aspects of the physician work associated with the service (57 FR 55917), we refer the service to a refinement panel, as discussed in further detail in sections III.I. and V.B.1. of this final rule with comment period.

In the interval between closure of the comment period and the subsequent year's PFS final rule with comment period, we consider all of the public comments on the interim final work, PE, and malpractice RVUs for the new, revised, and potentially

misvalued codes and the results of the refinement panel, if applicable. Finally, we address the interim final RVUs (including the interim final direct PE inputs) by providing a summary of the public comments and our responses to those comments, including a discussion of any changes to the interim final work or malpractice RVUs or direct PE inputs, in the following year's PFS final rule with comment period. We then typically finalize the direct PE inputs and the work, PE, and malpractice RVUs for the service in that year's PFS final rule with comment period, unless we determine it would be more appropriate to continue their interim final status for another year and solicit further public comment.

B. Addressing Interim Final RVUs from CY 2010

In this section, we address the interim final values published in Appendix C of the CY 2010 PFS final rule with comment period (74 FR 62144 through 62146), as subsequently corrected in the December 10, 2009 (74 FR 65449) and May 11, 2010 correction notices (75 FR 26350). We discuss the results of the CY 2010 refinement panel, respond to public comments received on specific interim final values (including direct PE inputs) from CY 2010, address the status of the interim final values of a number of potentially misvalued codes from CY 2009 and CY 2010, and address the other new, revised, or potentially misvalued codes with interim final values for CY 2010 that are not specifically discussed elsewhere in this final rule with comment period.

We note that the final CY 2011 direct PE database that lists the direct PE inputs is available on the CMS Web site under the downloads for the CY 2011 PFS final rule with comment period at:

http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage. The final CY

2011 work, PE, and malpractice RVUs are displayed in Addendum B to this final rule with comment period.

1. CY 2010 Interim Final Work RVUs Referred to the Refinement Panel

We received public comments on 4 CPT codes with CY 2010 interim final work values. We referred these services to the CY 2010 refinement panel for further review. For ease of discussion, we will be referring to these services as "refinement codes." Consistent with past practice (62 FR 59084), we convened a multispecialty panel of physicians to assist us in the review of the comments. The panel was moderated by our physician advisors, and consisted of the following voting members:

- One or two clinicians representing the commenting organization.
- Two primary care clinicians nominated by the American Academy of Family Physicians and the American College of Physicians.
- Three contractor medical directors (CMDs).
- Clinicians with practices in related specialties who were expected to have knowledge of the services under review.

We assembled a set of 300 reference services and asked the panel members to compare the clinical aspects of physician work for the refinement code to one or more of the reference services. In compiling the set of reference services, we attempted to include: (1) services that are commonly performed for which the work RVUs are not controversial; (2) services that span the spectrum of work intensity; and (3) at least three services performed by each of the major specialties that furnish the refinement codes so that the perspective of relevant specialties would be represented. The panel process was designed to capture each participant's independent judgment and his or her clinical

experience which informed and drove the discussion of the refinement code during the refinement panel proceedings. Following the discussion, each voting participant rated the physician work of the refinement code. Ratings were obtained individually and confidentially, with no attempt to achieve consensus among the panel members.

We then analyzed the ratings for each refinement code based on a presumption that the interim final work RVUs were correct unless the ratings clearly indicated a different result. Ratings of work were analyzed for consistency among the four different groups (commenting organization, primary care physicians, CMDs, and related clinicians) represented on the panel. In addition, we used statistical tests to determine whether there was sufficient agreement among the groups of the panel and whether the agreed-upon RVUs differed significantly from the interim final RVUs published in Addendum C of the CY 2010 final rule with comment period. We did not modify the interim final RVUs unless there was clear agreement for a change. If there was agreement across groups for change, but the groups did not agree on what the new RVUs should be, we eliminated the outlier group and looked for agreement among the remaining groups as the basis for new RVUs for the refinement code. This methodology is consistent with the historical refinement process as established in the November 25, 1992 PFS final rule with comment period (57 FR 55938).

Our decision to convene multispecialty panels of physicians and to apply the statistical tests described above has historically been based on our need to balance the interests of those who commented on the interim final work values with the redistributive effects that would occur in other specialties if the work values were changed. We refer readers to section III.I. of this final rule with comment period for a full discussion of the

changes to the refinement process that we are adopting for refinement panels beginning in CY 2011.

Table 50 lists those refinement codes reviewed under the CY 2010 refinement panel process described in this section. The table includes the following information:

- CPT Code. This is the CPT code for a service.
- Short Descriptor. This is an abbreviated version of the narrative description of the code.
- CY 2010 Interim Final Work RVUs. The interim final work RVUs that appeared in the CY 2010 PFS final rule with comment period (74 FR 61949 through 61953), as subsequently corrected in the December 10, 2009 (74 FR 65449) and May 11, 2010 correction notices (75 FR 26350), are shown for each reviewed code.
- Requested Work RVUs. This column identifies the work RVUs requested by the commenters.
- CY 2011 Final Work RVUs. This column contains the final work RVUs after consideration by the refinement panel.

We note that we are accepting the results of the CY 2010 refinement panel for all of these codes as the final work RVUs for CY 2011. These final values are also displayed in Addendum B to this final rule with comment period.

Table 50: CPT Codes Reviewed Under the CY 2010 Refinement Panel Process

CPT Code	Mod	Short Descriptor	CY 2010 Interim Final Work RVUs	Requested Work RVUs	CY 2011 Final Work RVUs
74261	26	Ct colonography, w/o dye	2.28	2.40	2.40
78451	26	Ht muscle image spect, sing	1.38	1.40	1.38
78452	26	Ht muscle image spect, mult	1.62	1.75	1.62
95905	26	Motor/sens nrve conduct test	0.05	0.15	0.05

2. CY 2010 Interim Final RVUs for Which Public Comments Were Received

a. Insertion of Breast Prosthesis (CPT code 19340)

CPT code 19340 (Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction) was identified by CMS for AMA RUC review as requested by the specialty society. The AMA RUC recommended 13.78 work RVUs for CY 2010, which CMS accepted. However, as noted by a public comment on the CY 2010 PFS final rule with comment period, the interim final CY 2010 work RVUs published in the CY 2010 PFS final rule with comment period (74 FR 61779, 62023 and 62144) for this service did not reflect the increases in the evaluation and management services for the post-operative visits associated with this service that resulted from the CY 2010 changes to the consultation code policy. The work RVUs for CPT code 19340 with these increases included are 13.99 RVUs. This correction was included in the May 11, 2010 correction notice to the CY 2010 final rule with comment period (75 FR 26356). We are finalizing the interim work RVUs for CPT code 19340 of 13.99 for CY 2011.

b. Computed Tomographic Colonography (CPT code 74261)

For CPT code 74261, (Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material), the AMA RUC recommended 2.40 work RVUs. During the AMA RUC meeting, this code was compared to two CPT codes: 75635 (Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing (work RVUs = 2.40)) and 78815 (Positron emission tomography (PET) with concurrently acquired computed

tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh (work RVUs = 2.44)). Based on the comparisons of similar physician work, physician time, and intensity/complexity measures, the AMA RUC determined that work RVUs of 2.40 were appropriate for CPT code 74261. We disagreed with the AMA RUC-recommended work RVUs and believe CPT code 74263 (Computed tomographic (CT) colonography, screening, including image postprocessing) represents a more comparable service because it has virtually the same description of work, pre-, intra-, and post-service time for which the AMA RUC recommended work RVUs of 2.28. Therefore, we assigned interim final work RVUs of 2.28 to CPT code 74261 for CY 2010.

Comment: Several commenters disagreed with the interim final work RVUs assigned by CMS and believe that equalizing the work RVUs for diagnostic and screening computed tomographic colonography ignores the reality that patients referred for diagnostic study, by definition, have greater complexity. These commenters believed that for this reason and the increased time involved with a diagnostic study, higher work RVUs are necessary to maintain the proper relativity with the corresponding screening CPT code 74263. The commenters recommended that CMS accept the AMA RUC-recommended work RVUs of 2.40 for CPT code 74261 and refer this code to the CY 2010 refinement panel for review.

Response: Based on the concerns expressed by the commenters, we referred this code to the CY 2010 refinement panel for review. As a result of the statistical analysis of the CY 2010 refinement panel ratings, we are assigning 2.40 work RVUs to CPT code 74261 as the final value for CY 2011.

c. Myocardial Perfusion Imaging (CPT codes 78451, 78452, 78453, and 78454)

For CPT code 78451 (Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)), the AMA RUC recommended 1.40 work RVUs, while the AMA RUC recommended 1.75 work RVUs for CPT code 78452 (Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection).

Upon review of the AMA RUC recommendations for these codes, it was unclear what methodology the AMA RUC used to calculate the recommended work RVUs for CPT code 78451. Therefore, we disagreed with the AMA RUC-recommended work RVUs of 1.40 for CPT code 78451 and believe the work RVUs for the survey 25th percentile were more appropriate. Therefore, we assigned interim final work RVUs of 1.38 to CPT code 78451 for CY 2010.

For CPT code 78452, we disagreed with the reference code used, CPT code 70496 (Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing (work RVUs = 1.75)). We believe CPT code 78452 is comparable to CPT code 73219 (Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s) (work RVUs = 1.62)), which has the same pre-, intra-, and post-service time. Therefore, we assigned interim final work RVUs of 1.62 to CPT code 78452 for CY 2010.

We accepted the CY 2010 recommendations of the AMA RUC for the direct PE inputs for CPT codes 78451, 78452, 78453, and 78454 (75 FR 61955).

Comment: Several commenters disagreed with the interim final work RVUs assigned by CMS for these two services. The commenters pointed out that the specialty and AMA RUC recommendations for both of these services already reflected a tremendous reduction from the work RVUs for the services as reported by multiple component codes in previous years and expressed disappointment that additional reductions were made by CMS. The commenters explained that in an effort to maintain relativity between CPT codes 78451 and 78452, the recommended RVUs for 78451 were derived by calculating the relationship between the median survey RVUs for CPT codes 78451 and 78452 and maintaining this relationship between the recommended RVUs for CPT codes 78451 and 78452. That is, the survey work RVU relationship between CPT code 78451: 78452 is [1.50 : 1.87], leading to the same relationship between the AMA RUC-recommended RVUs for 78451 : 78452 of [1.40 : 1.75]. The AMA RUC agreed that the computed work RVUs, 1.40 for CPT code 78451, maintain the relativity of the original survey data and provide an appropriate measure of the work for CPT code 78451.

The commenters believe that CMS does not have the special expertise necessary to choose a different reference code than the code selected by the multispecialty AMA RUC panel and disagreed with the reference code used by CMS for establishing work RVUs for CPT code 78452. The AMA RUC pointed out that the reference code has no associated computer post-processing analysis, requires the interpretation of fewer images, and has no additional cine-motion images to analyze and interpret, all of which are

included in the myocardial perfusion imaging procedures.

The commenters requested that CMS accept the AMA RUC recommendations of 1.40 work RVUs for CPT code 78451 and 1.75 work RVUs for CPT code 78452 and refer these codes to the CY 2010 refinement panel for review.

Response: Based on the concerns expressed by the commenters, these codes were referred to the CY 2010 refinement panel for review. As a result of the statistical analysis of CY 2010 refinement panel ratings, the work RVUs for these codes were unchanged. Therefore, we are adopting the interim final values for these codes as final, with 1.38 work RVUs for CPT code 78451 and 1.62 work RVUs for CPT code 78452 for CY 2011.

Comment: Several commenters asserted that CMS had incorrectly crosswalked equipment time inputs for several myocardial perfusion imaging codes (CPT codes 78451, 78452, 78453, and 78454), rather than accepting the AMA RUC recommendations for these codes as CMS had stated in the CY 2010 PFS final rule with comment period (74 FR 61955). One commenter further suggested that the useful life of 5 years for the Cobalt-57 flood source was incorrect.

Response: We appreciate the commenters' assistance, and we corrected the equipment times in the May 11, 2010 correction notice to the CY 2010 PFS final rule with comment period (75 FR 26356 and 26570). We are finalizing these direct PE inputs for CY 2011. We also proposed to change the useful life of the Cobalt-57 flood source from 5 to 2 years for CY 2011 (75 FR 40056). We address our final policies regarding this proposal in section II.A.3.b.(4) of this final rule with comment period.

Comment: Several commenters expressed concern that CMS applied fully

transitioned PE RVUs to the new and revised CY 2010 CPT codes, specifically CPT codes 78451, 78452, 78453, and 78554. The commenters argued that the result of the lack of a transition to use of the PPIS data was an immediate 26 percent reduction for myocardial perfusion imaging services, simply because the CPT code descriptors had been revised to capture multiple procedure components. The commenters requested that the new CPT codes follow the same blend of new and previous PE RVUs that was applied to the existing CPT codes in CY 2010 and later years.

Response: Our longstanding policy is that if the CPT Editorial Panel creates a new code for a given year, the new code would be paid at its fully implemented PFS amount and not at a transition rate for that year. Consistent with this policy, the new CY 2010 myocardial perfusion imaging codes, and all other new CY 2010 CPT codes, are not being paid based on transitional PE RVUs in CY 2010. We will continue to pay these services based on the fully implemented PE RVUs in CY 2011, the same approach we are applying to other CPT codes that were new for CY 2010 or CY 2011.

d. Nerve Conduction Test (CPT code 95905)

For CPT code 95905 (Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report), the AMA RUC recommended 0.05 work RVUs, which we accepted in the CY 2010 PFS final rule with comment (74 FR 61953).

Comment: One commenter requested that CMS refer CPT code 95905 to the CY 2010 refinement panel for review. The commenter believes the AMA RUC erred in its recommendation to CMS in regard to the physician work involved. The commenter

noted that when this code was discussed at the AMA RUC meeting, the commenter and other specialty societies that presented this code to the AMA RUC recommended assignment of 0.15 work RVUs. The commenter also believes that the undervaluation of the physician work for this service may undermine the ability of physicians to provide the service.

Response: Based on the concerns expressed by the commenter, this code was referred to the CY 2010 refinement panel for review. As a result of the statistical analysis of the CY 2010 refinement panel ratings, the work RVUs for this code were unchanged. Therefore, we are finalizing the interim final values for CPT code 95905 as 0.05 work RVUs for CY 2011.

e. Kidney Disease Education Services (HCPCS codes G0420 and G0421)

During rulemaking for CY 2010, we adopted policies to provide for the implementation of section 152(b) of the MIPPA which created a new benefit category for kidney disease education (KDE) services for Medicare beneficiaries diagnosed with Stage IV chronic kidney disease (CKD). The MIPPA also amended section 1848(j)(3) of the Act which allows for payment of KDE services under the PFS. For CY 2010, we proposed and finalized the RVUs for the two HCPCS G-codes established for the payment of KDE services (74 FR 61901), G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour) and G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour). For purposes of valuing the HCPCS codes for KDE services, we based the work RVUs and the PE inputs, with minor modifications, on CPT codes for medical nutrition therapy (MNT) services, specifically CPT code 97802

(Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes) and CPT code 97804 (Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes), because we believed these services to be similar. We crosswalked the work RVUs for HCPCS code G0420 from CPT code 97802 and for HCPCS code G0421 from CPT code 97804. We multiplied the work RVUs for HCPCS code G0420 by four and the work RVUs for HCPCS code G0421 by two to account for the fact that we crosswalked a 15 minute code to a 60 minute code (CPT code 97802 to HCPCS code G0420) and a 30 minute code to a 60 minute code (CPT code 97804 to HCPCS code G0421). In order to determine the direct PE inputs for the KDE services, we indicated that we did not perform straight multiplication of the actual MNT inputs because we did not believe that the required equipment and supplies for the KDE services would increase in direct proportion to the increased time for the codes. For both HCPCS codes G0420 and G0421, we noted that we did not increase the equipment time-in-use for the body analysis machine, printer, or scale, and that we did increase the inputs for the table, computer, paper, and other printed materials.

Comment: Several commenters expressed support for the CY 2010 work RVUs for the KDE HCPCS codes G0420 and G0421. However, one commenter requested that CMS include the supplies for the KDE services as directly proportional multiple units of the MNT services in order to appropriately pay for the costs of care, noting that HCPCS code G0420 (60 minutes) should have 4 times as many supplies as those in CPT code 97802 (15 minutes) and HCPCS code G0421 (60 minutes) should have 2 times as many as those in CPT code 97804 (30 minutes).

Response: We appreciate the commenters' support for the interim final work

RVUs we established for HCPCS codes G0420 and G0421 for KDE services and we are finalizing those work RVUs for CY 2011. After reviewing the direct PE inputs for supplies in both the KDE HCPCS G-codes (G0420 and G0421) and the MNT CPT codes (CPT codes 97802 and 97804), we agree with the commenter that we had not increased the number of sheets of paper for either HCPCS code G0420 or G0421 as we indicated we would (74 FR 61901). Therefore, we have increased the number of paper sheets from 2 in CPT code 97802 (15 minutes) to 8 in HCPCS code G0420 (60 minutes) and from 2 in CPT code 97804 (30 minutes) to 4 in HCPCS code G0421 (60 minutes). We have also made conforming changes to the printer times for both KDE HCPCS G-codes in the equipment file because we base the printer time on the number of sheets of paper. We are adopting these modified direct PE inputs for HCPCS codes G0420 and G0421 as final for CY 2011.

f. Excision of Soft Tissue and Bone Tumors (CPT codes 21011 through 21016, 21552, 21554 through 21558, 21930 through 21933, 21395, 21936, 22900 through 22905, 23071, 23073, 23075 through 23078, 23200, 23210, 23220, 24071, 24073, 24075 through 24077, 24079, 24150 through 24153, 25071, 25073, 25075 through 25078, 25170, 26111, 26113, 26115 through 26118, 26250, 26255, 26260, 26262, 27043, 27045, 27047 through 27049, 27059, 27075 through 27078, 27327 through 27329, 27337, 27339, 27364, 27365, 27615, 27616, 27618, 27619, 27632, 27634, 27619, 27645 through 27647, 28039, 28041, 28043, 28045 through 28047, 28171, 28173, and 28175)

For CY 2010, the CPT Editorial Panel split 31 excision codes into 62 codes differentiated by the size of the excised lesion, 18 codes were revised, and 12 additional codes were created. Although we had significant concerns with the pre-service times and

the AMA RUC-recommended work RVUs for these codes for CY 2010, in the context of public comments on the CY 2010 proposed rule regarding the site-of-service anomaly codes, we agreed to accept the AMA RUC-recommended work values for these codes on an interim final basis for CY 2010 (74 FR 61954). We also requested that the AMA RUC reexamine the minutes allocated for positioning of the patient for these codes. We noted that we would work with the AMA RUC to address our concerns about the valuation of these codes and would consider whether it would be appropriate to propose further changes in future rulemaking. We indicated that we did not agree with the AMA RUC's recommendations for the inclusion of inpatient hospital care services in these codes, particularly in the cases of codes that would be reported for the smaller-sized tumors. As a result, we stated that we would monitor the frequency data for these codes and may propose further changes to the work RVUs in the future based on these data. We emphasized that the AMA RUC itself recommended that these services be re-reviewed to determine the accuracy of the utilization assumptions once 2 years of utilization data were available.

In addition, we noted that the CPT 2010 instructions regarding the use of the excision and resection of soft tissue and bone tumor codes advised that a complex repair may be separately reported. However, longstanding Medicare policy generally includes payment for all simple, intermediate, and complex repairs of procedural incisions and, therefore, Medicare would not separately pay for complex repairs associated with procedures reported by these codes.

Comment: Several commenters were pleased that CMS agreed to accept the AMA RUC-recommended values for these new and revised codes. One commenter

endorsed CMS' decision to closely monitor the utilization rates for these codes and believes this would be important to ensure accurate payment. The commenters did not see a need for CMS or the AMA RUC to review the pre-service times assigned to the codes and stated that all of these times were derived from the AMA RUC's pre-service time package methodology, a methodology that CMS has historically supported. The commenters asserted that the times assigned are reflective of the actual patient positioning times. Therefore, the commenters urged CMS to withdraw the request that the AMA RUC revisit the pre-service times for these codes. The commenters asserted that further review would add extra time and work to the already significant workload of the AMA RUC and would not result in any changes.

Response: We appreciate the commenters' support for our acceptance of the AMA RUC-recommended values for these new and revised codes and we are finalizing the interim final work RVUs for these codes for CY 2011. As we stated in the CY 2010 PFS final rule with comment period, we will continue to monitor the frequency data for these codes and work with the AMA RUC to address our concerns and, if appropriate, propose further changes in future rulemaking. In addition, we are reiterating our request originally made in the CY 2010 PFS final rule with comment period (74 FR 61954) that the AMA RUC review the pre-service times for these codes and provide their recommendations to us.

g. Cryoablation of Prostate (CPT code 55873)

In June 2008, CMS requested that the AMA RUC review the nonfacility direct PE inputs for CPT code 55873 (Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement). During this review, the AMA

RUC recognized that this service was initially reviewed as a new code by the AMA RUC in February 2001. The AMA RUC believed that the intra-service physician time since the initial review had declined (from 200 minutes) as the service is now more commonly performed. The AMA RUC agreed with the specialty society that the service should be surveyed for physician work and also recommended revisions in the direct PE inputs. As a result of the AMA RUC review and input from the specialty society, the AMA RUC recommended 13.45 work RVUs and revisions to the direct PE inputs for this service for CY 2010. We reviewed these recommendations and accepted the AMA RUC-recommended work RVUs for this code and the direct PE inputs in the CY 2010 PFS final rule with comment (74 FR 61954 and 61955).

Comment: One commenter expressed concern about the reduction in the work RVUs for CPT code 55873 and the lack of public notice given prior to the reduction. The commenter believes that the intra-service time was underestimated and could vary based on the skill set of the physician. The commenter requested that CMS reinstate the work RVUs as included in the CY 2010 PFS proposed rule for CY 2010 (74 FR 33740).

Response: While we originally requested that the AMA RUC review the nonfacility direct PE inputs for CPT code 55873, we believe that it is appropriate for the AMA RUC to respond to its findings during a limited review by taking other actions that it believes to be appropriate for the particular circumstances, such as requesting that procedures be resurveyed. We followed our usual methodology for revised codes whereby we respond to the AMA RUC work recommendations and adopt interim final values in the final rule with comment period for the upcoming year. In this way, we facilitate appropriate payment for the services on an interim final basis while providing

public notice and the opportunity for public comment prior to finalizing the values in the following year.

We note that the RVUs for services paid under the PFS are resource-based, and individual services are valued based upon the typical resources used to provide the service. Because clinical utilization of this service has increased over the last several years and information from the current AMA RUC survey suggests there has been a decrease in intra-service time from 200 to 100 minutes, we continue to believe the reduction in intra-service time and the revised work RVUs as recommended to us by the AMA RUC are clinically appropriate for this service. We commonly expect greater work efficiency as clinical experience with a new service increases over time, and this service fits that profile. Therefore, we are finalizing the interim final work RVUs of 13.60 for CPT code 55873 for CY 2011.

Comment: One commenter stated that the 162 minutes of clinical labor time for CPT code 55873 in the final CY 2010 PFS direct PE database should be 168 minutes. The commenter also indicated that supply code SD074 be included as an input for CPT code 55873 based on the AMA RUC's CY 2010 recommendations.

Response: We appreciate the commenter bringing this information to our attention and agree with the commenter's assessment. The 6 minutes of clinical labor time missing from the direct PE inputs for CPT code 55873 have now been included, as has the filiform, and these changes are reflected in the final CY 2011 PFS direct PE database. We are finalizing these direct PE inputs for CPT code 55873 for CY 2011.

h. Urodynamics Studies (CPT Codes 51728 and 51729)

In February 2008, the AMA RUC identified CPT codes 51726 (Complex cystometrogram (ie, calibrated electronic equipment)); 51772 (Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique); 51795 (Voiding pressure studies (VP); bladder voiding pressure, any technique); and 51797 (Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)) through the "Codes Reported Together" potentially misvalued codes screen as combinations of codes that were reported together more than 95 percent of the time. The AMA RUC referred all four codes to the CPT Editorial Panel for creation of CPT codes for new comprehensive services and for reorganization of the coding structure to reflect the typical procedures performed. As a result, CPT codes 51772 and 51795 were deleted, CPT code 51797 was revised, and CPT codes 51727 (Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique); 51728 (Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique); and 51729 (Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique) were created for CY 2010. Accordingly, the AMA RUC reviewed the clinical labor inputs for the typical patient and made minor edits regarding the intra-service time for these services. In addition, the AMA RUC made adjustments to the medical supplies and equipment. As noted in the CY 2010 PFS final rule with comment period (74 FR 61955), we accepted these recommendations for the direct PE inputs on an interim final basis.

Comment: Several commenters asserted that CPT codes 51728 and 51729 should have additional clinical labor inputs, including a greater number of minutes during the intra-service period and minutes during the pre-service period. These commenters also requested revisions to the PE supply inputs for the codes.

Response: We discuss our CY 2011 proposal and the final CY 2011 policy with respect to the direct PE inputs for CPT codes 51728 and 51729 in section II.A.3.c.(5) of this final rule with comment period. As we state there, we reviewed the direct PE inputs for these two CPT codes and three related CPT codes following revised AMA RUC recommendations for CY 2011. We agreed with the AMA RUC recommendations regarding changes for CY 2011. Specifically, we believe the pre-service nonfacility clinical labor time for the 0-day global period CPT codes 51725 (simple cystometrogram (CMG) (eg, spinal manometer)) and 51726 should be removed and the intra-service clinical labor time for CPT code 51726 should also be reduced, consistent with the usual treatment of other 0-day global codes. We believe the AMA RUC provided recommendations to us regarding the direct PE inputs for these cystometrogram services that accurately reflect the costs of the resources (that is, the clinical labor, equipment, and supplies) typically required to furnish these services to Medicare beneficiaries.

Comment: Several additional commenters alerted CMS to incorrect supply inputs for CPT codes 51728 and 51729. The commenters noted that the AMA RUC direct PE recommendations for CPT code 51728 included an additional beaker. In the case of CPT code 51729, the commenters stated that CMS did not include the recommended beaker and tubing in the direct PE database for the CY 2010 final rule with comment period.

Response: We appreciate the commenters' assistance, and we made these corrections in the May 11, 2010 correction notice to the CY 2010 PFS final rule with comment period (75 FR 26356 and 26478). We are finalizing these direct PE inputs, as corrected, for CPT codes 51728 and 51239 for CY 2011.

i. Coronary Computed Tomographic Angiography (CPT codes 75571, 75572, 75573, and 75574)

In October 2008, the CPT Editorial Panel deleted eight Category III CPT codes (0144T through 0151T) and created four new codes for CY 2010, specifically CPT codes 75571 (Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium); 75572 (Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)); 75573 (Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)); and 75574 (Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)) to describe the evolution of the performance of cardiac and coronary computed tomography for specific clinical scenarios. We accepted the AMA RUC recommendations for direct PE inputs for these codes on an interim final basis for CY 2010 (74 FR 61955).

Comment: Several commenters stated that the final CY 2010 PFS direct PE database included incomplete direct PE inputs for CPT codes 75572 and 75573. The commenters also submitted updated pricing information for the 64-slice CT scanner.

Response: We appreciate the commenters' assistance, and we corrected these errors in the May 11, 2010 correction notice to the CY 2010 PFS final rule with comment period (75 FR 26356 and 26543). We are finalizing the direct PE inputs for CPT codes 75571, 75572, 75573, and 75574, as corrected, for CY 2011. Additionally, we proposed an updated price for the 64-slice CT scanner and its accompanying software in the CY 2011 PFS proposed rule (75 FR 40062). We address that proposal and our final CY 2011 policy in section II.A.3.c.(2) of this final rule with comment period.

j. Adjacent Tissue Transfer or Rearrangement (CPT codes 14301 and 14302)

CPT code 14300 (Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area) was identified by the Five-Year Review Identification Workgroup through its "Site-of-Service Anomalies" screen for potentially misvalued codes and subsequently identified through the "CMS Fastest Growing" screen. The service was referred to the CPT Editorial Panel to clarify the coding for tissue transfers involving different sizes area. As a result, CPT code 14300 was deleted and two new codes, CPT codes 14301 (Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm) and 14302 (Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)) were created. We accepted the AMA RUC recommendations for direct PE inputs on an interim final basis for CY 2010 (74 FR 61955).

Comment: One commenter stated that there were discrepancies between the AMA RUC recommendations and the direct PE inputs for CPT codes 14301 and 14302.

Response: We appreciate the commenters' assistance, and we corrected these errors in the May 11, 2010 correction notice to the CY 2010 PFS final rule with comment period (75 FR 26356 and 26368). Upon additional review of the direct PE inputs for consistency with the CY 2010 AMA RUC recommendations for this CY 2011 final rule with comment period, we also found that the instrument pack for CPT code 14301 should be EQ138 (instrument pack, medium ($1500 and up)) instead of EQ137 (instrument pack, basic ($500-$1499)). Furthermore, CPT code 14301 should have one SA054 (pack, post-op incision care (suture)) as a supply input in both the nonfacility and facility settings. The final CY 2011 PFS direct PE database reflects these additional corrections. We are finalizing the direct PE inputs for CPT codes 14301 and 14302 for CY 2011.

k. Insertion of a Temporary Prostatic Urethral Stent (CPT code 53855)

CPT code 53855 (Insertion of a temporary prostatic urethral stent, including urethral measurement) was created for CY 2010 to describe the service previously reported under the Category III CPT code 0084T. We accepted the AMA RUC recommendations for direct PE inputs on an interim final basis for CY 2010 (74 FR 61955).

Comment: One commenter stated that CPT code 53855 was incorrectly missing supply codes SD074 and SH050 as inputs in the final CY 2010 PFS direct PE database. The commenter also noted that SJ038 was incorrectly substituted for SJ032.

Response: We appreciate the commenter bringing these items to our attention and agree with the commenter's assessment. The supply items for CPT code 53588 (filiform and one unit of lidocaine) have been included in the direct PE inputs and we

have replaced petroleum jelly with lubricating jelly. These changes are reflected in the final CY 2011 PFS direct PE database. We are finalizing the revised direct PE inputs for CPT code 53855 for CY 2011.

l. High Dose Rate Brachytherapy (CPT codes 77785, 77786, and 77787)

CPT codes 77785 (Remote afterloading high dose rate radionuclide brachytherapy; 1 channel); 77786 (Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels); and 77787 (Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels) were identified by the Five-Year Review Identification Workgroup through the "CMS Fastest Growing" and "High Volume Growth" potentially misvalued codes screens and later revised by the CPT Editorial Panel for CY 2009. As a result, the AMA RUC made recommendations for physician work and direct PE inputs for these revised services for CY 2009, which we accepted in the CY 2009 PFS final rule with comment period (73 FR 69892). Upon acceptance of the AMA RUC recommendations, we received several comments concerning the direct PE direct inputs (for example, supply costs and the useful life of the renewable sources) related to several high dose radiation therapy and placement CPT codes. In the CY 2010 PFS proposed rule (74 FR 33532), we requested that the AMA RUC revisit the direct PE inputs for these services. In response to our request, the AMA RUC reviewed the direct PE inputs for these services and made adjustments to the clinical labor staff type, changed the time for some activities, and edited the medical supplies and equipment for the typical patient scenario. In addition, the AMA RUC also recommended further discussion between the specialty and CMS regarding appropriate resolution of the PE input price for the Iridium-192 brachytherapy source typically used in CPT codes 77785,

77786, and 77787. We accepted these direct PE recommendations for CY 2010 on an interim final basis (74 FR 61782).

Comment: One commenter informed CMS of two concerns regarding CPT codes 77785, 77786, and 77787. The commenter stated that the AMA RUC summary direct PE output table included incorrectly doubled PE inputs for each of the codes. The commenter also pointed out that the medical physicist clinical labor time for CPT code 77786 should be 54 minutes instead of 29 minutes.

Response: We appreciate the commenters' assistance, and we corrected these errors in the May 11, 2010 correction notice to the CY 2010 PFS final rule with comment period (75 FR 26356 and 26564). We are finalizing the direct PE inputs for CPT codes 77785, 77786, and 77787, as corrected, for CY 2011.

m. Injection of Facet Joint (CPT codes 64490, 64491, 64492, 64493, 64494, and 64495)

Facet joint injection services were identified by the Five-Year Review Identification Workgroup "High Volume Growth" potentially misvalued codes screen and referred to the CPT Editorial Panel to create an appropriate coding structure to report primary and additional injections. As a result, the four existing codes describing these services were deleted and CPT codes 66490 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level); 64491 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)); 64492 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint

(or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)); 64493 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level); 64494 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)); and 64495 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)) were created for CY 2010. Accordingly, the AMA RUC reviewed the direct PE inputs as recommended by the specialty and made some minor edits to the clinical labor and medical supplies to reflect the typical patient service, which we accepted in the CY 2010 PFS final rule with comment on an interim final basis (74 FR 61955).

Comment: Several commenters stated that the equipment and supplies listed in the final CY 2010 PFS direct PE database for CPT codes 64490, 64491, 64492, 64493, 64494, and 64495 were incorrect and not consistent with the AMA RUC's recommendations.

Response: We verified that the equipment and supplies listed as direct inputs for these codes in the final CY 2011 direct PE database match the CY 2010 recommendations provided to us by the AMA RUC. We encourage stakeholders who believe a change is required in the direct PE inputs associated with a particular service in

the typical case that is furnished in the facility or nonfacility setting to address these concerns with the AMA RUC. We are finalizing these direct PE inputs for CPT codes 64490, 64491, 64492, 64493, 64494, and 64495 for CY 2011.

n. Knee Arthroscopy (CPT code 29870)

In the CY 2008 PFS final rule (72 FR 66238), we deferred the establishment of nonfacility direct PE inputs for CPT code 29870 (Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)) and stated that the physicians performing arthroscopic services in the nonfacility setting should be given the opportunity to have a multispecialty review by the AMA RUC. We accepted the AMA RUC recommendations for nonfacility direct PE inputs in the CY 2010 PFS final rule with comment period on an interim final basis (74 FR 61955).

Comment: One commenter indicated that the wrong arthroscopic system was approved by the AMA RUC for CPT code 29870.

Response: We verified that the equipment input for this code in the final CY 2011 PFS direct PE database matches the recommendation provided to us by the AMA RUC. We encourage stakeholders who believe a change is required in the direct PE inputs associated with a particular service in the typical case that is furnished in the facility or nonfacility setting to address these concerns with the AMA RUC. We are finalizing the direct PE inputs for CPT code 298770 for CY 2011.

3. Status of Interim Final Work RVUs for Potentially Misvalued Site-of-Service Anomaly Codes from CY 2009 and CY 2010

In previous years, we have requested that the AMA RUC review codes that, according to Medicare claims data, have experienced a change in the typical site-of-

service since the original valuation of the code. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies. In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim final basis through CY 2010, we had ongoing concerns about the methodologies used by the AMA RUC to review these services. We requested that the AMA RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777).

For CY 2011, as discussed in more detail in section II.C.3.d. of this final rule with comment period, we are requesting that the AMA RUC reconsider its previously recommended values, which have been applied on an interim final basis in CYs 2009 and 2010, and revise the work RVUs to better reflect the intensity of the services and the revised physician times and post-procedure visits included in the valuation of these codes. Until we receive the revised values from the AMA RUC for CY 2012 and can make a determination regarding them, we are continuing to accept the existing AMA RUC-recommended work RVUs listed in Tables 14 and 15 in section II.C.3.d. of this final rule with comment period on an interim final basis for CY 2011.

4. Other New, Revised, or Potentially Misvalued Codes with CY 2010 Interim Final RVUs Not Specifically Discussed in the CY 2011 Final Rule with Comment Period

For all other CY 2010 new, revised, or potentially misvalued codes with CY 2010 interim final RVUs that are not specifically discussed in this final rule with comment

period, we are finalizing, without modification, the interim final work and malpractice RVUs and direct PE inputs that we initially adopted for CY 2010.

C. Establishment of Interim Final RVUs for CY 2011

In this section, we discuss the establishment of work, PE, and malpractice interim final RVUs for CY 2011 and issues related to the processes for establishing these values. These CY 2011 work, PE, and malpractice interim final RVUs, and the associated direct PE inputs, are open to comment on this CY 2011 final rule with comment period. In general, the work, PE, and malpractice RVUs and the associated direct PE inputs for the CY 2011 new and revised codes will be finalized in the CY 2012 PFS final rule with comment period, where we will also respond to the public comments received on the values and direct PE inputs that are adopted on an interim final basis in this CY 2011 final rule with comment period. The final CY 2011 PFS direct PE database and the crosswalks for the malpractice RVUs for new and revised codes are posted on the CMS Web site under the downloads for the CY 2011 PFS final rule with comment period at: http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage.

For CY 2011, we received AMA RUC recommendations for 325 new, revised, and potentially misvalued CPT codes and 93 recommended deletions. Of the 325 codes, 84 were identified as potentially misvalued, 125 as new, and 116 as revised. After subtracting out CPT codes for which no work RVU recommendation were given—including codes listed on the Clinical Lab Fee Schedule (CLFS), vaccine codes, and technical component only codes—there were 291 codes for which the AMA RUC provided work RVU recommendations for CY 2011: 82 CPT codes classified by the AMA RUC as potentially misvalued, 108 as new, and 101 as revised. Of note, as

displayed in Table 53, we consider 204 of the AMA RUC work recommendations for CY 2011 new and established CPT codes to be for codes identified through, created as a result of, or valued in association with service(s) identified through a potentially misvalued code screen. Additionally, we received direct PE input recommendations from the AMA RUC for 325 CPT codes for CY 2011.

For CY 2011, we note that the CPT Editorial Panel deleted CPT codes 0160T (Therapeutic repetitive transcranial magnetic stimulation treatment planning) and 0161T (Therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session) and created two new CPT codes, 90867 (Therapeutic repetitive transcranial magnetic stimulation treatment; planning) and 90868 (Therapeutic repetitive transcranial magnetic stimulation treatment; delivery and management, per session). Due to the timing of the creation of these codes, the AMA RUC was unable to provide work and PE recommendations for CY 2011. As a result, these codes will be contractor-priced for CY 2011.

1. Establishment of Interim Final Work RVUs for CY 2011

a. Background

As we previously explained in section V.A. of this final rule with comment period, on an annual basis, the AMA RUC provides CMS with recommendations regarding physician work values for new, revised, and potentially misvalued codes. We review the AMA RUC-recommended work RVUs on a code-by-code basis. We determine whether we agree with the AMA RUC's recommended work RVUs for a service (that is, we agree the valuation is accurate), or, if we disagree, we determine an alternative value that better reflects our estimate of the physician work for the service.

As stated earlier, the AMA RUC provided work RVU recommendations for 291 CPT codes. Of the 291, we are accepting 207 (71 percent) of the AMA RUC-recommended values and providing alternative values for the remaining 84 (29 percent). Over the last several years our rate of acceptance of the AMA RUC recommendations has been higher, at 90 percent or greater. However, in response to concerns expressed by MedPAC, the Congress, and other stakeholders regarding the accurate valuation of services under the PFS, we have intensified our scrutiny of the work valuations of new, revised, and potentially misvalued codes. We note that most recently, the law was amended (section 1848(c)(2)(L) of the Act (as added by section 3134 of the ACA)) to add a new requirement which specifies that the Secretary shall establish a formal process to validate RVUs under the PFS. The validation process may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work. Furthermore, the Secretary is directed to validate a sampling of the work RVUs of codes identified through any of the seven categories of potentially misvalued codes specified by section 1848(c)(2)(K)(ii) of the Act (as added by section 3134 of the ACA). While we are currently in the planning stage of developing a formal validation process, we believe we should be incorporating, where appropriate, the validation principles specified in the law. That is, in reviewing the CY 2011 AMA RUC recommendations for valuing the work of new, revised, and potentially misvalued services, we have expended significant effort in evaluating whether the recommended values reflect the work elements, such as time, mental effort, and professional judgment, technical skill and

physical effort, and stress due to risk, involved with furnishing the service. We subjected each of the CY 2011 codes to a rigorous clinical review, examining the pre-, post-, and intra-service components of the work. If we concluded that the AMA RUC's recommended value for a code was not accurate, we looked for comparisons with other established reference codes with clinical similarity or analogous pre-, post-, and intra-service times, and, where applicable, employed the building block approach to inform our interim final decision to establish an alternative value that we believe is more appropriate.

The AMA RUC has emphasized the need to value services "relative" to other services, explaining in its public comment on the CY 2011 PFS proposed rule that it will "continue to employ magnitude estimation in developing relative value recommendations as it is the cornerstone of the RBRVS (resource-based relative value scale)." We agree that services paid under the PFS should be reviewed and valued in manner consistent with Medicare payment policy to maintain appropriate relativity between services and promote accurate pricing. In our review of the 291 CY 2011 AMA RUC recommendations for work values, we noted that the AMA RUC used a variety of approaches and methodologies to arrive at the recommended work values. For some codes, the AMA RUC used magnitude estimation in conjunction with survey data from physician surveys conducted by the specialty societies to support the values. For other codes, the AMA RUC used magnitude estimation to override the results of the survey data, recommending to CMS a value that was not based on survey data but rather, justified in terms of its appropriate relativity within the system to other similar services. The AMA RUC may also elect to use a crosswalk approach in valuing a code by applying a work value from a currently valued code to the code under review based on the clinical

similarity of the procedures or explicit considerations of pre-, intra-, and post-service times. In some instances, the AMA RUC asserted that it used the building block methodology to value the code, a methodology CMS has historically supported (74 FR 61776).

We understand that the AMA RUC believes that it must approach valuation on a code-by-code basis, and depending on the context of the particular code, some methodologies may be better suited than others for valuation purposes. However, we remain concerned over the variations and some applications of the AMA RUC's methodologies which, if we continue to accept them, could contribute to inaccuracy in the relativity of physician work valued under the PFS for different services. Our concerns at this time include the following methodological issues which we observed during our review of the CY 2011 AMA RUC work recommendations:

- AMA RUC-recommended values without benefit of a survey: For a number of codes, the AMA RUC justified the work RVUs by crosswalking the codes to existing codes deemed comparable by the AMA RUC. Since the specialty society did not conduct a survey for these codes, there are no survey data to back up the recommended work RVUs.

- Surveys conducted on existing codes produced predictable results: In providing recommendations for existing potentially misvalued codes, the AMA RUC often recommended maintaining the current work RVUs and supported this valuation by citing the survey results. Upon clinical review of a number of these cases, we are concerned over the validity of the survey results since the survey values often are very close to the current code values. Increasingly, rather than

recommending the median survey value that has historically been most commonly used, the AMA RUC is choosing to recommend the 25th percentile value, potentially responding to the same concern we have identified.

- AMA RUC deviated significantly or disregarded survey results completely: For the majority of codes, the AMA RUC cited the survey results in support of the work RVU recommendations and in many instances adopted either the survey median or 25th percentile value as the AMA RUC-recommended value. However, in some instances, the AMA RUC recommended work RVUs which deviated significantly from the survey results. Rather than using the survey data, the AMA RUC appears to have relied on another methodology to value the code, such as "magnitude estimation" or crosswalk to a comparable code.

In reviewing the 291 work RVU recommendations from the AMA RUC for CY 2011, we concluded that the strongest support for the valuation of a code occurred when the AMA RUC cited multiple germane methodologies that all yielded a similar value that was also supported by the survey. We tended to accept the AMA RUC-recommended values in these instances. However, we found the weakest and least convincing valuations occurred in cases where the AMA RUC either deviated significantly or disregarded the survey results in favor of tweaking various components of the code in order to justify a value which the AMA RUC believed was correct due to perceived "magnitude estimation" for that code. We are concerned that such actions by the AMA RUC may create problems for any systematic validation processes that could be implemented in the future as required by section 1848(c)(2)(L) of the Act (as added by section 3134 of the ACA).

Accordingly, for those CY 2011 codes for which we did not accept the AMA RUC recommendations and are instead establishing alternative interim final values, we discuss our decisions based on groupings of codes in the following sections. Table GG4 at the end of this section displays the AMA RUC recommendations and interim final work RVUs for CY 2011 new, revised, and potentially misvalued codes.

b. CY 2011 Interim Final Work RVUs for New and Revised Codes

(1) CY 2011 New and Revised Codes that Do Not Represent Major New Comprehensive Services

We provide an explanation in the following sections of our rationale for not accepting particular AMA RUC-recommended or Health Care Professional Advisory Committee (HCPAC)-recommended work RVUs for CY 2011 new and revised CPT codes that do not represent major new comprehensive services that are listed in Table 51 and discussed in the subsequent section. The issues are arranged by type of service in CPT code order and address only work RVUs. These codes are listed in Table 53, which includes a complete list of all new, revised, and potentially misvalued CPT codes with CY 2011 AMA RUC work RVU recommendations and CMS' interim final decisions for CY 2011.

(A) Excision and Debridement (CPT codes 11010, 11011, 11012, 11042, 11043, 10144, 11045, 11046, 11047, and 97598)

CPT codes 11043 (Debridement; skin, subcutaneous tissue, and muscle) and 11044 (Debridement; skin, subcutaneous tissue, muscle, and bone) were identified by the AMA RUC's Five-Year Review Identification Workgroup through the "Site-of-Service Anomalies" potentially misvalued codes screen in September 2007. The AMA RUC

recommended that the entire family of services described by CPT codes 11040 through 11044 and 97597 and 97598 be referred to the CPT Editorial Panel because the current descriptors allowed reporting of the codes for a bimodal distribution of patients and also to better define the terms excision and debridement. These codes were included with many other codes under review by the CPT Excision and Debridement Workgroup. CPT codes 11010, 11011, 11012, and 11042 through 11047 were reviewed by the AMA RUC and CPT codes 97597 and 97598 were reviewed by the HCPAC.

The code descriptors for CPT codes 11010 (Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues); 11011 (Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, and muscle); and 11012 (Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone) were revised to clarify to payors and providers that these codes describe debridement of a single traumatic wound caused by an open fracture which creates a single exposure, despite the number of fractures or dislocations in the same anatomic site. The AMA RUC and the specialty society agreed that the revisions made to these descriptors were editorial and the current work RVUs for these services correctly related to the typical patient and should be maintained, recommendations which we have accepted on an interim final basis for CY 2011.

The CPT Editorial Panel revised the descriptor for CPT code 11042 (Debridement subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square

centimeters or less). As a result, the AMA RUC reviewed the specialty-recommended work RVUs for this service, 1.12 work RVUs (the previous AMA RUC HCPAC recommendation as valued during the CY 2005 Five-Year Review of Work), and noted that they were higher than the current PFS value for this service (0.80 work RVUs). The AMA RUC determined that there was compelling evidence to consider new work RVUs for this service. The AMA RUC also reviewed the survey data for CPT code 11042 and made slight changes to the pre-, intra-, and post-service times. This service was compared to the key reference CPT code 16020 (Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)) (work RVUs = 0.80) and MPC CPT code 56605 (Biopsy of vulva or perineum (separate procedure); 1 lesion) (work RVUs = 1.10). Based on these comparisons, the AMA RUC agreed that the previous AMA RUC HCPAC recommendation of 1.12 work RVUs was an appropriate value as it would maintain relativity between the key reference code and the surveyed code. The AMA RUC recommended work RVUs of 1.12 for CPT code 11042.

We disagree with the AMA RUC-recommended value for this service and are maintaining the current work RVUs of 0.80. We believe the AMA RUC-recommended value (1.12 work RVUs) was based on the old surveyed value. The reference code, CPT code 16020, has more overall time but is valued at 0.80 work RVUs. In addition, the reference code has a size limitation that varies by individual body size, but the surveyed CPT code 11042 has an add-on code (CPT code 11045) for each additional 20 square centimeters. Therefore, we are not accepting the AMA RUC recommendation and are assigning an alternative value of 0.80 work RVUs to CPT code 11042 on an interim final

basis for CY 2011.

For CPT code 11045 (Debridement subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure)), which is the add-on code to CPT code 11042, the AMA RUC recommended 0.69 work RVUs. This value was obtained by applying a 14 percent reduction to the median work value of 0.80 to maintain the relativity between CPT codes 11042 and 11045 of the survey data collected. Due to the reduction in work RVUs to CPT code 11042 by CMS, we reduced the AMA RUC-recommended work RVUs of 0.69 for CPT code 11045 and assigned 0.33 work RVUs to this service. This value was obtained by removing the pre- and post-service time from the interim final RVUs of 0.80 for the primary procedure (CPT code 11042). Therefore, we are assigning an alternative value of 0.33 work RVUs to CPT code 11045 on an interim final basis for CY 2011.

CPT codes 11043 (Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 square centimeters or less) and 11044 (Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 square centimeters or less) were surveyed as 90-day global codes. However, due to disagreement with the survey vignettes and the new global period (90 days), in addition to broad variations in surveyed facility length of stay, the AMA RUC requested that CMS change the global period to 0 days. CMS agreed and the codes were resurveyed as 0-day global codes.

For CPT code 11043, the AMA RUC recommended 3.00 work RVUs. The AMA RUC reviewed the survey data and compared the surveyed code to the key reference CPT

code 15002 (Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children) (work RVUs = 3.65). The AMA RUC noted that the reference code had significantly more total service time as compared to the surveyed code and that the surveyed code was less intense to perform in comparison to the reference code. Based on this comparison, the AMA RUC recommended work RVUs of 3.00, the survey 25th percentile for this service.

The AMA RUC-recommended work inputs for this service include less clinical time and fewer follow-up E/M visits than are currently attributed to the performance of this service; however, the AMA RUC-recommended work RVU value decreased by only 0.14 RVUs. We disagree with the AMA RUC-recommended RVUs for this service and believe 2.00 work RVUs, the survey low value, reflects a more appropriate decrease in work RVU value given the recommended decrease in clinical time and follow-up E/M visits. Therefore, we are assigning an alternative value of 2.00 work RVUs to CPT code 11043 on an interim final basis for CY 2011.

For CPT code 11046 (Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure)), which is the add-on code to CPT code 11043, the RUC recommended 1.29 work RVUs, the survey 25th percentile. To maintain consistency and relativity between this add-on code and its primary code (CPT code 11043), for which we are recommending the survey low value as discussed above, and given the time and intensity the AMA RUC recommended to

perform this service, we disagree with the AMA RUC-recommended work RVUs for this service and believe 0.70 work RVUs, the survey low value, are more appropriate. Therefore, we are assigning an alternative value of 0.70 work RVUs to CPT code 11046 on an interim final basis for CY 2011.

For CPT code 11044, the AMA RUC recommended 4.56 work RVUs. The AMA RUC reviewed the survey data and compared the surveyed code to the reference CPT code 15004 (Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children) (work RVUs = 4.58). The AMA RUC noted that the reference code had the same intra-service time and that the surveyed code and the reference code required similar mental effort and judgment to perform. Based on this comparison, the AMA RUC recommended work RVUs of 4.56, the survey 25th percentile, and believes this value accurately reflects the relative physician work to perform this service and maintains proper rank order with CPT codes 11042 and 11043. The AMA RUC-recommended work inputs for this service include less clinical time and fewer follow-up E/M visits than are currently attributed to the performance of this service; however, the AMA RUC-recommended work RVUs increased. We disagree with the AMA RUC-recommended work RVUs for this service and believe 3.60 work RVUs, the survey low value, reflect a more appropriate decrease in work RVU value given the recommended decrease in clinical time and follow-up E/M visits. Therefore, we are assigning an alternative value of 3.60 work RVUs to CPT code 11044 on an interim final basis for CY 2011.

For CPT code 11047 (Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 square centimeters, or part thereof) the AMA RUC recommended 2.00 work RVUs, the survey median value. To maintain consistency and relativity between this add-on code and its primary code (CPT code 11044), for which we are recommending the survey low value as discussed above, and given the time and intensity the AMA RUC recommended to perform this service, we disagree with the AMA RUC-recommended value and believe 1.20 RUVs, the survey low value, are more appropriate for this service. Therefore, we are assigning 1.20 work RVUs to CPT code 11047 on an interim final basis for CY 2011.

For CY 2011, the services previously reported by CPT codes 11040 (Debridement; skin, partial thickness) and 11041 (Debridement; skin, full thickness) will now be reported with revised CPT codes 97597 (Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 square centimeters or less) and 97598 (Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure)). The HCPAC recommended 0.54 work RVUs for CPT code 97597,

which is a value between the CY 2010 values for CPT code 11040 (0.50 work RVUs) and CPT code 97597 (0.58 work RVUs), which we have accepted on an interim final basis in this final rule with comment period for CY 2011. However, the work RVUs for this CPT code were further subject to a work budget neutrality adjustment, as discussed in section V.C.1.b.(iii) of this final rule with comment period.

For CPT code 97598, the HCPAC recommended 0.40 work RVUs, the survey 25th percentile. We disagree with the HCPAC-recommended value for this service and, given the similarity of code descriptors between the 11000 series and the 97000 series CPT codes, we believe a more appropriate value would be 0.25 RVUs, the survey low value, as it is more consistent with the work RVU value associated with new add-on CPT code 11045, discussed above. We also believe the post-service time for CPT code 97598 should be reduced to 0 minutes to coincide with the CPT codes in the 11000 series, which have 0 or 1 minute of post-service time. Therefore, we are assigning an alternative value of 0.25 work RVUs to CPT code 97598 and reducing the post-service time to 0 minutes on an interim final basis for CY 2011. However, the work RVUs for this CPT code were subject to a work budget neutrality adjustment, as discussed in section V.C.1.b.(iii) of this final rule with comment period.

(B) Arthrodesis Including Discectomy (CPT code 22551)

As a result of CPT code 22554 (Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical, below C2) being reviewed by the AMA RUC because of its identification by the Five-Year Review Identification Workgroup "Codes Reported Together" potentially misvalued codes screen in February 2008, CPT code 22551

((Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical, below C2)) was created by the CPT Editorial Panel in October 2009, to describe fusion and discectomy of the anterior cervical spine. The AMA RUC recommended 24.50 work RVUs. The specialty society requested 25.00 work RVUs. Upon review of the AMA RUC-recommended value and the reference codes used, it was unclear why the AMA RUC decided not to accept the specialty society's recommended value of 25.00 work RVUs. We disagree with the AMA RUC-recommended value of 24.50 and believe work RVUs of 25.00 are appropriate for this service. We are also requesting that the specialty society re-review with the AMA RUC the pre-service times for codes in this family since concerns were noted in the AMA RUC recommendation about the pre-service time for this service. Therefore, we are assigning an alternative value of 25.00 work RVUs to CPT code 22551 on an interim final basis for CY 2011.

(C) Strapping Lower Extremity (CPT codes 29540 and 29550)

CPT code 29540 (Strapping; ankle and/or foot) was identified by the Five-Year Review Identification Workgroup "Harvard-Valued" potentially misvalued codes screen with utilization over 100,000 screen in October 2009. The AMA RUC recommended this whole family of services be surveyed.

For CPT code 29540, the HCPAC recommended 0.39 work RVUs. The HCPAC compared the total time required for CPT code 29540 to 29580 (Strapping; Unna boot), 18 and 27 minutes, respectively, and noted that CPT code 29540 requires less time, mental effort/judgment, technical skill and psychological stress than CPT code 29580. The HCPAC determined that CPT code 29540 was approximately 30 percent less intense

and complex than CPT code 29580, resulting in work RVUs of 0.39 for CPT code 29540. We disagree with the HCPAC-recommended value for this service and believe work RVUs of 0.32 are appropriate. We believe CPT code 11720 (Debridement of nail(s) by any method(s); 1 to 5) (work RVUs = 0.32) is a more appropriate crosswalk. Therefore, we are assigning an alternative value of 0.32 work RVUs to CPT code 29540 on an interim final basis for CY 2011.

For CPT code 29550 (Strapping; toes), the HCPAC recommended 0.25 work RVUs. The HCPAC compared this service to CPT code 97762 (Checkout for orthotic/prosthetic use, established patient, each 15 minutes) (work RVUs = 0.25), which requires the same intensity and complexity to perform as CPT code 29550. The HCPAC recommended crosswalking the work RVUs for 29550 to reference CPT code 97762. The HCPAC reviewed the survey time and determined that 7 minutes pre-service, 5 minutes intra-service, and 1 minute immediate post-service time were appropriate to perform this service. We disagree with the HCPAC-recommended value for this service and believe work RVUs of 0.15, the survey low value, are appropriate, with 5 minutes of pre- and intra-service time and 1 minute of post-service time, as we believe the HCPAC-recommended pre-service time of 7 minutes is excessive. Therefore, we are assigning an alternative value of 0.15 work RVUs to CPT code 29550 on an interim final basis for CY 2011.

(D) Paraesophageal Hernia Procedures (CPT codes 43333 and 43335)

In February 2010, the CPT Editorial Panel deleted six existing codes and created ten new codes to remove obsolete and duplicative codes and add new codes to report current surgical techniques for paraesophageal hernia repair. For CPT code 43333

(Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis), the AMA RUC recommended 30.00 work RVUs. The AMA RUC recommended 33.00 work RVUs for CPT code 43335 (Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis). While the AMA RUC-recommended values are the survey median values, we disagree with them. We adjusted the AMA RUC-recommended values for the codes without implantation of mesh or other prosthesis upward by 2.50 work RVUs to account for the differential between those codes and the parallel codes with implantation of mesh or other prosthesis. We note that 2.50 work RVUs was the lowest differential that was recommended by the AMA RUC between the with/without implantation of mesh or other prosthesis codes in this family. That is, for CPT code 43333, the revised work RVUs were established by adding 2.50 work RVUs to the AMA RUC-recommended work RVUs of 26.60 for CPT code 43332 (Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis), which resulted in work RVUs of 29.10. Likewise, for CPT code 43335, the revised work RVUs were established by adding 2.50 work RVUs to the AMA RUC-recommended work RVUs of 30.00 for CPT code 43334 (Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis), resulting in work RVUs of 32.50. Therefore, we are assigning alternative work RVUs of 29.10 to CPT code 43333 and 32.50 to CPT code 43335 on an interim final basis for CY 2011. However, the work RVUs for this CPT code were subject to a work budget neutrality adjustment, as discussed in section V.C.1.b.(iii) of this final rule

with comment period.

(E) Vaginal Radiation Afterloading Apparatus for Clinical Brachytherapy (CPT codes 57155 and 57156)

CPT Code 57155 (Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy) was originally identified through the Five-Year Review Identification Workgroup "Site-of-Service Anomalies" potentially misvalued codes screen in September 2007 and was later revised by the CPT Editorial Panel to indicate insertion of a single tandem rather than tandems.

For CY 2011, the AMA RUC recommended 5.40 work RVUs for CPT code 57155 (Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy). This value was established based on the survey 25th percentile and a review of comparable services, specifically CPT codes 55920 (Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application)(work RVUs = 8.31); 50382 (Removal (via snare/capture) and replacement of internally dwelling urethral stent via percutaneous approach, including radiological supervision and interpretation) (work RVUs = 5.50); and 52001 (Cystourethroscopy with irrigation and evacuation of multiple obstructing clots) (work RVUs = 5.44). We disagree with the AMA RUC-recommended value for this service because the method used to derive the value lacked a defined logic. We believe work RVUs of 3.37 are appropriate for this service, which is the same as the value assigned to CPT code 58823 (Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)), which we also believe is a more comparable code. Therefore, we are assigning an alternative value of 3.37 work RVUs to CPT code 57155

on an interim final basis for CY 2011.

For CPT code 57156 (Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy), the AMA RUC recommended 2.69 work RVUs, the survey 25th percentile. Given our decision to revise downward the work RVUs for CPT code 57185, a related code, upon review of the AMA RUC recommendations for CPT code 57156, we believe that the AMA RUC-recommended value of 2.69 is too high. In light of this, we are crosswalking the value of CPT code 57156 from CPT code 62319 (Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)) (work RVUs = 1.87), which has the same intra-service time (30 minutes) and overall lower total time than the comparison services referenced by the AMA RUC. Therefore, we are assigning an alternative value of 1.87 work RVUs to CPT code 57156 on an interim final basis for CY 2011.

(F) Vagus Nerve Stimulator (CPT codes 61885, 64568, 64569, and 64570)

CPT code 61885 (Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array) was identified by the Five-Year Review Identification Workgroup by its "Site-of-Service Anomalies" screen for potentially misvalued codes in September 2007. After reviewing the vagal nerve stimulator family of services, the specialty societies agreed that the family lacked clarity and the CPT Editorial Panel created three new codes to accurately describe revision of a vagal nerve stimulator lead, the placement of the pulse

generator and replacement or revision of the vagus nerve electrode.

For CY 2011, the AMA RUC recommended 6.44 work RVUs for CPT code 61885. Upon review of the AMA RUC recommendations, the method used to establish the AMA RUC-recommended value for this service lacked a defined logic. Although the AMA RUC compared this service to the key reference service, CPT code 63685 (Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling) (Work RVUs = 6.05) and other relative services and noted the similarities in times, an appropriately rigorous methodology was not used. The AMA RUC-recommended work RVUs did not adequately account for the elimination of two inpatient visits and the reduction in outpatient visits for this service. We disagree with the AMA RUC-recommended value and believe 6.05 work RVUs, the survey 25th percentile, are appropriate for this service. Therefore, we are assigning an alternative value of 6.05 work RVUs to CPT code 61885 on an interim final basis for CY 2011.

For CPT code 64568 (Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator), the AMA RUC recommended 11.19 work RVUs. Similar to the rationale provided by the AMA RUC for the valuation of CPT code 61885, the method used to value this service lacked a defined logic. As with CPT code 61885 discussed above, to which this code is related, we disagree with the AMA RUC-recommended value for this service and believe the survey 25th percentile, 9.00 work RVUs, is appropriate. Therefore, we are assigning an alternative value of 9.00 work RVUs to CPT code 64568 on an interim final basis for CY 2011.

For CPT code 64569 (Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator), the

AMA RUC recommended 15.00 work RVUs, the survey median value, and 13.00 work RVUs, the survey median value, for CPT code 64570 (Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator). Based on the reduction in work RVUs for CPT codes 61885 and 64568 that we are adopting on an interim final basis for CY 2011 and to maintain relativity for the codes in this family, we believe work RVUs of 11.00, the survey 25th percentile, are appropriate for CPT code 64569 and work RVUs of 9.10, the survey 25th percentile, are appropriate for CPT code 64570. Therefore, we are assigning an alternative value of 11.00 work RVUs to CPT code 64569 and 9.10 work RVUs to CPT code 64570 on an interim final basis for CY 2011.

(G) Ultrasound of Extremity (CPT codes 76881 and 76882)

In October 2008, CPT code 76880 (Ultrasound, extremity, nonvascular, real time with image documentation) was identified by the Five-Year Review Identification Workgroup through its "CMS Fastest Growing" screen for potentially misvalued codes. In February 2009, the CPT Editorial Panel deleted CPT code 76880 and created two new codes, CPT codes 76881 (Ultrasound, extremity, nonvascular, real-time with image documentation; complete) and 76882 (Ultrasound, extremity, nonvascular, real-time with image documentation; limited anatomic specific) to distinguish between the comprehensive diagnostic ultrasound and the focused anatomic-specific ultrasound.

For CPT code 76881, the AMA RUC recommended work RVUs of 0.72 and a total time of 25 minutes. For CPT code 76882, the AMA RUC recommended 0.50 work RVUs and a total time of 21 minutes. The predecessor CPT code 76880 (Ultrasound, extremity, nonvascular, real time with image documentation) described a nonvascular ultrasound of the entire extremity and was assigned work RVUs of 0.59 and a total time

of 18 minutes. The new CPT codes describe a complete service, CPT code 76881, and a limited service, CPT code 76882 (defined as examination of a specific anatomic structure, such as a tendon or muscle).

We disagree with the AMA RUC recommendations for these services. For CPT code 76881, we do not believe an increase in work RVUs is justified given that this service will be reported for the evaluation of the extremity, as was CPT code 76800 which is being deleted for CY 2011. Therefore, we believe work RVUs of 0.59 are appropriate for this service, consistent with the value of the predecessor code. For CPT code 76882, we believe a value of 0.41 is more appropriate, representing a statistical computation based on maintaining the relationship between the AMA RUC-recommended values for CPT codes 76881 and 76882. Therefore, we are assigning alternative work RVUs of 0.59 to CPT code 76881 and 0.41 to CPT code 76882 on an interim final basis for CY 2011.

(H) Evaluation of Fine Needle Aspirate (CPT code 88172)

Due to confusion amongst payers and providers, in February 2010 the CPT Editorial Panel revised the descriptor for CPT code 88172 (Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s))and created a new code, CPT code 88177 (Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site), to report the first evaluation episode and each additional episode of cytopathology evaluation of fine needle aspirate. For CPT code 88172, the AMA RUC recommended work RVUs of 0.69 based on comparing this code to several other services, without the use of an appropriate

methodology. We disagree with the AMA RUC-recommended value and believe the current work RVUs of 0.60 are appropriate and should be maintained for this service. Although the code has been revised, no explanation by the AMA RUC was provided to demonstrate an increase in work, and we do not believe the work has changed. Therefore, we are assigning an alternative value of 0.60 work RVUs to CPT code 88172 on an interim final basis for CY 2011.

(I) Immunization Administration (CPT code 90460 and 90461)

The CPT Editorial Panel revised the reporting of immunization administration in the pediatric population in order to better align the service with the evolving best practice model of delivering combination vaccines. For CY 2011, the AMA RUC recommended 0.20 work RVUs for CPT code 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care profession; first vaccine/toxoid component) and 0.16 work RVUs for CPT code 90461 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health profession; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)). This is an increase from the current values for the predecessor services. The AMA RUC states that the increase in recommended work RVUs is due to increased time for patient education. In addition, effective January 1, 2011, reporting and payment for these services is to be structured on a per toxoid basis rather than a per vaccine (combination of toxoids) basis as it was in prior years. We disagree with the AMA RUC-recommended values for these services and are maintaining the current work RVUs for the related predecessor codes of 0.17 RVUs for CPT code 90460 and 0.15 work RVUs

for CPT code 90461 since these codes would be billed on a per toxoid basis in CY 2011. Therefore, we are assigning alternative values of 0.17 work RVUs to CPT code 90460 and 0.15 work RVUs to CPT code 90461 on an interim final basis for CY 2011.

(J) Diabetic Retinopathy Imaging (CPT code 92228)

In February, 2010 the CPT Editorial Panel established two codes for reporting remote imaging for screening retinal disease and management of active retinal disease. For CPT code 92228 (Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral), the AMA RUC recommended 0.44 work RVUs. The AMA RUC compared this service to CPT code 92250 (Fundus photography with interpretation and report) (Work RVUs = 0.44) due to similar times and believes this service is comparable to the service under review. We disagree with the reference service used by the AMA RUC and compared this code to another diagnostic service, CPT code 92135 (Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral) (Work RVUs = 0.35), which we believe is more equivalent but has more pre- and intra-service time. Upon further review of CPT code 92228 and the time and intensity needed to perform this service, we believe work RVUs of 0.30, the survey low value, are more appropriate. Therefore, we are assigning an alternative value of 0.30 work RVUs to CPT code 92228 on an interim final basis for CY 2011.

(K) Speech-Language Pathology Services (CPT codes 92508 and 92606)

Section 143 of the MIPPA specifies that speech-language pathologists may independently report services they provide to Medicare patients. Starting in July 2009,

speech-language pathologists were able to bill Medicare as independent practitioners. As a result, the American Speech-Language-Hearing Association (ASHA) requested that CMS ask the AMA RUC to review the speech-language pathology codes to newly value the professionals' services in the work and not the practice expense. ASHA indicated that it would survey the 12 speech-language pathology codes over the course of the CPT 2010 and CPT 2011 cycles. Four of these services were reviewed by the HCPAC or the AMA RUC and were included in the CY 2010 PFS final rule with comment period (74 FR 61784 and 62146). For CY 2011, the HCPAC submitted work recommendations for the remaining eight codes.

For CPT code 92508 (Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals), the HCPAC recommended 0.43 work RVUs which was derived by dividing the value for CPT code 92507 (Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual) (work RVUs = 1.30) by 3, as the specialty society stated to the AMA RUC that there are typically 3 participants in a group. We disagree with the HCPAC-recommended value for this service and believe it is too high. We believe work RVUs of 0.33 are more appropriate, which was derived by dividing the value for CPT code 92507 by 4 participants, as we understand from providers that 4 more accurately represents the typical number of participants in a group. Additionally, the work RVUs derived from dividing the RVUs for the related individual treatment code by 4, 0.33 RVUs, are appropriate for this group treatment service relative to the work RVUs of 0.27 for CPT code 97150 (Therapeutic procedure(s), group (2 or more individuals)) which is furnished to a similar patient population, namely patients who have had a stroke.

Therefore we are assigning alternative work RVUs of 0.33 to CPT code 92508 on an interim final basis for CY 2011.

For CPT code 92606 (Therapeutic service(s) for the use of non-speech-generating device, including programming and modification), the HCPAC recommended 1.40 work RVUs, the survey median value. This service is currently bundled under the PFS and we will maintain this status for CY 2011. We are publishing the AMA RUC-recommended value in Addendum B to this final rule with comment period in accordance with our usual practice for bundled services.

(L) Sleep Testing (CPT codes 95806 and 95807)

Sleep testing CPT codes were identified by the Five-Year Review Identification Workgroup as potentially misvalued codes through the "CMS Fastest Growing" potentially misvalued codes screen. The CPT Editorial Panel created separate Category I CPT codes to report for unattended sleep studies. The AMA RUC recommended concurrent review of the family of sleep codes.

For CPT code 95806 (Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)), the AMA RUC recommended 1.28 work RVUs. The AMA RUC recommended 1.25 work RVUs for CPT code 95807 (Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist). Although the AMA RUC-recommended values for these codes reflect the survey 25th percentile, we disagree with the values and believe the values should be reversed because of the characteristics of the services. CPT code 95807 has 5 minutes more pre-service time but a lower AMA RUC-recommended value.

Therefore, we have assigned alternative values of 1.25 work RVUs to CPT code 95806 and 1.28 work RVUs to CPT code 95807 on an interim final basis for CY 2011.

(M) Subsequent Hospital Observation Care

At the June 2009 CPT Editorial Panel meeting, three new codes were approved to report subsequent observation services in a facility setting. These codes are CPT code 99224 (Level 1 subsequent observation care, per day); CPT code 99225 (Level 2 subsequent observation care, per day): and CPT code 99226 (Level 3 subsequent observation care, per day).

The AMA RUC reviewed the survey data for CPT code 99224 and accepted the following physician times: 5 minutes of pre-service, 10 minutes of intra-service, and 5 minutes of post-service time. The AMA RUC believed this code was comparable in physician time and intensity to CPT code 99231 (Level 1 subsequent hospital care, per day, for the evaluation and management of a patient), and recommended work RVUs of 0.76. Similarly, the AMA RUC reviewed the survey data for CPT code 99225 and accepted the following physician times: 9 minutes of pre-service, 20 minutes of intra-service, and 10 minutes of post-service time. The AMA RUC believed this code was comparable in physician time and intensity to CPT code 99232 (Level 2 subsequent hospital care, per day, for the evaluation and management of a patient), and recommended work RVUs of 1.39. Finally, the AMA RUC reviewed the survey data for CPT code 99226 and accepted the following physician times: 10 minutes of pre-service, 30 minutes of intra-service, and 15 minutes of post-service time. The AMA RUC believed this code was comparable in physician time and intensity to CPT code 99233 (Level 3 subsequent hospital care, per day, for the evaluation and management of a

patient), and recommended work RVUs of 2.00.

Observation services are outpatient services ordered by a patient's treating practitioner. Admission of the patient to the hospital as an inpatient or the ending of observation services must also be ordered by the treating practitioner. CMS has stated that in only rare and exceptional cases would reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. Consequently, we believe that the acuity level of the typical patient receiving outpatient observation services would generally be lower than that of the inpatient level. We believe that if the patient's acuity level is determined to be at the level of the inpatient, the patient should be admitted to the hospital as an inpatient. We note that CMS has publicly stated in a recent letter to the AHA that "it is not in the hospital's or the beneficiary's interest to extend observation care rather than either releasing the patient from the hospital or admitting the patient as an inpatient…"

Consequently, we are not accepting the AMA RUC's recommendation to value the subsequent observation care codes at the level of subsequent inpatient hospital care services. Instead, to recognize the differences in patient acuity between the two settings, we removed the pre- and post-services times from the AMA RUC-recommended values for subsequent observation care, reducing the values to approximately 75 percent of the values for the subsequent hospital care codes. Therefore, we are assigning alternative work RVUs of 0.54 to CPT code 99224, 0.96 to CPT code 99225, and 1.44 to CPT code 99226 on an interim final basis for CY 2011.

(2) Comprehensive Codes for a Bundle of Existing Component Services

A subset of AMA RUC work RVU recommendations addressed valuing new CY 2011 CPT codes resulting from the bundling of two or more existing component services performed together 95 percent or more of the time. We expect this bundling of component services to continue over the next several years as the AMA RUC further recognizes the work efficiencies for services commonly furnished together. Stakeholders should expect that increased bundling of services into fewer codes will result in reduced PFS payment for a comprehensive service by explicitly considering the efficiencies in work and/or PE that may occur when component services are furnished together.

For CY 2011, the AMA RUC provided CMS with recommendations for several categories of new comprehensive services that historically have been reported under multiple component codes. In some CY 2011 cases, the CPT Editorial Panel undertook relatively minor bundling, such as bundling the associated imaging with a procedure in a single new CPT code. In other cases, the CPT Editorial Panel bundled significant component codes for distinct procedures that were previously separately reported. This section focuses on the latter cases, and we note that these codes fall into three major clinical categories: endovascular revascularization, computed tomography (CT), and diagnostic cardiac catheterization. While we acknowledge that each category of services is unique, since bundling of component services is likely to occur more often in the coming years we believe a consistent approach is especially important when valuing bundled services as part of the potentially misvalued codes initiative in order to ensure that we fully account for the resulting work efficiencies. Specifically, we recommend that the AMA RUC use, whenever possible, the building block approach, which is a

consistent and transparent methodology based on the components of a code.

The new CY 2011 comprehensive codes in these three clinical categories are displayed in Table 51 and our discussion of their work values follows.

Table 51: New CY 2011 Comprehensive Codes and Work RVUs for Endovascular Revascularization, CT, and Diagnostic Cardiac Catheterization Services

CPT Code	Long Descriptor	AMA RUC-Recommended Work RVUs	CY 2011 Interim Final Work RVUs
	Endovascular Revascularization		
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	8.15	8.15
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	10.00	10.00
37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	3.73	3.73
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed	4.25	4.25
37224	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty	9.00	9.00
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	12.00	12.00
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	10.49	10.49
37227	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	14.50	14.50
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty	11.00	11.00
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	14.05	14.05
37230	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) , includes angioplasty within the same vessel, when performed	13.80	13.80
37231	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	15.00	15.00
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	4.00	4.00
37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed	6.50	6.50
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed	5.50	5.50

CPT Code	Long Descriptor	AMA RUC-Recommended Work RVUs	CY 2011 Interim Final Work RVUs
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed	7.80	7.80
	CT Abdomen/CT Pelvis		
74176	Computed tomography, abdomen and pelvis; without contrast material	1.74	1.74
74177	Computed tomography, abdomen and pelvis; with contrast material	1.82	1.82
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions	2.01	2.01
	Diagnostic Cardiac Catheterization		
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	3.02	2.72
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	4.32	4.75
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	5.98	6.24
93454	Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	4.95	4.79
93455	with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	6.15	5.54
93456	with right heart catheterization	6.00	6.15
93457	with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	7.66	6.89
93458	with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	6.51	5.85
93459	with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	7.34	6.60
93460	with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	7.88	7.35
93461	with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	9.00	8.10
93563	Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization	2.00	1.11
93564	for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed	2.10	1.13
93565	for selective left ventricular or left arterial angiography	1.90	0.86
93566	for selective right ventricular or right atrial angiography	0.96	0.86
93567	for supravalvular aortography	1.08	0.97
93568	for pulmonary angiography	0.98	0.88

The AMA RUC used a variety of methodologies in developing RVUs for comprehensive codes in these three categories of bundled services. To develop the RVUs for the comprehensive endovascular revascularization services, the AMA RUC generally recommended the median work RVUs from the physician survey performed by the specialty society. The recommended values for the comprehensive services are an average of 27 percent lower than the summed RVUs of the component services (taking into consideration any MPPR that would currently apply) included in the bundle. To develop the RVUs for comprehensive CT services, the AMA RUC recommended taking the sum of 100 percent of the current work RVUs for the code with the highest RVUs and 50 percent for the second code. Under this methodology, the recommended work RVUs for the comprehensive CT codes are consistently approximately 25 percent lower than the sum of the RVUs for the component services. The approach of a uniform discount on the second CT service resembles an MPPR and, given the public concerns regarding our proposed expansion of current MPPR policies under the PFS for CY 2011 as discussed in section II.C.4. of this final rule with comment period, we are unsure how the AMA RUC's recommended CT methodology actually considered the physician work required for the specific component services being bundled. Nevertheless, while we believe that the application of a consistent approach to valuing comprehensive services is desirable, we agree that the decreased work RVUs the AMA RUC recommended for comprehensive services in these two categories reflect a reasonable estimation of the work efficiencies created by the bundling of the component services. Therefore, we are accepting as interim final work RVUs the AMA RUC-recommended values for

endovascular revascularization and CT services listed in Table 51 for CY 2011.

To develop the RVUs for comprehensive diagnostic cardiac catheterization services, the AMA RUC generally recommended the lower of either the sum of the current RVUs for the component services or the physician survey 25th percentile value. In most cases, the AMA RUC's recommendation for the comprehensive service was actually the sum of the current work RVUs for the component services and we are unsure how this approach is resource-based with respect to physician work. We are also concerned that the physician survey appears to have overstated the work for these well-established procedures so significantly that the 25th percentile value was usually higher than the sum of the current RVUs for the component services. Under this methodology, the AMA RUC-recommended RVUs for the comprehensive codes for diagnostic cardiac catheterization are an average of only one percent lower than the sum of the RVUs for the component services (taking into consideration any MPPR that would currently apply) included in the bundle.

We do not find the AMA RUC's methodology or the resulting values in this case to be acceptable for a major code refinement exercise of this nature. If we were to accept the AMA RUC's recommended values for these cardiac catheterization codes, we essentially would be agreeing with the presumption that there are negligible work efficiencies gained in the bundling of these cardiac catheterization services. On the contrary, we believe that the AMA RUC did not fully consider or account for the efficiency gains when the component services are furnished together, including the significant reduction in service time. Rather, the AMA RUC appears to have considered only the summation of the component services to the comprehensive service. Therefore,

we are requesting that the AMA RUC reexamine these codes as quickly as possible, given the significant PFS utilization and spending for cardiac catheterization services, and put forward an alternative approach to valuing these services that would produce relative values that are resource-based and do not rely predominantly on the current component service values in a circular rationale.

Since we believe that the new comprehensive diagnostic cardiac catheterization codes would be overvalued under the AMA RUC's CY 2011 recommendations, we have employed an interim methodology to determine alternative values for these services which we are assigning as the interim final work RVUs for CY 2011. To account for efficiencies inherent in bundling, we set the work RVUs for all of the CY 2011 cardiac catheterization codes for which we received AMA RUC recommendations to 10 percent less than the sum of the current work RVUs for the component codes, taking into consideration any MPPR that would apply under current PFS policy. These values are displayed in Table 51 and in Addendum B and C to this final rule with comment period. We recognize that this interim methodology is not highly specific and further acknowledge that the use of another approach by the AMA RUC may have differential effects on the values of the new comprehensive services compared to the proportionate reduction on the sum of the RVUs for the component services that we have adopted as a temporary methodology. However, given the complexity of the component code combinations that contribute to the comprehensive cardiac catheterization codes and the apparent overstatement of physician work from the physician survey, we are unable to present a more refined, code-specific methodology for the interim final values. Instead, based upon a very conservative estimate of the work efficiencies we would expect to be

present when multiple component services are bundled together into a single comprehensive service, we have set interim final work values for the cardiac catheterization codes using a 10 percent reduction on the current values. As points of comparison, we note that the current MPPR policies under the PFS for imaging and surgical services reduce payment for the second and subsequent procedures by 50 percent on the TC and complete service, respectively, and, as discussed in detail in section II.C.4. of this final rule with comment period, we are adopting a 25 percent MPPR on the PE component of payment for therapy services in CY 2011. We further note that the service-specific work efficiencies for the other two major categories of new bundled codes for CY 2011, specifically endovascular revascularization and CT, are generally between 20 and 35 percent.

(3) Work Budget Neutrality for Clinical Categories of CPT Codes

Work budget neutrality, as a concept, is applied to hold the aggregate work RVUs constant within a set of clinically related CPT codes, while maintaining the relativity of values for the individual codes within that set. In some cases, when the CPT coding framework for a clinically related set of CPT codes is revised by the creation of new CPT codes or existing CPT codes are revalued, the aggregate work RVUs recommended by the AMA RUC within a clinical category of CPT codes may change, although the actual physician work for the services has not changed. When this occurs, work budget neutrality may be applied to adjust the work RVUs of each clinically related CPT code so that the sum of the new/revised code work RVUs (weighted by projected utilization) for a set of CPT codes would be the same as the sum of the current work RVUs (weighted by projected utilization) for that set of codes.

When the AMA RUC recommends work RVUs for new or revised CPT codes, we review the work RVUs and adjust or accept the recommended values as appropriate, making note of whether any estimated changes in aggregate work RVUs would result from true changes (increases or decreases) in physician work or from structural coding changes. We then determine whether the application of budget neutrality within sets of codes is appropriate. That is, if, within a set of clinically related codes, the aggregate work RVUs would increase under the RVUs we would be adopting for the upcoming year but without a corresponding true increase in physician work, we generally view this as an indication that an adjustment to ensure work budget neutrality within the set of CPT codes is warranted.

As the AMA RUC and CMS move to bundle and revalue more existing codes, creating significant structural coding changes, ensuring work budget neutrality is an important principle so that these changes are not unjustifiably redistributive among PFS services. This year, we found four sets of clinically related CPT codes where we believe the application of work budget neutrality is appropriate. That is, in these clinical areas, we believe the increases in aggregate work RVUs for the related services that would result from the work RVUs we would adopt (either the AMA RUC-recommended work RVUs or the alternative work RVUs determined by CMS) would not represent a true increase in the physician work for these services. These codes are in the areas of paraesophageal hernia procedures, obstetrical care, esophageal motility and high resolution esophageal pressure topography, and skin excision and debridement.

Table 52 lists the CPT codes that are affected by an application of work budget neutrality in CY 2011.

Table 52: CY 2011 Work Budget Neutrality (BN) for Clinical Categories of New/Revised Codes

CPT Code	Short Descriptor	AMA RUC-Recommended Work RVUs	CMS-Recommended Work RVUs Pre-BN	CY 2011 Interim Final Work RVUs
Paraesophageal Hernia Procedures, BN Factor of 0.7374				
43283	Lap esoph lengthening	4.00	4.00	2.95
43327	Esoph fundoplasty lap	18.10	18.10	13.35
43328	Esoph fundoplasty thor	27.00	27.00	19.91
43332	Transab esoph hiat hern rpr	26.60	26.60	19.62
43333	Transab esoph hiat hern rpr	30.00	29.10	21.46
43334	Transthor diaphrag hern rpr	30.00	30.00	22.12
43335	Transthor diaphrag hern rpr	33.00	32.50	23.97
43336	Thorabd diaphr hern repair	35.00	35.00	25.81
43337	Thorabd diaphr hern repair	37.50	37.50	27.65
43338	Esoph lengthening	3.00	3.00	2.21
Obstetrical Care, BN Factor of 0.8922				
59400	Obstetrical care	32.69	32.16	28.69
59409	Obstetrical care	14.37	14.37	12.82
59410	Obstetrical care	18.54	18.01	16.07
59412	Antepartum manipulation	1.71	1.71	1.53
59414	Deliver placenta	1.61	1.61	1.44
59425	Antepartum care only	6.31	6.31	5.63
59426	Antepartum care only	11.16	11.16	9.96
59430	Care after delivery	2.47	2.47	2.20
59510	Cesarean delivery	36.17	35.64	31.80
59514	Cesarean delivery only	16.13	16.13	14.39
59515	Cesarean delivery	22.00	21.47	19.15
59610	Vbacdelivery	34.40	33.87	30.22
59612	Vbac delivery only	16.09	16.09	14.35
59614	Vbac care after delivery	20.26	19.73	17.60
59618	Attempted vbac delivery	36.69	36.16	32.26
59620	Attempted vbac delivery only	16.66	16.66	14.86
59622	Attempted vbac after care	22.53	22.00	19.63
Esophageal Motility and High Resolution Esophageal Pressure Topography, BN Factor of 0.8500				
91010	Esophagus motility study	1.50	1.50	1.28
91013	Esophgl motil w/stim/perfus	0.21	0.21	0.18
Skin Excision and Debridement, BN Factor of 0.9422				
97597	Rmvl devital tis 20 cm/<	0.54	0.54	0.51
97598	Rmvl devital tis addl 20 cm<	0.40	0.25	0.24

For the paraesophageal hernia procedures, the CPT Editorial Panel deleted six existing CPT codes and created ten new codes to remove obsolete and duplicative codes

and add new codes to report current surgical techniques for paraesophageal hernia procedures. Since in this case there would be more codes that describe the same physician work with a greater degree of precision, the aggregate increase in work RVUs that would result from our adoption of the CMS-recommended RVUs that are largely based on the AMA RUC's work RVU recommendations would not represent a true increase in physician work. Therefore, we believe it would be appropriate to apply work budget neutrality to this set of codes. After reviewing the AMA RUC-recommended work RVUs, we adjusted the work RVUs for two codes (CPT codes 43333 and 43335) as described previously in section V.C.1.b.(i)(4) of this final rule with comment period, and then applied work budget neutrality to the set of clinically related CPT codes. The work budget neutrality factor for these 12 paraesophageal hernia procedure CPT codes is 0.7374.

For the obstetrical care codes, the AMA RUC reviewed 17 existing obstetrical care codes as part of the potentially misvalued codes initiative. It recommended significant increases in the work RVUs for some of the comprehensive obstetrical care codes (incorporating more than one element of antepartum care, delivery, and/or postpartum care) largely to address the management of labor. While we generally agree with the resulting AMA RUC- recommended rank order of services in this family, the aggregate increase in work RVUs for the obstetrical services that would result from our adoption of the CMS-recommended work RVUs that are largely based on the AMA RUC work RVU recommendations is not indicative of a true increase in physician work for the services. Therefore, we believe it would be appropriate to apply work budget neutrality to this set of codes. After reviewing the AMA RUC-recommended work RVUs, we

adjusted the work RVUs for several codes as described in the following section V.C.1.c.(6) of this final rule with comment period, and then applied work budget neutrality to the set of clinically related CPT codes. The work budget neutrality factor for the 17 obstetrical care CPT codes is 0.8922.

For esophageal motility and high resolution esophageal pressure topography, two CPT codes were deleted and the services will be reported under a revalued existing CPT code and a new add-on code in CY 2011. We agree with the AMA RUC that there is compelling evidence to change the work RVUs for the existing code to account for the inclusion of procedures with higher work RVUs that would previously have been reported under the deleted codes. We also agree with the AMA RUC-recommended work RVUs for the add-on code. While we agree with the AMA RUC's recommendations for the new work RVUs for both codes, we do not believe that this structural coding change should result in an increase in aggregate physician work for the same services and, therefore, we believe it would be appropriate to apply work budget neutrality to this set of codes. The work budget neutrality factor for these 2 codes is 0.8500.

In the skin excision and debridement category, two CPT codes were deleted and the services that would previously have been reported under these codes will be reported under two existing codes in CY 2011. However, the two existing wound management codes have been restructured from describing two distinct procedures reported based on wound surface area to describing a primary procedure and an add-on procedure that would additionally be reported in the case of a larger wound. Once again, the increase in aggregate work RVUs that would result from our adoption of the CMS-recommended

work RVUs that are largely based on the AMA RUC work RVU recommendations do not represent a true increase in physician work for these procedures. Therefore, we believe it would be appropriate to apply work budget neutrality to this set of codes. After reviewing the AMA RUC-recommended work RVUs, we adjusted the work RVUs for one code (CPT code 97598) as described previously in section V.C.1.b.(i)(1) of this final rule with comment period, and then applied work budget neutrality to the set of clinically related CPT codes. The budget neutrality factor for these 2 codes is 0.9422.

c. CY 2011 Interim Final Work RVUs for Potentially Misvalued Codes

In the following section, we provide a discussion of our rationale for not accepting particular AMA RUC-recommended work RVUs for CY 2011 CPT codes that have been identified as potentially misvalued through the AMA RUC's screens and with CMS guidance. Table 53 lists all 291 CPT codes for which the AMA RUC has provided CMS with work RVU recommendations for CY 2011. Furthermore, the table displays the AMA RUC's recommended work value as well as CMS' interim final decisions for CY 2011. For CY 2011, the AMA RUC provided work RVU recommendations for a total of 82 codes identified as potentially misvalued in categories based on the screen that identified the codes, including "Harvard-Valued; "CMS Fastest Growing:" and "Site-of-Service Anomalies." For CY 2011, CMS is not accepting 26 of the 82 AMA RUC-recommended work values for codes identified as potentially misvalued. We are instead providing alternative interim final work RVUs as discussed in the forthcoming section.

(1) Excision and Debridement (CPT codes 11043 and 11044)

CPT codes 11043 (Debridement; skin, subcutaneous tissue, and muscle) and

11044 (Debridement; skin, subcutaneous tissue, muscle, and bone) were identified by the AMA RUC's Five-Year Review Identification Workgroup through the "Site-of-Service Anomalies" potentially misvalued codes screen in September 2007. The AMA RUC recommended that the entire family of services described by CPT codes 11040 through 11044 and 97597 and 97598 be referred to the CPT Editorial Panel because the current descriptors allowed reporting of the codes for a bimodal distribution of patients and also to better define the terms excision and debridement. For CY 2011, the AMA RUC reviewed this family of codes which includes the two potentially misvalued codes, CPT codes 11043 and 11044, and provided work RVU recommendations to CMS. Since the family also included other new and revised codes, we have consolidated the discussion of Excision and Debridement codes in section V.C.1.b.(i)(1), which discusses new and revised codes. Section V.C.1.b.(i)(1) provides the complete discussion of CMS' interim final work RVU decisions for this family of codes. However, to summarize the CMS decisions in brief, we disagree with the AMA RUC's CY 2011 work RVU recommendations and are assigning alternative values for both CPT codes 11043 and 11044 on an interim final basis for CY 2011.

(2) Strapping Lower Extremity (CPT code 29540)

CPT code 29540 (Strapping; ankle and/or foot) was identified as a potentially misvalued code through the Five-Year Review Identification Workgroup under the "Harvard Valued" codes potentially misvalued codes screen for services with utilization over 100,000. This code is also a member of a family of codes under review for CY 2011 and as such, the full discussion for the Strapping Lower Extremity family is provided in section V.C.1.b.(i)(3), which discusses new and revised codes . However, to summarize

the CMS decision in brief, we disagree with the AMA RUC's CY 2011 work RVU recommendations and are assigning an alternative value of 0.32 RVUs to CPT code 29540 on an interim final basis for CY 2011.

(3) Control Nasal Hemorrhage (CPT code 30901)

CPT code 30901 (Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method) was identified as a potentially misvalued code through the Five-Year Review Identification Workgroup under the "Harvard Valued" potentially misvalued codes screen for services with utilization over 100,000. The AMA RUC agreed with the specialty society, stating that there is no compelling evidence to change the current work RVUs of 1.21. To support the current valuation, the AMA RUC compared CPT code 30901 to CPT code 36620 (Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous), and agreed that CPT code 30901 required slightly more total service time to perform but required comparable intensity and complexity. The AMA RUC also compared CPT code 30901 to the key reference code CPT code 31231 (Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure) and agreed that code CPT code 30901 would be relatively more intense/complex. We disagree with the AMA RUC's CY 2011 work RVU recommendation to maintain the current work RVUs of 1.21 for code CPT code 30901 because the AMA RUC-recommended work value does not appropriately account for the significant reduction in intra-service time. We believe the more appropriate work RVUs are 1.10, based on the survey 25th percentile. Therefore, we are assigning an alternative value of 1.10 work RVUs to CPT code 29540 on an interim final basis for CY 2011

(4) Cystourethroscopy (CPT codes 52281 and 52332)

CPT codes 52281 (Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female) and 52332 (Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type) were identified as a potentially misvalued code through the Five-Year Review Identification Workgroup under the "Harvard Valued" potentially misvalued codes screen for services with utilization over 100,000.

The AMA RUC reviewed the survey results and determined that the physician time of 16 minutes pre-, 20 minutes intra-, and 10 minutes immediate post-service time and maintaining the current work RVUs of 2.80 appropriately account for the time and work required to perform this procedure. We disagree with the CY 2011 AMA RUC work RVU recommendation to maintain the current RVUs for this code because the physician time to perform this service (a building block of the code) has changed since the original "Harvard values" were established, as indicated by the AMA RUC-recommended reduction in pre-service time. Accounting for the reduction in pre-service time, we calculated work RVUs that are close to the survey 25th percentile. Therefore, we are assigning 2.60 work RVUs to CPT code 52281 on an interim final basis for CY 2011.

Similarly, for CPT code 52332, we disagree with the AMA RUC's CY 2011 work RVU recommendation to maintain the current value due to the same concerns, a significant reduction in pre-service time. Based on the same building block rationale we applied to CPT code 52281, the other code within this family, we believe 1.47, which is the survey 25th percentile and maintains rank order, is a more appropriate valuation for

52332. Therefore, we are assigning an alternative value of 1.47 work RVUs to CPT code 52332 on an interim final basis for CY 2011.

(5) Vaginal Radiation Afterloading Apparatus for Clinical Brachytherapy (CPT code 51755)

CPT code 57155 (Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy) was identified as a potentially misvalued code by the Five-Year Review Identification Workgroup through the "Site-of-Service Anomalies" potentially misvalued codes screen. This code is a member of a family of codes under review for CY 2011 and as such, the full discussion for the family is provided in section V.C.1.b.(1)(E), which discusses new and revised codes. However, to summarize the CMS decision in brief, we disagree with the AMA RUC's CY 2011 work RVU recommendations are assigning an alternative value of 3.37 RVUs to CPT code 57155 on an interim final basis for CY 2011.

(6) Obstetrical Care Codes (CPT codes 59440, 59410, 59510, 59515, 59610, 59614, 59618, and 59622)

As a result of being identified as potentially misvalued codes by the Five-Year Review Identification Workgroup "High IWPUT" screen for potentially misvalued codes, the AMA RUC reviewed the CPT codes that define obstetrical care (CPT codes 59400 through 59622). CPT codes 59400, 59410, 59510, 59515, 59610, 59614, 59618 and 59622 include antepartum care and/or delivery as well as postpartum care for which the AMA RUC recommended significantly increased work values. The AMA RUC recommended 32.69 work RVUs for CPT code 59400 (Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care); 18.54 work RVUs for CPT code 59410 (Vaginal delivery only (with or

without episiotomy and/or forceps); including postpartum care); 36.17 work RVUs for CPT code 59510 (Routine obstetric care including antepartum care, cesarean delivery, and postpartum care); 22.00 work RVUs for CPT code 59515 (Cesarean delivery only; including postpartum care), 34.40 work RVUs for CPT code 59610 (Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery); 20.26 work RVUs for CPT code 59614 (Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care), 36.69 work RVUs for CPT code 59618 (Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery); and 22.53 work RVUs for CPT code 59622 (Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care). For postpartum care with delivery, which is included in all of these codes, the AMA RUC recommended one CPT code 99214 (Level 4 established patient office or other outpatient visit).

We disagree with the AMA RUC-recommended work RVUs for these services and believe that one CPT code 99213 visit (Level 3 established patient office or other outpatient visit) more accurately reflects the services furnished for this postpartum care visit. Therefore, for all CPT code 99214 blocks for CPT codes that include postpartum care following delivery visits, we have converted the CPT code 99214 visit to a CPT code 99213 visit and have revised the work RVUs accordingly. Therefore, we are adopting alternative work RVUs and are assigning 32.16 work RVUs to CPT code 59400; 18.01 work RVUs to CPT code 59410; 35.64 work RVUs to CPT code 59510;

21.47 work RVUs to CPT code 59515; 33.87 work RVUs to CPT code 59610; 19.73 work RVUs to CPT code 59614; 36.16 work RVUs to CPT code 59618; and 22.00 work RVUs to CPT code 59622, prior to the work budget neutrality adjustment as discussed in section V.C.1.b.(3) of this final rule with comment period, on interim final basis for CY 2011.

(7) Vagus Nerve Stimulator (CPT code 61885)

CPT code 61885 (Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array) was identified as a potentially misvalued code by the Five-Year Review Identification Workgroup under the "Site-of-Service Anomalies" screen for potential misvalued codes. We discuss this code in the context of the Vagus Nerve Stimulator family, provided in section V.C.1.b.(i)(6), which discusses new and revised codes. However, to summarize the CMS decision in brief, we disagree with the AMA RUC's CY 2011 work RVU recommendations are assigning an alternative value of 6.05 RVUs to CPT code 61885 on an interim final basis for CY 2011.

(8) Transforaminal Epidural Injection (CPT code 64483)

CPT code 64483 (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; single level) was identified as a potentially misvalued code through the Five-Year Review Identification Workgroup under the "CMS Fastest Growing" potentially misvalued codes screen. The AMA RUC compared components of this code (pre-, intra-, and post-service times, in addition to intensity) to a number of other codes, although the AMA RUC's application of the crosswalk methodology was unclear to us. The AMA RUC recommended 1.90 work

RVUs; however, we disagree with AMA RUC's CY 2011 work RVU recommendation and believe 1.75 work RVUs, based on the survey 25th percentile, more appropriately accounts for the significant reductions in pre-, intra-, and post-service time. Therefore, we are assigning an alternative value of 1.75 work RVUs to CPT code 64483 on an interim final basis for CY 2011.

(9) CT Thorax (CPT code 71250)

CPT Code 71250 (Computed tomography, thorax; without contrast material) was identified as a potentially misvalued code by the Five-Year Review Identification Workgroup under the "CMS Fastest Growing" potentially misvalued codes screen. This service had never been surveyed by the AMA RUC until this review was conducted for CY 2011. The specialty recommended a pre-service time of 5 minutes based on the survey results and the AMA RUC concurred. The AMA RUC also agreed that the surveyed intra-service of 15 minutes and immediate post-service time of 5 minutes were typical for the physician work required for the service. While the AMA RUC accepted the survey results for physician times based on its comparisons to similar services and other considerations, the AMA RUC believed maintaining the code's current value of 1.16 work RVUs was more appropriate, noting that this recommended value is slightly lower than the survey 25th percentile of 1.20.

We disagree with the AMA RUC's CY 2011 work RVU recommendation to maintain the current value for CPT code 71250 and similar codes. As we have previously discussed, we are increasingly concerned over the validity of accepting work valuations based upon surveys conducted on existing codes as we have noticed a pattern of predictable survey results. That is, in providing recommendations for existing potentially

misvalued codes in CY 2011, the AMA RUC often recommended maintaining the current work RVUs and supported this valuation by citing the survey results. Upon clinical review of a number of these cases, we are concerned over the validity of the survey results since the survey values often are very close to the current known value for the code. We are concerned that this may indicate a bias in the survey results since respondents would know the current value for the existing code at the time the survey is being conducted. Increasingly, rather than recommending the median survey value that has historically been most commonly used, the AMA RUC is choosing to recommend the 25^{th} percentile value, potentially responding to the same concern we have identified. Therefore, based on our concern that CT codes would continue to be misvalued if we were to accept the AMA RUC recommendation to maintain the current value, we are assigning an alternative value of 1.00 work RVUs (the survey low value) to CPT code 71250 on an interim final basis for CY 2011.

(10) CT Spine (CPT code 72125)

CPT codes 72125 (Computed tomography, cervical spine; without contrast material); 72128 (Computed tomography, thoracic spine; without contrast material); and 72131 (Computed tomography, lumbar spine; without contrast material) were identified as potentially misvalued codes by the Five-Year Review Workgroup under the "CMS Fastest Growing" screen for potentially misvalued codes. For CPT code 72125, the AMA RUC concurred with the specialty-recommended pre-service time of 5 minutes based on the survey results. The AMA RUC also agreed that the surveyed intra-service of 15 minutes and immediate post-service time of 5 minutes were typical for the physician work required for the service. The AMA RUC compared this service to other

comparable services and concluded that it was appropriate to maintain the current work RVUs of 1.16.

Similarly, for CPT codes 72128 and 72131, the AMA RUC accepted the survey physician times, but also disregarded the survey work RVU results. Upon clinical review of these codes in this family, we are concerned over the validity of the survey results since the survey 25th percentile values are very close to the current value of 1.16 RVUs for the code. As we stated previously, we are concerned that this pattern may indicate a bias in the survey results. Therefore, based on our concern that the CT codes would continue to be misvalued if we were to accept the AMA RUC recommendation to maintain the current values, we are assigning alternative work RVUs of 1.00 (the survey low value) to CPT codes 72125, 72128, and 72131 on an interim final basis for CY 2011.

(11) CT Upper and CT Lower Extremity (CPT code 73200 and 73700)

CPT codes 73200 (Computed tomography, upper extremity; without contrast material and 73700 (Computed tomography, lower extremity; without contrast material) were identified as potentially misvalued codes by the Five-Year Review Workgroup under the "CMS Fastest Growing" screen for potentially misvalued codes. Similar to the other CT codes previously discussed, the AMA RUC reviewed the survey results and accepted the survey physician times, recommending maintaining the current work RVUs of 1.09 for these services. Our clinical review of the codes, CPT codes 73200 and 73700, as with the other CT codes previously discussed, concluded that maintaining the current values would result in an overvaluing of this type of service. We remain concerned over the validity of the survey results. Therefore, based on our concern that CT codes would continue to be misvalued if we were to accept the AMA RUC recommendation to

maintain the current values, we disagree with the AMA RUC's CY 2011 work RVU recommendations. We are assigning alternative work RVUs of 1.00 (the survey low RVU value) to CPT codes 73200, and 73700 on an interim final basis for CY 2011.

(12) Radiation Treatment Management (CPT code 77427)

CPT code 77427 (Radiation treatment management, 5 treatments) was identified as a potentially misvalued code by the Five-Year Identification Workgroup's "Site-of-Service Anomalies" screen for potentially misvalued codes in 2007. For CY 2011, the AMA RUC reviewed the specialty survey results and agreed that the surveyed physician time of 7 minutes pre-service, 70 minutes intra-service, and 10 minutes immediate post-service is appropriate. The AMA RUC also used the building block approach to value the treatment visits associated with CPT code 77427. The AMA RUC averaged the number of weekly E/M visits, that is, 4 of CPT code 99214 (Level 4 established patient office or other outpatient visit) and 2 of CPT code 99213 (Level 3 established patient office or other outpatient visit) over 6 weeks to calculate an E/M building block of 1.32 RVUs. Similarly, to value the post-operative office visits associated with this code, the AMA RUC calculated a building block of 0.57 to account for the average over 6 weeks of "E/M visits after treatment planning." The AMA RUC then crosswalked the physician times for CPT code 77427 to CPT code 77315 (Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)) and used the value of CPT code 77315 as the remaining building block for CPT code 77427. Accordingly, the AMA RUC calculated total work RVUs of 3.45 and recommended this value for CPT code 77427.

Upon clinical review, we modified one of the building blocks that the AMA RUC used to calculate the work RVUs associated with the treatment E/M office visits. We believe instead of the average based upon 4 units of CPT code 99214 and 2 units of CPT

code 99213, a more appropriate estimation would be an average of 3 units of CPT code 99214 and 3 units of CPT code 99213. Accordingly, we are assigning an alternative value of 2.92 work RVUs to CPT code 77427 on an interim final basis for CY 2011.

Table 53: AMA RUC Recommendations and Interim Final Work RVUs for CY 2011 New, Revised, and Potentially Misvalued Codes

CPT Code	Short Descriptor	Valued in Relation to a Potentially Misvalued Code Screen	AMA RUC-Recommended Work RVUs	CMS Decision	CY 2011 Interim Final Work RVUs
11010	Debride skin at fx site	x	4.19	Agree	4.19
11011	Debride skin musc at fx site	x	4.94	Agree	4.94
11012	Deb skin bone at fx site	x	6.87	Agree	6.87
11042	Deb subq tissue 20 sq cm/<	x	1.12	Disagree	0.80
11043	Deb musc/fascia 20 sq cm/<	x	3.00	Disagree	2.00
11044	Deb bone 20 sq cm/<	x	4.56	Disagree	3.60
11045	Deb subq tissue add-on	x	0.69	Disagree	0.33
11046	Deb musc/fascia add-on	x	1.29	Disagree	0.70
11047	Deb bone add-on	x	2.00	Disagree	1.20
11900	Injection into skin lesions	x	0.52	Agree	0.52
11901	Added skin lesions injection	x	0.80	Agree	0.80
12001	Repair superficial wound(s)	x	0.84	Agree	0.84
12002	Repair superficial wound(s)	x	1.14	Agree	1.14
12004	Repair superficial wound(s)	x	1.44	Agree	1.44
12005	Repair superficial wound(s)	x	1.97	Agree	1.97
12006	Repair superficial wound(s)	x	2.39	Agree	2.39
12007	Repair superficial wound(s)	x	2.90	Agree	2.90
12011	Repair superficial wound(s)	x	1.07	Agree	1.07
12013	Repair superficial wound(s)	x	1.22	Agree	1.22
12014	Repair superficial wound(s)	x	1.57	Agree	1.57
12015	Repair superficial wound(s)	x	1.98	Agree	1.98
12016	Repair superficial wound(s)	x	2.68	Agree	2.68
12017	Repair superficial wound(s)	x	3.18	Agree	3.18
12018	Repair superficial wound(s)	x	3.61	Agree	3.61
15823	Revision of upper eyelid	x	6.81	Agree	6.81
19357	Breast reconstruction	x	18.50	Agree	18.50
20005	I&d abscess subfascial	x	3.58	Agree	3.58
20664	Application of halo		10.06	Agree	10.06

CPT Code	Short Descriptor	Valued in Relation to a Potentially Misvalued Code Screen	AMA RUC-Recommended Work RVUs	CMS Decision	CY 2011 Interim Final Work RVUs
20930	Sp bone algrft morsel add-on		0.00	Agree	0.00
20931	Sp bone algrft struct add-on		1.81	Agree	1.81
22315	Treat spine fracture		10.11	Agree	10.11
22551	Neck spine fuse&remove addl	x	24.50	Disagree	25.00
22552	Addl neck spine fusion	x	6.50	Agree	6.50
22554	Neck spine fusion	x	17.69	Agree	17.69
22585	Additional spinal fusion	x	5.52	Agree	5.52
22851	Apply spine prosth device	x	6.70	Agree	6.70
23430	Repair biceps tendon	x	10.17	Agree	10.17
27065	Remove hip bone les super		6.55	Agree	6.55
27066	Remove hip bone les deep		11.20	Agree	11.20
27067	Remove/graft hip bone lesion		14.72	Agree	14.72
27070	Part remove hip bone super		11.56	Agree	11.56
27071	Part removal hip bone deep		12.39	Agree	12.39
29540	Strapping of ankle and/or ft	x	0.39	Disagree	0.32
29550	Strapping of toes	x	0.25	Disagree	0.15
29914	Hip arthro w/femoroplasty		14.67	Agree	14.67
29915	Hip arthro acetabuloplasty		15.00	Agree	15.00
29916	Hip arthro w/labral repair		15.00	Agree	15.00
30901	Control of nosebleed	x	1.21	Disagree	1.10
31256	Exploration maxillary sinus		3.29	Agree	3.29
31267	Endoscopy maxillary sinus		5.45	Agree	5.45
31276	Sinus endoscopy surgical		8.84	Agree	8.84
31287	Nasal/sinus endoscopy surg		3.91	Agree	3.91
31288	Nasal/sinus endoscopy surg		4.57	Agree	4.57
31295	Sinus endo w/balloon dil		2.70	Agree	2.70
31296	Sinus endo w/balloon dil		3.29	Agree	3.29
31297	Sinus endo w/balloon dil		2.64	Agree	2.64
31634	Bronch w/balloon occlusion		4.00	Agree	4.00
33411	Replacement of aortic valve		62.07	Agree	62.07
33620	Apply r&l pulm art bands		30.00	Agree	30.00
33621	Transthor cath for stent		16.18	Agree	16.18
33622	Redo compl cardiac anomaly		64.00	Agree	64.00
33860	Ascending aortic graft	x	59.46	Agree	59.46
33863	Ascending aortic graft	x	58.79	Agree	58.79
33864	Ascending aortic graft	x	60.08	Agree	60.08
34900	Endovasc iliac repr w/graft		16.85	Agree	16.85

CPT Code	Short Descriptor	Valued in Relation to a Potentially Misvalued Code Screen	AMA RUC-Recommended Work RVUs	CMS Decision	CY 2011 Interim Final Work RVUs
35471	Repair arterial blockage	x	10.05	Agree	10.05
36410	Non-routine bl draw > 3 yrs	x	0.18	Agree	0.18
37205	Transcath iv stent percut	x	8.27	Agree	8.27
37206	Transcath iv stent/perc addl	x	4.12	Agree	4.12
37207	Transcath iv stent open	x	8.27	Agree	8.27
37208	Transcath iv stent/open addl	x	4.12	Agree	4.12
37220	Iliac revasc	x	8.15	Agree	8.15
37221	Iliac revasc w/stent	x	10.00	Agree	10.00
37222	Iliac revasc add-on	x	3.73	Agree	3.73
37223	Iliac revasc w/stent add-on	x	4.25	Agree	4.25
37224	Fem/popl revas w/tla	x	9.00	Agree	9.00
37225	Fem/popl revas w/ather	x	12.00	Agree	12.00
37226	Fem/popl revasc w/stent	x	10.49	Agree	10.49
37227	Fem/popl revasc stnt & ather	x	14.50	Agree	14.50
37228	Tib/per revasc w/tla	x	11.00	Agree	11.00
37229	Tib/per revasc w/ather	x	14.05	Agree	14.05
37230	Tib/per revasc w/stent	x	13.80	Agree	13.80
37231	Tib/per revasc stent & ather	x	15.00	Agree	15.00
37232	Tib/per revasc add-on	x	4.00	Agree	4.00
37233	Tibper revasc w/ather add-on	x	6.50	Agree	6.50
37234	Revsc opn/prq tib/pero stent	x	5.50	Agree	5.50
37235	Tib/per revasc stnt & ather	x	7.80	Agree	7.80
38900	Io map of sent lymph node		2.50	Agree	2.50
37765	Stab phleb veins xtr 10-20	x	7.71	Agree	7.71
37766	Phleb veins - extrem 20+	x	9.66	Agree	9.66
43283	Lap esoph lengthening[1]		4.00	Disagree	2.95
43327	Esoph fundoplasty lap[1]		18.10	Disagree	13.35
43328	Esoph fundoplasty thor[1]		27.00	Disagree	19.91
43332	Transab esoph hiat hern rpr[1]		26.60	Disagree	19.62
43333	Transab esoph hiat hern rpr[1]		30.00	Disagree	21.46
43334	Transthor diaphrag hern rpr[1]		30.00	Disagree	22.12
43335	Transthor diaphrag hern rpr[1]		33.00	Disagree	23.97
43336	Thorabd diaphr hern repair[1]		35.00	Disagree	25.81
43337	Thorabd diaphr hern repair[1]		37.50	Disagree	27.65
43338	Esoph lengthening[1]		3.00	Disagree	2.21
43605	Biopsy of stomach		13.72	Agree	13.72
43753	Tx gastro intub w/asp		0.45	Agree	0.45

CPT Code	Short Descriptor	Valued in Relation to a Potentially Misvalued Code Screen	AMA RUC-Recommended Work RVUs	CMS Decision	CY 2011 Interim Final Work RVUs
43754	Dx gastr intub w/asp spec		0.45	Agree	0.45
43755	Dx gastr intub w/asp specs		0.94	Agree	0.94
43756	Dx duod intub w/asp spec		0.77	Agree	0.77
43757	Dx duod intub w/asp specs		1.26	Agree	1.26
47480	Incision of gallbladder	x	13.25	Agree	13.25
47490	Incision of gallbladder	x	4.76	Agree	4.76
49324	Lap insert tunnel ip cath		6.32	Agree	6.32
49327	Lap ins device for rt		2.38	Agree	2.38
49412	Ins device for rt guide open		1.50	Agree	1.50
49418	Insert tun ip cath perc	x	4.21	Agree	4.21
49419	Insert tun ip cath w/port	x	7.08	Agree	7.08
49421	Ins tun ip cath for dial opn	x	4.21	Agree	4.21
49422	Remove tunneled ip cath	x	6.29	Agree	6.29
50250	Cryoablate renal mass open		22.22	Agree	22.22
50542	Laparo ablate renal mass	x	21.36	Agree	21.36
51736	Urine flow measurement	x	0.17	Agree	0.17
51741	Electro-uroflowmetry first	x	0.17	Agree	0.17
52281	Cystoscopy and treatment	x	2.80	Disagree	2.60
52332	Cystoscopy and treatment	x	2.83	Disagree	1.47
53860	Transurethral rf treatment		3.97	Agree	3.97
55866	Laparo radical prostatectomy	x	32.06	Agree	32.06
55876	Place rt device/marker pros		1.73	Agree	1.73
57155	Insert uteri tandems/ovoids	x	5.40	Disagree	3.37
57156	Ins vag brachytx device	x	2.69	Disagree	1.87
59400	Obstetrical care[1]	x	32.69	Disagree	28.69
59409	Obstetrical care[1]	x	14.37	Disagree	12.82
59410	Obstetrical care[1]	x	18.54	Disagree	16.07
59412	Antepartum manipulation[1]	x	1.71	Disagree	1.53
59414	Deliver placenta[1]	x	1.61	Disagree	1.44
59425	Antepartum care only[1]	x	6.31	Disagree	5.63
59426	Antepartum care only[1]	x	11.16	Disagree	9.96
59430	Care after delivery[1]	x	2.47	Disagree	2.20
59510	Cesarean delivery[1]	x	36.17	Disagree	31.80
59514	Cesarean delivery only[1]	x	16.13	Disagree	14.39
59515	Cesarean delivery[1]	x	22.00	Disagree	19.15
59610	Vbac delivery[1]	x	34.40	Disagree	30.22
59612	Vbac delivery only[1]	x	16.09	Disagree	14.35

CPT Code	Short Descriptor	Valued in Relation to a Potentially Misvalued Code Screen	AMA RUC-Recommended Work RVUs	CMS Decision	CY 2011 Interim Final Work RVUs
59614	Vbac care after delivery[1]	x	20.26	Disagree	17.60
59618	Attempted vbac delivery[1]	x	36.69	Disagree	32.26
59620	Attempted vbac delivery only[1]	x	16.66	Disagree	14.86
59622	Attempted vbac after care[1]	x	22.53	Disagree	19.63
61781	Scan proc cranial intra	x	3.75	Agree	3.75
61782	Scan proc cranial extra	x	3.18	Agree	3.18
61783	Scan proc spinal	x	3.75	Agree	3.75
61885	Insrt/redo neurostim 1 array	x	6.44	Disagree	6.05
63075	Neck spine disk surgery	x	19.60	Agree	19.60
63076	Neck spine disk surgery	x	4.04	Agree	4.04
64415	Nblock inj brachial plexus	x	1.48	Agree	1.48
64445	Nblock inj sciatic sng	x	1.48	Agree	1.48
64447	Nblock inj fem single	x	1.50	Agree	1.50
64479	Inj foramen epidural c/t	x	2.29	Agree	2.29
64480	Inj foramen epidural add-on	x	1.20	Agree	1.20
64483	Inj foramen epidural l/s	x	1.90	Agree	1.90
64484	Inj foramen epidural add-on	x	1.00	Agree	1.00
64566	Neuroeltrd stim post tibial		0.60	Agree	0.60
64568	Inc for vagus n elect impl	x	11.19	Disagree	9.00
64569	Revise/repl vagus n eltrd	x	15.00	Disagree	11.00
64570	Remove vagus n eltrd	x	13.00	Disagree	9.10
64581	Implant neuroelectrodes	x	12.20	Agree	12.20
64611	Chemodenerv saliv glands		1.03	Agree	1.03
64708	Revise arm/leg nerve	x	6.36	Agree	6.36
64712	Revision of sciatic nerve	x	8.07	Agree	8.07
64713	Revision of arm nerve(s)	x	11.40	Agree	11.40
64714	Revise low back nerve(s)	x	10.55	Agree	10.55
65778	Cover eye w/membrane		1.19	Agree	1.19
65779	Cover eye w/membrane stent		3.92	Agree	3.92
65780	Ocular reconst transplant	x	10.73	Agree	10.73
66174	Translum dil eye canal		12.85	Agree	12.85
66175	Trnslum dil eye canal w/stnt		13.60	Agree	13.60
66761	Revision of iris	x	3.00	Agree	3.00
67028	Injection eye drug	x	1.44	Agree	1.44
69801	Incise inner ear	x	2.06	Agree	2.06
69802	Incise inner ear	x	13.50	Agree	13.50
71250	Ct thorax w/o dye	x	1.16	Disagree	1.00

CPT Code	Short Descriptor	Valued in Relation to a Potentially Misvalued Code Screen	AMA RUC-Recommended Work RVUs	CMS Decision	CY 2011 Interim Final Work RVUs
72125	Ct neck spine w/o dye	x	1.16	Disagree	1.00
72128	Ct chest spine w/o dye	x	1.16	Disagree	1.00
72131	Ct lumbar spine w/o dye	x	1.16	Disagree	1.00
73080	X-ray exam of elbow	x	0.17	Agree	0.17
73200	Ct upper extremity w/o dye	x	1.09	Disagree	1.00
73510	X-ray exam of hip	x	0.21	Agree	0.21
73610	X-ray exam of ankle	x	0.17	Agree	0.17
73630	X-ray exam of foot	x	0.17	Agree	0.17
73700	Ct lower extremity w/o dye	x	1.09	Disagree	1.00
74176	Ct abd & pelvis w/o contrast	x	1.74	Agree	1.74
74177	Ct abdomen & pelvis w/contrast	x	1.82	Agree	1.82
74178	Ct abd & pelv 1+ section/regns	x	2.01	Agree	2.01
75954	Iliac aneurysm endovas rpr		2.25	Agree	2.25
75960	Transcath iv stent rs&i	x	0.82	Agree	0.82
75962	Repair arterial blockage	x	0.54	Agree	0.54
75964	Repair artery blockage each	x	0.36	Agree	0.36
76881	Us xtr non-vasc complete	x	0.72	Disagree	0.59
76882	Us xtr non-vasc lmtd	x	0.50	Disagree	0.41
76942	Echo guide for biopsy		0.67	Agree	0.67
77003	Fluoroguide for spine inject		0.60	Agree	0.60
77012	Ct scan for needle biopsy		1.16	Agree	1.16
77427	Radiation tx management x5	x	3.35	Disagree	2.92
88120	Cytp urne 3-5 probes ea spec		1.20	Agree	1.20
88121	Cytp urine 3-5 probes cmptr		1.00	Agree	1.00
88172	Cytp dx eval fna 1st ea site		0.69	Disagree	0.60
88173	Cytopath eval fna report		1.39	Agree	1.39
88177	Cytp c/v auto thin lyr addl		0.42	Agree	0.42
88300	Surgical path gross	x	0.08	Agree	0.08
88302	Tissue exam by pathologist	x	0.13	Agree	0.13
88304	Tissue exam by pathologist	x	0.22	Agree	0.22
88305	Tissue exam by pathologist	x	0.75	Agree	0.75
88307	Tissue exam by pathologist	x	1.59	Agree	1.59
88309	Tissue exam by pathologist	x	2.80	Agree	2.80
88363	Xm archive tissue molec anal		0.37	Agree	0.37
88367	Insitu hybridization auto		1.30	Agree	1.30
88368	Insitu hybridization manual		1.40	Agree	1.40
90460	Imadm any route 1st vac/tox		0.20	Disagree	0.17

CPT Code	Short Descriptor	Valued in Relation to a Potentially Misvalued Code Screen	AMA RUC-Recommended Work RVUs	CMS Decision	CY 2011 Interim Final Work RVUs
90461	Inadm any route addl vac/tox		0.16	Disagree	0.15
90870	Electroconvulsive therapy	x	2.50	Agree	2.50
90935	Hemodialysis one evaluation	x	1.48	Agree	1.48
90937	Hemodialysis repeated eval	x	2.11	Agree	2.11
90945	Dialysis one evaluation	x	1.56	Agree	1.56
90947	Dialysis repeated eval	x	2.52	Agree	2.52
91010	Esophagus motility study[1]		1.50	Disagree	1.28
91013	Esophgl motil w/stim/perfus[1]		0.25	Disagree	0.18
91038	Esoph imped funct test > 1h	x	1.10	Agree	1.10
91117	Colon motility 6 hr study		2.45	Agree	2.45
91132	Electrogastrography		0.52	Agree	0.52
91133	Electrogastrography w/test		0.66	Agree	0.66
92081	Visual field examination(s)	x	0.30	Agree	0.30
92082	Visual field examination(s)	x	0.40	Agree	0.40
92132	Cmptr ophth dx img ant segmt	x	0.35	Agree	0.35
92133	Cmptr ophth img optic nerve	x	0.50	Agree	0.50
92134	Cptr ophth dx img post segmt	x	0.50	Agree	0.50
92227	Remote dx retinal imaging		0.00	Agree	0.00
92228	Remote retinal imaging mgmt		0.44	Disagree	0.30
92285	Eye photography	x	0.05	Agree	0.05
92504	Ear microscopy examination	x	0.18	Agree	0.18
92507	Speech/hearing therapy		1.30	Agree	1.30
92508	Speech/hearing therapy		0.43	Disagree	0.33
92606	Non-speech device service		1.40	Agree	1.40
92607	Ex for speech device rx 1hr		1.85	Agree	1.85
92608	Ex for speech device rx addl		0.70	Agree	0.70
92609	Use of speech device service		1.50	Agree	1.50
93040	Rhythm ecg with report	x	0.15	Agree	0.15
93042	Rhythm ecg report	x	0.15	Agree	0.15
93224	Ecg monit/reprt up to 48 hrs	x	0.52	Agree	0.52
93227	Ecg monit/reprt up to 48 hrs	x	0.52	Agree	0.52
93228	Remote 30 day ecg rev/report	x	0.52	Agree	0.52
93268	Ecg record/review	x	0.52	Agree	0.52
93272	Ecg/review interpret only	x	0.52	Agree	0.52
93451	Right heart cath	x	3.02	Disagree	2.72
93452	Left hrt cath w/ventrclgrphy	x	4.32	Disagree	4.75
93453	R&l hrt cath w/ventriclgrphy	x	5.98	Disagree	6.24

CPT Code	Short Descriptor	Valued in Relation to a Potentially Misvalued Code Screen	AMA RUC-Recommended Work RVUs	CMS Decision	CY 2011 Interim Final Work RVUs
93454	Coronary artery angio s&i	x	4.95	Disagree	4.79
93455	Coronary art/grft angio s&i	x	6.15	Disagree	5.54
93456	Rhrt coronary artery angio	x	6.00	Disagree	6.15
93457	Rhrt art/grft angio	x	7.66	Disagree	6.89
93458	Lhrt artery/ventricle angio	x	6.51	Disagree	5.85
93459	Lhrt art/grft angio	x	7.34	Disagree	6.60
93460	R&l hrt art/ventricle angio	x	7.88	Disagree	7.35
93461	R&l hrt art/ventricle angio	x	9.00	Disagree	8.10
93462	Lhrt cath trnsptl puncture	x	3.73	Agree	3.73
93463	Drug admin & hemodynmic meas	x	2.00	Agree	2.00
93464	Exercise w/hemodynamic meas	x	1.80	Agree	1.80
93563	Inject congenital card cath	x	2.00	Disagree	1.11
93564	Inject hrt congntl art/grft	x	2.10	Disagree	1.13
93565	Inject l ventr/atrial angio	x	1.90	Disagree	0.86
93566	Inject r ventr/atrial angio	x	0.96	Disagree	0.86
93567	Inject suprvlv aortography	x	0.97	Agree	0.97
93568	Inject pulm art hrt cath	x	0.98	Disagree	0.88
93652	Ablate heart dysrhythm focus	x	17.65	Agree	17.65
93922	Upr/l xtremity art 2 levels	x	0.25	Agree	0.25
93923	Upr/lxtr art stdy 3+ lvls	x	0.45	Agree	0.45
93924	Lwr xtr vasc stdy bilat	x	0.50	Agree	0.50
95800	Slp stdy unattended	x	1.05	Agree	1.05
95801	Slp stdy unatnd w/anal	x	1.00	Agree	1.00
95803	Actigraphy testing	x	0.90	Agree	0.90
95805	Multiple sleep latency test	x	1.20	Agree	1.20
95806	Sleep study unatt&resp efft	x	1.28	Disagree	1.25
95807	Sleep study attended	x	1.25	Disagree	1.28
95808	Polysomnography 1-3	x	1.74	Agree	1.74
95810	Polysomnography 4 or more	x	2.50	Agree	2.50
95811	Polysomnography w/cpap	x	2.60	Agree	2.60
95857	Cholinesterase challenge		0.53	Agree	0.53
95950	Ambulatory eeg monitoring	x	1.51	Agree	1.51
95953	Eeg monitoring/computer	x	3.08	Agree	3.08
95956	Eeg monitor technol attended	x	3.61	Agree	3.61
96105	Assessment of aphasia	x	1.75	Agree	1.75
96446	Chemotx admn prtl cavity		0.37	Agree	0.37
97597	Rmvl devital tis 20 cm/< [1]	x	0.54	Disagree	0.51

CPT Code	Short Descriptor	Valued in Relation to a Potentially Misvalued Code Screen	AMA RUC-Recommended Work RVUs	CMS Decision	CY 2011 Interim Final Work RVUs
97598	Rmvl devital tis addl 20 cm< [1]	x	0.40	Disagree	0.24
99224	Subsequent observation care		0.76	Disagree	0.54
99225	Subsequent observation care		1.39	Disagree	0.96
99226	Subsequent observation care		2.00	Disagree	1.44

Notes:
[1] CY 2011 interim final work RVUs reflect adjustment for work budget neutrality.

2. Establishment of Interim Final Direct PE Inputs for CY 2011

a. Background

As we previously explained in section V.A. of this final rule with comment period, on an annual basis, the AMA RUC provides CMS with recommendations regarding direct PE inputs, including clinical labor, supplies, and equipment, for new, revised, and potentially misvalued codes. These recommendations, therefore, include inputs for all direct PE categories excluding supply prices and equipment prices and useful life inputs, which are specifically discussed in section II.A.3.e.of this final rule with comment period.

We review the AMA RUC-recommended direct PE inputs on a code-by-code basis, including the recommended facility PE inputs and/or nonfacility PE inputs, as clinically appropriate for the code. We determine whether we agree with the AMA RUC's recommended direct PE inputs for a service or, if we disagree, we refine the PE inputs to represent inputs that better reflect our estimate of the PE resources required for the service in the facility and/or nonfacility settings. We also confirm that CPT codes should have facility and/or nonfacility direct PE inputs and make changes based on our clinical judgment and any PFS payment policies that would apply to the code.

We received direct PE input recommendations from the AMA RUC for 325 CPT codes for CY 2011, including those CPT codes where the AMA RUC recommended no changes to the direct PE inputs of existing codes. We note that we have included in this count those recommendations received from the AMA RUC that were provided for CY 2011 and addressed in the CY 2011 PFS proposed rule. These recommendations are discussed in section II.A.3.c. of this final rule with comment period. We have accepted for CY 2011, as interim final and without refinement, the direct PE inputs based on the recommendations submitted by the AMA RUC for the 258 codes listed in Table 54.

For the remainder of the AMA RUC's direct PE recommendations for 67 codes, we have accepted the PE recommendations submitted by the AMA RUC as interim final, but with refinements. These codes and the refinements to their direct PE inputs are listed in Table 55.

Accordingly, while Table 55 details the CY 2011 refinements of the AMA RUC's direct PE recommendations at the code-specific level, we discuss the general nature of some common refinements and the reasons for particular refinements in the following section. We note that the final CY 2011 PFS direct PE database reflects the refined direct PE inputs that we are adopting on an interim final basis for CY 2011. That database is available under downloads for the CY 2011 PFS final rule with comment period on the CMS Web site at:

http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage.

b. CY 2011 Interim Final Direct PE Inputs for New, Revised, and Potentially Misvalued Codes

(1) General Equipment Time

Many of the refinements to the AMA RUC direct PE recommendations were made in the interest of promoting a transparent and consistent approach to equipment time inputs. In the past, the AMA RUC did not always provide us with recommendations regarding equipment time inputs. In CY 2010, we requested that the AMA RUC provide equipment times along with the other direct PE recommendations. Subsequent to that request, we provided the AMA RUC with general guidelines regarding appropriate equipment time inputs. We appreciate the AMA RUC's willingness to provide us with these additional inputs as part of their direct PE recommendations.

In general, the equipment time inputs correspond to the intra-service portion of the clinical labor times. We have clarified that assumption to consider equipment time as the sum of the times within the intra-service period when a clinician is using the piece of equipment, plus any additional time the piece of equipment is not available for use for another patient due to its use during the designated procedure. In addition, when a piece of equipment is typically used during additional visits included in a service's global period, the equipment time should also reflect that use.

Certain highly technical pieces of equipment and equipment rooms are less likely to be used by a clinician over the full course of a procedure and are typically available for other patients during time that may still be in the intra-service portion of the service. We adjust those equipment times accordingly. For example, CPT code 74178 (Computed tomography, abdomen and pelvis; without contrast material in more than one body region) includes 3 minutes of intra-service clinical labor time associated with obtaining the patient's consent for the procedure. Since it would be atypical for this activity to

occur within the CT room, we believe these 3 minutes should not be attributed to the CT room.

We are refining the CY 2011 AMA RUC direct PE recommendations to conform to these equipment time policies. These refinements are reflected in the final CY 2011 PFS direct PE database and detailed in Table 55.

(2) Equipment Time and Clinical Labor for Conscious Sedation

In services that include conscious sedation recovery, clinical labor and equipment time inputs are generally established using a distinctive logic. In the case of these services, clinical labor time is based on 15 minutes of registered nurse (RN) recovery monitoring for each hour monitored following the procedure to account for a typical 1:4 nurse to patient ratio. Times for equipment used during the recovery monitoring period, therefore, are equal to four times the number of RN minutes during the recovery monitoring period.

Equipment time for pieces of equipment used in conscious sedation should generally include time to administer the anesthesia, time for the procedure, and time to monitor the patient following the procedures. Standard equipment and supplies for conscious sedation include: EQ011 (ECG, 3-channel (with SpO2, NIBP, temp, resp)); EF019 (stretcher chair); EQ032 (IV infusion pump); and SA044 (pack, conscious sedation).

We are refining the CY 2011 AMA RUC direct PE recommendations to conform to these policies. These refinements are reflected in the final CY 2011 PFS direct PE database and detailed in Table 55.

(3) Equipment Time for Add-On Codes

For add-on codes, only minutes allocated to the procedure itself are added to the time for the equipment, since any additional minutes would duplicate the equipment time already accounted for in the primary procedure that accompanies the add-on code.

We are refining the CY 2011 AMA RUC PFS direct PE recommendations to conform to this policy. These refinements are reflected in the final CY 2011 PFS direct PE database and detailed in Table 55.

(4) Changes in Standard Uses of Certain Supplies

As discussed in section II.A.3.b.(1) of this final rule with comment period, we are finalizing our proposal to remove the supply item "biohazard bag" from the direct PE database because the item is considered an indirect practice expense. Additionally, as discussed in section II.A.3.b.(6) of this final rule with comment period, we are finalizing our CY 2011 proposal to remove the pulse oximeter with printer (CMS Equipment Code EQ211) as an input for the 118 codes that also contain the ECG, 3-channel (with SpO2, NIBP, temp, resp) (CMS Equipment Code EQ011).

We are refining the CY 2011 AMA RUC PFS direct PE recommendations to conform to these policies. These refinements are reflected in the final CY 2011 PFS direct PE database and detailed in Table 55.

(5) New Supply and Equipment Items

When clinically appropriate, the AMA RUC generally recommends the use of supply and equipment items that already exist in the direct PE database for new, revised, and potentially misvalued codes. Some recommendations include supply or equipment items that are not currently in the direct PE database. In these cases, the AMA RUC has historically recommended a new item be created and has facilitated CMS' pricing of that

item by working with the specialty societies to provide sales invoices to us. We appreciate the contributions of the AMA RUC in that process.

Despite the assistance of the AMA RUC for CY 2011, we did not receive adequate information for pricing the following new supply items included in the AMA RUC's CY 2011 direct PE recommendations: SC098 (Catheter, angiographic, Berman); SD251 (Sheath Shuttle (Cook); SD255 (Reentry Device (Frontier, Outback, Pioneer); SD257 (Tunneler); and SD258 (Vacuum Bottle). We agree with the AMA RUC that these supply items are appropriate direct PE inputs for the associated procedures. However, because these items do not resemble current supplies in the PE database, we were unable to identify existing supplies with input prices to substitute for the AMA RUC-recommended direct PE inputs. We were also unable to estimate the prices for these new supply items based on analogy to existing supplies in the direct PE database because, as stated previously, they are not clinically similar to existing items in the direct PE database and we do not have information on the pricing of the new supply items. Therefore, our only alternative for these supply items for CY 2011 was to accept them as direct PE inputs for the associated services based on the AMA RUC recommendations, but to price them at $0 for CY 2011. For CY 2012, we will consider the prices for these supply items eligible to be updated through the process we are finalizing for CY 2011 that is described in section II.A.3.e. of this final rule with comment period.

In the case of certain other direct PE recommendations for CY 2011, the AMA RUC has recommended new supply or equipment items that we believe to be already described by existing items in the direct PE database. Therefore, we are refining the AMA RUC CY 2011 direct PE recommendations to utilize existing supply and

equipment items in the PE database where appropriate. These refinements are reflected in the final CY 2011 PFS direct PE database and detailed in Table 55.

(6) Endovascular Revascularization Stents

In reviewing the supply input recommendations from the AMA RUC for CPT codes describing certain endovascular revascularization services, we considered the quantity of high-cost stents associated with some of the codes. The recommendations included two or three stents for each of the following six CPT codes: 37226 (Revascularization, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s); 37227 (Revascularization, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy); 37230 (Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s)); 37231 (Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy); 37234 (Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure)); and 37235 (Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy (List separately in addition to code for primary procedure)).

Given the complex clinical nature of these services, their new pricing in the nonfacility setting under the PFS, and the high cost of each stent, we were concerned that two or three stents could overestimate the number of stents used in the typical office procedure that would be reported under one of the CPT code. Therefore, we examined CY 2009 hospital OPPS claims data for the combinations of predecessor codes that

would have historically been reported for each case reported in under CY 2011 under a single comprehensive code. Because of the OPPS device-to-procedure claims processing edits, all prior cases would have included HCPCS C-code for at least one stent on the claim for the case. Based on our analysis of these data, we determined that for each new CY 2011 comprehensive code, the predecessor code combinations would have used only one stent in 65 percent or more of the cases. We have no reason to believe that when these new CPT codes are reported for procedures performed in the nonfacility setting, patients would receive more than the one stent typically used in the hospital outpatient setting. Therefore, we are refining the CY 2011 AMA RUC recommendations to include one stent in the direct PE inputs for each of the six endovascular revascularization stent insertion codes, including the add-on codes. These refinements are reflected in the final CY 2011 PFS direct PE database.

(7) Nasal/Sinus Endoscopy Supply and Equipment Items

The AMA RUC recommendation for direct PE inputs for CPT code 31295 (Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa), included irregular supply and equipment inputs. The AMA RUC recommended two similar, new supply items, specifically "kit, sinus surgery, balloon (maxillary, frontal, or sphenoid)" and "kit, sinus surgery, balloon (maxillary)"as supply inputs with a quantity of one-half for each item. We believe that this recommendation was intended to reflect an assumption that each of these distinct supplies is used in approximately half of the cases when the service is furnished. In general, the direct PE inputs should reflect the items used when the service is furnished in the typical case. Therefore, the quantity of supply items associated with a code should

reflect the actual units of the item used in the typical case, and not be reflective of any estimate of the proportion of cases in which any supply item is used. We note, however, that fractional inputs are appropriate when fractional quantities of a supply item are typically used, as is commonly the case when the unit of a particular supply reflects the volume of a liquid supply item instead of quantity. Additionally, in the case of certain services with global service periods, fractional quantities of supplies may be appropriate when fractional numbers of post-service office visits are associated with a code.

Upon receipt of these recommendations, we requested that the AMA RUC clarify the initial recommendation by determining which of these supply items would be used in the typical case. The AMA RUC recommended that the supply item "kit, sinus surgery, balloon (maxillary, frontal, or sphenoid)" be included in the inputs for the code. We considered that recommendation, but we believe that the item "kit, sinus surgery, balloon (maxillary)" is more clinically appropriate based on the description of CPT code 32195.

The AMA RUC recommendation for equipment inputs for the same code (CPT code 31295) included a parallel irregularity by distributing half of the equipment minutes to each of two similar pieces of equipment, one existing and one new: "endoscope, rigid, sinoscopy" (ES013) and "fiberscope, flexible, sinoscopy" (new). We believe that this recommendation was intended to reflect an assumption that each of these distinct pieces of equipment is used in approximately half of the cases in which the service is furnished. In general, the direct PE inputs should reflect the items used when the service is furnished in the typical case. Therefore, the equipment time inputs associated with a code should reflect the number of minutes an equipment item is used in the typical case, and not be distributed among a set of equipment items to reflect an estimate of the proportion of

cases in which a particular equipment item might be used. However, we note that in the case of certain services with global service periods, distribution of equipment minutes among similar equipment items may be appropriate when fractional numbers of post-service office visits are associated with a code. Upon review of these items, we believe that the new piece of equipment, "fiberscope, flexible, sinoscopy," is more clinically appropriate based on the description of CPT code 32195.

We are refining the CY 2011 AMA RUC direct PE recommendations to conform to these determinations. These refinements are reflected in the final CY 2011 PFS direct PE database and detailed in Table 55.

Table 54: CPT Codes with Accepted AMA RUC Direct PE Recommendations for CY 2011 Codes

CPT Code	Short Descriptor
11010	Debride skin at fx site
11011	Debride skin musc at fx site
11012	Deb skin bone at fx site
11045	Deb subq tissue add-on
11046	Deb musc/fascia add-on
11047	Deb bone add-on
11900	Injection into skin lesions
11901	Added skin lesions injection
12001	Repair superficial wound(s)
12002	Repair superficial wound(s)
12004	Repair superficial wound(s)
12005	Repair superficial wound(s)
12006	Repair superficial wound(s)
12007	Repair superficial wound(s)
12011	Repair superficial wound(s)
12013	Repair superficial wound(s)
12014	Repair superficial wound(s)
12015	Repair superficial wound(s)
12016	Repair superficial wound(s)
12017	Repair superficial wound(s)
12018	Repair superficial wound(s)
15823	Revision of upper eyelid
19357	Breast reconstruction

CPT Code	Short Descriptor
20005	I&d abscess subfascial
20664	Application of halo
20930	Sp bone algrft morsel add-on
20931	Sp bone algrft struct add-on
22315	Treat spine fracture
22552	Addl neck spine fusion
22554	Neck spine fusion
22585	Additional spinal fusion
22851	Apply spine prosth device
23430	Repair biceps tendon
27065	Remove hip bone les super
27066	Remove hip bone les deep
27067	Remove/graft hip bone lesion
27070	Part remove hip bone super
27071	Part removal hip bone deep
29540	Strapping of ankle and/or ft
29550	Strapping of toes
29914	Hip arthro w/femoroplasty
29915	Hip arthro acetabuloplasty
29916	Hip arthro w/labral repair
30901	Control of nosebleed
31256	Exploration maxillary sinus
31267	Endoscopy maxillary sinus
31276	Sinus endoscopy surgical
31287	Nasal/sinus endoscopy surg
31288	Nasal/sinus endoscopy surg
33411	Replacement of aortic valve
33620	Apply r&l pulm art bands
33621	Transthor cath for stent
33622	Redo compl cardiac anomaly
33860	Ascending aortic graft
33863	Ascending aortic graft
33864	Ascending aortic graft
34900	Endovasc iliac repr w/graft
35471	Repair arterial blockage
36410	Non-routine bl draw > 3 yrs
37205	Transcath iv stent percut
37206	Transcath iv stent/perc addl
37207	Transcath iv stent open
37208	Transcath iv stent/open addl
37222	Iliac revasc add-on
37223	Iliac revasc w/stent add-on
37232	Tib/per revasc add-on
37233	Tibper revasc w/ather add-on

CPT Code	Short Descriptor
37765	Stab phleb veins xtr 10-20
37766	Phleb veins - extrem 20+
38900	Io map of sent lymph node
43283	Lap esoph lengthening
43327	Esoph fundoplasty lap
43328	Esoph fundoplasty thor
43332	Transab esoph hiat hern rpr
43333	Transab esoph hiat hern rpr
43334	Transthor diaphrag hern rpr
43335	Transthor diaphrag hern rpr
43336	Thorabd diaphr hern repair
43337	Thorabd diaphr hern repair
43338	Esoph lengthening
43605	Biopsy of stomach
43753	Tx gastro intub w/asp
47480	Incision of gallbladder
47490	Incision of gallbladder
49324	Lap insert tunnel ip cath
49327	Lap ins device for rt
49400	Air injection into abdomen
49412	Ins device for rt guide open
49419	Insert tun ip cath w/port
49421	Ins tun ip cath for dial opn
49422	Remove tunneled ip cath
50250	Cryoablate renal mass open
50542	Laparo ablate renal mass
50590	Fragmenting of kidney stone
50684	Injection for ureter x-ray
*51725	Simple cystometrogram
*51726	Complex cystometrogram
*51727	Cystometrogram w/up
*51728	Cystometrogram w/vp
*51729	Cystometrogram w/vp&up
51736	Urine flow measurement
51741	Electro-uroflowmetry first
52281	Cystoscopy and treatment
52332	Cystoscopy and treatment
55866	Laparo radical prostatectomy
55876	Place rt device/marker pros
59400	Obstetrical care
59409	Obstetrical care
59410	Obstetrical care
59412	Antepartum manipulation
59414	Deliver placenta

CPT Code	Short Descriptor
59425	Antepartum care only
59426	Antepartum care only
59430	Care after delivery
59510	Cesarean delivery
59514	Cesarean delivery only
59515	Cesarean delivery
59610	Vbac delivery
59612	Vbac delivery only
59614	Vbac care after delivery
59618	Attempted vbac delivery
59620	Attempted vbac delivery only
59622	Attempted vbac after care
61781	Scan proc cranial intra
61782	Scan proc cranial extra
61783	Scan proc spinal
61885	Insrt/redo neurostim 1 array
62268	Drain spinal cord cyst
62269	Needle biopsy spinal cord
62281	Treat spinal cord lesion
62319	Inject spine w/cath l/s (cd)
63075	Neck spine disk surgery
63076	Neck spine disk surgery
63610	Stimulation of spinal cord
*64420	Nblock inj intercost sng
*64421	Nblock inj intercost mlt
64480	Inj foramen epidural add-on
64484	Inj foramen epidural add-on
64508	Nblock carotid sinus s/p
64561	Implant neuroelectrodes
64566	Neuroeltrd stim post tibial
64568	Inc for vagus n elect impl
64569	Revise/repl vagus n eltrd
64570	Remove vagus n eltrd
64581	Implant neuroelectrodes
64611	Chemodenerv saliv glands
*64620	Injection treatment of nerve
64708	Revise arm/leg nerve
64712	Revision of sciatic nerve
64713	Revision of arm nerve(s)
64714	Revise low back nerve(s)
65778	Cover eye w/membrane
65780	Ocular reconst transplant
66761	Revision of iris
67028	Injection eye drug

CPT Code	Short Descriptor
69802	Incise inner ear
70010	Contrast x-ray of brain
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
73080	X-ray exam of elbow
73200	Ct upper extremity w/o dye
73510	X-ray exam of hip
73610	X-ray exam of ankle
73630	X-ray exam of foot
73700	Ct lower extremity w/o dye
74430	Contrast x-ray bladder
*75571	Ct hrt w/o dye w/ca test
*75572	Ct hrt w/3d image
*75573	Ct hrt w/3d image congen
*75574	Ct angio hrt w/3d image
75954	Iliac aneurysm endovas rpr
75960	Transcath iv stent rs&i
75962	Repair arterial blockage
75964	Repair artery blockage each
76000	Fluoroscope examination
76942	Echo guide for biopsy
77003	Fluoroguide for spine inject
*77011	Ct scan for localization
77012	Ct scan for needle biopsy
*77301	Radiotherapy dose plan imrt
77427	Radiation tx management x5
88120	Cytp urne 3-5 probes ea spec
88121	Cytp urine 3-5 probes cmptr
88172	Cytp dx eval fna 1st ea site
88173	Cytopath eval fna report
88177	Cytp c/v auto thin lyr addl
88300	Surgical path gross
88302	Tissue exam by pathologist
88304	Tissue exam by pathologist
88305	Tissue exam by pathologist
88307	Tissue exam by pathologist
88309	Tissue exam by pathologist
88363	Xm archive tissue molec anal
88367	Insitu hybridization auto
88368	Insitu hybridization manual
90460	Imadm any route 1st vac/tox
90461	Imadm any route addl vac/tox

CPT Code	Short Descriptor
90870	Electroconvulsive therapy
90935	Hemodialysis one evaluation
90937	Hemodialysis repeated eval
90945	Dialysis one evaluation
90947	Dialysis repeated eval
91013	Esophgl motil w/stim/perfus
*91038	Esoph imped funct test > 1h
91117	Colon motility 6 hr study
*91132	Electrogastrography
*91133	Electrogastrography w/test
92081	Visual field examination(s)
92082	Visual field examination(s)
92132	Cmptr ophth dx img ant segmt
92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92504	Ear microscopy examination
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92606	Non-speech device service
92607	Ex for speech device rx 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
93040	Rhythm ecg with report
93041	Rhythm ecg tracing
93042	Rhythm ecg report
93224	Ecg monit/reprt up to 48 hrs
93225	Ecg monit/reprt up to 48 hrs
93226	Ecg monit/reprt up to 48 hrs
93227	Ecg monit/reprt up to 48 hrs
93228	Remote 30 day ecg rev/report
93270	Remote 30 day ecg rev/report
93271	Ecg/monitoring and analysis
93272	Ecg/review interpret only
93462	L hrt cath trnsptl puncture
93463	Drug admin & hemodynmic meas
93563	Inject congenital card cath
93564	Inject hrt congntl art/grft
93565	Inject l ventr/atrial angio
93652	Ablate heart dysrhythm focus
93922	Upr/l xtremity art 2 levels
93923	Upr/lxtr art stdy 3+ lvls
93924	Lwr xtr vasc stdy bilat
95800	Slp stdy unattended
95801	Slp stdy unatnd w/anal

CPT Code	Short Descriptor
95803	Actigraphy testing
95805	Multiple sleep latency test
95806	Sleep study unatt&resp efft
95807	Sleep study attended
95808	Polysomnography 1-3
95810	Polysomnography 4 or more
95811	Polysomnography w/cpap
95857	Cholinesterase challenge
95950	Ambulatory eeg monitoring
95953	Eeg monitoring/computer
96105	Assessment of aphasia
97598	Rmvl devital tis addl 20 cm<
99224	Subsequent observation care
99225	Subsequent observation care
99226	Subsequent observation care

*CPT codes discussed in more detail in section II.A.3.c. of this final rule with comment period.

Table 55: CPT Codes with Refined AMA RUC Direct PE Recommendations for CY 2011 Codes

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
11042	Deb subq tissue 20 sq cm/<	Sedate/apply anesthesia	2 min	0 min	Anesthesia is not used for this code.
		EQ137	54 min	51 min	Instrument pack is allocated the total service period time less the time to clean the room (basic instrument pack).
11043	Deb musc/fascia 20 sq cm/<	EQ138	76 min	73 min	Instrument pack is allocated the total service period time less the time to clean the room (medium instrument pack).
11044	Deb bone 20 sq cm/<	EQ138	91 min	88 min	Instrument pack is allocated the total service period time less the time to clean the room (medium instrument pack).
22551	Neck spine fuse&remove addl	Other clin activity: coordination of care	15 min	0 min	The additional minutes of 15 pre-service minutes for coordination of care is redundant with description of other pre-service clinical labor times.
31295	Sinus endo w/balloon dil	Clean scope, L037D	10 min	30 min	The standard time to clean a flexible scope is 30 minutes.
		kit, sinus surgery, balloon (maxillary, frontal or sphenoid)	0.5 kit	Delete	See comments for kit, sinus surgery, balloon (maxillary) below.
		kit, sinus surgery, balloon (maxillary)	0.5 kit	1 kit	1 surgical kit is allocated rather than splitting two kits.
		ES013	31.5 min	Delete	The rigid endoscope time is not accepted by CMS. See comments for new equipment, fiberscope, flexible, bioscopy below.
		new equipment, fiberscope, flexible, sinoscopy	31.5 min	80 min	Scope allocated total service time less time to clean the room. CMS is accepting the new scope rather than splitting time between the rigid endoscope (see above) and the flexible fiberscope.
31296	Sinus endo w/balloon dil	ES013	73 min	70 min	Rigid endoscope allocated total service time less time to clean the room.
31297	Sinus endo w/balloon dil	ES013	71 min	68 min	Rigid endoscope allocated total service time less time to clean the room.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
31634	Bronch w/balloon occlusion	EQ211	85 min	Delete	Pulse oximeters are no longer standard equipment for conscious sedation.
		EF031	85 min	74 min	Table - Apply service period time less time to clean the scope, and monitoring patient post-op.
		EQ011	85 min	147 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	85 min	147 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ235	85 min	74 min	Suction machine - Apply service period time less time to clean the scope, and monitoring patient post-op.
		ER031	85 min	74 min	Fluoroscopic system - Apply service period time less time to clean the scope, and monitoring patient post-op.
		ES017	112 min	104 min	Fiberscope - Apply service period time less time to monitor the patient post-op.
		ES031	85 min	74 min	Video system, endoscopy - Apply service period time less time to clean the scope, and monitoring patient post-op.
		EF018	0 min	147 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
37220	Iliac revasc	EL011	90 min	77 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	90 min	77 min	Contrast media - Refined equipment time to reflect typical use exclusive to patient.
		ER029	90 min	77 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EQ032	153 min	302 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EF018	153 min	302 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ011	153 min	302 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
37221	Iliac revasc w/stent	EL011	120 min	107 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	120 min	107 min	Contrast media - Refined equipment time to reflect typical use exclusive to patient.
		ER029	120 min	107 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient.
		EQ032	183 min	332 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EF018	183 min	332 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ011	183 min	332 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
37224	Fem/popl revas w/tla	EL011	110 min	97 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	110 min	97 min	Contrast media - Refined equipment time to reflect typical use exclusive to patient.
		ER029	110 min	97 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EQ032	173 min	322 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EF018	173 min	322 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ011	173 min	322 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
37225	Fem/popl revas w/ather	EL011	148 min	135 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	148 min	135 min	Contrast media - Refined equipment time to reflect typical use exclusive to patient.
		ER029	148 min	135 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient.
		EQ032	211 min	360 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EF018	211 min	360 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ011	211 min	360 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
37226	Fem/popl revasc w/stent	SD254	3	1	Reduce quantity to reflect typical use.
		EL011	120 min	107 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	120 min	107 min	Contrast media - Refined equipment time to reflect typical use exclusive to patient.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		ER029	120 min	107 min	Film alternator -Refined equipment time to reflect typical use exclusive to patient.
		EQ032	183 min	332 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EF018	183 min	332 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ011	183 min	332 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		SD254	3	1	Reduce quantity to reflect typical use.
37227	Fem/popl revasc stnt & ather	EL011	155 min	142 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	155 min	142 min	Contrast media -Refined equipment time to reflect typical use exclusive to patient.
		ER029	155 min	142 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient.
		EQ032	218 min	367 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EF018	218 min	367 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ011	218 min	367 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
37228	Tib/per revasc w/tla	EL011	120 min	107 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EQ088	120 min	107 min	Contrast media -Refined equipment time to reflect typical use exclusive to patient.
		ER029	120 min	107 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient.
		EQ032	183 min	332 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EF018	183 min	332 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ011	183 min	332 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
37229	Tib/per revasc w/ather	EL011	150 min	137 min	Angiography room -Refined equipment time to reflect typical use exclusive to patient.
		EQ088	150 min	137 min	Contrast media - Refined equipment time to reflect typical use exclusive to patient.
		ER029	150 min	137 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient.
		EQ032	213 min	362 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EF018	213 min	362 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ011	213 min	362 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
37230	Tib/per revasc w/stent	SD266	2	1	Reduce quantity to reflect typical use.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EL011	150 min	137 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	150 min	137 min	Contrast media - Refined equipment time to reflect typical use exclusive to patient.
		ER029	150 min	137 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient
		EQ032	213 min	362 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EF018	213 min	362 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ011	213 min	362 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
37231	Tib/per revasc stent & ather	SD266	2	1	Reduce quantity to reflect typical use.
		EL011	165 min	152 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	165 min	152 min	Contrast media - Refined equipment time to reflect typical use exclusive to patient.
		ER029	165 min	152 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient.
		EQ032	228 min	377 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EF018	228 min	377 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EQ011	228 min	377 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
37234	Revsc opn/prq tib/pero stent	SD266	2	1	Reduce quantity to reflect typical use.
37235	Tib/per revasc stnt & ather	SD266	2	1	Reduce quantity to reflect typical use.
43754	Dx gastr intub w/asp spec	SM004	1	Delete	Biohazard bags are no longer recognized as direct inputs.
43755	Dx gastr intub w/asp specs	SM004	1	Delete	Biohazard bags are no longer recognized as direct inputs.
43756	Dx duod intub w/asp spec	EQ168	48 min	35 min	Exam light - Refined equipment time to reflect typical use exclusive to patient.
		EQ235	48 min	35 min	Suction machine - Refined equipment time to reflect typical use exclusive to patient.
		EQ269	48 min	35 min	Blood pressure monitor - Refined equipment time to reflect typical use exclusive to patient.
		EL014	48 min	35 min	Radiographic - Fluoroscopic room - Refined equipment time to reflect typical use exclusive to patient.
		EP030	48 min	35 min	pH conductivity meter - Refined equipment time to reflect typical use exclusive to patient.
		EF024	48 min	35 min	Fluoroscopy table - Refined equipment time to reflect typical use exclusive to patient.
		EF027	48 min	35 min	Table for equipment - Refined equipment time to reflect typical use exclusive to patient.
		SM004	1	Delete	Biohazard bags are no longer recognized as direct inputs.
43757	Dx duod intub w/asp specs	EQ168	65 min	52 min	Exam light - Refined equipment time to reflect typical use exclusive to patient.
		EQ235	65 min	52 min	Suction machine - Refined equipment time to reflect typical use exclusive to patient.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EQ269	65 min	52 min	Blood pressure monitor - Refined equipment time to reflect typical use exclusive to patient.
		EL014	65 min	52 min	Radiographic - Fluoroscopic room - Refined equipment time to reflect typical use exclusive to patient.
		EP030	65 min	52 min	pH conductivity meter - Refined equipment time to reflect typical use exclusive to patient.
		EF024	65 min	52 min	Fluoroscopy table - Refined equipment time to reflect typical use exclusive to patient.
		EF027	65 min	52 min	Table for equipment - Refined equipment time to reflect typical use exclusive to patient.
		SM004	1	Delete	Biohazard bags are no longer recognized as direct inputs.
49418	Insert tun ip cath perc	Film jacket	1	Delete	Film jackets are not disposable/consumable supplies.
		EF031	0 min	71 min	RUC recommendation missing table for procedure. Power table - Refined equipment time to reflect typical use exclusive to patient.
		EF015	136 min	71 min	Mayo stand - Refined equipment time to reflect typical use exclusive to patient.
		EQ168	136 min	71 min	Exam light - Refined equipment time to reflect typical use exclusive to patient.
		EQ011	136 min	282 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		New Code	136 min	71 min	Appropriate equipment item already in database: EQ250 (portable ultrasound machine); Refined equipment time to reflect typical use exclusive to patient. Refined equipment time to reflect typical use exclusive to patient.
		EL014	76 min	71 min	Radiographic - Fluoroscopic room - Refined equipment time to reflect typical use exclusive to patient.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		ER029	55 min	2 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient.
		ED024	55 min	2 min	Film processor - Refined equipment time to reflect typical use exclusive to patient
		ED032	9 min	2 min	Laser printer - Refined equipment time to reflect typical use exclusive to patient.
		EF018	0 min	282 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	0 min	282 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
53860	Transurethral rf treatment	Renessa Generator and accessories (new equipment)	$10,330	$9,995	Generator only (the generator itself includes accessories).
57155	Insert uteri tandems/ovoids	New equipment - T&P Applicator Set	80 min	77 min	Allocated total service period less time to clean the room.
		EQ137	80 min	77 min	Surgical instrument pack - Allocated total service period less time to clean the room.
		EQ011	70 min	122 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	70 min	122 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EF018	70 min	122 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
57156	Ins vag brachytx device	New equipment - Vaginal Applicator Kit	53 min	50 min	Allocated total service period less time to clean the room.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
64415	Nblock inj brachial plexus	EQ184	8 min	36 min	Nerve stimulator should be allocated total service period time.
64445	Nblock inj sciatic sng	EQ184	8 min	37 min	Nerve stimulator should be allocated total service period time
64447	Nblock inj fem single	EQ184	8 min	36 min	Nerve stimulator should be allocated total service period time.
64479	Inj foramen epidural c/t	Greet patient	5 min	3 min	Standard time is 3 minutes.
		RT to prep IV	2 min	0 min	Redundant time (time is already allocated to RN).
		EF018	40 min	43 min	Stretcher is allocated total service period less time to clean the room.
		EL014	27 min	22 min	Radiographic - Fluoroscopic room - Refined equipment time to reflect typical use exclusive to patient.
		ER067	27 min	22 min	X-ray view box - Refined equipment time to reflect typical use exclusive to patient.
		ED031	27 min	2 min	Printer, dye sublimation - Refined equipment time to reflect typical use exclusive to patient.
64483	Inj foramen epidural l/s	Greet patient	5 min	3 min	Standard time is 3 minutes.
		RT to prep IV	2 min	0 min	Redundant time (time is already allocated to RN).
		EF018	40 min	43 min	Stretcher is allocated total service period less time to clean the room.
		EL014	27 min	22 min	Radiographic - Fluoroscopic room - Refined equipment time to reflect typical use exclusive to patient.
		ER067	27 min	22 min	X-ray view box -Refined equipment time to reflect typical use exclusive to patient.
		ED031	27 min	2 min	Printer, dye sublimation - Refined equipment time to reflect typical use exclusive to patient.
65779	Cover eye w/membrane stent	EQ137	28 min	46 min	Instrument pack is allocated the total service period time less the time to clean the room.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EQ183	24 min	39 min	Operating microscope is allocated total service period less time to clean the instrument pack.
66174	Translum dil eye canal	EL005	72 min	180 min	Exam lane should be allocated total office visit time.
66175	Trnslum dil eye canal w/stnt	EL005	72 min	180 min	Exam lane should be allocated total office visit time.
69801	Incise inner ear	EQ138	64 min	61 min	Instrument pack is allocated the total service period time less the time to clean the room.
74176	Ct abd & pelvis w/o contrast	EL007	32 min	27 min	CT room - Refined equipment time to reflect typical use exclusive to patient.
		ER029	32 min	27 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient.
		ED032	32 min	8 min	Laser printer - Refined equipment time to reflect typical use exclusive to patient.
74177	Ct abdomen & pelvis w/contrast	EL007	48 min	42 min	CT room - Refined equipment time to reflect typical use exclusive to patient.
		ER029	48 min	42 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient.
		ED032	48 min	10 min	Laser printer - Refined equipment time to reflect typical use exclusive to patient.
74178	Ct abd & pelv 1+ section/regns	EL007	68 min	57 min	CT room - Refined equipment time to reflect typical use exclusive to patient.
		ER029	68 min	57 min	Film alternator - Refined equipment time to reflect typical use exclusive to patient.
		ED032	68 min	20 min	Laser printer - Refined equipment time to reflect typical use exclusive to patient.
76881	Us xtr non-vasc complete	Processor chemicals	1	Delete	Processor chemicals are not a valid supply input.
		Film jacket	1	Delete	Film jackets are not disposable/consumable supplies.
76882	Us xtr non-vasc lmtd	New Code	16 min	16 min	Appropriate equipment item already in database: EQ250 (portable ultrasound machine).

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
91010	Esophagus motility study	EF014	63 min	56 min	Surgical light allocated total service period less time to clean manometry equipment.
		New equipment, Manometry accessory cable	50 min	60 min	Manometry cable allocated total service period less time to clean the room.
		New equipment, Manometry system	50 min	60 min	Manometry system allocated total service period less time to clean the room.
		EF015	63 min	56 min	Mayo stand allocated total service time less time to clean the manometry equipment.
		EF023	63 min	56 min	Exam table allocated total service time less time to clean the manometry equipment
*91065	Breath hydrogen test	New equipment, BreathTrackerDigital SC Instrument stand, drying tube	3 separate pieces	Summed equipment	Equipment inputs summed into one line-item since these items are only used together
			none	53 min	used 53 minutes as the total time for all equipment items consistent with our general policy for establishing equipment times
92227	Remote dx retinal imaging	EL005	0 min	12 min	Ophthalmology exam lane typical for the procedure.
92228	Remote retinal imaging mgmt	EL005	0 min	12 min	Ophthalmology exam lane typical for the procedure.
92285	Eye photography	New equipment - Printer, color, photographic	10 min	10 min	Appropriate equipment item already exists in database: printer, dye, sublimation.
93229	Remote 30 day ecg tech supp	The AMA RUC recommended that the current inputs for this service be maintained. We address, in detail, our refinements of previous AMA RUC-recommended direct PE inputs associated with this code in section III.J. of this final rule with comment period.			
93268	Ecg record/review	The AMA RUC recommended that the current inputs for this service be maintained. We address, in detail, the direct PE inputs associated with this code in section II.A.3.b.(2) of this final rule with comment period.			
93451	Right heart cath	SM004	2	Delete	Biohazard bags are no longer recognized as direct inputs.
		ED018	82 min	44 min	Computer workstation, cath monitoring - Refined equipment time to reflect typical use exclusive to patient.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EQ088	82 min	44 min	Contrast media warmer - Refined equipment time to reflect typical use exclusive to patient.
		EQ011	82 min	152 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	82 min	152 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ211	82 min	Delete	Pulse oximeters are no longer standard equipment for conscious sedation.
		EL011	82 min	44 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EF018	82 min	152 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
93452	Left hrt cath w/ventrclgrphy	SM004	2	Delete	Biohazard bags are no longer recognized as direct inputs.
		ED018	112 min	44 min	Computer workstation, cath monitoring -Refined equipment time to reflect typical use exclusive to patient.
		EQ088	112 min	44 min	Contrast media warmer - Refined equipment time to reflect typical use exclusive to patient.
		EQ011	112 min	272 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	112 min	272 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ211	112 min	Delete	Pulse oximeters are no longer standard equipment for conscious sedation.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EL011	112 min	44 min	Angiography room -Refined equipment time to reflect typical use exclusive to patient.
		EF018	112 min	272 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
93453	R&l hrt cath w/ventriclgrphy	SM004	2	Delete	Biohazard bags are no longer recognized as direct inputs.
		ED018	127 min	59 min	Computer workstation, cath monitoring - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	127 min	59 min	Contrast media warmer - Refined equipment time to reflect typical use exclusive to patient.
		EQ011	127 min	287 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	127 min	287 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ211	127 min	Delete	Pulse oximeters are no longer standard equipment for conscious sedation.
		EL011	127 min	59 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EF018	127 min	287 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
93454	Coronary artery angio s&i	SM004	2	Delete	Biohazard bags are no longer recognized as direct inputs.
		ED018	112 min	44 min	Computer workstation, cath monitoring - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	112 min	44 min	Contrast media warmer - Refined equipment time to reflect typical use exclusive to patient.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EQ011	112 min	272 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	112 min	272 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ211	112 min	Delete	Pulse oximeters are no longer standard equipment for conscious sedation.
		EL011	112 min	44 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EF018	112 min	272 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
93455	Coronary art/grft angio s&i	SM004	2	Delete	Biohazard bags are no longer recognized as direct inputs.
		ED018	122 min	54 min	Computer workstation, cath monitoring - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	122 min	54 min	Contrast media warmer - Refined equipment time to reflect typical use exclusive to patient.
		EQ011	122 min	282 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	122 min	282 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ211	122 min	Delete	Pulse oximeters are no longer standard equipment for conscious sedation.
		EL011	122 min	54 min	Angiography room -Refined equipment time to reflect typical use exclusive to patient,

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EF018	122 min	282 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
93456	Rhrt coronary artery angio	SM004	2	Delete	Biohazard bags are no longer recognized as direct inputs
		ED018	122 min	54 min	Computer workstation, cath monitoring - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	122 min	54 min	Contrast media warmer - Refined equipment time to reflect typical use exclusive to patient.
		EQ011	122 min	282 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	122 min	282 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ211	122 min	Delete	Pulse oximeters are no longer standard equipment for conscious sedation.
		EL011	122 min	54 min	Angiography room -Refined equipment time to reflect typical use exclusive to patient.
		EF018	122 min	282 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
93457	Rhrt art/grft angio	SM004	2	Delete	Biohazard bags are no longer recognized as direct inputs.
		ED018	132 min	64 min	Computer workstation, cath monitoring - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	132 min	64 min	Contrast media warmer - Refined equipment time to reflect typical use exclusive to patient.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EQ011	132 min	292 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	132 min	292 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ211	132 min	Delete	Pulse oximeters are no longer standard equipment for conscious sedation.
		EL011	132 min	64 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EF018	132 min	292 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
93458	Lhrt artery/ventricle angio	SM004	2	Delete	Biohazard bags are no longer recognized as direct inputs.
		ED018	127 min	59 min	Computer workstation, cath monitoring -Refined equipment time to reflect typical use exclusive to patient.
		EQ088	127 min	59 min	Contrast media warmer - Refined equipment time to reflect typical use exclusive to patient.
		EQ011	127 min	287 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	127 min	287 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ211	127 min	Delete	Pulse oximeters are no longer standard equipment for conscious sedation.
		EL011	127 min	59 min	Angiography room -Refined equipment time to reflect typical use exclusive to patient.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EF018	127 min	287 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
93459	Lhrt art/grft angio	SM004	2	Delete	Biohazard bags are no longer recognized as direct inputs.
		ED018	132 min	64 min	Computer workstation, cath monitoring - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	132 min	64 min	Contrast media warmer - Refined equipment time to reflect typical use exclusive to patient.
		EQ011	132 min	292 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	132 min	292 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ211	132 min	Delete	Pulse oximeters are no longer standard equipment for conscious sedation.
		EL011	132 min	64 min	Angiography room -Refined equipment time to reflect typical use exclusive to patient.
		EF018	132 min	292 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
93460	R&l hrt art/ventricle angio	SM004	2	Delete	Biohazard bags are no longer recognized as direct inputs.
		ED018	132 min	64 min	Computer workstation, cath monitoring - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	132 min	64 min	Contrast media warmer -- Refined equipment time to reflect typical use exclusive to patient.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EQ011	132 min	292 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	132 min	292 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ211	132 min	Delete	Pulse oximeters are no longer standard equipment for conscious sedation.
		EL011	132 min	64 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.
		EF018	132 min	292 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
93461	R&l hrt art/ventricle angio	SM004	2	Delete	Biohazard bags are no longer recognized as direct inputs.
		ED018	147 min	69 min	Computer workstation, cath monitoring - Refined equipment time to reflect typical use exclusive to patient.
		EQ088	147 min	69 min	Contrast media warmer - Refined equipment time to reflect typical use exclusive to patient.
		EQ011	147 min	307 min	ECG used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ032	147 min	307 min	IV pump used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
		EQ211	147 min	Delete	Pulse oximeters are no longer standard equipment for conscious sedation.
		EL011	147 min	69 min	Angiography room - Refined equipment time to reflect typical use exclusive to patient.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EF018	147 min	307 min	Stretcher used in conscious sedation - Time includes administering anesthesia, procedure time, and monitoring patient.
93464	Exercise w/hemodynamic meas	EL011	29 min	26 min	This is an add-on code and the cleaning time for the angiography room is accounted for in the base code.
93566	Inject r ventr/atrial angio	Prepare equipment	3 min	0 min	This is an add-on code and the time to prepare equipment is accounted for in the base code.
		Clean imaging equipment	3 min	0 min	This is an add-on code and the time to clean imaging equipment is accounted for in the base code.
		ED018	23 min	17 min	Computer workstation - This is an add-on code and the time to clean and prepare equipment is in the base code.
		EQ088	20 min	15 min	Contrast media warmer - This is an add-on code and the time to clean and prepare equipment is in the base cod.
		EQ011	20 min	15 min	ECG - This is an add-on code and the only time allocated to the equipment is the procedure time.
		EQ032	20 min	15 min	IV Pump - This is an add-on code and the only time allocated to the equipment is the procedure time.
		EL011	23 min	15 min	Angiography room - This is an add-on code and the only time allocated to the equipment is the procedure time.
		EF018	0 min	15 min	The stretcher is a standard piece of equipment used in conscious sedation. This is an add-on code and the only time allocated to the equipment is the procedure time.
93567	Inject suprvlv aortography	Prepare equipment	3 min	0 min	This is an add-on code and the time to prepare equipment is accounted for in the base code.
		Clean imaging equipment	3 min	0 min	This is an add-on code and the time to clean imaging equipment is accounted for in the base code.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		ED018	18 min	12 min	Computer workstation - This is an add-on code and the time to clean and prepare equipment is in the base code.
		EQ088	15 min	10 min	Contrast media warmer - This is an add-on code and the time to clean and prepare equipment is in the base code.
		EQ011	15 min	10 min	ECG - This is an add-on code and the only time allocated to the equipment is the procedure time.
		EQ032	15 min	10 min	IV Pump - This is an add-on code and the only time allocated to the equipment is the procedure time.
		EL011	18 min	10 min	Angiography room - This is an add-on code and the only time allocated to the equipment is the procedure time.
		EF018	0 min	10 min	The stretcher is a standard piece of equipment used in conscious sedation. This is an add-on code and the only time allocated to the equipment is the procedure time.
93568	Inject pulm art hrt cath	Prepare equipment	3 min	0 min	This is an add-on code and the time to prepare equipment is accounted for in the base code.
		Clean imaging equipment	3 min	0 min	This is an add-on code and the time to clean imaging equipment is accounted for in the base code.
		ED018	23 min	17 min	Computer workstation - This is an add-on code and the time to clean and prepare equipment is in the base code.
		EQ088	20 min	15 min	Contrast media warmer - This is an add-on code and the time to clean and prepare equipment is in the base code.
		EQ011	20 min	15 min	ECG - This is an add-on code and the only time allocated to the equipment is the procedure time.
		EQ032	20 min	15 min	IV Pump - This is an add-on code and the only time allocated to the equipment is the procedure time.

CPT Code	Short Descriptor	CMS Code/Description	AMA RUC Recommendation	CMS Refinement	Comment
		EL011	23 min	15 min	Angiography room - This is an-add-on code and the only time allocated to the equipment is the procedure time.
		EF018	0 min	15 min	The stretcher is a standard piece of equipment used in conscious sedation. This is an add-on code and the only time allocated to the equipment is the procedure time.
95956	Eeg monitor technol attended	EF009	52 min	Delete	Medical recliner is redundant to other equipment package.
		EQ017	771 min	772 min	ECG should be allocated total service period time.
96446	Chemotx admn prtl cavity	EF002	101 min	104 min	Hospital bed allocated total service time less time to mix chemotherapy.
		EQ032	101 min	104 min	IV pump allocated total service time less time to mix chemotherapy.
97597	Rmvl devital tis 20 cm/<	EL005	47 min	44 min	Instrument pack is allocated the total service period time less the time to clean the room.

* CPT codes discussed in more detail in section II.A.3.c. of this final rule with comment period

3. Establishment of Interim Final Malpractice RVUs for CY 2011

According to our final policy as discussed in section II.B.2.of this CY 2011 final rule with comment period, we have assigned malpractice RVUs for CY 2011 new and revised codes by a crosswalk to a similar source code. We have reviewed the malpractice source code AMA RUC recommendations for 224 CY 2011 new and revised codes and we are accepting them all for CY 2011. According to our policy, we have adjusted the malpractice RVUs of the CY 2011 new/revised codes for differences in work RVUs (or, if greater, the clinical labor portion of the fully implemented PE RVUs) between the source code and the new/revised code to reflect the specific risk-of-service for the new/revised code. The source code crosswalks for the CY 2011 new/revised codes are subject to public comment on this CY 2011 final rule with comment period, as well as the CY 2011 malpractice RVUs of the new/revised codes that are listed in Addendum C to this final rule with comment period.

Table 8 lists the CY 2011 new/revised codes and their respective source codes for determining the interim final CY 2011 malpractice RVUs. We are also posting the crosswalk on the CMS Web site under the downloads for the CY 2011 PFS final rule with comment period at:

http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage.

VI. Provisions of the Affordable Care Act

The following section addresses certain provisions of the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) enacted on March 30, 2010 (collectively known as the Affordable Care Act (ACA)).

A. Section 3002: Improvements to the Physician Quality Reporting System

Section 3002 of the ACA makes a number of changes to the Physician Quality Reporting System (previously referred to as the Physician Quality Reporting Initiative ,or PQRI), including authorizing incentive payments through 2014, and requiring a payment adjustment beginning in 2015, for eligible professionals who do not satisfactorily submit quality data. For a more detailed discussion of the provisions of section 3002 of the ACA, please refer to section VII.F.1. of this final rule with comment period.

B. Section 3003: Improvements to the Physician Feedback Program and Section 3007: Value-based Payment Modifier Under The Physician Fee Schedule

1. Background

As required under section 1848 (n) of the Act, as added by section 131(c) of MIPPA, we established and implemented by January 1, 2009, the Physician Resource Use Measurement & Reporting (RUR) Program (now referred to as the Physician Feedback Program) for purposes of providing confidential reports to physicians that measure the resources involved in furnishing care to Medicare beneficiaries. Section 1848(n) of the Act also authorizes us to include information on the quality of care furnished to Medicare beneficiaries by a physician or group of physicians.

We are continuing a phased implementation of the Physician Feedback Program. Phase I was discussed in the CY 2010 proposed and final rules (74 FR 33589, and 74 FR 61844, respectively), and has been completed. Phase I consisted of several

activities including extensive data analysis to inform decisions about topics such as measures, attribution, and risk adjustment and formative testing of report design with practicing physicians. We concluded Phase I by sending to individual practicing physicians in 12 geographic areas[4] several hundred reports that contained per capita and episode-based cost information.

Phase I of the Physician Feedback Program focused on providing confidential feedback on resource use measures. Section 1848 (n)(1)(A)(iii) of the Act states that the Secretary may also include information on the quality of care furnished to Medicare beneficiaries by physicians (or groups of physicians) in the feedback reports. We believe that providing physicians with feedback on both quality and cost is consistent with the direction of other CMS value-based purchasing (VBP) initiatives. As a result, we decided to include quality measures in Phase II of the Physician Feedback Program and, in particular, we considered measures used in the Physician Quality Reporting System (previously referred to as the Physician Quality Reporting Initiative (PQRI)) and claims-based measures such as the measures used in the Generating Medicare Physician Quality Performance Measurement Results (GEM) project (74 FR 61846).

Section 1848 (n)(1)(A)(ii) of the Act also states that the Secretary may provide reports at the physician group level. Accordingly, as part of Phase II of the Physician Feedback Program, we will also include reporting to group practices, defined as more than one physician practicing medicine together (74 FR 61846). In addition, we noted that the definition applies to the following types of physician groups: (1) formally established single or multi-specialty group practices; (2) physicians practicing in defined geographic regions; and (3) physicians practicing within facilities or larger systems of

[4] The 12 geographic areas are: Boston, MA, Syracuse, NY, Northern New Jersey, Greenville, SC, Miami, FL, Little Rock, AR, Indianapolis, IN, Cleveland, OH, Lansing, MI, Phoenix, AZ, Seattle, WA, and Orange County, CA.

care (74 FR 61846). As we continue with Phase II, we plan to report to both physician group practices and their affiliated practitioners, recognizing that many physicians practice in arrangements other than solo practices. We believe that using both group and individual level reporting will also allow us to gain experience with the sample size issues that arise when individual physicians have too few Medicare beneficiaries with specific conditions to generate reliable information. (See the CY 2010 final rule with comment period (74 FR 61844) for a detailed discussion of plans for Phase II.)

2. Effect of the ACA of 2010 on the Program

The ACA contains two provisions relevant to the Physician Feedback Program. Section 3003 of the ACA continues the confidential feedback program and requires the Secretary, beginning in 2012, to provide reports that compare patterns of resource use of individual physicians to other physicians. In addition, section 3007 of the ACA requires the Secretary to apply a separate, budget-neutral payment modifier to the Fee-For-Service PFS payment formula. The value-based payment modifier, which will be phased in beginning January 1, 2015 through January 1, 2017, will provide for differential payment under the fee schedule to a physician or groups of physicians, and later, possibly to other eligible professionals, based upon the relative quality and cost of care of their Medicare beneficiaries. Accordingly, our goal is to have Medicare physicians receive a confidential feedback report prior to implementation of the value-based payment modifier. We view these two provisions as complementary, as we expect the work done for the Physician Feedback Program under section 3003 of the ACA will inform our implementation of the value-based payment modifier under section 3007 of the ACA. The approach used for performance assessment in the confidential feedback reports will serve as the foundation for implementing the value-based payment modifier. Specifically, throughout future phases of reports under the Physician Feedback Program,

we will continue to enhance our measures and methods and improve the content of the reports based on both our research and the feedback of stakeholders before the value-based payment modifier begins to affect physician payments in 2015.

We plan to engage in a large-scale effort to garner widespread stakeholder involvement with regard to how we continue to build and expand the confidential feedback program and transition to implementation of the value-based payment modifier. We recognize that such a payment modifier may have an impact on the delivery of care to Medicare beneficiaries. Reports that will be produced in the future based on changes as a result of section 3003 of the ACA will contain both cost and quality data, and work done to improve these reports with regard to fair and actionable measures in each of these domains will aid our decision making in how to apply the value-based payment modifier. We intend to seek stakeholder input on various aspects of program design, including cost and quality measures, methodologies for compositing measures, and feedback report content and delivery. Such feedback may be gathered through rulemaking, open door forums, or other mechanisms. Below we summarize the public comments received on the changes we proposed to make to Phase II of the Physician Feedback Program.

3. Summary of Comments and Phase II Proposed Changes

a. Episode Groupers

We intend that reports in Phase II of the Physician Feedback Program will be distributed in the fall of 2010. However, we proposed several changes to the program parameters for Phase II that were finalized in prior rules (75 FR 40114). First, we proposed to discontinue our use of commercially-available proprietary episode grouping software given limitations we noted in proprietary episode grouping software we used in previous phases of the program. In addition, we noted that section 3003 of the ACA requires that the Secretary develop a Medicare-specific episode grouper by

January 1, 2012, and make the details of the episode grouper available to the public . It is our intent that the Medicare-specific episode grouper will address the limitations we found in the proprietary software.

We recognize that, because of its disease/condition-specific focus, episode-based cost information can be more meaningful and actionable for physicians than per capita information. We plan to provide such information in feedback reports after public grouper software is developed. Prior to that, we may consider other potential interim options for episode grouping to provide such information. As we indicated, we believe that our use of proprietary episode grouping software in the previous phases of the program had certain limitations (75 FR 40114). These software products were not intended for use with Medicare claims data, and we discovered several problems with the data outputs. Specifically, the groupers do not work well to create episodes for beneficiaries with multiple chronic conditions, which is a significant portion of Medicare beneficiaries.

For example, when a beneficiary with a chronic disease is hospitalized for an acute condition, that beneficiary most likely also receives treatments unrelated to the condition for which he or she is hospitalized, but related to the chronic disease. The groupers, which are proprietary and often referred to as "black boxes," do not enable users to understand the coding to determine how to accommodate these issues. Therefore, we had to make several decisions about how to pre-process the claims data so that the groupers could recognize and attempt to deal with these issues in the clinical grouping logic. After report production in Phase I, we discovered several problems with the pre-processing, which resulted in inaccurate episode cost information being disseminated.

Until a Medicare-specific episode grouping software is developed, we plan to produce reports for Phase II that contain annualized per capita cost information. More specifically, instead of episode-specific cost information, we plan to provide all patient per capita cost information, as well as per capita cost information for those beneficiaries with five common chronic diseases: (1) diabetes; (2) congestive heart failure; (3) coronary artery disease; (4) chronic obstructive pulmonary disease; and (5) prostate cancer. This information will not be limited to the cost of treating the disease itself, but will provide total Part A/B per capita cost information, as well as service category breakdowns, for the care received by the subset of attributed beneficiaries with that disease.

Comment: Many commenters were supportive of CMS' decision to discontinue using the proprietary episode grouper software in Phase II and instead to develop a Medicare-specific grouper available to the public. Several of these commenters discussed the specific limitations of proprietary groupers and also the importance of developing and utilizing a Medicare-specific episode grouper available to the public. Many commenters urged CMS to include extensive testing and stakeholder input while developing the Medicare-specific grouper. These commenters asserted that it was important that the process to develop a Medicare-specific grouper be available to the public, as well as the methodology such a grouper will employ, remain transparent, and open for public review and recommendation. A few commenters expressed concern about CMS' ability to create a fair and accurate Medicare-specific episode grouper in the timeline allotted for its implementation. One commenter specifically requested that CMS, to the extent possible, express concern about the timeline enacted by Congress. Another commenter opposed dropping the episode grouper in Phase II and requested that CMS use this time to test and explore different episode grouping methodologies.

Response: We appreciate these comments in support of our proposal to discontinue our use of commercially-available proprietary episode grouping software due to concerns over their suitability for use with Medicare claims and the pending development of a Medicare-specific episode grouper. Our research has documented that the currently available episode groupers, as they are now configured, present significant challenges to their use with our highly complex patient population. Therefore, we believe it is appropriate to discontinue use of the commercially available episode groupers for the Phase II reports and until a Medicare-specific episode grouper is available. We acknowledge the suggestion, however, that CMS test and explore different episode grouping methodologies. We are bound by statute to make the details of the developed Medicare-specific episode grouper available to the public and intend to do so. We also intend to involve the stakeholder community and to receive their input during the testing stage. We acknowledge that there are many challenges involved in deciding on the methodologies to utilize in developing the episode grouper. We also acknowledge that the statutorily required timeframe for development of the grouper is one of those challenges. We believe that the episode grouper is a useful element in appropriately providing effective and actionable cost measures for physician feedback. We intend to research and test many different methodologies in order to create a fair and appropriate episode grouper for the Medicare population and will incorporate episode-based cost measures into the physician feedback reports as early as possible.

After considering all of the public comments received regarding this issue and for the reasons we explained above, we are finalizing our proposal to discontinue use of the commercially-available proprietary episode grouping software for Phase II reports.

b. Quality Measures

We proposed to exclude data from the Physician Quality Reporting System in the Physician Feedback Program reports even though commenters have been generally supportive of including Physician Quality Reporting System measures in the reports (75 FR 40114).

The first year of the Physician Quality Reporting System was 2007, participation was still quite low, and the first round of Physician Quality Reporting feedback reports contained errors that necessitated correction. To date, work by CMS' Physician Feedback Program support contractor has been based upon claims data from 2007. Because of the low number of physicians reporting under the Physician Quality Reporting System in 2007, and because providers have the flexibility to choose which measures to report under the Physician Quality Reporting System, we believe the resulting small numbers of physicians reporting an individual measure would greatly limit meaningful peer comparisons, and thus the number of providers who would receive a feedback report. Therefore for Phase II, we proposed to use the claims-based measures developed by CMS in the GEM project (75 FR 40115).[5] This is a core set of 12 process quality measures developed by HEDIS that can be calculated using only administrative claims data. Several chronic conditions that are prevalent in the Medicare population are captured by this set of measures. However, in future phases of the program, we intend to explore the possibility of linking the Physician Feedback Program to the Electronic Health Record (EHR) incentive program for meaningful use of EHR technology (as added by the Health Information Technology for Economic and Clinical Health Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act) (HITECH)), and the group practice reporting option (GPRO) in the Physician Quality Reporting System. Both of these programs offer measures and measure sets, as well as

[5] http://www.cms.gov/GEM

methods of reporting data which would be conducive to meaningful peer comparisons among physicians.

Comment: Several commenters agreed with our proposal to not use Physician Quality Reporting System measures during Phase II. These commenters argued that the Physician Quality Reporting System measures are voluntarily reported, some reports have contained errors, and therefore, these data are inadequate for assessing quality for many providers. Several commenters voiced concerns and/or disagreement with using GEM measures as an alternative to the Physician Quality Reporting System measures. These commenters claimed that the GEM measures are too focused on primary care and prevention, are limited in scope (for example, do not contain any measures for prostate cancer, and breast and colorectal cancer measures are only related to screening), and have few, if any, measures pertaining to some specialties. Some commenters advocated for the future use of Physician Quality Reporting System measures claiming that more eligible professionals are participating in the program now. Several commenters agreed with CMS' decision to explore linking the Physician Feedback Program with the EHR incentive program.

Response: We appreciate these comments and we understand the commenters' concern that the 12 core GEM measures may not fully measure the broad scope of care delivered to Medicare beneficiaries. However, the GEM measures serve as an initial core measure set, upon which a larger set can be built for purposes of including in future reports. We also believe that the GEM measures will yield sufficient information to allow peer group comparisons. In contrast, the Physician Quality Reporting System data available to us for the Phase II reports were very limited and would not provide sufficient data for the minimum case size and number of peers needed to report data for many physicians. We plan to take into account the limitations commenters raised as we explore

our options for choosing and developing measures for subsequent phases of the Physician Feedback Program and the development of the value-based payment modifier. As part of this process, we fully intend to explore the possibility of linking this program to the EHR incentive program for meaningful use of electronic health records, and the GPRO option in the Physician Quality Reporting System. We recognize the need to develop a comprehensive measure set that will fairly measure both quality and resource use. We intend to work with the stakeholder community to create a fair, reasonable, and actionable set of measures that we expect to publish not later than January 1, 2012 for future use in determining the value-based payment modifier.

After considering all of the comments we received and for the reasons discussed above, we are finalizing our proposal to not include Physician Quality Reporting System data in the Phase II reports.

c. Report Distribution

We proposed to distribute reports electronically in Phase II, by leveraging the infrastructure used to distribute Physician Quality Reporting System feedback reports (75 FR 40155). We believe this infrastructure will enable groups to utilize an electronic portal to download their Phase II reports. Individual practitioners will be able to contact their MACs/fiscal intermediaries to receive an emailed copy of their reports. We have received feedback from physicians that the reports distributed in Phase I were too long and cumbersome to manage in hard copy. We proposed consolidating the report and disseminating it electronically for easier navigation. Below we summarize our responses to public comments we received regarding this proposal.

Comment: Most commenters generally expressed support for our proposal to distribute reports electronically in Phase II utilizing the existing infrastructure that is used to distribute Physician Quality Reporting System feedback reports. One commenter in

particular, noted that the Physician Quality Reporting System portal was cumbersome and that security issues created access problems. Many commenters stressed that the reports need to be easy to navigate and need to be easily understood.

Response: We agree that electronic delivery is a desirable means of distribution for these reports and are continuing to evaluate and develop methods to make future reports easily accessible, user friendly and informative. We appreciate all of the feedback from commenters regarding this proposal. While we acknowledge that users have expressed difficulty in using the Physician Quality Reporting System portal, it was the best option for electronic dissemination of the Phase II reports. In the future we will consider all of the potential options available to us and will take these suggestions into account when developing future means of report distribution. After taking into consideration the comments summarized above, we are finalizing our proposal to distribute Phase II reports electronically utilizing the existing infrastructure used to distribute Physician Quality Reporting System feedback reports. In the future, as we disseminate increasing numbers of reports, we will provide information regarding how individuals and groups can access their reports through sub-regulatory guidance and other means of notification.

4. Implementation of Sections 3003 and 3007 of the ACA

Sections 3003 and 3007 of the ACA contain several important implementation dates. In addition to developing an episode grouper by January 1, 2012, we are required by the same date to publish the cost and quality measures we intend to use for purposes of the value-based payment modifier. The payment modifier will become effective for certain physicians and groups of physicians on January 1, 2015, with a phased implementation so that all physicians paid under the PFS will be subject to the value-based payment modifier by January 1, 2017. On or after January 1, 2017, we have

the authority to also apply the payment modifier to other eligible professionals. Through the rulemaking process in 2013, we will begin implementing the program parameters for the value-based payment modifier.

In anticipation of implementing sections 3003 and 3007 of the ACA, we intend to perform extensive data analysis and research, and to seek stakeholder input on issues related to cost and quality measures so that we can be prepared to publish, by January 1, 2012, measures we intend to use for purposes of the value-based payment modifier. We intend for the work done in establishing cost and quality measures for purposes of the payment modifier to inform the continued dissemination of confidential feedback reports to both individual physicians and physician groups. Specifically, the measures chosen for purposes of the value-based payment modifier will be included in future phases of the confidential feedback reports.

As noted previously, Phase I included reports to several hundred physicians. In Phase II, during Fall 2010, we anticipate disseminating reports to about 40 large physician groups and the approximately 2,000 physicians affiliated with those groups. We anticipate future phases of the reports to include additional dissemination to increasing numbers of practitioners and groups such that virtually every applicable Medicare practitioner receives a report prior to implementation of the value-based payment modifier.

5. Summary of Comments Sought on Specific Statistical Issues Related to the ACA Sections 3003 and 3007

We recognize that there are many important decisions to be made when implementing a program that compares physicians to their peers, especially when such information can lead to differential payment. Since the inception of the Physician Feedback program, all data have been price standardized which includes accounting for

geographic adjustments. We have identified important statistical issues in previous rules, and as we have done in previous rules, we sought input on several of these topics as they relate to future phases of reports. These include, but are not limited to: risk adjustment; attribution; benchmarking; peer groups; minimum case sizes; cost and quality measures; and compositing methods. Specific parameters of the Physician Feedback Program are based on the most current information we have available to us. These parameters will continue to evolve and we will continue to evaluate them as the state of the art in these areas continues to improve. Therefore, in the proposed rule, we solicited public comment on the following statistical and methodological issues (75 FR 40115).

a. Risk Adjustment

The cost data used in Phase I were risk adjusted. For the per capita costs, we used CMS' Hierarchical Condition Categories (HCC) model developed for risk adjustment in Medicare Advantage plans. This model takes into account beneficiary characteristics such as age, sex, and Medicaid status, and then predicts costs for beneficiaries based on their unique mix of health conditions. Several other socioeconomic factors, such as the median income per capita in the county where the physician practices, were used. For the episode-based costs, we used the risk adjustment method built into the proprietary grouper software. Regression analyses indicated that these additional socioeconomic factors did little to improve the fit of the model.

The cost data in Phase II are risk adjusted using the HCC model, but excluding the additional socioeconomic factors such as the median income per capita in the county where the physician practices, that had been used in Phase I. And since there are no episode-based costs in Phase II – only annual per capita costs - the HCC model will be the only method used. Other methods of risk adjustment, such as the CC (complications

and co-morbidities) and MCC (major complications and co-morbidities) indicators implemented in the 2008 MS-DRG system, were considered but not employed.

The quality data included in Phase II will not be risk adjusted because the GEM measures are all clinical process measures, measure specifications provided detailed inclusion/exclusion criteria, and it is generally accepted that such measures need not be risk adjusted. Beneficiaries should receive the indicated preventive services (for example, breast cancer screening) regardless of their demographic characteristics or presence or absence of health conditions.

We solicited comment on the appropriate method for risk adjusting cost data, as well as our reasoning for not risk adjusting clinical process quality measures (75 FR 40115) and the comments we received are summarized below.

Comment: There were a number of comments regarding the need to risk adjust for socioeconomic and cultural differences (including English proficiency, literacy, poverty, and family structure) and multiple co-morbidities in order to avoid creating a disincentive for physicians who treat disadvantaged or complex patient populations. If socioeconomic factors are not added to the HCC model, commenters suggested using an alternative method to account for these factors such as a stratified analysis and comparison among similar providers and/or similar patient groups. Similarly, some commenters suggested that patients with substance abuse and mental health co-morbidities should be stratified into a distinct cohort. Other commenters suggested that exclusions be allowed for patient non-adherence or for cases of terminal illness. While there was general agreement that process measures do not require risk adjustment, several of the commenters pointed out that socioeconomic factors can also impact process and claims-based measures and risk adjustment of these measures should be considered on a measure by measure basis. Commenters asserted that outcome measures should be

risk adjusted and some suggested that CMS use publically available risk models developed by specialty societies. Some commenters suggested that CMS provide evidence of the utility and reliability of using HCC to risk adjust per capita measures. Several commenters suggested that CMS test multiple methodologies for risk adjustment and perform appropriate statistical analyses to determine variability among the different methodologies. Commenters emphasized the need to implement a methodology that would be transparent to the public and all stakeholders.

Response: We thank the commenters for their thoughtful input. In Phase II reports, we will employ the same method of risk adjustment for per capita cost measures as we use in our Medicare Advantage (MA) program, that is, the hierarchal condition category (HCC) model. We will continue to seek stakeholder input as we consider these comments and ways to improve our risk adjustment methodology.

b. Attribution

Deciding which physician(s) is/are responsible for the care of which beneficiaries is an important aspect of measurement. We must strike a balance between only attributing cost information to physicians for the services they personally delivered, and attributing costs to physicians based on a more encompassing view of the services provided to each beneficiary so as to encourage better care coordination and accountability for patient outcomes.

There are several methods that are generally used for attributing beneficiaries' costs to physicians for the purposes of measuring and comparing performance. In Phase I, we used two different attribution methodologies. Half of the reports used the multiple-proportional attribution, in which a beneficiary's costs were summed, and then divided among the physicians who treated that beneficiary in the same proportion as their share of evaluation and management (E&M) services provided. The other half of the

reports used the plurality-minimum method, in which a beneficiary's entire cost (either for the episode or for the year) was attributed to the physician who performed the plurality of the E&M services, subject to a minimum percentage (in that case, 10 percent).

In Phase II reports, we plan to use the plurality-minimum method with a minimum percentage threshold of E&M services of 20 percent for individual physicians and a minimum percentage threshold of E&M services of 30 percent of the E&M services for physician group level reports (75 FR 40116). These minimum threshold determinations were based on our analysis of the claims data. We recognize that other attribution methods exist, which may be either more or less appropriate given the aspect of care one is measuring. For example, it may be desirable to attribute the entire cost of a surgical episode to the performing surgeon. Another method for attributing costs is referred to as multiple-even, in which the entire beneficiary's cost is attributed to multiple physicians who treated the beneficiary.

We sought comment on the topic of attribution methodologies, including both of those we have already used in the program, as well as others. The comments we received are summarized below.

Comment: Many commenters voiced concern about the plurality minimum attribution method that CMS has planned to use in its Phase II feedback reports. A number of commenters asked that we ensure that the plurality minimum method does not penalize primary care doctors by holding them accountable for all the services beneficiaries receive, since they only deliver a subset of all of the care a beneficiary receives. Other commenters were concerned that if there were too many visits to a specialist, the specialist might get penalized. Many commenters were opposed to the plurality minimum model, not wanting to be held accountable for care they do not

influence. Others expressed concern that costs could be attributed incorrectly and also that unintended changes in referral patterns might result, as physicians might be influenced by the cost of care without regard to quality. One commenter requested that CMS consider attribution options built on threshold concepts or specific agreement between a physician/medical group and patient on responsibility for management of a specific condition with the goal of focusing measurement and attribution assignment on those patients who are truly under the care of the physician or group for the condition. Another commenter asked CMS to ensure that the same patient is attributed for resource use and quality, and additionally to clarify if patients will be attributed to primary care and specialists. Generally, specialty physician associations supported the multiple-proportional attribution method, pointing out that there is shared accountability in delivering preventive and many other services. One commenter believed that the multiple-even method should be used, and in the case of surgical episodes, the entire cost should be attributed to the performing surgeon.

Other commenters believed that the plurality minimum method was acceptable, but strongly urged CMS to continually analyze whether this methodology results in fair and accurate reports under different clinical scenarios, especially those where multiple co-morbidities are present. In addition, these commenters urged CMS to statistically examine the impact of changing the minimum thresholds. Several commenters recommended that CMS test multiple attribution models and evaluate the results. Another commenter recommended extensive chart reviews in order to ensure that the claims data supports the attribution model used. Several commenters pointed out that the choice of attribution method will not influence patient behavior and suggested incorporating patient accountability, including compliance. There were several comments about hospital costs being attributed to physicians that suggested alignment

with other programs such as Hospital Value-Based Purchasing. One commenter suggested using multiple models and not a single model of attribution. One commenter noted that the problem of small numbers may make it difficult to fairly assess the costs at the individual level. Overall, commenters pointed out that the method(s) used should be accurate, transparent, and not disadvantage small or rural practices.

Response: We appreciate the input from commenters. We will continue to consider and evaluate how to apply attribution methods to physician feedback reports and seek stakeholder input. In Phase II reports, we plan to use the plurality-minimum method with a minimum percentage threshold of E&M services of 20 percent for individual physicians and a minimum percentage threshold of E&M services of 30 percent of the E&M services for physician group level reports.

c. Benchmarking and Peer Groups

Determining how to most relevantly compare physicians to a standard or to their peers is also an important policy aspect of the program. CMS' research conducted in Phase I of the program indicated that physicians prefer to be compared only to those physicians most like them (that is, the narrowest peer group). We recognize the importance of fair comparison, but are also faced with the challenge that very narrow peer groups, especially among specialist and subspecialists are most often not large enough to make statistically significant comparisons.

The individual-level reports in both phases of the program have contained, or will contain, two peer group comparisons: (1) physicians in the same specialty in the same geographic area; and (2) physicians in the same specialty across all 12 geographic areas. In each of these peer groups, a physician is shown where he or she falls on a distribution that specifically identified the 10^{th}, 50^{th}, and 90^{th} percentiles. These benchmarks were finalized on an interim basis in the CY 2010 proposed rule (74 FR 33589).

In determining differences among providers for episode-based measures in Phase I, we used a minimum frequency test. For per capita measures in Phase I, a physician had to have a case size of 20 or more beneficiaries to be measured and compared. There was no minimum peer group size requirement.

The original MIPPA mandate requires us to make comparisons among physicians on cost, and gives the Secretary the authority to include comparisons on quality. The use of quality measures in the program was finalized in the CY 2010 final rule (74 FR 61846). In Phase II, comparisons with appropriate peer groups will be made for both measures of cost and quality. Phase II reports will be provided only to those physicians that have 30 or more patients for each of the cost measures. For the quality measures, we plan to use the measure specifications in the GEM project to define minimum case sizes, which are at least 11 beneficiaries. We also plan to impose a minimum peer group size of 30 in Phase II for each of the cost and quality measures. A minimum sample size of 30 is generally accepted in the research community as the minimum sample size to represent a group and make comparisons.

We solicited comment on the most appropriate and relevant peer groups for comparison, including the appropriate minimum case sizes and minimum peer group sizes. We were also interested in suggested methodologies that could be applied to small case sizes. The comments we received are summarized below.

Comment: Several commenters recommended that CMS establish separate benchmark measures for teaching medical facilities. These commenters argued that the proposed methodology should take into account the multiple missions of academic clinical facilities because their cases are often more complex. Other commenters recommended that CMS establish benchmarks that compared physicians to other physicians with similar practices and/or who perform similar procedures and additionally

take into account sub-specialties and geography as peer groups will vary. These commenters suggested that CMS work with specialty groups and communities to develop the best comparisons. Other commenters noted that CMS needs to account for issues such as the difference between a practicing surgeon and a surgeon who does little surgery but acts more as a manager of care. These commenters asserted that this type of differentiation can be identified through review of claims history and data accessible through specialty organizations. Several commenters recommended that hospitalists and hospital groups be benchmarked against other hospital-based physicians or groups, preferably in similar practice settings, for example, emergency departments. A number of commenters suggested that CMS use metrics such as measures of statistical precision, multiple metrics including mean, median, percentiles in defining parameters for peer groups rather than use arbitrary numbers for minimum sample size. One commenter recommended that a power analysis be conducted to identify an appropriate sample size to be used for benchmarking.

Response: We appreciate the feedback we received from commenters and will take these into consideration for the future. While we will continue to explore these issues, in Phase II reports, we will use the peer group and minimum case size of 30 as outlined above and in the proposed rule.

d. Cost and Quality Measures and Compositing Methods

As mentioned above, and in previous rules, section 1848(n)(1)(A)(ii) of the Act gives the Secretary the authority to include both cost and quality information in the feedback reports. In Phase I, we chose to use only cost information, and used both per capita and episode cost measurements. As mentioned above, we previously finalized the use of quality measures in Phase II (74 FR 61846), but finalized our proposal to

discontinue our use of episode cost measurements. Accordingly, we have yet to include any composite measures of cost or quality in the feedback reports.

Section 3007 of the ACA requires us to establish a value-based payment modifier to pay physicians differentially based both on their quality of care and their costs of care using composites of both quality and cost measures. Accordingly, we will need to devise a methodology in the future for compositing cost measures and quality measures, including considering, among other things, possible methodologies to develop the value-based payment modifier. In the future, episode-based cost measures developed using the Medicare-specific episode grouper software also may be considered in developing a composite of cost measures. Other domains of measures that may be considered include patient-level utilization statistics (for example, emergency department visits per 1,000 patients) and structural measures such as whether a provider has adopted an electronic health record. We recognized that measure composites are methodologically and operationally complex and, therefore, we sought early comments on this topic (75 FR 40116). The comments we received are summarized below.

Comment: Many commenters stressed the importance of measuring both quality and cost of care to ensure useful and meaningful comparisons of physician work. Several commenters asserted that focusing on cost measures alone was insufficient and urged CMS to include quality measures in the comparison to resource utilization feedback reports. These commenters asserted that composite measures of cost and quality provide the most meaningful context to capture and review resource utilization. Several comments focused on the challenge of measuring quality at the physician level and the importance that the measures be fair, meaningful and actionable, and accurately applied. Incorporation of standards and measures endorsed by the National Quality Forum (NQF) was also recommended as well as annual measure updates of quality measures. A

number of commenters stressed the importance of maintaining the focus on quality and outcomes measurement. Types of quality measures suggested for inclusion in the reports included structure, patient safety, clinical processes of care, patient experience, care coordination and clinical outcomes, weighted toward clinical outcomes, care coordination, and patient experience. Several commenters remarked on the limitation of claims-based measures for quality and one recommended that outcomes measures be based on clinical rather than administrative data. One commenter stated that ICD-10 will enhance evaluation of physician performance and suggested evaluation of quality be delayed until ICD-10 is implemented. One commenter suggested a disease focus on peripheral vascular disease. Several commenters suggested that CMS work with specialty societies on using available registries of physician level data as a source of physician quality performance. Many commenters stated that quality should be weighted higher than cost, but agreed both need to be reported. Many commenters encouraged CMS to work expeditiously with stakeholders to improve quality measures for inclusion in the value-based payment modifier. Some commenters acknowledged CMS' recognition that measure composites are methodologically and operationally complex and urged CMS to carefully test and evaluate different composite methodologies before implementing the value-based payment modifier. These commenters argued that the first step in creating a composite measure is to identify the individual components (for example, individual measures) that should go into the composite, and therefore CMS should ensure that a reliable Medicare-specific episode grouper is in place as it would be essential to this initial process. One commenter suggested any composite measures developed by CMS should be reviewed by the multi-stakeholder consultative partnership defined in section 3014 of the ACA prior to any adoption into the physician payment program.

Some commenters mentioned that the National Quality Forum and the American Medical Association's Physician Consortium for Performance Improvement (PCPI) had developed guidance on creating composite measures. These commenters argued that CMS needed to engage in more empirical work on creating composite measures before implementing a modifier for physician payment. These commenters expressed concern that an accurate value-based payment modifier based on resource use would be ready for 2015, given the substantial statistical and methodological hurdles that must be overcome in creating cost and quality composites and a single cost and quality index. They concluded by saying that CMS should continue to seek stakeholder comment throughout the composite measure development process. One commenter urged CMS to ensure that compliance with preventive health service measurements be taken into account when developing the composite measures.

Response: As required under the statute, we plan to identify the measures of resource use and quality that will comprise composites of cost and quality for the physician feedback reports and for the value-based payment modifier by January 1, 2012. We thank the commenters for their many thoughtful suggestions and recommendations on cost and quality measures and compositing methods. As we stated above, we solicited public comment to inform potential future policies on these issues, and the Physician Feedback Program in general. We thank the public for their thoughtful comments and appreciate the feedback received from stakeholders. In addition, a number of societies and organizations volunteered support and also volunteered to share research findings that they believe is applicable to this program.

We fully expect to draw on the expertise of stakeholders as we continue to work on implementing the physician feedback program and implementation of the value-based payment modifier. Moreover, we plan to engage in open and continuing dialogue with

stakeholders on both the Physician Feedback Program and value-based payment modifier.

In addition to the comments we solicited and received on specific methodological issues related to production of the feedback reports, we also received a number of general comments and suggestions regarding the development of reports to ensure access, utility, and relevance.

Comment: A number of commenters suggested that the reports be: interactive, easy to understand, timely, actionable, inclusive of sufficient detail, inclusive of data on cost categories (for example, imaging use, prescriptions, hospitalizations, etc.) and impactful. Some commenters requested the capability to drill down on data, especially if a physician is shown to be a high cost outlier. One commenter requested that the physicians have the ability to review the reports and correct any data that they believe is inaccurate. Others reiterated that all methodologies and algorithms should be in the public domain along with clear plans for evaluating the viability and impact of the reports and reporting mechanisms. We received more than one suggestion for alignment with the HITECH payment incentive program and other programs, in order to alleviate reporting burden and variation. Another commenter supported the creation of group reports, but suggested CMS explore alternative ways to define and determine affiliation with a medical practice group rather than relying solely on tax identification numbers (TINs). Many strongly encouraged CMS to engage public stakeholders intensely and specifically mentioned the importance of working with specialists, specialty societies, clinical experts, treatment guideline developers, and manufacturers on the issues that specifically pertain to their respective interests and expertise in creating measures, composite measures, and performance reporting. Finally, a commenter requested that the reports include graphical and numerical illustrations of data.

In addition, we received a number of comments on the value-based payment modifier although we did not solicit specific comments or make proposals. Our summary of these comments follows:

Comment: A number of commenters supported the idea of a value-based payment modifier using the confidential feedback reports as the foundation and applauded CMS' intentions for a transparent process seeking stakeholder input on the methodology through rulemaking and other public forums. However, other commenters expressed caution in proceeding given the lack of experience with the quality and resource measures which are yet to be published, and the evolutionary nature of the methodology to develop quality and resource scores that will comprise the value-based payment modifier. Several commenters recommended that the value-based payment modifier program be delayed until CMS could demonstrate that it has in place reliable and accurate methodologies for implementation. Several of these commenters urged CMS to thoroughly test out multiple models and methodologies and discuss advantages and disadvantages with the multiple stakeholders.

Response: We appreciate the above input from stakeholders. We will continue to seek further stakeholder input and comment through future rulemaking and other venues, such as open door forums and listening sessions, as we continue to implement the Physician Feedback Program and develop the specifications to implement the value-based payment modifier.

C. Section 3102: Extension of the Work Geographic Index Floor and Revisions to the Practice Expense Geographic Adjustment under the Medicare Physician Fee Schedule, and Protections for Frontier States as amended by Section 10324

Section 1848(e)(1)(E) of the Act (as amended by section 3102(a) of the ACA) extended application of the 1.0 work GPCI floor for services furnished through

December 31, 2010. In addition, section 1848(e)(1) of the Act (as amended by section 3102(b) of the ACA) specified that for CY 2010 and CY 2011, the employee wage and rent portions of the PE GPCI must reflect only one-half of the relative cost differences for each locality compared to the national average and includes a "hold harmless" provision for any PFS locality that would receive a reduction to its PE GPCI resulting from the limited recognition of cost differences. Section 1848(e)(1) of the Act (as amended by section 3102(b) of the ACA) also required an analysis of the current methods and data sources used to determine the relative cost differences in office rent and employee wages compared to the national average and the cost share weights assigned to each PE GPCI component: employee wages, office rent, and supplies. Finally, section 1848(e)(1) of the Act (as amended by section 3102(b) of the ACA) required the Secretary to make appropriate adjustments to the PE GPCI by no later than January 1, 2012. In addition, section 1848(e)(1) of the Act (as amended by section 10324(c) of the ACA) established a 1.0 PE GPCI floor for services furnished in frontier states effective January 1, 2011. The provisions of the ACA related to the GPCIs are discussed in detail in section II.D. of this final rule with comment period.

D. Section 3103: Extension of Exceptions Process for Medicare Therapy Caps

Section 1833(g)(5) of the Act (as amended by section 3103 of the ACA) extended the exceptions process for spending limitations on therapy services in certain outpatient settings through December 31, 2010. Therapy caps are discussed in detail in section III.A. of this final rule with comment period.

E. Section 3104: Extension of Payment for Technical Component of Certain Physician Pathology Services

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554), as amended by section 732 of the

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), section 104 of division B of the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA) (Pub. L. 109-432), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (Pub. L. 110-173), and section 136 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275) was amended by section 3104 of the ACA to continue payment to independent laboratories for the TC of physician pathology services for fee-for-service Medicare beneficiaries who are inpatients or outpatients of a covered hospital through CY 2010. The technical component (TC) of physician pathology services refers to the preparation of the slide involving tissue or cells that a pathologist interprets. The professional component (PC) of physician pathology services refers to the pathologist's interpretation of the slide.

When the hospital pathologist furnishes the PC service for a hospital patient, the PC service is separately billable by the pathologist. When an independent laboratory's pathologist furnishes the PC service, the PC service is usually billed with the TC service as a combined service.

Historically, any independent laboratory could bill the Medicare contractor under the PFS for the TC of physician pathology services for hospital patients even though the payment for the costs of furnishing the pathology service (but not its interpretation) was already included in the bundled inpatient stay payment to the hospital. In the CY 2000 PFS final rule with comment period (64 FR 59408 through 59409), we stated that this policy has contributed to the Medicare program paying twice for the TC service: (1) to the hospital, through the inpatient prospective payment rate, when the patient is an inpatient; and (2) to the independent laboratory that bills the Medicare contractor, instead of the hospital, for the TC service. While the policy also permits the independent

laboratory to bill for the TC of physician pathology services for hospital outpatients, in this case, there generally would not be duplicate payment because we would expect the hospital to not also bill for the pathology service, which would be paid separately to the hospital only if the hospital were to specifically bill for it. We further indicated that we would implement a policy to pay only the hospital for the TC of physician pathology services furnished to its inpatients.

Therefore, in the CY 2000 PFS final rule with comment period, we revised §415.130(c) to state that for physician pathology services furnished on or after January 1, 2001 by an independent laboratory, payment is made only to the hospital for the TC furnished to a hospital inpatient. Ordinarily, the provisions in the PFS final rule with comment period are implemented in the following year. However, the change to §415.130 was delayed 1 year (until January 1, 2001), at the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements.

Full implementation of §415.130 was further delayed by section 542 of the BIPA and section 732 of the MMA, which directed us to continue payment to independent laboratories for the TC of physician pathology services for hospital patients for a 2-year period beginning on January 1, 2001 and for CYs 2005 and 2006, respectively.
In the CY 2007 MPFS final rule with comment period (71 FR 69624 and 69788), we amended §415.130 to provide that, for services furnished after December 31, 2006, an independent laboratory may not bill the carrier for the TC of physician pathology services furnished to a hospital inpatient or outpatient. However, section 104 of the MIEA-TRHCA continued payment to independent laboratories for the TC of physician pathology services for hospital patients through CY 2007, and section 104 of the MMSEA further extended such payment through the first 6 months of CY 2008.

Section 136 of the MIPPA extended the payment through CY 2009. Most recently, section 3104 of the ACA amended the prior legislation to extend the payment through CY 2010.

Consistent with this legislative change, we proposed to revise §415.130(d) to: (1) amend the effective date of our payment policy to reflect that for services furnished after December 31, 2010, an independent laboratory may not bill the Medicare contractor for the TC of physician pathology services furnished to a hospital inpatient or outpatient; and (2) reformat this subsection into paragraphs.

Comment: One commenter urged CMS to implement the provision to continue to pay independent laboratories for the TC of physician pathology services for fee-for-service Medicare beneficiaries who are inpatients or outpatients of a covered hospital on a permanent basis which would eliminate the potential for complicated billing that occurs each time the provision is set to expire and is subsequently extended by.

Response: Payment for the costs of furnishing the pathology service (but not its interpretation) is already included in the bundled inpatient stay payment to the hospital. We continue to believe that this payment provision represents a duplicate payment for the TC service: (1) to the hospital, through the inpatient prospective payment rate, when the patient is an inpatient; and (2) to the independent laboratory that bills the Medicare contractor, instead of the hospital, for the TC service.

After consideration of the public comment we received we are finalizing the proposed policy to continue payment to independent laboratories for the TC of physician pathology services for fee-for-service Medicare beneficiaries who are inpatients or outpatients of a covered hospital for CY 2010. Absent legislation that extends this provision, for services furnished after December 31, 2010, an independent laboratory may not bill the Medicare contractor for the TC of physician pathology services for

fee-for-service Medicare beneficiaries who are inpatients or outpatients of a covered hospital. Accordingly, we are finalizing the proposed revisions to §415.130(d) to reflect this change.

F. Sections 3105 and 10311: Extension of Ambulance Add-Ons

1. Amendment to Section 1834(l)(13) of the Act

Section 146(a) of the MIPPA amended section 1834(l)(13)(A) of the Act to specify that, effective for ground ambulance services furnished on or after July 1, 2008 and before January 1, 2010, the ambulance fee schedule amounts for ground ambulance services shall be increased as follows:

- For covered ground ambulance transports which originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 3 percent.

- For covered ground ambulance transports which do not originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 2 percent.

Sections 3105(a) and 10311(a) of the ACA further amend section 1834(l)(13)(A) of the Act to extend the payment add-ons described above for an additional year, such that these add-ons also apply to covered ground ambulance transports furnished on or after January 1, 2010 and before January 1, 2011. We stated in the CY 2011 PFS proposed rule (75 FR 40117) that we are revising §414.610(c)(1)(i) to conform the regulations to this statutory requirement. This statutory requirement is self-implementing. A plain reading of the statute requires only a ministerial application of the mandated rate increase, and does not require any substantive exercise of discretion on the part of the Secretary. For further information regarding the extension of these payment add-ons, please see Transmittal 706 (Change Request 6972) dated May 21, 2010.

2. Amendment to Section 146(b)(1) of MIPPA

Section 146(b)(1) of the MIPPA amended the designation of rural areas for payment of air ambulance services. The statute specified that any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished on December 31, 2006, shall continue to be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008 through December 31, 2009. Sections 3105(b) and 10311(b) of the ACA amend section 146(b)(1) of MIPPA to extend this provision for an additional year, through December 31, 2010. Accordingly, for areas that were designated as rural on December 31, 2006, and were subsequently re-designated as urban, we have re-established the "rural" indicator on the ZIP Code file for air ambulance services, effective January 1, 2010 through December 31, 2010. We stated in the CY 2011 PFS proposed rule (75 FR 40118) that we are revising §414.610(h) to conform the regulations to this statutory requirement. This statutory requirement is self-implementing. A plain reading of the statute requires only a ministerial application of a rural indicator, and does not require any substantive exercise of discretion on the part of the Secretary. For further information regarding the extension of this MIPPA provision, please see Transmittal 706 (Change Request 6972) dated May 21, 2010.

3. Amendment to Section 1834(l)(12) of the Act

Section 414 of the MMA added paragraph (12) to section 1834(l) of the Act, which specified that in the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2010, for which transportation originates in a qualified rural area (as described in the statute), the Secretary shall provide for a percent increase in the base rate of the fee schedule for such transports. The statute requires this percent increase to be based on the Secretary's estimate of the average cost per trip for

such services (not taking into account mileage) in the lowest quartile of all rural county populations as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of rural county populations. Using the methodology specified in the July 1, 2004 interim final rule (69 FR 40288), we determined that this percent increase was equal to 22.6 percent. As required by the MMA, this payment increase was applied to ground ambulance transports that originated in a "qualified rural area;" that is, to transports that originated in a rural area included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density. For this purpose, rural areas included Goldsmith areas (a type of rural census tract). Sections 3105(c) and 10311(c) of the ACA amend section 1834(l)(12)(A) of the Act to extend this rural bonus for an additional year through December 31, 2010. Therefore, as directed by the ACA, we are continuing to apply the rural bonus described above (in the same manner as in previous years), to ground ambulance services with dates of service on or after January 1, 2010 and before January 1, 2011 where transportation originates in a qualified rural area.

We stated in the CY 2011 PFS proposed rule (75 FR 40118) that we are revising §414.610(c)(5)(ii) to conform the regulations to this statutory requirement. This statutory requirement is self-implementing. The statute requires a 1-year extension of the rural bonus (which was previously established by the Secretary), and does not require any substantive exercise of discretion on the part of the Secretary. For further information regarding the extension of this rural bonus, please see Transmittal 706 (Change Request 6972) dated May 21, 2010.

A summary of the comments we received and our responses are included below.

Comment: Despite the extension of the ambulance payment add-ons under the ACA as discussed above, one commenter stated that "it has become increasingly difficult

to continue to operate with the reimbursement cuts that went into effect January 1, 2010". They expressed concern that Medicare payment rates for ambulance services are not keeping up with inflation in the industry. They were also concerned that this is the first time in nearly a decade that the ambulance industry will be experiencing negative growth.

Response: We are not sure what reimbursement cuts the commenter is referring to in 2010. As discussed above, pursuant to sections 3105 and 10311 of the ACA, we are required to extend certain ambulance payment add-ons through December 31, 2010. Thus, as discussed above, we are revising our regulations to conform the regulations to these statutory requirements. To date, Congress has not extended these payment add-ons beyond December 31, 2010, and thus we are not authorized to provide these add-ons beyond December 31, 2010.

Comment: One commenter stated that CMS must provide instructions to its contractors that direct them to reprocess claims paid at the original 2010 rates.

Response: Several provisions of the ACA require retroactive adjustments to Medicare claims, including claims for ambulance services, because these provisions have effective dates prior to the ACA's enactment or shortly thereafter. We are currently developing the best course of action for addressing past claims that were processed under pre-ACA rules. The volume of claims that must be adjusted is unprecedented and a careful process must be deployed to ensure that new claims coming into the Medicare program are processed timely and accurately, even as we address making retroactive adjustments. Once this process has been developed, we will provide instructions to our contractors regarding adjusting ambulance claims that were paid under the pre-ACA rules in order to apply the payment add-ons required by the ACA.

In this final rule with comment period, we are finalizing the revisions to §414.610(c)(1)(i), (c)(5)(ii), and (h), as discussed above and in the CY 2011 PFS

proposed rule, in order to conform the regulations to the requirements set forth in sections 3105 and 10311 of the ACA. We note that in §414.610(c)(1), we have made minor formatting revisions for clarification purposes. In addition, in §414.610(c)(1)(i), we have corrected a typographical error that appeared in the CY 2011 PFS proposed rule (75 FR 40258) by changing "December 21" to "December 31" to conform with the ACA requirements. As we discuss above, sections 3105 and 10311 of the ACA are self-implementing and do not require any substantive exercise of discretion by the Secretary.

G. Section 3107: Extension of Physician Fee Schedule Mental Health Add-On

Section 3107 of the ACA amended section 138(a)(1) of the MIPPA to continue the 5 percent increase in Medicare payment for specified mental health services through December 31, 2010. This payment increase was originally authorized under section 138 of the MIPPA from July 1, 2008 until December 31, 2009. Accordingly, payment for the 24 psychiatry CPT codes in Table 56, representing "specified services," remains increased by 5 percent through December 31, 2010.

TABLE 56: Specified Mental Health Services Subject to the Five Percent Increase in Medicare Payment through December 31, 2010

Office or Other Outpatient Facility
Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy
90804 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;)
90805 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services)
90806 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;)
90807 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services)
90808 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;)
90809 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services)

Interactive Psychotherapy
90810 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;)
90811 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services)
90812 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;)
90813 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services)
90814 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;)
90815 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services)
Inpatient Hospital, Partial Hospital or Residential Care Facility
Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy
90816 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;)
90817 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services)
90818 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;)
90819 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services)
90821 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;)
90822 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services)
Interactive Psychotherapy
90823 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;)
90824 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services)
90826 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;)

90827 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services)
90828 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;)
90829 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services)

Comment: One commenter supported CMS' proposal to continue the current 5 percent increase in Medicare payment for specified mental health services through December 31, 2010.

Response: We appreciate the support of our efforts to implement this mandated mental health add-on provision that extends the expiration of the 5 percent increase in payment for specified outpatient mental health services from January 1, 2010 to December 31, 2010.

After consideration of the public comment we received, we are finalizing the extension of the 5 percent increase in Medicare payment under the PFS from January 1, 2010 to December 31, 2010.

H. Section 3108: Permitting Physician Assistants to Order Post-Hospital Extended Care Services

The ACA included a self-implementing provision relating to SNFs. Section 3108 of the ACA adds physician assistants (PAs) to the list of practitioners (that is, physicians, nurse practitioners (NPs), and clinical nurse specialists) that can perform the required initial certification and periodic recertification under section 1814(a)(2)(B) of the Act with respect to the SNF level of care. Accordingly, we proposed to make appropriate revisions to include PAs in §424.20(e)(2), in which we refer to NPs, clinical nurse specialists, and PAs collectively as "physician extenders."

We received no comments on this proposal and, therefore, are finalizing this provision as proposed without further modification.

I. Section 3111: Payment for Bone Density Tests

Section 1848(b) of the Act (as amended by section 3111 of the ACA) changed the payment calculation for dual-energy x-ray absorptiometry (DXA) services described by two specified DXA CPT codes for CYs 2010 and 2011. This provision required payment for these services at 70 percent of the product of the CY 2006 RVUs for these DXA codes, the CY 2006 conversion factor (CF), and the geographic adjustment for the relevant payment year.

Effective January 1, 2007, the CPT codes for DXA services were revised. The former DXA CPT codes 76075 (Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)); 76076 (Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (for example, radius, wrist, heel)); and 76077 (Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment) were deleted and replaced with new CPT codes 77080, 77081, and 77082

that have the same respective code descriptors as the predecessor codes. Section 1848(b) of the Act (as amended by section 3111 of the ACA) specifies that the revised payment applies to two of the predecessor codes (CPT codes 76075 and 76077) and "any succeeding codes," which are, in this case, CPT codes 77080 and 77082.

Section 1848(b) (as amended by section 3111 of the ACA) revised the payment for CPT codes 77080 and 77082 during CY 2010 and CY 2011. We have provided payment in CY 2010 under the PFS for CPT codes 77080 and 77082 at the specified rates. (Additional information regarding the CY 2010 payment rates for these services is available in CR 6973, published May 10, 2010.)

Because the statute specifies a payment amount for these services as described previously, we proposed to impute RVUs for CY 2011 that would provide the specified payment amount for these services when multiplied by the CY 2011 CF. Specifically, we divided the payment amount based on the statutory requirements by the CY 2011 CF for the proposed rule and distributed the imputed total RVUs across the work, PE, and malpractice components proportionately to their CY 2006 distribution. Therefore, these imputed RVUs for CPT codes 77080 and 77082 were displayed in Addendum B to the CY 2011 proposed rule.

Comment: Many commenters supported the ACA provision requiring a specific payment amount for DXA services. Several commenters requested that CMS include in the final rule a sample payment calculation for CPT codes 77080 and 77082 to clarify the calculation for these two codes and to facilitate proper processing of claims by Medicare contractors. In addition, one commenter requested that CMS recalculate any imputed RVUs for DXA services based on the final conversion factor reflected in the CY 2011 PFS final rule with comment period.

Response: We appreciate the comments we received on our proposal. We note

that any changes to the proposed rule calculation that resulted from changes between proposed rule values and final rule values have been incorporated in the final determination of the RVUs for these codes upon which PFS payment is based. That said, we are updating our calculation for this final rule with comment period to reflect the final CY 2011 conversion factor applicable under current law that is discussed in section II.H.1.b. of this final rule with comment period. A sample payment calculation for CPT code 77080 is included below.

Sample CY 2011 Calculation of Medicare Payment Rates for CPT Code 77080 (CY 2006 CPT Code 76075)

As discussed above, section 1848(b) of the Act (as amended by section 3111 of the ACA) required us to provide payment for CPT code 77080 at 70 percent of the product of the CY 2006 RVUs for the specified DXA code, the CY 2006 CF, and the geographic adjustment for the relevant payment year in which the service is furnished.

The CY 2006 RVUs for CPT code 76075 (77080) can be found in Table 57 below.

Table 57: CY 2006 RVUs for CPT Code 77080 (CY 2006 CPT code 76075)

CY 2006 CPT Code	Mod	CY 2006 Short Descriptor	2006 Physician Work RVUs	2006 Nonfacility PE RVUs	2006 Facility PE RVUs	2006 Malpractice RVUs
76075	26	Dxa bone density, axial	0.30	0.10	0.10	0.01
76075	TC	Dxa bone density, axial	0.00	3.10	NA	0.17
76075		Dxa bone density, axial	0.30	3.20	NA	0.18

First, we multiplied the CY 2006 RVUs listed in Table 57 above by the CY 2006 CF, which was $37.8975. These results are shown in Table 58 below.

Table 58: CY 2006 RVUs for CPT code 77080 Multiplied by the CY 2006 CF

CY 2006 CPT Code	Mod	CY 2006 Physician Work RVUs * 2006 CF	CY 2006 Nonfacility PE RVUs * 2006 CF	CY 2006 Facility PE RVUs * 2006 CF	CY 2006 Malpractice RVUs * 2006 CF
76075	26	$11.37	$3.79	$3.79	$0.38
76075	TC	NA	$117.48	NA	$6.44
76075		$11.37	$121.27	NA	$6.82

Second, we took 70 percent of the result to arrive at the CY 2011 national payment amounts for each component of the CPT code. These results are shown in Table 59 below.

Table 59: CY 2011 National Payment Amounts for CPT code 77080

CY 2006 CPT Code	Mod	CY 2011 Physician Work Payment Amount	CY 2011 Nonfacility PE Payment Amount	CY 2011 Facility PE Payment Amount	CY 2011 Malpractice Payment Amount
76075	26	$7.96	$2.65	$2.65	$0.27
76075	TC	NA	$82.24	NA	$4.51
76075		$7.96	$84.89	NA	$4.78

Third, in order to determine the CY 2011 RVUs for CPT code 77080 (76075) that are displayed in Addendum B to this final rule with comment period, we divided the CY 2011 national payment amounts shown in Table 59 by the CY 2011 CF (discussed in section II.G.1. of this final rule with comment period) of $25.5217. These results are shown in Table 60 and in Addendum B to this final rule with comment period.

We note that RVUs under the PFS are generally resource-based and, therefore, are typically unaffected by changes to the CF. However, because the statute essentially sets a fixed payment amount for DXA services, the CF directly determines the RVUs for CPT code 77080 as we must impute RVUs for the DXA services in CY 2011. Therefore, when there are changes to the PFS CF, we must make corresponding changes to the RVUs for CPT codes 77080 and 77082 for CY 2010 and CY 2011 in order to maintain the fixed national payment amount specified in the statute, which is then subject to geographic adjustment as indicated below.

Table 60: CY 2011 RVUs for CPT Code 77080
(NOTE: Calculated using the current law CY 2011 CF of $25.5217)

CY 2011 CPT Code	Mod	CY 2011 Physician Work RVUs	CY 2011 Nonfacility PE RVUs	CY 2011 Facility PE RVUs	CY 2011 Malpractice RVUs
77080	26	0.31	0.10	0.10	0.01
77080	TC	0.00	3.22	NA	0.18
77080		0.31	3.32	NA	0.19

Finally, in order to provide payment for a specific DXA service furnished by a practitioner, the RVUs listed in Table 60 would be multiplied by the CY 2011 CF and subject to geographic adjustment based on the CY 2011 GPCIs that apply to the location where the service is furnished.

In summary, after consideration of the public comments we received, we are

finalizing our proposed CY 2011 payment methodology for CPT codes 77080 and 77082 in accordance with the section 1848(b) of the Act (as amended by section 3111 of the ACA). In CY 2011, payment for CPT codes 77080 and 77082 will be made at 70 percent of the product of the CY 2006 RVUs for the specified DXA codes, the CY 2006 CF, and the CY 2011 geographic adjustment.

J. Section 3114: Improved Access for Certified Nurse-Midwife Services

Section 1833(a)(1)(K) of the Act (as amended by section 3114 of the ACA) increased the amount of Medicare payment made under the PFS for certified nurse-midwife (CNM) services. Currently, section 1833(a)(1)(K) of the Act specifies that the payment amount for CNM services is 80 percent of the lesser of the actual charge or 65 percent of the PFS amount for the same service furnished by a physician. Under section 1833(a)(1)(K) of the Act (as amended by section 3114 of the ACA), effective for services furnished on or after January 1, 2011, Medicare payment for CNM services is increased to 100 percent of the PFS amount for the same service furnished by a physician (or 80 percent of the actual charge if that is less). We proposed to revise our regulations at §414.54 (Payment for certified nurse-midwives' services) accordingly to reflect the increased payment for CNM services effective for services furnished on or after January 1, 2011.

Although CNMs are currently paid under Medicare Part B for their professional services, there is no mention of CNMs under the regulatory provision that lists the providers and suppliers of services to whom payment is made under the Medicare Part B program. Accordingly, we proposed to make a technical revision to §410.150 (To whom

payment is made) to specify that Medicare Part B pays CNMs for professional services in all settings, as well as services and supplies furnished incident to those services.

CNMs are authorized under the statute to be paid directly for services that they are legally authorized to furnish under State law and that are of the type that would otherwise be covered if furnished by a physician or incident to a physician's services. Additionally, there is no requirement for physician oversight or supervision of CNMs. Accordingly, CNMs are authorized to personally furnish diagnostic tests that fall under their State scope of practice without regard to the levels of physician supervision required under the diagnostic tests benefit. Therefore, we proposed to revise §410.32(b)(2) (Exceptions to the levels of physician supervision required for diagnostic tests) to include CNMs who furnish diagnostic tests that fall within their State scope of practice.

Comment: Several commenters welcomed the proposed increase in Medicare payment for CNM services effective January 1, 2011, stating that this policy would provide equitable payment under Medicare to CNMs. These commenters claimed that Medicare payment to CNMs at 100 percent of the Medicare Part B PFS amount that would be paid to a physician (or 80 percent of the actual charge if that is less) represents policy reform resulting from advocacy over a number of years. The commenters believe that the Medicare payment increase will enable CNMs across the nation to expand services to women with disabilities of childbearing age, as well as to senior women who are Medicare patients. The commenters noted that previously the 35 percent payment differential between CNMs and other health professionals furnishing similar services limited the expansion of CNM services to Medicare patients. Additionally, the commenters asserted that CNMs serve a critical role as primary care providers for women

throughout their lifespan and claimed that regulatory changes to unleash the potential of this group of providers were critically needed to fill the gaps in primary care.

The commenters also supported CMS' proposed technical revisions to §410.150 and §410.32. The proposed changes to §410.150 would include CNMs as a supplier of services to whom Medicare payment can directly be made for their professional services in all settings and for services and supplies furnished incident to their professional services. Additionally, the commenters believe that the proposed changes to §410.32 would clarify that when CNMs personally perform diagnostic tests, these health professionals are not subject to physician supervision for payment of diagnostic tests.

Response: We appreciate the commenters' support for implementing the new statutory provision that increases Medicare Part B payment for CNM services, effective January 1, 2011, from 80 percent of the lesser of the actual charge or 65 percent of the PFS amount that would be paid to a physician to 100 percent of the Medicare Part B PFS amount that would be paid to a physician or 80 percent of the actual charge if that is less.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to increase the Medicare Part B payment amount for CNM services under the PFS from 65 percent of the PFS amount that would be paid to a physician to 100 percent of the PFS amount that would be paid to a physician, or 80 percent of the actual charge if that is less. We are also finalizing our proposed modification to §414.54 to reflect this statutory change, with clarification to state that the amount paid to a CNM may not exceed 100 percent of the PFS amount that would be paid to a physician for the same service furnished on or after January 1, 2011. In addition, we are finalizing, without modification, our proposed revisions to §410.32 and §410.150.

K. Section 3122: Extension of Medicare Reasonable Costs Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas

Section 416 of the MMA established a reasonable cost payment for outpatient clinical diagnostic laboratory tests furnished by hospitals with fewer than 50 beds that are located in qualified rural areas for cost reporting periods beginning during the 2-year period beginning on July 1, 2004.

Section 105 of the Tax Relief and Health Care Act of 2006 (Pub. L. 109-432) (TRHCA) extended the 2-year period in section 416(b) of the MMA for an additional cost-reporting year.

Section 107 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110-173) (MMSEA) extended the time period for cost reporting periods beginning on July 1, 2004 and ending on June 30, 2008. For some hospitals with cost reports that began as late as June 30, 2008, this extension affected services performed as late as June 29, 2009, because this was the date those cost reports would have closed.

Section 3122 of the ACA reinstitutes reasonable cost payment for clinical diagnostic laboratory tests performed by hospitals with fewer than 50 beds that are located in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010 through June 30, 2011. For some hospitals with cost reports that begin as late as June 30, 2011, this reinstitution of reasonable cost payment could affect services performed as late as June 29, 2012, because this is the date those cost reports will close.

We received no comments on this proposal and therefore are finalizing this

provision without modification.

L. Section 3134: Misvalued Codes Under the Physician Fee Schedule

Section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) required the Secretary to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of those services identified as being potentially misvalued. Section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) further specified that the Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services, as well as conduct surveys or implement other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment of the relative values of potentially misvalued codes. Finally, section 1848(c)(2)(L) of the Act (as added by section 3134 of the ACA) provided that the Secretary shall establish a process to validate relative value units under the PFS.

We note that over the past several years, we have been working with the AMA RUC to identify approaches to addressing the issue of potentially misvalued services. Our CY 2011 approaches to categories of potentially misvalued codes are discussed in section II.C. of this final rule with comment period.

M. Section 3135: Modification of Equipment Utilization Factor for Advanced Imaging Services

1. Adjustment in Practice Expense to Reflect Higher Presumed Utilization

Section 1848(b)(4)(C) of the Act (as added by section 3135(a) of the ACA) adjusted the utilization rate beginning in CY 2011 for expensive diagnostic imaging

equipment to a 75 percent assumption in the methodology for establishing the PE of the RVUs of procedures that use this equipment.

In the CY 2010 PFS final rule with comment period (74 FR 61755), we finalized a policy to increase the utilization rate to 90 percent for expensive diagnostic equipment priced at more than $1 million (CT and MRI scanners), providing for a 4-year transition to the 90 percent utilization rate from the CY 2009 utilization rate of 50 percent. Therefore, in CY 2010 we were transitioning to a 90 percent equipment utilization rate assumption, applying a 25/75 blend of the new and old PE RVUs, respectively, for the associated procedures. Section 1848(b)(4)(C) of the Act (as added by section 3135(a) of the ACA) does not provide for any further transition and, therefore, we are assigning a 75 percent equipment utilization rate assumption to CT and MRI scanners, effective January 1, 2011. Under section 1848(b)(4) of the Act (as amended by section 3135(a) of the ACA), this change in the equipment utilization rate assumption from CY 2010 to CY 2011 is not budget neutral under the PFS. The equipment utilization rate assumption remains at 50 percent for all other equipment included in the PFS PE methodology. Further discussion of our final CY 2011 policies regarding the equipment utilization rate assumption can be found in section II.A.3.a. of this final rule with comment period.

2. Adjustment in Technical Component "Discount" on Single-Session Imaging to Consecutive Body Parts

Section 1848(b)(4)(D) of the Act (as added by section 3135(a) of the ACA) increased the established PFS multiple procedure payment reduction (MPPR) for the TC of certain single-session imaging services to consecutive body areas from 25 to 50 percent, effective July 1, 2010, and section 1848(c)(2)(B)(v)(VI) of the Act (as

added by section 3135(b) of the ACA) exempted this percent change from the PFS budget neutrality provision. This policy is discussed in detail in section II.C.4 of this final rule with comment period.

Effective January 1, 2006, we adopted an MPPR of 25 percent for the TC of certain diagnostic imaging procedures, applied to the second and subsequent services when more than one service in one of 11 imaging families, defined by imaging modality and contiguous body area, is furnished in a single session (70 FR 70261 through 70263). The established imaging MPPR applies to TC services and to the TC of global services. It does not apply to PC services or to the PC of global services. Under this policy, full payment was made for the TC of the highest priced procedure, while payment was made at 75 percent of the TC for each additional procedure. As of July 1, 2010 and continuing in CY 2011, payment is made at full payment for the TC of the highest paying procedure, while at 50 percent of the TC for each additional procedure, consistent with the new statutory provision. Further discussion of the MPPR policies affecting nonsurgical PFS services can be found in section II.C.4. of this final rule with comment period.

N. Section 3136: Revision for Payment for Power-Driven Wheelchairs

1. Payment Rules for Power Wheelchairs

Durable medical equipment (DME) is defined at section 1861(n) of the Act and includes wheelchairs necessary for use in the patient's home. Section 1861(n) of the Act provides that wheelchairs included in the definition of DME "may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition." The general Medicare payment rules for DME are set

forth in section 1834(a) of the Act and 42 CFR part 414, subpart D of our regulations. Section 1834(a)(1) of the Act and §414.210(a) of our regulations establish that the Medicare payment for a DME item is generally equal to 80 percent of either the lower of the actual charge or the fee schedule amount for the item less any unmet Part B deductible. The beneficiary coinsurance is generally equal to 20 percent of either the lower of the actual charge or the fee schedule amount for the item once the deductible is met.

For Medicare payment purposes, power wheelchairs or power-driven wheelchairs are classified under various HCPCS codes based on the level of performance and functional characteristics of each power wheelchair that accommodate the specific needs of patients. Power wheelchairs classified under performance Groups 1 through 3 are covered under Medicare for use in the patient's home. Power wheelchair groups were established in 2006 with the release of the Power Mobility Device Coding Guidelines published by the Durable Medical Equipment Regional Carriers (DMERCs) currently called the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). The DMEPOS quality standards define certain power wheelchairs falling as "complex, rehabilitative" power wheelchairs, and these "complex, rehabilitative" power wheelchairs are treated as a separate product category for the purpose of implementing the DMEPOS Competitive Bidding Program (CBP) mandated by section 1847(a) of the Act. In both the quality standards and the DMEPOS CBP, complex, rehabilitative power wheelchairs are defined or identified as power wheelchairs classified as Group 2 power wheelchairs with power options that can accommodate rehabilitative features (for example, tilt in space) or Group 3 power wheelchairs. Section

1847(a)(2)(A)of the Act, as amended by section 154(a)(1)(B) of MIPPA, excludes complex, rehabilitative power wheelchairs classified within Group 3 from the DMEPOS CBP.

With the exception of power wheelchairs furnished during calendar year 1990, power wheelchairs have been paid under the capped rental category of DME since January 1, 1989. The payment rules for capped rental DME are provided at section 1834(a)(7) of the Act and §414.229 of our regulations. Payment for these items is generally on a monthly rental basis, with rental payments capped at 13 months. After a 13-month period of continuous use during which rental payments are made, the statute and regulations require that the supplier transfer title to the wheelchair to the beneficiary. In addition, effective for power wheelchairs furnished on or after January 1, 1991, section 1834(a)(7) of the Act, as amended by section 4152(c)(2)(D) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508), mandates that the supplier of the power wheelchair offer the patient the option to purchase rather than rent the item. Since 1991, over 95 percent of Medicare beneficiaries have exercised this lump-sum purchase option for power wheelchairs.

Consistent with payment for other DMEPOS items, §414.210(f)(1) permits payment for replacement of capped rental DME if the item has been in continuous use for the equipment's reasonable useful lifetime or is lost, stolen, or irreparably damaged. Section 414.210(f)(1) states the reasonable useful lifetime for equipment is determined through program instructions. In the absence of CMS program instructions, the carrier may determine the reasonable useful lifetime for equipment, but in no case can it be less than 5 years. Computation is based on when the equipment is delivered to the

beneficiary, not the age of the equipment. If the beneficiary elects to obtain a new capped rental item after the reasonable useful lifetime, a new 13-month rental payment period would begin for the new equipment in accordance with the requirements of §414.229.

Pursuant to section 1834(a)(7)(A)(i)(II) of the Act and §414.229(b), the current capped rental fee schedule amounts applicable to wheelchairs for months 1 thru 3 of the 13-month capped rental period are calculated to pay 10 percent of the purchase price recognized in the statute for the item. The rental fee schedule amounts for months 4 through 13 of the 13-month capped rental period are calculated to pay 7.5 percent of the purchase price for the item. The purchase price is determined consistent with section 1834(a)(8) of the Act and §414.229(c) and §414.220(e) and (f) and is calculated based on average allowed payments for the purchase of new items, and is updated by the covered item update, as required by section 1834(a)(14) of the Act and §414.229(d). The purchase fee schedule amount for new power wheelchairs acquired on a lump sum purchase basis is 100 percent of the purchase price calculated for the item, as discussed above.

2. Revision of Payment Amounts for Power Wheelchairs

Section 3136(a) of the ACA made several changes to section 1834(a)(7)(A) of the Act. Section 3136(a)(1) of the ACA amends section 1834(a)(7)(A) of the Act by adding a new subclause (III) to section 1834(a)(7)(A)(i) of the Act. Subclause (III) revises the capped rental fee schedule amounts for all power wheelchairs, modifying the current payment structure of 10 percent of the purchase price for months 1 through 3 and 7.5 percent of that purchase price for months 4 through 13 that was previously discussed.

The rental fee schedule amount for months 1 through 3 of the 13-month capped rental period for power wheelchairs is revised to 15 percent of the purchase price for the item. The rental fee schedule amounts for months 4 through 13 of the 13-month capped rental period for power wheelchairs is revised to 6 percent of the purchase price for the item. The statutory provision does not change the methodologies used to calculate and subsequently update of the purchase price of power wheelchairs. Therefore, the methodology described previously for determining the purchase price amounts will continue to apply.

Pursuant to section 3136(c) of the ACA, the changes made by section 3136(a) of the ACA apply to power-driven wheelchairs furnished on or after January 1, 2011. Furthermore, as discussed previously, section 3136(c)(2) of the ACA states that the changes made by section 3136(a) of the ACA, including the new payment structure for power wheelchairs, do not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Act for the DMEPOS CBP prior to January 1, 2011, which applies to the implementation of the first round of the DMEPOS CBP. As a result, contract suppliers furnishing power wheelchairs in competitive bidding areas (CBA) pursuant to contracts entered into prior to January 1, 2011, as part of Round 1 of the DMEPOS CBP will continue to be paid based under the current regulations using 10 percent of the purchase price for months 1 through 3 and 7.5 percent for each of the remaining months. We did not receive public comment on our proposed changes to §414.202, §414.229, and §414.408, and therefore we are finalizing our proposals without modification.

3. Elimination of Lump Sum Payment for Standard Power Wheelchairs

Section 3136(a)(2) of the ACA further amends section 1834(a)(7)(A)(iii) of the Act by inserting the term "complex, rehabilitative" before the term "power-driven wheelchairs." As a result, section 1834(a)(7)(A)(iii) of the Act now extends the lump sum purchase option only to complex, rehabilitative power wheelchairs. As discussed above, "complex, rehabilitative" power wheelchairs are power wheelchairs that are classified as: (1) Group 2 power wheelchairs with power options that can accommodate rehabilitative features (for example, tilt in space), or (2) Group 3 power wheelchairs. We consider all other power wheelchairs to be standard power wheelchairs. Therefore, we proposed to interpret the language "complex, rehabilitative" in section 1834(a)(7)(A) of the Act consistent with this longstanding classification. As a result, the changes made by section 3136 of the ACA to section 1834(a)(7)(A)(iii) of the Act eliminate the lump sum purchase option for standard power wheelchairs.

Pursuant to section 3136(c) of the ACA, the changes made to section 1834(a)(7)(A)(iii) of the Act apply to power-driven wheelchairs furnished on or after January 1, 2011. The lump sum purchase payment option will no longer extend to standard power driven wheelchairs furnished on or after January 1, 2011.

Furthermore, section 3136(c)(2) of the ACA states that the changes made by section 3136(a) of the ACA, including the limitation of the lump sum purchase payment option to complex, rehabilitative power wheelchairs, do not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Act for the DMEPOS CBP prior to January 1, 2011, pursuant to the implementation of the first round of the DMEPOS CBP. As a result, contract suppliers furnishing power wheelchairs in CBAs in accordance with contracts entered into prior to January 1, 2011

as part of Round 1 of the DMEPOS CBP must continue to offer beneficiaries the lump sum purchase option for all power wheelchairs.

We proposed changes to §414.229 and §414.408 to reflect our interpretation of these statutory requirements.

Comment: Several commenters stated that the changes regarding the lump sum payment option will make it more difficult for many suppliers to furnish standard power wheelchairs because suppliers usually purchase wheelchairs from manufacturers using the full lump sum payments. One commenter stated that some homecare providers will need to arrange for loans to obtain sufficient finances to purchase wheelchairs that are then paid for by the Medicare program and beneficiaries over the longer 1-month payment period and if the recent capital markets for loans do not improve, CMS should consider a delay in implementing our regulations.

Response: While we recognize that the regulatory changes require adjustments by standard power wheelchair suppliers, we do not believe that section 3136(a)(2) of the ACA provides flexibility to delay the implementation of this provision. Moreover, these concerns are related to the financial relationships developed by manufacturers of standard power wheelchairs with the suppliers who furnish patients with wheelchairs, which is not within the purview of our regulations. As we explained in the proposed rule (75 FR 40121), power wheelchairs have been paid under the capped rental category of DME since 1989, and the option to purchase in addition to the rental payment method was established in 1991. Thus, section 3136(a)(2) of the ACA and the regulatory changes implementing that provision are not establishing a new rental payment methodology. We expect suppliers will be able to adapt expeditiously to furnishing

standard power wheelchairs under a rental payment structure. Finally, we believe that there may be some financial benefit to suppliers as a result of this change. As is the case for manual wheelchairs furnished to Medicare beneficiaries, suppliers of standards power wheelchairs furnished to Medicare beneficiaries on or after January 1, 2011, may be able to rent these items to multiple beneficiaries if the beneficiaries use the items for fewer than 13 continuous months. In many cases where a power wheelchair is rented to multiple beneficiaries, the supplier and will receive more than 13 monthly payments for the item, including payments based on 15 percent of the statutory purchase price for the first 3 months that each beneficiary rents the item.

Comment: Several commenters raised a concern that the elimination of the lump sum payment method will cause a significant increase in monthly rental claims submitted for standard power wheelchairs; thereby, increasing administrative claims processing costs. One commenter noted that in the event claims processing contractors have difficulty processing claims, we did not discuss how to apply interest rates for Medicare overpayments or underpayments.

Response: We appreciate this comment regarding the efficient implementation of the provision of section 3136 of the ACA, which includes a requirement that payment for all standard power wheelchairs be made on a monthly rental basis effective January 1, 2011. We are working with our contractors to make the necessary changes to the claims processing systems in order to be ready to process additional standard power wheelchair rental claims with dates of service on or after January 1, 2011. Also, we have coordinated within CMS and our partners to update educational materials for our beneficiaries. With regard to overpayments or underpayments, these issues will be

handled in the same manner as overpayments or underpayments are handled for capped rental DME in general.

Comment: Several commenters stressed the need to clarify the conditions of payment requirements for power wheelchairs that are rented after a break in service or change in patient condition. These commenters stated that because the majority of power wheelchairs have been paid under the lump sum purchase payment method, physicians and suppliers performed the documentation requirements set forth in §410.38(c)(2) prior to initial delivery of the standard power wheelchairs. These documentation requirements specify the physician or treating practitioner must conduct a face-to-face examination of the patient to determine that the power wheelchair is medically necessary before it is dispensed to the beneficiary. In addition, the supplier must perform an on-site evaluation of the patient's home to develop supporting documentation for the initial delivery and payment for a power wheelchair. As a result of the elimination of the lump sum purchase option for standard power wheelchairs, more power wheelchairs will be paid under the rental payment method after January 1, 2011. Thus, the commenters urged that the regulations should clarify whether a new face-to-face examination and home evaluation must be performed when a break in service of greater than 60 days occurs.

Response: This comment is outside the scope of the CY 2011 PFS proposed rule. We did not propose any changes to the conditions of payment set forth in §410.28(c)(2). We again note, however, that payments on a rental basis for capped rental items, including power wheelchairs, have been made since January 1, 1989. The payment and coverage requirements identified by the commenters for power mobility devices (PMDs), including power-operated vehicles or scooters and standard and complex, rehabilitative

power wheelchairs, must be met before the item is furnished to the beneficiary on either a purchase or rental basis. Section 3136 of the ACA, which in part eliminates the purchase option for standard power wheelchairs furnished on or after January 1, 2011, has no impact on these requirements. They remain in effect for all PMDs furnished to Medicare beneficiaries on a purchase or rental basis, including rented power wheelchairs. Payment for capped rental items is limited to 13 months of continuous use, defined at §414.230. Section 414.230(d) sets forth the criteria for a new rental period: during this 13-month capped rental period, a break in use of the equipment for more than 60 continuous days, plus the days remaining in the rental month in which use ceases, would result in the start of a new period of continuous use and a new 13-month capped rental period if the supplier submits a new prescription, new medical necessity documentation, and documentation that describes the reason for the interruption in use and documents that medical necessity in the prior rental episode ended. Section 3136 of the ACA has no impact on the requirements set forth in §414.230 regarding continuous use of capped rental items.

Comment: One commenter requested a revision to the billing modifiers for Advance Beneficiary Notice of Noncoverage (ABN) to utilize when a supplier bills for furnishing a wheelchair that has features beyond what is covered by Medicare.

Response: This comment is outside the scope of the CY 2011 PFS proposed rule because we did not propose any changes to the billing modifiers for ABNs. Nevertheless, we encourage interested parties to follow our HCPCS editorial process and submit coding recommendations by following the instructions found at our website at www.cms.gov/MedHCPCSGenInfo.

Comment: One commenter requested clarification on whether the beneficiary retains ownership of power wheelchair associated accessories (for example elevated leg rests or adjustable height arms rests) during or after the rental period. These associated accessories are not included with the rental of the standard power wheelchair base equipment.

Response: Payment for accessories for power wheelchairs that are not included in the basic equipment package for the wheelchair and are separately payable items under the inexpensive or routinely purchased (IRP) DME category is made on either a rental or lump sum purchase basis. If payment is made on a lump sum basis to the supplier for an associated accessory, then the beneficiary owns the accessory for use with the standard power wheelchair during and after the 13-month wheelchair rental period. If payment is made on a rental basis for an accessory in the IRP category and it appears that the beneficiary will use the wheelchair for the full 13-month capped rental period, the beneficiary may elect to purchase the accessory, and the Medicare allowed payment for purchase of the accessory would be equal to the lowed of the actual charge or the purchase fee schedule amount, less cumulative paid rental amounts. Title to an accessory for a power wheelchair that is not included in the basic equipment package for the wheelchair and is a separately payable item under the capped rental DME category is transferred to the beneficiary following the 13-month capped rental period.

Comment: One commenter requested information on how to apply the calculation of the reasonable useful lifetime to a standard power wheelchair which had been in continuous use for 10 months prior to being returned to a supplier and then after appropriate cleaning and servicing is placed with a different beneficiary. Also, the

commenter requested how to apply the calculation of the reasonable useful lifetime if the standard power wheelchair is assigned to several beneficiaries under similar circumstances and remains in continuous use beyond 13 months because of use by multiple beneficiaries prior to title being transferred to the last beneficiary.

Response: The regulations applicable to calculation of the reasonable useful lifetime are located at §414.210(f) and state that computation of the reasonable useful lifetime of equipment is based on when the equipment is delivered to the beneficiary, not the age of the equipment. At the end of 13 months rental use of a DME item, the supplier must transfer title to the item, such as a power wheelchair, to the beneficiary in accordance with §414.229(f)(2). If, following transfer of title, it is determined that the power wheelchair will not last for the entire reasonable useful lifetime, the supplier is required by §414.210(e)(4) to replace the equipment at no cost to the beneficiary or the Medicare program.

Comment: One commenter expressed concern that the proposed changes to §414.408(f)(1) will force suppliers to convert to a rental payment model of furnishing standard power wheelchairs prior to the end of the 3 year contract period for DMEPOS Round 1 Rebid CBAs although their bids included an assumption that the lump sum payment method would continue into subsequent years. Another commenter believed inequalities occur by continuing the option of a lump sum payment method for standard power wheelchairs in Round 1 Rebid CBAs but not in other geographic areas.

Response: Section 3136(c)(2) of the ACA states that the change made by section 3136(a) of the ACA, eliminating the lump sum payment method for standard power wheelchairs, does not apply to payment made for items and services furnished pursuant to

contracts entered into under section 1847 of the Act for the DMEPOS CBP prior to January 1, 2011 pursuant to the implementation of the first round of the DMEPOS competitive bidding program (CBP). We noted that although these changes will not apply to payment made for items and services furnished pursuant to the contracts awarded following the Round 1 Rebid, contract suppliers must prepare for the elimination of the lump sum payment method for standard power wheelchairs that will take effect at the end of the 3 year contract period. When the Round 1 contracts are recompeted, suppliers will submit bids for furnishing power wheelchairs on a rental only basis.

Comment: One commenter suggested Medicare should consider implementing a serial number tracking program for power wheelchairs to improve anti-fraud efforts.

Response: This comment is outside the scope of the CY 2011 PFS proposed rule. We appreciate the commenter's suggestion and will consider studying the feasibility of a nationwide serial tracking program for power wheelchairs for future rulemaking efforts. We were informed that nationwide there are more than 106 styles of power wheelchairs available from 22 manufacturers. A nationwide serial tracking program would require significant program resources and stakeholder input which we would need to conduct prior to rulemaking.

After considering the comments received, we are adopting, without modification, our proposed changes to §414.229 and §414.408 that eliminate the lump sum payment option for standard power wheelchairs.

O. Section 3139: Payment for Biosimilar Biological Products

Section 3139 of the ACA amends section 1847A of the Act to provide for Medicare payment of biosimilar biological products using the average sale price (ASP) methodology.

Section 1847A(c)(6)(H) of the Act, as added by the ACA, defines a biosimilar biological product as a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act (PHSA). The reference biological product for a biosimilar biological product is defined by the statute as the biological product licensed under such section 351 of the PHSA that is referred to in the application of the biosimilar biological product.

The ACA also amends section 1847A(b) of the Act by adding paragraph 8 to specify that the payment amount for a biosimilar biological product will be the sum of the following two amounts: the ASP of all NDCs assigned to the biosimilar biological product determined using the methodology in section 1847A(b)(6) of the Act, and 6 percent of the payment amount determined using the methodology in section 1847A(b)(4) of the Act for the corresponding reference biological product. Sections 7001 to 7003 of the ACA also established a licensing pathway for biosimilar biological products, and in accordance with the statute, the effective date for Medicare ASP statutory provisions is July 1, 2010. We proposed to make conforming regulation text changes at §414.902 and §414.904 and we solicited comments regarding our conforming changes.

We anticipate that as biosimilar biological drug products are approved, we will receive ASP sales data through the ASP data submission process and publish national payment amounts in a manner that is consistent with our current approach to other drugs and biologicals that are paid under section 1847A of the Act and set forth in 42 CFR part 414 subpart J. Until we have collected sufficient sales data as reported by manufacturers, payment limits will be determined in accordance with the provisions in section 1847A(c)(4) of the Act. If no manufacturer data is collected, prices will be determined by local contractors using any available pricing information, including provider invoices. More information about the ASP payment methodology and the data submission process may be found on the CMS Web site at http://www.cms.gov/McrPartBDrugAvgSalesPrice/01_overview.asp and in section VII.A.1., "Carry Over ASP," of this final rule with comment period.

Comment: Several commenters supported the proposed regulation text changes.

Response: Based on the comments that we received, we are finalizing our proposal and regulation text without additional modification.

Comment: Several commenters requested that CMS assign biosimilars and other brand name drugs and biologicals separate HCPCS codes in order to facilitate the tracking of items paid under section 3139 of the ACA, as well as branded drugs and biologicals subject to fees under section 9008 of the ACA.

Response: We appreciate the, comments, however, our proposal did not address procedures for assignment of HCPCS codes, and so these comments are outside the scope of this rule. For more information about the HCPCS coding process, we refer you to http://www.cms.gov/MedHCPCSGenInfo/.

In summary, we are finalizing our proposed definitions of biosimilar biological, reference biological and our proposed payment methodology without additional modification.

P. Section 3401: Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements.

1. ESRD Market Basket Discussion

Section 3401(h) of the ACA amended section 1881(b)(14)(F) of the Act and directs the Secretary to annually increase payment amounts established under the ESRD market basket. Please see section VII.E. of this final rule with comment for a detailed description of these provisions.

2. Productivity Adjustment regarding the Ambulatory Surgical Center Payment System, and the Ambulance, Clinical Laboratory and DMEPOS Fee Schedules

Section 3401 of the ACA requires that the update factor under certain payment systems be annually adjusted by changes in economy-wide productivity. The year that the productivity adjustment is effective varies by payment system. Specifically, section 3401 of the ACA requires that, in CY 2011 (and in subsequent years) update factors under the ambulatory surgical center (ASC) payment system, the ambulance fee schedule (AFS), the clinical laboratory fee schedule (CLFS), and the DMEPOS fee schedules be adjusted by changes in economy-wide productivity. Section 3401(a) of the ACA amends section 1886(b)(3)(B) of the Act to add clause (xi)(II) which sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm

business multifactor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period) (the "MFP adjustment"). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private non-farm business MFP. Please see http://www.bls.gov/mfp which is the link to the BLS historical published data on the measure of MFP.

As stated in the PFS proposed rule (75 FR 40123), the projection of MFP is currently produced by IHS Global Insight (IGI), an economic forecasting firm. As described in the CY 2011 PFS proposed rule, in order to generate a forecast of MFP, IGI replicated the MFP measure calculated by the BLS using a series of proxy variables derived from the IGI US Macro-economic models. These models take into account a very broad range of factors that influence the total US economy. IGI forecasts the underlying proxy components such as Gross Domestic Product (GDP), capital, and labor inputs required to estimate MFP and then combines those projections according to the BLS methodology.

In Table 34 of the proposed rule (75 FR 40123), we identified each of the MFP component series employed by the BLS and the corresponding concepts estimated by IGI that appeared to be the best measure at the time of the proposed rule. IGI found that the historical growth rates of the BLS components used to calculate MFP and the IGI components identified and listed in the PFS proposed rule (75 FR 40123) were consistent across all series and therefore suitable proxies for calculating MFP. We proposed a method in which IGI uses the growth rates of the forecasted IGI concepts to project BLS' components of MFP. The resulting MFP adjustment derived from using this method was

proposed to be used under section 3401 of the ACA to adjust the updates for the ASC payment system, the AFS, the CLFS, and the DMEPOS fee schedules.

Since the proposed rule, BLS issued revised estimates of private nonfarm business MFP (released on August 24, 2010). We also received public comments on the proposed calculation of the MFP adjustment. We summarize these comments and our responses below.

Comment: Several commenters stated that CMS provided no details in the proposed rule on the data and calculations that it used in making the MFP estimates, instead referring readers to the BLS, which only provides historical data. The commenters stated that this level of information is insufficient for public comment. The commenters requested that CMS fully disclose the methods and data sources used for the MFP estimate for public comment before implementing the multifactor productivity adjustment to the ASC payment system and to the other payment systems. Another commenter stated that transparency is needed concerning the assumptions underlying the projection of MFP and the commenter asked that CMS address this in the final rule so a better understanding can be gained about how CMS arrived at its MFP adjustment.

Response: The CY 2011 PFS proposed rule included a citation to the BLS website. This link provided a lengthy detailed description of the methodology that is used by the BLS to construct an estimate of MFP for the private nonfarm business sector, including a discussion of the underlying series used in the MFP calculation. For the forecasted estimate of MFP, we then identified in Table 34 in the CY 2011 PFS proposed rule (75 FR 40123) the forecasted series that closely align to the series used by BLS. The data source for these forecasted series is IGI, an economic forecasting firm. Following

the methodology as described in the BLS documentation that we provided in the CY 2011 PFS proposed rule, a forecast of MFP was created using the IGI series. Given the information that was presented in the CY 2011 PFS proposed rule, we believe that we provided adequate information regarding the methods, calculations, and data sources used for the MFP estimate. In this final rule with comment period, we have included below a more detailed description of this methodology for even greater transparency.

In response to the public comments we received requesting additional information on the assumptions underlying the projection of MFP, we note that the projection of MFP is not driven by specific assumptions. The underlying series forecasted by IGI are derived from a set of complex economic forecasting models that project various components of the total US economy. These models are intended to capture many drivers of economic growth in the US economy. Therefore, the underlying series that IGI uses to calculate a forecast of MFP are products of this economy-wide macroeconomic model as opposed to being based on a specific set of assumptions.

Comment: Several commenters expressed concern that current economic conditions are distorting the factor used for the productivity adjustment, potentially leading to unintended consequences. These commenters claim that the original intent of the productivity adjustment was to hold providers to a standard of productivity improvement achieved by the rest of the economy. However, the commenters stated that when productivity gains are driven by undesirable trends in the economy, this adjustment could lead to excessive cuts. The current "jobless recovery" is inflating productivity as output increases but a key input – employment – continues to stagnate. The commenters claim that cutting Medicare payments by this inflated figure could hurt hospitals and

other health care providers and suppliers that have been one of the few sources of continued job growth in this economy.

Response: We are required by law to implement section 3401 of the ACA, which requires that in CY 2011 (and in subsequent years) update factors under the ASC payment system, the AFS, the CLFS, and the DMEPOS fee schedules be adjusted by the 10-year moving average of changes in annual economy-wide multi-factor productivity for the private non-farm business sector.

Although we believe that the IGI method of calculating a forecast of MFP discussed in the CY 2011 PFS proposed rule (75 FR 40123) is appropriate and accurately reflects the 10-year moving average of changes in annual economy-wide multi-factor productivity, in response to this comment, CMS and IGI reevaluated the series that are used to calculate MFP to ensure that the underlying components that are ultimately selected are those that will produce a measure of MFP that most closely tracks the official measure of MFP as published by BLS. While the concepts listed in Table 34 of the CY 2011 PFS proposed rule were similar to the underlying concepts used by BLS (as discussed in the proposed rule), CMS and IGI subsequently determined that there are technically superior IGI series for output and labor that can be used to derive a calculation of MFP (still using the method as described in the proposed rule), that will ultimately result in a more appropriate forecast of MFP. The IGI method is described in more detail below and we note that the methodology is the same methodology as was described in the CY 2011 PFS proposed rule, which is aligned closely with the methodology employed by the BLS. For more information regarding the BLS method for

estimating productivity we refer the commenter to the following link: http://www.bls.gov/mfp/mprtech.pdf.

Table 61 lists the MFP component series employed by the BLS and the corresponding concepts estimated by IGI as specified in Table 34 of the CY 2011 PFS proposed rule and in this final rule. Please note that, in BLS' revised MFP estimates published on August 24, 2010, the index series was rebased from 2000=100 to 2005=100. Thus, Table 61 refers to the BLS series in 2005 dollars whereas Table 34 of the CY 2011 PFS proposed rule referred to the BLS series in 2000 dollars.

Table 61: Multifactor Productivity Component Series Employed by the Bureau of Labor Statistics and IHS Global Insight

BLS series	IGI series – Proposed Rule	IGI series – Final Rule
Real value-added output, constant 2005 dollars	Real gross non-farm value added output, chained 2005 dollar billions	Non-housing non-government non-farm real GDP, Billions of chained 2005 dollars – annual rate
Private non-farm business sector labor input; 2005=100.00	Hours of all persons -private nonfarm business sector; 1992=1.0	Man-hours in private nonfarm establishments, Billions of hours – annual rate
Aggregate capital inputs; 2005=100.00	Real effective capital stock used for full employment GDP, chained 2005 dollar billions	Real effective capital stock used for full employment GDP, Billions of chained 2005 dollars

In this final rule with comment period, we are finalizing the same IGI method as described in the CY 2011 PFS proposed rule, with minor technical improvements to the underlying concepts used to calculate MFP. We have also included a more detailed description below of the methodology (which was described in the proposed rule and which we are finalizing in this final rule with comment period) used to calculate MFP in response to the public comments we received.

To create a forecast of BLS' MFP index, the forecasted annual growth rates of the "non-housing, non-government, non-farm, real GDP", "man-hours in private nonfarm establishments", and "real effective capital stock" series (ranging from 2009 to 2020) are used to "grow" the levels of the "real value-added output," "private non-farm business sector labor input," and "aggregate capital input" series published by the BLS. Using these three key concepts, MFP is derived by subtracting the contribution of labor and capital inputs from output growth.

However, in order to estimate MFP, we need to understand the relative contributions of labor and capital to total output growth. Therefore, two additional measures are needed to operationalize the estimation of the IGI MFP projection: labor compensation and capital income. The sum of labor compensation and capital income represents total income. The BLS calculates labor compensation and capital income (in current dollar terms) to derive the nominal values of labor and capital inputs. IGI uses the "non-government total compensation" and "flow of capital services from the total private non-residential capital stock" series as proxies for the BLS' income measures. These two proxy measures for income are divided by total income to obtain the shares of labor compensation and capital income to total income.

In order to estimate labor's contribution and capital's contribution to the growth in total output, the growth rates of the proxy variables for labor and capital inputs are multiplied by their respective shares of total income. These contributions of labor and capital to output growth are subtracted from total output growth to calculate the "change in the growth rates of multifactor productivity":

MFP = Total output growth – {(labor input growth*labor compensation share) + (capital input growth * capital income share)}

The change in the growth rates (also referred to as the compound growth rates) of the IGI MFP are multiplied by 100 in order to calculate the percent change in growth rates (the percent change in growth rates are published by the BLS for its historical MFP measure). Finally, the growth rates of the IGI MFP are converted to index levels based to 2005 to be consistent with the BLS' methodology.

For benchmarking purposes, the historical growth rates of IGI's proxy variables were used to estimate a historical measure of MFP, which was compared to the historical MFP estimate published by the BLS. The comparison revealed that the growth rates of the components were consistent across all series, and therefore validated the use of the proxy variables in generating the IGI MFP projections.

The resulting MFP index was then interpolated to a quarterly frequency using the Bassie method for temporal disaggregation. The Bassie technique utilizes an indicator (pattern) series for its calculations. IGI uses the index of output per hour (published by the BLS) as an indicator when interpolating the MFP index.

As discussed below, for each of these payment systems, the update factor is the percentage increase (or percentage decrease for the CLFS) in the consumer price index for all urban consumers (CPI-U) (referred to as the "CPI-U update factor").

For all four payment systems, section 3401 of the ACA generally states that the Secretary shall reduce the CPI-U adjustment by the MFP adjustment. In order to calculate the MFP-adjusted updates to these payment systems, we proposed that the MFP percentage adjustment would be subtracted from the CPI-U update factor. For example,

if the update factor (CPI-U) is 4.0 percent, and the projected MFP is 1.3 percent, the MFP-Adjusted update factor (or MFP-Adjusted CPI-U for these payment systems) would be a 2.7 percent increase.

We proposed that the end of the 10-year moving average of changes in the MFP should coincide with the end of this CPI-U timeframe (75 FR 40123). Since the CPI-U update factor is reduced by the MFP adjustment to determine the annual update for these payment systems, we stated that we believe it is appropriate for the numbers associated with both parts of the calculation to be projected as of the same end date. In this way, changes in market conditions are aligned.

In this final rule with comment period, we wanted to further clarify how for each payment system, the end of the 10-year moving average of changes in the MFP will coincide with the period on which the CPI-U is calculated. In the case of the ASC payment system, the CPI-U projected for the 12-month period ending with the midpoint of the year involved, which is CY 2011 for this final rule with comment period. Therefore, the end of the 10-year moving average of changes in the MFP is projected so that it ends with the midpoint of the year involves, which is CY 2011 for this final rule with comment period. In the case of the AFS, CLFS, and DMEPOS fee schedules, the CPI-U is estimated for the period ending June 30th of the year preceding the update year itself, which is CY 2010 for this final rule with comment period. Therefore, the end of the 10-year moving average of changes in the MFP is estimated so that it ends June 30th of the year preceding the update year itself, which is CY 2010 for this final rule with comment period.

We proposed to round the final annual adjustment to the one-tenth of one percentage point level up or down as applicable according to conventional rounding rules (that is, if the number we are rounding is followed by 5, 6, 7, 8, or 9, we will round the number up; if the number we are rounding is followed by 0, 1, 2, 3, or 4, we will round the number down).

In the following sections, we provide more information on the statutory requirements and proposals for each of the four payment systems. The statutory requirements for the ASC payment system were also addressed in the CY 2011 OPPS/ASC final rule with comment period. We note that, in the CY 2011 PFS proposed rule (75 FR 40123 through 40125), we described the legislative provision and outlined the methodology used to calculate and apply the MFP adjustment to determine the annual updates for ASC payment system, the AFS, the CLFS, and the DMEPOS fee schedules for CY 2011 and each subsequent year. We stated that we would set forth the final MFP adjustment for CY 2011 in this final rule with comment period. Also, we stated in the CY 2011 PFS proposed rule (75 FR 40123) that once we finalize the methodology for determining and applying the MFP adjustment to the CPI-U update factors for these payment systems, for subsequent calendar years, as we have done in the past, we would notify the general public of the annual update to the AFS, CLFS, and DMEPOS fee schedules via CMS instruction and on the CMS website. These notifications would set forth both the CPI-U percentage increase (or, for the CLFS, the percentage decrease) and the MFP adjustment for the applicable year. For ASCs, for subsequent calendar years, as we have done in the past, we stated that we would continue to notify the general public of

the annual update to the ASC payment amount via the annual OPPS/ASC rulemaking process.

In summary, as discussed previously, we are finalizing the same IGI method as described in the CY 2011 proposed rule to calculate the MFP adjustment, with minor technical improvements to the underlying concepts used to calculate the MFP adjustment. Furthermore, as proposed, the MFP adjustment is calculated so that the end of the 10-year moving average of changes in the MFP will coincide with the end of the CPI-U timeframe for each of the four payment systems (that is, the ASC payment system, AFS, CLFS, and DMEPOS fee schedules) so that market conditions are aligned. Also, as proposed, we will round the final annual adjustment to the one-tenth of one percentage point level up or down as applicable according to conventional rounding rules. Using the methodology finalized previously, the final MFP adjustment for CY 2011 is 1.3 percent for the ASC payment system, and 1.2 percent for the AFS, CLFS, and DMEPOS fee schedules. We are also finalizing our proposal to calculate the MFP-adjusted updates for the ASC payment system, the AFS, the CLFS and the DMEPOS fee schedules for CY 2011 and each subsequent year by subtracting the MFP adjustment from each payment system's CPI-U update factor, as further described in the following sections.

a. Ambulatory Surgical Centers (ASCs)

Section 1833(i)(2)(C)(i) of the Act requires that, if the Secretary has not updated the ASC payment amounts in a calendar year, the payment amounts "shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved." Because the Secretary does update the ASC payment

amounts annually, we adopted a policy, which we codified at §416.171(a)(2)(ii), to update the ASC conversion factor using the CPI-U for CY 2010 and subsequent calendar years. Therefore, the annual update to the ASC payment system is the CPI-U (referred to as the CPI-U update factor). Section 3401(k) of the ACA amends section 1833(i)(2)(D) of the Act by adding a new clause (v) which requires that "any annual update under [the ASC payment] system for the year [after application of any reduction in any update for failure to report on quality measures, if the Secretary implements a quality reporting program for ASCs] shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act" (which we refer to as the MFP adjustment) effective with the calendar year beginning January 1, 2011. Section 3401(k) of the ACA states that application of the MFP adjustment to the ASC payment system may result in the update to the ASC payment system being less than zero for a year and may result in payment rates under the ASC payment system for a year being less than such payment rates for the preceding year.

In accordance with section 1833(i)(2)(C)(i) of the Act, before applying the MFP adjustment, the Secretary first determines the "percentage increase" in the CPI-U, which we interpret cannot be a negative number. Thus, in the instance where the percentage change in the CPI-U for a year is negative, we proposed to hold the CPI-U update factor for the ASC payment system to zero. Section 1833(i)(2)(D)(v) of the Act, as added by section 3401(k) of the ACA, then requires that the Secretary reduce the CPI-U update factor (which would be held to zero if the CPI-U percentage change is negative) by the MFP adjustment, and states that application of the MFP adjustment may reduce this percentage change below zero. If the application of the MFP adjustment to the CPI-U

percentage increase would result in an MFP-adjusted CPI-U update factor that is less than zero, then the annual update to the ASC payment rates would be negative and payments would decrease relative to the prior year.

Table 62 provides illustrative examples of how we proposed the MFP adjustment would be applied to the ASC payment system. These examples show the implication of a positive CPI-U update factor with a smaller MFP adjustment, a positive CPI-U update factor with a large MFP adjustment, and a CPI-U update factor of zero. We discussed the application of the MFP adjustment to the CPI-U update factor for the ASC payment system under the OPPS/ASC CY 2011 proposed rule (75 FR 46359). We solicited comment on the specific mathematical calculation of the MFP adjustment and noted that comments on the application of the MFP adjustment to the CPI-U update factor under the ASC payment system should be made to the OPPS/ASC CY 2011 proposed rule (75 FR 46359). As discussed previously, we received and responded to comments on the calculation of the MFP adjustment and have finalized this methodology as described above. In the CY 2011 OPPS/ASC final rule with comment period, we respond to any comments received and finalize the methodology for applying the MFP adjustment to the CPI-U update factor for ASCs.

TABLE 62: Multifactor Productivity Adjusted Payment Update: Illustrative Example

CPI-U (Percent)	MFP Adjustment (Percent)	MFP-Adjusted CPI-U Update Factor (Percent)
4.0	1.3	2.7
4.0	4.7	-0.7
0.0	0.2	-0.2

b. Ambulance Fee Schedule (AFS)

In accordance with section 1834(l)(3)(B) of the Act, the AFS rates are required to be increased each year by the percentage increase in the CPI-U (U.S. city average) for the 12-month period ending with June of the previous year. We refer to this update as the Ambulance Inflation Factor (AIF). Section 3401(j) of the ACA amends section 1834(l)(3) of the Act to add a new subclause (C) which states that, for CY 2011 and each subsequent year, after determining the percentage increase under section 1834(l)(3)(B) of the Act (that is, the CPI-U percentage increase, or AIF), the Secretary shall reduce such percentage increase by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act (as discussed previously). Section 3401(j) of the ACA further amends section 1834(l)(3) of the Act to state that the application of subclause (C) (that is, the reduction of the CPI-U percentage increase by the MFP adjustment) may result in that percentage increase being less than zero for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

In accordance with section 1834(l)(3) of the Act as amended by section 3401(j) of the ACA, before applying the MFP adjustment, the Secretary first determines the "percentage increase" in the CPI-U, which we interpret cannot be a negative number. Thus, in the instance where the percentage change in the CPI-U for a year is negative, we proposed to hold the AIF to zero. The statute then requires that the Secretary reduce the CPI-U percentage increase (which would be held to zero if the CPI-U percentage change is negative) by the MFP adjustment, and states that application of the MFP adjustment may reduce this percentage increase below zero. If the application of the MFP adjustment to the CPI-U percentage increase would result in an MFP-adjusted AIF that is

less than zero, then the annual update to the AFS would be negative and payments would decrease relative to the prior year.

Table 63 provides illustrative examples of how we proposed the MFP adjustment would be applied to the AFS. Finally, we proposed to revise §414.610(f) to require that the AIF be reduced by the MFP adjustment as required by the statute in determining the annual update under the ambulance fee schedule for CY 2011 and each subsequent year, and to revise §414.620 to state that changes in payment rates resulting from the incorporation of the AIF and the MFP adjustment will be announced by CMS by instruction and on the CMS website, as we previously discussed.

TABLE 63: Examples of the Application of the Multifactor Productivity Adjustment to the Ambulance Fee Schedule

A	B	C	D
CPI-U	**AIF**	**MFP Adjustment**	**Final Update Rounded**
2.0%	2.0%	1.3%	0.7%
0.0%	0.0%	1.3%	-1.3%
-2.0%	0.0%	1.3%	-1.3%
1.0%	1.0%	1.3%	-0.3%

Comment: A few commenters stated that the payment rates for ambulances have consistently fallen further behind the actual cost of providing the service. One commenter stated that the annual update as adjusted by the MFP adjustment would create a permanent disparity between future increases in Medicare's reimbursement for ambulance services and the increased costs of providing those services. The commenter stated that the two largest operational costs for ambulance services are personnel and fuel, neither of which readily lends itself to operational efficiencies. In particular, they claim that small and rural providers lack the volume of transports needed to obtain any

meaningful economies of scale. These commenters acknowledge that the MFP adjustment is mandated by law, but they state that it will likely result in a net decrease in the already insufficient base reimbursement rate for air ambulances. One commenter urged CMS to take whatever steps are within its authority to mitigate the potentially devastating effects of this new requirement.

Response: As discussed previously and in the CY 2011 PFS proposed rule (75 FR 40124), we are required by law to implement section 3401(j) of the ACA, which requires that for CY 2011 and each subsequent year, after determining the percentage increase under section 1834(l)(3)(B) of the Act (that is, the CPI-U percentage increase, or AIF), the Secretary shall reduce such percentage increase by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. In response to the request that we "mitigate" any potentially negative effects of the MFP adjustment, we reiterate that we are required to apply the MFP adjustment to the AIF in the manner specified by the ACA, and we are not authorized by statute to implement measures to mitigate the effects of this adjustment. We note that certain temporary payment add-ons, currently codified at section 1834(l)(12) and (13) of the Act and at section 146(b)(1) of the MIPAA, were extended by the ACA through December 31, 2010 (see section VI.F(1) and (3). of this final rule). To date, Congress has not extended these payment add-ons beyond December 31, 2010. Therefore, we are finalizing the methodology for applying the MFP adjustment to the AIF for the AFS as described in the proposed rule. We did not receive any comments regarding the proposed changes to §414.610(f) and §414.620 as discussed above. Therefore, we are revising the regulation text in §414.610(f) and §414.620 as proposed, with the following minor technical change. In §414.610(f), for clarification

purposes, we have made a technical revision to refer to the definition of the productivity adjustment in section 1886(b)(3)(B)(xi)(II) of the Act.

c. Clinical Laboratory Fee Schedule

Section 1833(h)(2)(A)(i) of the Act, as amended by section 3401(l) of the ACA, states that the Secretary shall set the CLFS "for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by, subject to clause (iv) [as added by the ACA], a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average) minus, for each of the years 2009 through 2010, 0.5 percentage points". Therefore, the adjustment to the fee schedule can be an increase or a decrease.

Section 3401(l) of the ACA also adds new clause (iv) that applies in CY 2011 and each subsequent year. This clause requires the Secretary to reduce the adjustment in clause (i): (1) by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act for 2011 and each subsequent year and (2) by 1.75 percentage points for each year of 2011 through 2015 (the "percentage adjustment"). However, section 3401(l) of the ACA states that the MFP adjustment will not apply in a year where the adjustment to the fee schedule determined under clause (i) is zero or a percentage decrease for a year. Further, the application of the MFP adjustment shall not result in an adjustment to the fee schedule under clause (i) of less than zero for a year.

Therefore, we proposed to apply the MFP adjustment as follows:

- If the CPI-U update factor is positive, it would be reduced by the MFP adjustment. However, if application of the MFP adjustment would result in a negative update, the update would be held to zero.

- If the CPI-U update factor is zero or negative, the MFP adjustment would not be applied.

Section 3401(l) of the ACA also states that the application of the percentage adjustment may result in an adjustment to the fee schedule under clause (i) being less than zero for a year and may result in payment rates for a year being less than such payment rates for the preceding year. Therefore, we are applying the percentage reduction of 1.75 percentage points to any adjustment to the fee schedule under the CLFS as directed by section 3401(l) of the ACA.

Table 64 provides illustrative examples of how we proposed these adjustments would be applied to fees under the CLFS.

TABLE 64: Examples of the Application of the Multifactor Productivity Adjustment to the Clinical Lab Fee Schedule

A	B	C	D	E
CPI-U	**MFP Adjustment**	**Productivity Adjusted Update**	**(-1.75%) Percentage Point Reduction**	**Resultant Change to CLFS**
		Greater of 0.0% or (Col. A) -(Col. B)		Col. C –Col. D
2.0%	1.3%	0.7%	-1.75%	-1.05%
0.0%	N/A	0.0%	-1.75%	-1.75%
-2.0%	N/A	0.0%	-1.75%	-1.75%

We did not receive any public comments on the proposed methodology for applying the MFP adjustment and the percentage adjustment to the CPI-U update factor for the CLFS. Therefore, we are finalizing the methodology for applying the MFP adjustment and the percentage adjustment to the CPI-U update factor for the CLFS as described in the

proposed rule

d. DMEPOS Fee Schedule

Sections 1834(a)(14), 1834(h)(4), and 1842(s)(1) of the Act mandate annual updates to the fee schedule amounts established in accordance with these respective sections for covered items of durable medical equipment defined in section 1834(a)(13) of the Act, prosthetic devices, orthotics, and prosthetics defined in section 1834(h)(4)(B) and (C) of the Act, and parenteral and enteral nutrients, equipment, and supplies described in section 1842(s)(2)(D) of the Act. The annual updates for 2011 for these sections are based on the percentage increase in the CPI-U for the 12-month period ending with June 2010. The annual updates for years subsequent to 2011 will be based on the percentage increase in the CPI-U for the 12-month period ending with June of the previous year (that is, June 2011 for 2012, June 2012 for 2013, etc.). Since 1990 for durable medical equipment, prosthetic devices, orthotics, and prosthetics and since 2003 for parenteral and enteral nutrients, equipment, and supplies, we have notified the public of these annual fee schedule updates through program instructions.

Section 3401(m) of the ACA amends section 1834(a)(14) of the Act to add a new subparagraph (L) which provides that, for CY 2011 and each subsequent year, the fee schedule update factor based on the CPI-U for the 12-month period ending with June of the previous year is to be reduced by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act (as discussed previously). Section 3401(m) of the ACA further amends section 1834(a)(14) of the Act to state that the application of subparagraph (L) (that is, the reduction of the CPI-U percentage increase by the MFP adjustment) may result in that percentage increase being less than zero for a year, and

may result in payment rates for a year being less than such payment rates for the preceding year.

Section 3401(n) of ACA amends section 1834(h)(4)(A) of the Act to add a new clause (xi) which provides that, for CY 2011 and each subsequent year, the fee schedule update factor based on the CPI-U for the 12-month period ending with June of the previous year is to be reduced by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act (as discussed previously). Section 3401(n) of the ACA further amends section 1834(h)(4) of the Act to state that the application of subparagraph (A)(xi) (that is, the reduction of the CPI-U percentage increase by the MFP adjustment) may result in that percentage increase being less than zero for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

Section 3401(o) of ACA amends section 1842(s)(1) of the Act to add a new subparagraph (B) and clause (ii) which provides that, for CY 2011 and each subsequent year, the fee schedule update factor based on the CPI-U for the 12-month period ending with June of the previous year is to be reduced by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act (as discussed above). Section 3401(o) of the ACA further amends section 1842(s)(1) of the Act to state that the application of subparagraph (B)(ii) (that is, the reduction of the CPI-U percentage increase by the MFP adjustment) may result in that percentage increase being less than zero for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

The MFP adjustments to the CPI-U percentage increases used in calculating the fee schedule adjustment factors for these DMEPOS items and services as mandated by

sections 3401(m), (n), and (o) of ACA are simple mathematical calculations and are ministerial in nature. Therefore, we plan to implement these adjustments for 2011 and subsequent years as part of the annual program instructions related to the DMEPOS fees schedule updates.

Comment: Several commenters stated that there were flawed assumptions underlying the statutory requirements of section 3401 of the ACA. Since the MFP measures the contributions to productivity of all sectors involved in production, the commenters argued that the indiscriminate application of the MFP to DMEPOS items was fundamentally flawed.

Response: As discussed previously, sections 3401(m), (n), and (o) of the ACA require us to implement the MFP adjustments to the CPI-U percentage increases for DMEPOS items and services. Therefore, we are finalizing our proposal to apply the MFP adjustments to the CPI-U percentage increases for DMEPOS items and services for calendar year 2011 and subsequent years.

Q. Section 4103: Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan

1. Background and Statutory Authority

a. Medicare Coverage of Preventive Physical Examinations and Routine Checkups

Section 1862(a)(7) of the Act explicitly prohibits Medicare payment for routine physical checkups with certain exceptions. One exception is for the Initial Preventive Physical Exam (also referred to as the "Welcome to Medicare" exam) established for new beneficiaries effective for services furnished on or after January1, 2005. Section 4103 of the ACA has provided another exception to section 1862(a)(7) of the Act. Congress

expanded Medicare coverage under Part B to include an Annual Wellness Visit (AWV) Providing Personalized Prevention Plan Services (hereinafter referred to as the annual wellness visit) in sections 1861(s)(2)(FF) and 1861(hhh)of the Act. This expanded benefit is effective on January 1, 2011.

Preventive care has become an increasing focus of the Medicare program. For instance, section 101 of the MIPPA expanded Medicare's authority to establish coverage for additional preventive services that meet specified criteria. Among other things, the AWV will encourage beneficiaries to obtain the preventive services already covered by Medicare, and that are appropriate for each individual beneficiary.

b. Requirements for Coverage of an Annual Wellness Visit

Section 4103 of the ACA provides for coverage of an AWV, which includes and/or takes into account a health risk assessment (HRA), and creates a personalized prevention plan for beneficiaries, subject to certain eligibility and other limitations. Section 4103 of the ACA also requires the identification of elements that must be provided to a beneficiary as part of the first visit for personalized prevention plan services and requires the establishment of a yearly schedule for appropriate provision of such elements thereafter.

The ACA specifies elements to be included in a personalized prevention plan, including establishment of, or update to, the individual's medical and family history, a list of the individual's current providers and suppliers and medications prescribed for the individual; measurement of height, weight, body-mass index (BMI) or waist circumference, and blood pressure; detection of any cognitive impairment; establishment or update of an appropriate screening schedule for the next 5 to 10 years; establishment

or update of a list of risk factors and conditions (including any mental health conditions) for which interventions are recommended or underway; and furnishing of personalized health advice and referral, as appropriate, to health education or preventive counseling services or programs. The ACA also permits the Secretary to add other elements to the AWV determined to be appropriate.

2. Regulatory Revisions – Summary of Proposed Rule and Comments

The following is a summary of the provisions of the proposed rule and of the comments received. We received 75 public comments on the proposed rule regarding the AWV. Commenters included national and state professional associations, medical societies and national medical advisory groups, hospital associations and hospitals, physicians, registered dietitians, occupational therapists, senior advisory groups, health insurance associations, manufacturers, and others. While a number of commenters expressed concern that the proposal was either too prescriptive, not sufficiently targeted to development of an individual's personalized prevention plan, or was not broad enough to include additional screening or prevention services; a large majority of commenters applauded CMS' efforts in developing the rule and generally supported its major elements. Many suggested clarification and revision of the rule in a number of different areas, including the proposed definitions of "detection of any cognitive impairment," and "health professional," and the components of the first and subsequent AWVs. One special concern of a number of commenters was related to the health risk assessment (HRA). Some provisions of section 4103 of the ACA require the HRA be included in the new AWV, which is effective January 1, 2011. Other provisions of section 4103 of the ACA give the Secretary a longer period of time to develop an HRA in consultation with

relevant groups and entities.

a. Revisions to §411.15, Particular Services Excluded from Coverage

To conform the regulations to the statutory requirements of the ACA, we proposed to revise §411.15 by specifying an exception to the routine physical checkups exclusion from coverage in §411.15(a)(1) and modifying §411.15(k)(15). We proposed to add a provision to permit coverage of AWVs that meet the eligibility limitations and the conditions for coverage we are specifying in §410.15 (Annual Wellness Visit Providing Personalized Prevention Plan Services).

Coverage of the AWV is furnished under Medicare Part B only. As provided in the statute, this new coverage allows payment for an AWV if provided on or after January 1, 2011 for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period, and has not received either an IPPE or an AWV within the past 12 months.

b. Revisions to Part 410, Subpart B – Medical and Other Health Services

We proposed to add §410.15, Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage, to codify the coverage of the annual wellness visit providing personalized prevention plan services.

We proposed to define several terms in §410.15(a), including: (1) Detection of any cognitive impairment; (2) Review of the individual's functional ability and level of safety; (3) Health professional; (4) Establishment of, or update to the individual's medical and family history; (5) Eligible beneficiary; (6) First annual wellness visit providing personalized prevention plan services; and (7) Subsequent annual wellness visit providing personalized prevention plan services.

Further, the ACA allows the addition of any other element determined appropriate by the Secretary for inclusion in an AWV. We reviewed the relevant medical literature, current clinical practice guidelines, and the recommendations of the United States Preventive Services Task Force (USPSTF). Pursuant to that review, we proposed to add depression screening and functional status screening as elements of the first AWV only. In its December 2009 Recommendation Statement, the USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment and follow-up (Grade: B recommendation). That is, the USPSTF recommends the service; there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

The USPSTF is currently updating its 1996 recommendation regarding screening for hearing impairment in older adults as well as its recommendation on falls in the elderly. Until those recommendations can be published, functional status screening (including assessment of hearing impairment, ability to successfully perform activities of daily living, fall risk, and home safety) appears supportable by evidence only for the first AWV.

We also proposed that the definition of the term "Establishment of, or an update to the individual's medical and family history" include more than a list of all of an individual's prescribed medications as provided in the statute, but also supplements such as vitamins and calcium that an individual may be exposed to or use. Supplements such as these are commonly used by many beneficiaries and the medical literature supports that their use be closely monitored by health professionals because they can interact with prescribed medications and may result in unintended medical problems in individual

cases. The statute expressly permits the Secretary to add other elements such as this to the AWVs.

To facilitate future consideration of coverage of additional elements in the definitions of the first and subsequent AWVs in §410.15(a), we proposed that the determination of other required elements for those purposes will be made through the national coverage determination (NCD) process. The NCD process, as described in section 1862(l) of the Act, is evidence based, transparent, and furnishes the opportunity for public comment.

(1) Definitions

We proposed to add the following definitions to §410.15(a):

- Detection of any cognitive impairment, for purposes of this section, means assessment of an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers, or others.

Comment: A number of commenters strongly supported the mandatory inclusion of "detection of any cognitive impairment" in the new AWV, but several suggested the proposed definition did not go far enough and needed to be clarified. One commenter suggested that the definition was "too vague and may be interpreted as optional by a provider unless a subjective memory complaint is raised by the individual or a concern is raised by family members, friends, caretakers, or others", and that a brief cognitive screening test was necessary "to accurately identify the presence of cognitive deficits, and to indicate whether additional testing is necessary . . ." Another commenter expressed concern that "physicians cannot accurately assess cognitive function . . . by relying on

direct observation or by report of the patient or knowledgeable informant." The commenter cited several recent publications and their own experience in support of revising the definition to include use of a standardized screening test. A number of commenters supporting the importance of the "detection of cognitive impairment" element, however, agreed with the definition that is used in the proposed rule, which does not require a standardized screening tool.

Response: We agree with the commenters that the "detection of cognitive impairment" is an important element of the AWV. As Boustani and colleagues (Ann Internal Medicine 2003;138:927–937) noted: "Dementia causes a high burden of suffering for patients, their families, and society. For patients, it leads to increased dependency and complicates other comorbid conditions. For families, it leads to anxiety, depression, and increased time spent caring for a loved one. The annual societal cost of dementia is approximately $100 billion (health care and related costs as well as lost wages for patients and family caregivers)."

Several commenters suggested revising the proposed definition by the addition of a standardized screening tool. With the considerable variability in the range and causes of cognitive impairment, it is difficult to more specifically define this element without limiting it to specific diseases such as Alzheimer's since dementia in and of itself is broadly defined. The American Psychiatric Association stated: "the essential features of a dementia are acquired multiple cognitive deficits that usually include memory impairment and at least one of the following phenomena in the absence of a delirium that might explain the deficit: aphasia, apraxia, agnosia, or a disturbance in executive functioning (the ability to think abstractly and to plan, initiate, sequence, monitor, and

stop complex behavior)
(http://www.psychiatryonline.com/content.aspx?aID=152634#152634)." However, an evidence-based, standardized screening tool is not currently available. The USPSTF noted: "most screening tests have been evaluated in studies with small sample sizes, and the populations of patients on whom screening instruments have been tested have varied greatly, making it difficult to determine the overall performance of screening tests for dementia"
(http://www.uspreventiveservicestaskforce.org/3rduspstf/dementia/dementrr.pdf). They concluded "that the evidence is insufficient to recommend for or against routine screening for dementia in older adults (I grade)." Since there is no nationally recognized screening tool for the detection of cognitive impairments at the present time, we are adopting the language in §410.15(a) as proposed.

We disagree with one of the commenter's assertions that, in general, a physician cannot accurately assess cognitive function by direct observation or report of the patient or by report of the patient knowledgeable informant. We believe that physicians can use their best clinical judgment in the detection and diagnosis of cognitive impairments, along with determining whether additional resources may need to be used in the course of screening and treatment of the patient. We will continue to actively monitor advancements in screening, collaborate with the USPSTF, and will consider revising this element if the evidence is sufficient and a standardized screening test becomes available.

- Review of the individual's functional ability and level of safety, for purposes of this section includes, at a minimum, assessment of the following topics:

++ Hearing impairment;

++ Ability to successfully perform activities of daily living;

++ Fall risk;

++ Home safety.

Comment: One commenter asked CMS to add "assessment of level of support" to the proposed definition of "review of the individual's functional ability and level of safety" to recognize that the availability of a caregiver is an important indication of a beneficiary's ability to function and of their level of safety.

Response: We agree that family caregivers play an important role in the lives of the individuals they care for and support. However, we believe that the term as defined in the proposed rule is flexible enough to include a discussion of the availability of a caregiver as part of the review of functional ability and level of safety, if determined appropriate by the health professional furnishing the AWV. Therefore, we are not adopting this public comment and are adopting the definition as proposed.

- Health professional, for purposes of this section means:

++ A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act); or

++ A practitioner as described in clause (i) of section 1842(b)(18)(C) of the Act, that is, a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); or

++ A medical professional (including a health educator, registered dietitian, or nutritionist) or a team of medical professionals, who are working under the supervision of a physician as defined in this definition.

Comment: A number of commenters requested clarification of specific elements

of the definition of the term "Health professional" and offered specific suggestions for revisions that might be made in the definition in the final rule. One commenter suggested that section 4103 of the ACA provided that the AWV could be performed by a health professional or a team of health professionals such as a registered nurse that works under the supervision of a physician. When registered nurses or other medical professionals who are not Medicare-recognized providers or practitioners perform the AWV under the supervision of a physician, the commenter assumes that the visit "would be billed by the supervising physician who may or may not see the patient during the visit." The commenter believed that because the AWV has its own benefit category then Medicare payments would not fall under the "incident to" benefit (section 1861(s)(2)(B) of the Act and the 'incident to' criteria would not need to be met.

Response: We agree with the commenter that the AWV has its own benefit category as provided in section 1861(s)(2)(FF) and section 1861 (hhh) of the Act and, therefore, is not subject to the "incident to" rules. The commenter is also correct that our intent is that where the wellness visit is performed by a "team of medical professionals working under the supervision of a physician" it is the supervising physician who would bill Medicare Part B for the visit. In this final rule, we are clarifying that the visit would be furnished under the "direct supervision" (as defined in 42 CFR 410.32(b)(3)(ii)), of a physician (as defined in paragraph (i) of this definition). Direct supervision in the office setting means that the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed. In response to the public comment, we are amending the definition of the

term "health professional" in the final rule to read in paragraph (iii) as follows: "A medical professional (including a health educator, a registered dietitian, or nutrition professional, or other licensed practitioner or a team of such medical professionals, working under the direct supervision (as defined in 42 CFR 410.32(b)(3)(ii)) of a physician as defined in paragraph (i) of this definition."

Comment: A commenter asserted that the definition of "health professional" should recognize other potential members of the team beyond those listed in the examples in the statute. The commenter recommends that CMS "specify who may or should be a part of the team and should define 'medical professional' as licensed health practitioners whose services are specifically covered and regulated by Medicare. Otherwise, in the commenter's view, paraprofessionals, non-licensed providers or others may be inappropriately used as part of the team. The commenter supported the requirement "that the team should be directed by a physician," but believes "CMS should provide some standards for the members of the team as a protection for consumers and to assure that funding for this visit will be spent on authentic, appropriate and regulated services." The commenter also suggested that occupational therapists be specifically included as a potential component of the team.

Another commenter asked CMS to clarify "how the required tasks in the visit will be performed and how care coordination will occur among the eligible medical professionals and/or team that provides the AWV."

Response: While we appreciate the commenters' concerns, we are not assigning particular tasks or restrictions for specific members of the team in this final rule. We believe it is better for the supervising physician to assign specific tasks to qualified team

members (as long as they are licensed in the State and working within their state scope of practice). This approach gives the physicians and the team the flexibility needed to address the beneficiary's particular needs on a particular day. It also empowers the physician to determine whether specific medical professionals (such as occupational therapists) who will be working on his or her wellness team are needed on a particular day. The physician is able to determine the coordination of various team members during the AWV.

Comment: One commenter urged CMS to revise its proposed definition of "Health professional" to include the phrase "practicing in any particular patient care setting." The commenter believed that this clarification is needed to "encourage retail based practitioners to provide these services, thereby making this benefit more appealing for patients." The commenter suggested that "retail based health practitioners are uniquely positioned to ensure the optimal utilization of this new benefit."

Response: Although we are interested in encouraging the maximum use of the AWV and encourage all of the health professionals listed in section 1861(hhh)(3) of the Act that are qualified to furnish this service to participate in providing this part B service, we are not adopting the commenter's suggestion to include the phrase "practicing an any particular patient care setting." This particular phrase is not used in section 1861(hhh)(3) of the Act, which instead references specific health professionals that may furnish the AWV without regard to a particular physical location. Moreover, we note that the phrase "any particular patient care setting" is ambiguous, and may in fact unintentionally narrow the availability of the benefit or raise unnecessary questions regarding the setting. Therefore, we are not adopting the commenter's suggested revision of that definition to

include language on specific patient care settings.

Comment: One commenter noted that certified nurse-midwives (CNMs) are not specifically mentioned in the ACA as it relates to the AWV, though nurse practitioners and clinical nurse specialists are enumerated among practitioners eligible to participate. The commenter requested that CMS review the education, background and scope of practice services under the Medicare program and ensure that CNMs are clearly eligible to provide the Medicare AWV.

Response: Congress defined the term "health professional" as including certain practitioners "described in clause (i) of section 1842(b)(18)(C)" of the Act. Clause (i) specifically includes physician assistants (PAs), nurse practitioners (NPs) and clinical nurse specialists. CNMs, in contrast, are identified in clause (iii) of 1842 (b)(18)(C) of the Act. Given the specificity of the cross-reference to only clause (i), we presume that Congress acted intentionally by not including a reference to clause (iii). Thus, we believe additional legislation would be needed to recognize CNMs as a "health professional" under this section. However, we note, that it is possible that a CNM could be chosen by a physician as a member of the team of professionals under the physician's supervision.

Comment: One commenter requested that CMS clarify the language of the proposed rule in the definition of "medical professional" in §410.31(a). Section 4103 of the ACA uses the terms "registered dietitian" or "nutrition professional" in its definition of "medical professional" eligible to be involved in the AWV. The proposed rule used the term "nutritionist" instead of "nutrition professional." The commenter asks CMS to replace the term "nutritionist" with "nutrition professional" in §410.15(a).

Response: We agree with the commenter and we are replacing the term

"nutritionist" with the term "nutrition professional" in §410.15(a) of the final rule, which is consistent with the language used in section 4103 of the ACA.

Comment: One commenter is concerned about the CMS proposal to require the term "physician" for purposes of the definition of "health professional" to be either a doctor of medicine or a doctor of osteopathy as defined in section 1861(r)(1) of the Act. The commenter suggests that we use the full definition of a "physician as defined in section 1861(r) of the Act.

Response: Section 4103 of the ACA does not specifically define what type of physician is eligible for performing or supervising the team of health professionals who will be performing or supervising the AWV. In developing the proposed rule, we considered the various types of physicians that are identified in section 1861(r)(2), (r)(3), (r)(4), and (r)(5) of the Act. These include doctors of dental surgery, doctors of podiatric medicine, doctors of optometry, and chiropractors, whose scope of medical practice is generally limited by State law to a particular part (or parts) of the human anatomy. Given the State licensing restrictions, some individuals who are physicians for certain limited purposes under section1861(r) of the Act could exceed their scope of practice if they attempted to furnish the AWV. Based on this information, we are leaving the definition of a physician unchanged in the final rule.

- Establishment of, or an update to the individual's medical and family history, for purposes of this section, means, at minimum, the collection and documentation of the following:

++ Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments.

++ Use or exposure to medications and supplements, including calcium and vitamins.

++ Medical events experienced by the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the individual at increased risk.

Comment: A number of commenters requested that additional items be included in the definition of the term "Establishment of, or an update to the individual's medical and family history," such as tobacco use, sexual history, history and results of pelvic exams, and falls history.

Response: Our proposed definition at §410.15(a) was not intended to establish an exhaustive list of the elements of an individual's medical and family history. We included the phrase "at minimum" to reflect that the listed criteria represent a floor and not a ceiling on the items included in the medical and family history. We agree that the items of additional information identified by the commenters are relevant and could be included in the medical and family history that is maintained by the health professional for the Medicare beneficiary. However, we believe that the term as defined in the proposed rule is flexible enough to encompass the additional items requested by the commenters. Therefore, we are not adopting the commenters' specific language and are implementing the proposed definition in this final rule.

- Eligible beneficiary, for purposes of this section, means an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period, and has not received either an initial preventive physical examination or an AWV providing a personalized prevention plan within the past 12 months.

Comment: Several commenters suggested that CMS misinterpreted the eligibility criteria for the AWV and its relationship to the one-time initial preventive physical examination defined in section 1861(ww)(1) of the Act, which is only covered during the first 12 months after a beneficiary's enrollment in Medicare Part B takes effect.

In suggesting that CMS' proposed definition was inappropriate, one commenter pointed to statutory language that states: "A beneficiary shall only be eligible to receive an initial preventive physical examination (as defined under subsection (ww)(1)) at any time during the 12-month period after the date that the beneficiary's coverage begins under Part B and shall be eligible to receive personalized prevention plan services under this subsection provided that the beneficiary has not received such services within the preceding 12 month period." The commenter argued that this language intends either an initial preventive physical examination or an AWV to be available during the 12-month period after an individual's Part B coverage begins provided the individual has not received either service within the preceding 12-months. To further bolster this argument, the commenter points to clause (ii) of paragraph (G) directing the Secretary to "establish procedures to make beneficiaries aware of the option to select an initial preventive physical examination or personalized prevention plan services during the period of 12-months after the date that a beneficiary's coverage begins under Part B, which shall include information regarding any relevant differences between such services."

Response: The statutory text cited by the commenter fails to reflect a later Congressional amendment. Specifically, Congress replaced the language of paragraph (G) by section 10402(b) of the ACA. That amendment replaced the text cited by the commenter so that the version of paragraph (G) that was enacted into law reads: "A

beneficiary shall be eligible to receive only an initial preventive physical examination (as defined under subsection (ww)(1)) during the 12-month period after the date that the beneficiary's coverage begins under Part B and shall be eligible to receive personalized prevention plan services under this subsection each year thereafter provided that the beneficiary has not received either an initial preventive physical examination or personalized prevention plan services within the preceding 12-month period."

This amendment clarifies that only an initial preventive physical examination is covered during the 12-month period after an individual's Part B coverage begins, and that coverage of the new AWVs begins during the individual's second year of Part B coverage. In other words, they were intended to be sequential, not concurrent, benefits. We believe the proposed definition of "eligible beneficiary" included in the proposed rule correctly implements this aspect of sections 4103 and 10402(b) of the ACA. Therefore, we are finalizing the proposed definition without accepting the commenters' suggestion.

(2) Requirements of the First Annual Wellness Visit Providing Personalized Prevention Plan Services

We proposed that the first AWV providing personalized prevention plan services for purposes of this benefit include the following:

- Establishment of an individual's medical and family history.
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.
- Measurement of an individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements as deemed appropriate, based on the individual's medical and family history.

- Detection of any cognitive impairment that the individual may have.

- Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional as defined in this section may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

- Review of the individual's functional ability and level of safety, based on direct observation or the use of appropriate screening questions or a screening questionnaire, which the health professional as defined in this section may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

- Establishment of the following:

++ A written screening schedule, such as a checklist, for the next 5 to 10 years as appropriate, based on recommendations of the USPSTF and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.

++ A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under §410.16), and a list of treatment options and their associated risks and benefits.

- Furnishing of personalized health advice to the individual and a referral, as

appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

- Any other element determined appropriate through the National Coverage Determination process.

Comment: A number of commenters were supportive of the proposal to use the national coverage determination process and rely on the USPSTF recommendations in developing the definitions of the first and subsequent AWV definitions, along with the addition of any other elements in the future, since the services need to be based on evidence. One commenter suggested that CMS publish a notice in the **Federal Register** about consideration of other preventive services via the NCD process. The commenter expressed concern that many groups and members of the public were more familiar with the regulatory notification process than the NCD process.

Response: We appreciate the commenter's concerns regarding receiving timely information about topics that CMS is considering for coverage of preventive services via the NCD process. As discussed in the preamble, the NCD process is an evidence-based, transparent process and furnishes the opportunity for public comment, and is described in section 1862(l) of the Act. The CMS website at http://www.cms.gov/mcd/index_list.asp?list_type=nca contains a list of all national coverage analyses that are currently under consideration. Those interested in receiving information via email regarding national coverage analyses under consideration can sign up to receive email notifications via the CMS coverage listserv at

http://www.cms.gov/InfoExchange/03_listserv.asp#TopOfPage. Given the relatively fast timeline described in section 1862(l) of the Act, we do not believe it is feasible to add a requirement for publication of a notice in the **Federal Register** whenever an NCD is opened. Therefore, we are not adopting the public comment. Please note that we do publish a listing in the **Federal Register** of all NCDs that are issued. This information is included in the quarterly notice issued pursuant to section1871(c) of the Act.

Comment: Several commenters noted that we did not include the health risk assessment (HRA) in our proposal that section 4103 of the ACA ultimately requires to be part of the AWV. Several of these commenters strongly supported the CMS approach of not immediately implementing the HRA requirement on January 1, 2011. Some commenters noted that a separate ACA provision also concerns the establishment of an HRA, but used later deadlines. Specifically, section 1861(hhh)(4)(A) of the Act requires consultation to develop publically available guidelines for HRAs by March 23, 2011. One commenter noted that "the relative recent enactment of the Affordable Care Act provided CMS little time to establish standard processes related to a health risk assessment (HRA)." Another commenter stressed the need for a standardized HRA model or models that is/are recognized and accepted nationally. Another commenter urged us to act as expeditiously as possible in a consultative way by directly engaging the major medical organizations and stakeholders who represent physicians and other clinicians who see Medicare beneficiaries. One commenter recommended that the "HRA program should also be pilot-tested before widely imposed to determine such critical factors as the effectiveness of the guidelines and the administrative burden imposed on the physicians."

However, other commenters expressed the view that the HRA is such a fundamental element of the new AWV that it should be added to the final rule and required beginning January 1, 2011. One commenter indicated that the absence of an HRA "will delay the opportunity to improve beneficiaries' health and to control costs as a result. We believe that the HRA is the lynchpin that makes the wellness visit more than another office visit and should be included as a required element beginning January 1, 2011." Several of these commenters suggested that CMS should rely on the National Committee for Quality Assurance (NCQA) certification process, the Utilization Review Accreditation Committee (URAC) accreditation process, or another certification process that already exists effective January 1, 2011, at least as an interim measure.

Response: We agree with commenters that the HRA is an important part of the AWV and we are working to fully implement this relevant provision of the ACA. However, because the statute has specified a time frame and procedures that require consultation with relevant groups and entities prior to publication of the required HRA guidelines it is not possible to complete those procedures by January 1, 2011. Moreover, we do not believe it would be prudent to mandate an interim HRA without completing the consultation process that Congress has specifically required. The point of the consultation is to achieve a greater national consensus on the HRA to be used. As one of the large physician specialty groups has noted during the public comment period, a standardized HRA is needed to "ensure use of appropriate and robust HRA from a marketplace where considerable variation exists today." We agree with this commenter that what is needed is an HRA "that has been standardized by the Department of Health and Human Services." The development of an evidence-based, standardized model,

nonetheless, requires extensive work and input from a number of public agencies, professional societies and private organizations. It is important to carefully complete that process so that the evidence-based standard will have a sound scientific foundation and broad acceptance.

Consistent with the statutory deadlines, and one commenter's suggestion "that the Secretary of HHS expedite the development of a standardized HRA," CMS is collaborating with the Centers for Disease Control and Prevention (CDC) which is directed by section 4004(f) of the ACA to develop a personalized prevention plan tool and has an in-depth knowledge of HRAs. We understand that CDC is planning to convene an open scientific meeting in Atlanta at the beginning of 2011 to facilitate that development. This meeting should allow broad public input into the development of an evidence-based standardized HRA, as recommended by the American Medical Association (AMA) which urged "CMS to continue to develop the HRA guidelines, in consultation with the AMA and other relevant stakeholders representing physicians," and the American College of Physicians (ACP) which recommended "that the agency engage directly with the most relevant stakeholders . . . to ensure that the HRA fulfills the vital role of promoting optimal preventive care and related interventions envisioned by the ACA." CMS has also commissioned a technology assessment from the Agency for Healthcare Research and Quality (AHRQ) to be completed by the end of 2010 that will help in the development of the HRA guidelines and model.

While commenters have suggested that we require the use of one or more currently available assessment tools until an evidence-based standardized model is available, we believe it would be premature and inefficient to make such a

recommendation at this time without adequate scientific review and broader stakeholder input. As noted in the proposed rule, HRA guidelines and standards are being developed by the CDC and when a model HRA instrument is available and determined by the Secretary to be appropriate for the use of Medicare beneficiaries, we will revise these regulations to include the HRA as an element in the definition of the AWV.

Comment: Several comments expressed concern that there were too many required elements in the definition of the "First annual wellness visit" and that the definition should be modified so that some of the elements are discretionary based on an individual's medical history or the results of an HRA and one suggested that CMS should "clarify the role that the HRA care plan plays in addressing these elements as a prelude to the office visit." This commenter noted that the proposed CMS definition "assumes that the physician does not already know the patient's medical and family history or other providers and suppliers involved in the patient's care" which may not always be the case.

One commenter stated that the AWV "is supposed to deliver a service tailored to the specific needs of the patient based on some combination of the HRA results, medical history, and practitioner expertise. Some elements could be required for every patient because the level of appropriateness does not vary much from patient to patient based on age, gender, and other factors. However, there are some elements the need for which varies greatly from patient to patient and even over time." This commenter recommended "that CMS add general language stating that certain elements can be addressed, at least to some degree, as part of the HRA."

Response: We agree that a physician's or other health professional's need to include certain elements of the AWV may vary with the professional's knowledge of the

individual's medical and family history and, in particular, with the results of an HRA, if available. However, until HRA guidelines have been developed and a standardized HRA model or models has/have been recognized and accepted nationally by the Secretary for use by Medicare beneficiaries, we do not believe it is appropriate to include more flexibility or alternatives to the proposed elements of the first wellness visit. Therefore, we are leaving the proposed elements (i) through (viii) of the definition of the first AWV unchanged in this final rule.

(3) Requirements of Subsequent Annual Wellness Visits Providing Personalized Prevention Plan Services

We proposed that subsequent AWVs providing personalized prevention plan services for purposes of this benefit include the following:

- An update of the individual's medical and family history.
- An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing personalized prevention plan services.
- Measurement of an individual's weight (or waist circumference), blood pressure, and other routine measurements as deemed appropriate, based on the individual's medical and family history.
- Detection of any cognitive impairment, as that term is defined in this section, that the individual may have.
- An update to both of the following:

++ The written screening schedule for the individual as that schedule was developed at the first AWV providing personalized prevention plan services.

++ The list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual as that list was developed at the first AWV providing personalized prevention plan services.

- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs as that advice and related services are defined in paragraph (a) of this section.

- Any other element determined through the NCD process.

We proposed that body-mass index (BMI) should be calculated at the first AWV and may be recalculated at subsequent AWVs, if indicated. Given the general stability of adult height, we would not expect the BMI to meaningfully change in the absence of significant weight change. In the proposed rule, we did not require measurement of the individual's height in the subsequent annual visit.

We proposed to add two distinct elements to the definition of the first AWV only: depression screening and functional status and level of safety assessment. Our review of the medical literature and the USPSTF recommendations indicates that the optimum frequency for those services is unknown. In the proposed rule, we stated we believe it would be premature and beyond the current evidence to require depression screening and functional status assessment included in the definition of subsequent visits, but they may be performed at these visits, if indicated.

Comment: A number of commenters expressed concern that the proposed definition of the term "Subsequent annual wellness visit…" did not include the depression screening and the functional ability and level of safety screening, elements (v) and (vi), respectively, that were included in the proposed definition of the term "First

annual wellness visit." One commenter noted that "while the USPSTF states that the optimal interval for screening is unknown, it does recognize that recurrent screening may be needed for certain patients." At a minimum, the commenter suggested that "the regulations should require additional screening for depression after new chronic conditions are diagnosed and when reduction in functioning is noted." The commenter also indicated that yearly screening for functional ability and level of safety "is important to determine changes in functional impairments identified in previous screening as well as any new limitations. Such screening will assist in determining care plans, further assessments, and other services to allow a beneficiary to remain in the community as long as possible."

Response: We agree that depression screening in older adults is important. We have reviewed the USPSTF guidelines (http://www.uspreventiveservicestaskforce.org/uspstf09/adultdepression/addeprrs.htm) and have decided not to include it as a required element for subsequent AWVs largely since the USPSTF states that "the optimum interval for screening for depression is unknown." In addition, the USPSTF only recommends depression screening "when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up." It is unclear if these supports are universally available in physician offices to allow adequate routine screening at the AWV. The USPSTF further notes: "recurrent screening may be most productive in patients with a history of depression, unexplained somatic symptoms, comorbid psychological conditions (for example, panic disorder or generalized anxiety), substance abuse, or chronic pain." If an individual is determined to be in this category from prior screening, such as at the IPPE

or through an HRA, then it would appear appropriate on an individual basis to continue screening and to tailor the AWV based on risk.

Regarding functional ability and safety, we agree that for certain individuals, functional status and safety assessments (for example, fall prevention) may be important to consider on a more routine basis. For the general Medicare population, there are no A or B recommendations by the USPSTF in these areas and thus we have decided not to add functional status and safety assessments as universally required elements for the subsequent AWV. The AWV does allow for an individualized approach with a personalized prevention plan. For certain individuals where these areas are determined to be priorities, specific evaluations may be voluntary parts of subsequent visits. Since we closely monitor the USPSTF recommendations for updates or changes, if specific new or revised recommendations come out in the future, we may consider modifications at that time.

Comment: Several commenters requested that we add additional screening elements to the first and subsequent AWVs regarding: (1) Alcohol use status; (2) Tobacco use or other substance use status; (3) Sexual health and incontinence; (4) Physical activity level; (5) Risk of falls; (6) Nutrition status including under nutrition and/or malnutrition; (7) Vision and eye health; (8) an assessment for osteoarthritis; and (9) assessment of gait and balance.

Response: We appreciate the suggestions provided. The intent of the proposed definition for "establishment of, or an update to the individual's medical and family history" means at a minimum the collection and documentation of the information outlined in the proposed definition of this term. Additional items like those suggested by

the commenters can be identified and discussed as part of the establishment of, or an update to the individual's medical and family history. We do not believe that it is necessary to outline a exhaustive list of various items that may be included in the definition. We believe that physical activity level and risk of falls are adequately addressed in the definition of "review of the individual's functional ability and level of safety".

We recognize that the health professional (or supervising physician in the case of a team of medical professionals) furnishing the AWV is qualified and would be able to determine the specific additional information that needs to be discussed in order to establish a comprehensive medical and family history and provide the best care possible for the individual.

In the future, as the medical science continues to evolve, CMS may consider adding other elements to the first and subsequent AWVs through use of the national coverage determination process, if considered appropriate.

Comment: One commenter requested that the first and subsequent AWVs include a detailed current medications and supplements list as part of the individual's medical and family history.

Response: We agree that medications and supplements such as vitamins and calcium are an important part of an individual's medical and family history. We included in the proposed definition of the "Establishment of, or an update to the individual's medical and family history" provisions for the collection and documentation of use or exposure to medications and supplements, including calcium and vitamins. We believe the information included in the definition addresses the commenter's concerns and,

therefore, we are implementing element (i) of the first AWV and element (i) of the subsequent AWV, as proposed, in this final rule.

Comment: One commenter suggested that measurement of BMI be viewed as a vital sign that should be included in both the first and subsequent AWVs.

Response: We explained in the preamble to the proposed rule that "body mass index (BMI) should be calculated at the first AWV and may be recalculated at subsequent visits if indicated. Given the general stability of adult height, we would not expect the BMI to meaningfully change in the absence of significant weight change and, therefore we are not requiring measurement of the individual's height during subsequent AWVs. Accordingly, in this final rule, we are not adding the BMI requirement to the subsequent AWV.

Comment: Several commenters suggested CMS should specify in the final rule that an individual's family history of various diseases, obesity, or risk factors for a disease such as diabetes should be included in the list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended for an individual as described in element (vii)(B) of the first AWV and element (v)(B) of the subsequent AWV.

Response: We agree that the risk factors and conditions identified by the commenters should be reflected in the list of risk factors referenced in element (vii)(B) of the first AWV and element (V)(B) of the subsequent AWV for possible referral if the individual's health professional determines that it is appropriate to do so, based on the information obtained during the first and/or subsequent AWV. Therefore, we believe no additional changes to the description of "individual's medical and family history" as part

of the elements of the first and subsequent AWVs are in order.

Comment: We received a number of comments from physicians, health care providers, and others urging us to add voluntary advance care planning as an element to the definitions of both the "first annual wellness visit" and the "subsequent annual wellness visit." They base their recommendation upon a number of recent research studies, and the inclusion by statute of a similar element in the existing initial preventive physical examination (IPPE) benefit. One commenter noted that "the new wellness visit was wisely designed to build on the initial preventive physical exam, providing an ongoing, systematic focus on wellness and prevention by harmonizing Medicare services into a coordinated benefit." Another commenter stated that "the AWV provides an appropriate setting for providers to initiate voluntary conversations about future care wishes, as they counsel beneficiaries on other aspects of their health and achieving their personal health goals." The commenter added that the "care plans discussed in the 'Welcome to Medicare visit' should not be frozen in time, but revisited as an important component of patient wellness."

Response: We agree that voluntary advance care planning should be added as an element of the definitions of both the "first annual wellness visit" and the "subsequent annual wellness visit" based on the evidence described below, and the inclusion of a similar element in the IPPE benefit (also referred to as the Welcome to Medicare visit), since January 1, 2009. We believe that this will help the physician to better align the personal prevention plan services with the patient's personal priorities and goals.

Recently, Detering and colleagues (British Medical Journal 2010; 340:c1345) reported that "advance care planning improves end of life care and patient and family

satisfaction and reduces stress, anxiety, and depression in surviving relatives." Silveira and colleagues (New England Journal of Medicine 2010; 362:1211-8) reported that "data suggest that most elderly patients would welcome these discussions." Lastly, a study by Fischer and colleagues (Journal of the American Geriatric Society 2010; 58:400-401) found "no evidence that these (advance directive) discussions or completing an advance directive lead to harm."

Based on the available evidence and other relevant information, we are adding to the final regulation a definition of the term "voluntary advance care planning" to read as follows:

"Voluntary advance care planning" means, for purposes of this section, verbal or written information regarding the following areas:

(1) An individual's ability to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions.

(2) Whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

This definition is based on the definition of "end-of-life planning", which is included as an element of the IPPE as described in section 1861(ww)(3) of the Act. Thus, the addition of "voluntary advance care planning" to the AWVs extends to those visits a similar element to the one already in the one-time IPPE.

We are also revising the definitions of the terms "First annual wellness visit" and "Subsequent annual wellness visit" by inserting a new element (ix) to the definition of the term "first annual wellness visit" and a new element (vii) to the definition of the term "subsequent annual wellness visit" in §410.15 (a) of the final regulation text that would

read as follows: "Voluntary advance care planning as that term is defined in this section upon agreement with the individual."

Comment: Commenters requested that we specifically require that certain referrals for various services be included as part of the personalized prevention plan including: (1) community-based and other lifestyle management services; (2) kidney disease education services; (3) urogynecologist visits to discuss incontinence issues; and (4) tobacco use cessation counseling and related services.

Response: In the proposed rule, the definition for the first AWV included provisions for the furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition. Under the definition of the subsequent AWV, we included provisions for furnishing of personalized health advice to the individual and a referral as appropriate, to health education or preventive counseling services.

We believe that the health professionals who are furnishing the AWVs whether they be first or subsequent visits are the most qualified to determine an appropriate list of referrals for education services and preventive counseling services for each individual. We believe that the proposed definitions for the first and subsequent AWVs address commenters' concerns regarding community-based and lifestyle management services, kidney disease education services, referrals to further discuss treatment for incontinence issues, and tobacco use cessation counseling services.

Comment: One commenter suggested that CMS require the identification of a family caregiver that provides care for and supports a beneficiary with chronic conditions. The commenter states that "it is vitally important for medical professionals to know whether the beneficiary has a family caregiver or has a family member/friend who will fill that role."

Response: We appreciate the role that family caregivers provide in the lives of individuals with chronic conditions. We expect that the identification of a family care giver will be addressed when the health professional furnishing the AWV discusses the patient's ability to successfully perform activities of daily living. However, we do not believe the identification of a caregiver should be required of beneficiaries who wish to take advantage of AWVs so we are not requiring such identification in the final rule.

Comment: Several commenters suggested that CMS use its authority under section 4105 of the ACA to expand Medicare coverage of certain preventive services that are already available under Part B such as screening for abdominal aortic aneurysms, HIV screening, colorectal cancer screening, breast cancer screening (mammography), and counseling/intensive behavioral (nutrition) counseling in accordance with the USPSTF recommendations for these services. Other commenters suggested using this authority to expand Medicare Part B coverage for preventive immunizations to include vaccinations such as herpes zoster and tetanus shots, which are currently covered under Part D in accordance with the recommendations of the Advisory Committee on Immunizations Practices (ACIP) for adults age 65 and older.

Response: We appreciate the commenters' support for expanded coverage of preventive services under the Part B program. Section 4105 of the ACA grants the

Secretary the authority to modify or eliminate coverage of certain preventive services that are already available to certain beneficiaries to the extent that such modification or elimination of coverage is consistent with the recommendations of the USPSTF. Many of the items requested (including coverage of ultrasound screening for abdominal aortic aneurysms, medical nutrition therapy, certain colorectal cancer screening tests, and mammography) are already recognized as "preventive services" in section 1861(ww)(2) of the Act. Because those items are already covered by Medicare, we will need to further evaluate whether coverage for those items or services should be modified in light of the specific grades of the USPSTF as permitted under section 4105 of the ACA. Due to the complexities of considering whether to modify or eliminate coverage of certain preventive services under Medicare Part B, we decided not to address this subject in the proposed rule, which focuses instead on implementation of section 4103 and 4104 of the ACA.

We note that we may consider other expansions in Medicare coverage for "additional preventive services" in the future through section 1861(ddd)(1) of the Act. Under the "additional preventive service" statute, however, the recommendations of the Advisory Committee on Immunizations Practices (ACIP) alone do not provide a basis for expanded coverage. Additional information regarding Medicare coverage for additional preventive services can be found in the **Federal Register** (November 19, 2008, (73 FR 69869 through 69870 and 69933)) and §410.64. We will continue to monitor the USPSTF recommendations for updates or changes, and when appropriate, consider possible coverage through the NCD process. We also note that individuals can request a NCD using the procedures set forth in our Guidance Document: "Factors CMS Considers

in Opening a National Coverage Determination," available at http://www.cms.gov/mcd/ncpc_view_document.asp?id=6.

We also note that the Secretary has exercised the authority granted by section 1861(ddd)(1) of the Act to add coverage under Part B of "additional preventive services" such as HIV screening for individuals at high risk consistent with the USPSTF recommendations. Since many of the items that the commenters requested are already covered as "preventive services" or "additional preventive services," we are not making any changes based on these comments at the present time. We will continue to monitor access to these preventive services and may exercise the authority granted by section 4105 of the ACA in the future.

Comment: A commenter requested CMS to "consider whether there are opportunities to leverage its 'coverage with evidence development' process to help build the evidence base for new preventive services." The commenter further suggested CMS "review those preventive services with a USPSTF grade of 'I' ('insufficient evidence to recommend for or against') and consider the development of a 'coverage with evidence development' initiative to help generate the data needed to fully assess certain preventive services" via partnerships with other federal agencies.

Response: We are interested in increasing the evidence base concerning new preventive services. We will need to further consider whether the CED process could be used for items or services that currently are rated with an "I." We note that under §410.64 of these regulations, an "additional preventive service" must have a grade of A or B recommendation by the USPSTF. Because this suggestion will require further study, we are not making any changes to our final rule at this time.

Comment: Several commenters provided suggestions for continuing education and outreach regarding issues related to the new AWV. One commenter asked that we educate providers about evidence based recommendations for colorectal cancer screening and monitor adherence to guidelines via performance measures. Another commenter requested education and outreach materials regarding the AWV and materials that also explain the differences between the initial preventive physical examination and the new AWV. An additional commenter requested that we inform patients of the importance of preventive services including colorectal cancer screening options (colonoscopy, sigmoidoscopy, and fecal occult blood tests).

Response: We agree that it is important to raise awareness concerning the expanded Medicare coverage provided under the ACA. We will issue appropriate manual instructions and other educational information to the Medicare providers and beneficiaries, including an MLN Matters article (Medicare Learning Network) and information in the 2011 Medicare and You Handbook regarding implementation of the new AWV benefit.

Comment: One commenter recommended that we eliminate the initial preventive physical examination since it is similar to the provisions of the new AWV.

Response: We appreciate the attention being drawn to the similarity between the initial preventive physical examination and the new AWV. While we did model some of the elements of the new AWV after elements in the initial preventive physical exam, we note that these statutory provisions are separate and distinct benefits and that Medicare beneficiaries will be eligible to receive both of these benefits in sequence if the appropriate regulatory requirements are met.

In summary, as a result of the comments received, we are making the following changes in this final rule:

- We are amending the definition of the term "health professionals" to read in paragraph (iii) as follows: "A medical professional (including a health educator, a registered dietitian, or nutrition professional, or other licensed practitioner or a team of such medical professionals, working under the direct supervision (as defined in §410.32(b)(3)(ii)) of a physician as defined in paragraph (i) of this definition."

- We are adding to the final regulation the definition of the term "voluntary advance care planning" to read as follows:

"Voluntary Advance care planning" means, for purposes of this section, verbal or written information regarding the following areas:

(1) An individual's ability to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions.

(2) Whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

- We are also revising the definitions of the terms "First AWV" and "Subsequent AWV" by inserting a new element (ix) to the definition of the term "first AWV" and a new element (vii) to the definition of the term "subsequent AWV" in §410.15(a) of the final regulation text that would read as follows: "Voluntary advance care planning as that term is defined in this section upon agreement with the individual."

3. Payment for the Annual Wellness Visit Providing Personalized Prevention Plan Services (PPPS)

Section 4103 of the ACA created a new benefit for an "annual wellness visit"

(AWV) with personalized prevention plan services. The ACA amended section 1861(s)(2) of the Act by adding a new subparagraph (FF) to provide for coverage of the AWV beginning January 1, 2011. Section 4103 of the ACA also added new subsection (hhh) to section 1861 of the Act to define "personalized prevention plan services" and to specify who may furnish these services. Finally, section 4103 of the ACA amended section 1848(j)(3) of the Act and provided for payment of AWVs under the PFS, and specifically excluded the AWV from the hospital OPPS. Therefore, a single payment under the PFS would be made when an AWV is furnished by a physician, physician assistant, nurse practitioner, or clinical nurse specialist, or by a medical professional or team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

To allow for Medicare reporting and payment of the AWV, we proposed to create two new HCPCS G-codes for reporting the first wellness visit and creation of a personalized prevention plan and the subsequent visits available to the beneficiary every 12 months. Specifically, we proposed to establish the following two new HCPCS codes for CY 2011: GXXXA (AWV; includes a personalized prevention plan of service (PPPS), first visit) and GXXXB (AWV; includes a personalized prevention plan of service (PPPS), subsequent visit). A beneficiary's first AWV to any practitioner would be reported to Medicare under HCPCS code GXXXA, even if the beneficiary had previously received an initial preventive physical examination (IPPE) that was covered by Medicare. Beneficiaries, in their first 12 months of Part B coverage, would continue to be eligible only for an IPPE. After the first 12 months of Part B coverage, on or after January 1, 2011, beneficiaries would be eligible for an AWV described by HCPCS code

GXXXA or GXXXB, provided that the beneficiary has not received an IPPE or AWV within the preceding 12-month period.

Comment: Several commenters noted that the IPPE and the first AWV are very similar services with significant overlap. These commenters urged CMS not to develop a separate coding structure for the first AWV as it would be a burden for practitioners to review and determine the specific preventive service the beneficiary is eligible for on a given date. In addition, the commenters noted that a delay in information being available through the Common Working File (CWF) may cause practitioners to inaccurately determine a beneficiary's eligibility for a particular service, be it the IPPE, the first AWV, or a subsequent AWV. One commenter requested that CMS clarify that a beneficiary may choose either an IPPE or a first AWV during the beneficiary's first 12 months of Part B coverage

Response: The set of services described by the IPPE is very specific and while the services contained in the IPPE may be similar to the services included in the AWV, these are two separate benefits under Medicare. Just as there are component services specified for the IPPE, there are component services specified for the AWV. Moreover, according to section1861(hhh)(4)(G) of the Act (as added by section 4103(b) of the ACA), a beneficiary is eligible only for the IPPE during the 12-month period after the date the beneficiary's coverage begins under Part B and is only eligible for the AWV each year thereafter. Therefore, in order to be able to identify the particular benefit and services furnished to a beneficiary and ensure coverage of the services, we believe that we must distinguish between the IPPE and the AWV through the use of distinct HCPCS codes. We understand that there may be instances where practitioners may experience a

delay in the information available through the CWF, but we expect the situations where this would affect the services furnished (and subsequently billed) by a practitioner would be uncommon. The CWF will reflect the beneficiary's eligibility for the IPPE or first or subsequent AWV based on all claims submitted to date to the Medicare contractors. Only under the limited circumstances where a practitioner previously furnished an IPPE or AWV to the beneficiary but had not yet submitted the claim to Medicare would a practitioner inaccurately determine a beneficiary's eligibility for the IPPE or first or subsequent AWV.

Comment: Several commenters urged CMS to recognize the CPT codes in the Preventive Medicine Services series, ranging from 99381 (Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)) through 99397 (Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older), for reporting and payment of the AWV, rather than creating the two new HPCPCS G-codes as proposed. The commenters noted that the practitioner could report the appropriate CPT code based on the beneficiary's age and new or established patient status, allowing specific reporting of the AWV with a CPT code that would result in appropriate payment for the service provided to the beneficiary. In addition, the commenters urged CMS to use the existing CPT Editorial Panel and the

AMA RUCs process to modify these existing codes so they would be applicable for AWV services.

Response: Prior to the establishment of the IPPE benefit, Preventive Medicine Services CPT codes in the range from 99381 through 99397 were excluded from Medicare coverage because preventive medicine evaluation and management services were noncovered by Medicare. When the IPPE benefit was implemented, we created HCPCS code G0402 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment) as we have specifically defined through the regulatory process the elements that are required for this service to be billed and paid by Medicare. We refer readers to the Medicare Claims Processing Manual, Pub. 100-04, chapter 18, section 80 for additional information regarding the components of the IPPE. When implementing the IPPE, we recognized that CPT codes describing preventive services were available, but we did not believe it was appropriate to use these existing CPT codes for the IPPE, given the general nature of the services they describe in contrast to the specific nature of the IPPE service.

Similarly, in section VI.Q.2. of this final rule with comment period, we have adopted the final specific components of the AWV for CY 2011, consistent with the statutory requirements for the service. While we acknowledge that the elements of the preventive medicine evaluation and management (E/M) services reported by the CPT codes could significantly overlap with the components of the AWV, we believe that it is important to utilize specific HCPCS codes to identify the AWV as there are coverage periodicity requirements that apply to the AWV, as well as specific requirements regarding the elements of the AWV. While we understand the commenters' request to

use the established set of CPT codes for the AWV, we do not believe that the existing CPT code descriptors should be subject to adjustment and limitation based on this new benefit as these CPT codes are currently used by many practitioners to report noncovered preventive medicine E/M services furnished to Medicare beneficiaries. In addition, coverage for the AWV begins on January 1, 2011, and we believe that our authority to create and maintain Level II HCPCS codes allows us a mechanism to implement these codes quickly and effectively. While we would not necessarily be opposed to the use of CPT codes to report the AWV in the future if CPT codes existed that met our specific purposes, time does not allow for the establishment of new CPT codes or the revision of existing codes for the AWVs that are covered as of January 1, 2011.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to adopt two new HCPCS G-codes for reporting the AWV in CY 2011. While we proposed these codes as GXXXA and GXXXB for the first and subsequent AWVs, respectively, the final codes and their descriptors are G0438 (Annual wellness visit; includes a personalized prevention plan of service (PPPS), first visit) and G0439 (Annual wellness visit; includes a personalized prevention plan of service (PPPS), subsequent visit). We note that practitioners furnishing a preventive medicine E/M service that does not meet the requirements for the IPPE or the AWV would continue to report one of the preventive medicine E/M services CPT codes in the range of 99381 through 99397 as appropriate to the patient's circumstances, and these codes continue to be noncovered by Medicare.

A beneficiary would be eligible for one first AWV covered by Medicare that must include all of the required elements that we have adopted in our final policy for CY 2011,

as discussed in section VI.Q.2. of this final rule with comment period. All subsequent AWVs would include the required elements for those visits as also described in section VI.Q.2. of this final rule with comment period. All AWVs other than the beneficiary's first AWV would be reported as subsequent visits, even if a different practitioner furnished the subsequent AWV. We expect there to be continuity and communication among the practitioners caring for beneficiaries over time with respect to AWVs, and this would include the case where a different practitioner furnishing a subsequent AWV would update the information in the patient's medical record based on the patient's interval history since the previous AWV.

As we stated in the CY 2011 PFS proposed rule (75 FR 40128), the first AWV described by HCPCS code GXXXA (G0438) is similar to the IPPE that is currently reported with HCPCS code G0402 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment). We believe that the physician work and nonfacility PE of the IPPE and the first AWV are very similar, given that both represent an initial beneficiary visit focused on prevention. In the CY 2010 PFS final rule with comment period discussion of payment for the IPPE (74 FR 61767), we noted that in the context of physician work and intensity, HCPCS code G0402 was most equivalent to CPT code 99204 (Level 4 new patient office or other outpatient visit). Therefore, for CY 2011, we proposed to crosswalk the same physician work RVUs of 2.43 from CPT code 99204 to HCPCS codes G0402 and GXXXA (G0438). Similarly, we believe the direct PE inputs for all of these services are similar and, therefore, we proposed to assign the same direct PE inputs to HCPCS codes G0402 and GXXXA (G0438) as are included for CPT code 99204. We

noted that currently, the direct PE inputs for HCPCS code G0402 also include preventive assessment forms, and we proposed to add this supply to the PE for HCPCS code GXXXA (G0438) as well because we believe it would be used in the first AWV. The proposed CY 2011 PE and malpractice RVUs for HCPCS code GXXXA (G0438) were displayed in Addendum B to the proposed rule (75 FR 40640). We also noted that we proposed no facility PE RVUs for HCPCS code GXXXA (G0438) because only a single payment would be made under the PFS when this service is furnished. There is no separate facility payment for GXXXA (G0438) when a practitioner furnishes this service in the facility setting.

Moreover, in the CY 2011 PFS proposed rule (75 FR 40128), we also indicated that we believe that a subsequent AWV described by HCPCS code GXXXB (G0439) is most similar, from the perspectives of physician work and PE, to CPT code 99214 (Level 4 established patient office or other outpatient visit). The subsequent AWV is a patient visit for PPPS that includes certain required elements, such as updating information regarding the patient's history, risk factors, and regular medical care providers and suppliers since the prior AWV, and obtaining routine measurements. We believe the physician work and direct PE of a subsequent AWV are similar, in terms of E/M visit level, to the first AWV, which we proposed to value like a level 4 new patient office or other outpatient visit, as we had previously valued the IPPE. However, the subsequent AWV would typically be for an established patient and, as described earlier in this section, we proposed that only certain AWV elements must be furnished in the first AWV. As a result, in the CY 2011 PFS proposed rule (75 FR 40129), we stated that we believe it would be most appropriate to value the subsequent AWV based upon an E/M

visit for an established patient. Therefore, for CY 2011 we proposed to crosswalk the same physician work RVUs of 1.50 from CPT code 99214 to HCPCS code GXXXB (G0439). Furthermore, we believe the direct PE inputs for these two services are also similar and, therefore, we proposed to assign the same direct PE inputs to HCPCS code GXXXB (G0439) as were assigned to CPT code 99214. We note that we also proposed to add the same preventive assessment forms to the PE for HCPCS code GXXXB (G0439) as we proposed to add for HCPCS code GXXXA (G0438) because we believe this supply would be used in both the first and subsequent AWVs. The proposed CY 2011 PE and malpractice RVUs for HCPCS code GXXXB were displayed in Addendum B to the CY 2011 PFS proposed rule (75 FR 40640). Similar to our treatment of HCPCS code GXXXA (G0438) for the first AWV, we proposed no facility PE RVUs for HCPCS code GXXXB (G0439) as only a single payment would be made under the PFS when this service is furnished. There is no separate facility payment for GXXXB (G0439) when a practitioner furnishes this service in the facility setting.

Comment: A number of commenters supported the proposed payment for the first and subsequent AWVs based on a crosswalk to level 4 new and established patient office and other outpatient visits. Several commenters recommended that CMS vary the payment for the AWV based on the visit's complexity, arguing that beneficiaries with multiple health risk factors would require additional practitioner time and intensity for the AWV. One commenter recommended that CMS value the first and subsequent AWVs based on the values applicable to level 5 new and established patient office and other outpatient visits, arguing that the typical Medicare beneficiary would have multiple health risk factors that would need to be addressed in the AWV through a complex plan

specific to that beneficiary's situation. Other commenters argued that CMS should recognize the preventive medicine E/M services CPT codes from 99381 through 99387, whose values vary based on age and new or established patient status, to ensure appropriate payment for the first and subsequent AWVs. Furthermore, one commenter also pointed out that the existing preventive medicine E/M services CPT codes are currently being revalued by the AMA RUC as part of the Fourth 5-Year Review of Work to ensure that the values for the services are commensurate with the level of practitioner work involved in furnishing the medical service.

A few commenters noted that they currently bill preventive medicine services E/M CPT codes 99381 through 99397 which are noncovered in Medicare, and indicated as such with status "N" (Noncovered service), in conjunction with Medicare-covered E/M visits. The commenters requested that CMS clarify whether practitioners would continue to be able to bill additional preventive services in the CPT code range of 99381 through 99397 in conjunction with the AWV.

Response: As discussed earlier in this section, we are adopting the final HCPCS codes G0438 and G0439 for reporting the first and subsequent AWVs, rather than recognizing the CPT codes for preventive medicine E/M services as covered only for purposes of the AWVs. With respect to the values for those preventive medicine E/M services CPT codes that some commenters believe would be appropriate for payment of the first and subsequent AWVs, we have not adopted the values for Medicare because the codes are noncovered by Medicare. Nevertheless, we publish the AMA RUC-recommended work values and the PE RVUs that result from application of our standard PE methodology to the AMA RUC-recommended PE inputs in Addendum B for

the CPT codes. We compared the values we proposed for HCPCS codes G0438 and G0439 with the preventive medicine E/M services CPT codes because of the commenters' reasoning that these AMA RUC-recommended values would result in appropriate payment for AWVs. The values we proposed for HCPCS codes G0438 based on the work value and direct PE inputs for a level 4 new patient office or other outpatient visit are actually slightly higher (2.43 work RVUs; 2.14 fully implemented nonfacilty PE RVUs) than the new patient, 65 years and older CPT preventive medicine E/M services code (2.06 work RVUs; 1.87 nonfacility PE RVUs). In contrast, the values we proposed for HCPCS code G0439 based on the work value and direct PE inputs for a level 4 established patient office or other outpatient visit are slightly lower (1.50 work RVUs; 1.59 nonfacilty PE RVUs) than the establish patient, 65 years and old CPT preventive services code (1.71 work RVUs; 1.62 nonfacility RVUs). We note that if the AMA RUC provides revised recommendations to us for these preventive medicine E/M services CPT codes for a future year, we may conduct this analysis again based on that new information.

As discussed above, we note that additional preventive medicine services E/M CPT codes 99381 through 99397, noncovered by Medicare and indicated with status "N," may be furnished in conjunction with Medicare-covered E/M visits, including the AWV. However, we believe that it would be difficult to distinguish an AWV from another preventive medicine E/M service furnished in the same encounter that would be reported under a preventive medicine services E/M CPT code as there is substantial overlap in the components of CPT codes 99381 through 99397 and HCPCS codes G0438 and G0439 reported for the AWV.

Based on the final elements of the first and subsequent AWVs as adopted in section VI.Q.2. of this final rule, we do not believe that the first and subsequent AWVs would usually require the 60 or 40 minutes of physician face-to-face time that is typically associated with the level 5 new or established patient office or other patient visit, respectively. We continue to believe, as we proposed, that the typical physician time would be 45 or 25 minutes of face-to-face time, like that of the level 4 new or established patient office or other outpatient visit, respectively. We also believe the direct PE inputs for the AWV may be appropriately crosswalked to the direct PE inputs for the level 4 new or established patient office or other outpatient visit, with the addition of preventive assessment forms to both HCPCS codes G0438 and G0439, as we also proposed.

Comment: One commenter suggested that the upcoming definition of a health risk assessment (HRA) may add more work to the AWV. The commenter recommended that once the HRA has been established, CMS should incorporate the RVUs from CPT code 99420 (Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal) into the RVUs associated with the AWV to ensure that the costs of the HRA are recognized as part of the AWV service.

Response: As discussed previously in this section, the HRA guidelines and the model HRA tool are not yet available. As is our standard process, when more information becomes available on the nature of a particular service or the elements of the services change, we reevaluate the valuation of the services. Therefore, when the HRA is incorporated into the AWV, we will reevaluate the values for HCPCS codes G0438 and G0439.

After consideration of the public comments we received, we are finalizing our

CY 2011 proposal to crosswalk the physician work RVUs of 2.43 from CPT code 99204 (level 4 new patient office or other outpatient visit) to HCPCS codes G0402 (IPPE) and G0438 (first AWV) and the physician work RVUs of 1.50 from CPT code 99214 (level 4 established patient office or outpatient visit) to HCPCS code G0439 (subsequent AWV). Similarly, we believe the direct PE inputs for all of these services are similar and, therefore, we are assigning the same direct PE inputs to HCPCS codes G0402 and G0438 as are included for CPT code 99204 and the same direct PE inputs to HCPCS code G0439 as are assigned to CPT code 99214. Preventive assessment forms have been added as supplies to both HCPCS codes G0438 and G0439. The final direct PE inputs for these codes are included in the final CY 2011 direct PE database available under downloads for the CY 2011 PFS final rule with comment period on the CMS web site at: http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage. The final work, PE, and malpractice RVUs for HCPCS codes G0438 and G0439 are displayed in Addendum B to this final rule with comment period. There is no separate facility payment for HCPCS code G0438 or G0439 when a practitioner furnishes either service in the facility setting.

In the CY 2011 PFS proposed rule (75 FR 40129), we noted that while we believe there could be overlap in the direct PE, malpractice expense, and physician work in both history taking and examination of the patient in the context of the initial or subsequent AWV and another E/M service, we did not propose to limit the level of a medically necessary E/M visit when furnished and billed with an AWV. As we stated in the CY 2005 PFS final rule with comment period with respect to the IPPE (69 FR 66289 through 66290), we do not want to prohibit the reporting of an appropriate level of

service when it is necessary to evaluate and treat the beneficiary for acute and chronic conditions. However, at the same time, we believe the practitioner is better able to discuss health promotion, disease prevention, and the educational opportunities available with beneficiaries when their health status has been stabilized and the beneficiary is physically receptive. Therefore, depending on the clinical circumstances, a CPT code for a medically necessary E/M visit may be reported and appended with CPT modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to designate the E/M visit as a separately identifiable service from the initial or subsequent AWV. However, in the CY 2011 PFS proposed rule (75 FR 40129) we explained that we believe this scenario would be uncommon, and that we expect that no components of an encounter attributable to the AWV would be used in determining the level of a separate E/M visit that would also be reported.

Comment: A few commenters disagreed with CMS' assertion that reporting a significant, separately identifiable E/M visit for the same encounter as an AWV would be unusual. The commenters believe that reporting an E/M visit with an AWV would be typical, as the age and health conditions of the typical Medicare beneficiary would likely result in problem-oriented E/M services being furnished in association with the AWV in order to fully address the medical problems that were identified in the encounter. The commenters explained that providing this care during the same encounter as the AWV would be both clinically appropriate and convenient for the beneficiary.

Response: While we continue to believe that a practitioner is better able to discuss health promotion, disease prevention, and health education opportunities with

beneficiaries when their health status has been stabilized and the beneficiary is physically receptive to prevention, the goal of the AWV, we acknowledge that the AWV encounter may provide an annually recurring opportunity for a beneficiary to receive medical care for his or her health problems. However, we continue to believe that a beneficiary who has an acute medical problem or condition would not receive optimal benefit from the AWV, which focuses on health promotion in the longer term. We encourage practitioners to be thoughtful regarding the best timing of the AWV to maximize its impact on beneficiary health since the AWV is covered by Medicare no more frequently than once every 12 months. Therefore, as we proposed, depending on the clinical circumstances, a CPT code for a medically necessary E/M visit may be reported and appended with CPT modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to designate the E/M visit as a separately identifiable service from the initial or subsequent AWV.

With respect to beneficiary cost-sharing, section 4103(c)(1) of the ACA amended section 1833(a)(1) of the Act and added subparagraph (X), referring to the PPPS to state that the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848 of the Act, thereby eliminating coinsurance for the AWV. Finally, section 4103(c)(4) of the ACA amended section 1833(b) of the Act to specify that the Part B deductible will not apply to the AWV.

Comment: Many commenters expressed support for CMS' proposal to waive the beneficiary deductible and coinsurance for the AWV. The commenters noted that this

waiver would likely encourage more beneficiaries to receive an AWV.

Response: We appreciate the commenters' support for our proposal to eliminate the beneficiary cost-sharing for the AWV as the statute requires. We refer readers to section VI.R. of this final rule with comment period for further discussion of the waiver of the deductible and coinsurance for preventive services beginning in CY 2011.

In summary, for CY 2011 we are adopting the following new HCPCS G-codes for reporting the AWV: G0438 (Annual wellness visit; includes a personalized prevention plan of service (PPPS), first visit); and G0439 (Annual wellness visit; includes a personalized prevention plan of service (PPPS), subsequent visit). These codes are valued for payment under the PFS using a crosswalk methodology for the work RVUs and direct PE inputs from the level 4 new and established patient office or other outpatient visit CPT codes. The final work, PE, and malpractice RVUs for HCPCS codes G0438 and G0439 are displayed in Addendum B to this final rule with comment period. The deductible and coinsurance for the AWV is waived when coverage begins in CY 2011. Finally, the CPT code for a medically necessary E/M visit may be reported and appended with CPT modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to designate the E/M visit as a separately identifiable service from the initial or subsequent AWV when both are provided in the same encounter.

R. Section 4104: Removal of Barriers to Preventive Services in Medicare

1. Definition of "Preventive Services"

Section 4104 of the ACA revised section 1861(ddd) of the Act and added paragraph (3), which defined the term "preventive services" as follows:

- The specific services currently listed in section 1861(ww)(2) of the Act with the explicit exclusion of electrocardiograms (as specified in section 1861(ww)(2)(M) of the Act);

- The initial preventive physical examination (IPPE) established by section 611 of the MMA and defined in section 1861(ww)(1) of the Act; and

- The annual wellness visit including personalized preventive plan services, as specified by section 1861(hhh) of the Act as added by section 4103 of the ACA. We refer readers to section VI.Q. of this final rule with comment period for the CY 2011 provisions related to the coverage of and payment for the annual wellness visit. The regulations regarding coverage of the IPPE are specified in §410.16 and remain unchanged by the ACA.

The specific preventive services included in the definition of "preventive services" in section 1861(ddd)(3)(A) of the Act as cross-referenced to section 1861(ww)(2) of the Act, excluding electrocardiograms, include the following:

- Pneumococcal, influenza, and hepatitis B vaccine and administration.
- Screening mammography.
- Screening pap smear and screening pelvic exam.
- Prostate cancer screening tests.
- Colorectal cancer screening tests.
- Outpatient diabetes self-management training (DSMT).
- Bone mass measurement.
- Screening for glaucoma.
- Medical nutrition therapy (MNT) services.

- Cardiovascular screening blood tests.
- Diabetes screening tests.
- Ultrasound screening for abdominal aortic aneurysm (AAA).
- Additional preventive services identified for coverage through the national coverage determination (NCD) process.

In the CY 2011 PFS proposed rule (75 FR 41029), we indicated that at that time the only additional preventive service identified for coverage through the NCD process was HIV testing. A proposed NCD for smoking cessation services for asymptomatic patients was released in May 2010 on the CMS web site at: http://www.cms.gov/mcd/index_list.asp?list_type=nca. We stated that we would address the applicability of section 1861(ddd)(3)(A) of the Act (as added by section 4104 of the ACA) to these services if an NCD establishing them as additional preventive services was finalized. As of August 25, 2010, CMS finalized an NCD for "Counseling to Prevent Tobacco Use" and established smoking cessation services for asymptomatic patients, thus qualifying them as "additional preventive services" as defined at section 1861(ddd)(3)(A) of the Act, as cross-referenced to section 1861(ww)(2) of the Act.

We proposed to add the definition of "preventive services" in §410.2 to implement the provisions of section 1861(ddd)(3) of the Act (as added by section 4104 of the ACA).

Comment: Many commenters supported CMS' definition of "preventive services," observing that the definition was fully aligned with section 1861(ddd)(3) of the Act (as added by section 4104 of the ACA).

Response: We appreciate the support of the commenters and are adopting this definition of "preventive services" in this final rule with comment period.

Comment: Several commenters expressed confusion about Medicare's definition of "preventive services" and its relationship to those services with a United States Preventive Services Task Force (USPSTF) recommendation grade of A [An "A" rating means the USPSTF recommends the service. There is high certainty that the net benefit is substantial.] or B [A "B" rating means the USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.].

Response: It appears that some of the commenters' confusion may be due to the use of two similar terms in the Medicare Act. In section 1861(ddd) of the Act, Congress defined two terms of art. The term, "preventive services," is described in section 1861(ddd)(3) of the Act and in this final rule with comment period in §410.2. Congress also defined the term "additional preventive services" and that term was previously defined in §410.64 of our regulations. Under section 1861(ddd)(1) of the Act, in order for the Secretary to add an "additional preventive service," the Secretary is required to use the national coverage determination process. Moreover, in addition to other standards, the item or service must be recommended with a grade of A or B by the USPSTF.

In section 1861(ddd)(3) of the Act (as added by section 4104 of the ACA), Congress expanded Medicare coverage under Part B to encourage the use of "preventive services." Among other things, Congress removed some of the Part B cost-sharing obligations to encourage patients to obtain certain of these services. We note that

"additional preventive services" are one of the categories of specific services that are covered under section 1861(ww)(2) of the Act and, therefore, also fall within the term "preventive services" based on the cross-reference in section 1861(ddd)(3)(A) of the Act. Other specific services that are listed in section 1861(ww)(2) of the Act and that are included in the definition of "preventive services" are not required to have a grade A or B recommendation from the USPSTF. As we stated in the CY 2011 PFS proposed rule (75 FR 40130), "[n]ot all preventive services described in subparagraph (A) of section 1861(ddd)(3) of the Act are recommended by the USPSTF with a grade of A or B, and, therefore, some of the preventive services do not meet the criteria in sections 1833(a)(1) and (b)(1) of the Act for the waiver of the deductibles and coinsurance." We hope that this technical explanation helps to eliminate any confusion concerning the two separate terms of art.

Comment: Several commenters observed that some services, such as intensive behavioral (nutrition) counseling, have been given a grade A or B recommendation by the USPSTF but are not listed as "additional preventive services" in the CY 2011 PFS proposed rule. Another commenter requested that CMS identify all USPSTF-recommended services as "additional preventive services" and, therefore, recognize them as having a benefit category under Medicare, even if their coinsurance and deductible are not waived because their USPSTF recommendation is not a grade A or B.

Response: Under section 1861(ddd)(1) of the Act and our regulations in §410.64, an item or service must meet other standards in addition to having received a grade of A or B recommendation by the USPSTF in order for the Secretary to determine that an item

is an "additional preventive service." As we previously noted, "additional preventive services" must also be established by using the NCD process. While some of the services recommended by the commenters for addition to Medicare's list of "additional preventive services" have a grade A or B recommendation by the USPSTF, this recommendation alone is not sufficient for those services to be included as "additional preventive services" that are covered by Medicare Part B. For instance, some of the USPSTF recommendations may be directed to a particular patient population (for example, pediatric services) that may not include Medicare beneficiaries.

However, we acknowledge the potential value to Medicare beneficiaries of those preventive services recommended by the USPSTF for populations covered by Medicare based on the medical evidence that led to the grade A or B recommendation. While certain preventive services with such a recommendation may not yet be covered by Medicare, these services have the potential to improve the health of beneficiaries. Therefore, we plan to proactively pursue Medicare coverage of "additional preventive services" with a grade A or B USPSTF recommendation through our current processes on our own initiative in light of our commitment to the health and wellness of Medicare beneficiaries.

Comment: A few commenters suggested the inclusion of additional services in the definition of "preventive services," including items or services that have not been reviewed by the USPSTF or where there is no NCD. In addition, several commenters urged CMS to recognize recommendations from organizations other than the USPSTF when considering services for inclusion as "additional preventive services."

Response: Because the term "preventive services," is specifically defined by

statute in section 1861(ddd)(3) of the Act, we do not have unlimited authority to simply add items or services to this definition. As we have noted, however, the Secretary may add items or services as "additional preventive services" if the item or service meets the existing criteria in §410.64. Among other things, the statute specifically requires that a new "additional preventive service" must have a grade A or B recommendation by the USPSTF.

We do not have the authority under section 1861(ddd)(1)(B) of the Act to add "additional preventive services" based on the recommendations of other groups or organizations. We recognize that in other sections of the ACA, Congress specifically recognized the expertise of other organizations with respect to coverage of preventive health services. For instance, in section 1001 of the ACA, Congress amended section 2713 of the Public Health Service Act so that certain group health plans and health insurance issuers must provide coverage of preventive health services that were recommended by several other organizations. The Medicare statute, however, does not permit recommendations from other advisory bodies to substitute for recommendations from the USPSTF regarding Medicare coverage of "additional preventive services."

Comment: A number of commenters supported CMS' inclusion of certain vaccines in the definition of "preventive services." Other commenters were concerned that the USPSTF does not currently review or provide recommendations regarding vaccine or vaccine administration and instead urged CMS to consider recommendations from the CDC's Advisory Committee on Immunization Practices (ACIP). Several commenters requested that vaccines such as diphtheria, pertussis, herpes zoster, tetanus, hepatitis A vaccine, meningococcal vaccine, measles-mumps-rubella, and varicella be

considered "additional preventive services" as they are recommended by the ACIP. The commenters requested that CMS provide coverage for all vaccines recommended by the ACIP under Part B, noting that currently some vaccines are covered under Part B while others are covered under Part D.

Response: Medicare has covered certain vaccines and their administration under Part B, including influenza, pneumococcal, and hepatitis B, as a result of a specific statute, section 1861(s)(10) of the Act. Those services are specifically cross-referenced in section 1861(ww)(2)(A) of the Act, and are included in the definition of "preventive services" by section 1861(ddd)(3)(A) of the Act. While we acknowledge that the ACIP currently makes recommendations concerning immunizations, section 1861(ddd)(1) of the Act does not permit us to use recommendations from the ACIP as the basis for coverage of vaccines as "additional preventive services." As the commenters observed, vaccines that are not covered by Medicare Part B may be covered by Part D.

Comment: Several commenters requested that CMS not wait for an NCD for smoking cessation services but, instead, proactively identify smoking cessation services as preventive services effective for CY 2011.

Response: The Medicare statute requires the Secretary to use the national NCD process when considering adding services as an "additional preventive service." Consistent with the public process and timeframes required by section 1862(l) of the Act, our NCD expanding coverage for counseling to prevent tobacco use for asymptomatic patients was effective on August 25, 2010. Thus, the "additional preventive services" covered by Medicare Part B currently include services described by HCPCS codes G0436 (Smoking and tobacco cessation counseling visit for the asymptomatic patient;

intermediate, greater than 3 minutes, up to 10 minutes) and G0437 (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater that 10 minutes).

Comment: Several commenters requested coverage of routine HIV testing for all individuals, including persons at low risk for HIV infection, regardless of risk, based on more recent data, or based upon the C rating of the USPSTF.

Response: We are not able to accept the public comment to extend coverage for HIV screening for all individuals under the Medicare program because the USPSTF grade A or B recommendation was limited to specific populations and the USPSTF specifically made a grade C recommendation about HIV screening for "adolescents and adults who are not at increased risk for HIV infection." Our statute and regulations only permit coverage of "additional preventive services" which have been recommended with a grade of A or B by the USPSTF and do not permit coverage as "additional preventive services" of services with grade C recommendations.

As a result of the NCD, Medicare covers screening of at risk individuals for HIV described by three HCPCS codes, specifically G0432 (Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple-step method, HIV-1 or HIV-2, screening); G0433 (Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening); and G0435 (Infectious agent antigen detection by rapid antibody test or oral mucosa transudate, HIV-1 or HIV-2, screening)). These HCPCS codes are all listed in Table 65 of the following section because their beneficiary cost-sharing will be waived in CY 2011.

Comment: Several commenters encouraged CMS to develop transparency in its interactions with the USPSTF and CMS coverage determinations. The commenters urged CMS to support increased opportunities for stakeholders to participate in the USPSTF process.

Response: As required by section 1862(l) of the Act, the NCD process includes an opportunity for public comment on a proposed decision. With respect to any proposed NCD for an "additional preventive service," we include a summary of the USPSTF recommendations in our proposed decision memorandum. The Secretary is required to respond to the public comments when issuing a final determination. We believe that this process is open and transparent and that the public comments have improved the quality of our final decisions.

While some commenters have requested greater opportunities for public participation prior to the USPSTF recommendations, the process that the USPSTF utilizes in making its expert recommendations is beyond the scope of this rulemaking. The USPSTF, first convened by the U.S. Public Health Service in 1984, and since 1998 sponsored by the AHRQ, is an independent panel of private-sector experts in prevention and primary care that makes recommendations that are independent of the U.S. government. The USPSTF conducts impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. The mission of the USPSTF is to evaluate the benefits of individual services based on age, gender, and risk factors for disease; make recommendations about which preventive services should be incorporated routinely into primary medical care and for which populations; and identify a research agenda for

clinical preventive care. The USPSTF has partners from the fields of primary care, public health, health promotion, policy, and quality improvement. Liaisons from these groups and from Federal health agencies, including CMS, contribute their expertise in the peer review of draft USPSTF documents and help disseminate the work of the USPSTF to their members.

After consideration of the public comments we received, we are finalizing our proposed definition of preventive services. Specifically, preventive services include the IPPE; the AWV; pneumococcal, influenza, and hepatitis B vaccine and administration; screening mammography; screening pap smear and screening pelvic exam; prostate cancer screening tests; colorectal cancer screening tests; outpatient diabetes self-management training (DSMT); bone mass measurement; screening for glaucoma; medical nutrition therapy (MNT) services; cardiovascular screening blood tests; diabetes screening tests; ultrasound screening for abdominal aortic aneurysm (AAA); and additional preventive services identified for coverage through the NCD process. To date, two items or services have been added as "additional preventive services" by NCDs. These services are HIV screening for at risk individuals and smoking and tobacco cessation counseling for asymptomatic individuals.

We are adopting the proposed definition of "preventive services" in §410.2 to implement the provisions of section 1861(ddd)(3) of the Act (as added by section 4104 of the ACA), with modification of §410.2(3) to read "Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS) (as specified by section 1861(hhh)(1) of the Act)" to utilize wording that is consistent with final §410.15, Annual

Wellness Visits Providing Personalized Prevention Plan Services: Conditions for and Limitations on Coverage.

Furthermore, in this final rule with comment period, we are making a technical revision to §410.64 (Additional Preventive Services) to conform with section 1861(ddd)(1) of the Act, as amended by section 4104 of the ACA. We are revising §410.64(a) by removing the words "not otherwise described in this subpart" and adding the words "not described in subparagraphs (1) or (3) of §410.2 of this subpart" in their place. This change reflects section 1861(ddd)(1) of the Act (as amended by section 4104(a)(2) of the ACA).

2. Deductible and Coinsurance for Preventive Services

Section 4104(b)(4) of the ACA amended section 1833(a)(1) of the Act by requiring 100 percent Medicare payment for the IPPE and for those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual. In other words, this provision waived any coinsurance that would otherwise be applicable under section 1833(a)(1) of the Act for the IPPE and for those items and services listed in section 1861(ww)(2) of the Act (excluding electrocardiograms) to which the USPSTF has given a grade of A or B recommendation. In addition, section 4103(c)(1) of the ACA amended section 1833(a)(1) of the Act to waive the coinsurance for the AWV. The coinsurance represents the beneficiary's share of the payment to the provider or supplier for furnished services. Coinsurance generally refers to a percentage (for example, 20 percent) of the Medicare payment rate for which the beneficiary is liable and is applicable under the PFS, while copayment generally

refers to an established amount that the beneficiary must pay that is not necessarily related to a particular percentage of the Medicare payment, and is applicable under the OPPS. We refer readers to the CY 2011 OPPS/ASC final rule with comment period for provisions related to payment for preventive services, including waiver of the deductible and copayment, under the OPPS.

Section 4104(c) of the ACA amended section 1833(b)(1) of the Act to waive the Part B deductible for preventive services described in subparagraph (A) of section 1861(ddd)(3) of the Act that have a grade of A or B recommendation from the USPSTF for any indication or population and are appropriate for the individual. In addition, section 1833(b)(1) of the Act (as amended by section 4103(c)(4) of the ACA) waived the Part B deductible for the AWV including personalized prevention plan services. These provisions are effective for services furnished on or after January 1, 2011. Section 101(b)(2) of the MIPPA previously amended section 1833(b) of the Act to waive the deductible for the IPPE effective January 1, 2009.

Not all preventive services described in subparagraph (A) of section 1861(ddd)(3) of the Act are recommended by the USPSTF with a grade of A or B and, therefore, some of the preventive services do not meet the criteria in sections 1833(a)(1) and (b)(1) of the Act for the waiver of the deductible and coinsurance. However, with certain exceptions noted below, the changes made by section 4104 of the ACA do not affect most of the preexisting provisions in sections 1833(a) and 1833(b) of the Act (codified in regulations in §410.160(b) and §410.152) that waive the deductible and coinsurance for specific services. For example, section 1833(a)(1)(D) of the Act already waives the coinsurance and section 1833(b)(3) of the Act already waives the deductible

for clinical laboratory tests (including tests furnished for screening purposes). Section 4104 of the ACA does not change these provisions and, therefore, the waiver of both the deductible and coinsurance remain in place for all clinical laboratory tests, regardless of whether the particular clinical laboratory test meets the USPSTF grading criteria specified in sections 1833(a)(1) and 1833(b)(1) of the Act (as amended by section 4104 of the ACA) for waiver of the deductible and coinsurance as a preventive service. Similarly, both the deductible and coinsurance were already waived, prior to the ACA, for influenza and pneumococcal vaccines and their administration, and the deductible (but not the coinsurance) was already waived for screening mammography, screening pelvic exams, colorectal cancer screening procedures, ultrasound screening for abdominal aortic aneurysms, and the IPPE.

As discussed in the CY 2011 PFS proposed rule (75 FR 40130), the following preventive services listed in section 1833(ddd)(3)(A) of the Act (as added by section 4104 of the ACA) are not recommended by the USPSTF with a grade of A or B for any indication or population: digital rectal examination furnished as a prostate cancer screening service; glaucoma screening; DSMT services; and barium enema furnished as a colorectal cancer screening service.

Specifically, HCPCS code G0102 (Prostate cancer screening; digital rectal exam), which does not have a grade of A or B from the USPSTF for any indication or population, will continue to be subject to the deductible and coinsurance as there is no statutory provision to the contrary. However, the deductible and coinsurance for HCPCS code G0103 (Prostate cancer screening; prostate specific antigen test (PSA)) will continue to be waived in accordance with sections 1833(a)(1)(D) and 1833(b)(3) of the

Act (applying to clinical laboratory tests), even though this service also does not have a grade of A or B from the USPSTF.

Glaucoma screening services, described by HCPCS codes G0117 (Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist) and G0118 (Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist), will continue to be subject to the deductible and coinsurance because these services are not recommended with a grade of A or B by the USPSTF for any indication or population and there is no other statutory provision to exempt them. Similarly, DSMT services are currently not rated by the USPSTF, and there is no other statutory provision to except them from applicability of the deductible and coinsurance. Therefore the deductible and coinsurance requirements will continue to apply.

Barium enemas furnished as colorectal cancer screening tests, described by HCPCS codes G0106 (Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema) and G0120 (Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema), do not have a grade of A or B from the USPSTF for any indication or population. However, the deductible does not apply to barium enemas furnished as colorectal cancer screening tests, because colorectal cancer screening tests are explicitly excluded from the deductible in section 1833(b)(8) of the Act. However, there is no specific exclusion of barium enemas from the coinsurance requirement in section 1833(b)(1) of the Act and, therefore, this requirement, as applicable, continues to apply to barium enemas. We note that the USPSTF has given a grade A recommendation to screening colonoscopy, screening flexible sigmoidoscopy,

and fecal occult blood screening tests, and that, as a result, both the deductible and coinsurance are waived for these colorectal cancer screening tests under section 4104 of the ACA.

In developing recommendations regarding preventive services for the CY 2011 PFS proposed rule, we recognized that the USPSTF may make recommendations that are specific to a clinical indication or population, at times including characteristics such as gender and age in its recommendations. In accordance with section 4014 of the ACA, we proposed to waive the deductible and coinsurance for a Medicare-covered preventive service, with no limits on the indication or population, as long as that service is recommended by the USPSTF with a grade of A or B for at least one indication and/or population. However, we noted that all existing Medicare coverage policies for such services, including any limitations based on indication or population would continue to apply. In some cases, national coverage policies may currently limit Medicare coverage based on the indication or population, consistent with the USPSTF recommendations with a grade of A or B for the indication or population. In other cases where Medicare does not explicitly noncover preventive services for a specific population or indication, we stated that we would expect that, particularly in those cases where the USPSTF recommendation grade is a D (that is, the USPSTF recommends against the service because there is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits), practitioners would only order those preventive services that are clinically appropriate for the beneficiary. We noted that if we had concerns in the future about the appropriateness of preventive services for an indication or population in light of the USPSTF's recommendations, we may consider using our authority under

section 1834(n)(1) of the Act (as added by section 4105 of the ACA) to modify Medicare coverage of any preventive service to be consistent with the recommendations of the USPSTF.

We note also that the USPSTF ceased to make recommendations with regard to vaccines and vaccine administration after CY 1996, so as not to conflict with the recommendations of the CDC's ACIP. However, the USPSTF's most recent vaccine recommendations gave a grade of B to influenza and pneumococcal vaccines and their administration and a grade of A to hepatitis B vaccine and its administration. While sections 1833(a)(1) and 1833(b)(1) of the Act (as amended by section 4104 of the ACA) require that a preventive service receive a grade A or B recommendation from the USPSTF for the coinsurance and deductible to be waived, the statute does not specify that the recommended grade must be furnished by the USPSTF within any given timeframe. The USPSTF grades from 1996 for these vaccination services are the most current USPSTF grades and have never been withdrawn. Therefore, we believe that these preventive services meet the requirements of the statute for the waiver of the deductible and coinsurance. We also noted that the CDC's ACIP currently recommends influenza, pneumococcal, and hepatitis B vaccines.

We proposed to update §410.160(b), which lists the services for which expenses incurred are not subject to the Part B annual deductible and do not count toward meeting that deductible. Specifically, we proposed to revise §410.160(b)(2) to include influenza and hepatitis B vaccines and their administration, in addition to pneumococcal vaccine and its administration. In addition, in §410.160(b), we also proposed to add exceptions for bone mass measurement, MNT services, and the AWV.

In §410.152, we proposed to revise paragraph (l) to establish the amount of payment under the applicable payment system for providers and suppliers of the services listed in paragraph (1). Table 38 of the CY 2011 PFS proposed rule (75 FR 40131 through 40135) identified the HCPCS codes that we proposed to identify as "preventive services," in addition to the IPPE and the AWV, as well as the most recent USPSTF grade, if any, that was the basis for our policy with regard to waiver of the deductible and coinsurance. Table 38 also identified the Medicare payment system under which the HCPCS code would be paid when furnished outside of the facility setting.

Comment: Many commenters supported CMS' proposal to waive the deductible and coinsurance for those Medicare-covered preventive services with a grade A or B USPSTF recommendation for any indication or population, as well as for the IPPE and the AWV. The commenters acknowledged that CMS did not propose to modify current Medicare policy that may cover a preventive service only under specific circumstances. The commenters supported CMS' proposal to rely on practitioners' clinical judgment to order preventive services that are clinically appropriate for specific beneficiaries. Many commenters noted that CMS' "quick implementation" of this provision underscores the agency's commitment to removing barriers to preventive health care.

A few commenters expressed concern regarding how CMS may incorporate USPSTF recommendations into the Medicare benefit structure in the future and cautioned CMS not to adopt policies that would result in Medicare not covering important preventive services for an older population. For example, the USPSTF recommendations for mammography in women do not apply to individuals age 75 or older, and the commenters were concerned that future changes to CMS policies could result in

Medicare not covering important preventive services for an older population.

Response: We appreciate the commenters' support for our proposal to waive the beneficiary deductible and coinsurance for most preventive services beginning in CY 2011. We continue to believe that is appropriate to waive the beneficiary deductible and coinsurance for preventive services with a grade A or B recommendation by the USPSTF for any indication or population, if Medicare covers the particular service under Part B. However, we reiterate that if we develop concerns in the future about the appropriateness of preventive services for an indication or population in light of the USPSTF's recommendations, we may consider using our authority under section 1834(n)(1) of the Act (as added by section 4105 of the ACA) to modify Medicare coverage of any preventive service to be consistent with the recommendations of the USPSTF.

Comment: Several commenters expressed concern over the USPSTF rating of I for glaucoma screening [An "I" rating means that the USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined]. Others were concerned about the rating of D for prostate cancer screening [A "D" rating means that the USPSTF recommends against the service. There is moderate or high certainly that the service has no net benefit or that the harms outweigh the benefits]. Other commenters noted the lack of a specific USPSTF rating for DSMT services. The commenters argued that because these services were covered by Medicare as preventive services, the beneficiary cost-sharing should be waived to ensure access to these services.

Response: Glaucoma screening, digital prostrate screening, and DSMT services are covered by Medicare under Part B and are specific categories of "preventive services" included in section 1861(ddd)(3)(A) of the Act (as added by section 4014 of the ACA). However, as these services do not have a USPSTF grade A or B recommendation, the deductible and coinsurance cannot be waived. Thus, the coinsurance and deductible will continue to apply to these services when they are furnished to a Medicare beneficiary.

Comment: Some commenters were concerned that ultrasound screening for abdominal aortic aneurysm (AAA), while a preventive service covered by Medicare and with a grade B recommendation from the USPSTF, would continue to require a physician referral in order for the preventive service to be furnished and for the waiver of cost-sharing to apply. Furthermore, the commenters objected to the current requirement that coverage of ultrasound screening for AAA relies upon a referral as a result of the IPPE because the IPPE is only available to beneficiaries during their first 12 months of Part B enrollment.

Response: Ultrasound screening for AAA is a preventive service covered by Medicare, with certain restrictions set forth in §410.19 of our regulations. Because this service has a grade B recommendation from the USPSTF, the deductible and coinsurance will be waived beginning in CY 2011 for covered services. While we appreciate the commenters' concerns regarding the existing requirements for ultrasound screening for AAA, the current requirement for a referral as a result of the IPPE is required by section 1861(s)(2)(AA) of the Act and continues to apply.

Comment: In the context of many commenters' recommendations to add new preventive services for coverage under Part B as "additional preventive services," most

commenters also recommended that the beneficiary cost-sharing for these services be waived. The services addressed by the commenters included services with current grade A or B USPSTF recommendations, those with other grade USPSTF recommendations, those that have never been reviewed by the USPSTF, those with recommendations from other advisory organizations but the USPSTF, and other vaccines for which the USPSTF no longer makes recommendations.

Response: As discussed earlier in this section, the statute permits us to add "additional preventive services" to Medicare coverage only if those services have a grade A or B recommendation from the USPSTF. Other grade USPSTF recommendations or recommendations from other advisory groups, including the ACIP, cannot substitute for the grade A or B USPSTF recommendation. In the event that we add "additional preventive services" in the future, as we have HIV screening for at risk individuals and smoking and tobacco cessation counseling for asymptomatic individuals in CY 2010, the Medicare deductible and coinsurance will be waived for those services.

Comment: One commenter expressed concern that CMS was limiting the waiver of beneficiary cost-sharing to only those vaccines covered under Medicare Part B. The commenter contended that the ACIP recommends vaccines that are covered under Medicare Part D, and not Part B, and therefore not subject to the waiver.

Response: We recognize that many preventive vaccines such as herpes zoster and hepatitis A are covered for beneficiaries under Medicare Part D and the commenter is correct that Medicare Part D is not included in section 1861(ddd) of the Act (as amended by section 4104 of the ACA). Section 1861 (ddd)(1)(C) of the Act limits "additional preventive services" to those appropriate for individuals entitled to benefits under

Medicare Part A or enrolled under Medicare Part B only. In addition, the statute only permits expansions if the item or services based on a grade of A or B recommendation by the USPSTF

Comment: Several commenters appreciated the clarity of Table 38 in the CY 2011PFS proposed rule (75 FR 40131 through 40135), and requested that a table such as this be made available on the CMS Web site that reflects CMS' final policies regarding preventive services and beneficiary cost-sharing on a HCPCS code-specific basis. Other commenters requested additional provider and beneficiary educational materials to clarify preventive services benefits under Medicare, to identify which preventive services would continue to be subject to beneficiary cost-sharing, and to specify which preventive services would meet the requirements for the waiver of deductible and coinsurance where Medicare would make 100 percent payment.

Response: We are in the process of developing educational materials that will reflect and communicate to beneficiaries and providers the CY 2011 changes to beneficiary cost-sharing for preventive services under Medicare. We agree with the commenters that it is critical to effectively educate beneficiaries and providers about the preventive services covered by Medicare and specifically those services that will be paid at 100 percent by Medicare beginning in CY 2011 to help expand access to these important services. MLN Matters articles, quick reference guides, and the Medicare and You Handbook will all be developed and/or updated to reflect the provisions of the ACA and are examples of some the provider and beneficiary educational materials that will be available. We appreciate the recommendations of the commenters regarding the format

for specific information that we could make available on the CMS web site, and we will keep these suggestions in mind as we further refine our educational strategy.

After consideration of the public comments we received, we are finalizing our proposal to waive the deductible and coinsurance for most preventive services, and for the IPPE and the AWV, beginning in CY 2011.

Table 65 displays the HCPCS codes that we are finalizing as "preventive services" under section 1861(ddd)(3)(A) of the Act (as added by section 4014 of the ACA) and identifies the HCPCS codes for the IPPE and the AWV. Table 65 also indicates the most recent USPSTF grade, if any, that is the basis for our policy with regard to waiver of the deductible and coinsurance, as applicable, and the Medicare payment system under which the HCPCS code would be paid when furnished outside of the facility setting.

Since the publication of the CY 2011 PFS proposed rule, final Level II HCPCS codes have been assigned for the AWV, as well as the "additional preventive services" for HIV screening for at risk individuals and smoking and tobacco cessation counseling for asymptomatic individuals. Therefore, these services and their associated Level II HCPCS codes are all displayed in Table 65. In addition, beginning in CY 2011, Medicare will no longer recognize CPT code 90658 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use) but, instead will use 5 new HCPCS Q codes to report influenza vaccines that would otherwise have been reported under CPT code 90658. Therefore, these HCPCS Q-codes are included in Table 65, and they will be recognized as of January 1, 2011. CPT code 90658 is no longer displayed in the table. Finally, it has come to our attention since

publication of the CY 2011 PFS proposed rule that CPT code 86689 (HTLV or HIV antibody, confirmatory test (eg, Western Blot)) describes a diagnostic test, not specifically an HIV screening test that would be reported for a screening service that is covered by Medicare, and, therefore, this CPT is not included in Table 65.

We are adopting proposed §410.152 to specify the amounts of payment, with modification of (13) to read "Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS)" and proposed §410.160 to specify exclusion from the Part B annual deductible, with modification of (12) to read "Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS)." These modifications utilize wording that is consistent with final §410.15, Annual Wellness Visits Providing Personalized Prevention Plan Services: Conditions for and Limitations on Coverage.

Section 10501(i)(2) of the ACA amended the definition of Federally Qualified Health Center (FQHC) services as defined in section 1861(aa)(3)(A) of the Act by replacing the specific references to services provided under section 1861(qq) and (vv) of the Act (diabetes outpatient self-management training services and medical nutrition therapy services, respectively) with preventive services as defined in section 1861(ddd)(3) of the Act, as established by section 4014(a)(3) of the ACA. These changes are effective for services provided on or after January 1, 2011. Accordingly, we are proposing to conform the regulations to the new statutory requirement by adding a new section §405.2449 which would add the new preventive services definition to the definition of FQHC services effective for services provided on or after January 1, 2011.

Section 1861(ddd)(3) of the Act defines "preventive services" as consisting of the following three components:

- Screening and preventive services described in section 1861(ww)(2) of the Act (other than electrocardiograms described in subparagraph (M) of that subsection).

- An initial preventive physical examination, as defined in section 1861(ww) of the Act.

- Personalized prevention plan services as defined in section 1861(hhh)(1) of the Act.

We proposed to add each of these three components into the new Medicare FQHC preventive services definition in a new §405.2449.

Section 4104(b) of the ACA, as amended by section 10406 of the ACA, waives coinsurance for preventive services by adding section 1833(a)(1)(Y) to the Act to require waiver of coinsurance for preventive services that are recommended with a grade of A or B by the USPSTF for any indication or population. This provision is specifically designed to remove barriers to affording and obtaining such preventive services under Medicare.

In addition, section 10501(i)(3)(B)(ii) of the ACA added section 1833(a)(1)(Z) to the Act to require a 20 percent coinsurance on all FQHC services after implementation of the FQHC prospective payment system. We believe we can give both section 1833(a)(1)(Y) and (Z) of the Act, and the definition of FQHC services (revised to include the broader scope of preventive services) their best effect by providing Medicare payment at 100 percent for preventive services as defined at section 1861 (ddd)(3) of Act, effective January 1, 2011.

Section 1833(b)(4) of the Act stipulates that the Medicare Part B deductible shall not apply to FQHC services. The ACA makes no change to this provision; therefore

Medicare will continue to waive the Part B deductible for all FQHC services, including preventive services added by the ACA.

We received a number of public comments on the addition of preventive services to the Medicare FQHC benefit. These comments included questions regarding how these benefits are paid and clarification on the waiver of coinsurance on these benefits in the Medicare FQHC setting. The comments are addressed individually below.

Comment: One commenter indicated that prior to enactment of the ACA, many health centers provided added preventive services as part of the primary and preventive care offered at the center. Yet when provided to Medicare beneficiaries, they received no additional reimbursement. The commenter noted that since the inception of the Medicare FQHC benefit in 1992, Medicare added thirteen new services to its coverage, yet those services have not been included as FQHC services, except for diabetes self management training and medical nutrition therapy which were added by the Deficit Reduction Act.

Response: We recognize that prior to enactment of the ACA, many FQHCs may have provided some or all of the same preventive services since added to the Medicare FQHC benefit package by the ACA. We also agree that many new preventive services have been added to Medicare since 1992, and except for diabetes self management training and medical nutrition therapy, which were added by the Deficit Reduction Act of 2005, these services had not been specifically added to the Medicare FQHC benefit package under the law. We believe the addition of these preventive services to the Medicare FQHC benefit through provisions in the ACA, along with the waiver of beneficiary cost sharing for these services in the Medicare FQHC setting, eliminates both prior statutory restrictions from Medicare coverage in the FQHC setting as well as

potential financial barriers beneficiaries might otherwise face in obtaining these services.

Comment: One commenter requested further clarification in both this preamble and the final regulation text at §405.2449 on the application of the waiver of coinsurance in the FQHC setting and CMS' statement that it will allow 100 percent reimbursement for these preventive services. The commenter stated that health centers are reimbursed 100 percent of their costs for the provision of influenza, pneumococcal, and Hepatitis B vaccinations, in accordance with Section 1861(s)(10)(A) of the Act. The commenter further noted that this reimbursement is done separately and outside the Medicare FQHC upper payment limit. The commenter asserted that the payment limit negatively impacts an overwhelming majority of health centers, and therefore encouraged CMS to use a similar method to determine the reimbursement for these new FQHC preventive services. The commenter further asserted that using a similar method to determine reimbursement would allow for health centers to provide more comprehensive preventive care to their patients, alleviate the financial restrictions faced by health centers in providing these critical services, and would be in the best interests of CMS, health centers, and their patients. Finally, the commenter noted that because the list of new preventive services includes the provision of influenza, pneumococcal and hepatitis B vaccinations, CMS must ensure that health centers do not lose their current reimbursement structure for these services.

Response: No coinsurance will be imposed upon ACA-added preventive services in Medicare FQHCs. Accordingly, final settlement with FQHCs will reflect the policy that no coinsurance amounts will be subtracted from the reasonable cost of ACA-added preventive benefits. Final settlement is determined on the basis of the Medicare cost

report, the CMS-222-92. We made no proposal to exempt ACA-added preventive services from tests of reasonableness such as the Medicare FQHC upper payment limits. Further, we do not agree that CMS should use the same methodology presently employed to pay FQHCs for influenza and pneumococcal vaccinations (see discussion of Hepatitis B vaccinations below) to pay for new Medicare FQHC preventive services added by the ACA. We believe the average cost per-visit payment methodology, which is the general payment methodology employed by Medicare to pay for Medicare FQHC services, was implicit in the proposal as we proposed no changes to Medicare FQHC payment regulations to implement this new preventive services addition. In addition, we believe the general payment methodology for Medicare FQHCs, which is based on an all-inclusive-cost-per-visit, is better suited and most appropriate for payment of new preventive services such as the annual wellness visit. It is our belief that the Medicare FQHC per-visit upper payment limits ($126.10 urban and $109.14 rural in CY 2011) remain reasonable and adequate not only for existing Medicare FQHC services but also for new preventive services as well. Accordingly, we cannot accept the comment to exclude new preventive services from the Medicare FQHC upper payment limits. The Medicare FQHC upper payment limits and the general per-visit payment methodology employed to pay for Medicare FQHC services will apply to new Medicare FQHC preventive services.

While we clarify the waiver of coinsurance and application of Medicare FQHC payment methodology and upper payment limits to new preventive services in this preamble, we cannot accept the comment to provide further clarification within the final regulation text at §405.2449. Section 405.2449 is placed within Medicare FQHC

regulations which pertain to the description of Medicare FQHC services and not payment. We made no proposal to change payment and accordingly make no changes to Medicare FQHC payment regulations.

Finally, we note that we did not propose, nor are we making any changes to, how influenza, pneumococcal and hepatitis B vaccinations are paid in Medicare FQHCs. Accordingly, health centers will not lose their current reimbursement structure for these services. We agree that health centers are reimbursed 100 percent of their costs for the provision of influenza and pneumococcal vaccinations. We further agree that payment for influenza and pneumococcal vaccinations in Medicare FQHCs is done separately and outside the Medicare FQHC upper payment limit. However, we note for clarification purposes that prior to the effective date of the ACA provisions adding new preventive services to the Medicare FQHC benefit, the waiver of Part B coinsurance did not extend to Hepatitis B vaccinations. Hepatitis B vaccinations were covered in Medicare FQHCs in accordance with Section 1861(aa)(3)(A) of the Act which through reference to section 1861(aa)(1)(A) of the Act included all section 1861(s)(10) of the Act services including section 1861(s)(10)(B) of the Act, Hepatitis B vaccinations. The waiver of the 20 percent Medicare Part B coinsurance in Section 1833(a)(3)(A) of the Act extended only to Section 1861(s)(10)(A) of the Act services and not to section 1861(s)(10)(B) of the Act Hepatitis B vaccinations. To summarize this clarification, prior to the effective date of the ACA provisions adding new preventive services to the Medicare FQHC benefit, the waiver of Medicare Part B coinsurance did not extend to Section 1861(s)(10)(B) of the Act Hepatitis B vaccinations, hence these services were subject to Medicare Part B coinsurance and paid at 80 percent (not 100 percent) of reasonable costs in accordance

with the provisions in section 1833(a)(3) of the Act. Effective with implementation of ACA provisions on January 1, 2011, Part B coinsurance on Hepatitis B vaccinations is waived as they are now included in the definition of "preventive services' in section 1861(ddd)(3)(A) of the Act as cross-referenced to section 1861(ww)(2) of the Act.

Consistent with our response to public comment above, and in conformance with the preventive services definition in section 1861(ddd)(3) of the Act, we are finalizing this new Medicare FQHC preventive services provision without modification. We will conform the regulations to the new statutory requirements by adding a new section §405.2449, adding the new preventive services definition to the definition of FQHC services effective for services provided on or after January 1, 2011

TABLE 65: CY 2011 Deductible and Coinsurance for Preventive Services Under Section 1861(ddd)(3)(A) of the Act (Includes the IPPE and the Annual Wellness Visit)

Preventive Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	Payment Method	CY 2010 Coinsurance/Deductible	CY 2011 Coinsurance/Deductible
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	***Not Rated**	PFS	Coinsurance applies & deductible is waived	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		PFS	Not Waived	Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		PFS	Not Waived	Not Waived
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		PFS	Not Waived	Not Waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	B	PFS	Coinsurance applies & deductible is waived	WAIVED

Preventive Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	Payment Method	CY 2010 Coinsurance/Deductible	CY 2011 Coinsurance/Deductible
Cardiovascular Disease Screening	80061	Lipid panel	A	CLFS	WAIVED	WAIVED
	82465	Cholesterol, serum or whole blood, total		CLFS	WAIVED	WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		CLFS	WAIVED	WAIVED
	84478	Triglycerides		CLFS	WAIVED	WAIVED
Diabetes Screening Tests	82947	Glucose; quantitative, blood (except reagent strip)	B	CLFS	WAIVED	WAIVED
	82950	Glucose; post glucose dose (includes glucose)		CLFS	WAIVED	WAIVED
	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	***Not Rated**	CLFS	WAIVED	WAIVED
Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	***Not Rated**	PFS	Not Waived	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		PFS	Not Waived	Not Waived
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	B	PFS	Not Waived	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		PFS	Not Waived	WAIVED
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		PFS	Not Waived	WAIVED

Preventive Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	Payment Method	CY 2010 Coinsurance/Deductible	CY 2011 Coinsurance/Deductible
	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	B	PFS	Not Waived	WAIVED
	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		PFS	Not Waived	WAIVED
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	A	CLFS	WAIVED	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		PFS	Coinsurance applies & deductible is waived	WAIVED

Preventive Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	Payment Method	CY 2010 Coinsurance/Deductible	CY 2011 Coinsurance/Deductible
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	A	PFS	Coinsurance applies & deductible is waived	WAIVED
	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	A	CLFS	WAIVED	WAIVED
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	A	CLFS	WAIVED	WAIVED
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	A	CLFS	WAIVED	WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	A	CLFS	WAIVED	WAIVED
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	A	CLFS	WAIVED	WAIVED

Preventive Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	Payment Method	CY 2010 Coinsurance/Deductible	CY 2011 Coinsurance/Deductible
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		CLFS	WAIVED	WAIVED
	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		PFS	Coinsurance applies & deductible is waived	WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		PFS	Coinsurance applies & deductible is waived	WAIVED
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	A	PFS	Coinsurance applies & deductible is waived	WAIVED
Screening Mammography	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	B	PFS	Coinsurance applies & deductible is waived	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)		PFS	Coinsurance applies & deductible is waived	WAIVED
	G0202	Screening mammography, producing direct digital image, bilateral, all views			Coinsurance applies & deductible is waived	WAIVED

Preventive Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	Payment Method	CY 2010 Coinsurance/Deductible	CY 2011 Coinsurance/Deductible
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	B	PFS	Not Waived	WAIVED
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)		PFS	Not Waived	WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)		PFS	Not Waived	WAIVED
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)		PFS	Not Waived	WAIVED
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)		PFS	Not Waived	WAIVED
	77083	Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites		PFS	Not Waived	WAIVED
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	B	PFS	Not Waived	WAIVED
Colorectal Cancer	G0104	Colorectal cancer screening; flexible sigmoidoscopy	A	PFS	Coinsurance applies & deductible is waived	WAIVED

Preventive Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	Payment Method	CY 2010 Coinsurance/Deductible	CY 2011 Coinsurance/Deductible
Screening	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		PFS	Coinsurance applies & deductible is waived	WAIVED
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	***Not Rated**	PFS	Coinsurance applies & deductible is waived	Coinsurance applies & deductible is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		PFS	Coinsurance applies & deductible is waived	Coins. Applies &ded. is waived
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	A	PFS	Coinsurance applies & deductible is waived	WAIVED
	82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive		CLFS	WAIVED	WAIVED
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		CLFS	Coinsurance applies & deductible is waived	WAIVED
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	D	PFS	Not Waived	Not Waived
	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		CLFS	WAIVED	WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	I	PFS	Not Waived	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		PFS	Not Waived	Not Waived
Influenza Virus Vaccine	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	B	Drug Pricing File	WAIVED	WAIVED

Preventive Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	Payment Method	CY 2010 Coinsurance/Deductible	CY 2011 Coinsurance/Deductible
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		Drug Pricing File	WAIVED	WAIVED
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use		Drug Pricing File	WAIVED	WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		Drug Pricing File	WAIVED	WAIVED
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		Drug Pricing File	WAIVED	WAIVED
	Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria)		Drug Pricing File	WAIVED	WAIVED
	Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval)		Drug Pricing File	WAIVED	WAIVED
	Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin)		Drug Pricing File	WAIVED	WAIVED
	Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone)		Drug Pricing File	WAIVED	WAIVED

Preventive Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	Payment Method	CY 2010 Coinsurance/Deductible	CY 2011 Coinsurance/Deductible
	Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)		Drug Pricing File	WAIVED	WAIVED
	G0008	Administration of influenza virus vaccine		PFS	WAIVED	WAIVED
	G9141	Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)		PFS	WAIVED	WAIVED
	G9142	Influenza A (H1N1) vaccine, any route of administration		Drug Pricing File (if not supplied at no cost)	WAIVED	WAIVED
Pneumococcal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	B	Drug Pricing File	WAIVED	WAIVED
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use.		Drug Pricing File	WAIVED	WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		Drug Pricing File	WAIVED	WAIVED
	G0009	Administration of pneumococcal vaccine		PFS	WAIVED	WAIVED
Hepatitis B Vaccine	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	A	Drug Pricing File	Not Waived	WAIVED

Preventive Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	Payment Method	CY 2010 Coinsurance/Deductible	CY 2011 Coinsurance/Deductible
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		Drug Pricing File	Not Waived	WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		Drug Pricing File	Not Waived	WAIVED
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		Drug Pricing File	Not Waived	WAIVED
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		Drug Pricing File	Not Waived	WAIVED
	G0010	Administration of hepatitis B vaccine	A	PFS	Not Waived	WAIVED
HIV Screening	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple-step method, HIV-1 or HIV-2, screening	A	CLFS	WAIVED	WAIVED
	G0433	Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		CLFS	WAIVED	WAIVED
	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2 , screening		CLFS	WAIVED	WAIVED

Preventive Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	Payment Method	CY 2010 Coinsurance/Deductible	CY 2011 Coinsurance/Deductible
Smoking and Tobacco Cessation	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	A	PFS	N/A	WAIVED
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes		PFS	N/A	WAIVED
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	*****Not Rated	PFS	N/A	WAIVED
	G0439	Annual wellness visit, including PPPS, subsequent visit		PFS	N/A	WAIVED

[1] U.S. Preventive Services Task Force Recommendations:

A -- The USPSTF recommends the service. There is high certainty that the net benefit is substantial.

B -- The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

C -- The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.

The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.

I -- The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

3. Extension of Waiver of Deductible to Services Furnished in Connection With or in Relation to a Colorectal Cancer Screening Test that Becomes Diagnostic or Therapeutic

Section 4104(c) of the ACA amended section 1833(b) of the Act to waive the Part B deductible for colorectal cancer screening tests that become diagnostic. Specifically, section 1833(b)(1) of the Act (as amended by section 4104(c)(2) of the ACA) waived the deductible with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test. We proposed that all surgical services furnished on the same date as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema be considered to be furnished in connection with, as a result of, and in the same clinical encounter as the screening test. In the event of a legislative change to this policy (for example, a statutory change that would waive the coinsurance for these related services in addition to the deductible), we would reassess the appropriateness of this proposed definition of services that are furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test that becomes diagnostic. We also noted that the beneficiary's annual deductible would likely be met when any surgical procedure (related or not) is furnished on the same day as the scheduled screening test.

We proposed to implement this provision by creating a HCPCS modifier that providers and practitioners would append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a

diagnostic service. The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. We proposed that coinsurance would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

Comment: Many commenters expressed support for CMS' proposal to waive the deductible in cases where a screening colonoscopy for colorectal cancer becomes diagnostic. The commenters believe that the proposal to waive the Medicare deductible for any surgical service performed on the same day and in the same clinical encounter as a screening colonoscopy if the service is appended with a modifier is a sound approach to implementing the policy.

However, a few commenters requested that CMS also waive the coinsurance for a procedure that was a planned colorectal cancer screening test, regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, or as a result of, and in the same clinical encounter as a screening test. The commenters were concerned that beneficiaries may refrain from undergoing a covered colorectal cancer screening test if coinsurance could apply to a resulting diagnostic test and other services furnished in the same encounter as the planned colorectal cancer screening test. As an alternative, several commenters recommend that CMS not apply a coinsurance requirement to the part of the procedure that is screening in nature.

Response: We appreciate the commenters' support for our proposal, including the proposed administrative requirements for practitioners and providers to identify the

circumstances under which the waiver of the deducible would apply. As stated above, section 1833(b)(1) of the Act (as amended by section 4104(c)(2) of the ACA) waived the Part B deductible for colorectal cancer screening tests that become diagnostic. The statute does not currently permit waiver of coinsurance for these circumstances as the 20 percent coinsurance applies to all service furnished under the PFS unless there is a specific statutory exception. We believe that a statutory change would be necessary in order to waive the coinsurance for these related services, in addition to the waiver of the deductible.

In response to those commenters who suggested, as an alternative, that we identify the screening portion of the diagnostic test in order to waive the coinsurance for only that portion, we are unable to identify a portion of a diagnostic test that is "screening" because a HCPCS code for a diagnostic test would be reported and, therefore, we would consider the whole test to be diagnostic in nature.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to waive the deductible for colorectal cancer screening tests that become diagnostic. Providers and practitioners would append new HCPCS modifier -PT (Colorectal cancer screening test, converted to diagnostic test or other procedure) to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service. The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance would continue to apply to the diagnostic test

and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

S. Section 5501: Expanding Access to Primary Care Services and General Surgery Services

1. Section 5501(a): Incentive Payment Program for Primary Care Services

a. Background

Section 5501(a) of the ACA revised section 1833 of the Act by adding a new paragraph (x), "Incentive Payments for Primary Care Services." Section 1833(x) of the Act states that in the case of primary care services, furnished on or after January 1, 2011 and before January 1, 2016 by a primary care practitioner, there shall also be paid on a monthly or quarterly basis an amount equal to 10 percent of the payment amount for such services under Part B.

Section 1833(x)(2)(A) of the Act (as added by section 5501(a) of the ACA) defines a primary care practitioner as: (1) a physician, as described in section 1861(r)(1) of the Act, who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or (2) a nurse practitioner, clinical nurse specialist, or physician assistant as defined in section 1861(aa)(5) of the Act, and in all cases, for whom primary care services accounted for at least 60 percent of the allowed charges under Part B for the practitioner in a prior period as determined appropriate by the Secretary.

Section 1833(x)(2)(B) of the Act (as added by section 5501(a)(2)(B) of the ACA) defines primary care services as those services identified by the following HCPCS codes as of January 1, 2009 (and as subsequently modified by the Secretary, as applicable):

● 99201 through 99215 for new and established patient office or other outpatient E/M visits;

● 99304 through 99340 for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home (eg, boarding home), or custodial care E/M services; and domiciliary, rest home (eg, assisted living facility), or home care plan oversight services; and

● 99341 through 99350 for new and established patient home E/M visits.

These codes are displayed in Table 66. All of these codes remain active in CY 2011 and there are no other codes used to describe these services.

TABLE 66: Primary Care Services Eligible for Primary Care Incentive Payments in CY 2011

CPT Code	Description
99201	Level 1 new patient office or other outpatient visit
99202	Level 2 new patient office or other outpatient visit
99203	Level 3 new patient office or other outpatient visit
99204	Level 4 new patient office or other outpatient visit
99205	Level 5 new patient office or other outpatient visit
99211	Level 1 established patient office or other outpatient visit
99212	Level 2 established patient office or other outpatient visit
99213	Level 3 established patient office or other outpatient visit
99214	Level 4 established patient office or other outpatient visit
99215	Level 5 established patient office or other outpatient visit
99304	Level 1 initial nursing facility care
99305	Level 2 initial nursing facility care
99306	Level 3 initial nursing facility care
99307	Level 1 subsequent nursing facility care
99308	Level 2 subsequent nursing facility care
99309	Level 3 subsequent nursing facility care
99310	Level 4 subsequent nursing facility care
99315	Nursing facility discharge day management; 30 minutes
99316	Nursing facility discharge day management; more than 30 minutes
99318	Other nursing facility services; evaluation and management of a patient involving an annual nursing facility assessment.

CPT Code	Description
99324	Level 1 new patient domiciliary, rest home, or custodial care visit
99325	Level 2 new patient domiciliary, rest home, or custodial care visit
99326	Level 3 new patient domiciliary, rest home, or custodial care visit f
99327	Level 4 new patient domiciliary, rest home, or custodial care visit
99328	Level 5 new patient domiciliary, rest home, or custodial care visit
99334	Level 1 established patient domiciliary, rest home, or custodial care visit
99335	Level 2 established patient domiciliary, rest home, or custodial care visit
99336	Level 3 established patient domiciliary, rest home, or custodial care visit
99337	Level 4 established patient domiciliary, rest home, or custodial care visit
99339	Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes
99340	Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes or more
99341	Level 1 new patient home visit
99342	Level 2 new patient home visit
99343	Level 3 new patient home visit
99344	Level 4 new patient home visit
99345	Level 5 new patient home visit
99347	Level 1 established patient home visit
99348	Level 2 established patient home visit
99349	Level 3 established patient home visit
99350	Level 4 established patient home visit

b. Primary Care Incentive Payment Program (PCIP)

(1) Primary Specialty Designation

For primary care services furnished on or after January 1, 2011 and before January 1, 2016, we proposed to provide a 10 percent incentive payment to primary care practitioners, identified as the following: (1) in the case of physicians, enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics; or (2) in the case of nonphysician practitioners (NPPs), enrolled in Medicare with a primary care specialty designation of 50-nurse

practitioner, 89-certified clinical nurse specialist, or 97-physician assistant; and (3) for whom the primary care services displayed in Table 66 accounted for at least 60 percent of the allowed charges under Part B for such practitioner during the time period that is specified by the Secretary, and proposed in this section. Hereinafter, we refer to practitioners with these primary Medicare specialty designations as potential primary care practitioners and the potential primary care practitioner's ratio of primary care allowed charges to allowed charges under Part B (multiplied by 100) as the primary care percentage.

Comment: Many commenters expressed support for the PCIP and general appreciation for the increased payment for primary care services. Some commenters approved of the proposed inclusion of nonphysician practitioners (NPPs) in the program, but asked for clarification on the practice settings where these practitioners may furnish PCIP-eligible services. However, several commenters disagreed with the proposed specialty limitations for the PCIP. The commenters recommended that several additional specialties be eligible for the PCIP including, but not limited to, neurology, chiropractics, infectious disease, endocrinology, and certified nurse-midwives. The commenters contended that many practitioners in these other specialties provide primary care services and have the requisite education and training, similar to the potential primary care practitioners in the designated specialties to which payment under the PCIP was proposed.

Response: We appreciate the commenters' support of the PCIP. We recognize that a variety of specialties may provide primary care services as defined broadly under the statute by the E/M codes displayed in Table 66 and, in some cases, these specialist

practitioners may truly function as "primary care practitioners" in the common use of the term (providing first contact, coordinated, continuous care for certain patients under their care). However, section 1833(x) of the Act (as added by section 5501(a) of the ACA) specifies in the definition of primary care practitioner the physician specialties that are considered as primary care for purposes of the PCIP. Under section 1833(x)(2)(A)(i)(I) of the Act, only physicians with a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine are considered potential primary care physicians. The provision does not authorize us to add other Medicare specialty designations to the definition of a primary care practitioner for purposes of the PCIP. Therefore, as proposed, we will identify physicians that have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine (along with nurse practitioners, clinical nurse specialists, and physician assistants) for further evaluation as potential primary care practitioners for purposes of the PCIP.

We note that the PCIP does not place limitations on the setting of the primary care services for which a primary care practitioner may be paid an incentive payment. However, as a practical matter, the statutorily defined primary care services to which the PCIP applies may limit the setting of the services on which a PCIP payment is based. For example, there are no inpatient hospital care E/M services on the list of primary care services for purposes of the PCIP. The PCIP payment is an amount equal to 10 percent of the payment for primary care services furnished by the primary care practitioner.

Comment: Several commenters commended CMS for proposing that the PCIP payment would be in addition to payments under other incentive programs under

Medicare, arguing that this policy is particularly important to encourage the delivery of primary care services to underserved Medicare populations. However, some commenters recommended that CMS increase the amount of PCIP payments because the commenters believe that 10 percent is an insufficient financial incentive to encourage primary care practice over specialty practice as a career path for medical and other health professional students.

Response: We appreciate the commenters' suggestions that primary care should continue to be a Medicare priority and acknowledge that payment incentives are one of many factors that may influence health professional student career choice. While we recognize the importance of encouraging primary care practice and ensuring the accessibility of primary care services, section 1833(x) of the Act (as added by section 5501(a) of the ACA) explicitly states the incentive payment amount, and does not grant authority to the Secretary to adjust the payment amount. According to this provision, primary care practitioners (those who meet the specialty designation and primary care percentage criteria) qualify for an incentive payment equaling 10 percent of the payment amount under Part B for the primary care services they furnish. Therefore, we are maintaining the PCIP incentive payment amount at 10 percent, as we proposed. The statute also specifies that the PCIP payment is to be determined without regard to any payment for the primary care service under section 1833(m) of the statute (currently, the HPSA physician bonus payment program). Therefore, we are also adopting as final our proposal to make any PCIP payment in addition to, but determined without regard to, any HPSA physician bonus payment.

(2) Primary Care Percentage Calculation

In the CY 2011 PFS proposed rule (74 FR 10137), we proposed to use the most current full year of claims data to identify primary care practitioners eligible for the PCIP for a CY based on the practitioner's primary specialty (as identified on claims) and the practitioner's primary care percentage calculated based on the primary care services displayed in Table 66. We commonly use the most recent full year of claims data for purposes of establishing annual payment amounts under a number of Medicare's fee-for-service programs. A potential primary care practitioner would be eligible for the PCIP in a CY if the practitioner's primary care percentage, calculated as the practitioner's allowed charges for primary care services (identified in Table 66) (the numerator) divided by his or total allowed charges under Part B (the denominator) and multiplied by 100, meets or exceeds the 60 percent threshold. We note that the practitioner's specialty is applied to the claim by the claims processing system and reflects the practitioner's primary specialty designation for purposes of Medicare enrollment on the date the claim is processed, which would usually be close to the date on which the service was actually furnished to the beneficiary. We would identify primary care practitioners eligible for the PCIP for a year by the individual physician/practitioner national provider identifier (NPI) number using the most current full year of claims data available.

Comment: Many commenters described problems potential primary care practitioners would likely encounter in meeting the 60 percent eligibility threshold requirement for the PCIP. The commenters pointed to a few reasons why a potential primary care practitioner's primary care percentage may not meet the 60 percent threshold. Most commenters believe that the denominator in the primary care percentage calculation, or "allowed charges under Part B" as CMS proposed, was too broad, and

would limit the number of potential primary care practitioners who would qualify for the PCIP. For example, the commenters speculated that under the proposed threshold calculation, more than one-third of family practitioners and more than 60 percent of general internists would not qualify for the PCIP. Generally, the commenters requested that CMS interpret the phrase "allowed charges under this part" in section 1833(x) of the Act (as added by section 5501(a)(2)(A)(ii) of the ACA) more narrowly to decrease the denominator in the primary care percentage calculation and thereby increase the number of potential primary care practitioners who would qualify for the PCIP.

Several commenters, including MedPAC, recommended that CMS use only the total allowed charges under the PFS, rather than all charges under Part B, as the denominator in the potential primary care practitioner's primary care percentage calculation. The commenters argued that a potential primary care practitioner's billings under his or her NPI for Part B services not paid under the PFS (including laboratory services, drugs, and durable medical equipment (DME)) would depend upon the organizational structure of the potential primary care practitioner's practice and, therefore, would be unrelated to whether the practitioner was serving as a "true primary care practitioner" for Medicare beneficiaries under his or her care. The commenters asserted that under other sections of the Act, "allowed charges under this part" has been interpreted by CMS to mean "allowed charges under the PFS." The commenters did not believe that potential primary care practitioners serving as "true primary care practitioners" should be penalized with respect to PCIP eligibility because they furnish non-PFS Part B services to their patients.

In addition, other commenters argued that "true primary care practitioners" caring

for their patients across all settings in accordance with a traditional primary care model commonly furnish other types of services to their patients that are paid under the PFS but that are not defined as primary care services under the PCIP, such as inpatient hospital care and emergency department visits. The commenters were concerned that providing hospital care to their patients consistent with the goal of improved continuity of care would disadvantage "true primary care practitioners" with respect to the primary care percentage calculation and, ultimately, eligibility for the PCIP. Several commenters emphasized that potential primary care practitioners in rural areas would be more likely to provide a wider variety of services to their patients due to the lack of other more specialized providers in their area, which could make them less likely to qualify for the PCIP. Many commenters contended that the amount of these specific non-primary care PFS allowed charges would be sufficiently large to prevent "true primary care practitioners" from meeting the 60 percent primary care percentage threshold. MedPAC and several other commenters recommended that CMS remove hospital E/M visits from the denominator of the primary care percentage calculation, explaining that this approach would neither penalize nor reward potential primary care practitioners who provide hospital care to their patients with respect to eligibility for the PCIP.

Response: We understand commenters' concerns regarding the criteria for the PCIP eligibility determination, and in particular the total amount of allowed charges used in the denominator for calculation of the potential primary care practitioner's primary care percentage. We also believe that it is important that the eligibility determination be based on a fair representation of potential primary practitioners' services so that "true primary care practitioners" may meet or exceed the qualifying primary care percentage threshold

for the PCIP, regardless of how they may have chosen to organize their medical practice.

We agree with some commenters who suggested that section 1833(x)(2)(A)(ii) of the Act (as added by section 5501(a) of the ACA) allows some flexibility in implementing the PCIP primary care percentage calculation, based on the phrase in the 60 percent threshold specification that states, "at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary."

We considered several refinements to determine a potential primary care practitioner's allowed charges consistent with the goal of eliminating potential biases that could affect "true primary care practitioners" who practice under certain conditions and structural constraints. We reviewed recent Medicare claims data by specialty designation to determine which Part B services accounted for the highest allowed charges for primary care practitioners, focusing on those services that are not defined as primary care services and, therefore, contribute to increasing the magnitude of the denominator in the primary care percentage. We found that many potential primary care practitioners had significant allowed charges for hospital inpatient care and emergency department visits, which are not considered primary care services for purposes of the PCIP, consistent with the observations of some commenters. Due to the high allowed charges for these hospital visits compared to other primary care services, "true primary care practitioners" providing hospital inpatient and emergency department care for their patients would be less likely to qualify for the PCIP. We also found that rural practitioners, specifically family physicians, may be disproportionately unlikely to qualify for the PCIP because they typically provide a wider variety of services, including hospital inpatient care and

emergency department visits, than their urban counterparts. This difference in the profile of potential primary care practitioners' services was even greater for family physicians in frontier states.

Our review of non-PFS Part B services furnished by potential primary care practitioners, including laboratory services, drugs, and DME, showed that allowed charges for these services were typically only a small percentage of the total amount of a potential primary care practitioner's allowed charges under Part B. However, while less influential than the inclusion of hospital visits in the denominator of the primary care percentage for purposes of determining whether a potential primary care practitioner meets the PCIP eligibility threshold, we believe that the inclusion of the non-PFS services in the denominator could also lead to bias against "true primary care practitioners" who provide a full spectrum of care to their patients.

Therefore, in an effort to eliminate potential bias against potential primary care practitioners who are "true primary care practitioners" with certain primary care practice patterns, we are modifying our proposal and will remove certain services from the total allowed charges that is the denominator of the primary care percentage calculation. In the CY 2011 PFS proposed rule (74 FR 40136), we proposed to use all allowed charges under Part B as the denominator in the calculation to determine whether a potential primary care practitioner meets the 60 percent eligibility threshold requirement. Following our analysis of Medicare claims data, we will remove all non-PFS allowed charges and allowed charges for evaluation and management (E/M) services furnished to hospital inpatients and outpatients by potential primary care practitioners from the total allowed charges under Part B. The specific E/M services that we are removing from the

denominator for purposes of the primary care percentage calculation are displayed in Table 67. We note that we are not removing hospital inpatient consultation E/M services from the denominator, either face-to-face or via telehealth, because we believe these E/M services do not reflect the types of services that would be furnished by "true primary care practitioners" serving a primary care function for their patients as reflected in their primary care practice patterns.

In other words, PFS charges excluding allowed charges for hospital E/M services will be the denominator in the final primary care percentage calculation for PCIP eligibility determination: [primary care services/(PFS charges – hospital E/M charges)] multiplied by 100. The potential primary care practitioner primary care percentage calculation is subject to traditional rounding rules with respect to the 60 percent eligibility threshold, meaning 59.5 percent and above will be rounded to 60 percent.

These refinements remove the largest categories of non-primary care allowed charges furnished by "true primary care practitioners" from the primary care percentage calculation used for determination of PCIP eligibility, typically decreasing the magnitude of the denominator and resulting in a higher proportion of primary care to non-primary care services for a given potential primary care practitioner. Limiting the allowed charges to the PFS also removes drugs, laboratory services, and DME from the denominator calculation. While these non-PFS allowed charges are not a large percentage of most potential primary care practitioners' allowed charges under Part B, we acknowledge the commenters' assertions that many potential primary care practitioners who are "true primary care practitioners" furnish these services to their patients under certain primary care practice models. Therefore, we also believe it is

appropriate to remove the non-PFS allowed charges from the denominator of the primary care percentage calculation. In effect, removing allowed charges for hospital E/M and non-PFS services from the total allowed charges in the denominator of the primary care percentage calculation allows significantly more potential primary care practitioners to qualify for the PCIP, while still limiting the payment incentive to "true primary care practitioners" who predominantly serve a primary care function for their patients. With use of this revised denominator in the primary care percentage calculation, we estimate that over 80 percent of physicians who currently are enrolled in Medicare with a primary specialty designation of family medicine and almost 60 percent of physicians with a designation of internal medicine would qualify for the PCIP based on CY 2009 claims data. This revised calculation removes bias with respect to eligibility of "true primary care practitioners" for the PCIP based on the specific primary care practice characteristics and model they utilize in caring for their patients.

TABLE 67: Excluded Hospital Evaluation and Management Services from the Denominator for the PCIP Primary Care Percentage Calculation

CPT Code	Description
99217	Observation care discharge day management
99218	Level 1 initial observation care, per day
99219	Level 2 initial observation care, per day
99220	Level 3 initial observation care, per day
99221	Level 1 initial hospital care, per day
99222	Level 2 initial hospital care, per day
99223	Level 3 initial hospital care, per day
99231	Level 1 subsequent hospital care, per day
99232	Level 2 subsequent hospital care, per day
99233	Level 3 subsequent hospital care
99234	Level 1 observation or inpatient hospital care
99235	Level 2 observation or inpatient hospital care
99236	Level 3 observation or inpatient hospital care
99238	Hospital discharge day management;30 minutes or less
99239	Hospital discharge day management; more than 30 minutes.
99281	Level 1 emergency department visit
99282	Level 2 emergency department visit

CPT Code	Description
99283	Level 3 emergency department visit
99284	Level 4 emergency department visit
99285	Level 5 emergency department visit

Comment: A number of commenters recommended that CMS add additional services commonly furnished by "true primary care practitioners" to the list of primary care services for purposes of calculation of the primary care percentage and payment of the incentive payments themselves, which are made at 10 percent of the Medicare payment for primary care services. Among the numerous services recommended as additions by the commenters are hospital E/M visits, preventive services such as immunizations, certain diagnostic tests, and services related to home health. The commenters argued that, by increasing the numerator of the primary care percentage calculation used for determining PCIP eligibility, more potential primary care practitioners would qualify for the PCIP. Moreover, several commenters argued that, when furnished by "true primary care practitioners," these additional services are, in fact, primary care services and therefore should be subject to the incentive payment. The commenters suggested the phrase, "and as subsequently modified by the Secretary" in section 1833(x)(2)(B) of the Act (as added by section 5501(a) of the ACA) following the HCPCS codes defined as primary care services, could be read to provide CMS authority to add services to the list of primary care services. However, some commenters expressed concern that adding services, such as hospital E/M visits, to the list primary care services would qualify many hospitalists for the PCIP with the result that the PCIP would be applied inappropriately to practitioners predominantly furnishing hospital services. If CMS were to contemplate adding hospital E/M services to the list of primary care services, the commenters argued that CMS should exclude clinicians with

hospitalists' claim patterns, even when those practitioners have a potential primary care specialty designation.

Response: While we appreciate commenters' interest in increasing the number of practitioners qualifying for the PCIP, we do not believe that section 1833(x)(2)(B) of the Act (as added by section 5501(a) of the ACA) authorizes us to add services to the list of primary care services specified in the Act. Section 1833(x)(2)(B) of the Act (as added by section 5501(a) of the ACA) clearly specifies the HCPCS codes that are considered primary care services for purposes of the PCIP, stating "The term '"primary care services"' means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary)...." This phrase appears in other sections of the Act, and we have consistently interpreted it to refer to the same services that may be reported under different HCPCS codes when those codes change over time. We do not believe the phrase "and as subsequently modified by the Secretary" authorizes us to add codes (additional services) to the definition of primary care services.

Comment: Several commenters expressed concern regarding the reduced likelihood that "true primary care practitioners" in rural areas would qualify for the PCIP because primary care practitioners in remote areas commonly furnish a greater variety of services than those on the list of specific primary care services. The commenters recommended that rural practitioners be qualified for the PCIP based on another primary care percentage threshold that better suits the practice patterns of rural practitioners, including accounting for hospital E/M visits without penalizing the practitioners. Some commenters asserted that the PCIP would only benefit those practitioners furnishing services in health professional shortage areas (HPSAs) based on their belief that the PCIP

was limited to primary care practitioners furnishing primary care services in HPSAs or that primary care practitioners would benefit at the cost of other specialty practitioners because of considerations of budget neutrality under the PFS.

Response: We appreciate the concerns of the commenters regarding rural practitioners and their special practice patterns. As discussed earlier in this section, we have modified our primary care percentage calculation for purposes of comparison with the 60 percent PCIP eligibility threshold so that all potential primary care practitioners, including potential primary care practitioners in rural areas, will not miss the PCIP eligibility threshold as a result of furnishing hospital visits to their patients. With regard to applying special criteria for the primary care percentage calculation for rural practitioners, we note that section 1833(x) of the Act does not include any provision that would make the location of the primary care services or the primary care practitioner a factor for PCIP eligibility; the same eligibility determination is applicable to all potential primary care practitioners.

In contrast to the HPSA physician bonus payment program and the HPSA Surgical Incentive Program (HSIP), the PCIP does not consider geographic location in determining practitioner eligibility or the primary care services for which the incentive payments will be made. Although practitioners in rural areas will benefit from the PCIP in the same way as practitioners in other regions, as we note above, PCIP payments will be made in addition to the regular Part B payments for primary care services furnished by eligible primary care practitioners and, if applicable, the HPSA physician bonus payment will also be made. Finally, we note that primary care incentive payments are not subject to the budget neutrality adjustment under the PFS, so PCIP payments will not affect

payment for other services for which payment is made under the PFS.

After consideration of the public comments we received, we are finalizing our policy for calculation of the primary care percentage, with certain modifications from the proposed policy. The numerator of the primary care percentage for each NPI is the sum of the allowed charges for the primary care services listed in Table 66, as we proposed. However, the denominator is the allowed charges under the PFS minus the allowed charges for the hospital E/M services listed in Table 67, which is a change from our proposal. We will calculate the primary care percentage for each NPI of a potential primary care practitioner and, if the calculation rounds to 60 percent or greater, the potential primary care practitioner with that NPI will qualify to receive PCIP payments for the applicable year.

(3) Period of Claims Data for Primary Care Percentage Calculation

As we discussed in the CY 2011 PFS proposed rule (74 FR 40137), we proposed to use CY 2009 PFS claims data, processed through June 30, 2010, for determining PCIP practitioner eligibility for CY 2011. This would ensure analysis of about 99 percent of CY 2009 claims to determine practitioner eligibility for PCIP payment beginning January 2011. We note that the MMA changed the requirements for critical access hospital (CAH) billing for practitioners' professional services and, therefore, modifications were made to the Medicare claims processing system to require CAHs to identify the practitioner furnishing a service on the CAH claim for that professional service. However, because the rendering practitioner has only been identified on CAH claims since July 1, 2009, for the first year of the PCIP we are proposing to identify eligible practitioners using only 6 months of CAH data for those CAHs paid under the

optional method. Thereafter, we would update the list of practitioners eligible for the PCIP annually based on the most recent available full year of PFS and CAH claims data.

To the extent practitioners were paid under the PFS during the historical claims data year for some primary services, and CAHs were paid under the optional method for those same practitioners' other professional services, we would aggregate the historical claims data from all settings by the practitioner's NPI in order to determine whether the practitioner is eligible for PCIP payments. We proposed that for all potentially eligible primary care practitioners (both practitioners paid under the PFS and practitioners for whose professional services CAHs are paid under the optional method), the period of claims data used for the annual determination of the practitioner's primary care percentage would lag the PCIP payment year by 2 years (for example, CY 2010 claims data would be used for the CY 2012 PCIP). This 2-year lag is consistent with other areas of the Medicare program where we rely on information from claims data to inform payment in a future year, such as the use of CY 2009 PFS utilization data in the establishment of certain aspects of CY 2011 PFS payment rates.

Under the proposed PCIP eligibility determination method, it would be necessary to revise the list of PCIP-eligible primary care practitioners based on updated claims data regarding primary specialty designation and primary care percentage each year. The revised list of primary care practitioners developed prior to the beginning of the next CY would establish a practitioner's eligibility for PCIP payments for the full next CY. That is, once eligible for the PCIP for a given CY, the practitioner would receive PCIP payments for primary care services furnished throughout that full CY. We would then reassess the practitioner's PCIP eligibility for the next year's payments. As a result, under

our proposal, a practitioner newly enrolling in Medicare during a CY would not be eligible for the PCIP until Medicare claims data reflecting the practitioner's primary care specialty and primary care percentage that equals or exceeds the 60 percent threshold were available to establish the practitioner's eligibility for the next PCIP year. Similarly, an enrolled practitioner's change in primary specialty designation (either to or from a primary care specialty) would not affect that practitioner's eligibility for the PCIP until the practitioner's claims reflecting the change were available for analysis in preparation for the next applicable CY PCIP. In the CY 2011 PFS proposed rule (74 FR 40138), we indicated that, given the statutory requirement for PCIP eligibility that a potential primary care practitioner's primary care services account for at least 60 percent of the allowed charges under Part B for the practitioner in a prior period as determined by the Secretary, we saw no clear alternative methodologies that would allow PCIP payments to be made to those practitioners newly enrolling in Medicare without the 2-year lag in eligibility determination that was described previously. However, given our general interest in supporting primary care practitioners and entry into primary care practice by new physicians and nonphysician practitioners in order to ensure that Medicare beneficiaries have access to these important services, we asked for public comments on alternative approaches for establishing PCIP eligibility for newly enrolled practitioners that would be consistent with the statutory requirement.

Comment: Several commenters opposed the proposed 2-year lag in the data used for PCIP eligibility determination (for example, CY 2009 claims data for CY 2011 PCIP payment). The commenters contended that the 2-year lag would not accurately represent changes in practice or changes in specialty designation, and requested that CMS exercise

flexibility in determining the prior period in order to more closely align the eligibility and payment periods. Some commenters recommended that CMS decrease the timeframe of claims data used for eligibility determination to less than a year in order to use claims data from the year immediately prior to the incentive payment year. Other commenters suggested that CMS repeat the eligibility determination for potential primary care practitioners more frequently than annually, allowing multiple opportunities for potential primary care practitioners to meet the primary care percentage threshold because the commenters believe that practitioners may experience seasonal variations in their practice patterns.

The commenters were especially concerned about the eligibility determination for practitioners who newly enroll in Medicare because there would be no Medicare claims data for these practitioners from the 2 years prior to the PCIP payment year. The commenters were concerned that all newly enrolled potential primary care practitioners would, therefore, be ineligible for the PCIP for up to 2 years during their initial period of practice. The commenters contended that the 2-year interval would discourage, or at a minimum not encourage, primary care practice as a career choice. A few commenters also raised concerns about the corresponding 2-year lag time in PCIP eligibility for practitioners who change their Medicare-enrolled specialty to one that would make them potential primary care practitioners.

The commenters recommended a variety of approaches for CMS to consider in addressing PCIP eligibility for newly enrolled potential primary care practitioners. The commenters' recommendations included using claims data for a 6-month prior period in order to limit the lag time; making a lump sum PCIP payment after the conclusion of the

PCIP payment year once eligibility could be confirmed; placing PCIP payments into escrow accounts to be paid after the potential primary care practitioner's first year of practice if the primary care percentage threshold was met; or presuming the eligibility of all practitioners with the designated enrolled specialties until claims data demonstrated that they did not qualify for the PCIP.

Response: We appreciate the commenters' interest in closely aligning the period of claims data used to determine PCIP eligibility with the time period where the primary care services subject to the incentive payment would be furnished in order to identify those primary care practitioners with the most current primary care practice patterns for the PCIP. For practitioners who were enrolled in Medicare 2 years prior to the PCIP payment year, as we proposed, we believe it is important to consider a full year of claims data rather than a shorter period, in order to account for seasonal variations in care patterns and more accurately represent the totality of PFS services provided by the potential primary care practitioner. Medical practices often experience fluctuations in the services that they provide over a year. A longer data period helps to smooth the variation and, therefore, better represents the totality of the potential primary care practitioner's practice. Due to the time necessary to receive and process claims data, using the claims data from the full year prior to the PCIP payment year for calculating the primary care percentage would delay incentive payments until after the third quarter of the PCIP payment year for all eligible primary care practitioners, a delay which we believe is not desirable because the statute indicates that we should make quarterly or monthly PCIP payments. Therefore, we believe that the 2-year lag method, as described in the CY 2011 PFS proposed rule (74 FR 40137), is the most appropriate approach to

determining eligibility for most potential primary care practitioners because it allows for a review of a full year of claims data without delaying incentive payments for most eligible primary care practitioners.

However, we recognize the special circumstances of newly enrolled potential primary care practitioners, in that they do not have the claims history from 2 years prior to the PCIP payment year to determine their eligibility. We believe it is important to give potential primary care practitioners newly enrolling in Medicare in the year immediately preceding the PCIP payment year the opportunity to qualify for the PCIP with minimal delay. Therefore, for these practitioners, we will determine PCIP eligibility based on a different prior period than for those practitioners who are already enrolled in Medicare and who have Medicare claims data from 2 years prior to the PCIP payment year available for analysis. Section 1833(x) of the Act (as added by Section 5501(a) of the ACA) gives the Secretary the authority to establish the period of allowed charges used to assess the potential primary care practitioner's primary care percentage with regard to the minimum 60 percent threshold required for PCIP eligibility. For newly enrolled potential primary care practitioners only, we will use the available claims data from the year immediately preceding the PCIP payment year (for example, CY 2010 claims data for CY 2011 PCIP payment) to determine PCIP eligibility. We will use all claims data available for the newly enrolled potential primary care practitioner from that prior year to determine PCIP eligibility, with no minimum time period that the potential primary care practitioner must have been enrolled in Medicare in that prior year. Therefore, a newly enrolled potential primary care practitioner would need to wait no more than one year and potentially significantly less than one year following enrollment and first billing in order

for the primary care services furnished by that eligible primary care practitioner to be subject to the PCIP in the year following the practitioner's initial enrollment.

Due to the processing lag for claims data from the previous CY, PCIP payments for newly enrolled primary care practitioners will be delayed until after the end of the third quarter of the PCIP payment year, although the PCIP payments will ultimately be made for all primary care services the eligible practitioners furnished throughout the full PCIP payment year. Following that first PCIP eligibility determination in the year immediately following the potential primary care practitioner's enrollment in Medicare, PCIP eligibility will be determined as specified previously for a practitioner who was enrolled in Medicare 2 years prior to the PCIP payment year.

For example, if a practitioner newly enrolled in Medicare any time during CY 2010 with a primary specialty designation of family medicine and furnished services that were billed to Medicare, in CY 2011 we will evaluate the family physician's CY 2010 claims data to determine whether the physician meets the 60 percent primary care percentage eligibility threshold for CY 2011 payment under the PCIP. We would not be able to make this assessment until the CY 2010 claims data are substantially complete and, therefore, would anticipate making a determination regarding the physician's eligibility some time after the midpoint of CY 2011. If the family physician is eligible for the PCIP, we would make a lump sum payment for those primary care services furnished earlier in CY 2011 prior to the determination of eligibility and then we would begin making quarterly PCIP payments following the third quarter of CY 2011. For the same physician for the CY 2012 PCIP payment year, we would again refer to CY 2010 claims data to assess whether the physician is eligible for the PCIP and, if

applicable (eligibility could potentially change with more complete CY 2010 data than were available for the CY 2011 determination), make quarterly PCIP payments to that physician in CY 2012.

The use of a different prior period in the case of newly enrolled potential primary care practitioners will allow us more quickly to assess whether the practitioner qualifies for the PCIP and make any applicable PCIP payment, while allowing PCIP payments for established primary care practitioners to be made timely for each quarter of the PCIP payment year based on the use of a different prior period to determine the eligibility of previously enrolled potential primary care practitioners. The use of the more recent prior period for PCIP eligibility determination will not apply to practitioners who are already enrolled in Medicare 2 years prior to the PCIP payment year, but switch their specialty designation to a potential primary care specialty in the year immediately preceding the PCIP payment year. As we explained in the CY 2011 PFS proposed rule (74 FR 40138) and discuss further below, we do not want to encourage practitioners to change their specialty designation merely for the purpose of garnering PCIP payments. Moreover, if we were to make an accommodation for practitioners enrolled in Medicare who change their specialty to a potential primary care practitioner specialty after the data year used for PCIP eligibility determination, we would also need to devise a process to remove practitioners from PCIP eligibility if they changed to a non-primary care specialty during that same period. We believe the incentives and the practice challenges experienced by newly enrolling practitioners are not the same as those for established practitioners and, on balance, we continue to believe it is appropriate to establish PCIP eligibility based upon claims data for a full CY. This policy will also ensure greater predictability of

payment, which is an important objective of the PCIP and Medicare payment policy in general.

We do not agree with commenters who recommended that we make PCIP payments to newly enrolled potential primary care practitioners based on a self-certification process or presumptions about eligibility. Making incentive payments prior to review of a practitioner's eligibility based on claims data would inevitably result in inappropriate PCIP payments to potential primary care practitioners. Any such payments would constitute overpayments subject to recoupment, which would place a burden on our claims processing systems and on the practitioners themselves.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to use Medicare claims data for the year 2 years prior to the PCIP payment year to determine PCIP eligibility for those potential primary care practitioners who were enrolled in Medicare in that year. However, we are modifying the proposed policy to use claims data from the year immediately preceding the PCIP payment year in order to determine PCIP eligibility for potential primary care practitioners who newly enroll in Medicare in the year immediately preceding the PCIP payment year. The PCIP payments to newly enrolled potential primary care practitioners, if applicable, will be made as a lump sum for those primary care services furnished earlier in the PCIP payment year by the eligible primary care practitioner as a soon as an eligibility determination can be made in the PCIP payment year. Quarterly PCIP payments for these eligible primary care practitioners will begin following the third quarter of the PCIP payment year.

In the CY 2011 PFS proposed rule (74 FR 40138), we stated that we plan to

monitor changes in the primary specialty designations of enrolled practitioners over time and would expect not to see significant changes in the specialties of currently enrolled practitioners as a result of the PCIP payments. We would expect that physicians changing their primary specialty to one of the primary care specialties of family medicine, internal medicine, geriatric medicine, or pediatric medicine and who would be newly eligible for the PCIP are furnishing primary care services to the patients in their practices. Consistent with our past policies, we would expect that physicians changing their primary specialty designation under Medicare would make such changes only so that their primary specialty designation is fully consistent with the specific or unique type of medicine they practice. If we find that physicians are changing their specialty designations (for example, cardiologists who designate their primary specialty as internal medicine, although they practice cardiology) in order to take advantage of the PCIP payments, we would considering making future revisions to eliminate such an outcome.

Comment: Several commenters agreed that CMS should review the specialty designations of physicians and nonphysician practitioners to ensure there is no gaming of the system in order for practitioners to qualify for the PCIP.

Response: We appreciate the commenters' support and plan to follow closely the changes in the Medicare primary specialty designations of physicians and nonphysician practitioners. As we stated previously, if we find that practitioners are changing their specialty designations in order to become eligible for PCIP payments rather than to reflect their actual practice, we may consider making future revisions to address this problem.

(4) PCIP Payment

We proposed in the CY 2011 PFS proposed rule (74 FR 40138) that PCIP payments would be calculated by the Medicare contractors and made quarterly on behalf of the eligible primary care practitioner for the primary care services furnished by the practitioner in that quarter, consistent with the established Medicare HPSA physician bonus program (Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 90.4.4) and the proposed HSIP described in section III.S.2. of this final rule with comment period. The primary care practitioners' professional services may be paid under the PFS based on a claim for professional services or, where the practitioner has reassigned his or her benefits to a CAH paid under the optional method, to the CAH based on an institutional claim.

Comment: Several commenters supported CMS' proposal to make incentive payments quarterly. These commenters agreed that quarterly payments would mitigate the administrative burden and better account for the practice patterns of the various types of primary care practitioners submitting claims for primary care services.

Response: We appreciate the commenters' support of the quarterly PCIP payments. We agree that the quarterly payments would work well with the billing cycles of many practitioners and would be consistent with Medicare payment policies for other incentive programs.

As discussed in CY 2011 PFS proposed rule (74 FR 40138), eligible primary care practitioners would be identified on a claim based on the NPI of the rendering practitioner. If the claim is submitted by a practitioner's group practice or a CAH, the rendering practitioner's NPI must be included on the line-item for the primary care service (identified in Table 66) in order for a determination to be made regarding whether

or not the service is eligible for payment of the PCIP. We note that, in order to be eligible for the PCIP, physician assistants, clinical nurse specialists, and nurse practitioners must be billing for their services under their own NPI and not furnishing services incident to physicians' services. Regardless of the specialty area in which they may be practicing, these specific NPPs would be eligible for the PCIP based on their enrolled potential primary care practitioner specialty if their historical primary care percentage equals or exceeds the 60 percent threshold.

In the CY 2011 PFS proposed rule (75 FR 41038), we indicated that section 1833(x)(4) of the Act (as added by section 5501(a) of the ACA) specifies that "there shall be no administrative or judicial review under section 1869, or section 1878, or otherwise, respecting the identification of primary care practitioners." We believe that the inclusion of this language is intended to provide a means for the practical implementation of this provision. We explained that we must develop a process and identify primary care practitioners before we can make payments under the PCIP to the eligible primary care practitioners. The statute gives CMS the authority to make final determinations of eligible primary care practitioners that are not subject to appeal through the various channels normally available to practitioners, in order for the timely payments under the PCIP to occur. In contrast, if the eligibility determinations that we must make under this provision were subject to appeal, the timely implementation of this program could be jeopardized and payments under the PCIP could be significantly delayed. However, we stated that we did not believe that the "no administrative or judicial review" clause precludes CMS from correcting errors resulting from clerical or mathematical mistakes. Therefore, we indicated that practitioners would have the opportunity to notify CMS of

clerical or mathematical errors that may have occurred during the process of identifying eligible primary care practitioners for PCIP payment and that may have resulted in a mistaken eligibility determination for the PCIP.

Comment: Several commenters supported the review of the PCIP eligibility determinations for clerical or mathematical mistakes. The commenters agreed that a review of the data calculations may be necessary when errors are suspected. Some commenters further asked for clarification and transparency regarding the formula and data that are used for eligibility determinations. Finally, several commenters requested that CMS provide notification to individual qualifying primary care practitioners even if the PCIP payment is made to the group practice under a reassignment arrangement.

Response: We appreciate the support of the commenters for a review when suspected clerical or mathematical mistakes are identified. As described earlier in this section, the formula used to determine the primary care percentage for a potential primary care practitioner is the practitioner's allowed charges from the applicable data year (the prior period) for primary care services (listed in Table 66) divided by the total allowed charges under the PFS, excluding hospital E/M visits (listed in Table 67), and multiplied by 100. The specialty designation and allowed charges used to identify a potential primary care practitioner and calculate the primary care percentage are based on the claims data that are submitted by the practitioner during the applicable prior year for eligibility determination for the PCIP payment year, which depends on whether the potential primary care practitioner was newly enrolled in Medicare in the year immediately prior to the PCIP payment year or previously enrolled in Medicare. Those data will be reviewed when we are assessing a suspected mistake.

We note that Medicare contractors will post a list of individual primary care practitioners eligible for the PCIP for a year, along with their NPIs, on their web sites. We do not anticipate providing individual notices to PCIP-eligible primary care practitioners for each year. Rather, primary care practitioners, including those who have reassigned their benefits, can confirm their eligibility for the PCIP for a year without direct individual notification.

In the CY 2011 PFS proposed rule (75 FR 41038), we further noted that section 1833(x)(3) of the Act (as added by section 5501(a) of the ACA) authorizes payment under the PCIP as an additional payment amount for specified primary care services without regard to any additional payment for the service under section 1833(m) of the Act. Therefore, an eligible primary care physician furnishing a primary care service in a HPSA may receive both a HPSA physician bonus payment under the established program and a PCIP payment under the new program beginning in CY 2011, but the PCIP payment is made without regard to the HPSA physician bonus payment amount. In addition, payments for outpatient CAH services under section 1834(g)(2)(B) of the Act (as amended by section 5501(a) of the ACA) would not be affected by the PCIP payment amounts made to the CAH on behalf of the primary care practitioner.

(5) Summary of Final PCIP Policies

In summary, after consideration of the public comments we received, we are finalizing our CY 2011 proposals for the PCIP, with modification. Practitioners with a designated primary Medicare-enrolled specialty of family medicine, internal medicine, geriatric medicine, pediatric medicine, nurse practitioner, clinical nurse specialist, or physician assistant and whose primary care percentage, calculated as primary care

allowed charges divided by PFS allowed charges excluding hospital E/M visits, and then multiplied by 100, exceeds 60 percent will be eligible for the PCIP. The primary care percentage will be calculated based on claims data from 2 years prior to the PCIP payment year for practitioners enrolled in Medicare in that year, and from the year immediately prior to the PCIP payment year for practitioners newly enrolling in that year. Beginning immediately following the first quarter of CY 2011, incentive payments for primary care services furnished by eligible practitioners will be paid quarterly after the conclusion of the calendar quarter, in addition to payments by Medicare for the primary care services and other incentive program payments. The list of eligible primary care practitioners will be updated annually based upon our analysis of claims data from the subsequent reference period.

Accordingly, we are finalizing our regulation at new §414.80 to specify the requirements of the PCIP. While we are finalizing our proposed definition of primary care services in §414.80(a), we are revising our proposed definition of eligible primary care practitioners in §414.80(a)(i)(B) and (ii)(B) to specify that at least 60 percent of the physician's or practitioner's allowed charges under the PFS (excluding hospital evaluation and management visits) during a reference period specified by the Secretary are for primary care services. We are finalizing §414.80(b) as proposed to provide eligible primary care practitioners a 10 percent incentive payment for primary care services, in addition to the amount that would otherwise be paid for their professional services under Part B. Quarterly PCIP payments will be made to eligible practitioners or to CAHs paid under the optional method that are billing on behalf of practitioners for their professional services for identified primary care services.

2. Section 5501(b): Incentive Payment Program for Major Surgical Procedures Furnished in Health Professional Shortage Areas.

a. Background

Section 1833(m) of the Act provides for an additional 10 percent incentive payment when physicians' services are furnished to a covered individual in an area designated as a geographic Health Professional Shortage Area (HPSA) as identified by the Secretary prior to the beginning of such year. Section 5501(b) of the ACA revises section 1833 of the Act by adding new subparagraph (y), "Incentive Payments for Major Surgical Procedures Furnished in Health Professional Shortage Areas."

In the case of major surgical procedures furnished by a general surgeon on or after January 1, 2011 and before January 1, 2016, in an area designated under section 332(a)(1)(A) of the Act as a geographic HPSA, they would be paid on a monthly or quarterly basis an amount equal to 10 percent of the payment amount for eligible services under Part B. Section 1833(y)(2)(A) of the Act (as added by section 5501(b) of the ACA) defines a general surgeon as a physician who is described in section 1861(r)(1) of the Act and who has designated a CMS specialty code of 02-general surgery as his or her primary specialty code in the physician's enrollment in Medicare under section 1866(j) of the Act.

Section 1833(y)(2)(B) of the Act (as added by section 5501(b) of the ACA) defines major surgical procedures as surgical procedures for which a 10-day or 90-day global period is used for payment under the PFS under section 1848(b) of the Act. In Addendum B to the CY 2010 PFS final rule with comment period (74 FR 62017 through 62143), as corrected in the correction notice (74 FR 65455 through 65457), we identified

489 10-day global procedure codes and 3,796 90-day global procedure codes for a total of 4,285 surgical procedure codes that would have met the surgical procedure criteria for the incentive payment if it were applicable in CY 2010.

b. HPSA Surgical Incentive Payment Program (HSIP)

For services furnished on or after January 1, 2011 and before January 1, 2016, in the CY 2011 PFS proposed rule (75 FR 40139) we proposed to provide a 10 percent incentive payment to general surgeons, identified by their enrollment in Medicare with a primary specialty code of 02-general surgery, in addition to the amount they would otherwise be paid for their professional services under Part B, when they furnish a major surgical procedure in a location defined by the Secretary as of December 31 of the prior year as a geographic HPSA. As with the PCIP described above, we stated in the CY 2011 PFS proposed rule (75 FR 40139) that we did not believe surgeons would change their Medicare specialty designation in order to take advantage of the HSIP payments. However, we described our plan to monitor the specialty designations of enrolled physicians, and if we were to find that surgeons were changing their primary specialty designation to general surgery in order to take advantage of the HSIP payments, we would consider making future revisions to eliminate such an outcome.

Consistent with the established Medicare HPSA physician bonus program, we proposed that HSIP payments be calculated by Medicare contractors based on the criteria for payment discussed earlier in this section, and payments would be made quarterly on behalf of the qualifying general surgeon for the qualifying major surgical procedures. The surgeons' professional services would be paid under the PFS based on a claim for

professional services or, when a physician has reassigned his or her benefits to a CAH paid under the optional method, to the CAH based on an institutional claim.

Qualifying general surgeons would be identified on a claim for a major surgical procedure based on the primary specialty of the rendering physician, identified by his or her NPI, of 02-general surgery. If the claim is submitted by a physician's group practice or a CAH, the rendering physician's NPI must be included on the line-item for the major surgical procedure in order for a determination to be made regarding whether or not the procedure is eligible for payment under the HSIP.

For HSIP payment to be applicable, the major surgical procedure must be furnished in an area designated by the Secretary as of December 31 of the prior year as a geographic HPSA. We stated that we would provide HSIP payments for major surgical procedures furnished by general surgeons in the same HPSAs as we currently recognize for purposes of payment of all physicians under the established Medicare HPSA physician bonus program under section 1833(m) of the Act.

Each year, we publish a list of zip codes eligible for automatic payment of the HPSA physician bonus payment at: http://www.cms.gov/hpsapsaphysicianbonuses/01_overview.asp. We proposed to use the same list of zip codes for automatic payment of the incentive payment for qualifying surgical procedures furnished by general surgeons. We also proposed to create a new HCPCS code modifier to identify circumstances when general surgeons furnish qualifying surgical procedures in areas that are designated as HPSAs as of December 31 of the prior year, but that are not on the list of zip codes eligible for automatic payment. The new modifier would be appended to the major surgical procedure on claims

submitted for payment, similar to the current process for payment of the Medicare HPSA physician bonus when the geographic HPSA is not a HPSA identified for automatic payment.

Consistent with the statutory requirement, we would define major surgical procedures as those for which a 10-day or 90day global period is used for payment under the PFS. For CY 2011, approximately 4,300 10-day and 90-day global surgical procedures codes were identified in Addendum B to the CY 2011 PFS rule (75 FR 40262 through 40641) under the far right column labeled "Global" and designated with "010" or "090," respectively.

We further noted that section 1833(y)(3) of the Act (as added by section 5501(b)(1) of the ACA) authorizes payment under the HSIP as an additional payment amount for specified surgical services without regard to any additional payment for the service under section 1833(m) of the Act. Therefore, a general surgeon may receive both a HPSA physician bonus payment under the established Medicare HPSA physician bonus program and a HSIP payment under the new program beginning in CY 2011, but the HSIP payment would be made without regard to the HPSA physician bonus payment amount. In addition, payments for outpatient CAH services under section 1834(g)(2)(B) of the Act (as amended by section 5501(b) of the ACA) would not be affected by the HSIP payment amounts made to the CAH on behalf of the general surgeon.

Accordingly, for CY 2011, we proposed to revise §414.2 and add the definitions of "HPSA" and "major surgical procedure." We also proposed to revise §414.67 to move the existing provisions to paragraph (a) to be grouped as the "Health Professional Shortage Area (HPSA) physician bonus program" and adding a new paragraph (b) for the

"HPSA surgical incentive payment program" provisions. Section 414.67(b) would state that general surgeons who furnish identified 10-day and 90-day global period surgical procedures in an area designated by the Secretary as of December 31 of the prior year as a geographic HPSA that is recognized by Medicare for the HPSA physician bonus program as specified under renumbered §414.67(a)(1) would receive a 10 percent incentive payment in addition to the amount that would otherwise be paid for their professional services under Part B. Physicians furnishing services in areas that are designated as geographic HPSAs prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA surgical incentive payments are made would report a specified HCPCS code modifier to receive the HSIP payment. Quarterly incentive payments would be made to physicians or to CAHs paid under the optional method when billing on behalf of physicians for their professional services.

Comment: A number of commenters supported CMS' proposal to implement the HSIP. A few commenters recommended expanding the geographic eligibility criteria for the HSIP to increase the number of qualifying procedures furnished by general surgeons for which the incentive payment would be made. These commenters suggested that CMS introduce three modifications to the proposed criteria in order to provide the incentive payment for major surgical procedures furnished by general surgeons to Medicare beneficiaries who have limited access to general surgical care. Specifically, the commenters recommended that CMS additionally provide the incentive payment for: (1) qualifying surgical procedures performed by a general surgeon in a hospital adjacent to a recognized HPSA; (2) qualifying surgical procedures performed by a general surgeon who resides in a recognized HPSA; and (3) qualifying surgical procedures performed by

a general surgeon who has an office in a recognized HPSA. The commenters argued that the proposed policy would narrowly limit the availability of the general surgery incentive payments by linking payments only to surgical procedures furnished in established HPSAs. The commenters concluded that the proposed policy would result in relatively fewer general surgeons receiving the incentive payments and would not capture surgical procedures furnished in all of the nation's geographic areas in which there is a shortage of general surgeons.

Response: We appreciate the commenters' support for our proposal. Regarding commenters' requests for expansion of the locations for surgery when we would provide the incentive payment for major surgical procedures furnished by general surgeons, we do not believe that we have the authority to expand the care settings beyond the statutorily prescribed location, that is, "major surgical procedures….by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public health Service Act) as a health professional shortage area." Section 1833(y) of the Act (as added by section 5501(b) of the ACA) relies solely on section 332(a)(1)(A) of the Public Health Service Act to identify qualifying HPSAs and expressly notes that the HPSA must be identified by the Secretary prior to the beginning of the HSIP payment year.

Comment: One commenter requested that CMS extend HSIP payment to physician assistants who are trained as first assistants at surgery. The commenter encouraged CMS to provide the 10 percent incentive payment to physician assistants, trained in surgical specialties, who ensure both that beneficiaries in rural areas have access to appropriate surgical care and that general surgeons furnishing surgical procedures in these locations are appropriately supported by physician assistants trained

in surgical specialties.

Response: Section 1833(y)(2) of the Act (as added by section 5501(b) of the ACA) specifically limits HSIP eligibility to those physicians (a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action according to the definition in section 1861(r)(1)) of the Act who have designated 02-general surgery as their primary specialty code in Medicare's physician enrollment. On the other hand, physician assistants are not doctors of medicine or osteopathy and these practitioners are identified in Medicare enrollment with the specialty code 97-physician assistant. Therefore, we do not believe we have the statutory authority to extend HSIP payment to physician assistants who provide surgical support for major surgeries furnished by general surgeons in recognized HPSAs.

After consideration of the public comments we received, we are finalizing our CY 2011 HSIP proposal, with modification regarding the proposal to create a new HCPCS code modifier to identify circumstances when general surgeons furnish services in areas that are designated as HPSAs as of December 31 of the prior year, but that are not on the list of zip codes eligible for automatic payment. Under our final policy, under these circumstances practitioners would report the existing modifier –AQ (Physician providing a service in a HPSA) that is used for the established Medicare HPSA physician bonus program because we would make incentive payments under the HSIP for surgical procedures furnished by general surgeons in the same HPSAs that are recognized for the Medicare HPSA physician bonus program.

In summary, the HSIP provides a 10 percent incentive payment quarterly to qualifying physicians enrolled as general surgeons in Medicare (or to the CAHs to which

they have reassigned their benefits) for qualifying 10-day and 90-day global surgical procedures furnished on or after January 1, 2011 and before January 1, 2016 by those general surgeons in recognized geographic HPSAs. CMS will make automatic payments when the zip code for the location of service is found in the applicable file for the payment year on the CMS web site for the HPSA physician bonus program at: http://www.cms.gov/hpsapsaphysicianbonuses/01_overview.asp. Existing HCPCS modifier -AQ should be appended to the major surgical procedure on claims submitted for payment to identify circumstances when general surgeons furnish services in areas that are designated as HPSAs as of December 31 of the prior year, but that are not on the list of zip codes eligible for automatic payment.

We are also finalizing our proposed revisions to the code of federal regulations related to the HSIP, with minor modification. We are revising §414.2 as we proposed to add the definitions of "HPSA" and "major surgical procedure." We also are revising §414.67 as we proposed to move the existing provisions to paragraph (a) to be grouped as the "Health Professional Shortage Area (HPSA) physician bonus program" and adding new paragraph (b) for the "HPSA surgical incentive payment program" provisions. We are finalizing our proposal for §414.67(b) to state that general surgeons who furnish identified 10-day and 90-day global period surgical procedures in an area designated by the Secretary as of December 31 of the prior year as a geographic HPSA that is recognized by Medicare for the HPSA physician bonus program as specified under renumbered §414.67(a)(1) would receive a 10 percent incentive payment in addition to the amount that would otherwise be paid for their professional services under Part B. We are modifying the proposal to specify in §414.67(b)(3) that physicians furnishing services

in areas that are designated as geographic HPSAs prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA surgical incentive payments are made would report HCPCS modifier -AQ to receive the HSIP payment and to change the term "bonus" to "incentive" when referring to the HSIP. Quarterly incentive payments will be made to physicians or to CAHs paid under the optional method when billing on behalf of physicians for their professional services.

3. Sections 5501(a) and (b) of the ACA and Payment for Critical Access Hospital Professional Services Under the Optional Method

Section 1834(g) of the Act established the payment rules for outpatient services furnished by a CAH. In 1999, section 403(d) of the Balanced Budget Refinement Act of 1999 (Pub. L. 106-113) (BBRA) amended section 1834(g) of the Act to provide for two methods of payment for outpatient services furnished by a CAH. Specifically, section 1834(g)(1) of the Act, as amended by the BBRA, specifies that the amount of payment for outpatient services furnished by a CAH is equal to the reasonable costs of the CAH in furnishing such services. (The physician or other practitioner furnishing the professional service receives payment under the PFS.) In the alternative, the CAH may make an election, under section 1834(g)(2) of the Act, to receive amounts that are equal to "the reasonable costs" of the CAH for facility services plus, with respect to the professional services, the amount otherwise paid for professional services under Medicare, less the applicable Medicare deductible and coinsurance amount. The election made under section 1834(g)(2) of the Act is sometimes referred to as "method II" or "the optional method." Throughout this section we refer to this election as "the optional method."

In 2000, section 202 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000) (Pub. L. 106-554) (BIPA) amended section 1834(g)(2)(B) of the Act to increase the payment for professional services under the optional method to 115 percent of the amount otherwise paid for professional services under Medicare. In addition, in 2003 section 405(a)(1) of the MMA amended section 1834(g)(l) of the Act by inserting the phrase "equal to 101 percent of" before the phrase "the reasonable costs." However, section 405 of the MMA did not make a corresponding change to section 1834(g)(2)(A) of the Act regarding the amount of payment for facility services under the optional method. In 2010, section 3128 of the ACA amended section 1834(g)(2)(A) of the Act by inserting the phrase "101 percent of" before "the reasonable costs."

Section 5501(a) of the ACA amends section 1833 of the Act by adding a new paragraph (x), "Incentive Payments for Primary Care Services," that authorizes additional Part B payments to primary care practitioners for primary care services. Section 5501(b) of the ACA further amends section 1833 of the Act by adding new paragraph (y), "Incentive Payments for Major Surgical Procedures Furnished in Health Professional Shortage Areas," that authorizes additional Part B payments for major surgical procedures furnished by general surgeons in HPSAs. Sections 5501(a)(3) and 5501(b)(3) of the ACA make conforming amendments to section 1834(g)(2)(B) of the Act, which refers to payment to the CAH for professional services under the optional method, by adding at the end of section 1834(g)(2)(B) of the Act the following phrase, "Subsections (x) and (y) of 1833 of the Act shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence." As such, section

1834(g)(2)(B) of the Act (as amended by sections 5501(a)(2) and 5501(b)(2) of the ACA) requires that under the optional method, the 115 percent adjustment payment to the CAH for professional services is calculated without considering the incentive payments for primary care services furnished by primary care practitioners and major surgical procedures furnished by general surgeons in HPSAs as these terms are defined under sections 1833(x) and (y) of the Act.

The regulations implementing section 1834(g)(2)(B) of the Act, payment to the CAH for professional services under the optional method, are in §413.70(b)(3)(ii)(B). In order to implement the amendments to section 1834(g)(2)(B) of the Act as specified by sections 5501(a)(2) and 5501(b)(2) of the ACA, we are proposing to amend the regulations in §413.70(b)(3)(ii)(B) to state that, effective for primary care services furnished by primary care practitioners and major surgical procedures furnished by general surgeons in HPSAs on or after January 1, 2011 and before January 1, 2016, the additional incentive payment amounts as specified in §414.67 and §414.80 are not included in the determination of the payment for professional services made to the CAH under the optional method. Accordingly, we are proposing that payment for professional services to the CAH at 115 percent of the PFS amount under the optional method would not take into account the additional Part B incentive payments for primary services furnished by primary care practitioners and major surgical procedures furnished by general surgeons in HPSAs as provided in §414.67 and §414.80.

Comment: Several commenters supported CMS' proposal to make HSIP and PCIP payments to CAHs paid under the optional method for qualifying services furnished by eligible practitioners who have reassigned their billing rights to the CAHs. No

commenters addressed CMS' proposal to calculate the 115 percent adjustment payment to the CAH for professional services without considering the incentive payments for primary care services furnished by primary care practitioners and major surgical procedures furnished by general surgeons in HPSAs.

Response: We appreciate the commenters' support for our proposal to include qualifying professional services billed by CAHs paid under the optional method furnished by eligible practitioners in the PCIP and HSIP.

After considering the public comments we received, we are finalizing our CY 2011 proposal to include CAHs paid under the optional method in the PCIP and HSIP. Payment to a CAH paid under the optional method, will be made quarterly, for eligible professional services furnished by qualifying physicians and nonphysician practitioners who have reassigned their billing rights to the CAH. Furthermore, we are finalizing our CY 2011 proposal to specify that payment for professional services to the CAH at 115 percent of the PFS amount under the optional method would not take into account the additional Part B incentive payments for primary services furnished by primary care practitioners and major surgical procedures furnished by general surgeons in HPSAs. We are amending §413.70(b)(3)(ii)(B) as we proposed to reflect this final policy.

T. Section 6003: Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services

1. Background

Section 1877 of the Act (also known as the physician self-referral law): (1) prohibits a physician from making referrals for certain "designated health services"

(DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies; and (2) prohibits the entity from submitting claims to Medicare (or billing another individual, entity, or third party payer) for those DHS rendered as a result of a prohibited referral. The statute establishes a number of exceptions and grants the Secretary the authority to create regulatory exceptions that pose no risk of program or patient abuse.

Section 1877(b)(2) of the Act, entitled "In-office Ancillary Services" sets forth the exception that permits a physician in a solo or group practice to order and provide designated health services (DHS), other than most durable medical equipment and parenteral and enteral nutrients, in the office of the physician or group practice, provided that certain criteria are met. The requirements of the in-office ancillary services exception are described at §411.355(b).

Section 6003 of the ACA amended section 1877(b)(2) of the Act by creating a new disclosure requirement for the in-office ancillary services exception to the prohibition on physician self-referral. Specifically, section 6003 of the ACA provided that, with respect to referrals for magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), and any other DHS specified under section 1877(h)(6)(D) of the Act that the Secretary determines appropriate, the referring physician inform a patient in writing at the time of the referral that the patient may obtain the service from a person other than the referring physician or someone in the physician's group practice and provide the patient with a list of suppliers who furnish the service in the area in which the patient resides.

In the CY 2011 PFS proposed rule, we proposed regulations related to section 6003 of the ACA. We are finalizing that proposal with modification. We received approximately 45 comments related to this section. Most commenters offered support for the proposed rule and some stated that it was consistent with the intent of the legislation, which was to provide choice for patients, as well as a degree of protection against conflicts of interest. Others stated that disclosure might be a first step towards ending abuses in self referral, but questioned the overall effectiveness of the disclosure requirement in reducing overutilization. These commenters were nonetheless supportive of the reasonable mechanisms used to implement the requirement.

We are finalizing some elements of the proposal without modification. Elements that remain unchanged from the proposed rule include: application of the disclosure requirement to advanced imaging services only; the general disclosure requirements that the notice should be written in a manner sufficient to be reasonably understood by all patients and be given to the patient at the time of the referral; the list must include the requisite number of suppliers; the information about these suppliers must include name, address, and phone number; these suppliers are to be located within a 25-mile radius of the physician's office location at the time of the referral; and the effective date of January 1, 2011.

Elements that we are finalizing with changes include: reducing the number of suppliers that must be included from 10 to 5; removing the requirement that the supplier's distance from the physician's office be listed on the disclosure; clarifying that as long as the requisite number of suppliers are included in the alternate list, the physician may also list providers on the notice; and removing the requirement that the physician obtain the

patient's signature on the notice and retain a copy of the disclosure in the patient's medical record.

2. Disclosure Requirement

Based upon the comments received, we have finalized §411.355(b)(7) in a manner that addresses concerns of the industry while also maintaining the intended purpose of the provision. The comments received during the public comment period are discussed more fully below.

a. Services that Trigger the Disclosure Requirement

We proposed that the disclosure requirement should apply to only the advanced imaging services listed in section 6003 of the ACA (MRI, CT, and PET). We solicited comments regarding whether other radiology or imaging services under section 1877(h)(6)(D) of the Act should be included in the requirement. We are finalizing this element as proposed.

Comment: Most commenters were supportive of our proposal to apply the disclosure requirement only to those advanced imaging services listed in section 6003 of the ACA. A commenter stated that expanding application of the provision beyond the named services would add to confusion and increase negative effects on physician practices. The commenter noted that creating lists of alternate suppliers for the named services will be less burdensome than adding any other radiology services. Multiple commenters who were opposed to expanding the disclosure requirement stated that a disclosure requirement for diagnostic services such as x-rays or ultrasound services would place significant burden on physician groups and could interrupt continuity of care for patients, as these tests are often performed in the office immediately after the

physician has ordered the test.

Only one commenter urged CMS to fully exercise the authority granted by the Affordable Care Act and apply the disclosure requirement to all radiology services covered by section 1877(h)(6)(D) of the Act. The commenter stated that the disclosure requirement benefits Medicare beneficiaries through greater transparency regarding their freedom to choose a supplier of medical services and that there is no reason to draw a distinction between MRI, CT, and PET referrals and referrals for other radiology services. This commenter also did not believe that the burden on the referring physicians would be materially different if the list of affected imaging services is expanded to cover all radiology services, as it would only entail expanding the list that will serve as the notice to patients.

Response: We are finalizing this requirement as proposed and applying the disclosure requirement to only the advanced imaging services specified in section 6003 of the ACA, which are MRI, CT, and PET services. We decline to expand the disclosure requirement to any of the other radiology or imaging services that fall under section 1877(h)(6)(D) of the Act. X-ray and ultrasound services in particular are much more likely to be performed on the same day as the original visit compared to many advanced imaging services. Therefore, disclosures related to these additional services would not be as useful to the patient. We do not find that the benefit of expanding this disclosure requirement to other radiology services would outweigh the additional burden that would be placed on physicians.

Comment: One commenter requested that CMS clarify that any CT imaging service that is furnished integral to a procedure defined as a radiation therapy service for

purposes of the physician self-referral law is exempt from this disclosure requirement. The commenter provided the example of CT guidance used to localize tumors and focus the beam during the delivery of external beam radiation therapy treatments. Such imaging, although involving CT, is integral to the performance of radiation therapy treatments that are included in the DHS category of radiation therapy services and supplies.

Response: The disclosure requirement applies to all in-office referrals for CT imaging services that are categorized as "radiology and certain other imaging services" by the list of CPT/HCPCS Codes (as defined in §411.351). We note, however, that the request by a radiation oncologist for radiation therapy or ancillary services necessary for, and integral to, the provision of radiation therapy does not constitute a "referral," as defined in §411.351, if certain criteria are satisfied. The disclosure requirement would not apply to any request that is not a "referral" as defined in §411.351.

Comment: A commenter requested that CMS remove CPT code 77014 (computed tomography guidance for placement of radiation therapy fields) from the DHS category of "radiology and certain other imaging services," and add it to the category of "radiation therapy services and supplies," as such categories are set forth in the list of CPT/HCPCS Codes. The commenter asserts that this would be appropriate because while the code is for a service that involves imaging, the service is distinct from the other radiology codes and integral to the delivery of radiation therapy. The commenter noted that when a radiation oncologist performs radiation therapy services, it is not considered a referral under the law. However, if CPT code 77014 is included in the list of radiology services, it could be considered a referral and therefore radiation oncologists could be

required to fulfill the disclosure requirements for this service if it remains on the list of radiology services codes subject to the new disclosure requirements. According to the commenter, because CPT code 77014 is so integral to the delivery of certain radiation therapy treatments, it would be completely impractical, if not impossible, for a radiation oncologist to fulfill the disclosure requirements for this service.

Response: As noted in section X.B.3 of this preamble, we are removing CPT code 77014 from the list of CPT/HCPCS Codes because the service is always integral to, and performed during, a nonradiological medical procedure. Therefore, under §411.351, this service is excluded from the definition of "radiology and certain other imaging services" and is not subject to the disclosure requirement. We are not adding this code to the radiation therapy services category on the list of CPT/HCPCS Codes because it does not satisfy the definition of "radiation therapy services and supplies" as set forth in §411.351. As a practical matter, in many cases the service would not constitute a "referral" (as defined in §411.351) if requested by a radiation oncologist pursuant to a consultation.

Comment: A commenter requested that CMS stipulate that CPT code 77011, currently defined as "computed tomography guidance for stereotactic localization," is not subject to this disclosure requirement whenever it is furnished as part of a therapeutic or palliative radiation therapy service. This commenter stated that this clarification is essential since CPT code 77011 is not listed in Addendum I to the 2010 PFS final rule with comment period either as a radiology service or as a radiation therapy service.

Response: This code is for a service that is integral to the performance of a nonradiological medical procedure and is performed either during the nonradiological

procedure or immediately after the procedure to confirm placement of an item. Therefore, the service is excluded from the DHS category of "radiology and certain other imaging services" and is not subject to the disclosure requirement. The disclosure requirement applies only to MRI, CT, and PET services identified as "radiology and certain other imaging services" on the list of CPT/HCPCS Codes; MRI, CT, and PET services not identified as such on that list are not subject to the disclosure requirement.

Comment: Other commenters urged CMS to expand the disclosure requirement to other DHS that they perceive to be subject to abuse under the in-office ancillary services exception. These DHS included: physical therapy, anatomic pathology and radiation therapy services.

Response: Section 6003 of the ACA does not grant the Secretary the authority to expand application of this disclosure requirement to DHS other than those in section 1877(h)(6)(D) of the Act. We did not propose expansion beyond these services and did not solicit comments regarding other DHS categories that should have this requirement. The requested expansion to other DHS is beyond the Secretary's authority under this provision and cannot be accomplished in this rulemaking.

Comment: One commenter suggested that CMS expand the disclosure requirement to radiology practices and IDTFs so that they are also required to provide a list of alternate suppliers when self-referring for imaging studies in order to offer a more level playing field. Two commenters suggested that we require the same disclosure for hospitals to avoid the perception of conflict of interest in all settings.

Response: The first comment appears to incorrectly assume that section 6003 of the ACA would never apply to radiology practices and IDTFs. Section 6003 of the ACA

applies to physicians who make a "referral" (as defined in section 1877(h)(5) of the Act and §411.351 of our regulations) for certain advanced imaging services and rely on the in-office ancillary services exception to ensure their compliance with the physician self-referral prohibition. While many requests by radiologists for diagnostic imaging services will not constitute a "referral" as defined in the statute and our regulations, some requests by radiologists for advanced imaging services could implicate the self-referral prohibition, and such referrals would be subject to the disclosure requirement if the referring physician relies on the in-office ancillary services exception to ensure compliance with the physician self-referral prohibition. Similarly, the disclosure requirement would also apply when a physician relies on the in-office ancillary services exception to protect referrals for advanced imaging services furnished and billed by an IDTF that is wholly owned by the physician or his or her group practice.

We have no statutory authority to make the disclosure requirement apply to requests for advanced imaging services that are not "referrals." Mandating a similar disclosure requirement for hospitals would have to be accomplished under separate rulemaking and authority.

b. General Disclosure Requirements

We proposed that the disclosure notice should be written in a manner sufficient to be reasonably understood by all patients and must, as the ACA requires, be given to the patient at the time of the referral. The notice must indicate to the patient that the services may be obtained from a person other than the referring physician or his or her group practice and include a list of other suppliers who provide the service being referred (MRI, CT, or PET). We are finalizing this proposal without modification.

Comment: One commenter requested CMS to clarify how often the disclosure notice needs to be provided. The commenter asked if a physician can meet the requirement by giving patients the list of suppliers upon initiation of the physician-patient relationship and annually thereafter to ensure updated information is given, or if the information must be disclosed each time a patient is referred for MRI, CT or PET. Another commenter expressed concern regarding informing a patient in person at the time of the referral. This commenter described the situation where diagnostic tests are ordered after the patient has a previous abnormal diagnostic test; often they communicate this to the patient via phone call and do not want to require the patient to come into the office to receive the disclosure. The commenter asked if the disclosure could be mailed to the patient after the verbal notification via phone call.

Response: The statute requires the disclosure to be made "in writing at the time of the referral." In order to satisfy this element of the statute, we believe the disclosure must be presented to the patient each time one of the listed advanced imaging services is referred. Patients should receive the disclosure each time these services are needed, not just for the initial service. The patient should be made aware that he or she may obtain the services from another supplier any time advanced imaging is ordered. For subsequent referrals made via phone call, the written disclosure must still be provided to the patient and adequately documented as further described in the Documentation of Disclosure subsection below. Mailing or emailing the disclosure to the patient would be acceptable if verbal notification has also occurred.

Comment: Some commenters requested that CMS post a draft disclosure document that physicians can use as a model to ensure that all notices are drafted in a

neutral, comprehensive, and consistent manner.

Response: We do not plan to post standard disclosure language to be used for this requirement. Each physician office will be responsible for drafting the language employed in the notice. Because we are not setting out specific language that must be included in the disclosure, physicians will have more flexibility in drafting the notice.

Comment: Several commenters requested that CMS allow physicians to make it clear on the disclosure that there is no intended endorsement or recommendation of the facilities named on the list furnished by the referring physician.

Response: If the physician chooses to include language informing patients that inclusion of other suppliers is not intended as an endorsement or recommendation of those suppliers, there is nothing in section 6003 of the ACA or this final rule with comment that would preclude him or her from doing so.

c. List of Alternate Suppliers

We proposed that the notice list 10 alternate suppliers (as defined in section 1861(d) of the Act) located within a 25-mile radius of the physician's office at the time of the referral, unless there are fewer than 10 suppliers in the 25-mile radius, in which case the physician must list all suppliers up to ten in that area. In the proposed rule, we required the notice to include the name, address, phone number, and distance from the physician's office at the time of the referral. In this final rule with comment, we are decreasing the number of suppliers that must be listed to 5; and removing the distance from the physician's office from the information about the suppliers that must be listed in the disclosure notice. The final rule does not expand the list of alternate suppliers to include providers as part of the 5 required suppliers but is discussed further below. We

are finalizing our proposal that the suppliers be located within a 25-mile radius of the physician's location at the time of the referral.

We solicited comments related to whether there are procedures or circumstances in which it may be difficult or impractical to provide the written disclosure prior to the provision of advanced imaging services. We are finalizing this rule without creating such an exception.

We also solicited comments regarding an alternative notice that includes a "reasonable" list of other suppliers with general requirements for the disclosure to patients, while providing that if the physician meets the more specific requirements set forth in the proposed rule he or she will be deemed to have a "reasonable" disclosure. We are not finalizing this in the final rule as we did not receive comments in support of this alternative.

Comment: A number of commenters asked that the list of alternate suppliers include hospitals. Two commenters stated CMS has taken an overly literal interpretation of "suppliers" and has incorrectly excluded hospitals from the list of alternate sites. The commenters also noted that in many areas, especially rural, the community hospital is the largest or only remaining independent provider of imaging services. Another pair of commenters stated that providing a partial list of options is inconsistent with transparency, inconsistent with collaborative alignment between providers and suppliers, and that including both providers and suppliers would be more consistent with "informing a patient's decision-making regarding his or her own care."

Several commenters urged CMS to allow, and even to require, that physicians include hospitals and CAHs in the written list of alternate suppliers who provide imaging

services. The commenters stated that hospitals are often the only provider of this service within the 25-mile radius of the physician's office and allowing physicians to include hospitals and CAHs would provide patients with more options.

Finally, one commenter pointed out that including hospitals in the list of alternate suppliers would be consistent with the integrated and coordinated care models that are of interest to the Federal government, health plans, members of Congress and healthcare delivery reformers. The commenter also believes that this would increase convenience for its patients while preserving their ability to make decisions about their care.

One commenter supported CMS' proposal to limit the required disclosure list to suppliers of services. The commenter stated that this would protect the Medicare program from the higher imaging costs and Part B co-pays for beneficiaries associated with imaging services provided by hospital outpatient departments. The commenter encouraged CMS to finalize the proposed supplier only list.

Response: Section 6003 of the ACA requires physicians to provide patients with a written list of alternate "suppliers" (as defined in section 1861(d) of the Act). The ACA does not afford the flexibility requested by commenters to allow physicians to satisfy the disclosure requirement by furnishing a list that includes hospitals and other providers. However, physicians are not precluded from listing hospitals in the disclosure notice as long as the required number of suppliers is also included. For example, in rural areas where no other suppliers exist in the 25-mile radius, we encourage physicians to list a hospital on the disclosure notice as an alternate location for the patient to receive the referred imaging service if the hospital is the closest option.

Comment: Many of the commenters supported our proposal that the disclosure

notice include suppliers located within a 25-mile radius of the physician's location at the time of the referral, rather than in the area in which the patient resides.

Two commenters suggested that CMS set different radii requirements for rural versus urban areas. One of the two commenters stated that in an urban setting, there could be many more than 10 suppliers within a 25-mile setting placing making it difficult for the referring physician to make a decision regarding which providers to include in the written notification. The commenter noted that in a rural setting with fewer than 10 suppliers, the burden of identifying and providing all of the suppliers in the 25-mile radius is excessive for the physician.

Finally, a commenter objected to our concern in the proposed rule preamble that "physicians located in large metropolitan areas will draft a list that includes suppliers located mostly at the edges of the 25-mile radius, thereby increasing the chances that the patient will choose to receive imaging services from the referring physician's practice." The commenter asserted that physicians will strive to create lists that include the highest quality suppliers in the area.

Response: We are finalizing this requirement as proposed. We believe a list of suppliers located within a 25-mile radius of the physician's office is reasonable and large enough to generate a list that will be useful for patients. This same distance has also been used in other physician self-referral exceptions including the intra-family rural referrals exception (§411.355(j)) and the physician recruitment exception (§411.357(e)). In addition, we are reducing the number of required suppliers on the disclosure notice and believe this will help address the issue in some rural area settings where there may only be a few suppliers within a 25-mile radius.

Comment: One commenter indicated that requiring a list of 10 suppliers was excessive. Several commenters requested that we decrease the required number of alternate suppliers from 10 to 5 and one commenter suggested we reduce it to 3 in order to meet patient choice and reduce the compliance burden for medical groups and smaller practices. The commenters stated that listing 10 suppliers would be too burdensome on physicians and might be confusing for beneficiaries if too many choices are presented.

Response: We agree with the commenters and are decreasing the required number of alternate suppliers from 10 to 5. We believe a list of 5 suppliers is reasonable, not burdensome, and supports patient choice.

Comment: A commenter supported the inclusion of the proposed information of the disclosure notice because it is easily understood and contains useful information. One commenter recommended that the referring physician provide the name and telephone number for the alternate suppliers and that other information, such as the address and distance, should be included at the referring physician's discretion. A different commenter stated that the distance from the referring physician's office location at the time of the referral should not be included in the notice because it can be measured in a variety of ways and may vary greatly depending on the route taken between the listed supplier and the physician's offices. The commenter believes patients may get upset if the distance noted on the supplier list is different from what they actually encountered and recommends that the list simply state that all of the suppliers are within a 25-mile radius of the referring physician's office.

Response: We are modifying the proposal in the final rule to remove the requirement that the distance from the referring physician's office at the time of the

referral be included on the list provided to the patient. All alternate suppliers listed must be located within the 25-mile radius of the physician's office location at the time of the referral. Any reasonable method for measuring distance will be acceptable.

We are finalizing the other information required in the notice as proposed so that it must include the name, address and phone number of each supplier. This provides patients with the most useful information in making a decision about receiving the service from the referring physician or from another supplier.

Comment: Two commenters requested that CMS provide an exception to providing the disclosure notice to the patient at the time of referral, especially for services furnished on an emergency or time-sensitive basis as the commenters believe it is impractical to think that the list will be given and signed by the patient in an emergency or other time-sensitive case.

Response: We do not believe it is necessary to grant an exception to the disclosure requirement in cases of an emergency or time-sensitive nature. In those situations, physicians should make a reasonable attempt to provide the notice to the patient and document that the attempt was made. We believe the occurrence of emergencies in physician offices that require a referral for advanced imaging under the in-office ancillary services exception is rare enough that it does not warrant granting an exception. We believe having the physician make a reasonable attempt would not prevent or impede beneficiaries from receiving the necessary services. In most emergencies that arise in a physician's office, patients will be transferred to the emergency department of the nearest hospital rather than referred for imaging at the physician's office.

Comment: A commenter asked about compilation of the list of alternate suppliers and how physicians should go about this task. The commenter asked if a search of the internet or a telephone directory would be adequate. Also the commenter asked if Medicare contractors will have a list of entities providing such services. Another commenter recommended that CMS create a publicly available database of providers of the specified services and maintain this information online and in the Medicare provider directory that is published annually because, according to the commenter, it should be less work for CMS to create this list than it is for practices, since much of this information can be gleaned from information already furnished by practitioners to Medicare.

Response: We are not prescribing any one method for physicians to craft the list of alternate suppliers. A physician is able to use any reasonable means that he or she chooses in order to compile the list of five alternate suppliers. We do not plan to create a standard form or a publicly available database for this disclosure requirement nor will we require Medicare contractors to furnish lists of all entities providing such services. Some physicians may choose to compile the list of suppliers from an internet search, others may know suppliers in the 25-mile radius who provide quality imaging and list these. We are not limiting a physician's methods of creating the list so long as the other requirements of this disclosure requirement are satisfied.

Comment: A commenter requested that CMS emphasize that the list of alternate suppliers must provide the same service for which the patient has been referred, for example a 64-slice CT as opposed to a 16-slice CT.

Response: The disclosure is meant to inform patients that they "may obtain the

services for which the individual is being referred" from another supplier who furnishes such services in the area. The referring physician should list suppliers that are able to perform the services for which the patient is being referred. Listing suppliers that are unable to perform the needed test does not provide the patient with meaningful choices about his or her care.

Comment: Several commenters suggested that the quality of alternate suppliers should be indicated on the information provided to patients. Other commenters recommended that only credentialed facilities are listed on the notice, or that credentialed facilities be given special designation on the disclosure notice.

Response: We are not requiring any quality indication on the list of alternate suppliers at this time. Because the referring physician will most likely be reviewing the results of the advanced imaging service that the patient receives, it is reasonable to think that the physician will include quality suppliers on the list. We are not convinced to limit the list of suppliers to those who receive accreditation. Nothing in the statute or this final rule with comment prevents physicians from furnishing a list that designates a supplier's credentialing status.

Comment: Two commenters requested that CMS provide clarification on the frequency with which the physician must review and update the list of suppliers. For example, commenters asked if the notice should be reviewed for accuracy if a supplier relocates or any contact information changes. In addition, one of the commenters asked about the obligation of the referring physician to ensure that the suppliers listed are accepting new Medicare patients.

Response: We suggest that the list of suppliers should be reviewed annually for

accuracy and updated at that time, if necessary. We do not believe an annual update would be overly burdensome for physicians. We believe an inaccurate list of alternate facilities would lead to beneficiary confusion and that annually reviewing and modifying the notice as needed would ensure that patients receive complete and accurate information in accordance with this disclosure requirement.

In addition, referring physicians are not obligated to list only suppliers that are accepting new Medicare patients; however, as the disclosure notice is intended to allow patients to make informed choices, referring physicians should make a reasonable effort to ensure that the suppliers listed in the disclosure are viable options for all of their patients for the services being referred.

d. Documentation of Disclosure

We proposed that, in order to document that this disclosure notice was satisfied, a record of the patient's signature on the disclosure notification must be maintained as an element of the patient's medical record. We are modifying this proposal in this final rule with comment to remove the patient signature requirement.

Comment: Many commenters stated that the burden of obtaining and retaining the patient's signature in the medical record is burdensome. Other commenters noted that, as suppliers move toward maintaining electronic health records, an additional paperwork requirement seems counter to these goals and recommended that CMS include an electronic alternative to the maintenance of a signed copy of the disclosure notice in patients' medical records. Another commenter noted that because the notification of alternate suppliers is not a clinical document, it might not belong in a patient's medical record. A commenter asked if the disclosure document must be maintained in the

patient's main medical record or if it could be maintained instead with the patient's radiological documentation, which can be maintained electronically in a PACS system with the physician's orders for the study.

A commenter recommended that CMS accept as sufficient documentation, a note in the patient's chart that a member of the staff provided the letter and explained it to the patient. Another suggestion from a commenter was that physicians maintain a dated notification log at the front desk that patients will sign once they have received and reviewed their disclosure lists. These logs will then be retained and filed by the office for potential review by regulators or accreditors.

One commenter supported the requirement to maintain a copy of the disclosure in the patient's medical record.

Response: We acknowledge that obtaining the patient's signature and maintaining a copy of such in the medical record may be burdensome. In this final rule with comment we are removing the requirement to obtain the patient's signature on the disclosure and to maintain this documentation in the medical record. Nevertheless, as a matter of prudent business practices, physicians should be able to document or otherwise establish that they have complied with the disclosure requirement. For example, the physician could document in the patient's chart that the notice was given to the patient.

e. Effective Date

We proposed that the new disclosure requirement shall apply only to services furnished on or after the effective date of these final regulations, January 1, 2011. We did not receive any comments suggesting any alternate effective date. We are finalizing the effective date as proposed.

f. Other comments

Comment: Some commenters submitted comments addressing topics beyond the scope of this proposal. These comments included detailed discussions of the in-office ancillary services exception, services that should be excluded from that exception, MedPAC's analysis on the issue, as well as questions about the anti-markup payment limitation (§414.50) and a request that we respond to comments we requested regarding incentive payment or shared savings arrangements.

Response: These comments are beyond the scope of this rulemaking and are not addressed in this final rule with comment. If these issues are addressed in the future, we will publish a notice of proposed rulemaking that will be open to public comment at that time.

U. Section 6404: Maximum Period for Submission of Medicare Claims Reduced to Not More than 12 Months

1. Background

Sections 1814(a)(1), 1835(a), and 1842(b)(3)(B) of the Act establish time limits for filing Medicare Part A and B claims. Prior to the enactment of the ACA, under sections 1814(a)(1) and 1835(a) of the Act, providers could file for Part A and Part B claims, respectively, "...no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year…". Prior to the enactment of the ACA, CMS was authorized to establish a

minimum time limit for provider-submitted Part A and Part B claims of at least 1 calendar year from the date of service, and a maximum time limit not to exceed 4 years and 3 months after the date of service.

Additionally, prior to the enactment of the ACA, under section 1842(b)(3)(B) of the Act, Part B claims for physician and other supplier services could be filed with Medicare "... no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year)…". Therefore, prior to the enactment of the ACA, we were authorized to establish a minimum time limit for filing Part B claims of 15 months and a potential maximum of 27 months after the service was furnished, depending on what month of the year the service was furnished.

Section 424.44 of the regulations implements sections 1814(a)(1), 1835(a), and 1842(b)(3)(B) of the Act. In order to effectively administer the Medicare Program, we, through regulations, modified the potential minimum and maximum time periods for filing Part A claims. At §424.44(a), we adopted the minimum time limit of 15 months and potential maximum of 27 months after the service was furnished that was permitted under section 1842(b)(3)(B) of the Act for Part B claims and uniformly applied that 15 to 27 month time limit to both Part A and B claims. Also, under §424.44(b), we allowed providers and suppliers the opportunity to file claims after the 15 to 27 month deadline for filing claims expired when the failure to file "...was caused by error or misrepresentation of an employee, intermediary, carrier, or agent of the Department that was performing Medicare functions and acting within the scope of its authority."

2. Provisions of the ACA

Section 6404 of the ACA amended sections 1814(a)(1), 1835(a), and 1842(b)(3)(B) of the Act regarding Medicare fee-for-service (FFS) claims for services furnished on or after January 1, 2010. Under section 6404(b)(1) of the ACA, all claims for services furnished on or after January 1, 2010 must be filed within 1 calendar year after the date of service. Section 6404 of the ACA did not amend sections 1814(a)(1), 1835(a), and 1842(b)(3)(B) of the Act for services furnished before January 1, 2010. However, section 6404(b)(2) of the ACA created a new requirement that claims for services furnished before January 1, 2010 must be filed on or before December 31, 2010. Thus, the statutory provisions prior to the enactment of the ACA remain in effect for pre-2010 services, subject to this new requirement. The practical effect of this change is that any claims for services furnished before October 1, 2009 will follow the existing regulations. But for services furnished during the last 3 months of 2009, providers and suppliers must file claims no later than December 31, 2010. For services furnished between October 1, 2009 and December 31, 2009, providers and suppliers will only have 12 to 15 months to file a claim, whereas before the ACA amendments, they would have had an additional year to file their claims, or 24 to 27 months.

The majority of the comments that we received for the proposed rule were supportive of our proposed exceptions at §424.44(b)(2) and (3) concerning retroactive entitlement situations and dual-eligible beneficiary situations. However, some commenters encouraged us to either expand those proposed exceptions or suggested other new exceptions.

Comment: One commenter stated that CMS should instruct Medicare Intermediaries to process claims where provider representatives are submitting

retroactive claims within 6 months from the Social Security Administration's (SSA) notification date due to SSA's delay in processing beneficiaries' retroactive Medicare entitlement. Moreover, the commenter cited to an OIG evaluation report dated January 2006 (A-13-05-15028), which stated that the average number of years where beneficiaries are awarded retroactive Medicare benefits is about 8 years. Therefore, the commenter asserted that when SSA corrects the error and sends a notification letter to beneficiaries, providers should be allowed to submit claims to Medicare Intermediaries as long as the claims are submitted within 6 months from the notification letter from SSA and as long as supporting documentation is attached to the claims.

Response: As stated in the CY 2011 PFS proposed rule, if CMS or one of its contractors determines that one of the exceptions to the time limits for filing claims applies, then the time to file a claim will be extended. We will update its internet only manual instructions to its contractors so that Medicare's contractors are aware of the new timely filing requirements, the exceptions to those requirements, and process claims in accordance with these new requirements.

Comment: Two commenters disagreed that services furnished between October 1, 2009 through December 31, 2009 must be billed by December 31, 2010 and asserted that our proposed language at §424.44(a) is in contravention of explicit statutory language.

Response: We disagree with the commenter because section 6404(b)(2) of the ACA clearly states that—"In the case of services furnished before January 1, 2010, a bill or request for payment under section 1814(a)(1), 1842(b)(3)(B), or 1835(a) of the Act shall be filed not later than December 31, 2010". Therefore, because the statute

specifically addresses this issue, we must require that services furnished between October 1, 2009 through December 31, 2009 be filed by December 31, 2010.

Comment: Two commenters suggested that CMS create an additional exception to the timely filing rules to permit providers to submit claims for services at the request of a Medicaid State Agency or its agent under the terms of the regulation prior to these current revisions; that is, by the end of the calendar year following the year in which the services were delivered (with services delivered in the last quarter of a calendar year being treated as though they were delivered in the next calendar year). The commenters believe that this type of additional exception would permit Medicaid State Agencies to assure proper billing of services to Medicare, as an appropriate third party payer, without overtaxing providers or Medicare contractors by requiring them to submit multiple claims at varying times. Additionally, a third commenter stated that the third condition of the exception at §424.44(b)(3) could be interpreted to mean that the Medicaid agency must recover their payment from a provider or supplier prior to the provider or supplier billing Medicare. The commenter believes that it would be a better practice to notify providers of the Medicaid agency's intention to recover prior to performing the actual recovery.

Response: We were not persuaded to modify the rule in order to create an additional exception to permit providers and suppliers to submit claims for services at the request of a Medicaid State Agency prior to the State Medicaid Agency actually recovering the payment. Providers and suppliers do not necessarily have to wait for Medicaid to recover its payment (see §424.44(b)(3)) in order to utilize an exception to the timely filing rules in retroactive entitlement situations because the proposed exception at §424.44(b)(2) may be used by providers and suppliers in order to file claims prior to a

State Medicaid Agency recovering its payments. As we stated in §424.44(b)(2), if CMS or one of its contractors determines that at the time the service was furnished the beneficiary was not entitled to Medicare and the beneficiary subsequently received notification of Medicare entitlement effective retroactively to the date of the furnished service, then the time limit to file a claim may be extended.

Comment: Three commenters suggested that an exception to the timely filing rules should be created for Medicare beneficiaries who are retroactively disenrolled from a Medicare Advantage plan so that all claims for services provided to the beneficiary while enrolled in the Medicare Advantage plan (upon retroactive disenrollment) can be submitted for coverage and payment to original Medicare. The commenters stated that a beneficiary may be retroactively disenrolled from that plan under a variety of circumstances. Moreover the commenters asserted that if a retroactively disenrolled beneficiary is unable to have claims for services submitted to original Medicare because some of those services were delivered more than a year prior to the date of actual disenrollment, then the beneficiary will be unable to be made whole and the ability to disenroll from a Medicare Advantage plan will be rendered pyrrhic at best.

Response: We modified the final rule based on these comments and created an additional exception for retroactive disenrollment from Medicare Advantage plans at §424.44(b)(4). Although we did not receive a comment requesting an exception for retroactive disenrollment from Program of All-inclusive Care for the Elderly (PACE) provider organizations, we included retroactive disenrollment from PACE in the exception at §424.44(b)(4) because beneficiaries, providers, and suppliers could also be disadvantaged in retroactive disenrollment PACE situations.

Comment: Two commenters suggested that an exception to the timely filing rules should be created when a private payer recovers its payment from the provider 11 months or more after the date of service. The commenters stated that hospitals routinely experience payment retractions from private payers that are outside the hospitals' control and that may prevent a Medicare claim from being filed within one year of the date of service.

Response: We were not persuaded to modify the rule by these comments because providers are already required "to maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented". See §489.20(f). Also, section 1862(b)(6) of the Act states—"…no payment may be made for any item or service furnished under part B unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans". Therefore, we are not modifying the rule based on this comment because creating an exception to the timely filing limitations for these situations would allow providers and suppliers to circumvent the statutory and regulatory requirements stated above.

Comment: Two commenters suggested that CMS create an exception to the timely filing rules for Medicare Secondary Payer (MSP) claims when the initial payment determination by the primary payer is not received by the hospital in sufficient time to permit timely filing of the MSP claim. A third commenter recommended that in cases where Medicare is not the primary payer, the filing deadline be extended to 12 months

from the date the payment is made for the products or services by the payer immediately primary to Medicare (that is, the primary payer when Medicare is the secondary payer, and the secondary payer when Medicare is tertiary).

Response: We were not persuaded to modify the rule by these comments because Medicare may make conditional payments for services when a payer that is primary to Medicare does not pay promptly. "Prompt" or "promptly", when used in connection with primary payments, except as provided in §411.50, for payments by liability insurers, means payment within 120 days after receipt of the claim. See 42 CFR part 411 subparts B through H and §411.21 and §411.24 for the definitions of conditional payment and promptly. Moreover, because providers are already required "to maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented" (See §489.20(f)) we do not believe a provider's ability to meet the new 1 calendar year timely filing requirement will be compromised by the commenter's concerns.

Comment: Three commenters suggested that CMS create an exception to the timely filing rules so that hospitals are permitted to file inpatient Part B only claims for any inpatient cases that are retrospectively reviewed by a Medicare Recovery Audit Contractor (RAC) or other review entity and determined not to be medically necessary in an inpatient setting. The commenters pointed out that with the reduction of the timely filing period to one year from the date of service, legitimate rebilling opportunities are limited since Medicare RAC's may audit Medicare claims that were paid up to 3 years ago.

Response: We were not persuaded to modify the rule by these comments because

Medicare's billing guidelines instruct providers regarding what types of inpatient services may be billed to Part A and to Part B. Therefore, it is the responsibility of a provider to correctly submit claims to Medicare by coding the services appropriately.

Comment: In the CY 2011 PFS proposed rule, CMS solicited comments regarding whether CMS should provide a regulatory definition of "date of service" and, if so, how should it define this term. One commenter suggests that the "date of service" be defined through administrative instructions as the "through date" on the Medicare claim (UB-04 form locator 6, statement covers period). A second commenter stated that CMS should adopt as a final rule the guidance on "Date of Service" provided in MLN Matters Number 7080 and Transmittal 734, Change Request 7080. CMS Manual System, Pub 100-20 One-Time Notification, July 30, 2010. This guidance provides that for institutional claims that include span dates, the "Through" date on the claim will be used to determine the date of service for claims filing timeliness; for professional claims (CMS-1500 Form and 837P) submitted by physicians and other suppliers that include span dates of service, the guidance states that the line item "From" date will be used to determine the date of service and filing.

Response: We decided not to define "date of service" in the final rule because, as we stated in the CY 2011 PFS proposed rule, we recognize that for many Part A and B services it is difficult to craft a uniform rule that will apply a consistent date of service standard. Therefore, we decided to address the "date of service" issue via sub-regulatory guidance. We issued sub regulatory guidance on what constitutes the "date of service" for some items and services on May 7, 2010 via Change Request 6960 and on July 30, 2010 via Change Request 7080 to our Medicare contractors and it is our

intention to provide additional sub-regulatory guidance as the need arises for different Part A and B services.

Comment: One commenter believed an exception should be created for claims for consumers who retroactively enroll in original Medicare Part B, such as consumers who successfully apply for equitable relief. For example, a person may choose to take Part A (because it is premium free) but may mistakenly choose not to enroll in Medicare Part B due to cost or because they believe that other insurance for which they already pay a premium, such as retiree coverage or coverage through a group health plan provided by a small employer, will pay medical costs. As a result, insurance that is supposed to pay secondary to Medicare incorrectly pays primary. The commenter goes on to assert that if the insurance plan discovers that a person was eligible for Medicare Part B but did not enroll and therefore the plan was supposed to pay secondary, the insurer can recoup payments made back to the date the enrollee became Medicare Part B eligible. In some instances, a person may obtain a retroactive Medicare Part B start date back to the original date of Medicare eligibility. This retroactive start date can be a few months to a few years and is not limited by statute. As a result, providers from which secondary insurer's recouped payment would need the ability to submit claims to Medicare for services provided over one year in the past. In these cases, because the consumer is already enrolled in Medicare Part A and not Part B, the commenter is concerned that claims would not fall under the language of §424.44(2)(ii) as the consumer is already entitled to Medicare.

Response: Although this comment was unclear, we believe the commenter wants CMS to create an exception to the time limits for filing claims specifically for Part B

services. We were not persuaded to modify the rule by these comments because if a beneficiary is granted equitable relief under section 1837(h) of Act, the beneficiary may still be able to use the exception at §424.44(b)(2). Of course, all of the conditions for §424.44(b)(2) will need to be satisfied in order for an exception to be granted in a particular case. It is important to note that all of the exceptions in §424.44(b) (including the exception for §424.44(b)(2)) are not limited to just Part A services; the exceptions may also be granted for Part B services when applicable.

Comment: One commenter asked whether the 4 years from date of service limitation specified in §424.44(b)(1) applies when the SSA makes an administrative error in determining a beneficiary's retroactive entitlement decision since the SSA is not considered an agent or contractor to CMS. Or, would this be covered under §424.44(b)(2) or §424.44(b)(3) without the 4 year limitation? The commenter recommended that CMS clarify in the final rule that the 4 year limitation does not apply when the result of a retroactive Medicare decision was due to SSA's administrative error in incorrectly and untimely processing of beneficiaries eligibility determinations.

Response: Section 424.44(b)(1) only applies to errors or misrepresentations that are made by an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of the Department that was performing Medicare functions and acting within the scope of its authority. It does not apply to errors or misrepresentations made by the SSA; therefore, the 4 year restriction for §424.44(b)(1) would not apply because §424.44(b)(2) and (3) could be used in situations where the SSA makes an error. However, it is important to note that errors or misrepresentations by the SSA are not one of the conditions that must be met in order for

an extension of time to be granted under §424.44(b)(2) and (3).

Comment: Two commenters recommended that if the SSA cannot locate a copy of the original retroactive notification letter that was sent to the beneficiary, then CMS should allow providers or beneficiaries to submit the notification letter that they received from SSA that clearly indicates the beneficiary's retroactive entitlement date and the date in which the notification of SSA's retroactive decision was made. Therefore, the regulations and guidelines should address alternate proof of coverage in the event a copy of the actual Notice of Award is unavailable.

Response: We were not persuaded to modify the rule by these comments because we believe these types of documentation or proof of retroactive entitlement issues should be addressed via sub-regulatory guidance. Therefore, we will consider these comments when we update our internet only manual instructions to our contractors.

Comment: One commenter suggested that there should be an exception to account for claims filed for beneficiaries granted Medicare entitlement retroactively because of the 30+ years of systemic errors of SSA's Special Disability Workload (SDW). The commenter stated that this issue is currently in bill form before both houses of Congress and that failing a legislative solution this proposed rule would bar States from perfecting rightful claims for services provided over the years under Medicaid that should have been provided by Medicare. The commenter goes on to state that States will have great difficulty in reaching out to providers over 30 years of services to recoup third party liability from Medicare. Despite such difficulty, States should retain the right to file claims and they should not be barred by this proposed rule. The proposed rule states that "we believe that limiting this exception to 4 years after the dates of service strikes an

appropriate balance between fairness and equity for providers, suppliers, and beneficiaries and administrative finality for the Medicare program". The commenter asserts that the proposed rule does not show any consideration of States' interests in pursuing third party liability against Medicare based on systemic failures by SSA, the agency responsible for determining Medicare eligibility.

Response: The commenter's statement that States should retain the right to file claims is outside the scope of this rule; therefore, we will not address that particular comment. We were not persuaded to modify the rule by the other comments because §424.44(b)(1) only applies to errors or misrepresentations that are made by an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of the Department that was performing Medicare functions and acting within the scope of its authority. It does not apply to errors or misrepresentations made by the SSA; therefore, the 4 year restriction for §424.44(b)(1) would not apply in the situation described by the commenter, but §424.44(b)(2) and (3) could be used in situations where the SSA makes an error. However, it is important to note that errors or misrepresentations by the SSA are not one of the conditions that must be met in order for an extension of time to be granted under §424.44(b)(2) and (3).

Comment: One commenter suggested that CMS consider allowing the exception for dually-eligible beneficiaries at §424.44(b)(3) to apply if any one of the three conditions are met as opposed to all of the conditions.

Response: We were not persuaded to modify the rule by this comment because it would make the dual-eligible exception meaningless. The first condition of §424.44(b)(3) states—"At the time the service was furnished the beneficiary was not

entitled to Medicare". That first condition could apply to every service a person has ever received during his or her lifetime prior to becoming a Medicare beneficiary. Therefore, under the commenter's suggestion the exception would be meaningless.

Comment: One commenter suggested that the first condition of the exception at §424.44(b)(3) include cases in which Medicare coverage is unknown to the Medicaid agency at the time of service instead of using the condition that at the time the service was furnished the beneficiary was not entitled to Medicare.

Response: We were not persuaded to modify the rule by this comment because if the beneficiary was already entitled to Medicare at the time the service was furnished, then the provider or supplier could have taken the necessary actions to find out that the individual was a Medicare beneficiary. For example, the provider could have asked the beneficiary prior to admission, checked with CMS, etc.

Comment: One commenter stated that the second condition of the exception at §424.44(b)(3) assumes that because the beneficiary is notified about retroactive Medicare coverage that the provider of service and the State Medicaid Agency is concurrently notified, which may not always be the case. Because this is a direct communication between the Medicare program and its beneficiary, CMS should address how providers and the Medicaid agency will evidence dual eligibility to Medicare's contractors in an effort to meet this condition.

Response: We were not persuaded to modify the rule by these comments even though we agree that it is possible that providers, suppliers, and State Medicaid Agencies may not be notified concurrently about a beneficiary's retroactive Medicare entitlement. However, the exception at §424.44(b)(3) does not prevent providers and suppliers from

requesting an exception to the time limits for filing a claim because the provider or supplier will always be notified about a beneficiary's retroactive entitlement whenever a State Medicaid Agency recovers its payment.

Pursuant to §424.44(b)(5)(iii), the date when the State Medicaid Agency actually recovers its payment from the provider or supplier is when the extension of time to file the claim through the last day of the 6th calendar month is triggered. In other words, assuming that all three of the conditions for §424.44(b)(3) are met, providers and suppliers will possess the ability to file a claim through the last day of the 6th calendar month after the date the State Medicaid Agency recovers its payment. Unlike the 4 year restriction (§424.44(b)(5)(i)) placed on the exception at §424.44(b)(1), which is commonly referred to as the exception for "administrative error," there is no similar time restriction regarding when a provider or supplier may request an exception under §424.44(b)(3). Therefore, providers and suppliers should note that once the State Medicaid Agency recovers its payment for the services, providers and suppliers will only have through the last day of the 6th calendar month after that recovery date to file a claim (assuming that all three of the conditions for §424.44(b)(3) are met).

Comment: One commenter recommends that CMS define "retroactive Medicare" for the purpose of these proposed exceptions. The commenter stated that they understand retroactive Medicare to be the extension of benefits to a date in the past but believe that confirmation or clarification of this definition should be issued by CMS.

Response: Although this comment was unclear, we believe the commenter wants CMS to clarify what Medicare entitlement effective retroactively to or before the date of the furnished service means. We were not persuaded to modify the rule by this comment

because we did not use the term "retroactive Medicare" in the regulation text. Instead, the regulation text used the following language—"the beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service"-- which we believe makes it clear that a beneficiary is receiving his or her Medicare entitlement beginning at some date in the past.

Comment: One commenter recommends that in States which have a contract with the SSA to determine eligibility for Medicaid at the same time a determination is made for receipt of Social Security Income (SSI) benefits (see section 1634(a) of the Act), that CMS should clarify if Medicare retroactivity will include requests for prior month premium payments.

Response: Although this comment was unclear, we believe the commenter wants to know whether the exceptions to the time limits for filing claims is limited to just Part A services. Because the commenter refers to requests for prior month premium payments, we believe that the commenter is concerned about what happens when State Medicaid Agencies pay Part B premiums on behalf of dual-eligible beneficiaries. If a beneficiary receives notification of Medicare entitlement (Part A) effective retroactively to or before the date of a furnished service and a State Medicaid Agency (or the beneficiary or anyone else) pays for that beneficiary's Part B monthly premium retroactively to or before the date of a Part B furnished service, then those "old" Part B services for that beneficiary may be granted an extension to the time limits for filing as long as the other conditions for that particular exception are also met. In other words, the exceptions for §424.44(b)(2) and (3) are not limited to just Part A services; the exceptions may also be granted for Part B services when applicable.

Comment: One commenter stated that the ACA provision essentially provides providers with a 12 month period in which to file claims for services for which they have reason to believe Medicare may be responsible. However, in the exceptions proposed by CMS, a provider only has 6 months to file a claim. Consistency with the ACA would suggest that the time to file a claim under each exception should be extended through the last day of the 12th month following the month in which the exception applies. The commenter also stated that with regard to the proposed exceptions, the time limit should be based on the month in which the error or misrepresentation is corrected and the provider is notified of that fact. There may be some time between when the error or misrepresentation is corrected and when the provider is notified of that fact and the extended time limit should begin when the provider becomes aware of the correction. A second commenter stated that the timeframe for filing claims applicable to services provided to beneficiaries who become retroactively entitled to Medicare (regardless of whether they are dual-eligible beneficiaries) should be extended to the later of: (1) the date that is 12 months after the date that the beneficiary is notified of retroactive Medicare entitlement, or (2) the date that is 12 months after the provider or supplier becomes aware of retroactive Medicare entitlement.

Response: We are modifying §424.44(b)(5)(ii) based on these comments because we agree that in retroactive entitlement situations there could be situations where a provider or supplier may not be notified of a beneficiary's retroactive entitlement in order to utilize the exception at §424.44(b)(2). Therefore, we are modifying §424.44(b)(5)(ii) so that notification to either party (that is, the beneficiary or the provider/supplier) for the first time about a beneficiary's retroactive entitlement will

trigger when the extension of time to file the claim through the last day of the 6th calendar month begins. We understand that this rule may result in two extension of time triggers if the beneficiary and the provider/supplier are not notified on the same day (one for when the beneficiary is first notified and one for when the provider or supplier is first notified); however, we agree with the commenter that it would be unfair to providers and suppliers to limit the exception based only on when the beneficiary receives notification.

We are also modifying §424.44(b)(5)(i) based on these comments because we agree that there may be situations where a provider or supplier may be able to utilize the exception under §424.44(b)(1) commonly referred to as the "administrative error" exception, but the provider or supplier is not notified about the correction until it is too late to utilize the exception. Therefore, we are modifying §424.44(b)(5)(i) so that notification to either party (that is, the beneficiary or the provider/supplier) for the first time about the administrative error correction will trigger when the extension of time to file the claim through the last day of the 6th calendar month begins. We understand that this rule may result in two extension of time triggers if the beneficiary and the provider/supplier are not notified on the same day (one for when the beneficiary is first notified and one for when the provider or supplier is first notified); however, we agree with the commenter that it would be unfair to providers and suppliers to limit the exception based only on when the "administrative error" is actually corrected.

However, we were not persuaded to modify the rule for dual-eligible situations (see §424.44(b)(3)) because the extension of time to file a claim through the last day of the 6th calendar month is triggered in dual-eligible situations when the State Medicaid Agency recovers its payment from the provider or supplier. Therefore, providers and

suppliers will always receive sufficient notification in dual-eligible situations because the date that the State Medicaid Agency recovers its payment will be the provider's or supplier's notice that they have through the last day of the 6th calendar month in order to file a claim (assuming of course that CMS or its contractors determines that all the conditions in §424.44(b)(3) are met and grants an extension).

Also, we were not persuaded to modify the rule based on the comment that the time to file a claim under each exception should be extended through the last day of the 12th month following the month in which the exception applies. Because the triggering events for the exceptions at §424.44(b)(1), (2), and (3) cannot occur without the provider or supplier actually being notified, we believe that an extension of time to file a claim through the last day of the 6th calendar month after those triggering events gives providers and suppliers sufficient time to submit their claims.

Comment: Two commenters requested that CMS create an additional exception for those instances where the issuance of new Medicare provider numbers are delayed due to no fault of the provider. The commenter stated that numerous Medicare contractors are taking 60 to 120 days or longer to process and finalize CMS enrollment applications. Additionally, and more importantly, many State survey agencies are extremely behind on initial Medicare State surveys. In some cases, it is taking 2 years for the State to conduct the required survey for the providers. These delays significantly restrict a provider's ability to submit claims for services furnished prior to the effective date of the Medicare billing privileges and the commenter hopes that CMS would work with the provider community to process claims under these circumstances. Another commenter recommended that CMS should provide an exception for provider enrollment

delays caused by the MAC or CMS Regional Office that are outside the control of the provider. The commenter recommended that CMS should extend the time to file a claim through the last day of the 6th calendar month following the month in which provider enrollment was completed with an additional 30 days allowed for each full or partial month between the effective date of the provider enrollment and the approval date of the provider enrollment. This additional time is necessary to accommodate Medicare's sequential billing requirement.

Response: We were not persuaded to modify the rule based on these comments because regulations at §424.520, §424.521, and §489.13 already establish an effective billing date for providers and suppliers and those regulations have already established limitations on retroactive billing for providers and suppliers.

Comment: Two commenters stated that the Medicare Secondary Payer rules do allow a provider to file with Medicare if the otherwise primary payer is going to take awhile to pay. Notwithstanding, there have been situations which would warrant enumeration in an exceptions regulation. Providers have experienced situations where an insurance company has executed a retroactive denial of a previously paid claim after a year. When this happens, the timely filing clock should start with the denial date. Thus, the commenter recommends that:

- CMS should continue to allow for payment when a primary payer may take a substantial amount of time to pay;
- CMS should allow for a claim to be considered timely if it is filed within 1 year from the date that the primary payer has made its payment determination; and

● CMS should allow for a claim to be considered timely if it is filed within 1 year from the date that the primary payer retroactively denied a prior previously paid claim.

Response: We were not persuaded to modify the rule by these comments because Medicare may make conditional payments for services when a payer that is primary to Medicare does not pay promptly. "Prompt" or "promptly", when used in connection with primary payments, except as provided in §411.50, for payments by liability insurers, means payment within 120 days after receipt of the claim. See 42 CFR part 411 subparts B through H and §411.21 for the definitions of conditional payment and promptly.

Also, section 1862(b)(6) of the Act states—"…no payment may be made for any item or service furnished under part B unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans". Moreover, because providers are already required "to maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented" (See §489.20(f)) we do not believe a provider's ability to meet the new 1 calendar year timely filing requirement will be compromised by the commenter's concerns.

Comment: One commenter stated that providers have reported that they are experiencing a need to cancel previously processed Part B claims in order to submit benefits exhaust claims. Depending on the time frame for this, providers may be unable to resubmit the Part B charges. Providers need either a mechanism for submitting

benefits exhaust claims for older dates of service that does not require the cancelling of previously processed claims or they need an exception granted for resubmitting claims that had been processed timely but needed to be cancelled to submit benefits exhaust claims. The commenter recommends that CMS should provide a mechanism for submitting benefits exhaust claims for older dates of service that does not require the cancelling of previously processed claim.

Response: We are not aware of the specific scenario described by the commenter; however, we will monitor this issue and determine whether any additional sub-regulatory guidance is needed in this area.

Comment: One commenter stated that there have been cases in which a facility has been under a payment ban and the lifting of the remedy was not communicated to the facility in a timely manner, thus prohibiting the timely filing of claims. The commenter recommended that CMS should start the timely filing clock with the date that the lifting of a payment ban is communicated to the provider.

Response: We were not persuaded to modify the rule by this comment because if the failure to file a claim timely was the result of an error or misrepresentation that was made by an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of the Department that was performing Medicare functions and acting within the scope of its authority, then the provider may be able to utilize the exception under §424.44(b)(1) commonly referred to as the "administrative error" exception in order to file a claim.

Comment: One commenter stated that when a provider is trying to adjust a claim for the purpose of returning money to the Medicare program, timely filing should not

apply. Conversely, when a provider finds an error that had caused an underpayment, the provider should be allowed to file an amended claim and receive the increased compensation. Therefore, the commenter recommends that CMS should provide that timely filing under amended §424.44 not apply when a provider is trying to adjust a claim for the purpose of returning money to the Medicare program, or, conversely, when a provider finds an error that had caused an underpayment.

Response: We were not persuaded to modify the rule by these comments because the timely filing provision of section 6404 of the ACA and subsequent final rule amending §424.44 is not intended to address requests for re-determinations of initial determinations by Medicare contractors such as those described by the commenter. The regulations for such requests are detailed in 42 CFR part 405, subparts G, H, and I.

Comment: One commenter stated that they regularly file claims within 1 calendar year after the date of service that are either rejected or denied and that are subsequently approved after being re-filed. In certain instances, the date of re-filing, because of the time period before the rejection or denial, is more than one year after the date of service. The commenter recommends that the timely filing rule should be and is satisfied when an original claim is timely filed within 1 calendar year after the date of service, regardless of the date of any resubmission.

Response: We were not persuaded to modify the rule by this comment because, for example, if a provider or supplier fails to include a particular item or service on its initial claim, fails to include all the necessary information in order for an initial determination to be made on that claim or fails to file the claim on a form prescribed by us, then a provider or supplier cannot attempt to re-file that claim more than 1 calendar

year after the date that the service was furnished. An incomplete or rejected claim cannot act as a placeholder for a claim that has yet to be filed because that would clearly be a way for providers and suppliers to avoid the 1 calendar year requirement stated in section 6404 of the ACA. Moreover, it would create a multitude of problems for CMS to deal with operationally or administratively because CMS would need to have the ability to track all rejected claims or all claims that failed to receive an initial determination and be able to match those rejected or incomplete claims up with all of the complete or valid claims that would eventually be filed months or years later so that an initial determination could be made.

Comment: One commenter stated that it is unnecessary to impose an additional restriction to the exception for claims filed for services provided to dual-eligible individuals. The third condition for the exception at §424.44(b)(3) that a State Medicaid Agency recovers the Medicaid payment for the furnished service from a provider or supplier 11 months or more after the date of service is too restrictive and CMS should have used a different time period.

Response: We agreed with the commenter that the 11 months or more after the date of service requirement in §424.44(b)(3)(iii) was too restrictive and therefore we modified the final rule based on these comments by changing the time period from 11 months to 6 months or more after the service was furnished.

Comment: One commenter suggests that CMS amend the third condition of §424.44(b)(3) to read as follows-- "A State Medicaid agency or Provider recovered the Medicaid payment for the furnished service from the provider or supplier 11 months or more after the date of service." The commenter stated that occasionally providers

identify retroactive Medicare coverage after Medicaid has paid without receiving notification from the State Medicaid agency. The provider needs to have the ability to correct the payer order when necessary before their existing payment is recouped.

Response: We were not persuaded to modify the rule by these comments because when a provider refunds a payment that is made to it by a State Medicaid Agency, the provider is not recovering a State Medicaid payment. Instead, when the State Medicaid Agency accepts that refunded payment from the provider, we consider the State Medicaid Agency to actually be recovering that Medicaid payment. Therefore, when a State Medicaid Agency accepts a provider's refunded payment 6 months or more after the service was furnished, then the third condition of §424.44(b)(3) will be met. Of course, the first two conditions of §424.44(b)(3) will also need to be met in order for an extension to be granted under §424.44(b)(3).

Comment: One commenter stated that due to the limited home infusion benefit under Medicare Part B, home infusion suppliers often bill Medicare for the purpose of obtaining Medicare denial billing remittance advices, which are required by other payers. It would be unreasonably costly and confusing for home infusion suppliers to receive timely filing limit denials for services provided to individuals for whom the supplier is unaware of retroactive Medicare entitlement during the allowable filing period. The commenter urged CMS to ensure that infusion suppliers do not have to face this situation.

Response: Although this comment was unclear, we believe the commenter is concerned that home infusion suppliers will be disadvantaged by the exception at §424.44(b)(2). If the conditions for §424.44(b)(2) are met, then home infusion suppliers will be able to utilize that exception the same as any other provider or supplier and

therefore will not be adversely impacted by this rule.

Comment: One commenter urges CMS to make communication about this new deadline a priority for the Agency. This should include a prominent banner on the CMS website home page as well as clear and concise written communications with Medicare providers. It is important that providers not have claims rejected due to lack of awareness of new claims submission deadlines.

Response: Although this comment is outside the scope of this rule, we issued sub-regulatory guidance regarding section 6404 of the ACA on May 7, 2010 via Change Request 6960 and on July 30, 2010 via Change Request 7080. As a result of issuing that sub-regulatory guidance, two provider education articles were posted to CMS's Medlearn Matters website educating providers and suppliers about the new 1 calendar year timely filing requirement.

In order to effectuate the changes made by the ACA, we are finalizing our proposed changes to §424.44, with four modifications. First, we are including another exception at §424.44(b) by re-designating §424.44(b)(4) of the proposed rule to §424.44(b)(5) and designating the new exception for retroactive disenrollment from Medicare Advantage plans or Program of All-inclusive Care for the Elderly (PACE) provider organizations as §424.44(b)(4). We are adding this new exception so that beneficiaries, providers, and suppliers may be granted an extension to file claims in Medicare Advantage situations when the following conditions are met:

- At the time the service was furnished the beneficiary was enrolled in a Medicare Advantage plan or PACE provider organization.
- The beneficiary was subsequently disenrolled from the Medicare Advantage

plan or Program of All-inclusive Care for the Elderly (PACE) provider organization effective retroactively to or before the date of the furnished service.

- The Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.

In these situations, if we or one of our contractors determines that all of the conditions are met, then the time to file a claim will be extended through the last day of the 6th calendar month following the month in which the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from the provider or supplier.

The second modification changes §424.44(b)(5)(ii) because in retroactive entitlement situations there could be situations where a provider or supplier may not be notified of a beneficiary's retroactive entitlement in order to utilize the exception at §424.44(b)(2). Therefore, we are modifying §424.44(b)(5)(ii) so that notification to either party (that is, the beneficiary or the provider/supplier) for the first time about a beneficiary's retroactive entitlement will trigger when the extension of time to file the claim through the last day of the 6th calendar month begins.

The third modification changes §424.44(b)(5)(i) because there may be situations where a provider or supplier may be able to utilize the exception under §424.44(b)(1) commonly referred to as the "administrative error" exception, but the provider or supplier is not notified about the correction until it is too late to utilize the exception. Therefore, we are modifying §424.44(b)(5)(i) so that notification to either party (that is, the beneficiary or the provider/supplier) for the first time about the administrative error

correction will trigger the beginning of the extension of time to file the claim through the last day of the 6th calendar month.

The fourth modification changes the 11 months or more after the date of service requirement in §424.44(b)(3)(iii) to 6 months or more after the date of service because the 11 months or more requirement was too restrictive.

V. Section 6410 of the Affordable Care Act and Section 154 of MIPPA: Adjustments to the Metropolitan Statistical Areas (MSA) for Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Acquisition Program

In the July 13, 2010 proposed rule we proposed a number of revisions to the DMEPOS CBP as a result of changes to the statute made by both the Medicare Improvements for Patients and Provider Act of 2008 (MIPPA) and the ACA of 2010. Since both MIPPA and the ACA specify requirements for Metropolitan Statistical Area (MSA) selection for Round 2 and subsequent rounds, we outlined our proposals for implementing the statutory requirements related to MSA selection and the phase in of competitive bidding areas under the DMEPOS CBP. First, we proposed to use the authority provided by the statute at section 1847(a)(1)(D)(ii) of the Act, as amended by MIPPA, to subdivide MSAs with populations of greater than 8,000,000 under Round 2 of the DMEPOS CBP. Second, we proposed to exclude certain areas from competitive bidding after Round 2 as mandated by section 1847(a)(1)(D)(iii) of the Act, as amended by MIPPA. Third, we proposed to implement the requirement of section 6410 of the ACA to expand Round 2 of the program by adding 21 of the largest MSAs based on total population to the original 70 already selected for Round 2.

1. Background

Section VII.H of this final rule provides background on the DMEPOS CBP, including a description of many of the changes made to the program by section 154 of the MIPPA. In this section, we provide additional information regarding changes made by both section 154(a) of the MIPPA and section 6410 of the ACA. In addition to the changes discussed previously in this final rule, MIPPA also added subparagraph (D) to section 1847(a)(1) of the Act. Section 1847(a)(1)(D)(ii) of the Act, as added by MIPPA, addresses Round 2 of the DMEPOS CBP, and section 1847(a)(1)(D)(iii) of the Act addresses subsequent rounds of the Program.

Section 1847(a)(1)(D)(ii)(II) of the Act specifies that the Secretary shall implement DMEPOS competitive bidding in the areas previously selected for Round 2 of the program and also allows the Secretary, in implementing Round 2 of the program, to subdivide MSAs with populations of greater than 8,000,000 into separate CBAs. Section 1847(a)(1)(D)(iii) of the Act imposes new requirements on the Secretary for competitions occurring before 2015 in subsequent rounds of the program. For such competitions (other than national mail order), the following areas are to be excluded from the program: (I) rural areas; (II) MSAs not selected under Round 1 or 2 with a population of less than 250,000; and (III) certain areas with low population density within a selected MSA. These requirements do not apply to a national mail order program.

Finally, MIPPA required that we implement Round 2 of the DMEPOS CBP in the same MSAs that were designated as of June 1, 2008. In 2010, section 6410(a) of the ACA amended sections 1847(a)(1)(B)(i)(II) and (D)(ii) of the Act to expand Round 2 of the program from 70 MSAs to 91 MSAs by adding the next 21 largest MSAs by total population not already selected for Rounds 1 or 2.

2. Subdividing Large MSAs under Round 2

We have selected MSAs for Round 1 and for Round 2 consistent with MIPPA's requirement. For Round 1, CBAs generally were comparable to MSAs, however, for Round 2 we proposed to subdivide MSAs of 8,000,000 or more in population. The authority to subdivide MSAs into separate areas for competitive bidding purposes is set forth in section 1847(a)(1)(D)(ii)(II) of the Act which states, "[t]he Secretary may subdivide metropolitan statistical areas with populations (based upon the most recent data from the Census Bureau) of at least 8,000,000 into separate areas for competitive acquisition purposes." We have identified three MSAs which, based on the 2009 estimate from the Census Bureau data, we subdivided under section 1847(a)(1)(D)(ii)(II) of the Act: (1) Chicago-Naperville-Joliet, Illinois-Indiana-Wisconsin (IL-IN-WI) MSA with a population of 9,569,624; (2) Los Angeles-Long Beach-Santa Ana, California (CA) MSA with a population of 12,872,808; and (3) New York-Northern New Jersey-Long Island, New York-New Jersey-Pennsylvania (NY-NJ-PA) MSA with a population of 19,006,798. We proposed to divide these MSAs into separate CBAs because we believe this approach would create more manageable CBAs for contract suppliers to serve and allow more small suppliers to be considered for participation in the program.

We considered certain factors when deciding whether to subdivide the MSAs with populations of at least 8,000,000. We considered the geographic, social, and economic integration of each of the MSAs. We applied all of these factors when grouping counties into CBAs and we believe it is also appropriate to use these factors to determine: (1) whether or not to subdivide an MSA into separate CBAs, and (2) if the decision is made

to subdivide the MSA, how to subdivide the MSA. We considered the following factors, generally in the order in which they are listed:

- Geographic size of the MSA and the location of the counties within each MSA compared to neighboring counties.
- The driving distances from north to south and east to west within each MSA and county.
- The total population and the population of FFS Medicare beneficiaries using DMEPOS items subject to competitive bidding.
- The DMEPOS allowed charges for items subject to competitive bidding.
- Comparably sized Round 1 and Round 2 MSAs based on beneficiary counts and allowed charges for competitive bid items.
- The interstate highway infrastructures of the MSAs.
- The current service patterns of suppliers in each county of the MSA.

We used each of the factors to the extent practical to develop initial proposals for reasonable and workable subdivisions of these highly and densely populated MSAs. We believe consideration of these factors will help us meet our goal of subdividing large and densely populated MSAs and creating CBAs that are attractive to suppliers and incentivize them to bid competitively for a contract. With this goal in mind, we proposed to establish CBAs that provide for a good volume of DMEPOS business for winning bidders, avoid obvious geographic obstacles, mimic existing supplier service patterns, and, to the extent possible, do not cross State lines. We stated that we believed the factors we have selected will achieve those objectives.

We found that counties clearly delineate areas within a MSA, and as we have done for Round 1 by identifying CBAs by counties and zip codes, we proposed to subdivide the MSAs at a county level. Since the Office of Management and Budget (OMB) defines the MSAs by counties and county-based subdivisions are stable, we use counties to subdivide CBAs. When subdividing an MSA into counties, we consider counties that share social, economic, and geographic integration. We have first summarized the proposed subdivisions, then summarized the comments and finalized the CBAs.

The Chicago-Naperville-Joliet IL-IN-WI MSA comprises 14 counties within 3 States: Illinois, Indiana, and Wisconsin. This MSA has 207,106 beneficiaries and $218,161,562 of DMEPOS allowed charges subject to the DMEPOS CBP. Using the factors that we indentified, we proposed to subdivide the Chicago-Naperville-Joliet, IL-IN-WI MSA into four separate CBAs: Indiana-Chicago Metro CBA; South-West-Chicago-Metro CBA; Central-Chicago Metro CBA; and Northern-Chicago Metro CBA.

The Los Angeles-Long Beach-Santa Ana, CA MSA comprises two counties: Los Angeles County and Orange County. The MSA has 173,631 fee-for-service beneficiaries receiving DMEPOS subject to competitive bidding and $244,523,957 in DMEPOS allowed charges subject to the DMEPOS CBP. As mentioned previously, we proposed to subdivide MSAs using counties, and since the Los Angeles-Long Beach-Santa Ana, CA MSA only has two counties, it offers only one subdivision along the county lines. Hence, we proposed to divide the MSA by the two counties creating two CBAs: Los Angeles County CBA and Orange County CBA. We also proposed to use the authority in section 1847(a)(3)(A)of the Act to exclude certain areas within the Los Angeles-Long Beach-

Santa Ana, CA MSA. We believe these areas meet the requirement of section 1847(a)(3)(A) of the Act; they are rural areas with a low population density within an urban area that are not competitive. In the April 10, 2007 DMEPOS CBP final rule (72 FR 17992), we finalized our regulations at §414.410(c) that defined the factors we consider when determining an area is considered a low population density area or an area that would not be competitive. Based on our review of the County Subdivision Population from the 2000 Census from the U.S. Census Bureau, and using the factors set forth in the April 10, 2007 final rule, we proposed to exclude the area of Los Angeles County north of the San Gabriel Mountains. This large geographic area has a population of about 357,000, which is only 4 percent of the total population of Los Angeles County, and is separated from the rest of the county by the San Gabriel Mountains. The area north of the San Gabriel Mountains has one major road and many terrains which make this area remote. The majority of the population in Los Angeles County lives south of the San Gabriel Mountains. We believe that excluding this area will create a more manageable CBA that still provides sufficient volume of DMEPOS items while avoiding the geographic obstacle of the mountains. We believe including this area in the DMEPOS CBP would result in fewer small suppliers being considered for participation under the program, because we would not expect small suppliers to have the resources to serve these more remote areas. As a result, we expect that it will increase the number of bids submitted for the CBAs within the Los Angeles-Long Beach-Santa Ana, CA MSA.

The Los Angeles County includes the two islands of Santa Catalina and San Clemente off the west coast. We proposed that the two islands be included as a part of the Los Angeles County CBA in order to ensure that beneficiaries presently residing on

these islands or who move to these islands in the future are ensured access to competitively bid items by contract suppliers. San Clemente Island is a military base with a current population of zero; and therefore, the inclusion of this area in the CBA would not result in this island being a part of the supplier service area at this time.

The New York-Northern New Jersey-Long Island, NY-NJ-PA MSA comprises 23 counties in three States: New York, New Jersey and Pennsylvania. The MSA has 344,879 FFS beneficiaries receiving DMEPOS subject to the DMEPOS CBP and $350,449,795 in allowed charges for DMEPOS items subject to competitive bidding. We proposed to subdivide the New York-Northern New Jersey-Long Island, NY-NJ-PA MSA into five CBAs. The proposed Nassau-Brooklyn-Queens CBA would be contiguous to Suffolk County and would consist of the western part of Long Island and extend to the eastern part of New York City. The proposed Suffolk County CBA would consist of the eastern part of Long Island and would encompass most of Long Island. The proposed Bronx-Manhattan NY CBA would include the entire area of Manhattan and the Bronx. The proposed North-West NY Metro CBA would be situated north and west of New York City and would extend into New Jersey and Pennsylvania. The proposed Southern NY Metro CBA included Staten Island and would extend south to Ocean County, New Jersey.

At the March 17, 2010 meeting of the Program Advisory and Oversight Committee (PAOC), we presented these proposals for subdividing these three large MSAs. Various members of the PAOC had the following suggestions for subdividing these MSAs:

- Draw the boundaries of CBAs using the interstate highways rather than the divisions by County.

- Determine the current servicing areas of suppliers by MSA and product category by using a scatter plot.

- Use the Hudson River to divide the CBAs for the New York MSA.

- Carve out Pike and Putnam Counties from the New York MSA due to their location and their low population density.

- Include Manhattan as a separate CBA, due to its unique nature as a self contained area.

- Consider State licensure requirements when we divide the MSAs into CBAs.

- In the LA County CBA, exclude the area north of the San Gabriel Mountains from the CBA.

- Consider traffic patterns when dividing the Los Angeles MSAs into CBAs.

In the July 13, 2010 proposed rule, we stated that we would consider the PAOC's advice and recommendations and further invited comments on the proposed subdivision of the three MSAs.

Comment: One commenter suggested that CMS use main travel arteries to subdivide MSAs. The commenter further explained that using zip codes or county boundaries may be unworkable across a large MSA if the travel arteries do not correspond to the physical boundary lines for counties and zip codes.

Response: We examined travel arteries used by suppliers and supplier service and traffic patterns closely in developing the proposed CBAs. The commenter provided no rationale for use of travel arteries alone to establish CBA boundaries, nor did the

commenter provide a specific methodology or information to use in making selections regarding which of the various highways to use as boundaries. We believe it is appropriate to consider travel arteries as one factor when designing CBAs. However, using this factor alone would result in unworkable CBAs. For example, if the interstate highway system in the Chicago-Naperville-Joliet IL-IN-WI MSA, consisting of 11 different interstate highways (I-55, I-57, I-65, I-80, I-88, I-90, I-94, I-190, I-290, I-294, and I-355), were used as boundaries for CBAs, this would result in approximately 30 different, very small CBAs. As noted above, the numerous highway systems that cut through the MSAs were considered in determining which counties to include in each proposed CBA; therefore, travel arteries were considered and used to develop the CBAs.

In phasing in the competitive bidding program, we adopted the definition of the term "Metropolitan Statistical Area" consistent with that issued by the OMB. The MSA comprises the central county or counties containing the core, plus adjacent outlying counties having a high degree of social and economic integration with the central county as measured through commuting. Using OMB's standards for MSAs, we have found that counties clearly delineate areas within a MSA. Therefore, as we have done for Round 1, we will continue to identify CBAs by counties and zip codes. For the large MSAs, although we used the counties as the basis for determining the CBAs, we considered various factors when determining how to subdivide and group each county within the MSA, including which major travel arteries serve which counties or group of counties in a geographic location.

Comment: One commenter suggested that CMS should not finalize regulations expanding the DMEPOS CBP to implement Round 2 until the impact of implementation

of Round 1 of the program on Medicare beneficiaries, suppliers and providers is fully evaluated and understood.

Response: Section 1847(a)(1)(B)(i)(II) of the Act mandates that competitions occur in 2011 for Round 2 of the CBP.

We did not receive comments on the specific CBAs proposed for the Chicago-Naperville-Joliet, IL-IN-WI MSA and are finalizing the CBAs in that MSA as proposed. The counties that comprise each of the final CBAs for this MSA are shown in Table 68. The DMEPOS allowed amount, beneficiary count subject to competitive bidding, and the general population that comprise these four final CBAs are shown in this table.

TABLE 68:
Chicago-Naperville-Joliet, IL-IN-WI

CBA Name County	DMEPOS Allowed Charles*	DMEPOS Beneficiary Count Subject to Competitive Bidding*	General Population**
Indiana- Chicago Metro CBA			
Lake,IN	$18,600,917	16,637	493,800
Jasper,IN	$1,238,119	1,191	32,544
Newton,IN	$580,842	393	13,933
Porter,IN	$4,856,838	4,526	162,181
CBA TOTAL	**$25,276,716**	**22,747**	**702,458**
South-West- Chicago- Metro CBA			
Will,IL	$13,523,185	12,522	681,097
Grundy,IL	$1,417,511	1,405	47,958
Kendall,IL	$978,215	1,052	103,460
DeKalb,IL	$2,358,319	2,323	106,321
Kane,IL	$9,273,504	9,082	507,579
CBA TOTAL	**$27,550,734**	**26,384**	**1,446,415**
Central-Chicago Metro CBA			
Cook,IL	$124,854,279	116,360	5,294,664
DuPage,IL	$16,945,135	18,492	930,528
CBA TOTAL	**$141,799,414**	**134,852**	**6,225,192**
Northern- Chicago Metro CBA			
Lake,IL	$12,352,802	12,482	712,453
McHenry,IL	$7,020,768	6,852	318,641
Kenosha,WI	$4,161,128	3,789	164,465
CBA TOTAL	**$23,534,698**	**23,123**	**1,195,559**
MSA TOTAL	**$218,161,562**	**207,106**	**9,569,624**

*Source: Medicare claims from 10/1/08 to 9/30/09 for items subject to competitive bidding.
** Source U.S. Census Bureau 2009 population estimates.

We did not receive comments on the specific CBAs proposed for the Los Angeles-Long Beach-Santa Ana, CA MSA and are finalizing the CBAs in that MSA as proposed, with one exception, based on further consideration of issues raised by the PAOC. We will not include Santa Catalina Island and San Clemente Island in the Los Angeles County CBA as initially proposed. We discussed the factors to consider when excluding low population density areas from a CBA in the April 10, 2007 DMEPOS CBP final rule (72 FR 17992). Exclusion of low population density areas results in a smaller

CBAs that may reduce supplier costs in servicing the CBAs. Lower supplier costs may result in lower bids, which would increase savings under the program. Although an area may be a low population density area, in accordance with existing regulations at §414.410(c), it cannot be excluded from a CBA unless a determination is made that the area is non-competitive based on one or more of the following factors: low utilization of DMEPOS items by Medicare beneficiaries receiving fee-for-service benefits relative to similar geographic areas; low number of DMEPOS suppliers relative to similar geographic areas; or low number of Medicare fee-for-service beneficiaries relative to similar geographic areas. The island of San Clemente has a population of zero and including the island in the program would therefore result in no savings. Approximately 70 Medicare beneficiaries receiving $57,000 in DMEPOS items and services reside on the island of Santa Catalina. This area can therefore be considered a non-competitive area given the low number of Medicare beneficiaries and low level of DMEPOS utilization, especially considering that the total allowed charges for DMEPOS for Los Angeles County as a whole is over $200 million. We took into consideration, when deciding whether to finalize this proposal, comments from the March 17, 2010, meeting of the PAOC, during which a supplier of DMEPOS highlighted the high costs of furnishing items to Santa Catalina Island, 20 miles off the coast of mainland California and accessible only by boat, helicopter, or amphibious aircraft. Contract suppliers, and in particular small suppliers, that do not have a location near the ferry ports for this island would be burdened by having to serve this area in accordance with their contract, and we expect that this may have an impact on the bids submitted for this CBA. Medicare beneficiaries who are residents of Santa Catalina Island and require delivery of DMEPOS

items must currently make special arrangement with suppliers for delivery of those DMEPOS items. Suppliers are not currently obligated to serve this island, so it is the beneficiary and not the supplier that bears the cost of any additional expense associated with delivery of items. Under the DEMPOS CBP, the supplier would be obligated to serve this island, if it were included in the CBA, and the additional expense of delivering items to this remote island are therefore transferred from the beneficiary to the supplier. Although we originally proposed to include Santa Catalina Island in the Los Angeles CBA to ensure access to DMEPOS items for these beneficiaries, we have further examined this issue and believe that beneficiaries will continue to have the ability to make special arrangements for delivery of these items if this area is not included in the CBA. We therefore believe that excluding the islands of San Clemente and Santa Catalina from the Los Angeles CBA is consistent with existing regulations at §414.410(c).

The counties that comprise each of the final CBAs for this MSA are shown in Table 69. The DMEPOS allowed amount, beneficiary count subject to competitive bidding, and the general population that comprise these two final CBAs are shown in this table.

TABLE 69: Los Angeles-Long Beach-Santa Ana, CA

CBA Name	DMEPOS Allowed Amount*	DMEPOS Beneficiary Count*	General Population **
Los Angeles County CBA***	$201,244,121	137,408	9,862,049
CBA TOTAL	**$201,244,121**	**137,408**	**9,862,049***
Orange County CBA	$43,279,836	36,223	3,010,759
CBA TOTAL	**$43,279,836**	**36,223**	**3,010,759**
MSA TOTAL	**$244,523,957**	**173,631**	**12,872,808**

*Source: Medicare claims from 10/1/08 to 9/30/09 for items subject to competitive bidding.
** Source U.S. Census Bureau 2009 population estimates.
***The counts and amounts are not adjusted for the area excluded north of the San Gabriel Mountains

We did not receive comments on the specific CBAs proposed for the New York-Northern New Jersey-Long Island, NY-NJ-PA MSA. However, we have decided to make three changes based on further consideration of issues raised by the PAOC. We carefully considered the PAOC suggestion noted in the proposed rule to exclude Pike and Putnam counties from the New York-Northern New Jersey-Long Island, NY-NJ-PA MSA in order to result in a smaller and more manageable CBA than the proposed North-West NY Metro CBA. This proposed North-West NY Metro CBA is a large area situated north and west of New York City and covering the three states of New York, New Jersey, and Pennsylvania. Pike County, Pennsylvania is a low population density area and makes up only 0.3 percent of the total DMEPOS utilization for the New York-Northern New Jersey-Long Island, NY-NJ-PA MSA. Therefore, we believe that excluding Pike County from the North-West NY Metro CBA is consistent with existing regulations at §414.410(c). In addition, the PAOC pointed out that excluding Pike County, PA, would help reduce the burden of suppliers having to comply with different state licensure requirements. As noted in the proposed rule, the PAOC also suggested that CMS consider state licensure requirements when dividing the MSAs into CBAs. To eliminate the complexity of complying with different state licensure requirements, we have decided to split the proposed North-West NY Metro CBA into two CBAs: one containing the New Jersey counties of Bergen, Essex, Hudson, Morris, Passaic, and Sussex; and one containing the New York counties of Putnam, Rockland, and Westchester. To summarize, with regard to the proposed North-West NY Metro CBA, the PAOC suggested excluding Pike and Putnam counties to reduce the size of this large CBA we proposed for the area in the north and west of the MSA. It was noted by the

PAOC that removing Pike County would also reduce complications of multi-state licensing as Pennsylvania licensing rules and requirements would no longer be an issue. Based on the advice to reduce the size of the proposed North-West NY Metro CBA and reduce multi-state licensure complexities, we are removing Pike County from the CBA and are splitting the CBA into two new CBAs: a fairly large CBA containing the New Jersey counties from the proposed North-West NY Metro CBA; and a smaller CBA containing the New York counties from the proposed North-West NY Metro CBA. As a result of this change, there is now no need to remove Putnam County from the CBA as the three county area of Putnam, Rockland, and Westchester counties in New York will be served by suppliers contracted to furnish items in this area, which is now significantly smaller than the proposed North-West NY Metro CBA.

In further response to the PAOC's advice to consider State licensure requirements when subdividing the MSAs into separate CBAs, we have decided to remove Richmond County, NY from the proposed South New York Metro, leaving this CBA to be comprised of six counties in New Jersey. We are therefore moving Richmond County, NY to the Nassau-Brooklyn-Queens-County Metro CBA and have changed the name of the CBA to Nassau-Brooklyn-Queens- Richmond County Metro CBA. We note that Hudson River is in between Richmond County and the other counties in the Nassau-Brooklyn-Queens- Richmond County Metro CBA but we took into consideration the social integration of this area in that there is a major bridge/highway connecting Richmond County to Long Island. Also, we believe that for each final CBA set forth in this rule, the supplier servicing patterns supports our decision. We determined that both large and small suppliers in the MSA generally furnish items within the CBAs we

proposed. The counties, DMEPOS allowed amount and beneficiary count subject to competitive bidding and the general populations that comprise each CBAs based on our final provisions are shown in Table 70.

TABLE 70: New York-Northern New Jersey-Long Island, NY-NJ-PA

CBA Name County	DMEPOS Allowed Amount*	DMEPOS Beneficiary Count*	General Population **
Nassau-Brooklyn-Queens-Richmond County Metro CBA			
Nassau,NY	$30,888,889	29,857	1,351,625
Kings,NY	$47,044,915	44,893	2,556,598
Queens,NY	$33,406,236	32,798	2,293,007
Richmond, NY	$7,054,863	6,626	487,407
CBA TOTAL	**$118,394,903**	**114,174**	**6,688,637**
Suffolk County CBA			
Suffolk,NY	$31,950,806	31,476	1,512,224
CBA TOTAL	**$31,950,806**	**31,476**	**1,512,224**
Bronx-Manhattan NY CBA			
Bronx,NY	$19,791,646	17,002	1,391,903
New York,NY	$26,483,792	26,414	1,634,795
CBA TOTAL	**$46,275,438**	**43,416**	**3,026,698**
Northern NJ Metro CBA			
Hudson,NJ	$13,622,910	12,644	595,419
Bergen,NJ	$19,948,837	20,278	894,840
Passaic,NJ	$10,266,137	10,233	490,948
Essex,NJ	$9,911,767	10,735	770,675
Morris,NJ	$9,094,758	9,830	487,548
Sussex,NJ	$2,905,240	2,819	150,909
CBA TOTAL	**$65,749,650**	**66,540**	**3,390,339**
North East NY CBA Metro			
Putnam,NY	$1,997,668	1,876	99,244
Rockland,NY	$6,421,317	6,265	298,545
Westchester,NY	$16,971,210	17,220	953,943
CBA TOTAL	**$25,390,195**	**25,361**	**1,351,732**
Southern NY Metro CBA			
Hunterdon,NJ	$2,709,880	2,356	129,031
Union,NJ	$10,466,838	10,654	523,249
Middlesex,NJ	$15,803,473	16,649	789,102
Monmouth.NJ	$14,979,747	15,110	642,448
Ocean,NJ	$20,913,022	21,600	569,111
Somerset,NJ	$4,941,838	5,425	324,563

CBA Name County	DMEPOS Allowed Amount*	DMEPOS Beneficiary Count*	General Population **
CBA TOTAL	**$69,814,798**	**71,794**	**2,977,504**
MSA TOTAL	**$358,968,794**	**354,235**	**19,006,798**

In summary, we are finalizing our proposal to divide the Chicago-Naperville-Joliet, IL-IN-WI MSA into four CBAs. We are finalizing, with the modification discussed above, two CBAs in the Los Angeles-Long Beach-Santa Ana, CA MSA. Lastly, we are finalizing, with modifications discussed above, six CBAs in the New York-Northern New Jersey-Long Island, NY-NJ-PA MSA.

3. Exclusions of Certain Areas after Round 2 and Prior to 2015

Section 154(a) of MIPPA amended the statute by requiring that competition under Round 2 takes place in 2011 and by adding section 1847(a)(1)(D)(iii) of the Act that requires us to exclude the following areas from the competitive bid program for competitions after Round 2 of the program and before 2015:

- Rural Areas.
- Metropolitan Statistical Areas not selected under Round 1 or Round 2 with a population of less than 250,000.
- Areas with a low population density within a MSA that is otherwise selected consistent with section 1847(a)(3)(A) of the Act.

We proposed to incorporate these requirements and timeframes in proposed §414.410(c).

We received no comments on this proposal and therefore are finalizing this provision without modification.

4. Expansion of Round 2

Section 6410(a) of the ACA expanded the areas to be included in Round 2 of the program. As amended by section 6410(a) of the ACA, section 1847(a)(1)(B)(i)(II) of the Act requires that the competition for Round 2 of the program occur in 91 of the largest MSAs in 2011. Prior to this change, Round 2 was to include 70 MSAs. Section 1847(a)(1)(D)(ii)(II) of the Act, as added by section 6410(a) of the ACA, specifies that the additional 21 MSAs to be included in Round 2 "include the next 21 largest metropolitan statistical areas by total population" (after those already selected Round 2). The 2009 annual population estimates from the U.S. Census Bureau are the most recent estimates of population that will be available prior to the Round 2 competition mandated to take place in 2011. Therefore, we proposed to use these estimates to determine the additional 21 MSAs to be included in Round 2 of the program. Table 71 is a list of the additional 21 MSAs added to Round 2.

TABLE 71: Additional 21 MSAs Added to Round 2

21 Additional MSAs	2009 Total Population
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	5,968,252
Washington-Arlington-Alexandria, DC-VA-MD-WV	5,476,241
Boston-Cambridge-Quincy, MA-NH	4,588,680
Phoenix-Mesa-Scottsdale, AZ	4,364,094
Seattle-Tacoma-Bellevue, WA	3,407,848
St. Louis, MO-IL	2,828,990
Baltimore-Towson, MD	2,690,886
Portland-Vancouver-Beaverton, OR-WA	2,241,841
Providence-New Bedford-Fall River, RI-MA	1,600,642
Buffalo-Niagara Falls, NY	1,123,804
Rochester, NY	1,035,566
Tucson, AZ	1,020,200
Honolulu, HI	907,574
Albany-Schenectady-Troy, NY	857,592
Worcester, MA	803,701
Oxnard-Thousand Oaks-Ventura, CA	802,983
Springfield, MA	698,903
Bradenton-Sarasota-Venice, FL	688,126
Poughkeepsie-Newburgh-Middletown, NY	677,094

21 Additional MSAs	2009 Total Population
Stockton, CA	674,860
Boise City-Nampa, ID	606,376

We received no comments on this proposal and therefore are finalizing this provision without modification.

W. Section 10501(i)(3): Collection of HCPCS data for Development and Implementation of a Prospective Payment System for the Medicare Federally Qualified Health Center Program

The Omnibus Budget Reconciliation Act (OBRA) of 1989 amended the Act by creating new FQHC benefit programs under both Medicare and Medicaid. The Medicare FQHC benefit provides coverage for a full range of primary care services, including physician and certain nonphysician services (PAs, NPs), clinical social worker, psychologist services, and preventive services. FQHCs are "safety net" providers (for example, community health centers and programs serving migrants, the homeless, public housing centers, and tribal groups). The main purpose of the FQHC program is to enhance the provision of primary care services in underserved urban and rural communities. FQHCs typically enhance the availability of care to vulnerable populations, including Medicare, Medicaid, SCHIP, and the uninsured. Most of these health centers receive HRSA grants for services to the uninsured.

Medicare pays FQHCs on the basis of reasonable cost, subject to an upper payment limit on the reasonableness of incurred cost. Actual Medicare reasonable cost is determined based upon a Medicare cost report filed by the FQHC after the end of its fiscal year. Prior to the start of the year, an interim all-inclusive per-visit payment amount, based upon an estimate of Medicare reasonable costs, is calculated for each

Medicare FQHC. During the year, this interim all-inclusive per-visit payment amount is paid for each covered visit between a Medicare beneficiary and an FQHC health professional. After the end of the Medicare FQHC's cost reporting year, interim per-visit payments are reconciled to actual Medicare reasonable costs based upon the Medicare cost report filed by the FQHC. Section 10501(i)(3) of the ACA now amends this current Medicare FQHC payment policy with an entirely different payment system, effective with cost reporting periods beginning on or after October 1, 2014.

Section 10501(i)(3)(A) of the ACA amended section 1834 of the Act by adding a new subsection (o), Development and Implementation of Prospective Payment System. This subsection provides the statutory framework for development and implementation of a prospective payment system for Medicare FQHCs. Section 1834(o)(1)(B) of the Act, as established by the ACA, addresses collection of data necessary to develop and implement the new Medicare FQHC prospective payment system. Specifically, section 1834(o)(1)(B) of the Act, Collection of Data and Evaluation, grants the Secretary of HHS the authority to require FQHCs to submit such information as may be required in order to develop and implement the Medicare FQHC prospective payment system, including the reporting of services using HCPCS codes. Section 1834(o)(1)(B) of the Act requires that the Secretary impose this data collection submission requirement no later than January 1, 2011. Accordingly, we proposed to add a new paragraph (d) to §405.2470 to require Medicare FQHCs to begin reporting all services furnished using HCPCS codes for these services starting January 1, 2011. Beginning January 1, 2011, we proposed that the Medicare FQHC would be required to report on Medicare FQHC claims all pertinent service(s) provided for each Medicare FQHC visit (defined in §405.2463). This

additional reporting would include the information needed to develop and implement a PPS for FQHCs. For example, corresponding HCPCS code(s) would be required to be reported along with the presently required Medicare revenue code(s) for the Medicare FQHC visit(s). We noted in our proposal that our Medicare FQHC claims processing system would be revised to accept the addition of the new reporting requirements effective January 1, 2011. In our proposal, we also noted that the proposed new data collection effort would be for informational and data gathering purposes only, and would not be utilized to determine Medicare payment to the FQHC. Until the FQHC prospective payment system is implemented in 2014 and the Medicare claims processing system is revised to reflect such a system, we noted that Medicare FQHC payment would continue in the current manner (utilizing revenue codes and the interim per-visit payment rate methodology).

In our proposed rule, we further noted that Medicare FQHCs would be required to adhere to the information collection requirements in accordance with the content and terms of their Medicare agreement as stipulated at §405.2434. We indicated in the proposed rule that failure to do so could result in the termination of the FQHC's Medicare agreement in accordance with §405.2436 of the Medicare FQHC regulations.

At the time of publication of the proposed rule, we noted that we did not foresee additional claims or other information collection needs beyond collection of HCPCS codes. Accordingly, we did not propose additional information collection requirements at that time. However, we solicited public comment on any additional information FQHCs believe may be necessary in order to develop and implement a prospective payment system for Medicare FQHCs.

We received a number of comments on the proposed information collection requirements. We address these comments as follows:

Comment: One commenter requested that CMS ensure that its systems are appropriately updated to be able to accept HCPCS codes from Medicare FQHCs.

Response: CMS will work to assure that its contracts are provided with adequate notice allowing for claims processing systems to accept these new reporting requirements.

Comment: One commenter requested that health centers be given adequate time to learn the new reporting requirements, and to work with health centers that might need additional assistance.

Response: CMS, through its Contractors, presently works to assist and train all providers in Medicare reporting requirements, particularly new requirements such as the collection of HCPCS information from Medicare FQHCs. Medicare contractors have a variety of assistance measures at their disposal to train Medicare FQHCs in HCPCS coding. Assistance measures include seminars, web learning portals, and telephone information lines. We note that there are numerous private sector training and educational opportunities in HCPCS coding as well. With the specific language regarding HCPCS data collection from Medicare FQHCs included in the ACA itself, and the resultant lead time prior to January 1, 2011 implementation of the reporting requirements, we believe health centers have had sufficient time to prepare themselves to meet these requirements.

Comment: One commenter suggested that data collection begin with a representative sample of health centers, and that it generally be phased in across the

nation, in order to ensure that CMS not penalize health centers that might need additional assistance.

Response: With the tight ACA implementation time frames for implementation of a Medicare FQHC prospective payment system, as well as the limited total number of FQHCs, we believe both provider sampling and phase-in approaches to information collection requirements would jeopardize CMS' ability to meet statutory requirements for the Medicare FQHC PPS. Accordingly, we cannot accept comments to delay or limit collection of Medicare FQHC data we believe necessary to meet the statutory requirements.

Comment: One commenter suggested that HHS estimate the additional administrative burden placed on FQHCs and, if that is significant, increase reimbursement proportionately during the proposed collection period.

Response: Medicare FQHCs are paid on the basis of reasonable cost. Administrative costs attributable to added information collection requirements that might be incurred by Medicare FQHCs are already to be reported by the Medicare FQHC on its Medicare costs report and included as part of its Medicare FQHC all-inclusive rate.

Comment: One commenter suggested that HHS use the quality measures reported to CMS as part of its meaningful use of electronic health record requirements, instead of coding additional information into the claims.

Response: We do not believe that quality measures reported to CMS as part of meaningful use requirements would be sufficient in scope or representative in breadth in order to establish a National Medicare PPS sample which would be representative of the entire population of Medicare FQHCs. Accordingly, we cannot accept this comment.

As a result of these comments, we are making no changes to our proposal to require FQHCs to begin the reporting of services using HCPCS codes. Accordingly, we are finalizing this provision without modification. We will add a new paragraph (d) to §405.2470 to require Medicare FQHCs to begin reporting all services furnished using HCPCS codes for these services starting January 1, 2011.

We received no public comment suggesting collection of additional information collection requirements beyond HCPCS codes. Therefore we add no additional Medicare FQHC information collection requirements, beyond the collection of the aforementioned HCPCS data requirements, in this final rule.

VII. Other Provisions of the Proposed Regulation

A. Part B Drug Payment: Average Sales Price (ASP) Issues

1. "Carry Over" ASP

The average sales price (ASP) payment methodology is authorized under section 303(c) of the MMA, which amends Title XVIII of the Act by adding section 1847A. This section establishes the use of the ASP methodology for payment for Medicare Part B drugs and biologicals described in section 1842(o)(1)(C) of the Act furnished on or after January 1, 2005. For purposes of this part, unless otherwise specified, the term "drugs" will hereafter refer to both drugs and biologicals. The ASP methodology applies to most drugs furnished incident to a physician's service, drugs furnished under the DME benefit, certain oral anti-cancer drugs, and oral immunosuppressive drugs.

Sections 1847A and 1927(b) of the Act specify quarterly ASP data reporting requirements for manufacturers. Specific ASP reporting requirements are set forth in section 1927(b) of the Act. Although delays in reporting have been uncommon, they create a risk that: (1) could result in the publication of payment limits that do not reflect prices for drug products, and (2) could result in inaccurate payments, the need for correction of files and unintentional ASP payment limit variability.

As a result of these concerns, we sought to establish a process for addressing situations where manufacturers fail to report manufacturer ASP data in a timely fashion, that is within 30 days after the end of a quarter. The proposal in CY 2011 PFS proposed rule was intended to allow us to calculate and report ASP payment limits for a given quarter within the existing timelines and would not affect CMS or the OIG's authority to assess civil monetary penalties associated with untimely or false ASP reporting.

Manufacturers who misrepresent or fail to report manufacturer ASP data will remain subject to civil monetary penalties, as applicable and described in sections 1847A and 1927(b) of the Act.

For the purposes of reporting under section 1847A of the Act, the term "manufacturer" is defined in section 1927(k)(5) of the Act and means any entity engaged in the following: production, preparation, propagation, compounding, conversion, or processing of prescription drug product, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; or packaging, repackaging, labeling, relabeling, or distribution of prescription drug products. The term manufacturer does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law. However, manufacturers that also engage in certain wholesaler activities are required to report ASP data for those drugs that they manufacture. Note that the definition of manufacturers for the purposes of ASP data reporting includes repackagers.

In accordance with section 1847A of the Act, manufacturers are required to report data on the National Drug Code (NDC) level, which include the following elements: the manufacturer ASP for drugs; the Wholesale Acquisition Cost (WAC) in effect on the last day of the reporting period; the number of units sold; and the NDC. Currently, when manufacturer ASP data or specific data elements are not available, we calculate an ASP price for a billing code based on other applicable and available pricing data from manufacturers for that drug. This alternative method used when manufacturer data are not available for a billing code includes WAC prices from compendia. WAC prices tend to be higher than manufacturer ASP prices.

Although problems with reporting have been uncommon, we have recently encountered situations where delays in manufacturer ASP reporting could have led to significant ASP payment limit fluctuations for highly used HCPCS codes. The greatest potential impact occurs when data for high volume drug products within a HCPCS code that is represented by a limited number of NDCs have not been reported and cannot be included in the ASP volume weighted calculations described in section 1847A(b) of the Act. For multisource drugs, such a situation is likely to artificially increase or decrease Medicare ASP payment limits, which in turn would affect beneficiary cost sharing amounts. Such artificial fluctuations of the ASP payment limit could provide the appearance of instability unrelated to market forces and could also create access issues for providers and beneficiaries and confusion that could ultimately affect product demand in the marketplace.

In order to minimize the possibility of ASP payment limit fluctuations due to missing data, we proposed a process, consistent with our authority in section 1847A(c)(5)(B) of the Act, to update ASPs based on the manufacturer's ASP calculated for the most recent quarter for which data is available. Specifically, we proposed to carry over the previously reported manufacturer ASP for an NDC(s) when missing manufacturer ASP and/or WAC data could cause significant changes or fluctuations in ASP payment limits for a billing code, and efforts by CMS to obtain manufacturer-reported ASP before Medicare ASP payment limits publication deadlines are not successful. For example, the most recently reported manufacturer ASP prices for products on the market would be carried over to the next quarter if a manufacturer's entire submission were not received, manufacturer ASP price data for specific NDCs have not

been reported, or when only WAC data has been reported; however, NDCs that have zero sales or are no longer being manufactured will not be subjected to this process. Also, we proposed to apply the carryover process only in cases where missing data results in a 10 percent or greater change in the ASP payment limit compared to the previous quarter. Based on experience with ASP methodology since 2004, we believe that this percentage threshold constitutes significant change. We specifically sought comments on our use of 10 percent as the threshold amount. In order to better represent actual market trends, that is, actual increases or decreases in manufacturer reported ASP for the group of NDCs that represent the HCPCS code, we also proposed that the manufacturer ASP payment amounts for the individual NDCs that are carried over will be adjusted by the weighted average of the change in the manufacturer ASP for the NDCs that were reported during both the most recently available quarter and the current quarter. We requested comments about whether other methods to account for marketplace price trends could be a better substitute for applying the weighted average change. The previous quarter's sales volumes will be carried over. An example of the proposed process appears in Table 72.

We proposed to apply this process to both single source drugs and multiple source drugs. However, we are concerned that including single source drugs in the carry over process could create an incentive for nonreporting in situations where ASPs for a single source drug are falling and the manufacturer stops reporting ASPs in an effort to preserve a higher payment amount despite the risk of significant statutory penalties for such an action. Therefore, we specifically requested comments on this option and the effect of limiting this proposal to multiple source drugs only. We noted that we would consider these comments carefully before including both single source and multisource drugs in

the process.

TABLE 72: ASP Carryover Example for NDCs in a Specific HCPCS Code

Previous Quarter Reported NDCs	Previous Quarter Reported Volume	Previous Quarter ASP	Current Quarter Reported NDCs	Current Quarter Reported Volume	Current Quarter ASP	Current Quarter NDCs for Calculation	Current Quarter Volume for Calculation	Current Quarter Price for Calculation
12345-6789-10	2000	$1.000	12345-6789-10	2500	$0.980	12345-6789-10	2500	$0.980
12345-6789-11	3000	$1.000	12345-6789-11	1700	$0.980	12345-6789-11	1700	$0.980
12345-6789-12	5000	$1.000	12345-6789-12	5500	$0.980	12345-6789-12	5500	$0.980
45678-1234-90	9000	$1.100	missing	missing	missing	45678-1234-90	9000	$1.078*
45678-1234-99	27000	$1.100	missing	missing	missing	45678-1234-99	27000	$1.078*

* This result is obtained by calculating the weighted average price change in NDCs available (that is, 12345-6789-10 thru 12345-6789-12) in both the previous and current quarters, which is -2% [(0.98-1.00)*100], and applying that change to the previous quarter's manufacturer ASP for the missing NDCs (that is, 45678-1234-90 and 45678-1234-99). The last two columns on the right would be used to calculate the weighted ASP and payment limits for the 5 NDCs as a HCPCS code and accounts for missing prices for two high volume NDCs that represent most of the units sold within the HCPCS code and therefore heavily influence the price calculation for the HCPCS code.

Our proposed approach was intended to establish a straightforward and transparent solution that minimizes the effect of missing manufacturer ASP data on Medicare ASP payment limits. We believe that the availability of a mechanism to minimize non-market-related price fluctuations is desirable when efforts to obtain manufacturer's ASP data by deadlines have not been successful. Our proposed mechanism was not intended to alter or adjust reported prices and will not be used to do so, but instead is intended to more accurately represent prices in the marketplace in the rare circumstance where manufacturer ASP data for particular drug product(s) is missing. Based on our experience with ASP reporting since 2004, we do not believe that this process will be used frequently. However, as we stated previously, recent concerns about delays in reporting of manufacturer ASP data have led to this proposal.

We also remind manufacturers that significant civil monetary penalties (CMP) for not reporting or misrepresenting manufacturer ASP data are authorized under sections 1847A(d)(4) and 1927(b)(3)(C) of the Act and codified in regulations at §414.806. This proposal should not be interpreted to mean that CMS and the OIG will refrain from

collecting such penalties for ASP reporting violations. Late or missing reports will not be tolerated. This proposed policy would be implemented regardless of any efforts by the OIG to impose CMPs for nonreporting.

We would also like to remind manufacturers that additional specific information about reporting ASP data to us is available. (For examples, see the following: 69 FR 17936, 69 FR 66299, 70 FR 70215, 71 FR 69665, 72 FR 66256, 73 FR 69751, and 74 FR 61904.) Also, Frequently Asked Questions are posted in the related links inside CMS section of the ASP Overview Web page at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp#TopOfPage , and the downloads section of the same webpage contains a link to the ASP Data Form (Addendum A), which includes examples of how ASP data must be reported and formatted for submission. In particular, we would like to remind manufacturers to report sales volume in quantities of NDC units sold (not vials or other units of sale), and to use a zero (that is, the character "0") instead of a blank when reporting items that did not have any sales in a particular quarter. In addition, manufacturers should report both the ASP and the WAC for each NDC, the expiration date for the last lot sold, if applicable, and the date of first sale for an NDC.

We received several comments about our proposals. In general, comments supported our proposal, including the use of a weighted average when calculating the carry over amounts, but the comments also requested clarification about certain details. We did not receive any comments that would lead us to reconsider the 10 percent threshold that we proposed.

Comment: Several commenters specifically requested that CMS clarify what will

be done to obtain a manufacturer's ASP information before carrying over previous manufacturer ASP information. The comments recommended that CMS establish contact with manufacturers using contact information from the manufacturer's submission before applying the carryover policy.

Response: We follow a routine internal quality check process that prompts communication with contacts listed on manufacturers' ASP submissions when we believe that ASP data may be late, missing, or incomplete. The process includes contacting the manufacturer as recommended above. Our experience with using the reported contact information to reach the manufacturer generally has been satisfactory, and we plan to continue using it to manage and track submissions and to coordinate follow-up action by CMS or other agencies. However, we also believe that the carryover policy will serve as a backup in the event information cannot be obtained in a timely manner. Again, we reiterate that sections 1847A and 1927 of the Act require manufacturers to report ASP quarterly, and that that section 1847A(d)(5) of the Act provides for significant CMPs in situations when misreporting of ASP data occurs.

Comment: A few commenters requested that we clarify how we determine whether products are no longer being sold. The comments agreed with our approach to exclude from the carryover process products with no sales or those products that are no longer manufactured.

Response: In most cases, the manufacturers' ASP reports clearly establish whether a product is still being sold because manufactures are required to report NDCs with zero sales. As noted above, CMS also contacts the manufacturers, as needed, in order to clarify information. If a situation arises where the product's sales status is not

clear and we are unable to get clarification from the manufacturer, we use multiple sources of information, including but not limited to internal quality checks, compendia data, and public information about drug products to determine the product's status. Our experience has shown that this approach is effective, and we would use this approach to determine whether to apply the carryover policy if information supplied by the manufacturer was not available or not clear. Based on our experience, we believe that this approach will be sufficient to prevent the use of carryover data from products that are not sold during a quarter. We also would like to reiterate that manufacturers have a reporting obligation for NDCs with zero sales (71 FR 69676). In other words, the reporting obligation for an NDC ends only after the expiration date of the last lot sold. As mentioned above, a zero (the character "0") should be used to report the number of units of a drug product sold if that product had no reportable sales for a quarter.

Comment: A commenter requested that CMS announce the exact deadline for the application of the carryover policy each quarter.

Response: The ASP reporting deadline is specified in regulation text at §414.804, which states that data must be submitted to CMS within 30 days after the close of a quarter. We decline to provide an additional "grace period" beyond the stated statutory and regulatory deadline – not only have we not proposed such a grace period, but also we believe such a policy could be misconstrued as permitting late submission of manufacturer data. As we stated earlier, our proposal was not intended (nor should it be construed) to affect manufacturers' obligations to submit ASP data timely, and penalties for noncompliance with the timely reporting requirement continue to apply. For these reasons, we decline to adopt the commenter's suggestion.

Comment: A commenter recommended that the carryover policy not be used for more than one quarter due to a concern about the accuracy of payment amounts based on data that is more than 2 quarters old.

Response: We will not specify the duration for the carryover policy at this time in order to prevent a situation where prolonged nonreporting of ASP data could influence ASP payment limit calculations. Based on our experience, reporting problems and delays with a duration of 2 or more quarters would be unlikely.

Comment: Commenters recommended that CMS carry over prices only if there is a manufacturer rebate agreement in place and a "track record" of four or more quarters of data have been reported.

Response: We disagree with these comments. First of all, the carryover process is unrelated to the manufacturer's reporting obligations under sections 1847A and 1927 and the ASP regulations – in other words, our proposal does not serve to relieve manufacturers of any reporting obligations. Rather, our proposal is intended to solve the problem of how to accurately calculate ASP in instances where we do not have complete information. Thus, applying the carryover process only to certain manufacturers as the commenter suggests is not only unnecessary, but also, in our view, not appropriate. In addition, although we appreciate the commenter's desire to establish a baseline, for the reasons stated above, we do not believe that implementing a standard whereby we apply the carryover process only after a manufacturer has submitted four or more quarters of data is advisable. Such a policy would be contrary to our intent in making this proposal, which is to provide us with a standard procedure for addressing missing data. Further, we have no information indicating that manufacturers with four or more quarters of

reporting are any more or less likely to fail to submit data for a particular product in future reporting periods. Therefore, we will not be modifying our policy based on these comments.

Comment: One commenter agreed with carrying over a weighted average price, but suggested that the carryover weighting calculation be based on the manufacturer's own NDCs within the given HCPCS code rather than the NDCs for all manufacturers within a given HCPCS code instead of weighting based on all manufacturers NDCs in the HCPCS code. The commenter believes that price changes for the manufacturer's own NDCs in the same HCPCS code will better represent price changes for the manufacturer's missing NDCs.

The commenter also recommended that CMS only use all other manufacturers' NDCs in the carryover weighting calculation as proposed if a manufacturer has not reported any data for any NDCs in the code.

Response: We disagree with these comments. We believe that basing weighting calculations on all of the reported NDCs in the code is the best approach because it permits us to maintain ASP stability without potentially providing manufacturers with an incentive not to report their ASP data. We are concerned that basing the carryover weighting calculation solely on the manufacturer's own NDCs in the applicable code could incentivize manufacturer non-reporting, particularly in situations where a manufacturer has multiple NDCs that comprise a large share of sales for a HCPCS code. Indeed, we are aware of situations where a very wide variety of price changes have been reported for a single manufacturer's multisource products for a single code. If we were to calculate the weight for the carryover data using only the NDCs that the manufacturer

reported, then a manufacturer might decide to risk sanction and purposefully report only a subset of NDCs for the quarter in order to increase the ASP payment limit for the HCPCS code, and this would result in inaccurate payment limits. For example, if a manufacturer omitted data for a single NDC in a code that had a price decrease and only reported one or two NDCs in that code that had price increases, the carryover weighting calculations could be skewed toward overpayment if only the manufacturer's own price changes were used in the carryover calculation. Again, we reiterate that that Section 1847A of the statute requires manufacturers to report ASP quarterly, and that that section 1847A(d)(5) of the Act provides for significant CMPs in situations when misreporting of ASP data occurs.

Comment: Two commenters recommended that CMS expand our proposed regulation text at §414.904(i) to include more detail such as the 10 percent threshold, a requirement that we make contact with a manufacturer before applying the carryover policy, and that the policy not be applied to products with zero sales or products that are no longer being manufactured.

Response: Based on these comments, we will update the regulation text at §414.904(i) to state that the carryover policy will apply only if the ASP payment limit change due to missing data is significant. Our threshold for a "significant" change is 10 percent up or down. We do not believe that adding further detail to the regulation text is necessary at this time because the preamble language and the clarifications sufficiently detail our approach.

Comment: In the proposed rule, we specifically requested comments about the applicability of our proposals to single source and multiple source drugs. One

commenter agreed with our concerns that despite the potential for civil monetary penalties, single source drug manufacturers still could perceive an incentive not to report ASPs in order to maximize the margin between the ASP payment and the actual price for which providers acquire drugs. The commenter stated that the carryover process, if applied to single source drugs, could provide purchasers with an incentive to buy increased quantities of the product because of the widening gap between their purchase price and Medicare payments. Further, because of the potential for increased sales volume, manufacturers of single source drugs may determine that the gains in volume outweigh the statutory penalties. The commenter recommended applying the carryover policy only to multiple source drugs because the absence of data for one product within a multiple source code could result in payment rate instability from quarter to quarter unrelated to market forces.

Response: We are persuaded by the comment to finalize our proposal with limitation that the carryover policy applies to multiple source drugs only because we agree that including single source drugs in the policy could result in inappropriate ASP payment limits for a HCPCS code and may unintentionally provide an incentive for nonreporting of single source drugs despite the likelihood of CMPs. In contrast, we believe that for multiple source drugs the carryover process can improve payment stability and keep the payment calculation more in line with market forces. Moreover, multiple source drugs present less risk for nonreporting because data from more than one manufacturer is used in pricing calculations and thus, the impact of one manufacturer's missing data is decreased. For these reasons and based on the comment we received, we will limit our carryover policy to multisource drugs. However, we will continue to

monitor manufacturers' reporting practices for single source drugs, biologicals, and multiple source drugs.

In summary, we are finalizing our proposal as follows: When a manufacturer's reported data for a multiple source drug product with sales during a quarter is missing, and efforts by us to obtain manufacturer reported ASP data before Medicare ASP payment limits publication deadlines have not been successful, we will use the following process to calculate the payment limit for that drug product's billing code: First, we will determine whether calculating the payment limit without accounting for the missing data would result in a 10 percent or greater change in the ASP payment limit compared to the previous quarter. In that event, we will use (that is, carry forward) the most recent data available for that multiple source drug product(s) (that is, the individual NDCs), adjusted by the weighted average of the change in the manufacturer ASP for the NDCs that were reported during both the most recently available quarter and the current quarter. The previous quarter's sales volumes also will be carried over for the NDCs with missing data. The carryover process as described above applies, for example, if a manufacturer's entire submission was not received, manufacturer ASP price data for specific multiple source NDCs has not been reported, or when WAC data only has been reported. However, single source drugs and biologicals, and multiple source drug NDCs that have zero sales or that have been permanently discontinued by the manufacturer will not be subject to this process. We are also finalizing §414.804(i) with minor modifications as described elsewhere in this section.

Our process is intended to more accurately represent prices in the marketplace if manufacturer ASP data for particular drug product(s) is missing. Based on our

experience with ASP reporting since 2004, we do not believe that this process will be used frequently.

2. Partial Quarter ASP Data

Section 1847A(c)(4) of the Act states that, "In the case of a drug or biological during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales for the drug or biological is not sufficiently available from the manufacturer to compute an average sales price for the drug or biological, the Secretary may determine the amount payable under this section for the drug or biological based on—(A) the wholesale acquisition cost; or (B) the methodologies in effect under this part on November 1, 2003, to determine payment amounts for drugs or biologicals."

When a new drug product enters the market, the first date of sale rarely coincides with the beginning of a calendar quarter. Therefore, the ASP data for many new drug products falls into partial quarter status during the first quarter of sales. We are taking this opportunity to describe our policy regarding how we use data from the first quarter of sales in the calculation of ASP payment limits.

In accordance with section 1847A(c)(4)(A) of the Act, our policy has been to price new single source drugs and biologicals at WAC for the first quarter (unless the date of first sale is on the first day of the quarter), and to add new NDCs for multisource drugs and product line expansions of single source drugs and biologicals to the ASP calculation for a quarter as soon as these products are reported.

We believe that the approaches for single source drugs, biologicals, and multisource drugs are consistent with the statute, particularly section 1847A(c)(4) of the Act, and we intend to continue this policy.

Although this section of the rule did not contain any proposals, we received several comments about our description of current policy.

Comment: Several commenters asked that CMS clarify how our policy coincides with previously published preamble language from the CY 2005 PFS rule (69 FR 66302) that states that the initial period "start[s] on the date that sales of the drug begin and end[s] at the beginning of the quarter after we receive information from the manufacturer regarding ASP for the first full quarter of sales."

Response: We believe our clarification is consistent with previously published materials referenced by the commenters, and we appreciate the opportunity to better explain our approach. The CY 2011 PFS proposed rule discussion pertains to our determination of the ASP-based payment limits under section 1847A of the Act using data from the drug's first quarter of sales – in other words, how we calculate payment once we have received ASP data from the manufacturer for a drug. These payment limits become effective two quarters after the drug's first quarter of sales. In contrast, our preamble discussion in the CY2005 PFS rule pertained to payment under section 1847A of the Act in quarters before sufficient ASP data that is needed to calculate payment limits has been reported to CMS– that is, the CY2005 preamble discusses payment for drugs that are administered on dates of service during their first or second quarter of sales.

The ASP reporting and publishing time table has a two quarter lag, so payment limits calculated using data reported from the first quarter of sales become effective two quarters later. By way of example only, a manufacturer's prices for a new single source drug first sold on January 10 would be reflected in the ASP data that a manufacturer

reports to CMS no later than April 30, and that data would be considered partial quarter data because sales began after the first day of the quarter. If CMS determines that the drug should be added to the national price files (that is, the drug is not priced by a contractor/MAC), payment limits using the data from January 10 to March 31 would then be calculated and become effective for the first quarter of sales from July 1 to September 30 of that year. In this example, the first full quarter of sales of the new drug would take place between April 1 and June 30. ASP data from the new drug's first full quarter of sales would be reported to CMS no later than July 30, and payment limits calculated using this data would become effective for the period October 1 to December 31. Our approach is consistent with the initial period for ASP based payment limit calculations described in the CY 2005 PFS final rule (69 FR 66302), which states that the "time period will start on the date that sales of the drug begin and end at the beginning of the quarter after we receive information from the manufacturer regarding ASP for the first full quarter of sales."

Comment: Commenters also requested that CMS clarify whether we use 100 percent or 106 percent of WAC to set payment limits after new drugs are introduced.

Response: As we mentioned above, our discussion of partial quarter data in the 2011 PFS proposed rule is limited to situations where national payment limit determinations under section 1847A of the Act are being made using reported data from the first quarter of a drug's sales.

The national payment limits for single source drugs that are calculated from partial quarter data and are published in CMS's quarterly ASP price files use 106 percent of WAC. This percentage is consistent with sections 1847A(c)(4)(A) and 1847A(b) of

the Act and is also described in Chapter 17 Section 20.1.3 of the Medicare Claims Processing Manual.

Comment: Commenters requested that CMS make regulation text changes to clarify that 106 percent of WAC is applied as a payment limit for the period that starts on the date that sales of the drug begin and ends at the beginning of the quarter after we receive information from the manufacturer regarding ASP for the first full quarter of sales.

Response: Our policy is consistent with existing regulation text language at §414.904, the manual, and preamble language. Therefore, we are not making any regulation text changes.

Comment: One commenter asked that CMS clarify what "product line expansions of single source drugs" means.

Response: For the purpose of the discussion of partial quarter ASP data above, the term "line expansion" refers to an additional package size or sizes of a single source drug or biological; by way of example only, a new larger vial size of a new antibiotic that is introduced for sale nine months after the drug's initial sales begin would represent a line expansion. Sales data for such new, additional NDCs is incorporated into the weighted ASP payment limit calculation for single source drugs beginning with the first quarter of sales that is reported to CMS. In other words, data for NDCs added to a single source drug code that is already priced using the weighted average calculations is not considered partial quarter data.

Comment: CMS received several comments that request other changes to the regulations in connection with the first quarter of sales. These comments included

recommendations that CMS--

- Develop regulation text changes that describes an apparent expansion of the initial period described in section 1847A(c)(4)(A) of the Act;
- Define when invoice pricing may be used if payments are made under section 1847A;
- Discuss the determination of payment amounts made under section 1847A for dates of service during the first or second quarter of a drug's sales;
- Add additional information requirements to ASP reporting templates used by manufacturers; and
- Clarify how payments are calculated when a drug leaves the market.

Response: As noted previously, our discussion of partial quarter data is limited to and pertains to the use of less than a full quarter's worth of data to calculate an ASP-based payment limit, not to other issues such as the payment limit for drugs administered during the first quarter of sales, or reporting procedures. Thus, these comments are outside the scope of this rule.

We will continue to apply the policy as previously clarified in this section and described in the proposed rule.

3. Determining the Payment Amount for Drugs and Biologicals Which Include Intentional Overfill

The methodology for developing Medicare drug payment allowances based on the manufacturers' submitted ASP data is specified in 42 CFR part 414, subpart K. We initially established this regulatory text in the CY 2005 PFS final rule with comment period (69 FR 66424). We further described the formula used to calculate the payment

amount for each HCPCS billing code in the CY 2006 PFS proposed rule (70 FR 45844) and final rule with comment period (70 FR 70217). With enactment of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) (Pub. L. 110-173), the formula we use changed beginning April 1, 2008. Section 112(a) of the MMSEA amended section 1847A(b) of the Act to require CMS to calculate payment amounts using a specified volume-weighting methodology. In addition, section 112(b) of the MMSEA sets forth a special rule for determining the payment amount for certain drugs and biologicals. We addressed these changes in the CY 2009 PFS proposed and final rules (73 FR 38520 and 69571, respectively).

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

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

assigned to the billing and payment code. This process is discussed further in the CY2009 Physician Fee Schedule rule at 73 FR 69752.

The provisions in section 112 of the MMSEA were self implementing for services on and after April 1, 2008. Because of the limited time between enactment and the implementation date, it was not feasible to undertake and complete rulemaking on this issue prior to implementing the required changes. As a result of the legislation, we revised §414.904 to codify the changes to the determination of payment amounts consistent with section 112 of the MMSEA.

Since that time, we have become aware of situations where manufacturers, by design, include a small amount of "intentional overfill" in containers of drugs. We understand that this "intentional overfill" is intended to compensate for loss of product when a dose is prepared and administered properly. For instance, a hypothetical drug is intended to be delivered at a 0.5 mg dose that must be drawn into a syringe from a vial labeled for single use only. The vial is labeled to contain 0.5 mg of product but actually contains 1.5mg of product. The additional 1.0 mg of product is included, by design, and is intended to be available to the provider so as to ensure a full 0.5 mg dose is administered to the patient.

Our ASP payment calculations are based on data reported to us by manufacturers. This data includes the "volume per item". In our "Appendix A – Average Sales Price Reporting Data Elements" available on our web site at http://www.cms.gov/McrPartBDrugAvgSalesPrice/, we define "volume per item" as, "The amount in one item (ex., 10 ml in one vial, or 500 tablets in one bottle). Enter "1" for certain forms of drugs (for example, powders and sheets) when "Strength of the

Product" indicates the amount of the product per item." In order to accurately calculate Medicare ASP payment limits under section 1847A of the Act, we interpret "the amount in one item" to be the amount of product in the vial or other container as indicated on the FDA approved label.

It has been longstanding Medicare policy that in order to meet the general requirements for coverage under the "incident to" provision, services or supplies should represent an expense incurred by the physician or entity billing for the services or supplies (See Medicare Benefit Policy Manual (Publication # 100-02), Chapter 15, Sections 50.3, 60.1.A). Such physicians' services and supplies include drugs and biologicals under section 1861(s)(2)(A) of the Act. In accordance with this policy, providers may only bill for the amount of drug product actually purchased and that the cost of the product must represent an expense to the physician.

We further understand that when a provider purchases a vial or container of product, the provider is purchasing an amount of drug defined by the product packaging or label. Any excess product (that is, overfill) is provided without charge to the provider. In accordance with our current policy as explained above, providers may not bill Medicare for overfill harvested from single use containers, including overfill amounts pooled from more than one container, because that overfill does not represent a cost to the provider. Claims for drugs and biologicals that do not represent a cost to the provider are not reimbursable, and providers who submit such claims may be subject to scrutiny and follow up action by CMS, its contractors, and OIG.

Because such overfill is currently not included in the calculation of payment limits under the methodology in section 1847A of the Act and does not represent an

incurred cost to a provider, we proposed to update our regulations at 42 CFR part 414 Subpart K to clearly state that Medicare ASP payment limits are based on the amount of product in the vial or container as reflected on the FDA-approved label. We also proposed to update our regulations at Subpart J to clearly state that payment for amounts of free product, or product in excess of the amount reflected on the FDA-approved label, will not be made under Medicare.

We received several comments supporting our proposal. Several other comments raised concerns about whether our proposal attempts to regulate or even prohibit the use of overfill. Our policy is not intended to limit the use of intentional overfill during the care of beneficiaries or in medical practice; such measures are beyond CMS' authority. Rather, we are clarifying our ASP pricing and payment policies, describing how we utilize manufacturer reported data, and updating our regulations at 42 CFR part 414. The following is a summary of the comments we received and our responses.

Comments: Several commenters supported our proposal, agreeing that a provider does not incur a cost in obtaining the intentional overfill amount. One commenter noted that statute, regulations, and policies effective since CY 1965 regarding the "incident to" provision have required the provider to incur costs in order to receive Medicare payment. Another commenter supported the proposal because it protects the Medicare Trust Fund and the taxpayer, reduces fraud and abuse, and ensures quality patient care by reducing the influence of profit rather than clinical efficacy on medical decisions for the patient. One commenter agreed with the CMS proposal because of the variations in the amount of overfill that could be found in each vial or packaging. This commenter also noted previous OIG reports that expressly excluded intentional overfill in the calculation of

acquisition costs because of variability in the amount of and different practices for the use of overfill. Some commenters, in support of the proposal, mentioned ongoing litigation which alleges that some manufacturers provided kickbacks to providers by marketing and furnishing intentional overfill and encouraging providers to bill federal health care programs to increase the providers' profits and sales volumes for the drugs.

Response: We appreciate the comments in support of our proposal. We believe these comments help to illustrate the variety of perspectives regarding overfill.

Comments: Several commenters expressed concern that our proposed regulation changes are, in effect, a restriction on providers' ability to use intentional overfill. Comments emphasized that intentional overfill is provided to account for loss of drug during dosage preparation, and some comments noted that the FDA allows for intentional overfill to be included in the packaging to account for this loss of drug. Similarly, comments noted that current United States Pharmacopeia (USP) 797 standards for compounding sterile injections also allow for the use of overfill during drug preparation. Some comments suggested we work closely with the FDA and the USP to address the issue of intentional overfill in the manufacturing and packaging of the drugs. One comment suggested that we require providers to comply with USP 797 standards regarding the use of overfill. Commenters asserted that any regulation of intentional overfill should be imposed upon manufacturers rather than providers.

Response: We disagree with the commenters that believe our proposal would restrict the clinical use of intentional overfill. The comments that suggest that we impose requirements or implement standards regarding the amount or clinical use of overfill are beyond the scope of this rulemaking. In response to the commenters' concerns, however,

we believe it is necessary to reiterate the distinction between the amount of drug product that is contained in a vial or other packaging for use in the care of a beneficiary and the amount of drug product that manufacturers report to CMS for pricing purposes and used to calculate payment limits under section 1847A of the Act. Our policy discussion is limited to the latter issue. Our policy is not intended to allow, prohibit, or otherwise regulate the amount of overfill that manufacturers include in a container, or how that overfill is used in clinical practice. Indeed, we do not have the authority to regulate the manufacturing of drugs or biologicals or the practice of medicine. The appropriate use of drug products, including sterile products, depends on numerous factors, including, but not limited to: approved labeling, State law, the setting in which the product is prepared and used, how the product is stored, sterility, and chemical stability. For many drugs, overfill quantities are small and are not completely used. In many settings, harvesting small amounts of overfill, when appropriate, can make up for doses that are lost or are discarded because of an error, short stability, or accidental contamination, for example. Our proposal does not pertain to, or apply to, any of these issues. The intent of this proposal is merely to clarify that the Medicare ASP payment limit is based on the amount of drug conspicuously indicated on the FDA label, and that no payment will be made for any intentional overfill included as free drug for the proper preparation of a single therapeutic dose.

Comments: Some commenters estimated significant increases in Medicare costs if the proposal is finalized. These estimates were based on concerns that our policy would prohibit the use of overfill. These commenters emphasized that providers would be required to use additional vials and drugs if the use of intentional overfill were

prohibited. They stated that the proposal will not reduce Medicare costs, but will transfer the costs associated with intentional overfill from the pharmaceutical companies to the providers and, in turn, to the Medicare and its beneficiaries. Several commenters stated that providers minimize wastage and cost through the use of intentional overfill and efforts to schedule patients efficiently.

Response: Because we disagree that our proposal limits utilization of overfill, we accordingly disagree that our proposal will increase costs. We are not prohibiting the use of overfill, thus we do not anticipate providers or other entities buying additional amounts of drug as a result of this policy. Further, we do not believe that our policy will require significant changes in procedures or practices for most providers and suppliers because most providers and suppliers use overfill in clinically appropriate circumstances, and we therefore do not believe that our policy will cause them to incur significant costs on that basis.

However, as we stated in our proposal, we believe it is inappropriate for a provider or supplier to bill Medicare for any amount of intentional overfill beyond the labeled amount in a single-use vial or package, and we agree with the commenters that such inappropriate billing does not occur routinely.

Comments: Several commenters expressed concern that the proposed intentional overfill policy may cause lower reimbursement rates for overhead costs relating to procurement, preparation, and dispensing of affected drugs. Several comments expressed concern about the burden of tracking doses that are prepared as a service for providers who bill under Medicare Part B. Some commenters stated that the intentional overfill proposal is impossible to apply to multi-dose vials or packages, and will cause

unnecessary administrative burden to maintain accurate inventory and medical records regarding overfill and drug wastage from single-dose vials.

Response: We disagree with these comments. As we stated previously, our policy on intentional overfill pertains to payment under section 1847A of the Act-- it is not an attempt to mandate or direct how the contents of a drug product package are used. Our policy relates to the providers and suppliers who furnish drugs or biologicals under Part B and who bill for such services. We have no authority under section 1847A of the Act to dictate how entities that prepare and sell doses of drugs for use in various clinical settings set their rates. We would expect that providers and suppliers who purchase prepared doses from these entities have incurred a cost for them. For these reasons, we do not anticipate that our policy will affect entities that do not bill separately for Part B drugs, such as entities that prepare doses of sterile products for sale to providers or suppliers who bill Medicare for the drug.

This proposal also is not intended to affect the current cost or waste-saving batch processes in place when using multiple-dose vials or packages. Instead, the intent of this proposal is to clarify that the ASP payment limit is currently based on the amount of drug indicated on the FDA label, and that no payment will be made for any intentional overfill.

We expect that providers will continue to maintain accurate medical records for all beneficiaries as well as accurate inventory records of all drugs that were actually purchased and appropriately billed to Medicare.

Comment: One commenter noted an increased burden upon CMS to examine the beneficiaries' records to verify that no intentional overfill was billed to Medicare.

Response: For the reasons stated above, we do not believe that our proposal will significantly affect procedures used in most clinical settings. We therefore do not expect an additional burden for the agency to track and monitor this policy beyond the procedures that are in place right now.

Comment: One commenter noted that the proposal is contrary to our current policy regarding discarded drugs and specifically stated that billing Medicare for discarded drug is only appropriate for single-use vials, and that the provider must make good faith efforts to schedule patients to efficiently deliver the drugs to patients in a clinically appropriate manner, and that any discarded drug amount billed to Medicare must not be used on any other patient.

Response: We disagree with this comment. Although our policy on discarded drugs may appear to be similar to our proposed policy for overfill (in that they both pertain to how providers and suppliers deal with drug product that remains in a package after a dose has been administered), there is a key distinction. Our policy on discarded drugs acknowledges that providers and suppliers acting in good faith to minimize wastage should not be financially burdened when, for clinical reasons, it is not possible or advisable to use the full labeled amount of drug product in a single-use vial – in other words, we permit, in limited circumstances, billing for drugs for which the provider or supplier incurred a cost, but that the provider or supplier did not administer. In contrast, our policy on intentional overfill applies to drug product for which the provider or supplier did not incur a cost, that is, amounts of drug that are beyond the labeled amount. Thus, in addition to complying with the overfill policy, we expect providers to continue to make good faith efforts to efficiently minimize the amount of discarded drug by

facilitating clinically appropriate methods of administering the required dose to each beneficiary and is consistent with the discarded drug policy in Chapter 17 Section 40 of the Medicare Claims Processing Manual (http://www.cms.gov/manuals/downloads/clm104c17.pdf).

Comments: Several commenters agreed with our position that intentional overfill is considered free product for which the provider did not incur a cost. However, other commenters stated that the purchase of a drug includes not only the amount of drug identified on the FDA label, but also encompasses the entire package including accompanying items such as syringes, diluents, and intentional overfill that is required to assure the drug is prepared and administered properly. One commenter suggested that it is more appropriate to see any excessive overfill as an in-kind discount that reduces the per-unit price of a drug. This commenter believes that manufacturers have factored overfill into the pricing of their products and that providers indirectly pay for overfill regardless of its use. Some commenters also that intentional overfill is within the Discount Exception and Safe Harbor under the Anti-Kickback statute. These commenters believe that CMS should similarly interpret intentional overfill as a discount and require accurate reporting of the price of the item (taking into consideration the discount) by the manufacturer, but not should not require the provider to reduce the amount billed or refrain from billing for the overfill.

Response: We acknowledge that drugs and biologicals are supplied in various containers or kits that include accessories and diluents, as well as a variable amount of intentional overfill to ensure that the single dose is prepared and administered appropriately. Sections 1847A(b)(2) and (b)(5) of the Act require that payment limit

calculations be carried out without regard to any diluents or special packaging for the drug. We believe these statutory provisions support our position that overfill is not an in-kind discount. Further, we have authority under section 1847A(c)(3) of the Act to identify price concessions that must be included in the ASP calculation. However, we have a practical reason for declining to consider overfill to be a discount for purposes of the ASP calculation – namely, operational feasibility. The amount of overfill in vials varies from drug to drug and often is not easily or consistently quantifiable because actual fill amounts may also vary slightly due to the manufacturing process. In contrast, manufacturer sales data, ASP calculations, and ASP payment limits use exact quantities of drug that are represented by exact monetary values. Payment limits are currently calculated using the amount of drug that is reported by manufacturers to CMS each quarter. We base our price, in part, on the quantity indicated on the drug package, which does not indicate an overfill amount. The calculation of the Medicare payment limit is based on the reported data from the manufacturer. We do not have access to information that would permit us to account for overfill in the ASP calculation. Further, we are concerned that attempting to account for a variable amount of overfill could result in price instability or inaccuracy.

The application of safe harbor provisions to this proposal is outside the scope of this rule.

Comments: Some commenters suggested the issue of intentional overfill should be addressed in the ASP calculations. One commenter specifically suggested that the ASP calculation methodology be changed to consider intentional overfill when defining the units relevant to the calculation of the Medicare payment limit per billing code.

Response: Manufacturers are currently reporting ASP and sales data based on the labeled amount of the drug product. The intent of this proposal is to clarify that the ASP payment limit is based on the amount of drug clearly identified as the amount on the FDA label and packaging. We do not intend to change the ASP calculation methodology to include intentional overfill because of the operational difficulty in accurately identifying the amount of overfill.

Comments: Many commenters suggested CMS clarify the applicability of the proposal to specific providers. Other commenters suggested that the proposal be applied and enforced prospectively only in the physician office setting and not in hospitals or other provider settings. Another commenter noted that drugs furnished in the outpatient department are reimbursed based on ASP when separately payable, and requests clarification regarding whether this proposal must be required of hospital outpatient clinics paid under the Hospital Outpatient Prospective Payment System (OPPS). This commenter also requested that CMS clarify whether this proposal applies to acute care hospitals, skilled nursing facilities, dialysis facilities and other providers or suppliers of services under bundled payment methodologies. Another commenter requested the proposal not be applied to dialysis facilities. The commenter stated that intentional overfill is included in their costs reports, that the "incident-to" provision does not apply to dialysis facilities, and that the policy may cause confusion during the transition into the new End Stage Renal Disease payment bundle.

Response: Section 1847A(a)(1) of the Act specifies that the ASP methodology applies to drugs or biologicals described in section 1842(o)(1)(C) of the Act, which indicates that the ASP-based payment limit in 1847A of the Act affects a physician,

supplier or any other person that bills for Part B covered drugs that are not paid under a cost or prospective payment system. We did not propose to change the manner in which we calculate ASP-based payment limits to reflect the setting in which the drug was provided, and we believe that not only would such a policy be unduly complicated, but also would likely be beyond our authority under the ASP statute. We note that regardless of the benefit category for a drug or biological, if it is paid under section 1847A of the Act, we calculate the payment limit without regard to overfill – thus, the fact that certain providers or suppliers do not furnish drugs on an "incident to" basis is irrelevant to our policy for the ASP calculation. This rule's scope is limited to the payment of overfill under section 1847A of the Act.

Comment: One comment suggested that we encourage providers to the use intentional overfill and bill Medicare only for the amount administered to the patient, but not the wasted amount. The commenter also suggested that drug billing code increments be reduced for those drugs that are dosed in smaller amounts than what is currently on the billing code. For example, if a patient dose is 710mg but the billing increment is 100mg, then the provider must bill Medicare for 800mg and waste the left over 90mg.

Response: We are continuing to work closely to review all billing codes to assure that such codes describe drugs at the most clinically appropriate dosage descriptors. As stated in the discarded drug policy (Chapter 17 Section 40 of the Medicare Claims Processing Manual; http://www.cms.gov/manuals/downloads/clm104c17.pdf), Medicare will continue to make payment for the administered amount of drug plus any appropriately discarded drug that sums to the labeled amount on a single-use vial or package.

Comments: Some commenters disagree that Medicare has a longstanding policy that an expense must be incurred by the provider in order for payment to be made by Medicare. One commenter stated that there is no existing law or regulation that prohibits a provider from billing for intentional overfill or for any free product. This commenter further discussed previous OIG reports that identified providers were using intentional overfill which would alter their costs, and added that CMS did not express any concerns about these overfill utilization practices. Another commenter recommended that CMS determine overfill amounts for all injectable drugs and validate whether excess product pooled from more than one container and billed to Medicare does not represent a cost to the provider.

Response: We believe our preamble adequately describes the longstanding Medicare policy based upon section 1861(s)(2)(A) of the Act. We maintain that services or supplies reimbursed by Medicare under the "incident-to" provision should represent an expense incurred by the physician or entity billing for the drugs, services or supplies. Our policy clarifies that we will not pay for intentional overfill. For reasons described elsewhere in this preamble, we do not intend to track overfill amounts for injectable drugs.

Comments: Some commenters requested that CMS define what is meant by "intentional" overfill since many injectable drugs include a variable amount of overfill to allow the labeled dose to be appropriately prepared and administered to the patient. One comment cited that the USP recommends a 10 percent overfill by volume for liquid medicines, and stated that the example in the proposal describing a 100 percent overfill is inconsistent with USP guidelines.

Response: We described "intentional" overfill in the proposed rule (75 FR 40155) and we agree that the amount of intentional overfill may vary from product to product; however, we are not aware of an absolute limit on the amount of overfill. In summary, the preamble describes intentional overfill as any amount of drug greater than the amount identified on the conspicuous FDA approved label on the outside of the package, and characterizes overfill as excess or free product that does not represent a cost to the provider.

After reviewing the public comments, we are finalizing our proposal to update our regulations at 42 CFR part 414 Subpart J to clearly state that Medicare ASP payment limits are based on the amount of product in the vial or container as reflected on the FDA-approved label, and Subpart K to clearly state that payment for amounts of product in excess of the amount reflected on the FDA-approved label, will not be made under Medicare. We are finalizing the regulations as proposed. These provisions will be effective January 1, 2011.

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

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

- The widely available market price (WAMP) for these drugs and biologicals (if

any); and

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

Section 1847A(d)(3)(A) of The Act states, "The Secretary may disregard the ASP for a drug or biological that exceeds the WAMP or the AMP for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B))." Section 1847A(d)(3)(C) of the Act states that if the Inspector General (OIG) finds that the ASP for a drug or biological is found to have exceeded the WAMP or AMP by this threshold percentage, the OIG "shall inform the Secretary (at such times as the Secretary may specify to carry out this subparagraph) and the Secretary shall, effective as of the next quarter, substitute for the amount of payment otherwise determined under this section for such drug or biological, the lesser of -- (i) the widely available market price for the drug or biological (if any); or (ii) 103 percent of the average manufacturer price...."

The applicable threshold percentage is specified in section 1847A(d)(3)(B)(i) of the Act as 5 percent for CY 2005. For CY 2006 and subsequent years, section 1847A(d)(3)(B)(ii) of the Act establishes that the applicable threshold percentage is "the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the WAMP or the AMP, or both." In the CY 2006 (70 FR 70222), CY 2007 (71 FR 69680), CY 2008 (72 FR 66258), CY 2009 (73 FR 69752), and CY 2010 (74 FR 61904) PFS final rules with comment period, we specified an applicable threshold percentage of 5 percent for both the WAMP and AMP. We based this decision on the fact that data was too limited to support an adjustment to the current applicable threshold percentage.

For CY 2011, we proposed to specify two separate adjustments to the applicable threshold percentages. When making comparisons to the WAMP, we proposed the applicable threshold percentage to remain at 5 percent. The applicable threshold percentage for the AMP is addressed below in this section of the preamble. Although the latest WAMP comparison was published in 2008, the OIG is continuing to perform studies comparing ASP to WAMP. Based on available OIG reports that have been published comparing WAMP to ASP, we do not have sufficient information to determine that the 5 percent threshold percentage is inappropriate. As a result, we believe that continuing the 5 percent applicable threshold percentage for the WAMP is appropriate for CY 2011. Therefore, we proposed to revise §414.904(d)(3) to include the CY 2011 date.

As we noted in the CY 2010 PFS final rule with comment period (74 FR 61904), we understand that there are complicated operational issues associated with this policy. We continue to proceed cautiously in this area. We remain committed to providing stakeholders, including providers and manufacturers of drugs impacted by potential price substitutions with adequate notice of our intentions regarding such, including the opportunity to provide input with regard to the processes for substituting the WAMP for the ASP.

We solicited comments on our proposal to continue the applicable threshold percentage at 5 percent for the WAMP for 2011.

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

Comment*:* Several commenters supported maintaining the threshold at 5 percent. Other commenters commended CMS for the cautious approach toward determining price substitutions based on WAMP to ASP comparisons, and supported the exclusion of

WAMP from the price substitution proposal discussed elsewhere in this rule. One comment suggested the AMP threshold be increased to reflect recent changes to the definition of AMP but did not provide a specific percentage. One commenter suggested that OIG also review whether existing discrepancies in the various reporting rules for bundled arrangements and price concessions have impacted the reported pricing for the same products under AMP and ASP.

Response*:* We appreciate the comments supporting the continuation of the 5 percent threshold. As we noted in the CY 2010 PFS rule (74 FR 61904), we understand there are complex operational issues associated with potential payment substitutions. We will continue to proceed cautiously in this area and provide stakeholders, particularly manufacturers of drugs impacted by potential price substitutions, with adequate notice of our intentions regarding such, include the opportunity to provide input with regard to the processes for substituting the WAMP or the AMP for the ASP. As part of our approach we intend to continue to work closely with the OIG to develop a better understanding of the issues that may be related to certain drugs for which the WAMP and AMP may be lower than the ASP over time.

After reviewing the public comments, we are finalizing our proposal to continue the 5 percent WAMP threshold for CY2011.

5. AMP Threshold and Price Substitutions

As mentioned elsewhere in this final rule with comment period, when making comparisons of ASP to AMP, the applicable threshold percentage for CY 2005 was specified in statute as 5 percent. Section 1847A(d)(3) of the Act allows the Secretary to specify adjustments to this threshold percentage for years subsequent to 2005, and to

specify the timing for any price substitution. For CY 2006 (70 FR 70222) CY 2007 (71 FR 69680), CY 2008 (72 FR 66258), CY 2009 (73 FR 69752), and CY 2010 (74 FR 61904), the Secretary made no adjustments to the threshold percentage; it remained at 5 percent.

For CY 2011, we proposed with respect to AMP substitution to apply the applicable percentage subject to certain adjustment such that comparisons of ASP to AMP will only be made when the ASP exceeds the AMP by 5 percent in two consecutive quarters immediately prior to the current pricing quarter, or three of the previous four quarters immediately prior to the current quarter. We further proposed to apply the applicable AMP threshold percentage only for those situations where AMP and ASP comparisons are based on the same set of NDCs for a billing code (that is, "complete" AMP data).

Furthermore, we proposed a price substitution policy to substitute 103 percent of AMP for 106 percent of ASP for both multiple and single source drugs and biologicals as defined respectively at section 1847(A)(c)(6)(C) and (D) of the Act. Specifically, we proposed that this substitution:

- Would occur when the applicable percentage has been satisfied for a number of calendar quarters as discussed elsewhere in this rule (that is, for two consecutive quarters immediately prior to the current pricing quarter, or three of the previous four quarters immediately prior to the current quarter);

- Would permit for a final comparison between the OIG's volume-weighted 103 percent of AMP for a billing code (calculated from the prior quarter's data) and the billing code's volume weighted 106 percent ASP, as calculated by CMS, for the current quarter

to avoid a situation in which the Secretary would inadvertently raise the Medicare payment limit through this price substitution policy; and

- That the duration of the price substitution would last for only one quarter.

We also sought comment on other issues related to the comparison between ASP and AMP, such as:

- Any effect of definitional differences between AMP and ASP, particularly in light of the revised definition of AMP per the ACA;
- The impact of any differences in AMP and ASP reporting by manufacturers on price substitution comparisons; and,
- Whether and/or how general differences and similarities between AMP and manufacturer's ASP would affect comparisons between these two.

Comment: CMS received a number of comments pertaining to its proposals regarding the AMP threshold. Some commenters generally agreed that any proposal should be transparent, cautious, and should account for inter-quarter price fluctuations. Some commenters also supported our proposal to limit the price substitution to those HCPCS codes for which ASP and AMP comparisons are based on the same set of NDCs. One commenter requested that CMS specifically note that the volume used to calculate the volume-weighted AMP is identical to that used in the calculation of the volume-weighted ASP. Other commenters supported maintaining the applicable threshold at 5 percent for CY 2011.

Response: We appreciate the comments regarding our proposed AMP threshold policies. Since the publication of the PFS proposed rule, the preliminary injunction issued by the United States District Court for the District of Columbia in *National*

Association of Chain Drug Stores et al. v. Health and Human Services, Civil Action No. 1:07-cv-02017 (RCL) is still in effect. Additionally, CMS continues to expect to develop regulations that will implement the provisions of section 2503 of the ACA, which amended the definition of AMP. Moreover, section 202 of the Federal Aviation Administration Air Transportation Modernization and Safety Improvement Act (Pub. L. 111-226), (enacted on August 10, 2010) has further amended section 1927(k) of the Act. Finally, on September 3, 2010, we proposed to withdraw certain provisions of the AMP final rule published on July 17, 2007 (75 FR 54073).

In light of these factors and comments received, we are finalizing our proposal that the AMP applicable threshold be 5 percent for CY 2011. However, we are not finalizing our proposed adjustments to the 5 percent AMP threshold that would specifically apply the applicable percentage such that comparisons of ASP to AMP will only be made when--

- The ASP exceeds the AMP by 5 percent in two consecutive quarters immediately prior to the current pricing quarter, or three of the previous four quarters immediately prior to the current quarter; and

- For those situations where AMP and ASP comparisons are based on the same set of NDCs for a billing code (that is, "complete" AMP data).

We appreciate the submitted comments and will take them into account when we revisit the price substitution and AMP threshold issues in future rulemaking.

Comment: We received a number of comments regarding our price substitution proposed policies. Some commenters supported our proposal that any substitution would last only for a single quarter. The majority of commenters requested that any proposal

should not be implemented until after CMS published regulations on the revised definition of AMP. A few commenters also recommended that CMS provide adequate notice to manufacturers prior to making a price substitution. One commenter suggested that additional OIG comparison studies are needed to examine the impact of the new definition of AMP. Several commenters requested clarification on and suggested changes to our proposed regulatory language. Another commenter requested clarification on the timing of price substitutions and suggested that any price substitution policies should not be implemented until the lag time between when the comparison is made and when the substitution would be implemented was decreased. One commenter noted that the OIG studies are not a reliable indicator of predicted savings since the substitution timeframes within the studies differed from that in our proposal. All commenters agreed that any price substitution policy should not be implemented until after the preliminary injunction is vacated.

Moreover, several commenters provided additional information related to the comparison between ASP and AMP, including:

- How ASP and AMP each encompass different sales and rebate data and are calculated based on differing statutory definitions;
- The impact of restated AMP data on comparisons; and
- The effect of price substitutions on physician acquisition of drugs.

Response: We appreciate the comments submitted regarding our price substitution proposal. As discussed above, recent legislative and regulatory changes have further affected this issue.

After careful review and consideration of the comments received, we will not be finalizing our price substitution proposal at this time and thus we will not be finalizing the proposed regulation text at section 414.904(d). Specifically, we are not finalizing our proposal for a policy to substitute 103 percent of AMP for 106 percent of ASP for both multiple and single source drugs and biologicals as defined respectively at section 1847(A)(c)(6)(C) and (D) of the Act. This proposal specifically would have--

- Occurred when the applicable percentage had been satisfied for a number of calendar quarters as discussed elsewhere in this rule;
- Permitted for a final comparison between the OIG's volume-weighted 103 percent of AMP for a billing code (calculated from the prior quarter's data) and the billing code's volume weighted 106 percent ASP, as calculated by CMS, for the current quarter to avoid a situation in which the Secretary would inadvertently raise the Medicare payment limit through this price substitution policy; and
- Had the duration of the price substitution lasting for only one quarter.

We are finalizing the portion of our proposal that sets the AMP threshold at 5 percent CY2011 and have revised the regulations text accordingly. We remain committed to proceeding cautiously as we continue to evaluate the impact of any future policy developments in this area.

6. Out of Scope Comments

We received comments pertaining to: (1) Part B payment for insulin; (2) bona fide service fees; (3) price concessions and bundled arrangements in the calculation of manufacturer ASP data; (4) updating supplying and dispensing fees for Part B drugs; (5) developing standards for manufacturers to not submit related ASP data; (6) low

reimbursement in a HCPCS-based claims systems for pharmacies; (7) claims processing, claims rejection, and payment delays in Medicare Part B as compared to Part D; and (8) publishing reimbursement rates for radiopharmaceuticals on contractor websites. These comments are outside the scope of this rule, and therefore are not addressed in this final rule with comment period.

B. Ambulance Fee Schedule Issue: Policy for Reporting Units when Billing for Ambulance Fractional Mileage

Under the ambulance fee schedule, the Medicare program pays for transportation services for Medicare beneficiaries when other means of transportation are contraindicated and all other applicable medical necessity requirements are met. Ambulance services are classified into different levels of ground (including water) and air ambulance services based on the medically necessary treatment provided during transport. These services include the following levels of service:

- For Ground--
  - ++ Basic Life Support (BLS) (emergency and nonemergency).
  - ++ Advanced Life Support, Level 1 (ALS1) (emergency and nonemergency).
  - ++ Advanced Life Support, Level 2 (ALS2).
  - ++ Specialty Care Transport (SCT).
  - ++ Paramedic ALS Intercept (PI).
- For Air--
  - ++ Fixed Wing Air Ambulance (FW).
  - ++ Rotary Wing Air Ambulance (RW).

1. History of Medicare Ambulance Services

a. Statutory Coverage of Ambulance Services

Under sections 1834(l) and 1861(s)(7) of the Act, Medicare Part B (Supplementary Medical Insurance) covers and pays for ambulance services, to the extent prescribed in regulations, when the use of other methods of transportation would be contraindicated by the beneficiary's medical condition. The House Ways and Means

Committee and Senate Finance Committee Reports that accompanied the 1965 Social Security Amendments suggest that the Congress intended that--

- The ambulance benefit cover transportation services only if other means of transportation are contraindicated by the beneficiary's medical condition; and

- Only ambulance service to local facilities be covered unless necessary services are not available locally, in which case, transportation to the nearest facility furnishing those services is covered (H.R. Rep. No. 213, 89th Cong., 1st Sess. 37 and Rep. No. 404, 89th Cong., 1st Sess. Pt 1, 43 (1965)).

The reports indicate that transportation may also be provided from one hospital to another, to the beneficiary's home, or to an extended care facility.

b. Medicare Regulations for Ambulance Services

Our regulations relating to ambulance services are set forth at 42 CFR part 410, subpart B, and 42 CFR part 414, subpart H. Section 410.10(i) lists ambulance services as one of the covered medical and other health services under Medicare Part B. Therefore, ambulance services are subject to basic conditions and limitations set forth at § 410.12 and to specific conditions and limitations as specified in §410.40 and §410.41. Part 414, subpart H, describes how payment is made for ambulance services covered by Medicare.

2. Mileage Reporting – Provisions of the CY 2011 Proposed Rule

In the CY 2011 PFS proposed rule (75 FR 40159-40161, issued July 13, 2010), we proposed that, effective for claims with dates of service on and after January 1, 2011, ambulance providers and suppliers would be required to report mileage rounded up to the nearest tenth of a mile on all claims for mileage totaling up to 100 covered miles, as further discussed below. We stated that we would revise the instructions set forth in our

Claims Processing Manual to reflect the revised billing procedures. In this section, we describe our proposals in the CY 2011 PFS proposed rule, including the background and current process for reporting ambulance mileage, the proposed fractional mileage billing policy, and our reasons for proposing revisions to the current mileage reporting policy.

a. Background and Current Process for Reporting Ambulance Mileage

Historically, the Medicare FFS claims processing system lacked the capability to accept and process fractional unit amounts reported in any claim format. Therefore, the standard for reporting units for ambulance mileage was to bill in whole number increments. Thus, if the total units of service for ambulance mileage included a fractional amount, providers and suppliers of ambulance services (hereafter referred to collectively as "providers and suppliers") were instructed to round the fraction up to the next whole number. Claims billed with fractional units of service were, at that time, returned as unprocessable as CMS' claims processing systems could not accept nor adjudicate fractional unit amounts properly.

Consequently, in Change Request (CR) 1281 (Transmittal AB-00-88, issued on September 18, 2000), we instituted an operational procedure requiring whole-unit reporting of mileage on ambulance claims. Specifically, we instructed providers and suppliers that "If mileage is billed, the miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number." Our instructions also stated that "1" should be reported for trips totaling less than a single mile. This was an operational instruction based on Medicare's FFS system limitations and capabilities at the time, as our claims processing systems were not capable of accepting and processing claims submitted with fractional units of service. Since then, our claims processing

system functionality has evolved to the point where this rounding process is no longer necessary for ambulance transports, as it is now possible for our FFS systems to capture and accurately process fractional units on both paper and electronic forms.

Based on our prior instructions, providers and suppliers continue to report loaded mileage as whole-number units on both paper and electronic claims. Providers and suppliers utilize the appropriate HCPCS code for ambulance mileage to report the number of miles traveled during a Medicare-covered trip rounded up to the nearest whole mile at a minimum of 1 unit for the purpose of determining payment for mileage. Transmittal AB-00-88 established a list of HCPCS codes accepted by Medicare for the purpose of billing mileage. Providers and suppliers were instructed to use these specific HCPCS codes and enter the total number of covered miles in the "units" field of the claim form. For example, if a covered trip from the point of pickup (POP) to the Medicare-approved destination (see §414.40 for a list of approved destinations) totaled 9.1 miles, the provider would enter the appropriate HCPCS code for covered mileage and a "10" in the units field. Providers and suppliers billing for trips totaling, for example, 0.5 covered miles, would enter "1" in the units field along with the appropriate HCPCS code for mileage.

b. Concerns Regarding the Potential for Inaccuracies in Reporting Units and Associated Considerations

Often an ambulance provider will transport a distance that is either not an exact whole number of miles or less than one whole mile during a covered trip. Based on our current instructions, providers and suppliers billing for ambulance services must round up the total billable mileage to the nearest whole mile for trips that include a fraction of a

mile or less than one whole mile. Because of those instructions, a provider or supplier is required to bill as much as 0.9 of a mile more than what was actually traveled.

We have been contacted by suppliers on several occasions with concerns regarding our current instructions for reporting ambulance mileage. Certain suppliers believe that our instructions require them to bill inaccurately. One company in particular stated that they routinely need to bill for trips totaling less than 1 mile. The beneficiaries that are being transported by this company live in the immediate vicinity of the facility to which they are being transported, and therefore, the number of loaded miles for each trip totals approximately one half of a mile. The company was concerned that since Medicare requires that they enter a "1" in the units field of their claims for mileage, they are being overpaid by Medicare for mileage based on the service they actually provided.

However, the company's main concern revolved around the risk of creating an appearance of impropriety. Although our instructions clearly state that providers and suppliers should, as a matter of procedure, round up fractional mileage amounts to the nearest whole mile, some providers and suppliers indicated that they wanted to bill as accurately as possible and that they only wanted to be paid for the service they actually provided. We thoroughly considered these concerns while reevaluating the procedure for reporting units for fractional mileage amounts.

As we stated in the CY 2011 PFS proposed rule (75 FR 40160), our first priority in considering the issues raised by ambulance providers and suppliers was to ascertain the basis for the current mileage reporting instructions. As previously discussed, the original instructions for reporting fractional mileage were published in Transmittal AB-00-88, issued on September 18, 2000. We instructed providers and suppliers to round fractional

mileage amounts "up to the nearest whole mile" and to enter "1" for fractional mileage totaling less than one mile. This particular process had also been in place prior to issuance of the transmittal. The reason for the procedure was that our claims processing systems were not capable of accepting and processing claims submitted with fractional units of service – even if the service was commonly measured in fractional amounts, as with ambulance mileage.

In the CY 2011 PFS proposed rule (75 FR 40160), we then explored whether a change in our procedure would be: (1) appropriate; (2) possible considering our current system capabilities and industry standards of measurement; and (3) applicable to any service other than ambulance mileage. As to the appropriateness of changing the procedure for reporting units of service on provider claims for fractional ambulance mileage, we stated in the proposed rule (75 FR 40160) that we believe that we should make every effort to create and implement policies and processes that create the best opportunity for accuracy in billing. It is not our intention to put providers and suppliers in a position where they are required to bill inaccurately for the service they provide. We continue to strive toward ensuring that providers and suppliers bill and are paid only for services actually provided. In the CY 2011 PFS proposed rule (75 FR 40160), we stated that we believe that changing our current procedure for reporting units of service to require reporting of fractional mileage will help to ensure that providers and suppliers can submit claims that more precisely reflect actual mileage, and are reimbursed more accurately for the services they actually provided. We originally instituted a policy of accepting and processing only whole units because at that time system limitations prevented us from accepting and processing fractional ambulance mileage.

Second, we considered in the CY 2011 PFS proposed rule (75 FR 40160) whether it is currently possible for our claims processing systems to accept and process fractional unit amounts on both paper and electronic claims. Upon reevaluating our system capabilities, we found that technological advancements in Optical Character Recognition (OCR) and electronic claim submission have made it possible for our FFS systems to capture and accurately process fractional units on both paper and electronic claims. We note that our systems currently have the capability to accept fractional units with accuracy up to as much as one thousandth of a unit (that is, to 3 decimal places).

We also considered in the CY 2011 PFS proposed rule (75 FR 40160) whether ambulance providers and suppliers have the capability to measure fractional mileage. This was an important point because if providers and suppliers are not able to measure mileage with any more specificity than the nearest whole number mile, then there would be no need to modify the current procedure for billing fractional mileage. In that case, providers and suppliers would continue to report mileage as whole numbers since they could measure no more accurately than that. We stated in the proposed rule that both analog and digital motor vehicle odometers are designed to measure mileage accurately to within a minimum of a tenth of a mile. While we found that some vehicle odometers measure mileage more accurately than a tenth of a mile, most odometers are accurate to the nearest tenth of a mile. Additionally, aircraft geographic positioning system (GPS) technology provides the means to accurately determine billable mileage to the tenth of a mile.

Third, we considered whether a policy of billing fractional units would be applicable to any other service besides ambulance mileage. The units of service field on

both the electronic and paper claim is used to report the quantity of services or supplies provided to Medicare beneficiaries and is used to report a wide range of services and supplies including, but not limited to: number of office visits; anesthesia minutes; quantity of drugs administered; covered miles. Although Medicare currently makes payment based on fractional units for some services (for example, calculation of payment after conversion of anesthesia time reported in minutes to time units), there is currently no requirement that providers bill fractional units on the claim. We stated that if we were to implement a policy of requiring reporting of fractional units for other types of services or supplies, we would first need to evaluate whether it is possible to do so considering industry standards of measurement. As discussed in the CY 2011 PFS proposed rule (75 FR 40160), we found that providers and suppliers of ambulance services have the capability to determine fractional mileage using standard onboard equipment, that is, an odometer, GPS, and/or other similar equipment used to measure distance traveled. We stated that this would enable us to readily implement a fractional unit billing policy for ambulance mileage; whereas applicability to other areas (such as anesthesia, drugs, etc.) would require more analysis to determine whether a fractional unit billing policy is feasible, efficacious, and cost effective. Additionally, this issue was first raised by ambulance suppliers who were concerned about overbilling and being overpaid by Medicare. Therefore, we stated in the proposed rule (75 FR 40160) that we believe it is most reasonable to first address the area where concerns have been raised (that is, ambulance mileage) and consider applicability of this procedure to other types of services and items in the future.

Finally, and perhaps most importantly, we considered that our claims processing

system should be configured to process claims as accurately as possible so as to provide for more accurate payments and to safeguard Medicare dollars. As previously discussed, we found that ambulance providers and suppliers currently have the capability to measure mileage accurately to within a minimum of a tenth of a mile using devices (for example, odometers, and GPS technology, etc.) already equipped onboard their vehicles. We stated in the CY 2011 PFS proposed rule (75 FR 40160) that we believe that requiring ambulance providers and suppliers to round (and report) fractional ambulance mileage up to the next tenth of a mile strikes a proper balance between ensuring that the claims processing system adjudicates a claim as accurately as the system will permit without unduly burdening the ambulance community.

Based on all of the considerations note previously, we proposed that our claims processing instructions for submission of claims for ambulance mileage should be revised to reflect the current functionality of our claims processing systems so as to maximize the accuracy of claims payment, as further discussed in this section (75 FR 40160).

c. Billing of Fractional Units for Mileage

It is both reasonable and prudent that, in order to ensure accuracy of payment, we facilitate and allow submission of the most accurate information on all Medicare ambulance claims. Furthermore, since our claims processing systems are currently capable of accepting and processing fractional units of service, we believe that ambulance mileage should be billed to and paid by Medicare in fractional amounts to enhance payment accuracy. Based on all the considerations discussed previously, in the CY 2011 PFS proposed rule (75 FR 40161), we proposed to require that claims for mileage submitted by ambulance providers and suppliers for an ambulance transport

(ground and air) be billed in fractional units, by rounding up to the nearest tenth of a mile (with the exception discussed below). As previously discussed , we believe that requiring ambulance providers and suppliers to round (and report) fractional mileage up to the next tenth of a mile would allow us to provide for more accurate claims payment without unduly burdening the ambulance community.

Therefore, in the CY 2011 PFS proposed rule (75 FR 40161), we proposed that, effective for claims with dates of service on and after January 1, 2011, ambulance providers and suppliers would be required to report mileage rounded up to the nearest tenth of a mile for all claims for mileage totaling up to 100 covered miles. Providers and suppliers would submit fractional mileage using a decimal in the appropriate place (for example, 99.9). Since standard vehicle mileage (analog, digital, and GPS) is or can be calculated accurately to the nearest tenth of a mile, we proposed that the mileage billed to Medicare by ambulance providers and suppliers be reported by rounding up to the next tenth of a mile.

We also stated in the proposed rule (75 FR 40161) that although the electronic claim formats can accommodate fractional mileage when mileage is equal to or greater than 100 covered miles (for example, 100.0), the paper claim cannot. Because the Form CMS-1500 paper claim currently only supports four characters (including the decimal point) in the units field (Item 24G), we also proposed that mileage equal to or greater than 100 covered miles continue to be reported in whole number miles on both paper and electronic claims. We proposed that providers and suppliers would round up fractional mileage to the next whole number for mileage that exceeds 100 covered miles and report the resulting whole number in the units' field. We stated that we would revise the

instructions set forth in our Claims Processing Manual to reflect the revised procedures for submitting and paying claims for fractional ambulance mileage.

3. Analysis of and Responses to Public Comments

We received approximately 131 comments in response to the proposed rule. We received comments from, among others, public and private ambulance companies, national ambulance organizations, local fire and EMS departments as well as other interested parties such as attorneys and consultants. The responses we received pertained primarily to the proposed rule's financial and administrative impact, the impact on patient care, and the overall impact on the ambulance services industry. A summary of the comments and our responses are included below.

a. Basis for Reconsideration of the Ambulance Mileage Reporting Requirements

Comment: A few commenters believed that the concerns discussed in the proposed rule regarding certain suppliers' belief that the current mileage reporting requirement forced them to bill inaccurately, were an attempt by CMS to achieve budgetary savings by using the concerns of a few companies as justification. These commenters stated that CMS should have addressed the suppliers' concerns by educating providers and suppliers about its current policy of rounding up to the next whole mile so that they would be aware that this billing practice is appropriate, and suggested that CMS include the current whole mile billing policy in the regulations to further reinforce this, rather than implement the new fractional mileage policy. They stated that any change to the ambulance mileage reporting requirement would be unreasonable and unfounded. The commenters believed that if accuracy was a priority, then CMS should have implemented the fractional mileage billing policy in Transmittal AB-00-88, issued

September 18, 2000.

Response: While the impetus for reconsidering our policy on ambulance mileage billing was the concerns raised by ambulance suppliers wishing to bill accurately, our basis for moving forward with the proposed policy was that the conditions that dictated the original mileage billing policy have now changed. As we stated in the proposed rule (75 FR 40160), technological advancements in our system capabilities enabled us to reconsider our policy for reporting ambulance mileage. We were originally not capable of receiving or processing fractional unit amounts on electronic or paper claims, and thus, initially, it was necessary to implement a policy that required providers and suppliers to round mileage up to the nearest whole mile – even though that amount exceeded the miles actually traveled. As discussed in the CY 2011 PFS proposed rule (75 FR 40159), under the current policy, the result could be overpayment for mileage of up to 0.9 of a mile.

Therefore, this change to our policy regarding ambulance mileage billing represents a reasonable and appropriate change to improve payment accuracy. The fact that we did not implement such a policy in the Transmittal cited by commenters does not negate the fact that the change is both needed and appropriate. Again, the original policy for rounding mileage up to the nearest whole number mile was based on the fact that we could not capture and process fractional mileage on a Medicare claim. To ignore the current systems' capability to more accurately process claims than what was possible 10 years ago would unnecessarily perpetuate a less accurate method of processing claims and would result in less accurate payments than is possible with current system capabilities.

For the reasons discussed previously and in the CY 2011 PFS proposed rule, we continue to believe that it is reasonable and appropriate to revise our claims processing instructions as discussed in the proposed rule to require that ambulance mileage be reported in fractional amounts by rounding up to the next tenth of a mile.

b. Appropriateness of Fractional Mileage Reporting Policy

As we discussed in the CY 2011 PFS proposed rule (75 FR 40160), we believe that reporting of and payment based on fractional ambulance mileage is appropriate because it permits ambulance providers and suppliers to submit claims that more precisely reflect actual mileage and to be reimbursed more accurately for the services they provide. Although many commenters agreed that billing and payment accuracy are important, commenters cited various concerns regarding the appropriateness of the policy.

(1) Statutory Compliance and Financial Impact of Fractional Mileage Policy

Comment: Many commenters believed that the fractional mileage reporting policy does not adhere to the "budget neutrality principles" set forth in 42 U.S.C. §1395m(l)(3)(B). These commenters interpreted 42 U.S.C. §1395m(l)(3)(B) as requiring that CMS pay the same amount for ambulance services after implementation of the fee schedule as it did prior to the fee schedule with an inflation adjustment, and stated that in order to comply with this statute, the fractional mileage policy must be implemented in a manner such that any savings generated by this policy are reinvested in the ambulance fee schedule.

Furthermore, commenters asked that CMS comply with the "requirement and

commitment made during negotiated rulemaking to ensure that no money is taken out of the system." Commenters cited to the February 27, 2002 final rule implementing the ambulance fee schedule, in which we stated that we would monitor payment data and make adjustments to the conversion factor (CF) if the actual experience under the fee schedule is significantly different from the assumptions used to establish the original CF. (67 FR 9102 and 9102). Several commenters stated that the fractional mileage policy alters the fee schedule and therefore requires reconsideration of the conversion factor (CF) used to set the ambulance fee schedule payment amounts so that no money is removed from the system. Some commenters believed that the policy will have a greater effect on ground ambulance services and recommended a greater proportional increase to the CF for ground ambulance transports versus air ambulance rates.

Response: Section 1834(l)(3)(B) of the Act (42 USC § 1395m(l)(3)(B)) does not require that we pay the same aggregate amount for ambulance services after implementation of the fee schedule as we did before implementation of the ambulance fee schedule, or that we ensure that any savings generated by the fractional mileage policy be put back into the ambulance fee schedule. Rather, this statutory section sets forth the ambulance inflation factor to be used to update the ambulance fee schedule rates each year. Section 1834(l)(3)(B) of the Act requires that we set the ambulance fee schedule rates each year at the same level as the previous year increased by the percentage increase in the CPI-U (U.S. city average) for the 12-month period ending in June of the previous year (as discussed in section VI.P. of this final rule with comment period, effective January 1, 2011, the annual update to the fee schedule rates is subject to a productivity adjustment). We have interpreted this provision at §414.610(f) as

requiring that the CF, the air ambulance rates and the mileage rates be updated annually by the ambulance inflation factor set forth in the statute. The fractional mileage billing policy does not alter the payment rates set under the ambulance fee schedule; rather, it is a change to our operational instructions for reporting ambulance mileage intended to improve billing and payment accuracy. After implementation of the fractional mileage billing policy, we will continue to update the rates each year as required by section 1834(l)(3)(B) of the Act, and thus we believe this policy is consistent with section 1834(l)(3)(B) of the Act. Furthermore, we note that while section 1834(l)(3)(A) of the Act required the Secretary to ensure that the aggregate amount of payments made for ambulance services during 2000 (originally expected to be the first year of the ambulance fee schedule) did not exceed the aggregate amount of payments that would have been made for such services during such year absent the fee schedule, it did not set forth a budget neutrality requirement for subsequent years.

While some commenters stated that the fractional mileage billing policy alters the fee schedule and therefore requires reconsideration of the conversion factor (CF) used to set the ambulance fee schedule payment amounts so that no money is removed from the system (citing to the February 27, 2002 final rule implementing the ambulance fee schedule), we believe that commenters have misunderstood our statements in the February 27, 2002 final rule. In the February 27, 2002 final rule, we stated that we would monitor payment data and make adjustments to the conversion factor (CF) if the actual experience under the fee schedule is significantly different from the assumptions used to establish the original CF as discussed in the February 27, 2002 final rule (67 FR 9102 and 9103).

As stated previously, the fractional ambulance mileage billing policy does not change the rates under the ambulance fee schedule. Rather, it is a change to our operational procedures for reporting ambulance mileage intended to improve billing and payment accuracy. We do not believe that it is appropriate to adjust the CF or air ambulance rates as a result of this policy, as further discussed below.

In the February 27, 2002 final rule implementing the ambulance fee schedule (67 FR 9102-9103, 9127, 9134), we stated that we would monitor the payment data and adjust the CF and the air ambulance rates if actual experience under the fee schedule proved to be significantly different from the assumptions used to determine the initial CF and air ambulance rates (for example, the relative volumes of the different levels of service (service mix) and the extent to which providers and suppliers charge below the fee schedule (low billers)). Thus, in the February 27, 2002 final rule, we finalized §414.610(g), which at that time stated, in part, that the "Secretary will annually review rates and will adjust the CF and air ambulance rates if actual experience under the fee schedule is significantly different from the assumptions used to determine the initial CF and air ambulance rates."

In each of the 4 years following implementation of the ambulance fee schedule, we reevaluated the effects of the relative volume of different levels of ambulance service (service mix) and the extent to which ambulance providers and suppliers bill less than the ambulance fee schedule (low billers) to determine whether the assumptions used to set the CF were accurate when compared to actual billing data. We found only insignificant differences in the observed data versus our assumptions. The differences observed in any single year were not significant enough to warrant a change to the CF in any of the years

we monitored. (See 71 FR 69624, 69717, and 69718). Consequently, in the December 1, 2006 final rule (71 FR 69717-69718), we discontinued our annual review of the original CF assumptions and the air ambulance rates, and revised §410.610(g) to state, in part, that the "Secretary monitors payment and billing data on an ongoing basis and adjusts the CF and air ambulance rates *as appropriate* to reflect actual practices under the fee schedule."

We do not believe that adjustments to the CF or the air ambulance rates are appropriate as a result of the fractional mileage billing policy. First, as discussed previously, the fractional mileage billing policy has no effect on the fee schedule rates; rather, it is an operational procedure for reporting ambulance mileage. Second, the purpose of this policy is to improve billing and payment accuracy for ambulance mileage. As discussed previously, under the current whole mile reporting policy, ambulance providers and suppliers are billing as much as 0.9 of a mile more than what is actually traveled. Commenters suggest that adjustments to the CF and the air ambulance rates are necessary to make up for the fact that ambulance providers and suppliers will be permitted to round up only to the nearest tenth of a mile rather than the nearest whole mile, resulting in lower mileage reimbursement on some claims compared to under the current policy. The purpose of the fractional mileage billing policy is to provide for more accurate billing and payment for ambulance transports, which we do not believe can be achieved if we were to make the adjustments suggested by commenters. Furthermore, we note that the current regulation at §410.610(g) requires us to monitor billing and payment data and adjust the CF and air ambulance rates "as appropriate" to reflect actual practices under the fee schedule. This regulation does not require that we adjust the fee schedule

rates prospectively each time we adopt operational procedures that differ from those in place prior to implementation of the fee schedule.

Furthermore, we believe that the policy does not have a significant bearing on the original CF assumptions that were discussed in the February 27, 2002 final rule (67 FR 9102-03, 9115-16), and for this reason too, we do not believe that adjustments to the CF and air ambulance rates would be appropriate. Having reevaluated the CF during the 4 years after implementation of the ambulance fee schedule and finding no significant differences in the observed data versus our original assumptions, we believe that we will continue to find insignificant differences, if any at all, after implementation of the fractional mileage billing policy, such that changing the CF or air ambulance rates would be unnecessary.

However, as required by §410.610(g), we will continue to monitor the billing and payment data on an ongoing basis, and will consider adjusting the CF and air ambulance rates in the future if (and to the extent) we determine appropriate to reflect actual experience under the fee schedule after the policy is implemented.

Comment: The commenters believed that the proposed rule would lower ambulance reimbursement that is already too low and noted that the fee schedule rates have not been increased in the last 2 years. Most of the same commenters cited a May 2007 Government Accountability Office (GAO) report detailing GAO's research findings which indicated that Medicare's reimbursement for ambulance services averages between 6 percent and 17 percent less than the cost to ambulance companies for the services they provide.

Response: We reiterate that the fractional ambulance mileage billing policy does

not change the ambulance fee schedule rates. The base payment rate and mileage reimbursement rate will not be changed by the fractional mileage billing policy. The fractional mileage billing policy is strictly an effort to improve billing and payment accuracy, and as such, we believe that it is both reasonable and appropriate to implement this policy.

In response to the comment that the fee schedule rates have not been increased in the past 2 years, we note that the ambulance inflation factor for CY 2008 was 2.7 percent and in CY 2009 it was increased to 5 percent, and thus the CF, air ambulance rates and mileage rates were increased by 2.3 percent over the previous calendar year in accordance with the section 1834(l)(3)(B) of the Act. However, we recognize that the fee schedule rates were not increased in CY 2010 because the CPI-U for the 12 month period ending with June 2009 was negative, resulting in no increase to the rates under the statutory formula set forth in section 1834(l)(3)(B) of the Act.

The 2007 GAO report cited by commenters estimated that between 39 percent and 56 percent of ambulance providers and suppliers will realize a profit under the ambulance fee schedule after expiration of the temporary payment provisions in the MMA. The GAO also noted in the same report that providers' expected Medicare margins will vary greatly depending on their ability to keep their operating cost low, and because of that variance, they were not able to conclude with any certainty whether providers and suppliers would see a decrease, increase, or no change in their profitability as it relates to the Medicare reimbursement rates after expiration of the temporary payment provisions in the MMA.

We seriously considered the findings in the May 2007 GAO report and, although

we were not bound to the GAO findings, we agreed with their recommendation that CMS monitor utilization of ambulance transports to ensure that Medicare payments are adequate to provide for beneficiary access to ambulance services, particularly in "super rural" areas. We note that in the years since the May 2007 GAO report, certain temporary payment provisions originally set forth in §414 of the MMA have been increased and extended in subsequent legislation to address these issues. Specifically, §414(d) of the MMA added section 1834(l)(13) of the Act which set forth payment increases of 1 percent and 2 percent for urban and rural ground transports, respectively. Section 146(a) of the MIPPA modified section 1834(l)(13) of the Act to increase these percentages to 2 percent and 3 percent for urban and rural transports, respectively, and to extend these increases through December 31, 2009. Subsequently, sections 3105(a) and 10311(a) of the ACA extended these increases through December 31, 2010. Furthermore, section 414(c) of the MMA added section 1834(l)(12) of the Act which provided a "super rural" bonus for certain ground transports that originate in qualified rural areas effective through December 31, 2009. Sections 3105(c) and 10311(c) of the ACA extended this super rural bonus through December 31, 2010. Finally, we note that section 146(b)(1) of the MIPPA, as amended by sections 3105(b) and 10311(b) of the ACA, provides that any area that was designated as a rural area for purposes of making payment for air ambulance services furnished on December 31, 2006, shall continue to be treated as a rural area for purposes of making payment for air ambulance services furnished during the period July 1, 2008 through December 31, 2010. We have implemented these payment add-ons in §414.610(c)(1), (c)(5)(ii) and (h), respectively.

Comment: Several commenters stated that cutting already low reimbursement

rates for ambulance providers and suppliers would result in cutbacks that would make it difficult to stay in business and would, therefore, have a negative impact on patient care. Many commenters also noted that smaller companies would be impacted the most by lowered reimbursement rates, stating that small companies need the extra revenue to stay in business. Some commenters suggested that mileage charges are the only means ambulance providers and suppliers have of recovering increasing, variable costs for ancillaries – such as oxygen supplies, disposable supplies, etc. – that are not separately payable under the fee schedule. Other commenters believed that reporting mileage more accurately will be too costly and would increase the cost of doing business. Another commenter responded that the payment made for mileage represents payment for the variable cost of transporting patients and that even short trips have a cost associated with them. The same commenter pointed out that lowering the mileage reimbursement would not adequately reimburse ambulance providers and suppliers for the cost of transporting their patients.

Response: As previously stated, the fractional mileage billing policy is an effort to improve billing and payment accuracy. The policy does not modify the reimbursement rates under the ambulance fee schedule. While we remain cognizant of the need for ambulance providers and suppliers to remain financially solvent, we must also ensure that providers and suppliers bill accurately and that we pay accurately. We believe the payment implications of the fractional mileage billing policy are modest when considering the difference in reimbursement on a claim by claim basis, and should not have a significant impact on the overall financial viability of individual ambulance providers and suppliers or on patient care. We recognize that there is a cost of doing

business. However, as discussed previously, we believe that it is both reasonable and appropriate to implement the policy to provide for more accurate billing and payment for ambulance mileage under Medicare. We do not believe that it is appropriate to continue the current whole mileage reporting procedure, which results in less accurate billing and payment, in order to provide extra revenue for providers and suppliers.

Comment: One commenter responded that the lower reimbursement would "trickle down" to other payers. In other words, the commenter believes that other payers would follow CMS' lead by adopting similar mileage reporting requirements, thereby potentially lowering reimbursement from other payers as well.

Response: While other payers may choose to adopt similar requirements for reporting ambulance mileage, we would not have any involvement in that decision. As previously discussed, we believe that it is reasonable and appropriate to implement the fractional mileage billing policy under Medicare to provide for more accurate billing and payment for Medicare ambulance services.

c. Administrative Impact

Comment: Many commenters stated that the fractional mileage policy would be administratively burdensome for medical and billing staff and would distract their medical staff from their first priority which is caring for the patient. The same commenters also suggested that the policy would be particularly burdensome for small ambulance companies. One commenter stated that imposing a requirement to capture fractional mileage would complicate the already overwhelming documentation requirements that they face. Another commenter believed that the fractional mileage billing policy creates undue hardship on an ambulance industry which is already

overburdened and underfunded.

Response: We believe that capturing fractional mileage amounts in trip documentation and on claims will not create any undue burden on the ambulance industry. Proper documentation of trip details, including mileage traveled, is already a longstanding Medicare requirement that remains unchanged and, we believe, uncompromised by the requirement to capture the additional digit beyond the decimal point. As we stated in the proposed rule, we believe that implementation of the policy is a reasonable and appropriate measure to ensure that claims are adjudicated and paid as accurately as possible.

Comment: Many commenters responded that the fractional mileage billing policy would make it difficult for ambulance providers and suppliers to comply with State and local laws which prohibit billing fractional mileage. Several commenters cited the City of Los Angeles as an example of a locality requiring that mileage be rounded to a whole number.

Response: We are not aware of any State or local law(s) that regulate how claims must be submitted to Medicare. We did not find any language in the City of Los Angeles or the Los Angeles County ordinances that governs claims submission to other payers, including Medicare. Further, even if there were a State or local law that specified a billing requirement that differed from Medicare's requirement, the Medicare requirement would, nevertheless, be controlling for claims submitted for Medicare payment. We note that the fractional mileage billing policy applies only to claims submitted to Medicare and does not dictate how a provider or supplier reports mileage to other payers. Thus, while we recognize the possibility that the requirements for billing ambulance mileage to

State-funded or other payers may differ, we believe that the fractional mileage billing policy is reasonable and appropriate to ensure that claims submitted to Medicare more accurately reflect the service(s) rendered and that our payments to providers and suppliers are as accurate as possible.

Comment: Several commenters stated that, if the fractional mileage billing policy is implemented, the requirements for billing ambulance mileage to Medicare will be different than for other payers, and it would make it difficult for ambulance providers and suppliers to maintain compliance with the differing billing requirements. One commenter stated that since other payers allow whole number reporting of mileage, their ambulance company would be forced to manually change claims in order to submit fractional mileage to Medicare.

Response: We understand that payer requirements may, and often do, vary, and that providers and suppliers may need to comply with different payer billing requirements. Each payer sets its own requirements for billing and payment. We believe that most billing systems are capable of accommodating the reality of varying billing requirements amongst different payers. While additional changes to billing systems or procedures may be necessary in some cases to enable mileage to be reported differently for different payers, as we stated previously, we continue to believe that implementation of the fractional mileage billing policy is reasonable and appropriate to ensure more accurate reporting and payment of ambulance mileage under Medicare.

After considering the comments, for the reasons discussed previously and in the CY 2011 PFS proposed rule, we continue to believe that it is reasonable and appropriate to revise our claims processing instructions to require reporting of and payment based on

fractional mileage, as further discussed below.

(2) Technical and Other Considerations

(A) Ability to Measure Fractional Miles

Comment: Many commenters responded that most ambulance companies do not have the ability to measure fractional mileage because their odometer does not show tenths of a mile. These commenters stated that 67 percent of all new ambulances are Ford models which do not have a tenths display on the odometer. One commenter stated that digital odometers, in particular, only show whole miles. Another commenter asked that CMS prove its assertion that most vehicle odometers display tenths of a mile. Yet another commenter suggested that we provide guidance for ambulances that do not display tenths of a mile on the odometer. We also received a response from a commenter who believed that GPS can sometimes be unreliable.

Response: Based on the statement from many commenters that most new ambulances are Ford models, we reviewed owner's manuals for the Ford E250, E350, E450 as well as the F350 and F450 vehicles. Our research revealed that Ford E series and F series vehicle (typically trucks or vans) chassis typically provide the base for the Ford ambulance prep package. We reviewed Ford's gauge specifications for model years 1996 through 2010. In model years prior to 2004, the standard analog odometer reflected tenths of a mile. Model years 2004 and later include standard digital odometers that show fractional miles as well as a separate trip odometer that also displays mileage to the tenth of a mile. Additionally, the ambulance prep package includes an optional onboard trip computer and navigation system.

We also researched other vehicle chassis models that may provide the base for

other ambulance prep packages and may currently be in use by some providers or suppliers. We reviewed owner's manuals for the Dodge Ram 3500 and 4500 for model years 2008 and 2009 and we also researched GM/Chevrolet G4500 and 3500 for model years 2009 and 2010. We found that both Dodge and Chevrolet model vehicle gauges include odometers and/or trip odometers that display fractional mileage. Chevrolet models also include a retroactive reset feature on the trip odometer that will calculate the distance traveled since the engine was last started in the event the trip odometer is not reset at the beginning of the trip.

We found through our research that in many cases, trip odometers are mentioned as separate devices from the basic odometer, particularly in newer model cars that utilize both digital gauges. We also found that in some cases, the basic digital odometer does not, in fact, have a tenths display. In those cases, we found that the tenths display appears only on the trip odometer. In the proposed rule, we did not specify the types of odometers that that may be used to measure fractional mileage, and thus we are clarifying in this final rule with comment period that mileage may be measured using a separate trip odometer as well.

In light of our review of Ford vehicle chassis and the assertion that most new ambulances are Ford vehicles as well as our review of the other vehicle chassis models as discussed above, we believe that most ambulance companies have the ability to measure fractional mileage to the tenth of a mile. However, we recognize that there may be some ambulance companies that have a small number of vehicles wherein the gauges are damaged, missing, or otherwise unusable, or that may be using non-standard vehicles that do not have a fractional mileage display on the odometer, trip odometer, GPS navigation,

trip computer, or other onboard device that measures distance traveled. We believe that tools used to measure distance traveled (such as GPS navigation equipment) are readily available to the average consumer at a low cost. As such, ambulance providers and suppliers are responsible for ensuring that they have the necessary equipment to measure fractional mileage to the tenth of a mile, and ensuring that onboard vehicle gauges measuring trip mileage are in working order. If they are not able to repair said gauges, they are responsible for ensuring that they have the necessary equipment to measure mileage accurately to the tenth of a mile. Additionally, for those ambulance providers and suppliers who have vehicles that include a separate trip odometer, ambulance providers and suppliers are still responsible for ensuring that trip mileage is measured and reported accurately – even if they fail to reset the trip odometer at the beginning of a trip. For example, if the driver fails to reset the trip odometer at the beginning of the trip, he or she would simply document the mileage at the end of the trip and subtract the mileage for the previous trip from the total which would leave a remaining balance that should correspond to the distance of the current trip.

With regard to the statement that GPS can sometimes be unreliable, CMS is not aware of data that confirms or refutes this statement. However, in order to continue to provide ambulance providers and suppliers with flexibility in how they can measure fractional mileage, use of GPS devices will continue to be acceptable for the purpose of measuring fractional mileage.

(B) Ambulance Provider Versus Supplier Billing

Comment: We received responses from several commenters who believe that the fractional mileage billing policy establishes different requirements for Part A versus Part

B ambulance providers and suppliers. These commenters stated that neither electronic nor paper institutional claims can accommodate fractional unit amounts. They cited 42 U.S.C. 1395m(l)(1) which requires that all ambulance services be paid under the same fee schedule. Many commenters believed that Part A providers and Part B suppliers, respectively, will be treated differently under the fractional mileage billing policy and will, therefore, be paid differently.

Response: Per the version 4010A1 Implementation Guide and the version 5010 TR3 specifications, the ANSI 837I (institutional) electronic claim format has the capability to accept fractional unit amounts up to 3 decimal places, and thus both ambulance providers and suppliers will be able to bill fractional mileage on electronic claims. The commenters are correct that the Form UB-04 paper institutional claim does not currently support fractional unit amounts. However, the National Uniform Billing Committee (NUBC) has recently approved a change to the Form UB-04 that will allow fractional unit billing, and this change is scheduled to take effect in July 2011. Currently, less than 0.5 percent of all institutional providers bill Medicare using the paper Form UB-04. Based on the low number of providers billing ambulance services on the Form UB-04 and the fact that the form is expected to be capable of accepting fractional unit amounts in July 2011, we are delaying the implementation date for ambulance providers billing on the paper Form UB-04. If the Form UB-04 is capable of accepting fractional mileage unit amounts by the end of July 2011 as scheduled, ambulance providers billing on the paper Form UB-04 will be required to submit fractional mileage in accordance with this final rule with comment period for dates of service on and after August 1, 2011. If paper Form UB-04 is not capable of accepting fractional mileage by July 31, 2011,

then implementation of the fractional mileage policy for these ambulance providers will be further delayed until January 1, 2012 to allow ample time for any changes to the UB-04 to be implemented. As with other claim types, ambulance providers billing on the paper Form UB-04 will report fractional mileage on all claims for mileage totaling up to 100 miles.

We note that delayed implementation of the fractional mileage billing policy for the small number of providers using Form UB-04 does not result in suppliers and providers receiving different rates under the ambulance fee schedule. As discussed previously, the fractional mileage billing policy does not change the rates under the ambulance fee schedule for providers or suppliers. It is strictly a change to our operational instructions for reporting ambulance mileage intended to improve billing and payment accuracy. Thus, after implementation of the fractional mileage billing policy, providers and suppliers will continue to be paid under the same fee schedule and there will be no differentiation in rates between providers and suppliers.

(C) Billing Software

Comment: We received a few comments stating that billing systems will need to be modified to accommodate the fractional mileage billing policy. Three commenters stated that modification of billing software would be too costly, with one commenter further stating that the change would create a hardship for the billing software developer. Another commenter believed that changing their billing system would mean that they would have to report fractional mileage to all payers, not just Medicare.

Response: While minor changes to billing software may be required, any billing software that is compliant with ANSI 837 electronic claim standards should have the

capability to accept and submit fractional unit amounts in the appropriate field. For providers and suppliers using paper claim forms to submit claims to Medicare, again, we believe that only minor changes to the units field will be required in order to submit fractional mileage amounts.

As discussed previously, we understand that payer requirements may – and often do – vary, and that providers and suppliers may need to comply with different payer billing requirements. However, the requirement to bill fractional mileage to Medicare does not necessarily mean that providers and suppliers will have to also submit fractional mileage to other payers. Each payer sets its own requirements for billing and payment. We believe that most billing systems are capable of accommodating the reality of varying billing requirements amongst different payers. While additional changes to billing systems or procedures may be necessary in some cases to enable mileage to be reported differently for different payers, as we stated previously, we continue to believe that implementation of the fractional mileage billing policy is reasonable and appropriate to ensure more accurate reporting of and payment for ambulance mileage under Medicare.

(D) Enforcement and Compliance

Comment: One commenter stated that the fractional mileage billing policy would be impossible to verify and/or enforce.

Response: Upon implementation of the fractional mileage billing policy, ambulance providers and suppliers will still be subject to the same statutory and regulatory requirements regarding documentation, fraudulent billing, and pre- and post-payment review.

Comment: One commenter requested guidance for providers and suppliers who

cannot comply with the fractional mileage billing policy.

Response: We believe that providers and suppliers are capable of complying with the new policy. As discussed above, we believe that most ambulance companies have the ability to measure fractional mileage using standard onboard devices. Furthermore, we believe that tools used to measure distance traveled (such as GPS navigation) are readily available to the average consumer at a low cost. Thus, in those instances where gauges are damaged, missing or otherwise unusable, or where companies are using non-standard vehicles that do not include a device to measure fractional mileage, ambulance providers and suppliers are responsible for ensuring that they have the necessary equipment to measure fractional mileage to the tenth of a mile. Furthermore, billing software that is compliant with the ANSI 837 electronic claim format is capable of capturing and submitting fractional unit amounts, and fractional mileage units can be captured on paper claims (with the exception of paper Form UB04 claims as discussed previously). We believe that implementing the fractional mileage policy is a reasonable and appropriate measure to ensure more accurate billing and payment of Medicare ambulance transports and thus, ambulance providers and suppliers (except for providers billing on Form UB-04 as discussed previously) are expected to comply effective January 1, 2011 with the fractional mileage billing policy finalized in this final rule with comment period.

(E) Air Ambulance

Comment: One commenter responded that the air ambulance segment of the ambulance industry is overpaid by Medicare and suggested that we look to generate savings by changing the reimbursement for air ambulance mileage to be based on nautical miles instead of statutory miles.

Response: As we stated in the proposed rule, our claims processing system should be configured to process claims as accurately as possible so as to provide more accurate Medicare payments. Thus, we believe that the fractional mileage billing policy is a reasonable and appropriate measure to enhance billing and payment accuracy for both air and ground transports. The issue of basing air ambulance reimbursement on nautical miles versus statutory miles was not discussed or proposed in the CY 2011 PFS proposed rule, and thus we are not addressing this issue in this final rule with comment period.

Comment: A few commenters suggested that the fractional mileage billing policy will affect ground ambulance transports but not air ambulance transports.

Response: The fractional mileage billing policy will be applied in the same manner to, and will affect, both ground and air ambulance transports. However, since the fractional mileage billing policy does not apply to mileage exceeding 100 miles, we recognize that it may impact a greater percentage of ground transports than air transports, as a larger percentage of air transports may exceed 100 miles. We analyzed claim payment data for all Part B ambulance claims paid in 2008. If the fractional mileage billing policy had been implemented in 2008, approximately 92 percent of all claims for air ambulance mileage would have been impacted versus 99 percent of all claims for ground ambulance mileage. However, since air ambulance companies receive higher mileage reimbursement rates, we found that the average financial impact per claim would have been greater for air ambulance versus ground ambulance transports. Thus, when we consider both factors together, it is not clear whether the overall impact will be greater for ground ambulance companies than for air ambulance companies. Regardless of any potential differential impact, we believe that implementation of the fractional mileage

billing policy is a reasonable and appropriate measure to ensure more accurate reporting of mileage and more accurate payments under Medicare for both ground and air transports.

(F) Miscellaneous Comments

Comment: One commenter questioned whether the new rounding rule would create no reimbursement for 0.49 miles.

Response: No. The correct rounding, based on the fractional mileage billing policy, would be to always round up the hundredths place. Therefore, the provider or supplier in the commenter's example would bill 0.5 miles. Likewise, if the provider or supplier traveled 0.43 miles, they would bill 0.5 miles on their claim. CMS would apply the normal calculations for determining the payment amount using the fractional mileage units reported.

4. Applicability of the Fractional Billing Policy to Other Services

We received no comments regarding the applicability of the fractional unit billing policy to other services. Therefore, for the reasons discussed in the CY 2011 PFS proposed rule (75 FR 40160), we are applying the fractional unit billing policy only to ambulance mileage.

5. Final Fractional Mileage Billing Policy

For the reasons discussed above and in the CY 2011 PFS proposed rule (75 FR 40159), we believe that it is reasonable and appropriate to implement the fractional mileage billing policy as proposed in the CY 2011 PFS proposed rule effective for claims with dates of service on and after January 1, 2011 (with the exception discussed below relating to providers billing on paper Form UB-04).

Therefore, effective for claims with dates of service on and after January 1, 2011, ambulance providers and suppliers (except for providers billing on paper Form UB-04) are required to report mileage rounded up to the nearest tenth of a mile on all claims for mileage totaling up to 100 covered miles. Providers and suppliers must submit fractional mileage using a decimal in the appropriate place (for example, 99.9). For example, if the total miles traveled equals 1.59 miles, then the provider or supplier must report "1.6" on the claim for mileage. Likewise, if the total mileage equals 1.53 miles, the provider or supplier must report "1.6" on the claim.

Although the electronic claim formats can accommodate fractional mileage when mileage is equal to or greater than 100 covered miles (for example, 100.0), as discussed in the proposed rule, the paper claim cannot. The Form CMS-1500 paper claim currently only supports four characters (including the decimal point) in the units field (Item 24G). Therefore, we are finalizing our proposal that mileage equal to or greater than 100 covered miles must continue to be reported in whole number miles on both paper and electronic claims. Providers and suppliers must round up fractional mileage to the next whole number for mileage that exceeds 100 covered miles and report the resulting whole number in the unit field. The instructions set forth in our Claims Processing Manual will be updated to reflect the revised procedures for submitting and paying claims for fractional ambulance mileage.

Because the changes to the paper Form UB-04 necessary to accommodate fractional units are scheduled to be completed in July 2011, implementation of this policy for ambulance providers that are permitted to bill using the Form UB-04 is delayed until August 1, 2011 (that is, ambulance providers permitted to bill on paper form UB-04 will

be required to report fractional mileage in accordance with this final rule with comment period for dates of service on and after August 1, 2011). If the paper Form UB-04 is not capable of accepting fractional mileage by July 31, 2011, then implementation of this policy for these ambulance providers will be further delayed until January 1, 2012. As with other claim types, upon implementation of the fractional mileage policy for providers billing on the paper Form UB-04, these providers will report fractional mileage on all claims for mileage totaling up to 100 miles.

As discussed previously, providers and suppliers are responsible for ensuring that they have the necessary equipment to measure fractional mileage to the tenth of a mile, and ensuring that onboard vehicle gauges measuring trip mileage are in working order. If they are not able to repair said gauges, they are responsible for ensuring that they have the necessary equipment to measure mileage accurate to the tenth of a mile. Tools that may be used to measure trip mileage include, but are not limited to: digital or analog odometers, trip odometers, GPS navigation, onboard trip computers or navigation systems.

C. Clinical Laboratory Fee Schedule: Signature on Requisition

In the March 10, 2000 **Federal Register**, we published the "Medicare Program; Negotiated Rulemaking: Coverage and Administrative Policies for Clinical Diagnostic Laboratory Services" proposed rule (65 FR 13082) announcing and soliciting comments on the results of our negotiated rulemaking committee tasked to establish national coverage and administrative policies for clinical diagnostic laboratory tests under Part B of Medicare. In our final rule published in the November 23, 2001 **Federal Register** (66 FR 58788), we explained our policy on ordering clinical diagnostic laboratory

services and amended §410.32 to make our policy more explicit. Our regulation at §410.32(a) states the requirement that "[a]ll diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary." In the November 23, 2001 final rule, we added paragraph (d)(2) to §410.32 to require that the physician or qualified nonphysician practitioner (NPP) (that is, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners (NPs), and physician assistants (PAs)) who order the service must maintain documentation of medical necessity in the beneficiary's medical record (66 FR 58809). In the preamble discussions to the March 10, 2000 proposed rule and November 23, 2001 final rule (65 FR 13089 and 66 FR 58802, respectively), we noted that "[w]hile the signature of a physician on a requisition is one way of documenting that the treating physician ordered the test, it is not the only permissible way of documenting that the test has been ordered." In those preambles, we described the policy of not requiring physician signatures on requisitions for clinical diagnostic laboratory tests, but implicitly left in place the existing requirements for a written order to be signed by the ordering physician or NPP for clinical diagnostic laboratory tests, as well as other types of diagnostic tests. We further stated in the preambles of the proposed and final rules that we would publish an instruction to Medicare contractors clarifying that the signature of the ordering physician is not required for Medicare purposes on a requisition for a clinical diagnostic laboratory test (65 FR 13089 and 66 FR 58802).

On March 5, 2002, we published a program transmittal implementing the administrative policies set forth in the final rule, including the following instruction: "Medicare does not require the signature of the ordering physician on a laboratory service

requisition. While the signature of a physician on a requisition is one way of documenting that the treating physician ordered the service, it is not the only permissible way of documenting that the service has been ordered. For example, the physician may document the ordering of specific services in the patient's medical record." (Transmittal AB-02-030, Change Request 1998, dated March 5, 2002).

On January 24, 2003, we published a program transmittal in order to manualize the March 5, 2002 Transmittal. (Transmittal 1787, Change Request 2410, dated January 24, 2003). The cover note to the transmittal states, "Section 15021, Ordering Diagnostic Tests, manualizes Transmittal AB-02-030, dated March 5, 2002. In accordance with negotiated rulemaking for outpatient clinical diagnostic laboratory services, no signature is required for the ordering of such services or for physician pathology services." In the manual instructions in that transmittal in a note, we stated: "No signature is required on orders for clinical diagnostic services paid on the basis of the physician fee schedule or for physician pathology services." The manual instructions did not explicitly reference clinical diagnostic laboratory tests as the cover note did. Rather, the transmittal seemed to extend the policy set forth in the **Federal Register** (that no signature is required on requisitions for clinical diagnostic laboratory tests paid under the CLFS) to also apply to clinical diagnostic tests paid on the basis of the PFS and physician pathology services. In addition, the manual instructions used the term "order" instead of "requisition," which some members of the industry have asserted caused confusion.

When we transitioned from paper manuals to the current electronic Internet Only Manual system, these manual instructions were inadvertently omitted from the new Benefit Policy Manual (BPM).

In August 2008, we issued a program transmittal (Transmittal 94, Change Request 6100, dated August 29, 2008) to update the BPM to incorporate language that was previously contained in section 15021 of the Medicare Carriers Manual. The reissued language states, "No signature is required on orders for clinical diagnostic tests paid on the basis of the CLFS, the physician fee schedule, or for physician pathology services." Based on further review, we determined that there are no clinical diagnostic laboratory tests paid under the PFS. After Transmittal 94 was published, we received numerous inquiries from laboratory, diagnostic testing, and hospital representatives who had questions about whether the provision applied to all diagnostic services, including x-rays, MRIs, and other nonclinical laboratory fee schedule diagnostic services.

To resolve any existing confusion surrounding the implementation of the policy in 2001 and subsequent transmittals, we restated and solicited public comments on our policy in the CY 2010 PFS proposed rule (74 FR 33641). Our current policy is that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the CLFS. However, it must be evident, in accordance with our regulations at §410.32(d)(2) and (3), that the physician ordered the services.

We note that we solicited and received comments on this signature requirement during the notice and comment period for the March 10, 2000 proposed rule in the context of our proposal to add paragraph (d)(2)(i) to §410.32 to require that the practitioner who orders a diagnostic laboratory test must maintain documentation of medical necessity in the beneficiary's medical record. The majority of comments supported the adoption of a policy that the signature of the practitioner on a requisition for a clinical diagnostic laboratory test paid under the CLFS is not the only way of

documenting that the test has been ordered and, thus, should not be required provided such documentation exists in an alternate form.

This policy regarding requisitions for clinical diagnostic laboratory tests does not supersede other applicable Medicare requirements (such as those related to hospital Conditions of Participation (CoPs)) which require the medical record to include an order signed by the physician who is treating the beneficiary. Nor do we believe that anything in our policy regarding signatures on requisitions for clinical diagnostic laboratory tests supersedes other requirements mandated by professional standards of practice or obligations regarding orders and medical records promulgated by Medicare, the Joint Commission (TJC), or State law; nor do we believe the policy would require providers to change their business practices.

We also restated and solicited public comment on our longstanding policy consistent with the principle in §410.32(a) that a written order for diagnostic tests including those paid under the CLFS and those that are not paid under the CLFS (for example, that are paid under the PFS or under the OPPS), such as X-rays, MRIs, and the TC of physician pathology services, must be signed by the ordering physician or NPP. That is, the policy that signatures are not required on requisitions for clinical diagnostic laboratory tests paid based on the CLFS applies only to requisitions (as opposed to written orders) (74 FR 33642).

Additionally, we solicited public comments about the distinction between an order and a requisition (74 FR 33642). We note that an "order" as defined in our IOM, 100-02, Chapter 15, Section 80.6.1, is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary.

The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (for example, if test X is negative, then perform test Y). As set forth in the CY 2010 PFS final rule (FR 74 61930), an order may be delivered via any of the following forms of communication:

- A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility.
- A telephone call by the treating physician/practitioner or his or her office to the testing facility.
- An electronic mail, or other electronic means, by the treating physician/practitioner or his or her office to the testing facility.

If the order is communicated via telephone, both the treating physician/practitioner, or his or her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

In the CY 2010 PFS proposed rule (74 FR 33642), we defined a "requisition" as the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. It may contain patient information, ordering physician information, referring institution information, information about where to send reports, billing information, specimen information, shipping addresses for specimens or tissue samples, and checkboxes for test selection. We believe it is ministerial in nature, assisting laboratories with billing and handling of results, and serves as an administrative convenience to providers and patients. We believe that a written order, which may be part of the medical record, and the requisition,

are two different documents, although a requisition that is signed may serve as an order. We welcomed comments from the public about the distinction between requisitions and orders.

During the proposed and final rulemaking process for CY 2010, we received numerous comments on these issues, including, among others: expressions of continued confusion over the difference between an "order" and a "requisition"; requests that we develop a single policy for all outpatient laboratory services, without the distinction for those paid under the CLFS or the PFS; and concerns about reference laboratory technicians who believed compelled to perform a test in order to protect the viability of the specimen although they did not have the proper documentation. (See 74 FR 61929 through 61931 for a complete discussion of the comments received and responses to these issues.) In the CY 2010 PFS final rule with comment period (74 FR 61931), we stated that, in light of the issues and concerns raised during the comment period, and our desire to create policy that will address the concerns in a meaningful, clear and thoughtful way, we would continue to carefully consider the issues of physician signatures on requisitions and orders and that we plan to revisit these issues in the future paying particular attention to the definitions of order and requisition.

Since the publication of the CY 2010 PFS final rule with comment period, we have considered an approach that would address the concerns raised. Therefore, in the CY 2011 PFS proposed rule (75 FR 40162), we proposed to require a physician's or NPP's signature on requisitions for clinical diagnostic laboratory tests paid on the basis of the CLFS. We stated that we believe that this policy would result in a less confusing process because a physician's signature would then be required for all requisitions and

orders, eliminating uncertainty over whether the documentation is a requisition or an order, whether the type of test being ordered requires a signature, or which payment system does or does not require a physician or NPP signature. We also stated that we believe that it would not increase the burden on physicians because it is our understanding that, in most instances, physicians are annotating the patient's medical record with either a signature or an initial (the "order"), as well as providing a signature on the paperwork that is provided to the clinical diagnostic laboratory that identifies the test or tests to be performed for a patient (the "requisition") as a matter of course. Further, we stated that this policy would make it easier for the reference laboratory technicians to know whether a test is appropriately requested, and potential compliance problems would be minimized for laboratories during the course of a subsequent Medicare audit because a signature would be consistently required. We stated in the CY 2011 OPPS/ASC proposed rule that this minimizes confusion and provides a straightforward directive for laboratories to meet.

Comment: Some commenters stated that physicians continue to be unfamiliar with when a signature is required and when it is not required on requisitions for physician pathology services, x-ray services, and services other than clinical diagnostic laboratory tests paid under the CLFS. The commenters also asked for consistency in signature requirements between services required under the CLFS and the Physician Fee Schedule (PFS).

Response: We proposed to require a physician's or NPP's signature on requisitions for clinical diagnostic laboratory tests paid under the CLFS. We did not propose to change, and we are not changing, the signature requirements for other

services. One of the reasons we made this proposal is because we believed that it would be less confusing for a physician's signature to be required for all requisitions and orders, eliminating uncertainty over whether the documentation is a requisition or an order, whether the type of test being ordered requires a signature, or which payment system does or does not require a physician or NPP signature.

Comment: Some commenters were supportive of our proposal.

Response: We appreciate the commenters' support of our proposed policy, which we are finalizing in this rule.

Comment: The commenters seemed to interpret the proposed policy to mean that clinical diagnostic laboratory tests requested by telephone or electronic means would not be acceptable because they would not contain a signature. The commenters stated that there must be a way to validate electronic requests for services by the physician or NPP and that, as the medical world moves toward electronic records, everything must be annotated (that is, "signed") in some way to authenticate that the service is ordered by the physician.

Response: Our proposed policy does not concern electronic or telephonic requests, because we do not consider these types of requests to be requisitions. As we discussed previously, a requisition is the actual paperwork, such as a form, that is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. It may contain patient information, ordering physician information, referring institution information, information about where to send reports, billing information, specimen information, shipping addresses for specimens or tissue samples, and checkboxes for test selection. We believe it is ministerial in nature, assisting

laboratories with the billing and handling of results, and serves as an administrative convenience to providers and patients. When a physician or NPP chooses to use a requisition to request a clinical diagnostic laboratory test paid under the CLFS, under the policy we are adopting in this rule, the physician or NPP must sign the requisition.

Comment: The commenters pointed out that it should be evident from the medical record that the physician actually ordered the service.

Response: We did not propose to change any requirements with respect to orders. As discussed above, a requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. Our proposal only applies to signatures on requisitions for clinical diagnostic laboratory tests paid under the CLFS. A signature on a requisition should be sufficient for a clinical diagnostic laboratory to verify that a physician or NPP is requesting a clinical diagnostic laboratory test.

Comment: The commenters stated that the patient rarely takes the requisition to the laboratory himself/herself because the patient does not go to the laboratory. These commenters seemed to believe that, in those cases, a paper request for clinical diagnostic laboratory services would have to be created where there may not have been a need for one to exist. The commenters suggested that only the medical record, and not any other paper materials, should be signed or initialed by the physician.

Response: As stated previously, a requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. Under our proposed policy, which we are finalizing in this rule, if a physician or NPP chooses to use a requisition to request a clinical diagnostic

laboratory test paid under the CLFS, the physician or NPP must sign the form. However, this policy does not require a physician or NPP to use a requisition to request a clinical diagnostic laboratory test paid under the CLFS. Many physicians and NPPs currently request clinical diagnostic laboratory tests using an order, such as an annotated medical record or documented telephonic request, and they may continue to do so without being impacted by our new policy for requisitions.

Comment: The commenters suggested that physicians would need to be educated about the new signature requirement on requisitions for clinical diagnostic laboratory tests paid under the CLFS to alleviate problems such as physician non-compliance with this policy because they are unaware of it or do not understand it. Some commenters stated that they firmly believe that the physician will neglect to sign any document that directs the clinical diagnostic laboratory to perform a service. In order to incentivize physicians to provide a signature, some commenters suggested tying the physician's ability to bill for a service to the requirement to provide a signature.

Response: We understand the need to educate physicians and NPPs. As such, in addition to updating our manuals, we will direct the Medicare contractors to educate physicians and NPPs concerning this issue. We did not propose to adopt a policy linking the physician's ability to bill for a service to the requirement to provide a signature and we are not adopting such policy in this final rule.

Comment: The commenters believe that medical personnel are already required to provide an extensive amount of identifying information on the requisition. The commenters stated that either the physician or NPP is completing the paperwork but then, in most cases, not signing it or initialing it to confirm that the required service was

documented by a medical practitioner.

Response: If physicians and NPPs are completing extensive written documentation concerning each beneficiary on requisitions, the addition of a signature should not be an issue.

Comment: The commenters expressed continued confusion over the terms "requisition" and "order." The commenters stated that CMS should define "requisition" and "order" in the CMS Internet Only Manual (IOM) system.

Response: We recognize that there is confusion around the definition of these terms. However, as we stated above, we define an "order" (IOM, 100-02, Chapter 15, Section 80.6.1) as a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. We further provided that an order may be delivered via any of the following forms of communication: (1) a written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility; (2) a telephone call by the treating physician/practitioner or his or her office to the testing facility; or (3) an electronic mail, or other electronic means, by the treating physician/practitioner or his or her office to the testing facility. If the order is communicated via telephone, both the treating physician/practitioner, or his or her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records. We define a "requisition" as the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. It may contain patient information, ordering physician information, referring institution information, information about where to send reports, billing information, specimen information,

shipping addresses for specimens or tissue samples, and checkboxes for test selection. We believe it is ministerial in nature, assisting laboratories with billing and handling of results, and serves as an administrative convenience to providers and patients. We believe that a written order, which may be part of the medical record, and the requisition, are two different documents, although a requisition that is signed may serve as an order.

We are revising our manuals to reflect our new requirement for physicians' and NPPs' signatures on requisitions for clinical diagnostic laboratory tests paid under the CLFS.

Comment: The commenters note that there is no corresponding suggested change in the language of the Code of Federal Regulations (CFR) concerning the physician signature issue.

Response: We have determined that a change to §410.32(d)(2) is not necessary with respect to this issue because this provision involves orders not requisitions. We articulated our policy regarding requisitions for clinical diagnostic laboratory tests in our manuals and in preamble language. Therefore, we are changing our manuals to reflect our new policy.

Comment: The commenters suggested that the requirement to provide some type of signature represents an undue burden on the clinical diagnostic laboratory, especially in the long term care world where standing orders in the form of a "plan of care" are maintained in the beneficiary's records onsite and tests are ordered by the long term care staff as required based on directions provided by the physician. The commenters asserted that the physician rarely appears onsite at the facility to sign requests for medical services and, as a result, an exception for these types of facilities is warranted. However, commenters also pointed to a Drug Enforcement Administration (DEA) requirement for

long term care facilities which states that, "The facility must provide or obtain laboratory services only when ordered by the attending physician."

Response: Again, the change in policy discussed in this final rule only affects requisitions and does not affect orders. The policy that we proposed and are adopting as final in this rule is that a physician's or NPP's signature is required on requisitions for clinical diagnostic laboratory tests paid under the CLFS.

Comment: The commenters suggested that the following language was clear and should stand as the entire policy here: "A physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the Clinical Laboratory Fee Schedule (CLFS); however, it must be evident, in accordance with regulations at §410.32(d)(2) and (3), that the physician ordered the services."

Response: We appreciate the commenters' viewpoint. However, for the reasons discussed previously, we are finalizing our proposal, without modification, to require a physician's or NPP's signature on requisitions for clinical diagnostic laboratory tests paid under the CLFS

Comment: The commenters suggested that a pre-printed physician signature or letterhead showing the physician's name should serve in the place of a "signature."

Response: A pre-printed signature or letterhead cannot be construed as a document, the contents of which a physician or NPP has affirmed. In order to discourage fraud and abuse, and to affirm that a medical service was ordered by a medical practitioner who currently works in the practice, a signature is required.

Comment: The commenters stated that the services are transcribed from the medical record onto the requisition by office staff, not written and signed by the

physician. The commenters seemed to indicate that the medical record that would be maintained in the physician's office, but not necessarily the requisition, would be signed or annotated in some way.

Response: It seems that the commenters believe that a physician or his/her representative has no problem providing a signature or annotation for the medical record. In addition, some commenters consider the "requisition" to be the medical record and use it for a dual purpose – as the beneficiary's file and as the request for services.

After careful consideration of all the comments received, we are finalizing our proposed policy without modification to require a physician's or NPP's signature on requisitions for clinical diagnostic laboratory tests paid under the CLFS. This policy does not affect physicians or NPPs who choose not to use requisitions to request clinical diagnostic laboratory tests paid under the CLFS. Such physicians or NPPs can continue to request such tests by other means, such as by using the annotated medical records, documented telephonic requests, or electronically. We will make changes to our manuals to reflect this final policy.

D. Discussion of Budget Neutrality for the Chiropractic Services Demonstration

Section 651 of MMA requires the Secretary to conduct a demonstration for up to 2-years to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. Current Medicare coverage for chiropractic services is limited to manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Act. The demonstration expanded Medicare coverage to include "A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; B) and diagnostic and other services that a chiropractor is legally authorized to perform by the

State or jurisdiction in which such treatment is provided" and was conducted in four geographically diverse sites, two rural and two urban regions, with each type including a Health Professional Shortage Area (HPSA). The two urban sites were 26 counties in Illinois and Scott County, Iowa, and 17 counties in Virginia. The two rural sites were the States of Maine and New Mexico. The demonstration, which ended on March 31, 2007, was required to be budget neutral as section 651(f)(1)(B) of MMA mandates the Secretary to ensure that "the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented."

In the CY 2006, 2007, and 2008 PFS final rules with comment period (70 FR 70266, 71 FR 69707, 72 FR 66325, respectively), we included a discussion of the strategy that would be used to assess budget neutrality (BN) and the method for adjusting chiropractor fees in the event the demonstration resulted in costs higher than those that would occur in the absence of the demonstration**.** We stated BN would be assessed by determining the change in costs based on a pre-post comparison of total Medicare costs for beneficiaries in the demonstration and their counterparts in the control groups and the rate of change for specific diagnoses that are treated by chiropractors and physicians in the demonstration sites and control sites. We also stated that our analysis would not be limited to only review of chiropractor claims because the costs of the expanded chiropractor services may have an impact on other Medicare costs for other services.

In the CY 2010 PFS final rule with comment period (74 FR 61926), we discussed the evaluation of this demonstration conducted by Brandeis University and the two sets

of analyses used to evaluate budget neutrality. In the "All Neuromusculoskeletal Analysis," which compared the total Medicare costs of all beneficiaries who received services for a neuromusculoskeletal condition in the demonstration areas with those of beneficiaries with similar characteristics from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was an $114 million increase in costs. In the "Chiropractic User Analysis," which compared the Medicare costs of beneficiaries who used expanded chiropractic services to treat a neuromusculoskeletal condition in the demonstration areas, with those of beneficiaries with similar characteristics who used chiropractic services as currently covered by Medicare to treat a neuromusculoskeletal condition from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was a $50 million increase in costs.

As explained in the CY 2010 PFS final rule, we based the BN estimate on the "Chiropractic User Analysis" because of its focus on users of chiropractic services rather than all Medicare beneficiaries with neuromusculoskeletal conditions, including those who did not use chiropractic services and who may not have become users of chiropractic services even with expanded coverage for them (74 FR 61926 through 61927). Users of chiropractic services are most likely to have been affected by the expanded coverage provided by this demonstration. Cost increases and offsets, such as reductions in hospitalizations or other types of ambulatory care, are more likely to be observed in this group.

As explained in the CY 2010 PFS final rule (74 FR 61927), because the costs of this demonstration were higher than expected and we did not anticipate a reduction to the

PFS of greater than 2 percent per year, we finalized a policy to recoup $50 million in expenditures from this demonstration over a 5-year period, from CYs 2010 through 2014 (74 FR 61927). Specifically, we are recouping $10 million for each such year through adjustments to the chiropractic CPT codes. Payment under the PFS for these codes will be reduced by approximately 2 percent. We believe that spreading this adjustment over a longer period of time will minimize its potential negative impact on chiropractic practices.

We are continuing the implementation of the required budget neutrality adjustment by recouping $10 million in CY 2011. Our Office of the Actuary estimates chiropractic expenditures in CY 2011 to be approximately $524 million based on actual Medicare spending for chiropractic services for the most recent available year. To recoup $10 million in CY 2011, the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942) will be reduced by approximately 2 percent. We are reflecting this reduction only in the payment files used by the Medicare contractors to process Medicare claims rather than through adjusting the relative value units (RVUs). Avoiding an adjustment to the RVUs would preserve the integrity of the PFS, particularly since many private payers also base payment on the RVUs.

We received no comments on this policy and we will continue the implementation of the required budget neutrality adjustment in CY 2011 by reducing the payment amount under the PFS for chiropractic codes (that is, CPT codes 98940, 98941, and 98942) by approximately 2 percent resulting in a $10 million recoupment. This is the second year of an adjustment which is required in order to satisfy the budget neutrality requirement in

section 651 of MMA and that is being made over a 5-year period to recoup the costs of a demonstration that expanded Medicare coverage for chiropractic services. This reduction will only be reflected in the payment files used by Medicare contractors to process Medicare claims and not through an adjustment to the RVUs.

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

Subsequent to the July 13, 2010 publication of the CY 2011 PFS proposed rule (75 FR 40040) we published in the **Federal Register,** on August 12, 2010 a final rule entitled "End-Stage Renal Disease Prospective Payment System" (75 FR 49030). In that rule, we established a case-mix adjusted bundled PPS for renal dialysis services furnished beginning January 1, 2011, in accordance with the statutory provisions set forth in section 153(b) of MIPPA. The ESRD PPS is mandated to replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD services.

As explained in the ESRD PPS final rule (75 FR 49162), section 1881(b)(14)(E)(i) of the Act requires a 4-year transition (phase-in) from the current composite payment system to the ESRD PPS, and section 1881(b)(14)(E)(ii) of the Act allows ESRD facilities to make a one-time election to be excluded from the transition. Electing to be excluded from the 4-year transition means that the ESRD facility receives payment for renal dialysis services based on 100 percent of the payment rate established under the ESRD PPS, rather than a blended rate for each year of the transition based in part on the payment rate under the current payment system and in part on the payment rate under the ESRD PPS.

For renal dialysis services furnished during CY 2011, ESRD facilities that elect to go through the ESRD PPS the transition would be paid a blended amount that will consist of 75 percent of the basic case-mix adjusted composite payment system and the remaining 25 percent would be based on the ESRD PPS payment. Thus, we must

continue to update the basic case-mix adjusted composite payment system during the ESRD PPS 4-year transition (CYs 2011 through 2013).

For a historical perspective of the basic case-mix adjusted composite rate payment system for ESRD facilities that furnish outpatient dialysis services, see the following PFS final rules with comment period:

- CY 2005 (69 FR 66319 through 66334).
- CY 2006 (70 FR 70161 through 70171).
- CY 2007 (71 FR 69681 through 69688).
- CY 2008 (72 FR 66280 through 66285).
- CY 2009 (73 FR 69754 through 69761).
- CY 2010 (74 FR 61921 through 61926).

In the CY 2011 PFS proposed rule (75 FR 40165 through 40168), we outlined the proposed updates to the basic case-mix adjusted composite payment system established under section 1881(b)(12) of the Act, which included updates to the drug add-on, as well as the wage index values used to adjust the labor component of the composite rate. Specifically, as described in more detail below in this section, we proposed the following:

- A zero growth update to the drug add-on, resulting in a proposed 14.7 percent add-on adjustment to the composite rate for 2011 required by section 1881(b)(12)(F) of the Act to maintain a $20.33 per treatment drug add-on amount.
- An update to the wage index adjustment to reflect the latest available wage data, including a revised budget neutrality (BN) adjustment factor of 1.056929.
- A reduction to the ESRD wage index floor from 0.6500 to 0.6000.

We received very few comments on our proposals. The ESRD payment related

comments are discussed below in this section.

1. Update to the Drug Add-on Adjustment to the Composite Rate

In the CY 2011 PFS proposed rule (75 FR 40165), we described the drug payment methodology used to update the drug add-on adjustment to the composite rate. Since we now have 4 years of drug expenditure data based on ASP pricing, we proposed to continue estimating growth in drug expenditures based on the trends in available data.

We did not receive any comments objecting to the drug add-on update methodology, and therefore, we used the proposed update methodology to compute the drug add-on adjustment for CY 2011. We used trend analysis from drug expenditure data to update the per treatment drug add-on adjustment. We then removed growth in enrollment for the same time period from the expenditure growth, so that the residual reflects per patient expenditure growth (which includes price and utilization combined).

To estimate drug expenditure growth using trend analysis, we looked at the average annual growth in total drug expenditures between 2006 and 2009. First, we estimated the total drug expenditures for all ESRD facilities in CY 2009. For this final rule, we used the final CY 2006 through CY 2009 ESRD claims data with dates of service for the same timeframe updated through June 30, 2010 (that is, claims with dates of service from January 1 through December 31, 2009, that were received, processed, paid, and passed to the National Claims History File as of June 30, 2010).

Using the full-year 2009 drug expenditure figure, we calculated the average annual change in drug expenditures from 2006 through 2009. This average annual change showed an increase of 1.9 percent for this timeframe. We used this 1.9 percent increase to project drug expenditures for both CY 2010 and CY 2011.

2. Estimating Per Patient Growth

Once we had the projected growth in drug expenditures from 2010 to 2011 (1.9 percent), to calculate the per patient expenditure growth between CYs 2010 and 2011, we removed the enrollment component by using the estimated growth in enrollment data between CY 2010 and CY 2011, which was approximately 3.6 percent. Specifically, we divided the total drug expenditure factor between 2010 and 2011 (1.019) by enrollment growth of 3.6 percent (1.036) for the same timeframe. The result is a per patient growth factor equal to 0.984 (1.019/1.036=0.984). Thus, we are projecting a 1.6 percent decrease in per patient growth in drug expenditures between 2010 and 2011.

3. Update to the Drug Add-on Adjustment

As previously discussed, we estimate a 1.9 percent increase in drug expenditures between CY 2010 and CY 2011. Combining this reduction with a 3.6 percent increase in enrollment, as described above, we are projecting a 1.6 percent decrease in per patient growth of drug expenditures between CY 2010 and CY 2011. A 1.6 percent decrease in the per patient drug add-on of $20.33 would result in a decrease of 33 cents (.016*20.33=.33). Hence a decrease of 33 cents in the drug add-on would result in negative update equal to 0.2 percent (.33/138.53, 138.53 is the 2011 base composite rate). Therefore, we are projecting that the combined growth in per patient utilization and pricing for CY 2011 would result in a negative update equal to 0.2 percent. However, as we have done previously, we proposed a zero update to the drug add-on adjustment. We believe this approach is consistent with the language under section 1881(b)(12)(F) of the Act which states in part that "the Secretary shall annually increase" the drug add-on

amount based on the growth in expenditures for separately billed ESRD drugs. Our understanding of the statute contemplates "annually increase" to mean a positive or zero update to the drug add-on.

Also, as required by section 1881(b)(14)(F), as amended by section 3401(h) of the Affordable Care Act, a 2.5 percent ESRD market basket increase, as established in the ESRD PPS final rule (75 FR 49161), is applied to the current basic case-mix adjusted composite rate portion of the blended payment amount, resulting in a CY 2011 composite rate of $138.53 ($135.15*1.025). This 2.5 percent market basket increase does not apply to the drug add-on adjustment to the composite rate. Since the drug add-on is calculated as a percentage of the composite rate, we note that the drug add-on percentage would be reduced from 15.0 to 14.7 as a result of the increase to the composite rate in CY 2011.

Comment: Several commenters agreed with CMS' decision to apply a zero update to the drug add-on adjustment.

Response: We appreciate the commenters' support that we continue with a zero update to the drug add-on adjustment.

Accordingly, after a review of the public comments, we are finalizing the proposed policy decisions to apply a zero update to the drug add-on, maintain a $20.33 per treatment drug add-on amount, as well as apply a 14.7 percent add-on adjustment to the composite rate for CY 2011. Also, as previously discussed a 2.5 percent ESRD market basket increase is applied to the current basic case-mix adjusted composite rate portion of the blended payment amount, resulting in a CY 2011 composite rate of $138.53 ($135.15*1.025).

Comment: One commenter agreed with our decision to continue to use the ASP+6 percent methodology for separately billable drugs.

Response: This comment is out of the scope of the proposed ESRD provisions, however, we appreciate the commenters' support of our use of the ASP+6 percent methodology.

4. Update to the Geographic Adjustments to the Composite Rate

In the CY 2011 PFS proposed rule (75 FR 40165), we proposed to update the wage index adjustment to reflect the latest available wage data, The purpose of the wage index is to adjust the composite rates for differing wage levels covering the areas in which ESRD facilities are located. The wage indexes are calculated for each urban and rural area. In addition, we generally have followed wage index policies used under the inpatient hospital prospective payment system (IPPS), but without regard to any approved geographic reclassification authorized under sections 1886(d)(8) and (d)(10) of the Act or other provisions that only apply to hospitals paid under the IPPS (70 FR 70167). Therefore, for purposes of the ESRD wage index methodology, the hospital wage data we use is pre-classified, pre-floor hospital data and unadjusted for occupational mix.

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

In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB's CBSA-based geographic area designations to develop revised urban/rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. The CBSA-based geographic area designations are described in OMB Bulletin 03-04, originally issued June 6, 2003, and is available online at http://www.whitehouse.gov/omb/bulletins/b03-04.html. In addition,

OMB has published subsequent bulletins regarding CBSA changes, including changes in CBSA numbers and titles. We note that this and all subsequent ESRD rules and notices are considered to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage index used to determine the current ESRD wage index. The OMB bulletins may be accessed online at http://www.whitehouse.gov/omb/bulletins/index.html.

6. Updated Wage Index Values

In the CY 2007 PFS proposed rule (71 FR 69685), we proposed to update the ESRD wage index values annually. The ESRD wage index values for CY 2011 were developed from FY 2007 wage and employment data obtained from the Medicare hospital cost reports. As we indicated, the ESRD wage index values are calculated without regard to geographic classifications authorized under sections 1886(d)(8) and (d)(10) of the Act and utilize pre-floor hospital data that is unadjusted for occupational mix.

Comment: One commenter wanted CMS to consider the wage index policies that are adopted under the IPPS and that similar wage index policies should be developed for ESRD facilities.

Response: We appreciate the commenters concern as to how ESRD are geographically classified and although we did not propose a change in the geographic reclassification for ESRD facilities at this time, we will take the commenters suggestions into consideration in future rulemaking.

Comment: MedPAC commented that the statutory update to the composite rate for CY 2011 will benefit both rural and urban facilities, and they urge CMS to monitor

access to dialysis care especially in rural areas.

Response: We agree with MedPAC's recommendation and we plan to continue to monitor access to dialysis care in rural areas and the impact or influence these effects may have for the ESRD basic case-mix adjusted composite payment rate system wage index.

7. Wage index Values for Areas With No Hospital Data

In the CY 2011 PFS proposed rule (75 FR 40167), we proposed to use the methodology established in CY 2006 for wage index values for areas with no hospital data. While adopting the CBSA designations, we identified a small number of ESRD facilities in both urban and rural geographic areas where there are no hospital wage data from which to calculate ESRD wage index values. The affected areas were rural Puerto Rico, rural Massachusetts (Barnstable Town, MA (CBSA 12700), and Providence-New Bedford-Fall River, RI-MA (CBSA 39300)), and the urban area of Hinesville, GA (CBSA 25980). As with prior years, for CY 2011, we calculated the ESRD wage index values for those areas as follows:

- For the urban area of Hinesville-Fort Stewart, GA (CBSA 25980), which is an urban area without specific hospital wage data, we applied the same methodology used to impute a wage index value that we used in CY 2010. Specifically, we used the average wage index value for all urban areas within the State of Georgia.

- For rural Massachusetts, we adopted an alternative methodology we used for CY's 2008, 2009 and 2010, which we proposed to use to determine the wage index value for rural Massachusetts for CY 2011. Specifically, for rural areas without hospital wage data, we proposed to use the average wage index values from all contiguous CBSAs as a

reasonable proxy for that rural area. In determining the imputed rural wage index, we interpreted the term ‘‘contiguous’’ to mean sharing a border. In the case of Massachusetts, the entire rural area consists of Dukes and Nantucket Counties. We determined that the borders of Dukes and Nantucket counties are contiguous with CBSA 12700, Barnstable Town, MA, and Providence-New Bedford-Fall River, RI–MA. For purposes of rural Massachusetts, we proposed to use the same methodology for CY 2011.

- For rural Puerto Rico, because all geographic areas in Puerto Rico were subject to the wage index floor in CY 2011, we proposed to apply the ESRD wage index floor to rural Puerto Rico as well. For CY 2011, the ESRD wage index floor is 0.60. Therefore, we proposed to apply the ESRD wage index floor to 0.60 to facilities that are located in rural Puerto Rico. We note, however, that there are currently no ESRD facilities located in rural Puerto Rico.

We received no comments on our proposals for the wage areas as previously discussed with no hospital data. Therefore, we are finalizing our policies for wage areas with no hospital data. Also, we will continue to evaluate existing hospital wage data and possibly wage data from other sources such as the Bureau of Labor Statistics, to determine if other methodologies might be appropriate for imputing wage index values for areas without hospital wage data for CY 2010 and subsequent years. To date, no data from other sources, superior to that currently used in connection with the IPPS wage index has emerged. Therefore, for ESRD purposes, we continue to believe this is an appropriate policy. Also, the wage index values associated with these areas are located in the addenda section of this final rule.

Also, in the CY 2011 PFS proposed rule (75 FR 40167), we reported an additional urban area – Anderson, SC (CBSA 11340) – with no hospital data. For this urban area, we proposed to use the same methodology we have used for the other urban area with no hospital data, that is, Hinesville-Fort Stewart, GA (CBSA 25980). However, since the publication of the CY 2011 PFS proposed rule, we have received hospital wage data for this area, and therefore, the methodology we proposed no longer applies.

8. Reduction to the ESRD Wage Index Floor

In the PFS proposed rule (75 FR 40167), we proposed to continue to reduce the wage index floor to the composite rate portion of the blend during the transition. For CY 2011, we proposed that the ESRD wage index floor would be reduced from 0.65 to 0.60. We believe maintaining the wage index floor provides some relief for ESRD facilities going through the transition that have low wage index values.

For CY 2011, all urban areas in Puerto Rico that have a wage index are eligible for the ESRD wage index floor of 0.60. Currently there are no ESRD facilities located in rural Puerto Rico, however, should any facilities open in rural Puerto Rico, as previously discussed, we intend to apply the CY 2011 wage index floor of 0.60 to these rural facilities.

We received no comments on our proposal regarding the reduction to the ESRD wage index floor with regard to the composite rate portion of the blend during the transition. Therefore, we are finalizing our policy to reduce the wage index floor as proposed.

9. Budget Neutrality Adjustment

We have previously interpreted the statute as requiring that the geographic

adjustment be made in a budget neutral manner. Given our application of the ESRD wage index, this means that aggregate payments to ESRD facilities in CY 2011 would be the same as aggregate payments that would have been made if we had not made any changes to the geographic adjustments. We note that this BN adjustment only addresses the impact of changes in the geographic adjustments. A separate BN adjustment was developed for the case-mix adjustments required by the MMA.

Since we did not propose any changes to the case-mix measures for basic case-mix adjusted payment system for CY 2011, the current case-mix BN adjustment of 0.9116 would remain in effect for CY 2011. Consistent with prior rulemaking, for CY 2011, we will apply the wage-index BN adjustment factor of 1.056929 directly to the ESRD wage index values to the composite rate portion of the blend. Because the ESRD wage index is only applied to the labor-related portion of the composite rate, we computed the BN adjustment factor based on that proportion (53.711 percent).

To compute the CY 2011 wage index BN adjustment factor, we used the FY 2007 pre-floor, pre-reclassified, non-occupational mix-adjusted hospital data to compute the wage index values, 2009 outpatient claims (paid and processed as of June 30, 2010), and geographic location information for each facility which may be found through Dialysis Facility Compare Web page on the CMS Web site at http://www.cms.hhs.gov/DialysisFacilityCompare/. The FY 2011 hospital wage index data for each urban and rural locale by CBSA may also be accessed on the CMS Web site at http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp. The wage index data are located in the section entitled, "FY 2011 Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-Reclassified Wage Index by CBSA."

Using treatment counts from the 2009 claims and facility-specific CY 2010 composite rates, we computed the estimated total dollar amount each ESRD provider would have received in CY 2010. The total of these payments became the target amount of expenditures for all ESRD facilities for CY 2011. Next, we computed the estimated dollar amount that would have been paid for the same ESRD facilities using the ESRD wage index for CY 2011. The total of these payments becomes the new CY 2011 amount of wage-adjusted composite rate expenditures for all ESRD facilities.

After comparing these two dollar amounts (target amount divided by the new CY 2011 amount), we calculated an adjustment factor that, when multiplied by the applicable CY 2011 ESRD wage index value, would result in aggregate payments to ESRD facilities that would remain within the target amount of composite rate expenditures. When making this calculation, the ESRD wage index floor value of 0.60 is applied whenever appropriate. The wage BN adjustment factor for CY 2011 is 1.056929.

To ensure BN, we also must apply the BN adjustment factor to the wage index floor 0.60, which results in an adjusted wage index floor of 0.6342 (0.6000 x 1.056929) for CY 2011. This budget neutrality factor is not applied to the wage index values for the ESRD PPS portion of the blend.

10. ESRD Wage Index Tables

The CY 2011 ESRD final wage index tables are located in Addenda K and L of this final rule with comment period. Also, we indicated in the ESRD PPS final rule (75 FR 49117), we would finalize the CY 2011 ESRD PPS wage index tables in this final rule. The wage index tables lists two separate columns of wage index values. The first column lists the wage index values will be applied under the composite rate portion and

includes the budget neutrality adjustment of 1.056929. The second column lists the wage index values that will be applied under the ESRD PPS beginning January 1, 2011.

F. Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

1. Section 131: Physician Payment, Efficiency, and Quality Improvements - Physician Quality Reporting System

a. Program Background and Statutory Authority

Section 101 of Division B of the Tax Relief and Health Care Act of 2006 – the Medicare Improvements and Extension Act of 2006 (Pub. L. 109-432) (MIEA-TRHCA), which was enacted on December 20, 2006, required us to implement a physician quality reporting system in 2007, which we named the Physician Quality Reporting Initiative (PQRI). The Physician Quality Reporting System is a quality reporting program that provides an incentive payment to identified eligible professionals who satisfactorily report data on quality measures for covered professional services furnished during a specified reporting period. Under section 1848(k)(3)(B) of the Act, the term "eligible professional" means any of the following: (1) a physician; (2) a practitioner described in section 1842(b)(18)(C); (3) a physical or occupational therapist or a qualified speech-language pathologist; or (4) a qualified audiologist.

The PQRI was extended and further enhanced as a result of the MMSEA, which was enacted on December 29, 2007, and the MIPPA, which was enacted on July 15, 2008. Changes to the PQRI as a result of these laws, as well as information about the PQRI in 2007, 2008, 2009, and 2010, are discussed in detail in the CY 2008 PFS proposed and final rules (72 FR 38196 through 38204 and 72 FR 66336 through 66353, respectively), CY 2009 PFS proposed and final rules (73 FR 38558 through 38575 and 73 FR 69817 through 69847, respectively), and CY 2010 PFS proposed and

final rules (74 FR 33559 through 33600 and 74 FR 61788 through 61861, respectively). Further detailed information, about the PQRI program, related laws, and help desk resources, is available on the CMS Web site at http://www.cms.gov/PQRI.

The ACA makes a number of changes to the PQRI, including the following: authorizing incentive payments through 2014; requiring a payment adjustment beginning in 2015 for eligible professionals who do not satisfactorily report data on quality measures in the applicable reporting period for the year; requiring timely feedback to participating eligible professionals; requiring the establishment of an informal appeals process whereby eligible professionals may seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures for purposes of qualifying for a PQRI incentive payment; making available an additional incentive payment for those eligible professionals satisfactorily reporting data on quality measures for a year and having such data submitted on their behalf through a Maintenance of Certification Program and participating in a Maintenance of Certification Program practice assessment more frequently than is required to qualify for or maintain board certification status; requiring the establishment of a Physician Compare Web site; and requiring the development of a plan to integrate reporting on quality measures relating to the meaningful use of electronic health records (EHRs). Whereas in the past we only had the authority to continue the PQRI incentive payments for a specified period of time, we believe the changes authorized by the ACA (particularly the fact that the payment adjustments are authorized for 2015 and each subsequent year) lend permanency to the PQRI. To reflect this transition from the PQRI being a temporary initiative to a permanent quality reporting program, we are hereafter referring to the PQRI as the

"Physician Quality Reporting System, " We will be updating our documents and the relevant websites to reflect this name change over time.

In the CY 2011 PFS proposed rule (75 FR 40162) we proposed to add §414.90 to title 42 of the Code of Federal Regulations to implement the provisions of the Physician Quality Reporting System.

We received several comments from the public on the CY 2011 PFS proposed rule related to the Physician Quality Reporting System. General comments about the Physician Quality Reporting System are addressed as follows.

Comment: We received positive feedback supporting the Physician Quality Reporting System program as a whole, particularly efforts that encourage eligible professional reporting through registries, Maintenance of Certification Programs, and EHRs. We also received positive feedback regarding our proposals for providing timely feedback and the establishment of an informal appeals process.

Response: We appreciate the commenters' positive feedback. We believe that these options provide eligible professionals with greater flexibility.

Comment: We received one comment expressing dissatisfaction with the Physician Quality Reporting System program as a whole. The commenter stated that while they have been reporting Physician Quality Reporting System data for the past few years, they have not received the incentive payment. As a result, the commenter feels that their clinical professionalism and patient service is not improved by the program and that it diminishes the time they spend on direct patient care.

Response: We are sorry that the commenter has not received a Physician Quality Reporting System incentive. We are hopeful that the improvements that we are making

to the Physician Quality Reporting System will make it easier for eligible professionals to participate satisfactorily. We recommend that all participating eligible professionals review their Physician Quality Reporting System feedback report. In addition to providing performance information, eligible professionals who are not incentive eligible will be able to use their feedback report to determine why they did not qualify for an incentive payment. We encourage any eligible professional who has questions about the information contained in their feedback report to contact the QualityNet Help Desk at 866-288-8912 or qnetsupport@sdps.org. The Help Desk is available from 7 a.m. to 7 p.m. Central Time to answer a variety of questions about the Physician Quality Reporting System from general program questions to feedback report availability and access. The help desk can provide detailed information about the reasons that an eligible professional failed to earn an incentive as well.

Comment: Some commenters urged us to aggressively provide additional Physician Quality Reporting System education and training opportunities. One commenter requested we provide more "hands-on" Physician Quality Reporting System education and training opportunities at the local level by the state/regional contractors.

Response: We appreciate the commenters' valuable input. We will continue to work with national and regional stakeholder organizations to educate their members on Physician Quality Reporting System program requirements. We also expect to continue to host monthly national provider calls in which we would provide guidance on specific topics and provide updated educational materials and resources. To augment our portfolio of educational materials and resources, we also anticipate providing a series of

educational videos to help educate eligible professionals on Physician Quality Reporting System program requirements.

Comment: One commenter expressed disappointment with the exclusion of eligible professionals in institutional settings. Other commenters urged us to identify and adopt a Physician Quality Reporting System reporting mechanism that could apply to all eligible professionals in all settings, including eligible therapists providing services in CORFs, SNFs Part B, and outpatient departments of a hospital.

Response: As we stated in the CY 2010 PFS final rule with comment period (74 FR 61791), for professionals who practice in an institutional setting where the provider of service is an institution and not a physician or other professional paid under the PFS or where claims submission does not identify the professional by his or her NPI, we are unable to make the determination of satisfactory reporting and calculate earned incentive payment amounts at the individual eligible professional level without extensive modifications to the claims processing systems of CMS and providers, which would represent a material administrative burden to us and to providers. It would also require modifications to the industry standard claims formats, which would require substantial time to effect through established processes and structures that we do not maintain or control. We have also found that most institutions that employ eligible professionals do not tie the individual professional to the service rendered to an individual patient. In this case, there are no individual provider identifiers available to use in processing these claims.

Comment: One commenter was concerned that one of the analytical changes that was made to facilitate satisfactory Physician Quality Reporting System reporting may

have had an unintended consequence on radiologists by overly inflating their eligible cases, or reporting denominator. Specifically, the commenter is requesting that, for radiology, we look at the CPT/ICD-9 combinations only for the specific line item in which the CPT/ICD-9 combination is present rather than across any dates of service.

Response: We are aware of this issue and are currently analyzing the impact. We believe there are only a handful of measures where this is a concern because the measure specifications tie a procedure to a diagnosis. We are working with the appropriate measure developers/owners to analyze the specifications for these measures to see if they can be changed for 2011 to lessen the impact.

Comment: One commenter encouraged us to consider strategies to move the Physician Quality Reporting System toward a more robust role in quality improvement. Individual clinicians and smaller group practices' self-selection of measures, the small number of measures required to be reported, and variations in the required sample sizes make the measures less meaningful than they could be if the program was more structured and rigorous.

Response: The commenter brings up a number of valid points. As the program matures and we phase out the incentives for satisfactory reporting and phase in payment adjustments for failing to satisfactorily report, we envision continuing to make further refinements to the program to address the commenter's concerns. Any such changes would be described in notice and comment rulemaking prior to implementation.

Comment: Another commenter urged us to transition to rewarding performance, not just reporting. Changes made now should lay the groundwork for moving towards this goal.

Response: As we noted in the CY 2011 PFS proposed rule (75 FR 40114 through 40115), section 3007 of the ACA requires the Secretary to apply a separate, budget-neutral payment modifier to the FFS PFS payment formula. The payment modifier, which will be phased in beginning January 1, 2015 through January 1, 2017, will provide for differential payment under the fee schedule to a physician or groups of physicians, and later, possibly to other eligible professionals, based upon the relative quality and cost of care of their Medicare beneficiaries.

Comment: One commenter was concerned that eligible professionals would not decide to participate in the Physician Quality Reporting System. The commenter was concerned that given the current status of the industry in trying to meet 5010/ICD10 regulations and incentive requirements for achieving the meaningful use of EHR adoption, the additional reporting requirements will serve as a disincentive.

Response: We are unclear what additional reporting requirements the commenter is referring to nor are we clear on how they relate to the 5010/ICD10 regulations and the incentive requirements for achieving the meaningful use of EHR adoption. However, if the commenter is concerned that eligible professionals may not be motivated to participate in the Physician Quality Reporting System in light of other quality programs and/or requirements, we agree that this is a valid concern.

Upon consideration of the comments, we are finalizing our proposal to add §414.90 to title 42 of the Code of Federal Regulations to implement the provisions of the Physician Quality Reporting System as discussed in this section. We made certain technical changes to §414.90 as appropriate to reflect the change in the name of the PQRI to "Physician Quality Reporting System," to eliminate the unnecessary use of acronyms,

and to add cross-references to relevant statutory or regulatory provisions where appropriate, to specify the particular program year addressed in this rulemaking, and to make other technical changes as noted.

b. Incentive Payments for the 2011 Physician Quality Reporting System

For years 2011 through 2014, section 3002(a) of the ACA extends the opportunity for eligible professionals to earn a Physician Quality Reporting System incentive payment for satisfactorily reporting Physician Quality Reporting System quality measures. For the 2011 Physician Quality Reporting System, section 1848(m)(2)(B) of the Act, as amended by section 3002(a) of the ACA , authorizes a 1.0 percent incentive, and for 2012 through 2014, a 0.5 percent incentive, for qualified eligible professionals who satisfactorily submit Physician Quality Reporting System quality measures data.

The following is a summary of the comments we received regarding the 2011 Physician Quality Reporting System incentive payment amount.

Comment: One commenter expressed support for the extension of the Physician Quality Reporting System incentives through 2014 for eligible professionals who satisfactorily report.

Response: We appreciate the commenters' positive feedback.

Comment: Some commenters expressed concern that the incentive payment is too small to motivate eligible professionals to report Physician Quality Reporting System measures, even if they are providing quality care in their practice, or to drive quality. The commenters stated that added administrative cost and time should be considered when setting the incentive and disincentive rates, in an effort to better reflect the financial incentive to begin utilizing the measures and financial disincentives to maintain such

practice. Commenters were specifically concerned that the incentives are not commensurate with the burden of reporting.

Response: While we understand commenters' concerns with the costs and burdens associated with satisfactory reporting under the Physician Quality Reporting System, we have neither the authority to change the basis for calculation of the incentive payment nor the authority to change the incentive amount. We continue to seek ways to minimize impact on eligible professionals, such as by continuing to offer multiple reporting options in order to give eligible professionals the flexibility to choose the option that best fits their practice. Furthermore, we note that under section 1848(a)(8) of the Act, beginning 2015, eligible professionals who do not satisfactorily report Physician Quality Reporting System measures will be subject to a payment adjustment. Eligible professionals who participate in the Physician Quality Reporting System prior to 2015 receive the added benefit of familiarizing themselves with the Physician Quality Reporting System prior to the implementation of the payment adjustment. Moreover, beginning 2015, eligible professionals who satisfactorily report under the Physician Quality Reporting System will avoid the payment adjustment.

Comment: One commenter requested clarification and examples on how the incentive payment calculations are determined and an explanation of what is meant by "allowable."

Response: As stated in the CY 2011 PFS proposed rule (75 FR 40169), the Physician Quality Reporting System incentive payment amount is calculated using estimated Medicare Part B PFS allowed charges for all covered professional services, not just those charges associated with the reported quality measures. "Allowed charges"

refers to total charges, including the beneficiary deductible and coinsurance, and is not limited to the 80 percent paid by Medicare or the portion covered by Medicare where Medicare is secondary payer. Amounts billed above the PFS amounts for assigned and non-assigned claims will not be included in the calculation of the incentive payment amount. In addition, since, by definition under section 1848(k)(3)(A) of the Act, "covered professional services" are limited to services for which payment is made under, or is based on, the PFS and which are furnished by an eligible professional, other Part B services and items that may be billed by eligible professionals, but are not paid under or based upon the Medicare Part B PFS, are not included in the calculation of the incentive payment amount.

Therefore, eligible professionals and group practices that satisfactorily report quality data under the 2011 Physician Quality Reporting System will qualify for an incentive payment equal to 1.0 percent of their total estimated Medicare Part B PFS allowed charges for the all covered professional services furnished by the eligible professional during the applicable 2011 Physician Quality Reporting System reporting period. For satisfactory reporting at the individual level in 2011, 1.0 percent of allowed charges will be paid at the TIN/NPI level. For satisfactory reporting at the group practice level in 2011, 1.0 percent of allowed charges will be paid at the TIN level.

c. 2011 Reporting Periods for Individual Eligible Professionals

Under section 1848(m)(6)(C) of the Act, the "reporting period" for the 2008 Physician Quality Reporting System and subsequent years is defined to be the entire year, but the Secretary is authorized to revise the reporting period for years after 2009 if the Secretary determines such revision is appropriate, produces valid results on measures

reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. For the 2011 Physician Quality Reporting System, we proposed the following reporting periods: (1) 12-month reporting period for claims-based reporting and registry-based reporting (that is, January 1, 2011 through December 31, 2011); (2) 12-month reporting period for EHR-based reporting (that is, January 1, 2011 through December 31, 2011; and (3) 6-month reporting period for claims-based reporting and registry-based reporting (that is, July 1, 2011 through December 31, 2011). Additionally, we proposed the 12-month reporting period for the group practice reporting option (GPRO) for both the Physician Quality Reporting System and the Electronic Prescribing (eRx) Incentive Program Prescribing Incentive Program (January 1, 2011 through December 31, 2011).

The following is a summary of the comments we received regarding the proposed reporting periods.

Comment: We received comments generally supporting the proposed reporting periods as well as comments specifically supporting the 6-month reporting period for registry-based reporting.

Response: We appreciate the commenters' positive feedback. As these comments support our proposed reporting periods and for the reasons discussed, we are finalizing the reporting periods, as proposed.

Comment: One commenter was opposed to the elimination of the 6-month reporting period for claims-based reporting as this would create an unnecessary obstacle for the reporting mechanism that is available to nearly all eligible professionals.

Response: We agree with the commenter's urging of the preservation of the 6-month reporting period for 2011, and, as such, we did not propose to eliminate the 6-month reporting period for claims-based reporting. In an effort to encourage participation by eligible professionals who may not be ready to do so at the beginning of the year, for the 2011 Physician Quality Reporting System, there will continue to be both a 12-month and 6-month reporting period for all reporting options except for EHR reporting and the group practice reporting option.

Comment: Another commenter requested that we consider a 6-month reporting period for registry-based reporting.

Response: We proposed a 6-month reporting period for registry-based reporting in the CY 2011 PFS proposed rule (75 FR 40169). As previously stated, for the 2011 Physician Quality Reporting System, there will continue to be a 12-month and 6-month reporting period for all reporting options except for EHR reporting and the group practice reporting option.

Comment: One commenter requested that we consider providing both 6-month and 12-month EHR-based reporting options, consistent with the 6-month reporting period options available for the claims-based and registry-based reporting mechanisms.

Response: As we stated in the CY 2010 PFS final rule with comment period (74 FR 61794), we may consider including a 6-month reporting period for EHR reporting in future years once we have additional experience with EHR reporting in the Physician Quality Reporting System. At this time, no data has yet been collected from EHRs for the Physician Quality Reporting System. EHR data submission for the 2010 Physician

Quality Reporting System will not occur until early 2011. Therefore, we are not adding a 6-month reporting period for EHR-based reporting at this time.

Comment: One commenter opposed tying the incentive amount to the reporting period in which the eligible professional satisfactorily reports.

Response: Section 1848(m)(1)(A) of the Act specifies that the incentive payment is based on the covered professional services furnished during the reporting period for which the eligible professional or group practice satisfactorily reports. Therefore, we are obligated to tie the incentive amount to the reporting period in which the eligible professional satisfactorily reports. We note, however, the incentive is not limited to the charges for the services associated with the measures being reported. Rather the incentive is calculated based on all of covered professional services furnished during the applicable reporting period.

Upon consideration of the comments received, we will finalize the 2011 reporting periods as proposed. As discussed previously, if an eligible professional only satisfactorily reports for the 6-month reporting period, then the professional's incentive payment will be calculated based on the eligible professional's charges for covered professional services furnished between July 1, 2011 and December 31, 2011 only. Services furnished prior to July 1, 2011 would not be included in the professional's incentive payment calculation.

We are also deleting the definition for the term "quality reporting period" proposed at §414.90(b) since the reporting period is defined at §414.90(g)(1).

d. 2011 Physician Quality Reporting System Reporting Mechanisms for Individual Eligible Professionals

For the 2011 Physician Quality Reporting System, we proposed to retain the claims-based, registry-based, and EHR-based reporting mechanism from 2010 and invited comments on other options that could be included in the 2011 Physician Quality Reporting System. We also discussed in the CY 2011 PFS proposed rule that we continue to consider significantly limiting the claims-based mechanism of reporting clinical quality measures in future program years (75 FR 40170).

The following is a summary of the comments received with regard to the proposed 2011 Physician Quality Reporting System reporting mechanisms and our intent to lessen reliance on the claims-based reporting mechanism beyond 2011.

Comment: Several commenters supported the proposed reporting mechanisms for the 2011 Physician Quality Reporting System, including strong support for the continuation of claims-based reporting and continued availability of multiple reporting mechanisms. Many commenters noted that claims-based reporting is the only reporting mechanism available to all eligible professionals. One commenter believes claims-based reporting may be a more accurate reporting method overall and that it would be unduly burdensome and costly to force practitioners into changing their established reporting methods. Another commenter thought CMS should not totally discontinue claims-based reporting as some practitioners, such as radiologists, work at several different locations where they may not consistently have access to a registry or EHR. One commenter noted that many small practices may not yet be linked to EHR systems. Commenters also noted that registry reporting frequently requires additional costs, which adds another burden on eligible professionals who wish to participate in the Physician Quality Reporting System. Another commenter stated that in the transition to payment adjustments beginning in

2015, where it is crucial to encourage greater participation, it would be premature to eliminate claims-based reporting. Other commenters urged us to delay eliminating or lessening our reliance on claims-based reporting until eligible professionals can demonstrate that they understand how to use and capture quality data via EHRs or registers and can consistently and successfully do so. Finally, another commenter encouraged us to provide a one or two year transition period if we want to proceed with eliminating claims-based reporting in future years.

Response: We appreciate the commenters' positive feedback. We agree with some of the reasons cited by commenters for retaining claims-based reporting and/or retaining multiple reporting mechanisms. For these reasons and in the discussion that follows, we are retaining, for 2011, the three 2010 Physician Quality Reporting System reporting mechanisms for individual eligible professionals, including claims-based reporting.

Comment: While a majority of commenters requested that we delay or reconsider lessening our reliance on claims-based reporting after 2011, some commenters recommended that the claims-based reporting option be phased out with the expectation that registry-based and EHR-based reporting will become the mainstay of the program, especially as EHR adoption increases. Commenters noted that claims-based reporting has been problematic for eligible professionals and that transitioning the Physician Quality Reporting System away from claims-based reporting would maximize the potential of registries and EHRs for quality measurement reporting. One commenter requested clarification around the timing for phasing out claims-based reporting in order

to assist eligible professionals' decision-making around how and when to implement various parts of an EHR or registry.

Response: In addition to the reasons offered by commenters, our ability to lessen our reliance on the claims-based reporting mechanism is dependent on there being an adequate number and variety of registries available and/or EHR reporting options. We believe that it would be premature to eliminate the claims-based reporting mechanism for 2011 and doing so would create a barrier to participation. For 2009, approximately 75 percent of eligible professionals used claims-based reporting. We do not anticipate phasing out claims-based reporting while it continues to be actively used by eligible professionals.

Comment: One commenter requested that we allow certified registered nurse anesthetists (CRNAs) to submit Physician Quality Reporting System data through an EHR-based reporting mechanism.

Response: CRNAs are not precluded from reporting via a qualified Physician Quality Reporting System EHR. However, CRNAs may find the current measures available for Physician Quality Reporting System EHR reporting to be beyond their scope of practice. Additionally, CRNAs tend to collect the majority of their data in operating rooms and may require specific EHR products which, due to their specialization, may have Physician Quality Reporting System qualification later on their timeline.

Comment: One commenter expressed support for the use of registries as a recognized instrument to leverage existing clinical data collection efforts.

Response: We appreciate the supportive comment and agree that registries may be able to augment data collection efforts, particularly for measures that are more difficult to collect and require longer time horizons to get complete data information.

Comment: One commenter expressed concern about the discrepancy between claims-based reporting and registry reporting. Physician Quality Reporting System analysis for 2007 and 2008 showed that providers who did registry reporting had a 90 percent success rate for earning a Physician Quality Reporting System bonus and claims-based reporting had a 50 percent success rate. Due to this large discrepancy, the commenter believed that it will be very important to know which reporting method results in actual performance improvement based on patient outcomes and whether methods are subject to manipulation. The commenter encouraged us to ensure the processes and resulting data of the reporting methods are reliable and not susceptible to manipulation.

Response: We understand the commenter's concerns about the differences in the registry results compared to the claims results. We are continually assessing the accuracy and reliability of all data submitted under the Physician Quality Reporting System. We compare the data that is submitted to us from registries against claims data and are exploring reasons for any discrepancies found.

Comment: Some commenters, in the spirit of harmonization, noted that several aspects of the Physician Quality Reporting System are different from the Hospital Inpatient Quality Reporting Program, formerly known as the Reporting Hospital Quality Data Annual Payment Update Program (RHQDAPU). One commenter stated that while we are moving away from claims-based quality measures for eligible professionals, they

are moving toward claims-based quality measures for hospitals. The commenter strongly encouraged us to harmonize their programs and make this same conclusion for the Hospital Inpatient Quality Reporting Program.

Response: We understand the commenters' desire for harmonization of our various quality reporting programs and we attempt to do so when practical and feasible. We note, however, that the Physician Quality Reporting System and the Hospital Inpatient Quality Reporting Program are separate and distinct programs. The two programs apply to two different types of providers, have different goals, and are governed by different laws and requirements.

Claims-based submission for the Physician Quality Reporting System provides a means to submit additional data, using QDCs, beyond what is required for billing. Claims as used for hospital quality reporting does not require the submission of additional QDCs to be added to applicable patient claims.

Based upon consideration of the comments received and for the reasons previously explained, we are retaining the claims, registry, and EHR reporting mechanisms for use by individual eligible professionals for the 2011 Physician Quality Reporting System. As in previous years, depending on which Physician Quality Reporting System individual quality measures or measures groups an eligible professional selects, one or more of the 2011 reporting mechanisms may not be available for reporting a particular 2011 Physician Quality Reporting System individual quality measure or measures group. In addition, while eligible professionals can attempt to qualify for a Physician Quality Reporting System incentive under multiple reporting mechanisms, an eligible professional must satisfy the 2011 criteria for satisfactory

reporting with respect to a single reporting mechanism to qualify for a 2011 incentive. For example, an eligible professional who starts submitting individual Physician Quality Reporting System measures via claims in January 2011 and then switches to registry-based reporting for services furnished after April 2011 would be able to qualify for a 2011 Physician Quality Reporting System incentive based on a 12-month reporting period only if he or she satisfies the appropriate reporting criteria for either claims-based reporting or registry-based reporting for this reporting period. We will not combine data submitted via multiple reporting mechanisms to determine incentive eligibility.

(1) Final Requirements for Individual Eligible Professionals Who Choose the Claims-based Reporting Mechanism

For eligible professionals who choose to participate in the 2011 Physician Quality Reporting System by submitting data on individual quality measures or measures groups through the claims-based reporting mechanism, we proposed the eligible professional would be required to submit the appropriate Physician Quality Reporting System quality data codes (QDCs) on the professionals' Medicare Part B claims. QDCs for the eligible professional's selected individual Physician Quality Reporting System quality measures or measures group may be submitted to CMS at any time during 2011. However, as required by section 1848(m)(1)(A) of the Act, all claims for services furnished between January 1, 2011 and December 31, 2011, would need to be processed by no later than February 28, 2012, to be included in the 2011 Physician Quality Reporting System analysis.

We did not receive any comments specific to the requirements for individual eligible professionals who choose claims-based reporting. Therefore, we are finalizing

the requirements as proposed (75 FR 40171) and previously discussed. Eligible professionals should refer to the "2011 Physician Quality Reporting System Implementation Guide" to facilitate satisfactory reporting of QDCs for 2011 Physician Quality Reporting System individual measures on claims and to the "Getting Started with 2011 Physician Quality Reporting System Reporting of Measures Groups" to facilitate satisfactory reporting of QDCs for 2011 Physician Quality Reporting System measures groups on claims. By no later than December 31, 2010, both of these documents will be posted on the Physician Quality Reporting System section of the CMS Web site at http://www.cms.gov/pqri.

(2) Final Requirements for Individual Eligible Professionals Who Choose the Registry-based Reporting Mechanism

We proposed that in order to report quality data on the 2011 Physician Quality Reporting System individual quality measures or measures groups through a qualified clinical registry, an eligible professional must enter into and maintain an appropriate legal arrangement with a qualified 2011 Physician Quality Reporting System registry. Such arrangements would provide for the registry's receipt of patient-specific data from the eligible professional and the registry's disclosure of quality measures results and numerator and denominator data on Physician Quality Reporting System quality measures or measures groups on behalf of the eligible professional to CMS. Thus, the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as "data submission vendors." The "data submission vendors" would have the requisite legal authority to provide clinical quality measures results and

numerator and denominator data on individual quality measures or measures groups on behalf of the eligible professional for the Physician Quality Reporting System.

We proposed that the registry, acting as a data submission vendor, would submit CMS-defined registry-derived measures information to our designated database for the Physician Quality Reporting System, using a CMS-specified record layout, which would be provided to the registry by CMS. Similarly, we proposed that eligible professionals choosing to participate in the Physician Quality Reporting System through the registry-based reporting mechanism for 2011 would need to select a qualified Physician Quality Reporting System registry and submit information on Physician Quality Reporting System individual quality measures or measures groups to the selected registry in the form and manner and by the deadline specified by the registry.

In addition to meeting the proposed requirements specific to registry-based reporting, we proposed that eligible professionals who choose to participate in the Physician Quality Reporting System through the registry-based reporting mechanism would need to meet the relevant criteria proposed for satisfactory reporting of individual measures or measures groups that all eligible professionals must meet in order to satisfactorily report for the Physician Quality Reporting System 2011.

We did not receive any comments specific to the requirements for individual eligible professionals who choose registry-based reporting. Therefore, we are finalizing the requirements for individual eligible professionals who choose the registry-based reporting mechanism as proposed (75 FR 40171 through 40173) and previously discussed.

We will post a list of qualified registries for the 2011 Physician Quality Reporting System on the Physician Quality Reporting System section of the CMS Web site at http://www.cms.gov/pqri, which will include the registry name, contact information, and the 2011 measures and/or measures group and eRx reporting (if qualified) for which the registry is qualified and intends to report. However, we do not anticipate making this list available prior to the start of the 2011 program year as we had proposed. We proposed to post the names of the 2011 Physician Quality Reporting System qualified registries in 3 phases starting with a list of those registries qualified for the 2011 Physician Quality Reporting System based on: (1) being a qualified registry for a prior Physician Quality Reporting System program year that successfully submitted 2008 and/or 2009 Physician Quality Reporting System quality measures results and numerator and denominator data on the quality measures; (2) having received a letter indicating their continued interest in being a Physician Quality Reporting System registry for 2011 by October 31, 2010; and (3) the registry's compliance with the 2011 Physician Quality Reporting System registry requirements. As discussed further in section VII.F.1.j. of this final rule with comment period, we proposed and are finalizing new requirements for the 2011 Physician Quality Reporting System registries. Since there are new requirements that did not apply to previously qualified registries, we will need to ensure that the previously qualified registries meet the new requirements for 2011. While we fully expect all of the previously qualified registries to meet the new registry requirements for the 2011 Physician Quality Reporting System, we do not expect to be able to determine previously qualified registries' compliance with these new registry requirements for 2011 until the middle of 2011. Thus, by Summer 2011, we expect to post a list of registries (this list

will include both registries that were previously qualified and those that self-nominate to be newly qualified for 2011) that are conditionally qualified to submit numerator and denominator data on 2011 Physician Quality Reporting System measures and measures groups and Physician Quality Reporting System measure results. After we receive a test file from the registries, we will finalize the list of 2011 Physician Quality Reporting System registries. We anticipate finalizing the list of 2011 Physician Quality Reporting System registries by Fall 2011.

An eligible professional's ability to report Physician Quality Reporting System quality measures results and numerator and denominator data on Physician Quality Reporting System quality measures or measures groups using the registry-based reporting mechanism should not be impacted by the list of qualified registries for the 2011 Physician Quality Reporting System being made available after the start of the reporting period. First, registries will not begin submitting eligible professionals' Physician Quality Reporting System quality measures results and numerator and denominator data on the quality measures or measures groups to CMS until 2012. Second, if an eligible professional decides that he or she is no longer interested in submitting quality measures results and numerator and denominator data on Physician Quality Reporting System individual quality measures or measures groups through the registry-based reporting mechanism after the complete list of qualified registries becomes available, this does not preclude the eligible professional from attempting to meet the criteria for satisfactory reporting through another 2011 Physician Quality Reporting System reporting mechanism.

In any event, even though a registry is listed as "qualified," we cannot guarantee or assume responsibility for the registry's successful submission of the required Physician Quality Reporting System quality measures results or measures group results or required data elements submitted on behalf of a given eligible professional.

(3) Final Requirements for Individual Eligible Professionals Who Choose the EHR-based Reporting Mechanism

For 2011, in addition to meeting the criteria for satisfactory reporting of at least 3 individual measures, we proposed the following requirements associated with EHR-based reporting: (1) selection of a Physician Quality Reporting System qualified EHR product; and (2) submission of clinical quality data extracted from the EHR to a CMS clinical data warehouse in the CMS-specified manner and format (75 FR 40172). Similar to the 2010 Physician Quality Reporting System, a test of quality data submission from eligible professionals who wish to report 2011 quality measure data directly from their qualified EHR product will be required and is anticipated to occur in early 2012 immediately followed by the submission of the eligible professional's actual 2011 Physician Quality Reporting System data. This entire final test/production 2011 data submission timeframe is expected to be January 2012 through March 2012. As discussed in the CY 2010 PFS final rule with comment period (74 FR 61801 through 61802), we are currently vetting newly self-nominated EHR vendor products for possible qualification for the 2011 Physician Quality Reporting System program year. We expect to list any additional Physician Quality Reporting System qualified EHR products by January 2011. It is expected that these newly qualified products would be able to submit 2011 Physician Quality Reporting System data in early 2012.

The following is a summary of the comments we received regarding the proposed requirements for individual eligible professionals whose choose the EHR-based reporting mechanism for the 2011 Physician Quality Reporting System.

Comment: One commenter recommended that we consider accepting measure rates from EHRs rather than just numerator and denominator data. Rates generated within the system will be more readily available for local quality improvement purposes and timely feedback to eligible professionals and office staff. Timely feedback has been and will continue to be a problem for this program. System characteristics that promote and facilitate local improvement efforts should be designed in from the outset.

Response: We agree that an EHR's ability to calculate measure results locally will provide useful and timely information to eligible professionals who are participating in the Physician Quality Reporting System. However, receiving individual data elements allows us to ensure that measure results are calculated in a more standardized fashion across eligible professionals. Individual data elements can also more readily be combined with other data from other sources. Additionally, if measure specifications change, there would be no need to recode the EHR to account for these specification changes. Rather we can make one change to the measures engine to obviate the need for a change to the EHR itself.

Comment: One commenter finds problematic the definition of a qualified EHR as one incorporating eRx functionality. Such functionality is unnecessary and costly for eligible professionals who do not prescribe. As a result, the current proposed definition of EHR could disenfranchise practitioners lacking prescriptive authority by automatically denying them the opportunity to use EHRs for reporting performance measures. Another

commenter requested clarification on whether the electronic prescription function is E-Prescribing, which requires the patient's pharmacy benefits information, or E-Prescription Writing, which does not.

Response: We believe the commenters are referring to the eRx functionality required of a certified EHR for the EHR Incentive Program, which is beyond the scope of this final rule with comment period. This final rule is limited to the use of EHRs in the Physician Quality Reporting System and eRx Incentive Programs as one of multiple reporting mechanisms available to eligible professionals to report on Physician Quality Reporting System measures and/or the electronic prescribing quality measure.

Upon consideration of the comments and for the reasons we highlighted based on our experience thus far with EHR-based reporting, eligible professionals who choose the EHR-based reporting mechanism for the 2011 Physician Quality Reporting System will be required to (in addition to meeting the appropriate criteria for satisfactory reporting of individual measures):

- Have a Physician Quality Reporting System qualified EHR product;
- Have access to the identity management system specified by CMS (such as, but not limited to, the Individuals Authorized Access to CMS Computer Systems, or IACS) to submit clinical quality data extracted from the EHR to a CMS clinical data warehouse;
- Submit a test file containing real or dummy clinical quality data extracted from the EHR to a CMS clinical data warehouse via an identity management system specified by CMS during a timeframe specified by CMS;
- Submit a file containing the eligible professional's 2011 Physician Quality Reporting System clinical quality data extracted from the EHR for the entire reporting

period (that is, January 1, 2011 through December 31, 2011) via the CMS-specified identify management system during the timeframe specified by CMS in early 2012.

Measures groups reporting continues to not be an option for EHR-based reporting of quality measures for the 2011 Physician Quality Reporting System.

We also cannot assume responsibility for the successful submission of data from eligible professionals' EHRs. Any eligible professional who chooses to submit Physician Quality Reporting System data extracted from an EHR should contact the EHR product's vendor to determine if the product is qualified and has been updated to facilitate 2011 Physician Quality Reporting System quality measures data submission. Such professionals also should begin attempting submission soon after the opening of the clinical data warehouse in order to assure the professional has a reasonable period of time to work with his or her EHR and/or its vendors to correct any problems that may complicate or preclude successful quality measures data submission through that EHR.

The specifications for the electronic transmission of the 2011 Physician Quality Reporting System measures identified in Tables 81 and 82 of this final rule with comment period as being available for EHR-based reporting in 2011 are posted in the Alternative Reporting Mechanisms page of the Physician Quality Reporting System section of the CMS Web site. The requirements that an EHR vendor must meet in order for one or more of its products to be considered qualified for purposes of an eligible professional submitting 2011 Physician Quality Reporting System data extracted from the EHR product(s) were described in the CY 2010 PFS final rule with comment period (74 FR 61800 through 61802) and are posted on the Alternative Reporting Mechanisms page of the Physician Quality Reporting System section of the CMS Web site. We

expect to post the names of the EHR vendors and the specific product(s) and version(s) that are qualified for the 2011 Physician Quality Reporting System on the Alternative Reporting Mechanisms page of the Physician Quality Reporting System section of the CMS Web site by January 2011.

(4) Final Qualification Requirements for Registries

For the 2011 Physician Quality Reporting System, we proposed to require a self-nomination process for registries wishing to submit 2011 Physician Quality Reporting System quality measures or measures groups on behalf of eligible professionals for services furnished during the applicable reporting periods in 2011 (75 FR 40173). To be considered a qualified registry for purposes of submitting individual quality measures and measures groups on behalf of eligible professionals who choose this reporting mechanism, we proposed that both registries new to the Physician Quality Reporting System and those previously qualified must:

- Be in existence as of January 1, 2011;
- Have at least 25 participants by January 1, 2011;
- Provide at least 1 feedback report per year to participating eligible professionals;
- Not be owned and managed by an individual locally-owned single-specialty group (in other words, single-specialty practices with only 1 practice location or solo practitioner practices would be prohibited from self-nominating to become a qualified Physician Quality Reporting System registry);
- Participate in ongoing 2011 Physician Quality Reporting System mandatory support conference calls hosted by CMS (approximately 1 call per month), including an

in-person registry kick-off meeting to be held at CMS headquarters in Baltimore, MD. Registries that miss more than one meeting will be precluded from submitting Physician Quality Reporting System data for the reporting year (2011);

- Be able to collect all needed data elements and transmit to CMS the data at the TIN/NPI level for at least 3 measures in the 2011 Physician Quality Reporting System (according to the posted 2011 Physician Quality Reporting System Measure Specifications);
- Be able to calculate and submit measure-level reporting rates or the data elements needed to calculate the reporting rates by TIN/NPI;
- Be able to calculate and submit, by TIN/NPI, a performance rate (that is, the percentage of a defined population who receive a particular process of care or achieve a particular outcome) for each measure on which the TIN/NPI reports or the data elements needed to calculate the reporting rates;
- Be able to separate out and report on Medicare Part B FFS patients;
- Provide the name of the registry;
- Provide the reporting period start date the registry will cover;
- Provide the reporting period end date the registry will cover;
- Provide the measure numbers for the Physician Quality Reporting System quality measures on which the registry is reporting;
- Provide the measure title for the Physician Quality Reporting System quality measures on which the registry is reporting;
- Report the number of eligible instances (reporting denominator);
- Report the number of instances of quality service performed (numerator);

- Report the number of performance exclusions;
- Report the number of reported instances, performance not met (eligible professional receives credit for reporting, not for performance);
- Be able to transmit this data in a CMS-approved XML format.
- Comply with a CMS-specified secure method for data submission, such as submitting the registry's data in an XML file through an identity management system specified by CMS or another approved method such as over the NHIN (national health information network) if technically feasible;
- Submit an acceptable "validation strategy" to CMS by March 31, 2011. A validation strategy ascertains whether eligible professionals have submitted accurately and on at least the minimum number (80 percent) of their eligible patients, visits, procedures, or episodes for a given measure. Acceptable validation strategies often include such provisions as the registry being able to conduct random sampling of their participant's data, but may also be based on other credible means of verifying the accuracy of data content and completeness of reporting or adherence to a required sampling method;
- Perform the validation outlined in the strategy and send the results to CMS by June 30, 2012 for the 2011 reporting year's data;
- Enter into and maintain with its participating professionals an appropriate Business Associate agreement that provides for the registry's receipt of patient-specific data from the eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the Physician Quality Reporting System program;

- Obtain and keep on file signed documentation that each holder of an NPI whose data are submitted to the registry has authorized the registry to submit quality measures and numerator and denominator data to CMS for the purpose of Physician Quality Reporting System participation. This documentation must be obtained at the time the eligible professional signs up with the registry to submit Physician Quality Reporting System quality measures data to the registry and must meet any applicable laws, regulations, and contractual business associate agreements;

- Provide CMS access (if requested for validation purposes) to review the Medicare beneficiary data on which 2011 Physician Quality Reporting System registry-based submissions are founded or provide to CMS a copy of the actual data (if requested);

- Provide the reporting option (reporting period and reporting criteria) that the eligible professional has satisfied or chosen; and

- Provide CMS a signed, written attestation statement via mail or e-mail which states that the quality measure results and any and all data including numerator and denominator data provided to CMS are accurate and complete.

For registries that intend to report on 2011 Physician Quality Reporting System measures groups, we proposed that both registries new to the Physician Quality Reporting System and those previously qualified must:

- Indicate the reporting period chosen for each eligible professional who chooses to submit data on measures groups;

- Base reported information on measures groups only on patients to whom services were furnished during the 12-month reporting period of January through

December 2011 or the 6-month reporting period of July 1, 2011 through December 31, 2011;

- Agree that the registry's data may be inspected or a copy requested by CMS and provided to CMS under our oversight authority;

- Be able to report data on all applicable measures in a given measures group on either 30 or more Medicare Part B FFS patients from January 1, 2011 through December 31, 2011, or on 80 percent of applicable Medicare Part B FFS patients for each eligible professional (with a minimum of 15 patients during the January 1, 2011, through December 31, 2011, reporting period or a minimum of 8 patients during the July 1, 2011, through December 31, 2011, reporting period).

Although these proposed qualification requirements for 2011 registries are similar to those in previous years, we noted that registries would no longer be permitted to include non-Medicare patients for measures group reporting. Additionally, in an effort to reduce the variation in measures results across registries and better allow eligible professional comparisons, we also proposed that all current and future registries would have to meet the following new requirements:

- Use Physician Quality Reporting System measure specifications and the CMS provided measure calculation algorithm, or logic, to calculate reporting rates or performance rates unless otherwise stated. CMS will provide registries a standard set of logic to calculate each measure and/or measures group they intend to report in 2011.

- Provide a calculated result using the CMS supplied measure calculation logic and XML file for each measure that the registry intends to calculate. The registries will be required to show that they can calculate the proper measure results (that is, reporting

and performance rates) using the CMS-supplied logic and send the calculated data back to CMS in the specified format.

- Provide us the individual data elements used to calculate the measures if so requested by CMS for validation purposes, if aggregated data submission is still the selected method of data collection. Registries that are subject to validation will be asked to send discrete data elements for a measure (determined by CMS) in the required data format for us to recalculate the registries' reported results. Validation will be conducted for several measures at a randomly selected sample of registries in order to validate their data submissions.

We also invited comments on an alternative considered in which registries would be required to send CMS beneficiary-level data provided to the registry by the eligible professional and CMS would use the data to calculate the eligible professional's measure results (that is, reporting and performance rates).

The following is a summary of the comments we received regarding the proposed qualification requirements and self-nomination process for registries for the 2011 Physician Quality Reporting System.

Comment: One commenter supported the CMS proposal to limit registries based on size and sophistication. The intent of allowing registry reporting was to allow physicians to benefit from an infrastructure that could enable real time reporting and comparison with other groups. A registry from a single physician practice does not meet the intent of why registry reporting was allowed and should not be allowed for registry reporting.

Response: We believe that the costs (time and money) associated with creating and testing a registry for Physician Quality Reporting System qualification are not insignificant. This and the increased potential for individual practices to "game" Physician Quality Reporting System has influenced our decision to require registries to report on larger numbers of eligible professionals or be third party vendors.

Comment: One commenter indicated that it is not clear if reporting needs to be at both the TIN and NPI level or the TIN or NPI level and recommended that all quality reporting be required to include NPI information and feedback at that level.

Response: Reporting from registries is to be submitted at the individual TIN/NPI level. Feedback is available at the individual NPI level as well as a TIN's rolled-up NPI report, that is, all NPIs under a particular TIN. For reporting 2011 measures groups via a registry, we will no longer accept data from non-Medicare beneficiaries. This will allow a better comparison of registry-submitted data and measure calculations to ensure accurate reporting and meaningful feedback reports to eligible professionals.

Comment: Some commenters supported the proposal that registries would no longer use their own measure calculation logic or measure flows to calculate measure results but instead use a CMS-specified standard set of logic for calculating measures. Some commenters supported the proposal based on the fact that registry data results have been inconsistent in the past, and the results do not yield reliable information for eligible professionals to analyze their performance results for practice improvement.

Response: We agree with the commenter and plan to provide registries with a calculation flow diagram for each measure they intend to report and also provide the registry with a use case. As part of their qualification process, registries will need to

calculate the measure reporting and performance rates and send this information to CMS or our contractor in the specified XML format.

Comment: One commenter, while supporting the use of a CMS-specified measure calculation logic, suggested that at least three months be provided to account for the development time necessary to convert measures to use CMS's algorithms. The actual development effort for a registry, however, would be proportionate to the quantity of measures supported by a registry.

Response: We respect and appreciate the time requirements of registries as they attempt qualification. We try to balance the needs of the registries with the importance of letting eligible professionals know which registries are qualified so they can begin selecting and reporting to their registry of choice.

Comment: Another commenter who supported the use of a CMS-specified measure calculation logic, suggested that we make the logic public prior to implementation in order to determine the best logic and calculations for measure results.

Response: We do not believe that public input for measure logic calculation beyond what is already allowed for measure development and endorsement is prudent. We attempt to use the measures as the developer intended and only make changes when necessary for implementation purposes or as required by Medicare policy.

Comment: Some commenters opposed the proposal for registries to use a CMS-specified logic to calculate measures results. One commenter stated they do not believe requiring registries to use a CMS-specified measure calculation logic will lessen the observed variation in measure results. The commenter believes the rate calculation from the numerator and denominator data involves simple arithmetic and is unlikely to be

the cause of the observed variation. The more likely cause is a variation in how the data is collected or defined within the system. Another commenter was concerned that a CMS-developed logic might not accurately calculate measure reporting or performance rates in all instances for all eligible professionals since it will likely be based on claims and may not be appropriate to examine the data that is submitted to registries.

Response: We appreciate these comments and agree that a CMS-specified logic may not eliminate all of the data variations or inconsistencies but believe providing a specific logic calculation will help reduce these data differences.

Comment: One commenter believes that registries should have reasonable latitude in interpreting the measure flows or logic provided by us to account for variability in the ways that data are collected by the registries.

Response: While this may seem like a good idea on the surface, this proposal would allow too much data variation and prevent us and outside stakeholders from comparing an eligible professional's performance. This is contrary to our desire to increase standardization in the way registries calculate measure reporting and performance rates.

Comment: A few commenters did not support the alternative approach in which registries would be required to send us discrete data elements and we would calculate the results for eligible professionals.

Response: We do not intend to adopt this method of registry data submission for the 2011 Physician Quality Reporting System.

Comment: One commenter requested that we publish the list of registries and EHR products qualified for purposes of submitting Physician Quality Reporting System data prior to the beginning of the reporting year.

Response: We strive to qualify registries and EHRs in as timely a manner as is possible, however while we do not guarantee successful submission of data by an EHR or a given registry, we want to be as thorough as possible in vetting these systems to increase the likelihood of successful data submission. To date, we have not had any qualified registries who have not successfully reported data to us. We do try to post a partial list of qualified registries (based on successful participation in a prior year) prior to the start of the next reporting period.

Comment: One commenter urged us to include additional information related to the registries such as the physician participants' success rate, the number of participants and the cost.

Response: We agree that providing cost information may be helpful to eligible professionals as they choose a qualified registry. There has been considerable objection by the registries to listing this information on our website as the registries report that comparison of their fees is misleading since some of the registries solely report Physician Quality Reporting System information on behalf of eligible professionals to us while others provide additional information and tools to their participants.

Upon considering the comments received, we are finalizing the 2011 qualification requirements as proposed (75 FR 40173 through 40175), including the new requirements for registries to:

- Use Physician Quality Reporting System measure specifications and a standard set of measure calculation logic provided by CMS to calculate reporting rates or performance rates unless otherwise stated;

- Provide a calculated result using the CMS-supplied logic and XML file for each measure that the registry intends to calculate; and

- Provide us the individual data elements used to calculate the measures if so requested by CMS for validation purposes.

We intend to post the final 2011 Physician Quality Reporting System registry requirements on the Physician Quality Reporting System section of the CMS Web site at http://www.cms.gov/PQRI by November 15, 2010 or shortly thereafter. We anticipate that new registries that wish to self-nominate for 2011 would be required to do so by January 31, 2011.

Similar to the 2010 Physician Quality Reporting System, registries that were "qualified" for 2010 and wish to continue to participate in 2011 will not need to be "re-qualified" for 2011 but instead demonstrate that they can meet the new 2011 data submission requirements. For technical reasons, however, we do not expect to be able to complete this vetting process for the new 2011 data submission requirements until mid-2011. Therefore, we will not be able to post the names of registries that are qualified for the 2011 Physician Quality Reporting System until we have determined the previously qualified registries that wish to be qualified for the 2011 Physician Quality Reporting System are in compliance with the new registry requirements.

Nevertheless, registries "qualified" for 2010, who were successful in submitting 2010 Physician Quality Reporting System data, and wish to continue to participate in

2011 will need to indicate their desire to continue participation for 2011 by submitting a letter to CMS indicating their continued interest in being a Physician Quality Reporting System registry for 2011 and their compliance with the 2011 Physician Quality Reporting System registry requirements by no later than October 31, 2010. Additionally, registries that are unsuccessful submitting 2010 Physician Quality Reporting System data (that is, fail to submit 2010 Physician Quality Reporting System data per the 2010 Physician Quality Reporting System registry requirements) will need to go through a full self-nomination vetting process for 2011.

Similar to the 2010 Physician Quality Reporting System, if a qualified 2010 Physician Quality Reporting System registry fails to submit 2010 Physician Quality Reporting System data per the 2010 Physician Quality Reporting System registry requirements, the registry will be considered unsuccessful at submitting 2010 Physician Quality Reporting System data and will need to go through the full self-nomination process again to participate in the 2011 Physician Quality Reporting System. By March 31, 2011, registries that are unsuccessful at submitting quality measures results and numerator and denominator data for 2010 will need to be able to meet the 2011 Physician Quality Reporting System registry requirements and go through the full vetting process again. This would include CMS receiving the registry's self-nomination by March 31, 2011. As discussed in another section of this final rule with comment period, the aforementioned registry requirements will also apply for the purpose of a registry qualifying to submit the electronic prescribing measure for the 2011 Electronic Prescribing Incentive Program.

(5) Final Qualification Requirements for EHR Vendors and Their Products

The EHR vendor qualification process for the 2011 Physician Quality Reporting System was finalized in the 2010 PFS final rule with comment period (74 FR 61800 through 61802) and is currently underway. We anticipate the 2011 EHR vendor vetting process will be complete in early 2011, at which point those EHR products meeting all of the 2011 vendor requirements will be listed on the Physician Quality Reporting System section of the CMS Web site as a "qualified" Physician Quality Reporting System EHR product.

During 2011, we proposed to use the same self-nomination process described in the "Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2011 Physician Quality Reporting System EHR Testing Program" posted on the Physician Quality Reporting System section of the CMS Web site at http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp#TopOfPage, to qualify additional EHR vendors and their EHR products to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse for the 2012 Physician Quality Reporting System. Specifically, we proposed that the 2011 Physician Quality Reporting System EHR test vendors, who, if their testing is successful, may report 2012 Physician Quality Reporting System data to CMS, must meet the following requirements:

- Be able to collect and transmit all required data elements according to the 2012 EHR Specifications.
- Be able to separate out and report on Medicare Part B FFS patients only.

- Be able to include TIN/NPI information submitted with an eligible professional's quality data.
- Be able to transmit this data in the CMS-approved format.
- Comply with a secure method for data submission.
- Not be in a beta test form.
- Have at least 25 active users.

Additionally, we proposed that previously qualified Physician Quality Reporting System EHR vendors and 2012 EHR test vendors must participate in ongoing Physician Quality Reporting System mandatory support conference calls hosted by CMS (approximately one call per month). These requirements would apply not only for the purpose of a vendor's EHR product being qualified so that the product's users may submit data extracted from the EHR for the 2012 Physician Quality Reporting System in 2013, but also for the purpose of a vendor's EHR product being qualified so that the product's users may electronically submit data extracted from the EHR for the electronic prescribing measure for the 2012 eRx Incentive Program in 2013. We proposed that if a vendor misses more than one mandatory support call or meeting, the vendor and their product would be disqualified for the Physician Quality Reporting System reporting year, which is covered by the call.

We proposed that previously qualified vendors and new vendors will need to incorporate any new EHR measures (that is, electronically-specified measures) added to the Physician Quality Reporting System for the reporting year they wish to maintain their Physician Quality Reporting System qualification, as well as update their electronic measure specifications and data transmission schema should either or both change.

The following is a summary of the comments received regarding the proposed 2012 EHR vendor qualification requirements and/or process.

Comment: We received a comment disagreeing that an EHR should be required to support all new measures. The commenter noted that an EHR might not collect all the necessary data points for all measures and that this is not required for the EHR Incentive Program.

Response: While the commenter makes a valid point, selecting an appropriate EHR can be challenging for eligible professionals. As such, we are requiring qualified EHRs to be able to report all Physician Quality Reporting System measures with electronic specifications. We believe that this will lessen the burden on eligible professionals in deciding which system to purchase. That is, either the EHR is qualified for the Physician Quality Reporting System (completely) or not at all.

Upon consideration of these comments, we are finalizing the 2012 EHR vendor qualification requirements that will be used to vet EHR vendors in 2011 for 2012 Physician Quality Reporting System data submission in 2013 as proposed in the CY 2011 PFS proposed rule (75 FR 40175 through 40176). Any EHR vendor interested in having one or more of their EHR products "qualified" to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse for the 2012 Physician Quality Reporting System will be required to submit their self-nomination letter by January 31, 2011. Instructions for submitting the self-nomination letter will be provided in the 2012 EHR vendor requirements, which we expect to post in the 4th quarter of CY 2010. Specifically, for the 2012 Physician Quality Reporting System, only EHR vendors

that self-nominate to participate in the 2012 EHR Test Program will be considered qualified EHR vendors for the 2012 Physician Quality Reporting System.

e. Criteria for Satisfactory Reporting of Individual Quality Measures for Individual Eligible Professionals

Section 1848(m)(3)(A) of the Act established the criteria for satisfactorily submitting data on individual quality measures as at least 3 measures in at least 80 percent of the cases in which the measure is applicable. If fewer than 3 measures are applicable to the services of the professional, the professional may meet the criteria by submitting data on 1 or 2 measures for at least 80 percent of applicable cases where the measures are reportable. For years after 2009, section 1848(m)(3)(D) of the Act provides additional authority to the Secretary, in consultation with stakeholders and experts, to revise the criteria for satisfactorily reporting data on quality measures. Based on this authority and the input we have previously received from stakeholders, we proposed (75 FR 40176), for 2011, the following 2 criteria for claims-based reporting of individual measures by individual eligible professionals:

- Report on at least 3 measures that apply to the services furnished by the professional; and
- Report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

To the extent that an eligible professional has fewer than 3 Physician Quality Reporting System measures that apply to the eligible professional's services, we proposed

the eligible professional would be able to meet the criteria for satisfactorily reporting data on individual quality measures by meeting the following 2 criteria:

- Report on all measures that apply to the services furnished by the professional (that is 1 to 2 measures); and
- Report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

We also proposed for 2011 the requirement that an eligible professional who reports on fewer than 3 measures through the claims-based reporting mechanism may be subject to the Measure Applicability Validation (MAV) process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures. This process was applied in prior years. Under the proposed MAV process, when an eligible professional reports on fewer than 3 measures, we propose to review whether there are other closely related measures (such as those that share a common diagnosis or those that are representative of services typically provided by a particular type of eligible professional). We further proposed that if an eligible professional who reports on fewer than 3 measures in 2011 reports on a measure that is part of an identified cluster of closely related measures and did not report on any other measure that is part of that identified cluster of closely related measures, then the eligible professional would not qualify as a satisfactory reporter in the 2011 Physician Quality Reporting System or earn an incentive payment. In 2011, we proposed that these criteria for satisfactorily reporting data on fewer than 3 individual quality measures would apply for the claims-based reporting mechanism only.

For the 2011 Physician Quality Reporting System, we proposed the following 2 criteria for satisfactory reporting of data on individual Physician Quality Reporting System quality measures for registry-based and EHR-based reporting:

- Report on at least 3 measures that apply to the services furnished by the professional; and
- Report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

We also proposed, in 2011, not to count measures that are reported through a registry or EHR that have a zero percent performance rate. That is, if the recommended clinical quality action is not performed on at least 1 patient for a particular measure or measures group reported by the eligible professional via a registry or EHR, we will not count the measure (or measures groups) as a measure (or measures group) reported by an eligible professional. We proposed to disregard measures (or measures groups) that are reported through a registry or EHR that have a zero percent performance rate in the 2011 Physician Quality Reporting System because we are assuming that the measure was not applicable to the eligible professional and was likely reported from EHR-derived data (or from data mining) and was unintentionally submitted from the registry or EHR to CMS. We also seek to avoid the possibility of intentional submission of spurious data solely for the purpose of receiving an incentive payment for reporting.

The following is a summary of the comments received regarding the criteria for satisfactory reporting of individual quality measures for individual eligible professionals.

Comment: We received several comments in support of the proposal to decrease the reporting sample from 80 percent to 50 percent of applicable cases where the measures are reportable as this would encourage greater Physician Quality Reporting System participation. One commenter expressed support for the lower percentage due to the errors and complexity seen to date with claims-based reporting in the Physician Quality Reporting System. Other commenters noted that a less restrictive requirement is a step forward in decreasing the costs and burdens associated with Physician Quality Reporting System participation.

Response: We appreciate the commenters' positive feedback. In lowering the reporting threshold for claims-based reporting from 80 percent to 50 percent, we are, as indicated by a commenter, acknowledging the complexity of claims-based reporting. As stated in the CY 2011 PFS proposed rule (75 FR 40176), a major reason that eligible professionals who participate in the Physician Quality Reporting System via claims-based reporting fail to do so satisfactorily is that they fail to report at the required 80 percent. As shown in the quarterly QDC Error Reports that we post on the CMS Physician Quality Reporting System website at http:www.cms.gov/PQRI , eligible professionals often do not report QDCs on claims that are eligible for inclusion in a measure's denominator or report QDCs on claims that are not eligible for inclusion in a measure's denominator. When an eligible professional fails to report QDCs on eligible cases, it negatively impacts their reporting rate for that measure or measures group. When an eligible professional reports QDCs on ineligible cases, it neither improves nor negatively impacts their reporting rate for that measure or measures group. Thus, while lowering the reporting threshold may decrease the number of cases on which an eligible professional is

required to report, it is still crucial that eligible professionals carefully review and understand the measure specifications for each measure or measures group they intend to report in order to be able to properly identify eligible cases.

Comment: A few commenters supportive of the proposal to reduce the reporting sample requirement from 80 percent to 50 percent recommended we also use our existing authority to apply the new 50 percent threshold retrospectively to the 2010 Physician Quality Reporting System.

Response: We finalized the 2010 Physician Quality Reporting System criteria for satisfactory reporting by individual eligible professionals in the CY 2010 PFS final rule with comment (74 FR 61802 through 61807). Therefore, we are not applying the 50 percent threshold retrospectively to the 2010 Physician Quality Reporting System. Any eligible professional who would have participated in the 2010 Physician Quality Reporting System had they known that we were lowering the reporting threshold for claims-based reporting to 50 percent would be disadvantaged. Such eligible professionals are not likely to be able to start participating in the 2010 Physician Quality Reporting System and meet the 2010 criteria for satisfactory reporting in the time between publication of this final rule with comment period and December 31, 2010.

Comment: A couple of commenters requested that the threshold for registry-based and EHR-based reporting also be reduced to 50 percent in order to facilitate overall participation via an EHR or registry.

Response: As we stated in the CY 2011 PFS proposed rule (75 FR 40177), we do not believe that reducing the reporting sample to 50 percent for registry-based reporting and EHR-based reporting would substantially impact the portion of participating eligible

professionals who qualify for the Physician Quality Reporting System incentive. Over 90 percent of eligible professionals submitting data through registries were incentive eligible. The level of effort for EHR-reporting should be the same regardless of whether the reporting threshold is 50 percent, 80 percent, or 100 percent since the EHR could theoretically be programmed to submit data on all eligible cases to CMS.

Comment: A few commenters opposed the proposal to weaken the standard for claims-based reporting from 80 percent to 50 percent. The commenters stated it was unclear why we would suggest that we want to move toward more meaningful reporting mechanisms such as registries and EHRs, while at the same time lowering the bar for claims-based reporting. Another commenter suggested that we strengthen the reporting requirements.

Response: In light of the Physician Quality Reporting System payment adjustments that are required by section 1848(a)(8) of the Act beginning in 2015 for eligible professionals who do not satisfactorily report and the fact that claims-based reporting still remains the only reporting mechanism that is available to all eligible professionals, we believe that it is important to take steps to facilitate Physician Quality Reporting System reporting where feasible. As we have seen from Physician Quality Reporting System results from prior years, meeting the 80 percent reporting threshold for claims-based reporting is challenging because of the multiple billing codes as specified by the measure developer, that can place patients in the denominator of a measure combined with the inability to resubmit claims solely for the purpose of adding a QDC. Thus far, we have not experienced the same issues with other reporting mechanisms. As we stated in the CY 2011 PFS proposed rule (75 FR 40176), we believe that lowering the

reporting threshold for claims-based reporting will encourage greater participation in the Physician Quality Reporting System without increasing the likelihood that professionals will selectively report based on whether the performance expectation of a measure is met for that particular patient. Once a substantial proportion of eligible professionals begin participating in the Physician Quality Reporting System, we envision that we will gradually strengthen the reporting requirements.

Comment: A few commenters recommended we remove the restriction on registry reporting for those eligible professionals that cannot report 3 measures, especially given that our results show that those who report via a registry are roughly twice as successful as those who report via claims.

Response: We have received similar comments to this effect in the past. We continue to maintain that permitting an eligible professional to report fewer than 3 measures through the registry-based reporting mechanism (if fewer than 3 measures apply to him or her) would be inefficient. It would be analytically difficult in that if an eligible professional submits fewer than 3 measures via registries, we would not know whether the eligible professional did so because only 2 measures applied to him or her or because the registry only accepts data for 2 of the professional's measures and he or she is reporting the third measure via claims. We also look for the most favorable method of reporting (that is, did the eligible professional report via a different method for a longer reporting period as well as whether an eligible professional satisfactorily reported under a different reporting option if he or she did not satisfactorily report for a particular reporting period. Accepting fewer than 3 measures from registries would increase the

amount of cross-checking already required, which would impact the timeline for paying incentives.

Comment: Some commenters recommended we change the reporting requirements for individual eligible professionals with respect to increasing the number of required measures and/or requiring reporting on a standard cluster of measures. One commenter recommended that we create a standard risk-adjusted list of Physician Quality Reporting System quality measures for all eligible professionals that we would update annually. Similarly, another commenter suggested that we assign a core set of measures that applies across eligible professions. The commenter also suggested that we assign sets of measures for individual and small group practice participants for high-volume conditions, based on services provided to their patient population. Additional recommendations for strengthening the reporting requirements include, requiring eligible professionals to stratify measures by patient race, ethnicity, preferred language and gender, constructing composites for the current measures groups, using a reliability threshold of 0.70 in lieu of, or in conjunction with, a minimum sample size, increasing the sample size for larger group practices, and maintaining the reporting threshold of 80 percent for claims-based reporting.

Response: We appreciate the constructive feedback and agree with the potential benefit of core measures, moving to more sets or groups of measures, and being more specific as to which measures eligible professionals should report in order to achieve more consistency of reporting across eligible professionals in the future

After consideration of the comments and for the reasons we previously explained, the final 2011 criteria for satisfactory reporting of data on individual Physician Quality

Reporting System quality measures for individual eligible professionals are summarized in Table 73 and are arranged by reporting mechanism and reporting period.

TABLE 73: 2011 Criteria for Satisfactory Reporting of Data on Individual Physician Quality Reporting System Quality Measures, by Reporting Mechanism and Reporting Period

Reporting Mechanism	Reporting Criteria	Reporting Period
Claims-based reporting	• Report at least 3 PQRI measures, or 1-2 measures if less than 3 measures apply to the eligible professional; and • Report each measure for at least 50% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1, 2011 – December 31, 2011
Claims-based reporting	• Report at least 3 PQRI measures, or 1-2 measures if less than 3 measures apply to the eligible professional; and • Report each measure for at least 50% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	July 1, 2011 – December 31, 2011
Registry-based reporting	• Report at least 3 PQRI measures (measures with a 0% performance rate will not be counted); and • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1,2011 – December 31, 2011
Registry-based reporting	• Report at least 3 PQRI measures (measures with a 0% performance rate will not be counted); and • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	July 1, 2011 – December 31, 2011
EHR-based reporting	• Report at least 3 PQRI measures (measures with a 0% performance rate will not be counted); and • Report each measure for at least 80 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1, 2011 – December 31, 2011

For the 2011 Physician Quality Reporting System, we are finalizing a total of 5 reporting options, or ways, in which an eligible professional may meet the criteria for

satisfactory reporting on individual measures. Each reporting option consists of the criteria for satisfactory reporting such data and results on individual quality measures relevant to a given reporting mechanism and reporting period. Eligible professionals must meet the requirements for at least 1 of these 5 reporting options using a single reporting mechanism in order to qualify for a 2011 Physician Quality Reporting System incentive for satisfactorily reporting individual measures. CMS will not combine data received via different reporting mechanisms to determine whether the reporting criteria are met. It is possible, however, for eligible professionals to potentially qualify as satisfactorily reporting individual quality measures under more than one of the reporting criteria, reporting mechanisms, and/or for more than one reporting period. In this case, only one incentive payment will be made to an eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports.

f. Criteria for Satisfactory Reporting Measures Groups for Individual Eligible Professionals

For the 2011 Physician Quality Reporting System, we proposed that individual eligible professionals have the option to report measures groups instead of individual quality measures to qualify for the 2011 Physician Quality Reporting System incentive, using claims or registries. The criteria that we proposed for 2011 for satisfactory reporting of measures groups through claims-based or registry-based reporting for either the 12-month or 6-month reporting period are as follows: (1) for claims-based reporting, the reporting of at least 1 measures group for at least 50 percent of patients to whom the measures group applies, during the reporting period; or (2) for registry-based reporting, the reporting of at least 1 measures group for at least 80 percent of patients to whom the

measures group applies during the reporting period. Eligible professionals, for both claims-based and registry-based reporting under these criteria, would be required to submit data on a minimum of 15 unique Medicare Part B FFS patients for the 12-month reporting period and a minimum of 8 Medicare Part B FFS patients for the 6-month reporting period.

Additionally for 2011, we proposed to retain the criteria, available only for the 12-month reporting period, based on reporting on at least 1 measures group for at least 30 unique patients for whom services were furnished between January 1, 2011, and December 31, 2011, to whom the measures group applies. As in previous years, we proposed that for 2011, the patients, for claims-based reporting, would be limited to Medicare Part B FFS patients. Finally, for registry-based reporting in 2011, in contrast to prior program years, we proposed to require that the minimum patient numbers or percentages must be met by Medicare Part B FFS patients exclusively and not non-Medicare Part B FFS patients.

The following is a summary of the comments received regarding the proposed criteria for reporting measures groups for individual eligible professionals.

Comment: One commenter strongly supported the proposed Physician Quality Reporting System measures group reporting option for claims-based and registry reporting, especially the change in the reporting threshold for claims-based reporting from 80 percent to 50 percent .

Response: We appreciate the commenter's positive feedback.

Comment: A few commenters supported the proposal that for registry reporting of measures groups for 2011 that the minimum patient numbers or percentages must be

met by Medicare Part B FFS patients exclusively and exclude data on non-Medicare Part B FFS patients. It is thought that this will reduce the difficulty of analyzing the data we received from registries where patients other than Medicare Part B FFS patients are included. Another commenter was concerned that this change eliminates any benefit that eligible professionals had for using the registry more broadly than just for Medicare patients. The commenter also noted that registries are most useful for improved patient care when all patients in the practice with a particular condition are included in the system.

Response: We appreciate the supportive comment. We believe that limiting the reporting sample for registry-based reporting of measures groups to Medicare Part B FFS patients will facilitate validation of registry-submitted data against the Medicare claims data.

Comment: One commenter supported our proposal to eliminate the requirement for reporting on consecutive patients for registry-based reporting of measures groups.

Response: We appreciate the commenter's support. We assume that the commenter is referring to a requirement in the 2008 and 2009 Physician Quality Reporting System where eligible professionals were required to report on patients seen consecutively by date of service. We note that we removed the requirement for reporting on consecutive patients for registry-based reporting of measures groups for the 2010 Physician Quality Reporting System. We did not propose nor are we requiring eligible professionals to report on consecutive patients when reporting measures groups for the 2011 Physician Quality Reporting System.

Based on the comments, the final 2011 criteria for satisfactory reporting of data on measures groups are summarized in Table 74 and are arranged by reporting mechanism and reporting period.

TABLE 74: 2011 Criteria for Satisfactory Reporting on Measures Groups, by Reporting Mechanism and Reporting Period

Reporting Mechanism	Reporting Criteria	Reporting Period
Claims-based reporting	• Report at least 1 PQRI measures group ; • Report each measures group for at least 30 Medicare Part B FFS patients.	January 1, 2011– December 31, 2011
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 50 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2011 – December 31,2011
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 50 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	July 1, 2011– December 31, 2011
Registry-based reporting	• Report at least 1 PQRI measures group (measures groups with a 0% performance rate will not be counted); • Report each measures group for at least 30 Medicare Part B FFS patients.	January 1, 2011 – December 31, 2011
Registry-based reporting	• Report at least 1 PQRI measures group (measures groups with a 0% performance rate will not be counted); • Report each measures group for at least 80 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2011 – December 31, 2011

Reporting Mechanism	Reporting Criteria	Reporting Period
Registry-based reporting	• Report at least 1 PQRI measures group (measures groups with a 0% performance rate will not be counted); • Report each measures group for at least 80 % of the EP's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	July 1, 2011 – December 31, 2011

As illustrated in Table 74, there are a total of 6 reporting options, or ways in which eligible professionals may meet the criteria for satisfactory reporting of measures groups for the 2011 Physician Quality Reporting System. As we stated previously, eligible professionals may potentially qualify as satisfactorily reporting for the 2011 Physician Quality Reporting System on measures groups under more than one of the reporting criteria, reporting mechanisms, and/or for more than one reporting period; however, only one incentive payment will be made to an eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports. In addition, although an eligible professional could submit data under multiple reporting mechanisms, CMS will not combine data received from different reporting mechanisms to determine whether the eligible professional satisfactorily reported. Similarly, an eligible professional could also potentially qualify for the Physician Quality Reporting System incentive payment by satisfactorily reporting both individual measures and measures groups. However, only one incentive payment will be made to the eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports.

g. Reporting Option for Satisfactory Reporting on Quality Measures by Group Practices

(1) Background and Authority

Section 1848(m)(3)(C)(i) of the Act required the Secretary to establish and have in place a process by January 1, 2010 under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under the Physician Quality Reporting System if, in lieu of reporting measures under the Physician Quality Reporting System, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary. Section 1848(m)(3)(C)(ii) of the Act requires that this process provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Medicare Physician Group Practice (PGP) demonstration project under section 1866A of the Act. A group practice reporting option (GPRO) was established for the 2010 Physician Quality Reporting System in the CY 2010 PFS final rule with comment period (74 FR 61807 through 61811).

For the 2011 Physician Quality Reporting System, we proposed to continue to allow a group practice, as a whole (that is, for the TIN(s)), to participate in the 2011 Physician Quality Reporting System and to submit Physician Quality Reporting System quality measures for 2011 and qualify to earn an incentive (75 FR 40178-40183). If, however, an individual eligible professional is affiliated with a group practice participating in the GPRO and the group practice satisfactorily reports under the GPRO, the eligible professional will be considered as satisfactorily reporting Physician Quality

Reporting System quality measures data at the individual level under that same TIN (that is, for the same TIN/NPI combination).

(2) Definition of "Group Practice"

As stated previously, section 1848(m)(3)(C)(i) of the Act authorized the Secretary to define "group practice." For purposes of determining whether a group practice satisfactorily submits Physician Quality Reporting System quality measures data, we proposed that for the 2011 Physician Quality Reporting System a "group practice" would consist of a physician group practice, as defined by a TIN, with 2 or more individual eligible professionals (or, as identified by NPIs) who have reassigned their billing rights to the TIN. This proposed definition for group practice is different from the 2010 Physician Quality Reporting System definition of group practice in that we proposed to change the minimum group size from 200 to 2 to enable more group practices to participate in the Physician Quality Reporting System GPRO in 2011.

As our intent is to build on an existing quality reporting program with which group practices may already be familiar, we proposed to be consistent with the PGP demonstration and use one GPRO process, which we refer to as "GPRO I" that would be available only to similar large group practices. For group practices that have fewer than 200 members, we proposed, if technically feasible, an alternative GPRO process which we refer to as "GPRO II".

In order to participate in the 2011 Physician Quality Reporting System through the GPRO, we proposed to require group practices to complete a self-nomination process and to meet certain technical and other requirements. For 2011, we proposed that group practices must participate in the Physician Quality Reporting System group practice

reporting option in order to be eligible to participate in the eRx group practice reporting option for the 2011 Physician Quality Reporting System. As this is the current requirement under the 2010 Physician Quality Reporting System and eRx Incentive Program, we proposed that a group practice wishing to participate in both the Physician Quality Reporting System group practice reporting option and the electronic prescribing group practice reporting option must notify CMS of its desire to do so at the time that it self-nominates to participate in the Physician Quality Reporting System group practice reporting option.

In addition, we proposed that group practices that are participating in Medicare demonstration projects, as approved by the Secretary, would also be considered group practices for purposes of the 2011 Physician Quality Reporting System GPRO. Specifically, for the 2011 Physician Quality Reporting System we proposed to deem group practices participating in the PGP, Medicare Care Management Performance (MCMP), and EHR demonstrations to be participating in the Physician Quality Reporting System GPRO since many of the measures being reported under these demonstration programs are similar to Physician Quality Reporting System measures. As a result, such practices do not need to separately self-nominate to participate in the Physician Quality Reporting System GPRO, although it would be necessary for such groups to meet the requirements for incentive qualification under their respective approved demonstration project. For example, the MCMP demonstration sites would be required to meet the requirements for earning a Physician Quality Reporting System incentive specified under the MCMP demonstration.

For purposes of the 2011 eRx Incentive Program, however, we proposed that

group practices participating in CMS-approved demonstration projects previously discussed would be required to meet the proposed 2011 eRx Incentive Program GPRO requirements or the proposed 2011 eRx Incentive Program requirements for individual eligible professionals in order to qualify for a 2011 eRx incentive. Such group practices would not be able to qualify for a 2011 eRx incentive via participation in an approved demonstration project since there is no eRx requirement under these demonstrations.

We also sought comment on alternatives for expanding GPRO in 2011. One option that we considered was to expand GPRO I to include smaller group practices. Specifically, we considered allowing groups of 100 or more eligible professionals to participate in the Physician Quality Reporting System under GPRO using the same reporting mechanism and reporting criteria required under the 2010 Physician Quality Reporting System GPRO and proposed for the 2011 Physician Quality Reporting System GPRO I. We also considered modifying the definition of "group practice" to include groups that have and use multiple TINs.

The following is a summary of the comments received regarding the proposed definition of "group practice" and the alternatives that were considered.

Comment: Several commenters expressed support for the proposed 2011 definition of a group practice as 2 or more individual eligible professionals who have reassigned their billing rights to the appropriate TIN, as opposed to a group practice with 200 or more individual eligible professionals as was the case in 2010. Commenters believed that this will greatly expand the opportunities for participation in the group practice reporting option and aligns with the current environment.

Response: We agree that our proposed definition of "group practice" will expand opportunities to participate in the group practice reporting option. To allow for expanded use of the group practice reporting option, we are finalizing our proposal to define "group practice" as 2 or more individual eligible professionals. However, as noted in the discussed that follows, we are modifying the definition of "group practice" with respect to group practices participating in Medicare demonstration projects approved by the Secretary." Rather than including such group practices in the definition of "group practice" at §414.90(b), we are indicating that such practices are deemed to be participating in the Physician Quality Reporting System at §414.90(g)(1).

Comment: One commenter believes that the GPRO requirement that physicians reassign their billing rights to the taxpayer identification number (TIN) could be problematic for some practices where individual physicians continue billing Medicare on their behalf rather than reassigning to the group practice. Yet, these practices still function as a group and use the same data systems. It was recommended that we reconsider the reassignment requirement, as well as continue to add more specialty-specific measures groups in an effort to make the GPRO a more viable and attractive option.

Response: We understand that there are various scenarios that may occur that would result in an individual eligible professional not reassigning his or her billing rights to a group TIN as required for inclusion in the GPRO I group. However, Physician Quality Reporting System GPRO I patient assignment, sample selection and incentive calculations are based at the TIN/NPI level. We believe it would be burdensome on the GPRO as well as the individual eligible professionals to track all individual NPIs who

may practice periodically with their group while accounting for the instances when the NPI is not providing services to beneficiaries assigned to the group.

Comment: One commenter requested that we expand the definition of "group practice" to include non-physician providers.

Response: We are finalizing our proposal to define "group practice" as a single TIN with 2 or more eligible professionals, as identified by their individual NPI, who have reassigned their billing rights to the TIN, but as noted in the following discussion, we are modifying our definition with respect to group practices participating in Medicare demonstration projects approved by the Secretary. Therefore, although the term "physician group" may sometimes be used when referring to group practices, it is not intended to infer that group practices are only physicians.

Comment: A couple of commenters commended us for taking positive steps to reduce the reporting burden for eligible professionals. The commenters were specifically referring to our proposal to deem group practices participating in the PGP, MCMP, and EHR demonstrations to be participating in the Physician Quality Reporting System such that all eligible professionals participating in these demonstrations automatically will receive Physician Quality Reporting System bonus payments. The commenters requested that we extend this same waiver to all types of providers who participate in demonstrations. One commenter noted that the majority of participants in the PGP demonstration are hospitals and, like the Physician Quality Reporting System program, many of the measures that hospitals report to the RHQDAPU program overlap with the measures required for participation in the demonstration.

Response: We agree with trying to lessen the burden on eligible professionals who are participating in demonstrations when practical and feasible. We specifically focused on these three demonstrations because their participants are required to report on measures that are very similar to the Physician Quality Reporting System GPRO I measures and to do so using a process very similar to the Physician Quality Reporting System GPRO I process for their demonstrations. At this time, we are not aware of other demonstrations that require the same measures and reporting processes. Therefore, we are not granting waivers with regard to the group practice reporting option to providers who are participating in demonstrations other than the PGP, MCMP, and EHR demonstrations. In addition, this waiver does not apply to any quality reporting program other than the Physician Quality Reporting System. We also further note that demonstration participants will not automatically receive Physician Quality Reporting System incentive payments. Rather, they must meet the requirements for Physician Quality Reporting System incentive qualification under their respective approved demonstration project.

Comment: One commenter noted that practices participating in either the MCMP or EHR demonstrations could consist of solo practitioner practices. In addition, practices participating in the PGP, MCMP, or EHR demonstrations could consist of multiple TINs. The commenter requested clarification on whether such practices would still be considered a "group practice" for purposes of the Physician Quality Reporting System GPRO.

Response: Our intent, in proposing to include practices that are participating in these demonstrations in the definition of "group practice" was to reduce the burden on

eligible professionals who are already reporting using a process similar to the Physician Quality Reporting System GPRO I method and on similar measures, regardless of the composition of the actual group. Therefore, we are modifying the definition of "group practice" with respect to group practices participating in Medicare demonstration projects approved by the Secretary." Rather than including such group practices in the definition of "group practice" at §414.90(b), we are indicating that such practices are deemed to be participating in the Physician Quality Reporting System at §414.90(g)(1). In addition, we are clarifying at §414.90(g)(1) that such practices are "group practices of any size (including solo practitioners) or comprised of multiple TINs participating in a Medicare demonstration project approved by the Secretary."

Based on these comments, we are finalizing the proposed definition of "group practice" with the changes discussed previously for purposes of the 2011 Physician Quality Reporting System group practice reporting option. We recognize that a group's size can fluctuate throughout the year as professionals move from practice to practice. Therefore, a group practice's size, for purposes of determining which reporting criteria the group must satisfy, will be the size of the group at the time the group's participation in one of the 2011 GPRO options is approved by CMS.

We also recognize that, for various reasons, there potentially could be a discrepancy between the number of eligible professionals (that is, NPIs) submitted by the practice during the self-nomination process and the number of eligible professionals billing Medicare under the practice's TIN. Therefore, if we find more NPIs in the Medicare claims than the number of NPIs submitted by the practice during the self-nomination process and this would result in the practice being subject to different

criteria for satisfactory reporting, then we will notify the practice of this finding as part of the self-nomination process. At this point, the practice will have the option of either agreeing to being subject to the different criteria for satisfactory reporting, justifying why they should not be subject to the different criteria for satisfactory reporting, or opting out of participation in the Physician Quality Reporting System as a group practice. For example, if we determine that a group practice that self-nominates for GPRO II has more than 199 eligible professionals billing Medicare under the practice's TIN, the practice would have the option of agreeing to participate in the Physician Quality Reporting System under GPRO I, explaining why the practice actually has fewer than 200 eligible professionals (for example, some of the eligible professionals who billed Medicare have since retired), or opting out of participation in the Physician Quality Reporting System GPRO for 2011. If a group practice that self-nominates for GPRO I has fewer than 200 NPIs billing Medicare under the practice's TIN, then we will give the practice the opportunity to participate in GPRO II.

(3) Process for Physician Group Practices to Participate as Group Practices and Criteria for Satisfactory Reporting

(A) Group Practice Reporting Option for Physician Group Practices with 200 or More NPIs-GPRO I

As stated previously, we proposed that group practices interested in participating in GPRO I must self-nominate to do so. For group practices selected to participate in the Physician Quality Reporting System GPRO I for 2011, we proposed to retain the existing 12-month reporting period beginning January 1, 2011. We proposed that group practices participating in GPRO I submit information on a proposed common set of

26 NQF-endorsed quality measures using a data collection tool based on the GPRO Tool used in the 2010 Physician Quality Reporting System GPRO by 36 participating group practices to report quality measures under the Physician Quality Reporting System. As part of the data submission process for 2011 GPRO I, we proposed that during 2012, each group practice would be required to report quality measures with respect to services furnished during the 2011 reporting period (that is, January 1, 2011, through December 31, 2011) on an assigned sample of Medicare beneficiaries.

Once the beneficiary assignment has been made for each group practice, which we anticipate will be done during the fourth quarter of 2011, we proposed to provide each group practice selected to participate in the Physician Quality Reporting System GPRO I with access to a database (that is, a data collection tool) that will include the group's assigned beneficiary samples and the final GPRO I quality measures. We proposed to pre-populate the data collection tool with the assigned beneficiaries' demographic and utilization information based on all of their Medicare claims data. The group practice will be required to populate the remaining data fields necessary for capturing quality measure information on each of the assigned beneficiaries. Identical to the sampling method used in the PGP demonstration, we proposed that the random sample must consist of at least 411 assigned beneficiaries. If the pool of eligible assigned beneficiaries is less than 411, then the group practice must report on 100 percent, or all, of the assigned beneficiaries to satisfactorily participate in the group practice reporting option. For each disease module or preventive care measure, the group practice would be required to report information on the assigned patients in the order in which they appear in the group's sample (that is, consecutively). These proposed reporting criteria are

identical to the reporting criteria used in the PGP demonstration and in the 2010 Physician Quality Reporting System GPRO.

For 2011, we proposed an exclusive reporting mechanism for eligible professionals identified as part of the group practice with respect to the group as identified by the TIN. However, eligible professionals who are part of the group practice, and who separately practice with respect to another TIN to which the eligible professional has reassigned benefits, could separately qualify as individual eligible professionals with respect to the other practice (TIN).

We invited comments on our proposal for 2011 to retain 200 as the number of NPIs for a TIN required for each group practice under the GPRO I. We also invited comment on our proposal to allow those "qualified" for 2010 GPRO to be rolled over for automatic qualification for 2011 GPRO I.

The following is a summary of the comments received regarding the proposed process for physician group practices with 200 or more NPIs (that is, GPRO I).

Comment: A commenter expressed support for continuation of GPRO I.

Response: We appreciate the commenter's support. We are finalizing the GPRO I as proposed. We believe that this process provides an effective means of collecting quality data from large group practices.

Comment: A commenter expressed support for our proposal that 2010 GPRO participants would not need to go through the self-nomination process to participate in 2011.

Response: We appreciate the time and effort taken by the commenter to state support of our proposal to not have 2010 GPRO participants go through self nomination

process for GPRO I participation for 2011. We will not require 2010 GPRO participants to go through the self-nomination process for 2011 but they will need to inform us of their desire to participate in the 2011 GPRO I.

Comment: To encourage group reporting for large practices, and to reduce the risk to individual eligible professionals if the practices do not qualify for an incentive, one commenter requested that we allow the individual eligible professionals within GPRO I to continue reporting through traditional methods. Thus, those participants might be eligible for incentives if the group practice does not satisfactorily submit data.

Response: We considered the feasibility of analyzing Physician Quality Report System data submissions for GPRO I participants at the individual NPI level, but we decided against this option . Analyzing Physician Quality Reporting System data submissions for GPRO I participants at the individual NPI level would require individual eligible professionals who are part of a group practice participating in GPRO I to collect and report quality data in multiple ways, which would be inefficient. In addition, doing so would require additional CMS resources and potentially delay availability of the incentive payments for all participants. Furthermore, we believe that a group practice should have little difficulty in satisfactorily reporting under GPRO I since they will receive feedback prior to submission of the data to CMS.

Comment: We received a few comments on the proposed reporting criteria for GPRO I. One commenter suggested that the GPRO reporting requirements be limited to 411 patients in total, rather than 411 patients per measure, in order to reduce the associated resource burdens to participation. Another commenter was concerned with the considerable resources required to complete the data collection tool for this sample in

such a short time frame. Given the methodology used, the commenter believes a smaller sample size would provide an accurate representation of a group's performance and urges us to reevaluate the sample sizes required.

Response: The sample size for GPRO I is based on research done through the PGP demonstration. Since 2010 is the first year that GPRO was used for the Physician Quality Reporting System, there is insufficient data to warrant changing the sample size at this time. We note, however, that the GPRO I is for group practices with 200 or more eligible professionals. On average, these group practices typically have 20,000 patients assigned to each group practice. Thus, the number of measures and the required sample size is considered to be equitable for practices with this volume of patients and eligible professionals. We will continue to evaluate the number and types of measures and modules for future program years.

Comment: One commenter recommended that group practices with 50 or more eligible professionals be eligible to participate in GPRO I.

Response: The GPRO I is based on the methodology researched through the PGP demonstration project. We would like to further explore the impact of a smaller patient sample size before implementing GPRO I for group practices less than 200 NPI's. We are, however, finalizing a group practice option for groups with less than 200 eligible professionals (GPRO II) that group practices with 2-199 eligible professionals can participate in for 2011. With the implementation of GPRO II for 2011 it would be a potential drain on resources to also implement GPRO I for smaller practice at the same time.

For the reasons discussed previously and after taking into consideration the

comments, we are finalizing the process group practices will be required to use to report data on quality measures for the 2011 as a group practice under GPRO I and the associated criteria for satisfactory reporting of data on quality measures by GPRO I practices, which are summarized in Table 75. Group practices participating in the Physician Quality Reporting System GPRO I as a group practice will be required to report on all of the measures listed in Table 75 of this final rule with comment period. These quality measures are grouped into preventive care measures and four disease modules: heart failure, diabetes, coronary artery disease, and hypertension.

TABLE 75: 2011 Process for Physician Group Practices to Participate as Group Practices and Criteria for Satisfactory Reporting of Data on Quality Measures by Group Practices for GPRO I

Reporting Mechanism	Reporting Criteria	Reporting Period
A pre-populated data collection tool provided by CMS	• Report on all measures included in the data collection tool (26 measures); and • Complete the tool for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.	January 1, 2011 – December 31, 2011

As stated in the CY 2011 PFS proposed rule (75 FR 40179), group practices interested in participating in GPRO I must submit a self-nomination letter accompanied by an electronic file submitted in a format specified by CMS (such as, a Microsoft Excel file) that includes the group practice's TIN(s) and name of the group practice, the name and email address of a single point of contact for handling administrative issues, as well as the name and email address of a single point of contact for technical support purposes. We will validate that the group practice consists of a minimum of 200 NPIs and will supply group practices with this list. The self-nomination letter must also indicate the group practice's compliance with the following requirements:

- Agree to attend and participate in all mandatory GPRO training sessions; and
- Have billed Medicare Part B on or after January 1, 2010 and prior to October 29, 2010.

We are not finalizing our proposal requiring group practices to indicate in their self-nomination letter that they have an active IACS user account. This was a requirement that we proposed to retain from the 2010 Physician Quality Reporting System GPRO self-nomination process. However, since an active IACS user account will not be needed to submit 2010 Physician Quality Reporting System GPRO data to us, we have decided not to require an IACS user account for the 2011 Physician Quality Reporting System GPRO I. Although access to a CMS identity management system will not be required for submitting 2011 PQRI GPRO I data to us, a group practice will need to have access to a CMS identity management system in order to access their 2011 PQRI feedback report.

We intend to post the final 2011 Physician Quality Reporting System GPRO I participation requirements for group practices, including instructions for submitting the self-nomination letter and other requested information, on the Physician Quality Reporting System section of the CMS Web site at http://www.cms.gov/PQRI by November 15, 2010 or shortly thereafter. Group practices that wish to self-nominate for 2011 will be required to do so by January 31, 2011. Upon receipt of the self-nomination letters we will assess whether the participation requirements were met by each self-nominated group practice using 2010 Medicare claims data. We will not preclude a group practice from participating in the GPRO I if we discover, from analysis of the 2010 Medicare claims data, that there are some eligible professionals (identified by NPIs) that are not established Medicare providers (that is, have not billed Medicare Part B on or

after January 1, 2010 and prior to or on October 29, 2010) as long as the group has at least 200 established Medicare providers. NPIs who are not established Medicare providers, however, would not be included in our incentive payment calculations. Group practices that were selected to participate in the 2010 Physician Quality Reporting System GPRO will automatically be qualified to participate in the 2011 Physician Quality Reporting System GPRO I and will not need to complete the 2011 Physician Quality Reporting System GPRO I self-nomination process.

The 2010 Physician Quality Reporting System GPRO Tool will be updated as needed to include the 2011 Physician Quality Reporting System GPRO I measures. We believe that use of the GPRO data collection tool allows group practices the opportunity to calculate their own performance rates for reporting quality measures.

As stated in the CY 2011 PFS proposed rule (75 FR 40180 through 40181), we intend to provide the selected physician groups with access to this pre-populated database by no later than the first quarter of 2012. For purposes of pre-populating this GPRO I tool, we will assign beneficiaries to each group practice using a patient assessment methodology modeled after the patient assignment methodology used in the PGP demonstration. Based on our desire to model the Physician Quality Reporting System GPRO I after the PGP demonstration, we will also consider applying any refinements made to the methodology used in the PGP demonstration prior to January 1, 2011 to the 2011 Physician Quality Reporting System. We anticipate using Medicare claims data for dates of service on or after January 1, 2011 and submitted and processed by approximately October 31, 2011 (that is, the last business day of October2011) to assign Medicare beneficiaries to each group practice. Assigned beneficiaries will be limited to

those Medicare Part B FFs beneficiaries with Medicare Parts A and B for whom Medicare is the primary payer. Assigned beneficiaries will not include Medicare Advantage enrollees. A beneficiary will be assigned to the group practice that provides the plurality of a beneficiary's office or other outpatient office evaluation and management allowed charges. Beneficiaries with only 1 office visit to the group practice will be eliminated from the group practice's assigned patient sample for purposes of the 2011 Physician Quality Reporting System GPRO I. We will pre-populate the GPRO I tool with the assigned beneficiaries' demographic and utilization information based on their Medicare claims data.

Upon receipt of the pre-populated data collection tool, the group practice will need to populate the remaining data fields necessary for capturing quality measure information on each of the assigned beneficiaries up to 411 beneficiaries for each disease module and preventive care measure. If the pool of eligible assigned beneficiaries for any disease module or preventive care measure is less than 411, then the group practice must populate the remaining data files for 100 percent of eligible assigned beneficiaries for that disease module or preventive care measure. For each disease module or preventive care measure, the group practice must report information on the assigned patients in the order in which they appear in the group's sample (that is, consecutively).

(B) Group Practice Reporting Option for Group Practices of 2 – 199 NPIs – GPRO-II

As discussed previously, section 1848(m)(3)(C) of the Act authorized us to define the term "group practice" and required us to establish a process under which eligible professionals in group practices shall be treated as satisfactorily submitting data on Physician Quality Reporting System quality measures, but was not prescriptive with

regard to the characteristics of this process. Although for 2010 we did not provide a process for groups of less than 200 NPIs to report under the GPRO, we believe that there are significant potential benefits to allowing reporting at the group level generally. Thus, based on this authority we proposed a new group practice reporting option (GPRO II) for groups of 2-199 NPIs in a TIN for 2011 (75 FR 40181). For GPRO II in 2011, we proposed to require groups of eligible professionals who decide to report as a group to self-nominate. We did not propose to preclude a group practice from participating in the GPRO II if we discover, from analysis of the 2010 Medicare claims data, that there are some eligible professionals (identified by NPIs) that are not established Medicare providers (that is, have not billed Medicare Part B on or after January 1, 2010 and prior to or on) as long as the group has at least 2 established Medicare providers.
October 29, 2010 NPIs who are not established Medicare providers, however, would not be included in our incentive payment calculations.

We also proposed that self-nominating groups would need to indicate in this letter if the group intends to report as a group for the eRx Incentive Program and the reporting mechanism the group intends to use to report as a group for the eRx Incentive Program.

Since GPRO II would be a new process available to groups in 2011, we proposed to initially pilot the GPRO II process with a limited number of groups. We proposed to select the first 500 groups that meet the proposed eligibility requirements to participate in the 2011 GPRO II. We proposed to use the postmark to determine the order in which groups self-nominated for GPRO II. We proposed to consider only self-nomination letters postmarked between January 3, 2011 and January 31, 2011. We did not propose to consider letters postmarked prior to January 3, 2011 to prevent groups from self-

nominating before the GPRO II requirements are finalized and to discourage groups from self-nominating for GPRO II prior to reviewing the final GPRO II requirements.

For purposes of quality data submission, we proposed, for the GPRO II, to allow eligible professionals to submit their data through claims or through a qualified GPRO registry to the extent registries are technically capable of collecting, calculating and transmitting the required data to CMS and that we are able to accept such data from registries.

For GPRO II, we proposed that in addition to reporting a specific number of individual measures, the group would have to report one or more proposed 2011 Physician Quality Reporting System measures groups depending on the size of the group practice.

For purposes of satisfying the requirements under section 1848(m)(3)(C)(i) of the Act for groups of 2-199 NPIs, we proposed that in order to be treated as satisfactorily reporting under GPRO II, the group practice would be required to report on 50 percent or more (if submitting through claims) of all Medicare Part B patients who fit into the measures group denominator or 80 percent or more of Medicare patients if using a registry to report.

Additionally, to earn a Physician Quality Reporting System incentive payment for all allowed Medicare Part B services that are provided by the TIN, we proposed that a group practice must report on three to six individual 2011 Physician Quality Reporting System measures, depending on the size of the group. We proposed that the group practice may select from among any of the 2011 Physician Quality Reporting System measures on which to submit data, provided the measures selected are not duplicated in

the measures group(s) reported.

We proposed that, to satisfactorily report individual Physician Quality Reporting System measures, a group must report each measure at the same rate (percentage) as determined by the method of submission as individual eligible professionals. For example, if reporting via claims, to satisfactorily report individual measures, each measure would need to be reported on at least 50 percent of eligible Medicare Part B FFS patients.

An alternative which we considered and sought comment on was to require that the individual measures be selected from a more limited set of measures, such as measures closely linked to improved population health, or other measures perceived to address the greatest potential benefit from improved performance. A second alternative that we considered and sought comment on was to require group practices, as part of the self-nomination process, to designate whether they were a multispecialty group with primary care, a multispecialty group without primary care, or a single specialty group, and if so, the specialty. Depending on what type of specialty the group is, we would identify a set of Physician Quality Reporting System measures pertaining to the group's specialty and require the group practice to report on the identified set of specialty-specific Physician Quality Reporting System measures.

If a group practice participating in the 2011 Physician Quality Reporting System GPRO II wants to also participate in the 2011 eRx Incentive Program as a small group, we proposed that the group would need to indicate that preference in their self-nomination letter and would need to report on a specified number of unique encounters based on their group size. For GPRO II reporting in the 2011 eRx Incentive

Program, we proposed the following reporting mechanisms: claims, a GPRO eRx qualified registry or a GPRO qualified EHR. As with the 2011 eRx Incentive Program for individual eligible professionals and the 2011 eRx Incentive Program GPRO I, at least 10 percent of a GPRO II group's charges would need to be comprised of codes in the denominator of the electronic prescribing measure and the group would need to use an electronic prescribing system that meets the requirements of the 2011 electronic prescribing measure. Similar to proposed GPRO I, if a GPRO II group self-nominates to report the electronic prescribing measure as a group, we proposed that all members of the group practicing under the group's TIN would be ineligible to report as an individual electronic prescriber.

The following is a summary of the comments received regarding our proposal on the GPRO II option and process for group practices to report Physician Quality Reporting System quality data measures.

Comment: We received favorable support for the proposed addition of GPRO II as a group reporting option, including the requirement to self-nominate and report a measures group along with 3 individual relevant performance measures. One commenter stated that GPRO II will help spur more eligible professionals, specifically those with 2-199 member practices, to participate in the Physician Quality Reporting System.

Response: We appreciate the commenters' support and are finalizing our proposal to add GPRO II as a group reporting option. We note, however, that the number of measures groups and individual measures on which a group practice will be required to report will vary by the group practice's sizes. The specific requirements are described in Table 76 of this final rule with comment period.

Comment: Some commenters opposed the proposed cap of the first 500 groups that self-nominate for GPRO II. Commenters were primarily concerned that this would be too limiting. Another commenter noted that this reporting option has the advantage of mid-year interim feedback reports to assist participating groups in determining whether their Physician Quality Reporting System data is being captured appropriately. One commenter recommended that all self-nominations postmarked in the month of January 2011 be accepted for this reporting option. Another commenter urged us to expand GPRO II quickly beyond the initial cap of 500 practices.

Response: We appreciate the commenters' enthusiasm for this new reporting option and would like to be able to make it available to as many groups as possible, but will need to initially limit the number of groups participating in GPRO II for operational reasons. We will accept at least 500 groups, but could potentially accept more depending on our ability to handle a higher volume of groups participating in this option. We expect that we will be able to expand this option further in future years to make it available to more groups. In addition, we would like to clarify that we did not propose to provide interim feedback reports for group practices participating in GPRO II. Rather, we proposed to provide interim feedback reports for individual eligible professionals who submitted measures group data via claims during the first 2 months of 2011. However, as noted in this section, we are not finalizing this proposal.

Comment: Since we proposed to limit participation in GPRO II to 500 groups in 2011, it was recommended that we strive for diversity of specialty representation rather than just a first-come, first-served approach.

Response: We appreciate the commenter's suggestions. As stated previously, we will accept as many groups as resources allow and select a minimum of 500 GPRO II practices for 2011.

Comment: One commenter requested that GPRO II be made available to groups of any size. The commenter believed this would allow group practices to decide whether to participate in GPRO I or GPRO II depending on which option works best for their practice.

Response: We appreciate the commenter's valuable input. As we explore ways to further expand the GPRO II in future years we may consider making it available to groups of any size.

Comment: One commenter suggested that we reduce the number of individual and group measures required to report for GPRO II. Other commenters stated that the requirement to report at least 1 measures group would disadvantage those group practices for which none of the existing measures groups applies or there are a limited number of applicable measures groups.

Response: We understand the commenters' concerns and are revising the criteria for satisfactory reporting. Whereas we proposed to require group practices to report on a specified percentage of patients for both individual measures and measures groups, we are requiring, for 2011, that group practices report on a specified percentage of patients for the individual measures only. For measures groups, group practices will need to report on only the specified minimum number of patients (see Table 76 of this final rule with comment period). In addition, we believe that, on average, the total reporting burden per eligible professional in a group practice is less than the reporting burden for

eligible professionals reporting individually. For example, for a group of 5 eligible professionals that is required to report on 1 measures group and 3 individual measures, this means that the group is required to report on less than 2 measures per eligible professionals compared to 3 measures or 1 measures group per individual eligible professional.

With respect to the commenter's concerns that groups with a limited number of applicable measures groups could be disadvantaged, we believe that as we increase the numbers of measures groups available, this would be less of a concern over time. In the meantime, eligible professionals in group practices that do not have any applicable measures groups are still able to report individual measures as individual eligible professionals and meet the criteria for satisfactory reporting individually.

Comment: One commenter requested that we not restrict the selection of Physician Quality Reporting System measures (for example, only population health measures) for GPRO II, given that multi-specialty groups with primary care, multi-specialty groups without primary care, and single specialty groups will be participating in this reporting option. Restrictions to select Physician Quality Reporting System measures may limit the diversity of practices that elect to report through this option. Similarly, another commenter was concerned that requiring so many primary care measures will make it difficult for specialists, such as psychiatrists, to participate in large numbers.

Response: The commenters appear to be suggesting that we are placing restrictions on the selection of measures for the GPRO II, which is not correct. While GPRO I groups are required to report on a standard set of 26 measures, the GPRO II

groups can select any 2011 Physician Quality Reporting System individual measures and measures groups that are relevant to their practice as long as they report the required number of individual measures and measures groups for their group size (see Table 76 of this final rule with comment period). However, in future years and in future rulemaking we expect to reconsider alternative reporting requirements, including the alternatives of identifying a core set of measures for which broad reporting may be required.

Comment: One commenter requested that we clearly indicate how we derived the performance results for each individual professional if we post performance information derived from the GPRO II on the Physician Compare Web site. The commenter was concerned that the reported performance that will be attributed to an individual eligible professional through GPRO II will not necessarily reflect individual performance.

Response: We appreciate the commenter's feedback. To date, we have not made any Physician Quality Reporting System performance rates publicly available. We value input from external stakeholders. Opinions and alternatives that are provided will assist us in future policy decisions as we develop our plans for the Physician Compare Web site. With respect to the commenter’s concern that performance information derived from GPRO II will be attributed to an individual eligible professional, group practice reporting is attributed to the entire group, not to the individual. Additionally, we do not intend to publicly report Physician Quality Reporting System performance results for 2011.

Upon consideration of the comments received, group practices that wish to participate in the GPRO II will need to self-nominate. The self-nomination process will consist of sending a letter with the name of the group, the TIN, an email address of the

contact person, and the names and NPIs of all of the eligible professionals practicing under that group's TIN. The self-nomination letter must also be accompanied by an electronic file submitted in a format specified by CMS (such as Microsoft Excel) with the group practice's TIN and NPIs. Self-nomination letters should be sent to: GPRO II, c/o CMS, 7500 Security Blvd., Mail Stop S3-02-01, Baltimore, MD 21244, and must be postmarked by January 31, 2011, for consideration in the program. We are also finalizing our proposal to initially limit the number of groups participating in GPRO II. We seek to make this option available to as many groups as possible but have limited resources. Therefore, as stated previously, we will accept at least 500 groups, but could potentially accept more depending on our ability to handle a higher volume of groups participating in this option. We expect that we will be able to expand this option further in future years to make it available to more groups.

Table 76 sets forth the final criteria for satisfactory reporting under the 2011 Physician Quality Reporting System GPRO II and requirements for each group based on their respective group size (number of eligible professionals). As stated previously, GPRO II groups will be required to report on a specified percentage of patients for reporting the individual measures only. To satisfactorily report measures groups for the 2011 Physician Quality Reporting System GPRO II, the group practice need only report on the minimum number of patients specified in Table 76 for their group size. In addition, since we will not have the ability to determine whether the registries can ensure that only unique patients are counted, GPRO II groups must report the 2011 Physician Quality Reporting System data via claims unless the only measures groups that apply to the practice are one of the four registry-only measures groups listed in section

VII.F.2.(i).(5). of this final rule with comment period. Group practices that must report on one of the four registry-only measures groups in order to meet the criteria for satisfactory reporting will be able to use the registry-reporting mechanism to submit their 2011 Physician Quality Reporting System data and must submit all of their 2011 Physician Quality Reporting System GPRO II data via the registry reporting mechanism. However, we anticipate that the list of registries qualified to submit 2011 Physician Quality Reporting System GPRO II data will not be available until summer 2011. Group practices will need to indicate the reporting mechanism they intend to use for the 2011 Physician Quality Reporting System GPRO II in their self-nomination letter.

TABLE 76: 2011 Process for Physician Group Practices to Participate as Group Practices and Criteria for Satisfactory Reporting of Data on Quality Measures by Group Practices for GPRO II

Group size (Number of Eligible Professionals)	Number of Measures Groups Required to be Reported	Minimum Number of Medicare Part B Patients in Denominator for Satisfactory Reporting of Measures Groups	Number of Individual Measures Required to be Reported	Percent of Medicare Part B Patients in Denominator for Satisfactory Reporting of Individual Measures via Claims	Percent of Medicare Part B Patients in Denominator for Satisfactory Reporting of Individual Measures via registries	Required Number of Unique Visits Where an E-prescription was Generated to be a Successful Electronic Prescriber
2-10	1	35	3	50%	80%	75
11-25	1	50	3	50%	80%	225
26-50	2	50	4	50%	80%	475
51-100	3	60	5	50%	80%	925
101-199	4	100	6	50%	80%	1875

We are not finalizing our proposal to analyze the individual professional's data to see if they satisfactorily reported at the individual TIN/NPI level if the group does not satisfactorily report as a GPRO II group. We have determined that this is neither practical nor feasible for us. This should have no impact on how groups will report Physician Quality Reporting System data under GPRO since claims will identify both the

TIN and the individual eligible professional rendering the service regardless of whether we analyze the claims at the group or individual level. Although there will be some risk to eligible professionals who are part of a GPRO II group if the group fails to satisfactorily report, we believe this risk is outweighed by the additional resources that would be required to process a group's data at both the group and individual levels and the fact that all participants' incentive payments could potentially be delayed.

h. Statutory Requirements and Other Considerations for 2011 Physician Quality Reporting System Measures

(1) Statutory Requirements for 2011 Physician Quality Reporting System Measures

Under section 1848(k)(2)(C)(i) of the Act, the Physician Quality Reporting System quality measures shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under subsection 1890(a) of the Act (currently, that is the National Quality Forum, or NQF). However, in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the NQF, section 1848(k)(2)(C)(ii) of the Act authorizes the Secretary to specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance. In light of these statutory requirements, we believe that, except in the circumstances specified in the statute, each proposed 2011 Physician Quality Reporting System quality measure would need to be endorsed by the NQF. Additionally, section 1848(k)(2)(D) of the Act requires that for each 2011 Physician Quality Reporting System quality measure, "the Secretary shall ensure that eligible professionals have the

opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish."

The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted previously, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement were developed. The basic steps for developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards.

(2) Other Considerations for 2011 Physician Quality Reporting System Measures

As stated previously, in addition to reviewing the 2010 Physician Quality Reporting System measures for purposes of developing the proposed 2011 Physician Quality Reporting System measures, we reviewed and considered measure suggestions including comments received in response to the CY 2010 PFS proposed and final rules with comment period. Additionally, suggestions and input received through other venues, such as an invitation for measures suggestions via the Listening Session held

February 2, 2010, were also reviewed and considered for purposes of our development of the list of proposed 2011 Physician Quality Reporting System quality measures.

With respect to the selection of new measures, we applied the following considerations, which include many of the same considerations applied to the selection of 2009 and 2010 Physician Quality Reporting System quality measures for inclusion in the 2011 Physician Quality Reporting System quality measure set previously described:

- High Impact on Healthcare.

++ Measures that are high impact and support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries. These current and long term priority topics include the following: prevention; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections and other conditions; improved care coordination; improved outcomes; improved efficiency; improved patient and family experience of care; improved end-of-life/palliative care; effective management of acute and chronic episodes of care; reduced unwarranted geographic variation in quality and efficiency; and adoption and use of interoperable HIT.

- Measures that are included in, or facilitate alignment with, other Medicare, Medicaid, and CHIP programs in furtherance of overarching healthcare goals.

- NQF Endorsement.

++ Measures must be NQF-endorsed by June 1, 2010, in order to be considered for inclusion in the 2011 Physician Quality Reporting System quality measure set except as provided under section 1848(k)(2)(C)(ii) of the Act.

++ Section 1848(k)(2)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF).

++ The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted previously, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement are developed. The basic steps for developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards. The requirements under section 1848(k)(2)(C) of the Act pertain only to the selection of measures and not to the development of measures.

- Address Gaps in the Physician Quality Reporting System Measure Set.

++ Measures that increase the scope of applicability of the Physician Quality Reporting System measures to services furnished to Medicare beneficiaries and expand opportunities for eligible professionals to participate in the Physician Quality Reporting System.

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

Other considerations that we applied to the selection of measures for 2011, regardless of whether the measure was a 2010 Physician Quality Reporting System measure or not, were--

- Measures that are functional, which is to say measures that can be technically implemented within the capacity of the CMS infrastructure for data collection, analysis, and calculation of reporting and performance rates. For example, we proposed to replace existing 2010 Physician Quality Reporting System measures #114 and #115 with updated and improved measure #TBD (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention), which is less technically challenging to report.

- In the 2011 Physician Quality Reporting System, as in the 2010 Physician Quality Reporting System, for some measures that are useful, but where data submission is not feasible through all otherwise available Physician Quality Reporting System reporting mechanisms, a measure may be included for reporting solely through specific reporting mechanism(s) in which its submission is feasible.

In the proposed rule, we invited comments on the implication of including or excluding any given measure or measures for our proposed 2011 Physician Quality Reporting System quality measure set, as well as feedback relative to our proposed approach in selecting measures (75 FR 40185). We indicated that while we welcome all constructive comments and suggestions, and may consider such recommended measures for inclusion in future measure sets for the Physician Quality Reporting System and other

programs to which such measures may be relevant, we were not able to consider such additional measures for inclusion in the final 2011 measure set.

As discussed previously, section 1848(k)(2)(D) of the Act requires that the public have the opportunity to provide input during the selection of measures. We also are required by other applicable statutes to provide opportunity for public comment on provisions of policy or regulation that are established via notice and comment rulemaking. Measures that were not included in the proposed rule for inclusion in the 2011 Physician Quality Reporting System that are recommended to CMS via comments on the proposed rule have not been placed before the public to comment on the selection of those measures within the rulemaking process. Even when measures have been published in the **Federal Register**, but in other contexts and not specifically proposed as Physician Quality Reporting System measures, such publication does not provide true opportunity for public comment on those measures' potential inclusion in the Physician Quality Reporting System. Thus, such additional measures recommended for selection for the 2011 Physician Quality Reporting System via comments on the CY 2011 PFS proposed rule cannot be included in the 2011 measure set. However, as discussed previously, we will consider comments and recommendations for measures, which may not be applicable to the final set of 2011 Physician Quality Reporting System measures, for purposes of identifying measures for possible use in the Physician Quality Reporting System in future years or other initiatives to which those measures may be pertinent.

In addition, as in prior years, we again note that we do not use notice and comment rulemaking as a means to update or modify measure specifications. Quality measures that have completed the consensus process have a designated party (usually, the

measure developer/owner) who has accepted responsibility for maintaining the measure. In general, it is the role of the measure owner, developer, or maintainer to make changes to a measure. Therefore, comments requesting changes to a specific proposed Physician Quality Reporting System measure's title, definition, and detailed specifications or coding should be directed to the measure developer identified in Tables 78 through 96. Contact information for the 2010 Physician Quality Reporting System measure developers is listed in the "2010 PQRI Quality Measures List," which is available on the Physician Quality Reporting System section of the CMS Web site at http://www.cms.gov/PQRI.

However, we stress that inclusion of measures that are not NQF endorsed or AQA adopted is an exception to the requirement under section 1848(k)(2)(C)(i) of the Act that measures be endorsed by the NQF. We may exercise this exception authority in a specified area or medical topic for which a feasible and practical measure has not been endorsed by NQF, so long as due consideration is given to measures that have been endorsed by the NQF.

(3) Summary of Comments and Responses

The following is summary of the comments we received regarding the statutory requirements and other considerations for the selection of 2011 Physician Quality Reporting System measures.

Comment: Some commenters strongly support the adoption of NQF-endorsed measures only. One commenter stated that the AQA is no longer doing measure evaluation work and should not be allowed to approve measures for the Physician Quality Reporting System as a way to sidestep the well-designed and well-executed process of the NQF.

Response: We agree that endorsement of measures by the NQF is an important criteria for inclusion in the Physician Quality Reporting System. However, section 1848(k)(2)(C)(i) of the Act provides an exception to the requirement that measures be endorsed by the NQF. We may exercise this exception authority in a specified area or medical topic for which a feasible and practical measure has not been endorsed by NQF, so long as due consideration is given to measures that have been endorsed by the NQF. For this reason, we retain the ability to include non-NQF endorsed measures in the Physician Quality Reporting System. Once those measures work through the NQF process, we may remove those that were not endorsed by the NQF from the program.

Comment: A few commenters opposed our conclusion that any organization can develop quality measures. The AMA-specialty society quality consortium, the PCPI, should be recognized by us to specify the quality measures and adequately test them for inclusion in the Meaningful Use program.

Response: We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out the basic development of measures for physicians and other eligible professionals, such as restricting the initial development to physician-controlled organizations. While we agree that expertise in measure development is important in the measure development and consensus processes, any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards. In addition, physicians are not the only types of professionals eligible to participate in the Physician Quality Reporting System.

Comment: Another commenter encouraged us to allow for other means for measure endorsement due to NQF's lack of timeliness and consistency issues.

Response: As stated previously, section 1848(k)(2)(C)(i) of the Act provides an exception to the requirement that measures be endorsed by the NQF. We may exercise this exception authority in a specified area or medical topic for which a feasible and practical measure has not been endorsed by NQF, so long as due consideration is given to measures that have been endorsed by the NQF. In certain circumstance, we have exercised this exception authority to include measures that have not yet gone through the NQF endorsement process to address measure gaps.

Comment: Many commenters requested that we encourage the development and use of measures in specific areas or topics. The specific areas or topics that commenters recommended as priorities included sub-specialty specific measures, measures that reflect the day-to-day treatment of cancer patients, risk-adjusted outcome measures (as opposed to process measures), measures that better reflect patient preferences, patient experience, functional status, and care coordination, measures that capture demographic data in ways that enable measures to be stratified and used to identify and address health disparities, measures that address high-burden disease areas especially prevalent in the Medicare beneficiary population, broader measures to enhance accurate identification and treatment of atrial fibrillation, measures that will be retooled for future use in EHR reporting, measures that must be retooled for the impending ICD-10-CM/PCS compliance date, and measures to capture whether patients have received preventive vaccinations.

Response: We appreciate the commenters' recommendations for expanding criteria for measure selection and prioritization. We note, however, that we largely

depend on the development of measures by professional organizations and other measure developers and encourage professional organizations and other measure developers to fund and develop measures that address the priority areas identified by the commenters. In addition, if there are specific measures that commenters would like us to consider for future years to address these areas, we urge them to submit the specific measure suggestions via the 2012 Call for Measures. Information on the 2012 Call for Measures will be posted on the Physician Quality Reporting System section of the CMS Web site when it becomes available. We anticipate conducting the 2012 Call for Measures in late 2010 or early 2011.

Comment: One commenter suggested the proposed addition of Physician Quality Reporting System measures for 2011 be re-visited in context with the August 2010 publication of 69 NQF-endorsed® ambulatory performance measures.

Response: We appreciate the commenter's valuable input. As stated previously and in the proposed rule (75 FR 40185), we are not able to consider additional measures for inclusion in the final 2011 Physician Quality Reporting System measure set beyond what we proposed. However, we may consider them for inclusion in future measure sets for the Physician Quality Reporting System.

Comment: A few commenters recommended that we implement more meaningful and impactful measures. Some of the actions specifically recommended by the commenters include:

- Require the collection of patient experience surveys, if there is an NQF-endorsed survey available for that professional;

- Remove measures that "document" the presence of evaluation, assessment, and counseling as there is no relationship between such measures and patient outcome;
- Consider adding measures from NQF's Ambulatory Care Measures Using Clinically Enriched Administrative Data that are appropriate for the Medicare population; and
- Develop measures that will fill gaps in the Physician Quality Reporting System measure set and that adhere to key criteria for robust measures.

Response: We appreciate the commenter's feedback regarding the use of more meaningful and impactful measures in the Physician Quality Reporting System. We appreciate the time and effort taken in providing your recommendation and, as stated previously, we urge the commenter to work with professional organizations and other measure developers to fund and develop measures that address the priority areas identified by the commenter and/or submit recommendations for specific measures that the commenter would like us to consider for future years via the 2012 Call for Measures.

Comment: One commenter urged us to be mindful of the resources required to translate quality data into improved provider performance. Therefore, we should ensure appropriate phasing-in of new measures into our current quality reporting programs.

Response: We appreciate the commenter's valuable input. While we strive to identify gaps of care and ensure that specialties have measures to report, we also recognize that there is a level of effort associated with translating the quality data reported into better care. As such, we are adding limited set of new measures that focuses on identified gaps and ensures specialties have measures to report.

Comment: One commenter requested that we further explore and discuss the phase-in dates in context with the ICD-10-CM/PCS transition date.

Response: We are planning for implementation of ICD-10 and are working in collaboration with the Physician Quality Reporting System measure developers/owners towards the coding transition. More information on the phase-in dates for this transition will be provided once it becomes available.

i. The Final 2011 Physician Quality Reporting System Quality Measures for Individual Eligible Professionals

For 2011, we proposed to include a total of 200 measures (this includes both individual measures and measures that are part of a proposed 2011 measures group) on which individual eligible professionals can report for the 2011 Physician Quality Reporting System (75 FR 40185 through 40198).

The following is a summary of the comments received on the proposed 2011 Physician Quality Reporting System measures in general and comments on the measures from the 2010 Physician Quality Reporting System not proposed for inclusion in the 2011 Physician Quality Reporting System.

Comment: One commenter suggested that we consider publishing a list of reportable measures for each eligible profession. This would make the reporting process more clear and accessible to professionals trying to participate in the program by helping them quickly determine which measures are relevant to their practices.

Response: In August 2010, we posted on the Analysis and Payment page of the Physician Quality Reporting System section of the CMS Web site http://www.cms.gov/pqri, a 1st quarter 2010 aggregate QDC error report by specialty.

For each 2010 Physician Quality Reporting System measure, this report lists the specialties that submitted valid QDCs for the measure during the 1st quarter of 2010. Thus, an eligible professional could use this report to ascertain whether a measure is reportable by his or her profession.

Comment: One commenter suggested that it would be useful for participating eligible professionals, as well as other stakeholders, if we developed a table that clearly summarizes the status of a measure's NQF endorsement, AQA endorsement, owner, and how the measure aligns with meaningful use clinical quality measure requirements.

Response: Tables 78 through 97 of this final rule with comment period includes the status of each measure's NQF endorsement, as well as AQA endorsement if applicable and the measure is not NQF endorsed. In addition, Tables 55 and 56 of the CY 2011 PFS proposed rule (75 FR 40193), which lists the measures available for EHR reporting in 2011, includes information as to whether a measure is included in the EHR Incentive Program for program years 2011 and 2012. We note, however, that the electronic specifications for measures that are included in the Physician Quality Reporting System and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.

Comment: We received numerous comments in support of the 2010 Physician Quality Reporting System quality measures proposed for inclusion in the 2011 Physician Quality Reporting System. Specific measures or measures topics on which we received favorable support include the measures on osteoporosis, audiology, speech-language pathology, and measures 9, 106, 107, 124, 126, 127, 128, 130, 131, 134, 148, 149, 150,

151, 154, 155, 173, 181, 188, 189, 190, and 200. Commenters often cited the applicability of a specific measure to their specialty and/or profession.

Response: We appreciate the feedback and are finalizing our proposals to include these measures in the 2011 Physician Quality Reporting System measure set. These measures address one or more of the considerations for measures selected for inclusion in the 2011 Physician Quality Reporting System previously discussed.

Comment: A couple of commenters asked us to reconsider the proposal to retire Measure #135, Chronic Kidney Disease (CKD): Influenza Immunization. Although the measure was considered for endorsement by NQF but was ultimately not endorsed, the measure is adopted by the AQA.

Response: On August 26, 2010, we published a correction notice in the **Federal Register** (75 FR 52487) indicating we inadvertently included this measure in the table that lists the 2010 Physician Quality Reporting System measures not proposed to be included in the 2011 Physician Quality Reporting System. As such, we are including Measure #135 in the 2011 Physician Quality Reporting System individual measures set only. We are not, however, finalizing our proposal to include Measure # 135 from the CKD Measures Group. The reporting requirements for Measure #135 are different from the other measures in the CKD measures group

Comment: A couple of commenters recommended keeping Measure #136, Melanoma: Follow-Up Aspects of Care, for purposes of reporting to the 2011 Physician Quality Reporting System. The commenters believe that although the measure is no longer endorsed by the National Quality Forum, it is still a valuable tool in clinician quality improvement. The commenters also noted that this measure is most effective as

part of a set with Measures # 137: Melanoma: Continuity of Care—Recall System and #138: Melanoma: Coordination of Care, which are maintained in the list of measures available for 2011 Physician Quality Reporting System.

Response: We are finalizing our proposal to not include Measure #136 in the 2011 Physician Quality Reporting System measure set. As stated in the proposed rule, (75 FR 40186) and by the commenter, Measure #136 was considered by NQF for possible endorsement but ultimately was not NQF-endorsed. We note, also, that we proposed and are finalizing a new melanoma measure, Melanoma: Overutilization of Imaging Studies in Stage 0-1A Melanoma, for the 2011 Physician Quality Reporting System. This measure meets one or more of the considerations for measures selected for inclusion in the 2011 Physician Quality Reporting System.

Comment: We received one comment in support of our proposal to retire Measure #139 Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement. Another commenter, however, requested that this measure be retained because it evaluates safe and appropriate use of cataract surgery.

Response: We appreciate the commenters' feedback. Based on the fact that the measure was reviewed for endorsement by the NQF and ultimately not endorsed, we are finalizing our proposal to not include this measure in the 2011 Physician Quality Reporting System measure set.

Comment: In addition to the quality measures and measures groups for individual eligible professionals we had proposed in Tables 52 through 54 of the CY 2011 PFS proposed rule (75 FR 40186 through 40192), several commenters suggested quality measures, measures groups, and/or topics for which additional measures or measures

groups should be added for the 2011 Physician Quality Reporting System. Specifically, commenters recommended that we adopt--

- A measure for AAA ultrasound screening;
- A COPD measures group;
- A stroke measures group comprised of the following 5 measures: (1) Deep vein thrombosis (DVT) prophylaxis; (2) Discharged on antithrombotic therapy; (3) Patients with atrial fibrillation/flutter receiving anticoagulant therapy; (4) Thrombolytic therapy;and (5) Discharged on statin medication;
- A measures group that focuses on quality measures common to every long-term care resident, which could include Physician Quality Reporting System measures #47, 110, 111, 130, 154, and 155;
- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients; and
- Comprehensive Colonoscopy Documentation

Response: As stated previously, we have not included in this final rule with comment period for the 2011 Physician Quality Reporting System any individual and measures groups that were not identified in the CY 2011 PFS proposed rule as proposed 2011 Physician Quality Reporting System measures. We are obligated by section 1848(k)(2)(D) of the Act to give eligible professionals an opportunity to provide input on measures recommended for selection, which we do so via the proposed rule. Thus, such additional measures recommended via comments on the proposed rule cannot be included in the 2011 Physician Quality Reporting System quality measure set. However, we have captured these recommendations and will have them available for consideration in

identifying measure sets/groups for the Physician Quality Reporting System for future years and other initiatives to which those measures or measures groups may apply.

Comment: Some commenters asked that we reconsider measures or measures groups that had been previously submitted to us as suggestions for 2011 Physician Quality Reporting System measures but were not proposed for inclusion in the 2011 Physician Quality Reporting System measure set. Specifically, commenters requested that we reconsider inclusion of the Parkinson's disease and epilepsy measurement sets in the Physician Quality Reporting System program, a diabetic retinopathy measures group with 2 measures, and a cataracts measures group with 2 measures.

Response: All measures or measures groups that were previously submitted to us as suggestions for 2011 Physician Quality Reporting System measures were reviewed for possible inclusion in the 2011 Physician Quality Reporting System measure set. Upon review, however, some measures either failed to meet the threshold criteria for inclusion in the 2011 Physician Quality Reporting system measure set (as described previously) or did not meet the definition of "measures group" proposed and finalized at 42 CFR 414.90. These measures that did not pass the review process were not proposed for inclusion in the 2011 Physician Quality Reporting System measure set.

Comment: Several commenters recommended changes to the detailed specifications or coding for one or more of the proposed measures or measures groups. Many of the requests were specifically concerned that measures be expanded to include additional professionals to whom the measure(s) may apply.

Specifically, one commenter requested that any measure used by primary care physicians be expanded to include not just the office, but home and domiciliary codes as

well. One commenter requested that the denominator codes for the CAP measures group be expanded to include other infectious pneumonia ICD-9-CM diagnostic codes than "acute" pneumonia diagnosis codes so pulmonologists can have sufficient numbers of patients to report this measures group. A few commenters requested that the age range for the proposed asthma measures group be expanded, instead of being restricted to 5 to 50 years of age. One commenter requested that the Initial Hospital Admit Evaluation and Management codes (99221, 99222, and 99223) be removed from the denominators of measures #32, #33 and #36 and added to measures #56-59 for 2011. The commenter also requested that an exemption be given to eligible professionals penalized for not reaching an 80 percent reporting threshold on measures #32, #33, and #36 because of the unintended effect of substituting the 99221, 99222, and 99223 series codes for the consultation 99251- 99255 series that had been eliminated from the Medicare program. Lastly, another commenter requested that allowable performance exclusion codes be created for measures #201 and #202.

Response: Although the Secretary is required to provide opportunities for public comment on selected measures and do so through notice and comment rulemaking, we do not use notice and comment rulemaking as a means to update or modify measure specifications. In general, it is the role of the measure owner, developer, or maintainer to make substantive changes to the measures, such as the changes suggested by the commenters. The measure maintainer and/or the developer/owner of a measure included in the final set of 2011 Physician Quality Reporting System measures is identified in the "Measure developer" column of Tables M6 through M24. In addition, for those measures

which are NQF-endorsed, the NQF has an established maintenance process that could be accessed to recommend the changes suggested by the commenters.

Comment: One commenter supported our proposal to replace Physician Quality Reporting System Measures #114 and #115 with the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure (NQF Measure Number 0028). Another commenter, however, requested that Physician Quality Reporting System Measures #114 and #115 be included in the 2011 Physician Quality Reporting System as these measures are included in the EHR Incentive Program clinical quality measures and thus will be of great interest for eligible professionals to report on.

Response: Although Physician Quality Reporting System Measures #114 and #115 are included as clinical quality measures under the EHR Incentive Program, we have decided, for the Physician Quality Reporting System, to replace Physician Quality Reporting System Measures #114 Preventive Care and Screening: Inquiry Regarding Tobacco Use and #115 Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit with an NQF-endorsed measure, Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. We believe this measure is more comprehensive and less technically challenging than Physician Quality Reporting System Measures #114 and #115. We may consider aligning the preventive care and screening measures related to tobacco use and smoking under these 2 programs in future years.

Comment: One commenter stressed the importance of publishing the detailed Physician Quality Reporting System specifications for individual measures and measures groups by November 15, 2010.

Response: We will make every attempt to post the detailed specifications and specific instruction for reporting 2011 individual and measures groups on the Physician Quality Reporting System section of the CMS Web site at http://www.cms.hhs.gov/PQRI as close to November 15, 2010 as possible. In any event, the detailed specifications will be posted by no later than December 31, 2010.

Based on the criteria previously discussed and our review of these comments, we are including the individual measures listed in Tables M6 through M10 in the final 2011 Physician Quality Reporting System individual quality measure set. We are also including 14 measures groups in the final 2011 Physician Quality Reporting System quality measure set, which are listed in Tables M11 through M24. The individual measures selected for the 2011 Physician Quality Reporting System can be categorized as follows:

- 2011 Individual Quality Measures Selected From the 2010 Physician Quality Reporting System Quality Measures Set Available for Claims-based Reporting and Registry-based Reporting;
- 2011 Individual Quality Measures Selected From the 2010 Physician Quality Reporting System Quality Measures Set Available for Registry-based Reporting Only;
- New Individual Quality Measures for 2011; and
- 2011 Measures Available for EHR-based Reporting.

In addition, we are retiring the 5 measures in Table 77 because they did not meet one or more of the considerations for selection of 2011 measures. Specifically, we retired Physician Quality Reporting System Measures #136, #139, and #174 for 2011 because they were considered by NQF for possible endorsement but ultimately were not

NQF-endorsed. In addition, we are replacing 2010 Physician Quality Reporting System Measures #114 and #115 with an updated and improved measure (#TBD "Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention"), which is less technically challenging to report.

TABLE 77: 2011 Physician Quality Reporting System Quality Measures Not Included in the 2011 Physician Quality Reporting System

Physician Quality Reporting System Measure Number	Measure Title
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit
136	Melanoma: Follow-Up Aspects of Care
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement
174	Pediatric End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis

(1) 2011 Individual Quality Measures Selected From the 2010 Physician Quality Reporting System Quality Measures Set Available for Claims-based Reporting and Registry-based Reporting

For 2011, we proposed to retain 171 measures currently used in the 2010 Physician Quality Reporting System. These 171 proposed measures include 45 registry-only measures currently used in the 2010 Physician Quality Reporting System, and 126 individual quality measures for either claims-based reporting or registry-based reporting (75 FR 40186 through 40190 and 52489 through 52490). These 171 proposed measures did not include any measures that are proposed to be included as part of the 2011 Back Pain measures group. Similar to the 2010 Physician Quality Reporting System, for 2011, we proposed that any 2011 Physician Quality Reporting System measures that are included in the Back Pain measures group would not be reportable as individual measures through claims-based reporting or registry-based reporting.

Although they were ultimately not NQF-endorsed, we proposed to exercise our exception authority under section 1848(k)(2)(C)(ii) of the Act and include measures #188, #189, and #190, since we are not aware of any other NQF-endorsed measures that are available to audiologists.

The following is a summary of the comments received on the proposed 2011 individual quality measures selected from the 2010 Physician Quality Reporting System quality measures set available for claims-based reporting and registry-based reporting.

Comment: A commenter urged us to continue to allow reporting of measure #175, Plan of Care for Inadequate Hemodialysis in 2011, regardless of NQF endorsement since this was approved by the AQA in 2008.

Response: We are unclear whether the commenter is referring to measure #174, which is the Pediatric ESRD: Plan of Care for Inadequate Hemodialysis measure or measure #175, which is the Pediatric ESRD: Influenza Immunization measure since both of these are AQA adopted measures. For the reasons described previously, we are not retaining measure #174 for the 2011 Physician Quality Reporting System. We are, however, retaining measure #175 for the 2011 Physician Quality Reporting System.

Comment: A commenter supported the 2011 proposed measures selected from the 2010 Physician Quality Reporting System measure set available for either claims-based reporting or registry-based reporting but noted there have been inquiries about how the process component of Measure #193: Perioperative Temperature Management is defined. As a result, the commenter pointed out that this measure is undergoing revision.

Response: We appreciate the commenter's valuable input and will continue to monitor the status of this measure.

For the reasons discussed previously and based on the comments received, we are finalizing in the 2011 Physician Quality Reporting System quality measure set the 171 2010 Physician Quality Reporting System measures that were proposed to be available in the 2010 Physician Quality Reporting System for claims and registry reporting identified in Table 78. The 171 individual 2010 Physician Quality Reporting System measures selected for inclusion in the 2011 Physician Quality Reporting System quality measure set as individual quality measures for either claims-based reporting or registry-based reporting are listed by their Physician Quality Reporting System Measure Number and Title in Table 78, along with the name of the measure's developer/owner and NQF measure number, if applicable. The Physician Quality Reporting System Measure Number is a unique identifier assigned by CMS to all measures in the Physician Quality Reporting System measure set. Once a Physician Quality Reporting System Measure Number is assigned to a measure, it will not be used again to identify a different measure, even if the original measure to which the number was assigned is subsequently retired from the Physician Quality Reporting System measure set. A description of the measures listed in Table 78 can be found in the "2010 PQRI Quality Measures List," which is available on the Measures and Codes page of the Physician Quality Reporting System section of the CMS Web site at http://www.cms.hhs.gov/PQRI.

TABLE 78: 2011 Individual Measures Selected From the 2010 Physician Quality Reporting System Quality Measure Set Available for Either Claims-based Reporting or Registry-based Reporting

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA	0059
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	NCQA	0064

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA	0061
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	AMA-PCPI	0067
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD	NCQA	0105
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports	AMA-PCPI/NCQA	0246
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	AMA-PCPI/NCQA	0086
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	AMA-PCPI/NCQA	0087
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	AMA-PCPI/NCQA	0088
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care	AMA-PCPI/NCQA	0089
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician	AMA-PCPI/NCQA	0270
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	AMA-PCPI/NCQA	0268
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	AMA-PCPI/NCQA	0271
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	AMA-PCPI/NCQA	0239
24	Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	AMA-PCPI/NCQA	0045
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	AMA-PCPI/NCQA	0092
30	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics	AMA-PCPI/NCQA	0270
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	AMA-PCPI/NCQA	0240
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	AMA-PCPI/NCQA	0325
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	AMA-PCPI/NCQA	0243
36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	AMA-PCPI/NCQA	0244
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	AMA-PCPI/NCQA	0046

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	AMA-PCPI/NCQA	0045
41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	AMA-PCPI/NCQA	0049
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	Society of Thoracic Surgeons (STS)	0516
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	STS	0235
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	AMA-PCPI/NCQA	0637
46	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	AMA-PCPI/NCQA	0097
47	Advance Care Plan	AMA-PCPI/NCQA	0326
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA	0098
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA	0099
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA	0100
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	AMA-PCPI	0091
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	AMA-PCPI	0102
53	Asthma: Pharmacologic Therapy	AMA-PCPI	0047
54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	AMA-PCPI/NCQA	0090
55	12-Lead Electrocardiogram (ECG) Performed for Syncope	AMA-PCPI/NCQA	0093
56	Community-Acquired Pneumonia (CAP): Vital Signs	AMA-PCPI/NCQA	0232
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	AMA-PCPI/NCQA	0094
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status	AMA-PCPI/NCQA	0234
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic	AMA-PCPI/NCQA	0096
64	Asthma: Asthma Assessment	AMA-PCPI	0001
65	Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use	NCQA	0069
66	Appropriate Testing for Children with Pharyngitis	NCQA	0002

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	AMA-PCPI/American Society of Hematology (ASH)	0377
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	AMA-PCPI/ASH	0378
69	Multiple Myeloma: Treatment with Bisphosphonates	AMA-PCPI/ASH	0380
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	AMA-PCPI/ASH	0379
71	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	AMA-PCPI/American Society of Clinical Oncology (ASCO)/National Comprehensive Cancer Network (NCCN)	0387
72	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	AMA-PCPI/ASCO/NCCN	0385
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol	AMA-PCPI	0464
79	End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD	AMA-PCPI	0227
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	AMA-PCPI	0395
85	Hepatitis C: HCV Genotype Testing Prior to Treatment	AMA-PCPI	0396
86	Hepatitis C: Antiviral Treatment Prescribed	AMA-PCPI	0397
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	AMA-PCPI	0398
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	AMA-PCPI	0401
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	AMA-PCPI	0394
91	Acute Otitis Externa (AOE): Topical Therapy	AMA-PCPI	AQA adopted Currently under NQF review
92	Acute Otitis Externa (AOE): Pain Assessment	AMA-PCPI	AQA adopted Currently under NQF review
93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	AMA-PCPI	AQA adopted Currently under NQF review
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility	AMA-PCPI	AQA adopted Currently under NQF review

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	AMA-PCPI/College of American Pathologists (CAP)	0391
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	AMA-PCPI/CAP	0392
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients	AMA-PCPI	0389
104	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients	AMA-PCPI	0390
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy	AMA-PCPI	0388
106	Major Depressive Disorder (MDD): Diagnostic Evaluation	AMA-PCPI	0103
107	Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	0104
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	NCQA	0054
109	Osteoarthritis (OA): Function and Pain Assessment	AMA-PCPI	0050
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA-PCPI	0041
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA	0043
112	Preventive Care and Screening: Screening Mammography	NCQA	0031
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA	0034
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	NCQA	0058
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA	0055
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	NCQA	0062
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorous, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	AMA-PCPI	Not applicable
122	Chronic Kidney Disease (CKD): Blood Pressure Management	AMA-PCPI	AQA adopted
123	Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	AMA-PCPI	AQA adopted
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	CMS/Quality Insights of Pennsylvania (QIP)	0488

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	American Podiatric Medical Association (APMA)	0417
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	APMA	0416
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS/QIP	0421
130	Documentation of Current Medications in the Medical Record	CMS/QIP	0419
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up	CMS/QIP	0420
134	Screening for Clinical Depression and Follow-Up Plan	CMS/QIP	0418
135	Chronic Kidney Disease (CKD): Influenza Immunization	AMA-PCPI	AQA adopted
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	AMA-PCPI/NCQA	0566
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of Plan of Care	AMA-PCPI/NCQA	0563
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications	AMA-PCPI	0051
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	AMA-PCPI/NCQA	0510
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	AMA-PCPI/NCQA	0508
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	AMA-PCPI	0511
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	AMA-PCPI	AQA adopted
154	Falls: Risk Assessment	AMA-PCPI/NCQA	AQA adopted
155	Falls: Plan of Care	AMA-PCPI/NCQA	AQA adopted
156	Oncology: Radiation Dose Limits to Normal Tissues	AMA-PCPI	0382
157	Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection	STS	0455
158	Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy	Society of Vascular Surgeons (SVS)	0466
163	Diabetes Mellitus: Foot Exam	NCQA	0056
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula	SVS	0259

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	AMA-PCPI	AQA adopted
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization	AMA-PCPI	AQA adopted
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	AMA-PCPI/NCQA	AQA adopted
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	AMA-PCPI/NCQA	AQA adopted
178	Rheumatoid Arthritis (RA): Functional Status Assessment	AMA-PCPI/NCQA	AQA adopted
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	AMA-PCPI/NCQA	AQA adopted
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	AMA-PCPI/NCQA	AQA adopted
181	Elder Maltreatment Screen and Follow-Up Plan	CMS/QIP	AQA adopted
182	Functional Outcome Assessment in Chiropractic Care	CMS/QIP	AQA adopted
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	AMA-PCPI	0399
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	AMA-PCPI	0400
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	AMA-PCPI/NCQA	AQA adopted Currently under NQF review
186	Wound Care: Use of Compression System in Patients with Venous Ulcers	AMA-PCPI/NCQA	AQA adopted
188	Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear	Audiology Quality Consortium (AQC)	Not applicable
189	Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear Within the Previous 90 days	AQC	Not applicable
190	Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progessive Hearing Loss	AQC	Not applicable
193	Perioperative Temperature Management	AMA-PCPI	0454
194	Oncology: Cancer Stage Documented	AMA-PCPI/ASCO	0386
195	Stenosis Measurement in Carotid Imaging Studies	AMA-PCPI/NCQA	0507
201	Ischemic Vascular Disease (IVD): Blood Pressure Management Control	NCQA	0073
202	Ischemic Vascular Disease (IVD): Complete Lipid Profile	NCQA	0075
203	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control	NCQA	0075
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NCQA	0068

Please note that detailed measure specifications, including the measure's title, for 2010 individual Physician Quality Reporting System quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2011. The 2011 Physician Quality Reporting System quality measure specifications for any given individual quality measure may, therefore, be different from specifications for the same quality measure used in prior years. Specifications for all 2011 individual Physician Quality Reporting System quality measures, whether or not included in the 2010 Physician Quality Reporting System program, must be obtained from the specifications document for 2011 individual Physician Quality Reporting System quality measures, which will be available on the Physician Quality Reporting System section of the CMS Web site on or before December 31, 2010.

(2) 2011 Individual Quality Measures Selected From the 2010 Physician Quality Reporting System Quality Measures Set Available for Registry-based Reporting Only

We proposed to include 45 registry-only individual measures from the 2010 Physician Quality Reporting System (75 FR 40191). As in the 2010 Physician Quality Reporting System, we proposed to designate these measures as registry-only measures for 2011 to relieve ongoing analytical difficulties encountered with claims-based reporting of these measures in prior program years. The following is a summary of the comments received on the proposed registry-only measures.

Comment: One commenter expressed concern over our proposal to limit measure# 174, Pediatric End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis, to registry-based reporting for 2011. The commenter stated that since there are only two pediatric ESRD measures included in the Physician Quality Reporting

System for 2010 and we require eligible professionals who report via a registry to report 3 measures, it is difficult for pediatric nephrologists to participate in this valuable program. Further, the commenter indicated that even if participation could be based on the reporting of two measures, the registry process itself is not available to the vast majority of pediatric nephrologists who practice in small, academic departments, none of whose other members care for Medicare beneficiaries. Thus, the commenter suggested that similar to the provision that allows one of the pediatric ESRD measures (influenza immunization) to be reported in this individual manner, a mechanism be made available allowing pediatric dialysis centers to report adequacy results separately. In the absence of changes in the requirement to report at least three measures, separate reporting of individual measures would allow more pediatric nephrologists to participate in the Physician Quality Reporting System and advance the ultimate goal of quality improvement.

Response: We appreciate the comment and interest expressed on behalf of the pediatric nephrology community. For the 2011 Physician Quality Reporting System, we have decided not to include Physician Quality Reporting System Measure #174, since this measure was recently reviewed by NQF but not endorsed. As a result, only 1 of the 2 individual measures identified by the commenter as being relevant to pediatric nephrologists, #175, Pediatric End-Stage Renal Disease (ESRD): Influenza Immunization, is included in the final 2011 Physician Quality Reporting System measure set. This measure is available for claims-based reporting. Eligible professionals who have fewer than 3 applicable measures can still participate in the 2011 Physician Quality Reporting System via claims. Such eligible professionals would need to report on the

applicable measure available for claims-based reporting via claims and meet the appropriate criteria for satisfactory reporting of individual measures in order to qualify for a 2011 Physician Quality Reporting System incentive payment.

For the reasons discussed previously and based on the comments received, we are finalizing in the 2011 Physician Quality Reporting System quality measure set 44 of the 45 proposed 2010 Physician Quality Reporting System measures identified in Table 78 of the proposed rule for registry reporting only. As stated previously, we are not finalizing Physician Quality Reporting System Measure #174 because the measure was reviewed for endorsement by NQF but not ultimately endorsed.

The 44 2010 Physician Quality Reporting System measures selected for the 2011 Physician Quality Reporting System that are available for registry reporting only are listed in Table 79 of this final rule with comment period. These measures are listed by their Physician Quality Reporting System Measure Number and Title, along with the name of the measure's developer/owner and NQF endorsement status, if applicable. A description of the measures listed in Table 79 can be found in the "2010 PQRI Quality Measures List," which is available on the Measures and Codes page of the Physician Quality Reporting System section of the CMS Web site at http://www.cms.hhs.gov/PQRI.

TABLE 79: 2011 Individual Measures Selected From the 2010 Physician Quality Reporting System Quality Measure Set Available for Registry-based Reporting Only

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0081

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	AMA-PCPI	0070
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0083
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge	AMA-PCPI/NCQA	0241
81	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients	AMA-PCPI	0323
82	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis	AMA-PCPI	0321
83	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia	AMA-PCPI	0393
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0066
137	Melanoma: Continuity of Care – Recall System	AMA-PCPI/NCQA	0650
138	Melanoma: Coordination of Care	AMA-PCPI/NCQA	0561
143	Oncology: Medical and Radiation – Pain Intensity Quantified	AMA-PCPI	0384
144	Oncology: Medical and Radiation – Plan of Care for Pain	AMA-PCPI	0383
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	AMA-PCPI/NCQA	0404
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	AMA-PCPI/NCQA	0405
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	AMA-PCPI/NCQA	0406
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	AMA-PCPI/NCQA	0407
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)	STS	0129
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	STS	0130
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)	STS	0131
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency	STS	0114
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	STS	0115
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	STS	0237
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	STS	0238
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling	STS	0118
187	Stroke and Stroke Rehabilitation: Thrombolytic Therapy	AHA/ASA/ TJC	0437

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
191	Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery	AMA-PCPI/NCQA	0565
192	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	AMA-PCPI/NCQA	0564
196	Coronary Artery Disease (CAD): Symptom and Activity Assessment	AMA-PCPI	0065
197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	AMA-PCPI	0074
198	Heart Failure: Left Ventricular Function (LVF) Assessment	AMA-PCPI	0079
199	Heart Failure: Patient Education	AMA-PCPI	0082
200	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation	AMA-PCPI	0084
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea	AMA-PCPI/NCQA	0409
206	HIV/AIDS: Screening for High Risk Sexual Behaviors	AMA-PCPI/NCQA	0413
207	HIV/AIDS: Screening for Injection Drug Use	AMA-PCPI/NCQA	0415
208	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis	AMA-PCPI/NCQA	0410
209	Functional Communication Measure - Spoken Language Comprehension	American Speech Language Haring Association (ASHA)	0445
210	Functional Communication Measure - Attention	ASHA	0449
211	Functional Communication Measure - Memory	ASHA	0448
212	Functional Communication Measure - Motor Speech	ASHA	0447
213	Functional Communication Measure - Reading	ASHA	0446
214	Functional Communication Measure - Spoken Language Expression	ASHA	0444
215	Functional Communication Measure - Writing	ASHA	0442
216	Functional Communication Measure - Swallowing	ASHA	0443

Although we are designating certain measures as registry-only measures, we cannot guarantee that there will be a registry qualified to submit each registry-only measure for 2011. We rely on registries to self-nominate and identify the measures for which they would like to be qualified to submit quality measures results and numerator and denominator data on quality measures. If no registry self-nominates to submit

measure results and numerator and denominator data on a particular measure for 2011, then an eligible professional would not be able to report that particular measure.

We note also that detailed measure specifications, including a measure's title, for 2010 Physician Quality Reporting System quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2011. Therefore, the 2011 Physician Quality Reporting System quality measure specifications for any given quality measure may be different from specifications for the same quality measure used for 2010. Specifications for all 2011 individual Physician Quality Reporting System quality measures, whether or not included in the 2010 Physician Quality Reporting System, must be obtained from the specifications document for 2011 individual Physician Quality Reporting System quality measures, which will be available on the Physician Quality Reporting System section of the CMS Web site on or before December 31, 2010.

(3) New Individual Quality Measures for 2011

We proposed to include in the 2011 Physician Quality Reporting System quality measure set 20 measures that were not included in the 2010 Physician Quality Reporting System quality measures set provided that each measure obtains NQF endorsement by June 1, 2010 and its detailed specifications are completed and ready for implementation in the Physician Quality Reporting System by August 15, 2010 (75 FR 40192). Besides having NQF endorsement, we proposed that the development of a measure is considered complete for the purposes of the 2011 Physician Quality Reporting System if by August 15, 2010: (1) the final, detailed specifications for use in data collection for the Physician Quality Reporting System have been completed and are ready for

implementation, and (2) all of the Category II Current Procedural Terminology (CPT II) codes required for the measure have been established and will be effective for CMS claims data submission on or before January 1, 2011.

Due to the complexity of their measure specifications, we proposed that 8 of these 20 measures would be available as registry-only measures for the 2011 Physician Quality Reporting System. The remaining 15 measures were proposed to be available for reporting through either claims-based reporting or registry-based reporting.

The following is a summary of the comments received on the 20 new individual quality measures proposed for 2011.

Comment: We received numerous comments in support of the proposed additional quality measures for the 2011 Physician Quality Reporting System. One commenter stated that the new Physician Quality Reporting System measures will help to spur additional eligible professional participation in the Physician Quality Reporting System. Several comments were received specifically in support of the following 'Change in Risk-Adjusted Functional Status' measures, developed by FOTO:

- Change in Risk-Adjusted Functional Status for Patients with Knee Impairments
- Change in Risk-Adjusted Functional Status for Patients with Hip Impairments
- Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments
- Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments
- Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments

- Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist or Hand Impairments
- Change in Risk-Adjusted Functional Status for Patients with a Functional Deficit of the Neck, Cranium, Mandible, Thoracic Spine, Ribs or other General Orthopedic Impairment

Commenters stated these measures support "improved quality and efficiency of care for Medicare beneficiaries including: high cost and high volume conditions; improved outcomes; improved efficiency; improved patient and family experience of care; reduced unwarranted variation in quality and efficiency." We also received support for the inclusion of the following measures:

- Hypertension (HTN): Plan of Care;
- Heart Failure (HF): Left Ventricular Function (LVF) Testing;
- Reminder System for Mammograms measure;
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Recording of Performance Status Prior to Lung or Esophageal Cancer Resection; and
- Pulmonary Function Tests Before Major Anatomic Lung Resection.

Response: We appreciated the commenters' support of the proposed measures and agree with the reasons stated by the commenters. We are finalizing the all of the proposed new measures supported by the commenters. The new individual quality measures for the 2011 Physician Quality Reporting System are identified in Table 80 of this final rule with comment period.

Comment: Several commenters expressed support for the inclusion of the new care transitions measures developed by the AMA-PCPI as these measures are based on evidence-based processes that have been shown to reduce readmissions, limit medication errors, and improve the patient perspective of their care. The measures' developer, however, commented that the measures were not designed for individual physician level measurement. The measures are specified at the facility (hospital) level, using the UB04 administrative data to identify the denominator population.

Response: We appreciate the commenters' support for the new care transitions measures. Based on the measure developer's comments, however, we are not finalizing our proposal to include the following measures in the final 2011 Physician Quality Reporting System measure set:

- Care Transitions: Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care);
- Care Transitions: Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care);
- Care Transitions: Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care); and
- Care Transitions: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care.

Comment: One commenter recommended that the proposed Hypertension (HTN): Plan of Care measure not be included in the final set of 2011 Physician Quality Reporting System measures, claiming that this measure was developed as a "test

measure" and was not designed for individual physician accountability, but rather internal quality improvement.

Response: We appreciate the commenter's input but are finalizing our proposal to include this measure in the 2011 Physician Quality Reporting System measure set. This measure meets the considerations for the selection of 2011 Physician Quality Reporting System measures and is also a clinical quality measure under the EHR Incentive Program.

Based on the reasons discussed previously and upon consideration of the comments received, we are finalizing in the 2011 Physician Quality Reporting System quality measure set 16 of the 20 proposed 2011 Physician Quality Reporting System measures identified in Table 80 of the proposed rule. In addition to not finalizing our proposal to include the 4 new care transitions measures previously listed, we note that 3 measures—Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection; Thoracic Surgery: Pulmonary Function Test Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy); and Melanoma: Overutilization of Imaging Studies in Stage 0-1A Melanoma – that were proposed to be available for either registry or claims reporting will be made available for registry reporting only for the 2011 Physician Quality Reporting System. Upon further analysis of these measures, we have determined that these measures would be analytically challenging to collect via claims and, therefore, are not finalizing such measures for the claims-based reporting option for the 2011 Physician Quality Reporting System.

The titles of the 16 additional, or new, Physician Quality Reporting System measures for 2011 are listed in Table 80 along with the name of the measure developer, the reporting mechanism(s) available (that is, whether the measure will be reportable using claims, registries, or both), and the NQF Measure Number, if applicable.

TABLE 80: New Individual Quality Measures for 2011

Measure Title	NQF Measure Number	Measure Developer	Reporting Mechanism(s)
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments	0422	FOTO	Registry
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments	0423	FOTO	Registry
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments	0424	FOTO	Registry
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments	0425	FOTO	Registry
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments	0426	FOTO	Registry
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist or Hand Impairments	0427	FOTO	Registry
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairment	0428	FOTO	Registry
Hypertension (HTN): Plan of Care	0017	AMA-PCPI	Claims, Registry
Heart Failure (HF): Left Ventricular Function (LVF) Testing	0079	CMS	Registry
Melanoma: Overutilization of Imaging Studies in Stage 0-IA Melanoma:	0562	AMA-PCPI	Registry
Radiology: Reminder System for Mammograms	0509	AMA-PCPI	Claims, Registry
Asthma: Tobacco Use: Screening – Ambulatory Care Setting	Not applicable	AMA-PCPI	Claims, Registry
Asthma: Tobacco Use: Intervention – Ambulatory Care Screening	Not applicable	AMA-PCPI	Claims, Registry
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI	Claims, Registry
Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection	0457	Society of Thoracic Surgery (STS)	Registry

Measure Title	NQF Measure Number	Measure Developer	Reporting Mechanism(s)
Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection	0458	Society of Thoracic Surgery (STS)	Registry

(4) 2011 Measures Available for EHR-based Reporting

For 2011, we proposed to again accept Physician Quality Reporting System data from EHRs for a limited subset (22) of the proposed 2011 Physician Quality Reporting System quality measures, contingent upon the successful completion of our 2010 EHR data submission process and a determination that accepting data from EHRs on quality measures for the 2011 Physician Quality Reporting System continues to be practical and feasible. The 22 measures we proposed to be available for EHR-based reporting in the 2011 Physician Quality Reporting System include the 10 measures available for EHR-based reporting in the 2010 Physician Quality Reporting System and 12 additional measures that overlap with the clinical quality measures used in the EHR incentive program established by the American Recovery and Reinvestment Act (ARRA) (75 FR 40193).

The following is a summary of the comments received on the proposed electronic submission of these 22 measures.

Comment: Commenters were pleased that we proposed the addition of new measures for EHR-based reporting as this will permit additional physician specialties to participate using this reporting mechanism. We specifically received support for the following proposed measures for EHR-based reporting:

- Measure #1: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus;

- Measure #2: Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus;
- Measure #3: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus;
- Measure #5: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD);
- Measure #7: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI);
- Measure #110: Preventive Care and Screening: Influenza Immunization for Patients ≥50 Years Older
- Measure #111: Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older
- Measure #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- Measure #173: Preventive Care & Screening: Unhealthy Alcohol Use—Screening
- Measure #TBD: Hypertension (HTN): Blood Pressure Measurement
- Measure #TBD: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Measure #TBD: Body Mass Index (BMI) 2 Through 18 Years of Age

Response: We appreciate the commenters' support of our proposal to expand the number of measures available for EHR reporting and for the measures previously listed.

We are finalizing our proposal to have all of the measures previously listed available for 2011 Physician Quality Reporting System EHR reporting.

Comment: One commenter was concerned by the limited number of quality measures available for EHR reporting. The commenter stated that the current list of quality measures for reporting via EHR does not facilitate widespread participation because the 22 measures proposed for EHR reporting will restrict the number and type of eligible professionals able to report with their EHR system. This commenter believed the future requirements to align the Physician Quality Reporting System and EHR incentive programs highlight the importance of expanding this list.

Response: We agree with the commenter and are working to expand the list of electronically specified measures for future years. However, EHR-derived measures data will be accepted for the Physician Quality Reporting System directly from a qualified EHR for the first time in early 2011 (with 2010 Physician Quality Reporting System data). For this reason, we believe that a limited set of measures this early in the process will increase the program's chance of being successful in accepting this quality data.

Comment: A few commenters noted that many current measures are not specified for electronic reporting and that additional resources are needed to work with measure developers to re-specify or "retool" measures to be effectively collected via EHRs. One commenter noted that a hybrid approach of data collected via EHR and manual abstraction may potentially be needed.

Response: As noted previously, we are planning to continue to electronically specify measures to add to the list of those measures that are currently electronically specified for future years.

Comment: Because the following measures were not included in the Final Rule for Stage 1 of the EHR Incentive Program, one commenter suggested that they be removed from the list of 2011 EHR-based measures in favor of measures that are included in the EHR Incentive Program: Measures #39, 41, 47, 48, 142, 173, and Drugs to Be Avoided in the Elderly.

Response: While we are required to develop a plan to integrate the reporting of quality measures under the Physician Quality Reporting System with reporting under the EHR Incentive Program, they are two distinct programs. Therefore, we believe that it may be appropriate to have different measures in each of them and are retaining such measures in the Physician Quality Reporting System for 2011. However, we note that we are not finalizing our proposal to have Physician Quality Reporting System Measures #41 and #142 available for 2011 Physician Quality Reporting System EHR reporting. The electronic specifications and Quality Reporting Document Architecture (QRDA) for submitting these measures electronically were not fully developed.

Based on the reasons discussed previously and upon consideration of the comments received, we are finalizing the option of accepting clinical quality data extracted from qualified EHRs on 20 of the 22 proposed 2011 Physician Quality Reporting System quality measures identified in Tables 81 and 82 of the proposed rule. We are not finalizing our proposal to have Physician Quality Reporting System Measures #41 and #142 available for 2011 Physician Quality Reporting System EHR reporting because the specifications for submitting these measures electronically are not ready. The final 2011 measures available for EHR-based reporting are identified in Tables 81 and 82 of this final rule with comment period.

TABLE 81: 2011 Measures Available for EHR-based Reporting from 2010 Physician Quality Reporting System

Physician Quality Reporting System	Measure Title	Measure Developer	NQF Measure Number
1	***Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA	0059
2	***Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	NCQA	0064
3	***Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA	0061
5	***Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0081
7	***Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	AMA-PCPI	0070
110	**Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA-PCPI	0041
111	***Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA	0043
112	***Preventive Care and Screening: Screening Mammography	NCQA	0031
113	***Preventive Care and Screening: Colorectal Cancer Screening	NCQA	0034
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	CMS/QIP	0488

*This measure is a Core clinical quality measure for the Electronic Health Record Incentive Program under the ARRA HITECH regulation for program years 2011-2012. The electronic specifications for measures that are included in the PQRI and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.

**This measure is an Alternate Core clinical quality measure for the Electronic Health Record Incentive Program under the ARRA HITECH regulation for program years 2011-2012. The electronic specifications for measures that are included in the PQRI and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.

***This measure is included in the Electronic Health Record Incentive Program under the ARRA HITECH regulation for program years 2011-2012. The electronic specifications for measures that are included in the PQRI and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.

TABLE 82: Additional Measures Available for EHR-based Reporting In 2011

Physician Quality Reporting System	Measure Title	Measure Developer	NQF Measure Number
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	AMA-PCPI/NCQA	0046
47	Advance Care Plan	AMA-PCPI/NCQA	0326
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA	0098

Physician Quality Reporting System	Measure Title	Measure Developer	NQF Measure Number
128	*Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up	CMS/Quality Insights of Pennsylvania	0421
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	AMA-PCPI	AQA Adopted
TBD	*Hypertension (HTN): Blood Pressure Measurement	AMA-PCPI	0013
TBD	Drugs to be Avoided in the Elderly	NCQA	0022
TBD	**Weight Assessment and Counseling for Children and Adolescents	NCQA	0024
TBD	*Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	AMA-PCPI	0028
TBD	**Childhood Immunization Status	NCQA	0038

*This measure is a Core clinical quality measure for the Electronic Health Record Incentive Program under the ARRA HITECH regulation for program years 2011-2012. The electronic specifications for measures that are included in the PQRI and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.
**This measure is an Alternate Core clinical quality measure for the Electronic Health Record Incentive Program under the ARRA HITECH regulation for program years 2011-2012. The electronic specifications for measures that are included in the PQRI and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.
***This measure is included in the Electronic Health Record Incentive Program under the ARRA HITECH regulation for program years 2011-2012. The electronic specifications for measures that are included in the PQRI and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.

(5) Measures Proposed for Inclusion in 2011 Measures Groups

We proposed to retain the following 13 2010 Physician Quality Reporting System measures groups for the 2011 Physician Quality Reporting System: (1) Diabetes Mellitus; (2) CKD; (3) Preventive Care; (4) CABG; (5) Rheumatoid Arthritis; (6) Perioperative Care; (7) Back Pain; (8) CAD; (9) Heart Failure; (10) IVD; (11) Hepatitis C; (12) HIV/AIDS; and (13) CAP. For 2011, we proposed that the CABG, CAD, Heart Failure, and HIV/AIDS measures groups continue to be reportable through the registry-based reporting mechanism only, while the remaining Diabetes Mellitus, CKD, Preventive Care, Rheumatoid Arthritis, Perioperative Care, Back Pain, IVD, Hepatitis C, and CAP measures groups will continue to be reportable through either claims-based reporting or registry-based reporting for the 2011 Physician Quality Reporting System (75 FR 40193).

In addition to the 13 measures groups that we proposed to retain from the 2010 Physician Quality Reporting System, we proposed 1 new Asthma Measures Group, which could be reported through either claims-based reporting or registry-based reporting.

Finally, as in previous program years, for 2011, we proposed that the measures included in any proposed 2011 measures group be reportable either as individual measures or as part of a measures group, except for the Back Pain measures group, which will continue to be reportable only as part of a measures group and not as individual measures in 2011 (75 FR 40193 through 40197).

As with measures group reporting in the 2008, 2009, and 2010 Physician Quality Reporting System, we proposed that each eligible professional electing to report a group of measures for 2011 must report all measures in the group that are applicable to each patient or encounter to which the measures group applies at least up to the minimum number of patients required by the applicable reporting criteria.

The following is a summary of the comments received on the proposed 2011 measures groups.

Comment: One commenter expressed support for the movement to greater use of measures groups as a method of Physician Quality Reporting System participation, as they are easier to manage and monitor.

Response: We appreciate the commenter's positive feedback and continue to encourage eligible professionals to report on measures groups. As we have stated in prior years, we believe that measures groups can present a more complete picture of the quality of care provided clinical condition or clinical focus than individual measures reporting.

Comment: We received favorable support for the proposed inclusion of the following measures groups:

- Asthma.
- Back Pain.
- CAD.
- CAP.
- CABG.
- Diabetes Mellitus.
- Heart failure.

Some of the reasons stated by commenters include that these are important chronic conditions and collecting information on the treatment of these conditions could lead to improved care and treatment, which would result in reduced costs.

Response: We agree. For these reasons, we are finalizing our proposal to include all of these measures groups in the 2011 Physician Quality Reporting System.

Comment: One commenter proposed the removal of Measure #135, Chronic Kidney Disease (CKD): Influenza Immunization, from the CKD Measures Group to ensure maximum satisfactory reporting. The commenter noted that Measure # 135 differs from other measures in the CKD Measures Group in its method of reporting. Whereas measures in the CKD Measures Group are Patient Process (where the measures are reported once per reporting period), Measure # 135 is now Patient Periodic (where the measure is reported during certain periods of time). The commenter is concerned that this difference in reporting methods may be too confusing for satisfactory reporting.

Response: We agree with the commenter's recommendation and are removing Measure # 135, Influenza, from the CKD Measures Group for the reasons cited by the commenter. However, the CKD Influenza Measure # 135 will still be reportable as an individual measure.

Comment: One commenter supported the proposed retention of the 2010 HIV/AIDS Physician Quality Reporting System measures group for the 2011 Physician Quality Reporting System, but encouraged, to the extent feasible, HIV/AIDS quality measures that can be reported through the claims-based method in addition to the registry-based method.

Response: We are pleased with the commenter's support for the HIV/AIDS measures group. Based on the current processing of claims data, it was determined that the claims system will not accurately capture these measures. Registry reporting provides an intricate process to capture these measures accurately.

Comment: For the 2011 Physician Quality Reporting System measures group on preventive care, the addition of a process measure for HIV screening of "high-risk" patients, as endorsed by the National Quality Forum and USPSTF previously (level "A" recommendation), be added. The commenter urged that this measure be modified if and when coverage is expanded to include routine HIV screening, consistent with the recommendations of the Centers for Disease Control and Prevention (CDC).

Response: We appreciate the commenter's suggestion to add HIV screening of "high risk' patients into the Preventive Care Measures Group. Measure groups are created based on measures with a particular clinical condition or focus. The current Preventive Care Measures Group is intended for a more general patient population and

would not be appropriate for the addition of the HIV measure(s) suggested by the commenter. The commenter should consider utilizing the 2012 Call for Measures as an avenue for submitting suggestions for possibly creating a new measure group for screening "high risk" patients. We also urge the commenter to direct such suggestions to the appropriate measure developer/owner(s) for consideration.

Based on the reasons discussed previously and upon consideration of the comments received, we are finalizing the following proposed 2011 measures groups: (1) Diabetes Mellitus; (2) Preventive Care; (3) CABG; (4) Rheumatoid Arthritis; (5) Perioperative Care; (6) Back Pain; (7) CAD; (8) Heart Failure; (9) IVD; (10) Hepatitis C; (11) HIV/AIDS; (12) CAP; and (13) Asthma. We are also finalizing the proposed CKD measures group for 2011 with one modification. As stated previously, we are removing Measure #135: Chronic Kidney Disease (CKD): Influenza Immunization from the CKD measures group for 2011 because the reporting requirements for this measure are different from the reporting requirements for the other measures in this measures group. The following 4 measures groups are reportable through the registry-based reporting mechanism only: (1) CABG; (2) CAD; (3) Heart Failure; and (4) HIV/AIDS.

The measures selected for inclusion in each of the 2011 measures groups are identified in Tables 83 through 96 of this final rule with comment period. Some measures selected for inclusion in these 14 measures group are current 2010 individual Physician Quality Reporting System measures. The title of each such measure is preceded with its Physician Quality Reporting System Measure Number in Tables 83 through 96. As stated previously, the Physician Quality Reporting System Measure Number is a unique identifier assigned by CMS to all measures in the Physician Quality

Reporting System measure set. Once a Physician Quality Reporting System Measure Number is assigned to a measure, it will not be used again, even if the measure is subsequently retired from the Physician Quality Reporting System measure set. Measures that are not preceded by a number (in other words, those preceded by "TBD") in Tables 83 through 96 were never part of a Physician Quality Reporting System measure set prior to 2011. A number will be assigned to such measures for 2011.

TABLE 83: Measures Included in the 2011 Diabetes Mellitus Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	0059	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	0064	NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	0061	NCQA
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	0055	NCQA
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	0062	NCQA
163	Diabetes Mellitus: Foot Exam	0056	NCQA

TABLE 84: Measures Included in the 2011 CKD Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	Not applicable	AMA-PCPI
122	Chronic Kidney Disease (CKD): Blood Pressure Management	AQA adopted	AMA-PCPI
123	Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	AQA adopted	AMA-PCPI
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	AQA adopted	AMA-PCPI

TABLE 85: Measures Included in the 2011 Preventive Care Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	0046	AMA-PCPI/NCQA
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	0098	AMA-PCPI/NCQA
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	0041	AMA-PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	0043	NCQA
112	Preventive Care and Screening: Screening Mammography	0031	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening	0034	NCQA
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	0421	CMS/QIP
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	AQA adopted	AMA-PCPI
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI

TABLE 86: Measures Included in the 2011 CABG Measures Group*

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	0516	Society of Thoracic Surgeons (STS)
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	0235	STS
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)	0129	STS
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	0130	STS
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)	0131	STS
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency	0114	STS
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	0115	STS
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	0237	STS
170	Coronary Artery Bypass Graft	0238	STS

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
	(CABG): Beta-Blockers Administered at Discharge		
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling	0118	STS

* This measures group is reportable through registry-based reporting only.

TABLE 87: Measures Included in the 2011 Rheumatoid Arthritis Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	0054	NCQA
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	AQA adopted	AMA-PCPI/NCQA
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	AQA adopted	AMA-PCPI/NCQA
178	Rheumatoid Arthritis (RA): Functional Status Assessment	AQA adopted	AMA-PCPI/NCQA
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	AQA adopted	AMA-PCPI/NCQA
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	AQA adopted	AMA-PCPI/NCQA

TABLE 88: Measures Included in the 2011 Perioperative Care Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician	0270	AMA-PCPI/NCQA
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	0268	AMA-PCPI/NCQA
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	0271	AMA-PCPI/NCQA
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	0239	AMA-PCPI/NCQA

TABLE 89: Measures Included in the 2011 Back Pain Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
148	Back Pain: Initial Visit	0322	NCQA
149	Back Pain: Physical Exam	0319	NCQA
150	Back Pain: Advice for Normal Activities	0315	NCQA
151	Back Pain: Advice Against Bed Rest	0313	NCQA

TABLE 90: Measures Included in the 2011 CAD Measures Group*

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	0067	AMA-PCPI
196	Coronary Artery Disease (CAD): Symptom and Activity Assessment	0065	AMA-PCPI
197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	0074	AMA-PCPI
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI

* This measures group is reportable through registry-based reporting only.

TABLE 91: Measures Included in the 2011 Heart Failure Measures Group*

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	0081	AMA-PCPI
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	0083	AMA-PCPI
198	Heart Failure: Left Ventricular Function (LVF) Assessment	0079	AMA-PCPI
199	Heart Failure: Patient Education	0082	AMA-PCPI
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI

* This measures group is reportable through registry-based reporting only.

TABLE 92: Measures Included in the 2011 IVD Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
201	Ischemic Vascular Disease (IVD): Blood Pressure	0073	NCQA

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
	Management Control		
202	Ischemic Vascular Disease (IVD): Complete Lipid Profile	0075	NCQA
203	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control	0075	NCQA
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	0068	NCQA
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI

TABLE 93: Measures Included in the 2011 Hepatitis C Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	0395	AMA-PCPI
85	Hepatitis C: HCV Genotype Testing Prior to Treatment	0396	AMA-PCPI
86	Hepatitis C: Antiviral Treatment Prescribed	0397	AMA-PCPI
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	0398	AMA-PCPI
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	0401	AMA-PCPI
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	0394	AMA-PCPI
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	0399	AMA-PCPI
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	0400	AMA-PCPI

TABLE 94: Measures Included in the 2011 HIV/AIDS Measures Group*

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	0404	AMA-PCPI/NCQA
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	0405	AMA-PCPI/NCQA
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	0406	AMA-PCPI/NCQA
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	0407	AMA-PCPI/NCQA
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea	0409	AMA-PCPI/NCQA
206	HIV/AIDS: Screening for High Risk Sexual Behaviors	0413	AMA-PCPI/NCQA
207	HIV/AIDS: Screening for Injection Drug Use	0415	AMA-PCPI/NCQA
208	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis	0410	AMA-PCPI/NCQA

* This measures group is selected to be reportable through registry-based reporting only.

TABLE 95: Measures Included in the 2011 CAP Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
56	Community-Acquired Pneumonia (CAP): Vital Signs	0232	AMA-PCPI/NCQA
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	0094	AMA-PCPI/NCQA
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status	0234	AMA-PCPI/NCQA
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic	0096	AMA-PCPI/NCQA

TABLE 96: Measures Included in the 2011 Asthma Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
53	Asthma: Pharmacologic Therapy	0047	AMA-PCPI
64	Asthma: Asthma Assessment	0001	AMA-PCPI
TBD	Asthma: Tobacco Use: Screening – Ambulatory Setting	Not applicable	AMA-PCPI
TBD	Asthma: Tobacco Use: Intervention – Ambulatory Screening	Not applicable	AMA-PCPI

As with measures group reporting in the 2008, 2009, and 2010 Physician Quality Reporting System, each eligible professional electing to report a group of measures for 2011 must report all measures in the group that are applicable to each patient or encounter to which the measures group applies at least up to the minimum number of patients required by the applicable reporting criteria. The measures selected for the Back Pain Measures Group continue to be reportable only as part of a measures group and not as individual measures for the 2011 Physician Quality Reporting System. Measures selected for inclusion in all other 2011 Physician Quality Reporting System measures groups are reportable either as individual measures or as part of a measures group.

We note that the specifications for measures groups do not necessarily contain all the specification elements of each individual measure making up the measures group. This is based on the need for a common set of denominator specifications for all the measures making up a measures group in order to define the applicability of the measures group. Therefore, the specifications and instructions for measures groups will be provided separately from the specifications and instructions for the individual 2011 Physician Quality Reporting System measures. We will post the detailed specifications and specific instructions for reporting measures groups on the Physician Quality Reporting System section of the CMS Web site at http://www.cms.hhs.gov/PQRI by no later than December 31, 2010.

Additionally, the detailed measure specifications and instructions for submitting data on those 2011 measures groups that were also included as 2010 Physician Quality Reporting System measures groups may be updated or modified prior to 2011. Therefore, the 2011 Physician Quality Reporting System measure specifications for any given measures group could be different from specifications and submission instructions for the same measures group used for 2010. These measure specification changes do not materially impact the intended meaning of the measures or the strength of the measures.

j. 2011 Physician Quality Reporting System Quality Measures for Group Practices Selected to Participate in the Group Practice Reporting Option (GPRO I)

For 2011, we proposed that group practices selected to participate in the 2011 Physician Quality Reporting System GPRO I would be required to report on 26 proposed measures listed in Table 97 of the proposed rule (75 FR 40197 through 40198). We proposed these measures because they are NQF-endorsed measures currently collected as

part of the PGP and/or MCMP demonstrations and in the 2010 Physician Quality Reporting System GPRO.

The following is a summary of the comments received on the proposed 2011 Physician Quality Reporting System quality measures for group practices selected to participate in the group practice reporting option (GPRO I).

Comment: We received a comment noting general support for the 26 proposed GPRO I measures. Another commenter expressed specific support for the diabetes measures proposed for the Group Practice Reporting Option (GPRO), "Diabetes Mellitus: Hemoglobin A1c Testing" and "Diabetes Mellitus: Lipid Profile."

Response: We appreciate the positive feedback and are finalizing the 26 GPRO I measures as proposed. We believe these measures target high-cost chronic conditions and preventive care.

Comment: A couple of commenters encouraged us to expand the list of GPRO I measures and/or develop different measure sets to address the care delivered in different group practices. One commenter encouraged us to adopt additional diabetes measures into the GPRO to ensure the most comprehensive evidence-based assessment of diabetes care.

Response: We agree that in order to make GPRO I more broadly applicable we would need to expand the list of GPRO I measures and/or develop different measures to address the care delivered in different group practices. As we stated in the proposed rule (75 FR 40180), we hosted a listening session on February 2, 2010, to solicit input on a number of aspects of the Physician Quality Reporting System, including the measures for the 2011 Physician Quality Reporting System GPRO. We did not, however, receive any

suggestions for additional disease modules for GPRO I. Therefore, we encourage commenters to use the 2012 Call for Measures as an avenue to submit specific measures for us to consider for future expansion of the GPRO I measure set. As stated previously, additional measures recommended for selection for the 2011 Physician Quality Reporting System via comments to the proposed rule cannot be included in the 2011 Physician Quality Reporting System measure set.

Comment: With regard to the 26 GPRO measures, one commenter asked us to consider whether some of the testing and patient education measures are sufficiently proximate to the desired clinical outcome to justify the effort of data collection, analysis, and comparative reporting.

Response: We value the commenter's thoughtful input and agree that as we expand the Physician Quality Reporting System measure set, including the GPRO I measure set, in future years we may want to consider whether the measures lead to the desired outcomes.

Based on the reasons discussed previously and after considering the comments, for the 2011 Physician Quality Reporting System, group practices selected to participate in the Physician Quality Reporting System GPRO I will be required to report on all measures listed in Table 97.

TABLE 97: Measures for Physician Groups Participating in the 2011 Physician Quality Reporting System Group Practice Reporting Option (GPRO I)

Physician Quality Reporting System	Measure Title	Measure Developer	NQF Measure Number
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA	0059
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	NCQA	0064
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA	0061

Physician Quality Reporting System	Measure Title	Measure Developer	NQF Measure Number
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0081
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	AMA-PCPI	0067
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	AMA-PCPI	0070
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0083
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA-PCPI	0041
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA	0043
112	Preventive Care and Screening: Screening Mammography	NCQA	0031
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA	0034
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA	0055
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0066
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	NCQA	0062
163	Diabetes Mellitus: Foot Exam	NCQA	0056
229	Diabetes Mellitus: Hemoglobin A1c Testing	NCQA	0057
230	Diabetes Mellitus: Lipid Profile	NCQA	0063
228	Heart Failure: Left Ventricular Function (LVF) Testing	CMS	
198	Heart Failure: Left Ventricular Function (LVF) Assessment	AMA-PCPI	0079
227	Heart Failure: Weight Measurement	CMS AMA-PCPI not maintaining	0085
199	Heart Failure: Patient Education	AMA-PCPI	0082
200	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation	AMA-PCPI	0084
197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	AMA-PCPI	0074
TBD	Hypertension: Blood Pressure Measurement	AMA-PCPI	0013
TBD	Hypertension (HTN): Blood Pressure Control	NCQA	0018
TBD	Hypertension (HTN): Plan of Care	AMA-PCPI	0017

A separate measures specifications manual and other supporting documents will be available for group practices participating in the 2011 Physician Quality Reporting System GPRO I. We anticipate that the group practice measures specifications manual will be available by November 15, 2010 or shortly thereafter on the Physician Quality Reporting System section of the CMS Web site at http://www.cms.hhs.gov/PQRI.

k. Public Reporting of Physician Quality Reporting System Data

Section 1848(m)(5)(G) of the Act requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submitted data on quality measures for the Physician Quality Reporting System and the names of the eligible professionals (or group practices) who are successful electronic prescribers. In addition, section 10331(a)(1) of the ACA, requires the Secretary to develop a Physician Compare Internet Web site by January 1, 2011, on which information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting System would be posted.

In accordance with section 1848(m)(5)(G) of the Act, we proposed to continue to make public the names of eligible professionals and group practices that satisfactorily submit quality data for the 2011 Physician Quality Reporting System. Previously, we intended to post such information on the Healthcare Provider Directory. To meet the ACA deadline of January 1, 2011, we proposed to use the current Healthcare Provider Directory (previously known as the Physician and Other Health Care Professional Directory) as a foundation for the Physician Compare Web site. Therefore, we proposed to post the names of the 2011 Physician Quality Reporting System satisfactory reporters

on the Physician Compare Web site that must be developed by January 1, 2011.

Specifically, we proposed to post the names of eligible professionals who: (1) submit data on the 2011 Physician Quality Reporting System quality measures through one of the reporting mechanisms available for the 2011 Physician Quality Reporting System; (2) meet one of the proposed satisfactory reporting criteria of individual measures or measures groups for the 2011 Physician Quality Reporting System as previously described; and (3) qualify to earn a Physician Quality Reporting System incentive payment for covered professional services furnished during the applicable 2011 Physician Quality Reporting System reporting period, for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act, on the Physician Compare Web site (75 FR 40198). Similarly, for purposes of publicly reporting the names of group practices, on the Physician Compare Web site, for 2011, we proposed to post the names of group practices that: (1) submit data on the 2011 Physician Quality Reporting System quality measures through one of the proposed group practice reporting options; (2) meet the proposed criteria for satisfactory reporting under the respective group practice reporting option; and (3) qualify to earn a Physician Quality Reporting System incentive payment for covered professional services furnished during the applicable 2011 Physician Quality Reporting System reporting period for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act.

We did not propose to make performance information publicly available at either the group practice or individual level for 2011 Physician Quality Reporting System. However, we note that section 10331 of the ACA requires that not later than January 1, 2013, and with respect to reporting periods that begin no earlier than

January 1, 2012, we implement a plan for making publicly available through Physician Compare, information on physician performance, including measures collected under the Physician Quality Reporting System. Consistent with section 10331 of the ACA, we expect, in the future, to publicly report performance information based on the Physician Quality Reporting System.

The following is a summary of the comments we received regarding the public reporting of Physician Quality Reporting System data required under section 1848(m)(5)(G)(i) of the Act and Physician Compare website required under section 10331 of the ACA.

Comment: Many commenters supported the development of a Physician Compare Website. Some commenters supported public reporting of the names of eligible professionals who satisfactorily report Physician Quality Reporting System measures and/or who are successful e-prescribers, noting that this is an appropriate first step in CMS' efforts to further transparency. Another commenter supported public reporting of the names of eligible professionals who participate in the Physician Quality Reporting System or Maintenance of Certification Programs as a way to enhance informed consumer choice based on quality and outcomes.

Response: We appreciate the commenters' support. We note, however, that we did not propose to publicly report the names of eligible professionals who participate in the Physician Quality Reporting System or Maintenance of Certification Programs. Instead, we proposed to publicly report the names of eligible professionals who satisfactorily report 2011 Physician Quality Reporting System measures and are finalizing our proposal to post the names of eligible professionals who satisfactorily

report 2011 Physician Quality Reporting System measures on the Physician Compare Web site.

Comment: Some commenters agreed with CMS' decision to not publicly report individual or group level Physician Quality Reporting System performance results at this time. Many of the commenters believe that it would be premature to do so. One commenter believed that CMS' decision to not post 2011 Physician Quality Reporting System performance data will allow eligible professionals to analyze their 2010 data and resolve any identified concerns with the GPRO reporting and analysis process. Another commenter noted that a different level of scrutiny is required to report performance rates. A commenter generally opposes the use of quality data for the purpose of physician profiling because it could exacerbate gaps in quality and access through risk avoidance and by inhibiting collaborative efforts by the profession to improve care for all patients.

Response: Although we are not planning to post 2011 Physician Quality Reporting System performance results, we note that section 10331 of the ACA requires that not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, we implement a plan for making publicly available through Physician Compare, information on physician performance, including measures collected under the Physician Quality Reporting System. Therefore, consistent with section 10331 of the ACA, we expect, in the future, to publicly report performance information based on the Physician Quality Reporting System. It is conceivable that we could begin publicly reporting performance information based on the Physician Quality Reporting System starting with 2012 Physician Quality Reporting System performance results. If and when we move towards public reporting of physician performance information, as

contemplated under section 10331 of the ACA, we will need to consider and address the commenters' concerns.

Comment: As we move towards posting performance information, one commenter urged us to start with posting measure results on group practices only until there is sufficient experience and data to determine which, if any, measures can be reported at the individual practitioner level with relative certainty that the information portrayed is accurate. Specifically, we should monitor the group practice level reporting for unintended consequences before reporting performance information at the individual practitioner level.

Response: We appreciate the commenter's valuable input. We are committed to taking steps to ensure that the information portrayed is accurate. As we develop our plans for posting performance information on the Physician Compare website, we may consider initially limiting the performance information to measure results at the group practice level as suggested by the commenter. As stated previously, we will discuss our plans for posting performance information in more detail in future notice and comment rulemaking.

Comment: Some commenters suggested that we work with stakeholders to--

- Identify how best to relay this information in a user-friendly manner to the public;
- Develop reliable, comparable benchmarks, with a sufficient sample size to ensure validity;
- Ensure that specific reporting and performance results are indeed quality indicators;

- Ensure that the site accurately represents physician performance and facilitates consumer decision-making;

- Provide an opportunity for physicians, other eligible professionals, and group practices to review their data before it is made public. As with Hospital Compare, eligible professionals should have the right to suppress any data that are inaccurate; and

- Establish a method for ensuring that any publicly reported information is--

++ Correctly attributed to those involved in the care;

++ Appropriately risk-adjusted; and

++ Accurate, user-friendly, relevant and helpful to the consumer/patient. CMS must educate consumers/patients about the publicly reported performance measures and corresponding benchmarks.

Response: We agree with commenters on the importance of receiving stakeholder input on the Physician Compare Web site. We are required, by section 10331(d) of the ACA to take into consideration input provided by multi-stakeholder groups, consistent with section 1890(b)(7) and 1890(A) of the Act, as added by section 3014 of the ACA , in selecting quality measures for the Physician Compare Web site. In addition, on October 27, 2010, we held a Town Hall Meeting to solicit input from stakeholders on the further expansion of the Physician Compare Web site (75 FR 58411 and 58412). Finally, as we stated in the CY 2011 PFS proposed rule, we will be working on a plan to expand the information that is publicly reported on the Physician Compare in future years, which will be described in future rulemaking. Stakeholders would have an opportunity to comment on any plans described in future rulemaking as well.

Comment: One commenter voiced concerns about various issues and challenges

that need to be resolved before any performance information is made public. Specific issues include measure gaps, challenges associated with risk adjustment and attribution, accuracy of the data, and eligible professionals' ability to control the factors that influence their performance.

Response: We agree that these issues will need to be addressed as we move towards public reporting of performance information on individual eligible professionals. We look forward to receiving input from stakeholders on these and other important methodological considerations as we develop our plans for the expansion of the Physician Compare Web site to include performance information.

Comment: A few commenters suggested that physicians be given an opportunity to review and appeal any data that will be made public prior to the data being made public. Commenters stated that physicians also should be given an opportunity to comment and make changes to the data on the Physician Compare Web site should the information be incorrect.

Response: With respect to the development and implementation of a plan for making physician performance information publicly available on the Physician Compare Web site, section 10331(b) of the ACA specifically requires the Secretary, to the extent practicable, to include processes by which a physician or other eligible professional whose performance measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public. Thus, as we describe our plans for making physician performance information publicly available on the Physician Compare Web site in future notice and comment rulemaking, we anticipate addressing the commenter's suggestions in further detail.

Comment: Some commenters had concerns about the posting of the names of eligible professionals and group practices who satisfactorily report Physician Quality Reporting System measures. Some commenters requested that CMS delay posting this information until problems with the Physician Quality Reporting System are addressed and both success rates and participation rates improve significantly. Commenters were concerned that this information could be misinterpreted or misperceived by the public. Some commenters noted that successful reporting of the mostly process measures that comprise the Physician Quality Reporting System would not be a valid surrogate for patients to evaluate the actual quality of care or quality of service provided by an individual practitioner. Furthermore, consumers already face a challenge when attempting to evaluate providers. The commenter thinks it will be even more confusing for consumers to understand the difference between claims-based or registry reporting and which is more accurate or reflects actual quality of care. Commenters stressed the importance of educating consumers about why eligible professionals may choose not to participate in the Physician Quality Reporting System. Another commenter noted that consumers must be made aware that non-participation in the Physician Quality Reporting System is not an indication that an eligible professional or group practice provides low quality care. Finally, a commenter also suggested that this information be accompanied with explanatory language regarding the limitations of posting this data.

Response: While we understand the commenters' concerns, section 1848(m)(5)(G)(i) of the Act requires us to post on a CMS web site the names of eligible professionals and group practices that satisfactorily submit data on quality measures under the Physician Quality Reporting System. We intend to provide explanatory

language on the website that would address many of the commenters' concerns, including information about the intended uses and/or limitations of the information being presented in the form of a disclaimer.

Comment: One commenter urged CMS to consider how the appeals process will be connected to the Physician Compare Web site. The commenter questioned whether the Web site would be updated if professionals are successful during the appeals process.

Response: We are assuming that the commenter is referring to the informal appeals process required under section 1848(m)(5)(I) of the Act and discussed in section VII.F.1.e .of this final rule with comment period. To the extent that an eligible professional seeks a review of our determination that he or she did not satisfactorily report and our review results in a determination that the professional did satisfactorily report, we anticipate that we would update the Physician Compare Web site to indicate that the professional satisfactorily reported Physician Quality Reporting System quality measures.

Comment: We received a few comments related to public reporting and maintenance of certification. One commenter offered to work with us to provide information on Maintenance of Certification Program status for posting on the Physician Compare Web site and the value as it relates to quality, safety, efficiency, and patient experiences of physician care. The commenter would also like the Physician Compare Web site to include a link to ABMS. Another commenter urged us to make available information on whether a physician received an additional bonus for successfully meeting Maintenance of Certification Program requirements. A third commenter was concerned that public reporting of physicians who satisfy the Physician Quality Reporting System

requirements through the Maintenance of Certification Program Part IV pathway could inadvertently lead to confusion about whether those same physicians have satisfied all of the requirements of the Boards' Maintenance of Certification Program programs.

Response: We agree that it may be valuable to consumers to have information on an eligible professional's Maintenance of Certification Program status and would be interested in exploring the feasibility of posting this information on the Physician Compare Web site in the future. We could also explore posting information on whether a physician or other eligible professional received the additional 0.5 percent incentive associated with participation in a Maintenance of Certification Program. However, as noted by one of the commenters, we feel that this information could be misinterpreted and would not be as valuable as information on an eligible professional's Maintenance of Certification Program status. As we describe in section VII.F.1.l.(1) of this final rule with comment period, in order for an eligible professional to qualify for this additional 0.5 percent incentive, not only does he or she have to satisfactorily participate in the Physician Quality Reporting System, participate in a qualified Maintenance of Certification Program, and successfully complete a Maintenance of Certification Program practice assessment, but he or she must participate in the qualified Maintenance of Certification Program and successfully complete a Maintenance of Certification Program practice assessment more frequently than is required to qualify for or maintain board certification status.

After considering the comments, we intend to post the names of eligible professionals who: (1) submit data on the 2011 Physician Quality Reporting System quality measures through one of the reporting mechanisms available for the 2011

Physician Quality Reporting System; (2) meet one of the satisfactory reporting criteria of individual measures or measures groups for the 2011 Physician Quality Reporting System; and (3) qualify to earn a Physician Quality Reporting System incentive payment for covered professional services furnished during the applicable 2011 Physician Quality Reporting System reporting period for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act, on the Physician Compare Web site that will be developed by January 1, 2011.

Similarly, for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act with respect to group practices, on the Physician Compare Web site, we intend to post the names of group practices that: (1) submit data on the 2011 Physician Quality Reporting System quality measures through GPRO I or GPRO II; (2) meet the criteria for satisfactory reporting under the GPRO I or GPRO II; and (3) qualify to earn a Physician Quality Reporting System incentive payment for covered professional services furnished during the applicable 2011 Physician Quality Reporting System reporting period for group practices.

We will discuss our plans for further expansion of the Physician Compare Web site in future notice and comment rulemaking.

l. Other Relevant ACA Provisions

(1) Section 3002 (b) - Incentive Payment Adjustment for Quality Reporting

Beginning 2015, a payment adjustment will apply under the Physician Quality Reporting System. Specifically, under section 1848(a)(8) of the Act, as added by section 3002(b) of the ACA , with respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does

not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year, the fee schedule amount for services furnished by such professionals during the year shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services. The applicable percent for 2015 is 98.5 percent and for 2016 and each subsequent year it is 98.0 percent. In the proposed rule, we stated that we will address this provision of the ACA in future notice and comment rulemaking (75 FR 40199).

The following is a summary of comments received regarding the incentive payment adjustment for quality reporting required under section 3002(b) of the ACA.

Comment: Some commenters expressed opposition to the use of payment adjustments under the Physician Quality Reporting System program. One commenter believes participation should remain voluntary as the Physician Quality Reporting System has not yet been shown to improve patient outcomes and therefore does not warrant penalties for nonparticipating eligible professionals. Other commenters stated that, to be successful, performance measurement should be nonpunitive and transparent.

Response: While we acknowledge the commenters' concerns, we note that section 1848(a)(8) of the Act, as added by the ACA, requires us to implement a payment adjustment for eligible professionals who do not satisfactorily report Physician Quality Reporting System measures beginning in 2015. In the meantime, we will continue to assess whether we can make additional improvements to the Physician Quality Reporting System to facilitate satisfactory reporting and to encourage greater participation prior to implementation of the payment adjustments required under section 1848(a)(8) of the Act

beginning for 2015. We will address our plans for implementing the payment adjustment that begins in 2015 in future notice and comment rulemaking.

(2) Section 3002(c) – Maintenance of Certification Programs and Section 10327 Improvements to the Physician Quality Reporting System

Section 3002(c) of the ACA amends section 1848(k)(4) of the Act to require a mechanism whereby an eligible professional may provide data on quality measures through a maintenance of certification program (Maintenance of Certification Program) operated by a specialty body of the American Board of Medical Specialties (ABMS). In addition, section 1848(m)(7)of the Act ("Additional Incentive Payment"), as added by section 10327(a) of the ACA , provides for an additional 0.5 percent incentive payment for years 2011 through 2014 if certain requirements are met. In accordance with section 1848(m)(7)(B) of the Act, in order to qualify for the additional incentive payment, an eligible professional must--

- Satisfactorily submit data on quality measures under the Physician Quality Reporting System for a year and have such data submitted--

++ On their behalf through a Maintenance of Certification Program that meets the criteria for a registry under the Physician Quality Reporting System; or

++ In an alternative form and manner determined appropriate by the Secretary; and

- More frequently than is required to qualify for or maintain board certification status:

++ Participate in such a Maintenance of Certification Program for a year and

++ Successfully completes a qualified Maintenance of Certification Program

practice assessment for such year.

Section 1848(m)(7)(C)(i) of the Act defines "Maintenance of Certification Program" as a continuous assessment program, such as a qualified ABMS Maintenance of Certification Program, or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communications skills and professionalism. Such a program shall require a physician to do the following:

(1) Maintain a valid, unrestricted medical license in the United States;

(2) Participate in educational and self-assessment programs that require an assessment of what was learned;

(3) Demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty;

(4) Successful completion of a qualified Maintenance of Certification Program practice assessment.

As defined in section 1848(m)(7)(C)(ii) of the Act, a "qualified Maintenance of Certification Program practice assessment" means an assessment of a physician's practice that--

(1) Includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

(2) Includes a survey of patient experience with care; and

(3) Requires a physician to implement a quality improvement intervention to

address a practice weakness identified in the initial assessment and then to remeasure to assess performance after such intervention.

To qualify for the additional incentive payment, section 1848(m)(7)(B)(iii) of the Act also requires the Maintenance of Certification Program to submit to CMS, on behalf of the eligible professional, information:

(1) In a form and manner specified by the Secretary, that the eligible professional more frequently than is required to qualify for or maintain board certification status, participates in the Maintenance of Certification Program for a year and successfully completes a qualified Maintenance of Certification Program practice assessment for such year;

(2) If requested by the Secretary, information on the survey of patient experience with care; and

(3) As the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

Section 1848(m)(7) of the Act ("Additional Incentive Payment") further specifies that the additional 0.5 percent incentive payment is available only for years 2011, 2012, 2013, and 2014. For years after 2014, if the Secretary determines it to be appropriate, the Secretary may incorporate participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality for care furnished pursuant to the physician fee schedule payment modifier.

To implement the provisions under sections 1848(k)(4) and 1848(m)(7) of the Act

("Additional Incentive Payment"), we proposed for 2011 to require the following (75 FR 40199 and 40200):

- An eligible professional wishing to be eligible for the additional Physician Quality Reporting System incentive payment of 0.5 percent must meet the proposed requirements for satisfactory Physician Quality Reporting System reporting, for program year 2011, based on the 12-month reporting period, due to the statutory language that the eligible professional must satisfactorily report "for a year." For purposes of satisfactory reporting under the Physician Quality Reporting System, we proposed that the eligible professional may participate as an individual eligible professional using either individual Physician Quality Reporting System measures or measures groups and submitting the Physician Quality Reporting System data via claims, a registry, or an EHR or participate under one of the GPRO options (I or II). Alternatively, eligible professionals may satisfactorily report under the Physician Quality Reporting System based on submission of Physician Quality Reporting System data by a Maintenance of Certification Program, provided that the Maintenance of Certification Program has qualified as a Physician Quality Reporting System registry for 2011. As indicated previously, an eligible professional would not necessarily have to qualify for the Physician Quality Reporting System through a Maintenance of Certification Program serving as a registry. Rather, we proposed that an eligible professional may qualify for the additional incentive, without regard to the method by which the eligible professional has met the basic requirement of satisfactory reporting under the Physician Quality Reporting System.

- In addition to meeting the proposed requirements for satisfactory reporting for the Physician Quality Reporting System for program year 2011, the eligible professional

must have data submitted on his or her behalf through a Maintenance of Certification Program, for the Maintenance of Certification Program in which the eligible professional participates. Although the Maintenance of Certification Program need not become a qualified registry for data submission for Physician Quality Reporting System purposes, the Maintenance of Certification Program must meet the criteria for a registry for submission of the Maintenance of Certification Program data as specified below.

- An eligible professional must, more frequently than is required to qualify for or maintain board certification, participate in a Maintenance of Certification Program for a year and successfully complete a qualified Maintenance of Certification Program practice assessment for such year. We believe that the "more frequently" requirement applies both to the elements of the Maintenance of Certification Program itself and the requirement to successfully complete a qualified Maintenance of Certification Program practice assessment. With regard to the elements other than completing a qualified Maintenance of Certification Program practice assessment, we proposed to require that the Maintenance of Certification Program certify that the eligible professional has "more frequently" than is required to qualify for or maintain board certification "participated in a Maintenance of Certification Program for a year" as required by section 10327 of the ACA. We did not propose to specify with respect to participation how an eligible professional must meet the more frequently requirement, but rather that the Maintenance of Certification Program so certify that the eligible professional has met this requirement. We noted that we did not believe that the "more frequently" requirement is applicable to the licensure requirement, given that one cannot be licensed "more frequently" than is required. However, we stated that the eligible professional must "more frequently" than

is required to qualify for or maintain board certification, participate in educational and self-assessment programs that require an assessment of what was learned; demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty; and successfully complete a qualified Maintenance of Certification Program practice assessment.

With respect to the Maintenance of Certification Program practice assessment, which is specifically delineated in section 1848(m)(7)(B)(ii) of the Act as being required more often than is necessary to qualify for or maintain board certification, we stated that we believe we needed to be more specific regarding our interpretation of the phrase "more frequently" (75 FR 40200). Additionally, we stated that we were aware that some specialty boards have varying Maintenance of Certification Program requirements for physicians to maintain board certification, based on the date of original certification. Some, we believe, may not be required to participate in a Maintenance of Certification Program at all in order to maintain board certification. Accordingly, we recognize that "more often" may vary among physicians certified by the same specialty board. We interpreted the statutory provisions as requiring participation in and successful completion of at least one Maintenance of Certification Program practice assessment. Therefore, we proposed, as a basic requirement, participation in and successful completion in at least one Maintenance of Certification Program practice assessment. For physicians who are not required to participate in a Maintenance of Certification Program to maintain board certification, "more often" would be more than 0, and therefore only once. For physicians, however, who are

otherwise required by the specialty board to participate in a Maintenance of Certification Program to maintain board certification status, these physicians would need to complete the Maintenance of Certification Program practice assessment a second time in order to qualify for the additional incentive payment. If a Maintenance of Certification Program practice assessment were required more than once during a particular cycle, the eligible professional would be required to complete the Maintenance of Certification Program practice assessment a third time in order to qualify for the additional incentive.

We are also aware that ABMS boards are at various stages in implementing the practice assessment modules, and some may not have such assessment modules in place. However, inasmuch as we interpret the statute to require a Maintenance of Certification Program practice assessment at least once as part of the Maintenance of Certification Program, eligible professionals who do not have available, through their boards or otherwise, a Maintenance of Certification Program practice assessment are not eligible for the 0.5 percent incentive.

We believe that the experience of care survey provides particularly valuable information and proposed that a qualified Maintenance of Certification Program practice assessment must include a survey of patient experience with care. The Secretary may request information on the survey of patient experience with care, under section 1848(m)(7)(B)(iii) of the Act. In view of the importance of this information, and the lack of readily available alternative sources, we proposed to require that Maintenance of Certification Programs submit information as to the survey of patient

experience with care for the eligible professional regarding whom information is being submitted by the Maintenance of Certification Program.

We proposed that Maintenance of Certification Programs wishing to enable their members to be eligible for an additional Physician Quality Reporting System incentive payment for the 2011 Physician Quality Reporting System will need to go through a self-nomination process by January 31, 2011. We proposed the board will need to include all of the following information in their self-nomination letter to CMS:

- Provide detailed information regarding the Maintenance of Certification Program with reference to the statutory requirements for such program.

- Indicate the organization sponsoring the Maintenance of Certification Program, and whether the Maintenance of Certification Program is sponsored by an ABMS board. If not an ABMS board, indicate whether the program is substantially equivalent to the ABMS Maintenance of Certification Program process.

- The frequency of a cycle of Maintenance of Certification Program for the specific Maintenance of Certification Program of the sponsoring organization; including what constitutes "more frequently" for the Maintenance of Certification Program practice assessment for the specific Maintenance of Certification Program of the sponsoring organization.

- What was, is, or will be the first year of availability of the Maintenance of Certification Program practice assessment for completion by an eligible professional.

- What data is collected under the patient experience of care survey and how this information would be provided to CMS.

- How the Maintenance of Certification Program monitors that an eligible professional has implemented a quality improvement process for their practice.

- Describe the methods, and data used under the Maintenance of Certification Program, and provide a list of all measures used in the Maintenance of Certification Program for 2010 and to be used for 2011, including the title and descriptions of each measure, the owner of the measure, whether the measure is NQF endorsed, and a link to a website containing the detailed specifications of the measures, or an electronic file containing the detailed specifications of the measures.

We proposed that sponsoring organizations who desire to participate as a Maintenance of Certification Program will need to be able to provide CMS the following information in a CMS-specified file format by no later than the end of the first quarter of 2012:

- The name, NPI and applicable TIN(s) of the eligible professional who would like to participate in this process;

- Attestation from the board that the information provided to CMS is accurate and complete;

- The board has signed documentation from the eligible professional that the eligible professional wishes to have the information released to CMS;

- Information from the experience of care survey;

- Information certifying that the eligible professional has participated in a Maintenance of Certification Program for a year, more frequently than is required to qualify for or maintain board certification status, including the year that the physician met the board certification requirements for the Maintenance of Certification Program, and

the year the eligible professional participated in a Maintenance of Certification Program "more frequently" than is required to maintain or qualify for board certification; and

- Information certifying that the eligible professional has completed the Maintenance of Certification Program practice assessment one additional time more than is required to qualify for or maintain board certification, including the year of the original Maintenance of Certification Program practice assessment or that a Maintenance of Certification Program practice assessment is not required for the eligible professional, and the year of the additional Maintenance of Certification Program practice assessment completion.

We proposed that specialty boards that also desire to send Physician Quality Reporting System information to CMS on behalf of eligible professionals should be able to meet the proposed requirements for registry data submission and should follow the directions for self-nomination to become a qualified registry. Boards may also participate as registries for Physician Quality Reporting System data provided that they meet the registry requirements. As an alternative to requiring boards to either operate a qualified Physician Quality Reporting System registry or to self-nominate to submit Maintenance of Certification Program data to CMS on behalf of their members, we also considered having the various boards submit the Maintenance of Certification Program data to the ABMS and having ABMS channel the information from the various boards to CMS (75 FR 40200).

The following is a summary of the comments received on the proposed requirements for qualifying for the additional 0.5 percent incentive for 2011, the proposed mechanism for receiving Maintenance of Certification Program data from the

specialty boards, as well as on the alternative mechanism that we considered.

Comment: Commenters raised concerns as to whether the CY 2011 PFS proposed rule uses the term "Maintenance of Certification Program" in a manner that may be confusing to the public and unnecessarily raises trademark concerns. Specifically, the commenter recommended changes related to the use of the acronym "MOCP," such as referring to "maintenance of certification program" (all lower-case letters) or using different letters for the acronym.

Response: We appreciate the commenter's input. We will not use any acronym, including "MOCP." Instead, we will spell out the term "Maintenance of Certification Program" using capital letters as it is done in section 1848(m)(7) of the Act ("Additional Incentive Payment").

Comment: Several commenters provided positive feedback regarding the availability of an additional 0.5 percent incentive payment for meeting specific maintenance of certification requirements, including support for the inclusion of patient experience of care surveys as a required element of the Maintenance of Certification Program practice assessment component.

Response: We appreciate the commenter's support of the additional Maintenance of Certification Program incentive for eligible professionals participating in the 2011 Physician Quality Reporting System, authorized by the ACA.

Comment: One commenter believes that the "maintenance of certification" reporting option is premature. The commenter noted that the state of New Jersey may not currently have operational and tested "practice assessment" capability and funding for this program may not be available.

Response: While we recognize that this option may not be a feasible option for all eligible professionals, we are required to have this option available for the 2011 Physician Quality Reporting System under section 1848(m)(7) of the Act ("Additional Incentive Payment"). We note that participation in this option is voluntary and is not required to participate in the Physician Quality Reporting System or earn the Physician Quality Reporting System incentive. Therefore, eligible professionals who do not have the ability to participate in a maintenance of certification program can still participate in the Physician Quality Reporting System for 2011 and potentially qualify for a 1 percent incentive payment by satisfactorily reporting 2011 Physician Quality Reporting System measures. Participation in a maintenance of certification program provides eligible professionals an opportunity to earn an additional 0.5 percent incentive above and beyond what they could earn by satisfactorily reporting Physician Quality Reporting System measures.

Comment: One commenter urged us to implement regulations that would ensure that all eligible professionals have access to the additional 0.5 percent incentive.

Response: While we appreciate the commenter's support for the additional 0.5 percent incentive, we note that section 1848(m)(7) of the Act ("Additional Incentive Payment") explicitly ties the additional 0.5 percent incentive to participation in a Maintenance of Certification Program. Section 1848(m)(7)(C)(i) of the Act specifies that the term "Maintenance of Certification Program" means "a continuous assessment program…that advances quality and the lifelong learning and self-assessment of board certified specialty physicians…." This suggests that Maintenance of Certification Programs apply only to physicians and only physicians can participate in a Maintenance

of Certification Program and qualify for this additional 0.5 percent incentive payment. We do not believe we have the authority to broaden the applicability of this additional 0.5 percent incentive payment.

Comment: One commenter recommended that we allow eligible professionals who complete a Part IV Maintenance of Certification practice assessment be eligible for an additional 0.5 percent bonus if they are also satisfactorily report Physician Quality Reporting System measures, regardless of whether they satisfactorily reported through claims or another registry method. In contrast, other commenters believe the requirements for receiving a Maintenance of Certification Program payment are too onerous for both eligible professionals and Maintenance of Certification Program boards and should not be tied to satisfactorily reporting Physician Quality Reporting System measures.

Response: Section 1848(m)(7)(B)(i)(I) of the Act specifically requires that "…in order to qualify for the additional incentive payment..., an eligible professional shall…satisfactorily submit data on quality measures for [the Physician Quality Reporting System] for a year." As stated in the proposed rule (75 FR 40199), we proposed that an eligible professional "…may participate as an individual eligible professional using either individual Physician Quality Reporting System measures or measures groups and submitting the Physician Quality Reporting System data via claims, a registry, or an EHR or participate under one of the GPRO options (I or II)." We also proposed that an eligible professional "may qualify for the additional incentive, without regard to the method by which the [eligible professional] has met the basic requirement of satisfactorily reporting under the PQRI [that is, the Physician Quality Reporting

System]." Therefore, eligible professionals wishing to qualify for the additional 0.5 percent incentive payment can satisfactorily report Physician Quality Reporting System measures using any available Physician Quality Reporting System method and are not limited to a specific one.

Comment: Although the ABMS has issued guidelines for Maintenance of Certification Program, one commenter believes that the individual boards have a fair amount of latitude in how they implement those guidelines. As a result, the commenter favors the plan to have individual specialty boards meet the CMS criteria if they wish to be deemed to verify individual eligible professional qualification for Physician Quality Reporting System incentives.

Response: We recognize the variability in the boards' maintenance of certification program requirements and appreciate the commenter's support of our proposal to allow individual boards to verify that their eligible professionals have met the appropriate maintenance of certification program requirements for the additional 0.5 percent incentive. Accordingly, we are finalizing the requirement to have the various boards submit information to us on eligible professionals' behalf attesting that an eligible professional has more frequently than is required to qualify for or maintain board certification status, participated in a maintenance of certification program for a year and successfully completed a qualified Maintenance of Certification Program practice assessment for such year.

Comment: Some commenters requested additional clarification on the requirements for qualifying for the additional 0.5 percent incentive so that eligible professionals can understand the necessary processes needed to qualify. One commenter

requested more information on how Maintenance of Certification Program would work for specialty boards, such as the American Board of Internal Medicine (ABIM), that oversee the maintenance of certification processes for multiple subspecialties.

Response: As discussed previously, we recognize that there is variability in the boards' maintenance of certification program requirements. Therefore, eligible professionals will need to work with their specific Maintenance of Certification Program for information as to the processes of that program as it relates to qualifying for the additional 0.5 percent incentive.

We did not propose any requirements for self-nomination of each subspecialty of a board. Rather the board would have to provide information to CMS on each Maintenance of Certification Program that the board sponsors, where it sponsors more than one.

Comment: In response to the request in the proposed rule for input on an alternative to requiring Boards to either operate a qualified Physician Quality Reporting System registry or to self-nominate to submit Maintenance of Certification Program data to CMS on behalf of their members (75 FR 40201), one commenter noted that many of the ABMS member boards do not have the capacity to develop and implement CMS-approved registries to support their diplomates' participation in the Maintenance of Certification Program pathway for Physician Quality Reporting System reporting. The commenter suggested that developing a registry that can be shared across multiple Boards will allow for an efficient and cost-effective approach to facilitate participation in Physician Quality Reporting System reporting for their diplomates. Such a registry could collect and submit physician quality improvement data, provide attestation that the

quality improvement data was collected as part of a qualified ABMS MOC® Part IV activity, and also serve as an intermediary in transmitting successful maintenance of certification participation in the Physician Quality Reporting System to CMS. Depending upon the vendor(s) identified to support the registry function, the commenter felt that this may also provide a mechanism for submission of patient experience of care surveys.

Response: We note that we did not propose to require boards to implement Physician Quality Reporting System qualified registries to support their diplomates' participation in the Maintenance of Certification Program pathway for Physician Quality Reporting System reporting. We merely highlighted that boards may wish to self-nominate to become a qualified Physician Quality Reporting System registry to facilitate eligible professionals' reporting of Physician Quality Reporting System data, as well as participation in the Maintenance of Certification Pathway. To the extent that a board or other entity wishes to become a qualified registry for the purposes of Physician Quality Reporting System data submission, the board or other entity must self-nominate to do so and meet all of the registry qualification requirements described in section VII.F.1.(4). of this final rule with comment period. In addition, to the extent an entity wishes to submit Physician Quality Reporting System data and/or data regarding participation in Maintenance of Certification Program(s) on behalf multiple boards, the entity will need to comply with the appropriate registry and/or Maintenance of Certification Program qualification requirements. More specifically, in order to submit data on participation in the Maintenance of Certification Pathway for multiple boards, the entity, must include the following information for each Maintenance of Certification Program that it wishes to submit data on in their self-nomination letter to CMS:

- Provide detailed information regarding the Maintenance of Certification Program with reference to the statutory requirements for such program.

- Indicate the organization sponsoring the Maintenance of Certification Program, and whether the Maintenance of Certification Program is sponsored by an ABMS board. If not an ABMS board, indicate whether the program is substantially equivalent to the ABMS Maintenance of Certification Program process.

- The frequency and cycle of Maintenance of Certification for the specific Maintenance of Certification Program of the sponsoring organization; including what constitutes "more frequently" for the Maintenance of Certification Program practice assessment for the specific Maintenance of Certification Program of the organization.

- What was, is, or will be the first year of availability of the Maintenance of Certification Program practice assessment for completion by an eligible professional.

- What data is collected under the patient experience of care survey and how information on the survey would be provided to CMS.

- How the Maintenance of Certification Program monitors that an eligible professional has implemented a quality improvement process for their practice.

- Describe the methods, and data used under the Maintenance of Certification Program, and provide a list of all measures used in the Maintenance of Certification Program for 2010 and to be used in 2011, including the title and descriptions of each measure, the owner of the measure, whether the measure is NQF-endorsed, and a link to a Web site containing the detailed specifications of the measures, or an electronic file containing the detailed specifications of the measures.

With respect to submitting data on Maintenance of Certification Program

participation, the qualified entity must submit:

- The name, NPI, and applicable TIN(s) of the eligible professional who would like to participate in this process;
- Attestation from each board that the information provided to CMS is accurate and complete;
- Signed documentation from the eligible professional that the eligible professional wishes to have their information released to CMS;
- Information on the patient experience of care survey;
- Information from the appropriate board attesting that the eligible professional has participated in a Maintenance of Certification Program for a year, more frequently than is required to qualify for or maintain board certification status, including the year that the physician met the board certification requirements for the Maintenance of Certification Program and the year the eligible professional participated in a Maintenance of Certification Program "more frequently" than is required to qualify for board certification; and
- Information from the appropriate board certifying that the eligible professional has completed the Maintenance of Certification Program practice assessment one additional time more than is required to qualify or maintain board certification, including the year of the original Maintenance of Certification Program practice assessment or that a Maintenance of Certification Program practice assessment is not required for the eligible professional, and the year of the additional Maintenance of Certification Program practice assessment completion.

Comment: Several comments indicated that we misinterpreted the intent of the

"more frequently" requirement under section 1848(m)(7)(B)(ii) of the Act. Specifically, some commenters believe the intent of the "more frequently" requirement applies specifically to the Maintenance of Certification Program Part IV, practice assessment, requirement only and not to Parts II or III of the Maintenance of Certification Program (that is, the educational and self-assessment programs and the formalized, secure examination portion of the Maintenance of Certification Program). To that end, commenters requested the final rule provide additional clarification regarding the implementation of the "more frequently" requirement. One commenter also requested that we work closely with the ABMS to determine a means for implementing this provision which would be the least disruptive to existing maintenance of certification programs. One commenter noted that adding a requirement to participate in a maintenance of certification program "more frequently" than is required by the specialty board undermines the boards' standards and their expertise.

Response: As discussed in the proposed rule (75 FR 40199 through 40201), we believe that, as constructed, sections 1848(m)(7)(C)(i)(II) and 1848(m)(7)(C)(i)(III) of the Act applies the "more frequently" requirement to both the Maintenance of Certification Program itself and the successful completion of a Maintenance of Certification Program practice assessment. While we understand the commenter's question of this interpretation, we do not interpret the legislation as applying the "more frequently" requirement simply to the practice assessment activity. Rather we interpret the legislation as providing an additional incentive for eligible professionals who are actively pursuing activities involved in a continuous assessment program, such as a qualified ABMS Maintenance of Certification Program or an equivalent program.

However, with respect to the "more frequently" requirement as it relates to the Maintenance of Certification Program itself, as opposed to the "more frequently" requirement for the practice assessment, we do not specify how an eligible professional must meet the more frequently requirement. Rather, we require only that the Maintenance of Certification Program indicate that the eligible professional has met the requirement.

Comment: A few comments opposed linking payers to the Maintenance of Certification Program.

Response: We are unclear what the commenters mean with respect to linking Medicare to the Maintenance of Certification Program. As we noted previously, participation in a Maintenance of Certification Program is not required for an eligible professional to earn a Physician Quality Reporting System incentive. Rather, participation in a Maintenance of Certification Program provides eligible professionals an opportunity to earn an additional 0.5 percent incentive above and beyond what they could earn under the Physician Quality Reporting System.

Comment: Several commenters suggested the "more frequently" requirement be based on the March 2009 ABMS MOC® Standards adopted by the ABMS, which applies to the 24 ABMS member boards. Under these standards, "more frequently" would mean that a Part IV activity must be completed every 1 to 4 years, by physicians who voluntarily decide to participate in the Maintenance of Certification Program Physician Quality Reporting System pathway. One of the commenters believes that diplomats should not be expected to participate more frequently than once a year in a process of collecting and reporting performance data and then acting on those results.

Response: With regard to the commenters' suggestion to adopt the standards

adopted by ABMS in 2009, we believe that by requiring the Maintenance of Certification Program to confirm that their eligible professionals meet the requirements "more frequently" than required will allow flexibility for the Maintenance of Certification Programs that have differing cycles of completion. Since we are looking to see that both the Maintenance of Certification Program itself and the practice assessment completed once more than required, we feel that a broader interpretation rather than an exact instance provides a greater opportunity for participation. For example, if an eligible professional's cycle states that they must complete one practice assessment activity every two to five years, more frequently would be completion of an additional activity within that cycle. If an eligible professional's cycle states they must complete two practice assessment activities during a cycle (for example, every two to five years), they would have to complete an additional activity (total of three) within their cycle.

Comment: Although several commenters favor measuring patients' experience with care, some suggested that we waive the requirement for reporting patient experience until 2012, once a definitive ABMS standard has been adopted. One commenter suggested that we work with the Boards to monitor the adoption of accurate and applicable patient experience methodologies. Another commenter requested clarification on why the patient experience is required for the Physician Quality Reporting System Maintenance of Certification Program practice assessment when many specialty boards do not require a survey of patient experience to satisfy practice assessment or maintenance of certification requirements.

Response: We agree that the survey of patient experience is an important mechanism for improving quality of care. While we appreciate the intent of the

comments of ensuring a standard is available under ABMS Maintenance of Certification Programs, this additional 0.5 percent incentive is also available to non- ABMS boards as long as the process is substantially similar to the ABMS Maintenance of Certification Program process. The survey of patient experience with care is a required part of the practice assessment as defined under section 1848(m)(7)(B)(iii) of the Act. Therefore, we will finalize this requirement of a survey of patient experience with care as a required element of the practice assessment.

Comment: One commenter requested that we provide CRNAs with the opportunity to report quality measures through a nursing maintenance of certification program mechanism. Conversely, other commenters expressed that the rule should clearly state that physicians who are not participating in the ABMS MOC® are not eligible for the additional 0.5 percent incentive via the Maintenance of Certification pathway. One commenter specifically objected to the proposed rule language that, if not an ABMS Board, a program that is "substantially equivalent" to the ABMS Maintenance of Certification Program process may participate. The commenter noted that to be "substantially equivalent" to the ABMS Maintenance of Certification Program, any other program would have to first assure that its physicians had (1) successfully completed an Accreditation Council for Graduate Medical Education (ACGME)-approved training in their specialty, (2) successfully completed all the requirements of the ABMS Member Board to be certified, and (3) engaged in the ABMS Maintenance of Certification® program that is sponsored by the relevant Member Board. Items one and two are essential and should be included in any reference to the concept of "substantially equivalent."

Response: Under section 1848(m)(7)(C)(i) of the Act, a Maintenance of Certification Program is "a continuous assessment program such as a qualified American Board of Medical Specialties Maintenance of Certification Program or an equivalent program (as determined by the Secretary)." Therefore, eligible professionals participating in an equivalent program (that is, one that satisfies the definition of "Maintenance of Certification Program" under section 1848(m)(7)(C)(i) of the Act and §414.90(b), that has a "qualified Maintenance of Certification Program practice assessment" as defined under section 1848(m)(7)(ii) of the Act and §414.90(b), and meets the self-nomination process as proposed and previously described) will be able to submit Maintenance of Certification Program data on behalf of eligible professionals for purposes of the eligible professional qualifying for the additional 0.5 percent incentive. This additional 0.5 percent incentive payment is not limited to only those eligible professionals who participate in an ABMS MOC®. However, as previously stated, we believe that the definition of the term "Maintenance of Certification Program" under section 1848(m)(7)(C)(i) of the Act limits applicability of Maintenance of Certification Programs to physicians. Therefore, this additional 0.5 percent incentive would not apply to other eligible professionals, such as CRNAs.

Comment: One commenter supports creation of a mechanism whereby an eligible professional may provide data on quality measures through a Maintenance of Certification Program operated by a member specialty body of the American Board of Medical Specialties or American Osteopathic Association. Specifically, the commenter expressed support for the American Board of Radiology (ABR) and American Osteopathic Board of Radiology (AOBR) Maintenance of Certification Programs.

Response: We appreciate the commenter's support of the additional 0.5 incentive for eligible professionals participating in the 2011 Physician Quality Reporting System, authorized by the ACA. With respect to the specific Maintenance of Certification Programs that the commenter is in support of, these entities must follow the self-nomination process finalized in this final rule with comment period.

After considering the comments received and for the reasons we previously articulated, we are implementing the requirements that an eligible professional must meet to qualify for the additional 0.5 percent incentive authorized by section 1848(m)(7) of the Act ("Additional Incentive Payment"), previously described. We are also implementing the requirements for entities to self-nominate to submit Maintenance of Certification Program data on behalf of eligible professionals as proposed and previously described. We do not anticipate completing the qualification process until mid-2011. We will conditionally qualify entities until we complete testing of the entities' ability to submit Maintenance of Certification Program data to us in the specified manner. We anticipate posting the names of these conditionally qualified entities on the Physician Quality Reporting System section of the CMS Web site in the Spring 2011 and we will update this list with the entities qualified for 2011 as soon as we finish testing the entities' ability to submit Maintenance of Certification Program data to us in the specified manner.

To the extent an eligible professional participates in multiple Maintenance of Certification Programs and meets the requirements under section 1848(m)(7) of the Act (Additional Incentive Payment) under multiple programs, the eligible professional can qualify for only one additional 0.5 percent incentive per year.

(3) Section 3002(d) – Integration of Physician Quality Reporting and EHR Reporting

Section 1848(m)(7) of the Act ("Integration of Physician Quality Reporting and EHR Reporting"), as added by section 3002(d) of the ACA requires us to move towards the integration of EHR measures with respect to the Physician Quality Reporting System. Section 1848(m)(7) of the Act specifies that by no later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under the Physician Quality Reporting System with reporting requirements under subsection (o) relating to the meaningful use of EHRs. Such integration shall consist of the following:

(A) The selection of measures, the reporting of which would both demonstrate—

(i) Meaningful use of an EHR for purposes of the EHR incentive program; and

(ii) Quality of care furnished to an individual; and

(B) Such other activities as specified by the Secretary.

In an effort to align the Physician Quality Reporting System with the EHR Incentive Program, we proposed and finalized many ARRA core clinical quality measures for inclusion in the 2011 Physician Quality Reporting System (see section VII.F.1.i.(4)) of this final rule with comment period), to demonstrate meaningful use of EHR and quality of care furnished to individuals. We are working towards a plan to integrate reporting on quality measures to make available by January 1, 2012.

The following is a summary on comments received regarding the integration of Physician Quality Reporting System and EHR reporting.

Comment: With respect to the integration of the Physician Quality Reporting System and the EHR Incentive Program, one commenter requested clarification on how we will deal with eligible professionals excluded from one program or the other in the alignment process. The commenter noted that we have not provided a feasible way for

physicians excluded from the EHR Incentive Program to be able to participate in a program that combines these two initiatives. For example, pathologists employed at independent laboratories may be eligible for the EHR incentive but cannot participate in the Physician Quality Reporting System because of the billing mechanism they use.

Response: While we appreciate the commenter's interest in participating in both the Physician Quality Reporting System and the EHR Incentive Program, we note that these are two different, distinct programs. In addition, the term "eligible professional" is defined differently under these programs. We understand that, as a consequence, professionals may be eligible for one program but not the other. While we encourage participation in both the Physician Quality Reporting System and the EHR Incentive Program, we are not able to change the criteria for participation eligibility in each program in order to accommodate professionals who would like to participate in both programs, but do not meet the eligibility requirements for both.

Regarding the specific concern that pathologists who bill through independent laboratories are unable to participate in the Physician Quality Reporting System, independent laboratories are suppliers and do not fit into the Physician Quality Reporting System definition of "eligible professional" under section 1848(k)(3)(B) of the Act. Pathologists who bill directly to Medicare, however, are eligible to participate in the Physician Quality Reporting System.

Comment: Many commenters expressed support for linking the Physician Quality Reporting System with the EHR Incentive Program as it will reduce the burden and variability of reporting and streamline administrative processes for health care providers and for CMS and offered suggestions for us to consider as we develop our plan to

integrate quality measures reporting under the two programs. One commenter, while favoring alignment of measures between the Physician Quality Reporting System and EHR Incentive Program, points out that the purpose of each is different, which will make it difficult to achieve this integration. The commenter stated that quality reporting is only one of the meaningful use features, so Physician Quality Reporting System measures should qualify for that objective. Commenters stated that Physician Quality Reporting System incentives should not require participation in meaningful use and meaningful use incentives should not specifically require participation in the Physician Quality Reporting System. Commenters particularly supported alignment of the quality measures, noting that the degree to which any of the measures could share a dual purpose would be an added advantage for those who are trying to implement these programs. Another commenter suggested that we consult with specialty societies on a phased-in approach for integrating Physician Quality Reporting System and meaningful use measures that allow attestation in 2012 followed by incremental targeted percentage requirements would promote a smooth transition to full integration of Physician Quality Reporting System and meaningful use measures. Another commenter requested that we make it clear how we plan to update the outpatient measures required for meaningful use based on any changes implemented in the Physician Quality Reporting System.

Response: We appreciate the commenters' valuable input and will take the opinion offered by the commenters into consideration as we work towards making a plan to integrate reporting on quality measures available by January 1, 2012.

Comment: One commenter expressed concern that if we use the same proposed methodology for excluding measures with a zero percent performance rate in the

Physician Quality Reporting System program that it does for assessing compliance with HITECH Meaningful Use measures then many physicians will be deemed "not capable" when attempting to demonstrate reporting capability of quality data. This is because eligible professionals are allowed the flexibility to demonstrate compliance with meaningful use capability when reporting clinical quality measures by reporting a zero denominator.

Response: A zero percent performance rate indicates that the eligible professional is reporting on a measure that is not clinically relevant to their practice. We do not preclude practices from doing this. However, since the Physician Quality Reporting System does not mandate a certain core set of measures and eligible professionals can select which measures apply to them, eligible professionals should be able to find 3 measures which pertain to their practice. We do recognize that eligible professionals may be somewhat limited for 2011 as there are only 20 measures available for Physician Quality Reporting System EHR reporting and those eligible professionals who wish to report measures without electronic specifications for the Physician Quality Reporting System will need to do so using a qualified registry or through claims (if claims-based reporting is permitted for the selected measure). We intend to discuss our plan to integrate reporting on quality measures under the Physician Quality Reporting System with reporting requirements under the EHR Incentive Program in future notice and comment rulemaking prior to implementation of the plan.

(4) Section 3002(e) - Feedback

Section 3002 (e) of the ACA amends section 1848(m)(5) of the Act by adding subparagraph (H), which requires the Secretary to provide timely feedback to eligible

professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures. Since the inception of the program in 2007, the Physician Quality Reporting System has provided eligible professionals who have reported Physician Quality Reporting System data on quality measures feedback reports at the TIN/NPI level detailing participation in the Physician Quality Reporting System, including reporting rate and performance rate information. For 2008, we improved the format and content of feedback reports based on stakeholder input. We also developed an alternate report distribution method whereby each eligible professional can directly request and receive a feedback report. We will continue to provide feedback reports to individuals and group practices that satisfactorily submit Physician Quality Reporting System quality measure and thus qualify to earn a Physician Quality Reporting System incentive.

We believe that the requirements under section 1848(m)(5)(H) of the Act, as added by section 3002(e) of the ACA, for "timely" feedback reports is met by providing the feedback reports on or about the time of issuance of the incentive payments. Thus, we proposed to provide 2011 feedback reports on or about the time of issuance of the 2011 incentive payments in 2012, consistent with our current practice. In addition, we proposed to provide interim feedback reports for eligible professionals reporting 2011 measures groups through the claims-based reporting mechanism. These reports would be similar in content and format to the reports that we currently provide for such eligible professionals using claims for dates of service between January 1, 2011 and February 28, 2011. We indicated that we expected that we would be able to make these interim feedback reports available to eligible professionals in June 2011. We stated that

we believe interim feedback reports would be particularly valuable to eligible professionals reporting measures groups, because it would let an eligible professional know how many more cases he or she needs to report to satisfy the criteria for satisfactory reporting for claims-based reporting of measures groups. We also indicated that we intend to continue to explore methods to facilitate Physician Quality Reporting System feedback report distribution, as discussed in the proposed rule (75 FR 40201).

The following is a summary of comments received regarding our proposal to provide timely feedback reports for the Physician Quality Reporting System.

Comment: We received some positive comments regarding our proposal to provide timely feedback. One commenter stated that eligible professionals will benefit from timely feedback reports on whether they are satisfactorily submitting data on quality measures. While some commenters supported our proposal to provide interim feedback reports for those who are reporting measures groups via claims, other commenters urged us to focus our efforts on providing other options for interim feedback. One commenter stated that the timeframe for feedback should be revised to a point during the reporting period so that eligible providers can act on the information they receive and that this was the legislation's intention. Commenters indicated that providing feedback after the close of the reporting period or just ahead of incentive payments is of minimal value since eligible professionals are not able to assess their reporting status and revise their reporting practices as needed. Commenters specifically recommended receiving quarterly or monthly feedback reports or upon request.

Response: We appreciate the commenters' suggestions to provide more interim feedback reports in a timely manner. Although section 1848(m)(5) of the Act requires us

to provide "timely feedback" to eligible professionals on satisfactorily submitting data on quality measures, it is not a requirement to distribute "interim" feedback reports. While we agree that eligible professionals would benefit from timely, interim feedback, we have determined that we will not be able to complete the programming and development work necessary to provide the proposed interim feedback reports for eligible professionals who report 2011 measures groups using the claims-based reporting mechanism in the time frame that we proposed for the 2011 Physician Quality Reporting System. If we were to provide these interim feedback reports for 2011, they would more than likely not be available until late 2011. Since receiving interim feedback this late in the reporting period would be of little utility to eligible professionals, we are not finalizing our proposal to provide eligible professionals who report measures groups using the claims-based reporting mechanism with interim feedback reports for 2011. We intend, instead, to provide these interim feedback reports for 2012. In addition, as discussed further in section VII.F.2 of this final rule, we plan to provide an interim eRx report in the fall of 2011, which will include 2012 eRx payment adjustment information. We also will continue to provide timely annual feedback reports and anticipate providing additional interim reports for 2012. Furthermore, we are working internally to improve eligible professionals' electronic access to Physician Quality Reporting System and eRx reports by report type, program, and year for 2011.

Comment: Several commenters were disappointed by our proposal and suggested that it does not meet the statutory requirements and requested that we revise our proposal to increase the timeliness and frequency of the reports. One commenter suggested we revise the feedback report proposal to expedite the reports and ensure that the process

improves successful participation in the Physician Quality Reporting System. Several comments specifically recommended that interim feedback reports be provided to all Physician Quality Reporting System participants, regardless of reporting mechanism used, rather than only to those reporting measures groups via claims-based reporting, as proposed. Other commenters specifically requested that interim feedback reports be provided to those reporting individual quality measures. Other commenters recommended we provide more frequent, or real-time, feedback reports to ensure that this process improves successful participation in the Physician Quality Reporting System. One commenter specifically encouraged CMS to provide feedback reports throughout the process, so that participants are aware of their progress in the program. Another commenter recommended that the system be redesigned to automatically generate a report as soon as the requirements for an individual eligible professional have been satisfied, much like what most of the registry systems do and why they have such a high level of successful completion. Another commenter suggested including the most recent Physician Quality Reporting System data available in the confidential feedback reports. Issuing the reports at the time of the incentive payment, as proposed, may discourage many from participating in the program the following year given that they are not certain whether or not they were successful the previous year and renders the reports not useful for quality improvement. The commenters believe the lack of timeliness of feedback reports is one of the major reasons for dissatisfaction with the Physician Quality Reporting System.

Response: Section 1848(m)(5)(HH) of the Act requires that we provide timely feedback to eligible professionals on the performance of the eligible professional with

respect to satisfactorily submitting data on Physician Quality Reporting System measures but does not define the term "timely" or specify a deadline for providing feedback. As we stated in the proposed rule (75 FR 40201), we believe that this requirement is met by providing a timely, annual feedback report at or about the time of issuance of the incentive payments. In addition to providing an annual feedback report, we also proposed to provide an interim feedback report for eligible professionals who submit measures groups via claims. Although, for the reasons discussed previously, we are not finalizing our proposal to provide this interim feedback report for 2011, we intend to do so for 2012. The processing of claims data from the NCH file, along with the necessary programming required to produce reports and subsequently distribute to eligible professionals is time intensive. We are actively working to facilitate this process so that the interim feedback reports for claims-based reporting of measures groups and other interim feedback reports can be available for the 2012 Physician Quality Reporting System. We are continuing to work on ways to provide eligible professionals with timely and accurate feedback reports while working with the limitations of the claims-based reporting method. We also intend to work with registries and EHR vendors to explore ways in which we can leverage these alternative reporting mechanisms to provide interim feedback reports.

Comment: One commenter suggested that the interim feedback reports be provided for the first quarter of data instead of 2 months of data as proposed.

Response: While we agree that interim feedback reports for the first quarter of data would be valuable, we do not, for the reasons stated previously, have the technical ability to make interim feedback reports based on just the first 2 months of data available

before July 1, 2011. We agree with commenters that interim feedback reports need to be issued at a point during the reporting period that eligible professionals can act upon the information to increase their chances of reporting satisfactorily, especially when they are required to report on percentage of applicable cases or patients. As stated previously, since the utility of receiving feedback reports in late 2011, (at the earliest) is minimal, we are not finalizing our proposal to provide eligible professionals who report measures groups using the claims-based reporting mechanism with interim feedback reports for 2011.

Comment: While we received favorable comments regarding our efforts to streamline and simplify distribution of Physician Quality Reporting System feedback reports, some commenters suggested that we continue to improve access to the feedback reports. Commenters noted that many individual eligible professionals and small practices still have difficulty obtaining their feedback reports. Commenters noted the numerous problems and issues using the Physician Quality Reporting System portal to download these reports. One commenter suggested that the feedback reports should be published for all eligible professionals without requiring them to submit a request.

Response: We are preparing, in the near future, to launch tools to provide eligible professionals access to all reporting years and report types via the CMS portal. We anticipate this level of access to be ready in mid- to late 2011. CMS security system access requirements are mandated by the information systems and security component of CMS and unfortunately cannot be changed by the Physician Quality Reporting System or eRx program requirements. A quick reference guide on IACS accounts, which is the

current identity management system required for accessing feedback reports, is currently under development to assist eligible professionals with accessing their feedback reports.

Comment: One commenter recommended providing aggregate data to specialty societies so that they can assist in educating members on the program and potential issues. Another commenter suggested that we improve upon the aggregate quality data error reports by individual measures, currently distributed 4 times per year, by increasing their frequency to monthly.

Response: We appreciate the commenter's valuable input. As we explore ways to provide more timely feedback, we will also evaluate commenter's suggestion and explore its feasibility.

Comment: One commenter requested clarification as to whether eligible professionals could utilize the informal appeals process to dispute data contained in the interim feedback reports.

Response: We would expect that initial questions arising from the interim reports would be addressed by the QualityNet Help Desk, as is done today with the annual feedback reports. As discussed below, the main difference between the current inquiry process via the QualityNet Help Desk and the informal appeals process is that we have established timeframes around when requests for an informal review must be submitted and when a response must be provided.

Upon consideration of the comments and for the reasons we discussed previously, we are finalizing our proposal to provide feedback reports to all Physician Quality Reporting System participants on or about the time of issuance of the incentive payments. We also finalize our proposal to provide interim feedback reports for eligible

professionals reporting measures groups through the claims-based reporting mechanism. For the 2011 Physician Quality Reporting System, however, we do not believe that we will have the technical capability needed to issue these interim feedback reports until the second half of the year. Since we do not believe that these interim feedback reports would be of much value at that point, we do not anticipate generating interim feedback reports for eligible professionals reporting measures groups until the 2012 Physician Quality Reporting System. For 2012, we also anticipate being able to provide additional interim feedback reports.

(5) Section 3002(f) - Appeals

Section 1848(m)(5)(I) of the Act, as amended and added by section 3002(f)(2) of the ACA, requires that the Secretary establish and have in place, no later than January 1, 2011, an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under the Physician Quality Reporting System. We note that except as provided under the informal process under section 1848(m)(5)(I) of the Act, section 1848(m)(5)(E) of the Act, as amended by section 3002(f) of the ACA, specifies that, with respect to the Physician Quality Reporting System, there shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of--

(1) The determination of measures applicable to services furnished by eligible professionals under the Physician Quality Reporting System;

(2) The determination of satisfactory reporting under the Physician Quality Reporting System; and

(3) The determination of any Physician Quality Reporting System incentive payment and Physician Quality Reporting System payment adjustment.

We proposed to base the informal process on our current inquiry process whereby an eligible professional can contact the Quality Net Help Desk (via phone or e-mail) for general Physician Quality Reporting System and eRx Incentive Program information, information on Physician Quality Reporting System feedback report availability and access, and/or information on Physician Quality Reporting System Portal password issues (75 FR 40201). For purposes of the informal process required under section 1848(m)(5)(E) of the Act, we proposed the following inquiry process:

- An eligible professional electing to utilize the informal process must request an informal review within 90 days of the release of his or her feedback report.

- An eligible professional can request the informal review by notifying the Quality Net Help Desk via email at qnetsupport@sdps.org. The email requesting the initiation of the informal review process should summarize the concern(s) of the eligible professional and the reason(s) for requesting an informal review.

- We proposed to provide the eligible professional with a response to his or her request for an informal review within 60 days of receiving the original request.

- As this process is informal and the statute does not require a formal appeals process, we will not include a hearing or evidence submission process, although the eligible professional may submit information to assist in the review.

- Based on our informal review, we will provide a written response. Where we find that the eligible professional did satisfactorily report, we proposed to provide the applicable incentive payment.

- Given that this is an informal review process and given the limitations on review under section 1848(m)(5)(E) of the Act, decisions based on the informal review will be final, and there will be no further review or appeal.

The following is a summary of comments received on the proposed informal appeals process and our responses.

Comment: Several comments expressed support for the establishment of an informal appeals process, believing that eligible professionals' ability to challenge the results of the program is a necessary step to encouraging participation in the program and in promoting transparency. One commenter specifically indicated that having 90 days to electronically file an "informal appeal" is a sufficient amount of time and that having the ability to electronically submit these requests will help to ensure a timely, streamlined process. Another commented that the current lack of recourse for eligible professionals has contributed to a lack of interest in, and even skepticism, about the Physician Quality Reporting System.

Response: We appreciate the commenters' support of the informal appeals process and are hopeful that providing eligible professionals with an avenue to request an informal review of the determination that they did not satisfactorily report will encourage greater participation in the Physician Quality Reporting System.

Comment: Some commenters felt the period for requesting an informal review should be extended. One commenter suggested extending the timeframe to file an appeal through the end of the following year. Another commenter recommended extending the timeframe to the end of the reporting year, as those in large practices may not see their Physician Quality Reporting System report for a month or two after CMS sends it. Some

commenters suggested that any results that are successfully appealed should be incorporated in public reporting of physician performance.

Response: While we understand the commenters' desire to extend the timeframe for submitting a request for an informal review, doing so could potentially impact the timeliness of future years' Physician Quality Reporting System incentive payments, because we would not be able to start analyzing the next year's data until we have completed our analysis of the current year's data. Therefore, we are requiring eligible professionals to submit their requests for an informal review within 90 days of the feedback reports becoming available, as proposed.

Comment: One commenter indicated that eligible professionals who successfully obtain an incentive payment are unlikely to a request a review. The commenter believes the review for those who are unsuccessful is unlikely to overturn the initial adjudication, since it can only be based on data present in the CMS system as there is no opportunity for evidence submission. The commenter feels that eligible professionals submitting data could easily be given feedback immediately about whether the data set was complete or not, both in terms of the individual data points and the number of eligible patients.

Response: We agree with the commenter's assertion that eligible professionals who are successful in obtaining a Physician Quality Reporting System incentive are unlikely to request an informal review. With respect to the claim that the "review for those who are unsuccessful is unlikely to overturn the initial adjudication, since it can only be based on data present in the CMS system as there is no opportunity for evidence submission," we disagree. CMS strives to ensure the accuracy of our initial determinations. However, recognizing errors may arise, CMS implemented the informal

review process whereby Physician Quality Reporting System participants may request via the Quality Net Help Desk a review of the determination that the eligible professional did not satisfactorily submit data. In prior program years, the informal review method has resulted in supplemental payments for some eligible professionals despite the restriction on submitting additional evidence. This informal process has proven to be successful in finding errors in prior years, and we believe it will continue to do so. While we agree that it would be ideal to be able to provide immediate feedback as to whether the data set was complete or not both in terms of the individual data points and the number of eligible patients, this would not be technically feasible under the current claims processing system. However, we do intend to provide interim feedback reports as previously described.

Comment: In support of implementing a successful informal review process, some commenters recommended that the Quality Net Help Desk be expanded with additional telephone lines and more trained, experienced, and qualified staff. Commenters reported that some eligible professionals have faced challenges getting through to a CMS staff person and/or accessing the information they need through the existing Quality Net Help Desk. Another commenter stated that they believe the Quality Net Help Desk should be able to help eligible professionals and their staff immediately.

Response: We agree that in implementing an informal review process that utilizes the existing inquiry support framework additional resources will be needed and anticipate putting additional resources towards the Quality Net Help Desk.

Comment: Some commenters felt the proposed process was too informal to provide a fair and appropriate appeal. One commenter suggested the agency consider

basing the informal process on the current inquiry process as merely a starting point and plan to expand the process in the future. Similarly, other commenters indicated that the appeals process needs to be a structured, transparent, and user-friendly appeals process so that eligible professionals have an avenue to quickly remedy erroneous determinations.

Response: We note that section 1848(m)(5)(I) of the Act does not require a formal appeals process; rather, it only requires an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under the Physician Quality Reporting System. We believe that the process that we proposed and are finalizing adequately allows an eligible professional to seek an informal review of the determination that the professional did not satisfactorily report. However, we agree that a timely response to eligible professionals who are questioning the outcome of their Physician Quality Reporting System reporting rate calculation will benefit the eligible professional. We plan to communicate the informal review process to eligible professionals through education and outreach. We also agree that the process needs to be user friendly and are using the lessons learned from inquiries received related to previous program years in determining the most timely and user-friendly method for the informal appeals process.

Comment: Another commenter suggested as payment adjustments begin to apply in 2015, we work with Congress to implement a more formal appeals process that includes standardized and transparent rules for submitting and reviewing evidence.

Response: For the 2011 Physician Quality Reporting System, we plan to implement the informal review process as described previously and required under

section 1848(m)(5)(I) of the act. We plan to use any lessons learned from this process to make further enhancements to the process in future years.

Upon consideration of the comments, we are finalizing the informal review process as proposed and previously described. As stated in the proposed rule, we anticipate posting, by December 31, 2011 (75 FR 40202) on the CMS Physician Quality Reporting System Web site, further information regarding the operational aspects of the informal review process for the 2011 Physician Quality Reporting System. As we are implementing this informal review process beginning with the 2011 Physician Quality Reporting System and our expectation that we will be unable to generate 2011 Physician Quality Reporting System interim feedback reports prior to the start of the July 1, 2011 reporting period, we anticipate that eligible professionals will first have an opportunity to avail themselves of this informal process when the 2011 Physician Quality Reporting System feedback reports are made available in 2012.

2. Section 132: Incentives for Electronic Prescribing (eRx) – The Electronic Prescribing Incentive Program

a. Program Background and Statutory Authority

As described in the CY 2011 PFS proposed rule (75 FR 40202 through 40203), Electronic Prescribing (eRx) is the transmission using electronic media, of prescription or prescription-related information between prescriber, dispenser, pharmacy benefit manager (PBM), or health plan, either directly or through an intermediary, including an eRx network. The intention of the 2011 eRx Incentive Program, which is separate from, and in addition to, incentive payments that eligible professionals may earn through the Physician Quality Reporting System, is to continue to encourage significant expansion of

the use of electronic prescribing by authorizing a combination of financial incentives and payment adjustments. Individual eligible professionals do not have to participate in the Physician Quality Reporting System in order to participate in the eRx Incentive Program (and vice versa). We proposed to add §414.92 to title 42 of the Code of Federal Regulations to implement and codify the provisions of the eRx Incentive Program.

For 2011, which is the third year of the eRx Incentive Program, the Secretary is authorized to provide eligible professionals who are successful electronic prescribers an incentive payment equal to 1.0 percent of the total estimated Medicare Part B PFS allowed charges (based on claims submitted not later than 2 months after the end of the reporting period) for all covered professional services furnished by the eligible professional during the 2011 reporting period. The applicable electronic prescribing percent (1.0 percent) authorized for the 2011 eRx Incentive Program is different from that (2.0 percent) authorized for the 2009 and 2010 eRx Incentive Program. Under section 1848(m)(2)(C) of the Act, the incentive payments for successful electronic prescribers for future years are authorized as follows:

- 1.0 percent for 2012.
- 0.5 percent for 2013.

In addition, section 1848(m)(2)(D) of the Act, as added by section 4101(f)(2)(B) of Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub.L. 111-5) (ARRA-HITECH) which authorized the Medicare EHR Incentive Program, specifies that the eRx incentive does not apply to an eligible professional (or group practice), if, for the EHR reporting period, the eligible professional (or group

practice) earns an incentive payment under the Medicare EHR Incentive Program beginning in 2011.

For the eRx Incentive Program, when reporting the G-codes for purposes of qualifying for the incentive payment for electronic prescribing in 2011, we proposed that the eligible professional must have and regularly use a "qualified" electronic prescribing system, as defined in the electronic prescribing measure specifications.

In addition, under section 1848(a)(5)(A) of the Act, a PFS payment adjustment applies beginning in 2012 to those professionals who are not successful electronic prescribers. Specifically, for 2012, 2013, and 2014, if the eligible professional is not a successful electronic prescriber for the reporting period for the year, the PFS amount for covered professional services furnished by such professionals during the year as previously referenced shall be less than the PFS amount that would otherwise apply over the next several years by--

- 1.0 percent for 2012.
- 1.5 percent for 2013.
- 2.0 percent for 2014.

We believe that the criteria for determination of successful electronic prescriber for the eRx incentive payment are not required to be identical to the criteria that will be used to determine the applicability of the payment adjustment that begins in 2012. In general, we believe that an incentive should be broadly available to encourage the widest possible adoption of eRx, even for low volume prescribers. On the other hand, we believe that a payment adjustment should be applied primarily to assure that those who have a large volume of prescribing do so electronically, without penalizing those for

whom the adoption and use of an electronic prescribing system may be impractical given the low volume of prescribing. Under section 1848(m)(6)(A) of the Act, the definition of "eligible professional" for purposes of eligibility for the eRx Incentive Program is identical to that for the Physician Quality Reporting System under section 1848(k)(3)(B) of the Act. Eligible professionals include physicians, other practitioners, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. However, as we have noted in prior years, for purposes of the eRx Incentive Program, eligibility is further restricted by scope of practice to those professionals who have prescribing authority. Detailed information about the types of professionals that are eligible to participate in the eRx Incentive Program is available on the eRx Incentive Program section of the CMS Web site at http://www.cms.gov/ERXIncentive.

As in the 2010 eRx Incentive Program, we proposed for 2011 that the eRx Incentive Program continue to be an incentive program in which determination of whether an eligible professional is a successful electronic prescriber will be made at the individual professional level, based on the NPI. Inasmuch as some individuals (identified by NPIs) may be associated with more than one practice or TIN, the determination of whether an eligible professional is a successful electronic prescriber will be made to the holder of each unique TIN/NPI combination (75 FR 40202). Then, as in previous years, payment will be made to the applicable holder of the TIN. For 2011, the determination of whether an eligible professional is a successful electronic prescriber will continue to be made for each unique TIN/NPI combination. However, section 1848(m)(3)(C) of the Act required the Secretary by January 1, 2010 to establish and have in place a process under

which eligible professionals in a group practice (as defined by the Secretary) would be treated as meeting the requirements for submitting data on electronic prescribing quality measures for covered professional services for a reporting period (or, for purposes of the payment adjustment under section 1848(a)(5) of the Act, for a reporting period for a year) if, in lieu of reporting the electronic prescribing measure, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary. Therefore, in addition to making incentive payments for 2011 to individual eligible professionals based on separately analyzing whether the individual eligible professionals are successful electronic prescribers, we proposed to also make incentive payments to group practices based on the determination that the group practice, as a whole, is a successful electronic prescriber in accordance with section 1848(m)(3)(C) of the Act (75 FR 40203).

The following is a summary of the general comments received on the CY 2011 PFS proposed rule related to the eRx Incentive Program and our responses.

Comment: Some commenters provided overall support for the eRx Incentive Program. Specific aspects of the program for which the commenters voiced support include the numerator and denominator codes, the reporting mechanisms, what constitutes a "qualified" electronic prescribing system, the criteria for being a successful electronic prescriber for purposes of the 2011 incentive payment, and the 10 percent limitation under section 1848(m)(2)(B) of the Act.

Response: We appreciate the commenters' positive feedback.

Comment: A couple of commenters highlighted the importance of providing eligible professionals feedback on whether they have successfully completed all requirements for this program and establishing an appeals process to allow eligible professionals to appeal decisions that affect their eligibility to take part in the eRx Incentive Program or that affect their ability to get eRx incentives.

Response: We agree with the commenters on the importance of feedback to eligible professionals. In addition to providing an annual feedback report, we anticipate making interim feedback reports for the program available to any eligible professional who bills for a denominator-eligible case during the first half of 2011. We anticipate that interim feedback reports will be available in the fall of 2011 and will include information related to the 2012 eRx payment adjustment. Although there is a required informal review process for the Physician Quality Reporting System, we are not establishing such a process for the eRx Incentive Program (nor are we required to do so). We expect that any questions arising from the interim feedback reports or the eligibility for an eRx incentive will be addressed by the Quality Net Help Desk as is currently done.

Comment: One commenter urged us to make available to individual eligible professionals the percentage of their prior year's Medicare charges that resulted from the outpatient CPT codes included in the electronic prescribing measure's specifications.

Response: Unfortunately, we do not have resources to calculate and provide feedback to eligible professionals regarding the composition of their charges. Most electronic billing systems, however, will have this functionality and should be able to provide eligible professional who use such billing systems with this information. In addition, eligible professionals who participate in the eRx Incentive Program will receive

feedback reports with information on the percentage of an eligible professional's charges that resulted from the denominator codes included in the electronic prescribing's specifications.

Comment: One commenter sought guidance for physicians whose patients participate in the Medicaid PACE program and use a contracted pharmacy that may not be able to receive electronic prescriptions. The commenter asked whether these visits would be excluded from the requirements of the eRx Incentive Program.

Response: The eRx Incentive Program requires that an eligible professional use a qualified eRx system to electronically prescribe during the office visit. Hence, if the qualified system used by the eligible professional meets the requirements for a qualified eRx system, as described below and listed on the CMS eRx Incentive Web site at http://www.cms.gov/erxincentive, and the prescription is sent electronically, then the eligible professional will be able to report the electronic prescribing event even if the pharmacy was not able to receive the prescription electronically. The use of a pharmacy that cannot receive an electronic prescription does not invalidate the electronic prescribing event and the eligible professional would still get credit for electronically prescribing as long as he or she reports this event for a denominator-eligible visit.

Upon consideration of the comments, we are finalizing our proposal to add §414.92 to title 42 of the Code of Federal Regulations to implement and codify the provisions of the eRx Incentive Program. Details regarding the specific aspects of the eRx Incentive Program that are being finalized, including our rationale, are described below. We have made some technical changes to the regulations at §414.92, such as

eliminating the unnecessary use of acronyms and inserting or revising cross-references as needed.

b. The 2011 eRx Incentive

(1) The 2011 Reporting Period for the eRx Incentive Program

Section 1848(m)(6)(C)(i)(II) of the Act defines "reporting period" for the 2011 eRx Incentive Program to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, however, authorizes the Secretary to revise the reporting period if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. We proposed the 2011 eRx Incentive Program reporting period for purposes of the 2011 incentive payment to be the entire calendar year (January 1, 2011 through December 31, 2011) based on the definition of "reporting period" specified under section 1848(m)(6)(C)(i)(II) of the Act. We proposed that successful electronic prescribers would be eligible to receive an incentive payment equal to 1.0 percent of the total estimated allowed Medicare Part B charges (based on claims submitted by no later than February 28, 2012) for all covered professional services furnished January 1, 2011 through December 31, 2011.

We did not receive any comments related to the proposed reporting period for the 2011 eRx incentive. Therefore, the reporting period for the 2011 eRx incentive will be the entire 2011 calendar year, or January 1, 2011 through December 31, 2011.

(2) Criteria for Determination of Successful Electronic Prescriber for Eligible Professionals

Under section 1848(m)(3)(B) of the Act, in order to qualify for the incentive payment, an eligible professional must be a "successful electronic prescriber," which the Secretary is authorized to identify using 1 of 2 possible criteria. One criterion, under section 1848(m)(3)(B)(ii) of the Act, is based on the eligible professional's reporting, in at least 50 percent of the reportable cases, on any electronic prescribing quality measures that have been established under the physician reporting system, under subsection 1848(k) of the Act and are applicable to services furnished by the eligible professional during a reporting period. We applied this criterion in 2009. However, for years after 2009, section 1848(m)(3)(D) of the Act permits the Secretary in consultation with stakeholders and experts to revise the criteria for submitting data on electronic prescribing measures under section 1848(m)(3)(B)(ii) of the Act.

The second criterion, under section 1848(m)(3)(B)(iii) of the Act, is based on the electronic submission by the eligible professional of a sufficient number (as determined by the Secretary) of prescriptions under Part D during the reporting period. If the Secretary decides to use the latter standard, then, in accordance with section 1848(m)(3)(B)(iv) of the Act, the Secretary is authorized to use Part D drug claims data to assess whether a "sufficient" number of prescriptions have been submitted by eligible professionals. However, under section 1848(m)(3)(B)(i) of the Act, if the standard based on a sufficient number (as determined by the Secretary) of electronic Part D prescriptions is applied for a particular reporting period, then the standard based on the reporting on electronic prescribing measures would no longer apply.

For 2011, we proposed to continue to require eligible professionals to report on the electronic prescribing measure used in the 2009 and 2010 eRx Incentive Program to

determine whether an eligible professional is a successful electronic prescriber, but we also proposed to again use modified measure specifications and to use modified reporting criteria based on the authority provided under section 1848(m)(3)(D) of Act, as discussed below (75 FR 40203).

(A) Reporting the Electronic Prescribing Measure

We proposed, for purposes of the 2011 incentive payment and 2012 and 2013 payment adjustments, to retain the 3 reporting mechanisms available to individual eligible professionals to report the electronic prescribing measure in 2010 to maintain program stability. First, we proposed to again retain the claims-based reporting mechanism that is used in the 2009 and 2010 eRx Incentive Program. In addition, similar to the Physician Quality Reporting System, for the eRx Incentive Program, we proposed to continue the registry-based reporting mechanism and, we also proposed that the EHR-based reporting mechanism be available for the electronic prescribing measure for 2011 (75 FR 40203).

We proposed that only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2011 Physician Quality Reporting System would be qualified to submit measure results and numerator and denominator data on the electronic prescribing measure on behalf of eligible professionals for the 2011 eRx Incentive Program (75 FR 40204).

We proposed that qualified registries would need to submit the electronic prescribing measure for the 2011 eRx Incentive Program to CMS in two separate transmissions. Such qualified registries would first need to submit 2011 data on the electronic prescribing measure between July 1, 2011 and August 19, 2011, following the

end of the 2012 payment adjustment reporting period (which is the first 6 months of 2011), for purposes of the eRx payment adjustment described in section VII.F.2.c. of this final rule with comment period. The second submission for purposes of the 2011 incentive would occur following the end of the 2011 incentive payment reporting period (which is the whole calendar year of 2011).

Similarly, we proposed that only EHR products "qualified" to potentially be able to submit clinical quality data extracted from the EHR to CMS for the 2011 Physician Quality Reporting System would be considered "qualified" for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2011 eRx Incentive Program (75 FR 40204). The self-nomination process and requirements for EHR vendors for the Physician Quality Reporting System would continue to apply to the EHR vendors for the 2011 eRx Incentive Program.

We proposed that eligible professionals who want to use a qualified EHR to submit the electronic prescribing measure for the 2011 eRx Incentive Program would be required to transmit 2011 electronic prescribing measure data to CMS in two separate transmissions. Such eligible professionals would first need to submit 2011 data on the electronic prescribing measure between July 1, 2011 and August 19, 2011, following the end of the 2012 payment adjustment reporting period, for purposes of the eRx payment adjustment described in section VII.F.2.c. of this final rule with comment period. The second submission for purposes of the 2011 incentive would occur following the end of the 2011 incentive payment reporting period.

The following is a summary of the comments received regarding the proposed mechanisms for reporting the electronic prescribing measure in 2011 for purposes of the

2011 incentive payment, and for purposes of the 2012 and 2013 payment adjustments described in sections VII.F.2.c. and d. of this final rule with comment period.

Comment: Some commenters agreed with retaining the same reporting mechanisms for 2011 that were in place for 2010, particularly our decision to continue offering claims-based reporting and the inclusion of an EHR-based reporting mechanism.

Response: We appreciate the commenters' positive feedback and are finalizing our proposal to include a claims, registry, and EHR reporting for the 2011 eRx incentive.

Comment: One commenter thinks the requirement to submit electronic prescribing measure data in two submissions is burdensome for eligible professionals and suggests exploring alternatives where only one submission is required.

Response: We proposed two data submissions during 2011 for EHR-based reporting and registry-based reporting for different purposes. One was a submission between July 1, 2011 and August 19, 2011, that was intended to be solely for purposes of the 2012 payment adjustment. The second submission, which was to occur following the end of the 2011 incentive payment reporting period, was solely for purposes of the 2011 incentive payment. For purposes of the 2012 payment adjustment, we will not be able to finalize the registry and EHR-based reporting mechanisms because it will not be operationally feasible for us to accept the data submissions from the EHRs and registries in the timeframe needed for us to be able to have sufficient time to be analyze the data and make the determination whether an eligible professional is subject to the 2012 payment adjustment prior to January 1, 2012. Therefore, there will not be two submissions of electronic prescribing measure data from registries and EHRs during 2011.

Eligible professionals who intend to use the EHR-based reporting mechanism to submit data on the electronic prescribing measure for purposes of the 2011 incentive payment will need to submit the electronic prescribing measure data via their EHR following the end of the 2011 incentive payment reporting period. Similarly, registries that are submitting electronic prescribing data on behalf of eligible professionals or group practices for purposes of the 2011 incentive payment will need to do so following the end of the 2011 incentive reporting period. If an eligible professional chooses to use a qualified registry or qualified EHR for purposes of submitting electronic prescribing measure data for the 2011 incentive, we will not combine data from multiple reporting mechanisms. Therefore, an eligible professional must make sure that the required number of eRx events for purposes of the 2011 incentive payment is reported to us via a single reporting mechanism.

After considering the comments and for the reasons previously explained, we are finalizing our proposal to provide a claims, registry, and EHR reporting mechanism for the 2011 eRx incentive. As in 2010, not all registries qualified to submit quality measures on behalf of eligible professionals for the 2011 Physician Quality Reporting System will be qualified to submit quality measures results and numerator and denominator data on the electronic prescribing measure under the eRx Incentive Program. The electronic prescribing measure is reportable by an eligible professional any time he or she bills for one of the procedure codes for Part B services included in the measure's denominator. Some registries that self-nominate to become a qualified registry for the Physician Quality Reporting System may not choose to self-nominate to become a qualified registry for submitting electronic prescribing measures that require reporting at

each eligible visit, such as the electronic prescribing measure. Registries need to indicate their desire to qualify to submit measure results and numerator and denominator data on the electronic prescribing measure for the 2011 eRx Incentive program at the time that they submit their self-nomination letter for the 2011 Physician Quality Reporting System. The self-nomination process and requirements for registries for the Physician Quality Reporting System, which also will apply to the registries for the 2011 eRx Incentive Program, are discussed in section VII.F.1. of this final rule with comment period. We will post a final list of qualified registries for the 2011 eRx Incentive Program on the eRx Incentive Program section of the CMS Web site at http://www.cms.gov/ERXIncentive when we post the final list of qualified registries for the 2011 Physician Quality Reporting System on the Physician Quality Reporting System section of the CMS Web site.

Similarly, EHR vendors are required to indicate their desire to have one or more of their EHR products qualified for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2011 eRx Incentive Program at the time when they submit their self-nomination letter for the 2011 Physician Quality Reporting System. A list of qualified EHR vendors and their products (including the version that is qualified) for the 2011 eRx Incentive Program will be posted on the eRx Incentive Program section of the CMS Web site at http://www.cms.gov/ERXIncentive when we post the list of qualified EHR products for the 2011 Physician Quality Reporting System on the Physician Quality Reporting System section of the CMS Web site.

Although we are finalizing three reporting mechanisms for use by eligible professionals for the 2011 eRx incentive, for purposes of the 2012 eRx payment adjustment, we are finalizing only the claims-based reporting mechanism given that, for operational reasons, we will not have the ability to accept registry and EHR data in the timeframe that we need to be able to complete our analysis of the data and make the determination of whether an eligible professional is subject to the 2012 payment adjustment prior to January 1, 2012. As discussed in the proposed rule (75 FR 40208), all claims for services furnished between January 1, 2011 and June 30, 2011, must be processed by no later than one month after the reporting period to be included in our analysis for purposes of the 2012 payment adjustment. Accordingly, to the extent an eligible professional intends to use a registry or EHR to submit electronic prescribing measure data for purposes of qualifying for the 2011 incentive, the eligible professional would still need to submit electronic prescribing measure data on claims for services furnished between January 1, 2011 and June 30, 2011, in order to avoid the 2012 payment adjustment.

(B) The Reporting Denominator for the Electronic Prescribing Measure

The electronic prescribing measure, similar to the Physician Quality Reporting System measures, has two basic elements, which include: (1) a reporting denominator that defines the circumstances when the measure is reportable; and (2) a reporting numerator.

The denominator for the electronic prescribing measure consists of specific billing codes for covered professional services. The measure becomes reportable when any one of these procedure codes is billed by an eligible professional for Part B covered

professional services. As initially required under section 1848(k)(2)(A)(ii) of the Act, and further established through rulemaking and under section 1848(m)(2)(B) of the Act, we may modify the codes making up the denominator of the electronic prescribing measure. As such, we expanded the scope of the denominator codes for 2010 to covered professional services outside the professional office and outpatient setting, such as professional services furnished in skilled nursing facilities or the home care setting.

For 2011, we proposed to retain the 2010 electronic prescribing measure's denominator codes. The following is a summary of the comments received regarding the proposed denominator codes for the 2011 electronic prescribing measure.

Comment: A couple of commenters supported our proposal to retain the denominator codes from denominator of the 2010 electronic prescribing measure denominator. Conversely, other commenters opposed retaining the 2010 electronic prescribing denominator codes because they do not allow for surgeons to effectively participate in the eRx Incentive Program. The commenters did not suggest additional codes for inclusion in the electronic prescribing measure’s denominator though.

Response: With respect to the commenters' suggestions to add other denominator codes that were not proposed, we are not able to do so since the public would not have had an opportunity to comment on these additional codes. We welcome, however, specific suggestions for additional codes for consideration for the 2012 electronic prescribing measure. We believe that the existing denominator codes are representative of the types of services in which prescriptions are most often generated.

Comment: Another commenter was concerned that we have unnecessarily restricted the electronic prescribing's denominator by associating a prescription with a

patient visit. The commenter noted that a vast majority of prescriptions in an internal medicine or family practice office are generated outside of a patient visit through the prescription renewal workflow while new prescriptions – the minority – are often coincident with the patient visit. The commenter believes that this sets up a cascade of filters that may prevent many otherwise successful providers from meeting the denominator criteria. The commenter stated that pharmacies either have, or can easily acquire, the capability to report the manner in which the prescription was received and CMS should consider a determined number of pharmacy claims of electronic prescriptions for Medicare beneficiaries, where the prescriber and manner of prescription delivery are clearly defined, as acceptable minimum criteria to determine a successful electronic prescriber. The commenter believes that the infrastructure to support this is laid in the requirements that Medicare D claims be submitted electronically to CMS and would allow CMS to identify successful electronic prescribers independent of the office-generated claims.

Response: As we stated in the proposed rule (75 FR 40203), we believe that the completeness and accuracy of the Part D data with respect to whether a prescription was submitted electronically is unknown, which is why we are continuing to require reporting on an electronic prescribing measure. As stated previously, we welcome suggestions for additional denominator codes for use in future years but believe that the existing denominator codes are generally representative of the types of services in which prescriptions are often generated.

Comment: One commenter supported the proposal to "expand the scope of the denominator codes for 2010 to professional services outside the professional office and

outpatient setting, such as professional services furnished in skilled nursing facilities or the home-care setting."

Response: We are unclear why the commenter is providing feedback on the 2010 denominator codes as the scope of the rule is limited to the 2011 electronic prescribing measure. The 2010 denominator codes were finalized in the 2010 PFS final rule with comment period (74 FR 61852). Since the 2010 denominator codes already reflected our desire to include some professional services outside the professional office and outpatient setting, for 2011, we did not propose any changes to the denominator codes. Therefore, for 2011, we are retaining the 2010 denominator codes for the reasons listed by the commenter. Accordingly, after considering the comments, we are finalizing the following CPT codes in the denominator of the electronic prescribing measure for 2011: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109. We believe these codes represent the types of services for which prescriptions are likely to be generated.

There are no diagnosis codes in the measure's denominator and there are no age/gender requirements in order for a patient to be included in the measure's denominator (that is, reporting of the electronic prescribing measure is not further limited to certain ages or a specific gender). For purposes of both the incentive payment and payment adjustments discussed in sections VII.F.2.c. and d. of this final rule with comment period, eligible professionals who do not bill for one of the procedure codes for

Part B covered professional services included in the measure's denominator will have no occasion to report the electronic prescribing measure. In other words, the measure is not applicable unless the professional bills for one of the codes included in the measure's denominator. In addition, in order to qualify for an incentive or avoid the payment adjustment, eligible professionals are not required to report this measure in all cases in which the measure is applicable. There are specific reporting thresholds, or reported electronic prescribing events, that an eligible professional must meet in order to be considered a "successful electronic prescriber" for purposes of the 2011 incentive payments, which are described in section VII.F.2.b.(2).(E). of this final rule with comment period. In addition, there are specific reporting thresholds that an eligible professional must meet in order to be considered a "successful electronic prescriber" for purposes of the 2012 and 2013 payment adjustments, which are described in sections VII.F.2.c. and d. of this final rule with comment period, respectively.

By no later than December 31, 2010, we will post the final specifications of the measure on the "eRx Measure" page of the eRx Incentive Program section of the CMS Web site at http://www.cms.gov/ERXIncentive.

(C) Qualified Electronic Prescribing System – Required Functionalities and Part D eRx Standards

To report the electronic prescribing measure in 2011, we again proposed that the eligible professional must report one of the measure's numerator G-codes, as discussed below. However, when reporting any of the G-codes in 2011, we proposed that the professional must have and regularly use a "qualified" electronic prescribing system, as defined in the electronic prescribing measure specifications. If the professional does not

have general access to an eRx system in the practice setting, then the eligible professional does not have any data to report for purposes of the incentive payment. For 2011, we proposed to retain what constitutes a "qualified" electronic prescribing system as a system based upon certain required functionalities that the system can perform. We proposed to retain the same functionalities that were required in 2010.

In addition, section 1848(m)(3)(B)(v) of the Act specifies that to the extent practicable, in determining whether an eligible professional is a successful electronic prescriber, "the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D-4(e)." The Part D standards for electronic prescribing systems establish which electronic standards Part D sponsors, providers, and dispensers must use when they electronically transmit prescriptions and certain prescription related information for Part D covered drugs that are prescribed for Part D eligible individuals. For 2011, we proposed that to be a qualified electronic prescribing system, electronic systems must convey the information for the required functionalities using the standards currently in effect for the Part D electronic prescribing program.

We did not receive any comments on the proposed required functionalities or Part D eRx standards. For this reason, we are finalizing the required functionalities and Part D eRx standards as described below.

Required Functionalities for a "Qualified" Electronic Prescriber System.

For 2011, a "qualified" electronic prescribing system is one that can do the following:

(a) Generate a complete active medication list incorporating electronic data received from applicable pharmacies and PBMs, if available.

(b) Allow eligible professionals to select medications, print prescriptions, electronically transmit prescriptions, and conduct alerts (written or acoustic signals to warn the prescriber of possible undesirable or unsafe situations including potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions). This functionality must be enabled.

(c) Provide information related to lower cost, therapeutically appropriate alternatives (if any). The ability of an electronic prescribing system to receive tiered formulary information, if available, would again suffice for this requirement for 2011 and until this function is more widely available in the marketplace.

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

Part D Electronic Prescribing Standards.

To be a qualified electronic prescribing system under the 2011 eRx Incentive Program, electronic systems must convey the information listed previously under (a) through (d) using the standards currently in effect for the Part D electronic prescribing program. Additional Part D electronic prescribing standards were implemented April 1, 2009. These latest Part D electronic prescribing standards, and those that had previously been adopted, can be found on the CMS Web site at http://www.cms.gov/eprescribing.

To ensure that eligible professionals utilize electronic prescribing systems that meet these requirements, the electronic prescribing measure requires that those functionalities required for a "qualified" electronic prescribing system utilize the adopted Part D electronic prescribing standards. The Part D electronic prescribing standards relevant to the four functionalities for a "qualified" system in the electronic prescribing measure described previously and listed as (a), (b), (c), and (d), currently are as follows:

(a) Generate medication list – Use the National Council for Prescription Drug Programs (NCPDP) Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide, Version 8, Release 1, October 2005 (hereinafter "NCPDP SCRIPT 8.1") Medication History Standard;

(b) Transmit prescriptions electronically – Use the NCPDP SCRIPT 8.1 for the transactions listed at §423.160(b)(2);

(c) Provide information on lower cost alternatives – Use the NCPDP Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0 (Version 1.0), October 2005 (hereinafter "NCPDP Formulary and Benefits 1.0");

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan – use--

(1) NCPDP Formulary and Benefits 1.0 for communicating formulary and benefits information between prescribers and plans;

(2) Accredited Standards Committee (ASC) X12N 270/271-Health Care Eligibility Benefit Inquiry and Response, Version 4010 , May 2000, Washington Publishing Company, 004010X092 and Addenda to Health Care Eligibility Benefit

Inquiry and Response, Version 4010A1, October 2002, Washington Publishing Company, 004010X092A1 for communicating eligibility information between the plan and prescribers; and

(3) NCPDP Telecommunication Standard Specification, Version 5, Release 1 (Version 5.1), September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000 for communicating eligibility information between the plan and dispensers.

However, there are Part D electronic prescribing standards that are in effect for functionalities that are not commonly utilized at this time. One example is Rx Fill Notification, which is discussed in the Part D electronic prescribing final rule (73 FR 18926). For purposes of the 2011 Electronic Prescribing Program, we again are not requiring that an electronic prescribing system contain all functionalities for which there are available Part D electronic prescribing standards since many of these functionalities are not commonly available. For those required functionalities previously described, a "qualified" system must use the adopted Part D electronic prescribing standards for electronic messaging.

There are other aspects of the functionalities for a "qualified" system that are not dependent on electronic messaging and are part of the software of the electronic prescribing system, for which Part D standards for electronic prescribing do not pertain and are not required for purposes of the eRx Incentive Program. For example, the requirements in qualification (b) that require the system to allow professionals to select medications, print prescriptions, and conduct alerts are functions included in the particular software, for which Part D standards for electronic messaging do not apply.

We are aware that there are significant numbers of eligible professionals who are interested in participating in the eRx Incentive Program but currently do not have an electronic prescribing system. The electronic prescribing measure does not require the use of any particular system or transmission network; only that the system be a "qualified" system having the functionalities previously described based on Part D electronic prescribing standards. If the professional does not have general access to an electronic prescribing system in the practice setting, the eligible professional would not be able to report the 2011 electronic prescribing measure. In addition to not being eligible for a 2011 incentive payment, an eligible professional who does not report the electronic prescribing measure for 2011 may be subject to the 2012 eRx payment adjustment discussed in section VII.F.2.c. of this final rule with comment period.

(D) The Reporting Numerator for the Electronic Prescribing Measure

The proposed criteria for reporting for purposes of being a 2011 successful electronic prescriber are designed to reward those eligible professionals who demonstrate that they have adopted a qualified electronic prescribing system and used the system in a substantial way to electronically prescribe. Accordingly, for the 2011 electronic prescribing measure, we proposed to retain the following numerator G-code from the 2010 electronic prescribing measure's numerator: G8553 (At least 1 prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system) (75 FR 40206).

We did not receive any comments related to the proposed electronic prescribing measure numerator G-code for 2011. Therefore, we are finalizing G-code G8553 for the 2011 electronic prescribing measure's numerator.

We intend to post the final 2011 electronic prescribing measure specifications on the "eRx Measure" page of the eRx Incentive Program section of the CMS Web site at http://www.cms.gov/ERXIncentive by no later than December 31, 2010.

Because the electronic prescribing quality measure will apply only when an eligible professional furnishes services indicated by one of the codes included in the measure's denominator, for claims-based reporting, for example, it will not be necessary for an eligible professional to report G-codes for the electronic prescribing measure on claims not containing one of the denominator codes. However, if reporting a G-code, the G-code data submission will only be considered valid if it appears on the same Medicare Part B claim containing one of the electronic prescribing quality measure's denominator codes.

In addition, if the eligible professional submits a Medicare Part B claim containing one of the electronic prescribing measure's denominator codes, he or she can report the numerator G-code only when the eligible professional furnishes services indicated by the G-code included in the measure's numerator. That is, only when at least 1 prescription created during the encounter is generated and transmitted electronically using a qualified electronic prescribing system.

(E) Criteria for Successful Reporting of the Electronic Prescribing Measure

As discussed previously, section 1848(m)(3)(D) of the Act authorizes the Secretary to revise the criteria for submitting data on the electronic prescribing measure from the criteria specified under section 1848(m)(3)(B)(ii) of the Act, which requires the measure to be reported in at least 50 percent of the cases in which the measure is reportable. For the 2010 eRx incentive, we revised the criteria for successful electronic

prescriber such that an eligible professional shall be treated as a successful electronic prescriber for a reporting period based on the eligible professional's reporting of the electronic prescribing measure which counts the generation and reporting of one or more prescriptions associated with a patient visit electronically for a minimum of 25 unique visits per year of applicable cases in the denominator of the electronic prescribing for 2010. For 2011, we again proposed to make the determination of whether an eligible professional is a successful electronic prescriber for purposes of the eRx incentive based on a count of the number of times (minimum threshold of 25) an eligible professional reports that at least one prescription created during the encounter is generated using a qualified electronic prescribing system (that is, reports the G8553 code).

The following is a summary of comments received regarding the criteria for the determination of a successful electronic prescriber for eligible professionals for the 2011 eRx incentive payment.

Comment: One commenter requested that we define and share for public comment the actual number of Part D prescriptions that would suffice to document successful electronic prescribing.

Response: We did not propose to use Part D prescriptions as the standard to determine whether an eligible professional is a successful e-prescriber for purposes of the 2011 eRx incentive payment. As stated in the proposed rule (75 FR 40203), we may consider doing so in the future. At such time, we would define the actual number of Part D prescriptions that would be required to be prescribed electronically via notice and comment rulemaking.

Comment: Several commenters supported the electronic prescribing measure reporting threshold of 25, while others stated that they support our plan to reduce the electronic prescribing measure reporting burden from 50 percent of all applicable services to reporting just 25 times.

Response: We appreciate the commenters' feedback regarding the proposed electronic prescribing measure reporting threshold for purposes of the 2011 eRx incentive payment. For 2011, we are finalizing our proposal to require that professionals report on 25 unique electronic prescribing events in order to be considered a successful e-prescriber for the purpose of qualifying for a 2011 eRx incentive payment. We believe that this reporting threshold simplifies the reporting burden and encourages participation.

Comment: Some commenters expressed concern that the reporting threshold of 25 unique visits is too low a standard for incentive payments as it is unclear how this threshold will drive improvements for all Medicare beneficiaries. A more robust standard was recommended. One commenter specifically recommended a reporting threshold of between 250-500 prescriptions per year per eligible professional and 25,000-50,000 per year per GPRO I group practice. Another commenter recommended that we require eligible professionals to transmit more than 40 percent of written prescriptions electronically, which is in line with the EHR Incentive Program.

Response: We appreciate the commenters' valuable input. We have reviewed several eRx Incentive Program management reports in order to determine the feasibility of using the "25" visit threshold and we believe that this threshold simplifies the eRx reporting burden. In establishing this threshold we also took into account the many valid circumstances that would prevent eligible professionals who have adopted a qualified

electronic prescribing system from having 25 unique electronic prescribing events during the calendar year and variations in practice characteristics. Our goal is to increase participation in the eRx Incentive Program and, more importantly, to encourage the continued adoption and use of electronic prescribing systems.

After considering the comments received and for the reasons previously explained, we are finalizing our proposal to make the determination of whether an eligible professional is a successful electronic prescriber for purposes of the CY 2011 incentive payment based on a count of the number of times (minimum threshold of 25) an eligible professional reports that at least one prescription created during the encounter is generated using a qualified electronic prescribing system (that is, reports the G8553 code) during the 2011 reporting period (that is, January 1, 2011 through December 31, 2011).

(3) Determination of the 2011 Incentive Payment Amount for Individual Eligible Professionals Who Are Successful Electronic Prescribers

Section 1848(m)(2)(B) of the Act imposes a limitation on the electronic prescribing incentive payment. The Secretary is authorized to choose 1 of 2 possible criteria for determining whether or not the limitation applies to a successful electronic prescriber. The first criterion is based upon whether the Medicare Part B allowed charges for covered professional services to which the electronic prescribing quality measure applies are less than 10 percent of the total Medicare Part B PFS allowed charges for all covered professional services furnished by the eligible professional during the reporting period. The second criterion is based on whether the eligible professional submits (both electronically and non-electronically) a sufficient number (as determined by the Secretary) of prescriptions under Part D (which can, again, be assessed using Part D drug

claims data). If the Secretary decides to use the latter criterion, then, in accordance with section 1848(m)(2)(B) of the Act, the criterion based on the reporting on electronic prescribing measures would no longer apply. The statutory limitation also applies with regard to the application of the payment adjustment. Based on our proposal to make the determination of whether an eligible professional is a "successful electronic prescriber" based on submission of the electronic prescribing measure, we proposed to apply the criterion under section 1848(m)(2)(B)(i) of the Act for the limitation for both the 2011 incentive payment and the 2012 payment adjustment (the application of the limitation with regard to the 2012 eRx payment adjustment is discussed in section VII.F.2.c.(3). of this final rule with comment period).

Since, as discussed previously, we proposed for 2011 to make the determination of whether an eligible professional is a "successful electronic prescriber" based on submission of the electronic prescribing measure, we also proposed to retain the requirement to analyze the claims submitted by the eligible professional at the TIN/NPI level to determine whether the 10 percent threshold is met in determining the receipt of an electronic prescribing incentive payment for 2011 by an eligible professional (75 FR 40206). For purposes of the 2011 eRx incentive payment, this calculation is expected to take place in the first quarter of 2012 and will be performed by dividing the eligible professional's total 2011 Medicare Part B PFS allowed charges for all such covered professional services submitted for the measure's denominator codes by the eligible professional's total Medicare Part B PFS allowed charges for all covered professional services (as assessed at the TIN/NPI level). If the result is 10 percent or more, then the statutory limitation will not apply and a successful electronic prescriber

will qualify to earn the electronic prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the eligible professional will not earn an electronic prescribing incentive payment even if he or she electronically prescribes and reports a G-code indicating that he or she generated and transmitted a prescription electronically at least 25 times for those eligible cases that occur during the 2011 reporting period. Although an individual eligible professional may decide to conduct his or her own assessment of how likely this statutory limitation is expected to apply to him or her before deciding whether or not to report the electronic prescribing measure, an individual eligible professional may report the electronic prescribing measure without regard to the statutory limitation for the incentive payment.

The following is a summary of the comments received on the determination of the 2011 incentive payment amount for individual eligible professionals who are successful electronic prescribers.

Comment: Several commenters felt we should allow eligible professionals to earn an incentive both for the eRx Incentive Program as well as for the Medicare EHR Incentive Program. The commenters did not think these incentives should be mutually exclusive, claiming that the eRx payment adjustment applies even if the eligible professional is participating in both programs.

Response: We do not have the authority to allow eligible professionals to earn an incentive under the eRx Incentive Program and the Medicare EHR Incentive Program. Section 1848(m)(2)(D) of the Act specifies that the incentive under the eRx Incentive Program shall not apply to an eligible professional (or, in the case of a group practice) if, for the EHR reporting period the eligible professional (or group practice) receives an

incentive payment under the EHR Incentive Program with respect to a certified EHR technology that has the capability of electronic prescribing.

We will, however, be developing a plan, as described under section 1848(m)(7) of the Act ("Integration of Physician Quality Reporting and EHR Reporting"), to integrate measure reporting requirements under the Physician Quality Reporting System, eRx Incentive Program, and the EHR Incentive Program, with respect to selection of measures to demonstrate meaningful use under the EHR Incentive Program, quality of care furnished to an individual, and such other activities as specified by the Secretary.

With regards to the commenters' statement that the eRx payment adjustment still applies even if an eligible professional participates in both programs, this is not accurate. The eRx payment adjustment applies only to the extent that the eligible professional is not a successful electronic prescriber. We would also like to clarify that the limitation under section 1848(m)(2)(D) of the Act with respect to EHR incentive payments does not preclude the 10 percent limitation under section 1848(m)(2)(B)(i) of the Act from applying with regard to the eRx payment adjustment to an eligible professional who earns an EHR incentive.

Comment: One commenter requested that we clarify the way in which we intend to calculate the group eRx incentives if individual members of the group have received Medicare EHR incentives.

Response: We will assess the group practice's data first to determine eRx incentive eligibility. If the group practice is eligible for an eRx incentive, then we will filter out the allowed charges for all NPIs who earn an EHR incentive before calculating the group's incentive amount.

Comment: We also received feedback pertaining to the eRx Incentive Program and EHR Incentive Program having different threshold criteria. Specifically, the commenter was concerned that the in order to qualify for the EHR incentive, eligible professionals must use a qualified EHR to generate and transmit 40 percent of all permissible prescriptions electronically but for the eRx Incentive Program, the threshold is 25 successful electronic prescriptions during the reporting period for purposes of the incentive payment. Since eligible professionals must still participate in the eRx Incentive Program to avoid the 2012 payment adjustment, a commenter stated that having different threshold criteria for the two programs causes confusion and recommended the establishment of a consistent threshold for electronic prescriptions. Another commenter felt that different thresholds are appropriate given that the EHR Incentive Program is voluntary and the eRx Incentive Program is mandatory to maintain full payment.

Response: We note that the EHR Incentive Program and the eRx Incentive Program are two separate, distinct programs with different purposes and underlying statutory provisions. Professionals eligible for the eRx Incentive Program are encouraged to be successful electronic prescribers using qualified electronic prescribing systems. The Medicare EHR Incentive Program will provide incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that are meaningful users of certified EHR technology. Electronic prescribing is merely one component of the EHR Incentive Program.

As such, we believe, at this time that it is appropriate to have different reporting thresholds. However, as noted previously, we will be developing a plan, as described under section 1848(m)(7) of the Act ("Integration of Physician Quality Reporting and

EHR Reporting"), to integrate measure reporting requirements under the Physician Quality Reporting System, eRx Incentive Program, and the EHR Incentive Program. In the plan, we will study potential ways to address the commenters' concerns.

(4) Reporting Option for Satisfactory Reporting of the Electronic Prescribing Measure by Group Practices

Section 1848(m)(3)(C) of the Act required that we establish and have in place a process under which eligible professionals in a group practice shall be treated as a successful electronic prescriber. In addition, we are prohibited from making double payments under section 1848(m)(3)(C)(iii) of the Act, which requires that payments to a group practice shall be in lieu of the payments that would otherwise be made under the eRx Incentive Program to eligible professionals in the group practice for being a successful electronic prescriber. For 2011, we proposed to make incentive payments to group practices based on the determination that the group practice, as a whole, is a successful electronic prescriber for 2011 (75 FR 40207). An individual eligible professional who is affiliated with a group practice participating in the group practice reporting option that successfully meets the requirements for group practices would not be eligible to earn a separate eRx incentive payment for 2011 on the basis of his or her successfully reporting the electronic prescribing measure at the individual level.

The following is a summary of the comments received regarding the two group practice options for reporting the electronic prescribing measure in 2011.

Comment: One commenter supports the proposed eRx GPRO II, including the proposed reporting criteria for GPRO II groups.

Response: We appreciate the commenter's positive feedback and are finalizing the eRx GPRO II as proposed. We believe that the eRx GPRO II will expand opportunities for group practices to participate in the eRx Incentive Program

Comment: One commenter appreciated that we have recognized the burden of claims-based reporting for the Physician Quality Reporting System and the eRx Incentive Program but the commenter was "disappointed that a GPRO-specific alternative for the eRx Incentive Program was not proposed. Most groups using [electronic prescribing technology] can readily obtain detailed information on physician utilization of the system." The commenter felt that this data could be easily reported, in detail, on the GPRO I data collection tool and urges CMS to consider this alternative for 2011 reporting.

Response: We assume that the "GPRO-specific alternative" that the commenter is referring to is the addition of the electronic prescribing measure to the GPRO I data collection tool so that the groups participating in GPRO I can use this data collection tool to submit quality measures data for both the Physician Quality Reporting System and the eRx Incentive Program. Similar suggestions have been considered in the past but were not implemented due to fiscal concerns and concerns about the timing of when an updated GPRO I data collection tool could be available. We will continue to explore the feasibility of adding the electronic prescribing measure to the GPRO I data collection tool so that practices can use the data collection tool to submit the electronic prescribing measure instead of claims, a qualified registry, or a qualified EHR.

Based on these comments, we are finalizing two group practice reporting options for the eRx Incentive Program for 2011 – GPRO I and GPRO II. GPRO I is the reporting

option for large group practices with 200 or more eligible professionals and GPRO II is the reporting option for group practices with fewer than 200 eligible professionals. The reporting criteria under these 2 options differ depending on the size of the group practice. Eligibility and reporting requirements for the 2011 eRx GPRO I and GPRO II are described below. We believe that these 2 options will encourage greater participation in the eRx Incentive Program by reducing overall reporting burden for eligible professionals who are part of a group practice.

(A) Definition of "Group Practice"

Section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define "group practice." For purposes of determining whether a group practice is a successful electronic prescriber for 2011, we proposed that consistent with the definition of group practice proposed for the Physician Quality Reporting System group practice reporting option (GPRO), a "group practice" would be defined as a single Taxpayer Identification Number (TIN) with 2 or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN. "Group practice" would also include group practices participating in Medicare demonstration projects approved by the Secretary (75 FR 40207).

In addition, we proposed to restrict participation in the 2011 eRx GPRO to group practices participating in the 2011 Physician Quality Reporting System GPRO (either through GPRO I or GPRO II) or group practices that are deemed to be participating in the 2011 Physician Quality Reporting System GPRO (that is, group practices participating in a CMS-approved Medicare demonstration) that have indicated their desire to participate in the 2011 eRx GPRO (75 FR 40207).

We also proposed that a group practice that wishes to participate in the 2011 eRx Incentive Program under the group practice reporting option will have to indicate how the group practice intends to report the electronic prescribing measure. That is, the group practice will need to indicate in its self-nomination letter which reporting mechanism (that is, claims, registries or EHRs) the group practice intends to use for purposes of participating in the 2011 eRx Incentive Program group practice reporting option.

We did not receive any comments related to the proposed definition of "group practice" for purposes of the eRx Incentive Program. For this reason, we are finalizing our proposal as previously described.

Unlike individual eligible professionals who may choose not to participate in the Physician Quality Reporting System, to be eligible to earn an electronic prescribing incentive in 2011, group practices that wish to participate in the electronic prescribing group practice reporting option will be required to participate in the Physician Quality Reporting System group practice reporting option or be deemed to be participating in the Physician Quality Reporting System group practice reporting option based on the practice's participation in an approved Medicare demonstration project. Participation in the eRx Incentive Program, including participation in the electronic prescribing group practice reporting option is, however, optional for group practices that are participating in the Physician Quality Reporting System under the group practice reporting option. If a group practice wishes to participate in the 2011 eRx Incentive Program under the group practice reporting option, the group practice must indicate its desire to do so at the time that the group practice self-nominates to participate in the 2011 Physician Quality Reporting System group practice reporting option. However, group practices are not

required to indicate their intent to participate in the 2011 eRx Incentive Program as individual eligible professionals, when the group practice self-nominates to participate in the 2011 Physician Quality Reporting System group practice reporting option.

As discussed in section VII.F.1.g. of this final rule with comment period, group practices interested in participating in the 2011 Physician Quality Reporting System through the group practice reporting option will be required to submit a self-nomination letter to CMS, requesting to participate in the 2011 Physician Quality Reporting System group practice reporting option. Instructions for submitting the self-nomination letter will be posted on the Physician Quality Reporting System section of the CMS Web site by November 15, 2010. A group practice that had indicated their desire to participate in the eRx Incentive Program group practice reporting option when they self-nominated to participate in the 2011 Physician Quality Reporting System group practice reporting option will be notified of the selection decision with respect to participation in the eRx Incentive Program at the same time that it is notified of the selection decision for the Physician Quality Reporting System group practice reporting option.

(B) Process for Group Practices to Participate as Group Practices and Criteria for Successful Reporting of the Electronic Prescribing Measure by Group Practices

For group practices selected to participate in the electronic prescribing group practice reporting option for purposes of the 2011 eRx incentive payment, we proposed that the reporting period would be January 1, 2011 to December 31, 2011 (75 FR 40207). We proposed that group practices selected to participate in the 2011 eRx Incentive Program and qualify for the eRx incentive payment through the group practice

reporting option would be able to choose to report the electronic prescribing measure through the claims-based, the registry-based, or, the EHR-based reporting mechanism.

In order for a group practice participating in the Physician Quality Reporting System GPRO I to be considered a successful electronic prescriber for purposes of the 2011 eRx incentive, we proposed that the group practice would have to report that at least 1 prescription during an encounter was generated and transmitted electronically using a qualified electronic prescribing system in at least 2,500 instances during the reporting period. In order for a group practice participating in the Physician Quality Reporting System GPRO II to be considered a successful electronic prescriber, we proposed that the group practice would have to report that at least 1 prescription during an encounter was generated and transmitted electronically using a qualified electronic prescribing system for 75-1,875 instances, based on the group's size (75 FR 40208).

Section 1848(m)(2)(B) of the Act specifies that the 10 percent threshold limitation on the applicability of the electronic prescribing incentive applies to group practices as well as individual eligible professionals. Therefore, in determining whether a group practice will receive an electronic prescribing incentive payment for 2011 by meeting the proposed reporting criteria previously described, we would determine based on the claims, whether 10 percent of a group practice's charges comprised of codes in the denominator of the electronic prescribing measure.

We did not receive any comments related to the proposed process for group practices to participate as group practices and the proposed criteria for successful reporting of the electronic prescribing measure by group practices for purposes of the 2011 eRx Incentive. Therefore, for purposes of the 2011 eRx incentive, we are finalizing

our proposal to require GPRO I practices to report the electronic prescribing measure for 2,500 instances during the January 1, 2011 through December 31, 2011. We are also finalizing our proposal to require GPRO II practices to report the electronic prescribing measure for the number of instances specified in Table 76 (see section VII.F.1.g.(3).(B). of this final rule with comment period) during the January 1, 2011 through December 31, 2011 reporting period. We believe these are reasonable thresholds to demonstrate use of electronic prescribing technology.

In addition, we are finalizing our proposal to allow group practices participating in the 2011 eRx Incentive Program under GPRO I and GPRO II to submit data on the electronic prescribing measure using claims, a qualified registry, or a qualified EHR for purposes of qualifying for the 2011 eRx incentive payment. In addition, for purposes of the 2011 eRx incentive, we will not combine data on the electronic prescribing submitted via multiple reporting mechanisms. That is, a group practice must meet the relevant 2011 GPRO reporting criteria for the 2011 incentive using a single reporting mechanism. Combining data received via multiple reporting mechanisms would add significant complexity to our analytics and potentially delay incentive payments.

c. The 2012 eRx Payment adjustment

Section 1848(a)(5) of the Act requires that with respect to covered professional services furnished by an eligible professional in 2012, if the eligible professional is not a successful electronic prescriber for the reporting period for the year, the fee schedule amount for such services furnished by such professional during 2012 shall be equal to 99 percent of the fee schedule amount that would otherwise apply to such PFS services.

The following is a summary of general comments received regarding the eRx payment adjustment and our responses.

Comment: Some commenters were opposed to implementation of the eRx payment adjustment because of the eRx Incentive Program is relatively new. Commenters noted that we have not released any summary results regarding how many eligible professionals are reporting and how many are earning incentives, eligible professionals have not received feedback reports on their progress for 2009 or 2010, and there is no evidence that the program is working. As a result, commenters suggested that CMS should ensure that eligible professionals who attempt to report but are unsuccessful due to the data submission process are not penalized.

Response: Section 1848(a)(5) of the Act requires us to implement a payment adjustment beginning with covered professional services furnished by an eligible professional during 2012, if the eligible professional is not a successful electronic prescriber. We do not have the authority to delay implementation of this payment adjustment.

Comment: One commenter suggested that we exercise additional flexibility in assigning payment adjustments carefully by reviewing each eligible professional's circumstances prior to assigning any payment adjustments.

Response: Although we value the commenter's input, this suggestion is not technically feasible. Given the short period of time between the end of the data submission period for the 2012 eRx payment adjustment and when we would have to begin adjusting eligible professional’s 2012 payments, it would not be feasible for us to review every eligible professional’s circumstances individually. In addition, section

1848(a)(5) (A)(i) of the Act requires us to apply the payment adjustment "if the eligible professional is not a successful electronic prescriber." We believe that the criteria for becoming a successful electronic prescriber for purposes of the payment adjustment that we have proposed and are finalizing below are reasonable in that we have limited the number of electronic prescribing events required to avoid the payment adjustment. Furthermore, as discussed further in section VII.F.2.c.(4).of this final rule with comment period we have provided a process whereby eligible professionals can request a significant hardship exception on a case-by-case basis under section 1848(a)(5)(B) of the Act.

Comment: Several commenters urged us to synchronize the eRx Incentive Program and EHR Incentive Program so that eligible professionals who receive Medicare EHR incentives will be exempt from the eRx payment adjustments. Commenters stated that the EHR Incentive Program provides an opportunity and payment adjustment that did not exist when the original eRx Incentive Program regulations were put in place, and adjustments should be made due to the amount of overlap between programs. As it is, the eRx Incentive Program and the EHR Incentive Program represent a form of "double jeopardy" for physicians. For instance, a physician who gets the first year "meaningful use" subsidy via Medicaid could also be penalized for not using electronic prescribing. Also, commenters claimed that in some cases, in order to avoid the eRx payment adjustment, a physician would have to purchase a stand-alone electronic prescribing program and then transition to a full EHR once the certification standards are determined. Furthermore, the list of "certified" EHRs for the EHR Incentive Program will not be available until January 2011. Another commenter stated that it is unfair to penalize

eligible professionals who are working in good faith to adopt a comprehensive EHR under the EHR Incentive Program. Another commenter suggested that every effort be made to align the EHR Incentive Program and the eRx payment adjustment to remove the burden from eligible professionals of having to submit electronic prescribing measure data more than once.

Response: We agree with the desire to align the EHR Incentive Program and the eRx payment adjustment and understand the commenters' concerns. The EHR Incentive Program and the eRx Incentive Program are governed by different laws, and have different reporting requirements. While section 1848(m)(2)(D) explicitly limits eligible professionals or group practices that receive an EHR incentive from qualifying for an eRx incentive payment in the same year, there is not a similar statutory provision that explicitly limits an eligible professional or group practice that receives an EHR incentive from being subject to the eRx payment adjustment. At this time an eligible professional who wishes to participate in the EHR Incentive Program would also have to participate in the eRx Incentive Program during 2011 to avoid an eRx payment adjustment in 2012 since the two programs have different requirements with respect to electronic prescribing. Eligible professionals, however, are not penalized for participating in both programs. Rather, an eligible professional who qualifies for an eRx incentive and a Medicare EHR incentive cannot earn an eRx incentive for the same year. However, we are making the effort to study possible methods of aligning the two programs by developing a plan, as described under section 1848(m)(7) of the Act ("Integration of Physician Quality Reporting and EHR Reporting"), to integrate measure reporting requirements under

Physician Quality Reporting System, eRx Incentive Program and the EHR Incentive Program.

We note that although section 1848(m)(2) precludes an eligible professional who has earned an incentive payment under the EHR Incentive Program from also earning an eRx incentive payment, the statute does not preclude the eligible professional from being subject to the eRx payment adjustment. In order to avoid the eRx payment adjustment, an eligible professional participating in the Medicare EHR Incentive Program still must meet the relevant eRx payment adjustment criteria for being a successful electronic prescriber.

(1) The eRx Payment Adjustment Reporting Period

For purposes of the 2012 eRx payment adjustment, we proposed to make a determination of whether an eligible professional or a group practice is a successful electronic prescriber based on the January 1, 2011 through June 30, 2011 reporting period (75 FR 40208). For eligible professionals and group practices using the claims-based reporting mechanism, we proposed that all claims for services furnished between January 1, 2011 and June 30, 2011 must be processed by no later than one month after the reporting period, for the claim to be included in our data analysis.

The following is a summary of comments received on the proposed reporting period for the 2012 eRx payment adjustment and our proposal to require claims to be submitted by no later than 1 month after the reporting period.

Comment: Several commenters expressed a desire for us to revise or delay the 2012 eRx payment adjustment reporting period, asserting that basing the 2012 eRx payment adjustment on electronic prescribing activity in 2011 conflicts with the law.

Although some commenters acknowledged the need for time to complete a data analysis to determine if an eligible professional was a successful electronic prescriber prior to 2012, these commenters expressed opposition to the shorter reporting period. Other commenters believed that payment adjustments for 2012 should be based on a reporting period in 2012 rather than a reporting period in 2011. Commenters preferred that the reporting period for the 2012 and 2013 payment adjustments be the full 2012 and 2013 calendar years, respectively. One commenter requested an April 1 through September 30, 2011 for the 2012 payment adjustment. One commenter noted that some organizations might have planned an implementation of a qualified electronic prescribing system prior to January 1, 2012, to avoid the 2012 eRx payment adjustment. Such organizations would now have to complete that implementation more than six months in advance, potentially causing a significant financial burden for the organization. Another commenter stated that the 2012 eRx payment adjustment may cause some practices to reduce their Medicare patient roster (or refuse to accept new Medicare patients) in order to reduce the size of the payment adjustment, because they claim they would not have adequate time to meet the proposed 2011 requirements to avoid the payment adjustment in 2012.

Response: With respect to commenters' claims that the proposed reporting period for purposes of applying the 2012 eRx payment adjustment conflicts with the law, section 1848(a)(5) of the Act requires that the PFS amount for covered professional services furnished by an eligible professional during 2012, be reduced by 1 percent during 2012, if the eligible professional is not a successful electronic prescriber for the reporting period

for the year. Under section 1848(a)(5)(D) of the Act, we have the discretion to define the "reporting period" for purposes of the payment adjustment with respect to a year.

While we appreciate the commenters' suggestions to use data from the entire 2011 calendar year, a later part of 2011, or from 2012 for such an assessment for purposes of applying the 2012 eRx payment adjustment for services furnished in 2012, we believe it is necessary to reduce the PFS amount concurrently with claims submissions in 2012. The alternatives to reducing the PFS amount concurrently with claims submissions in 2012 would be having to recoup payments after the determination is made about whether the payment adjustment applies, providing added payments if the claims are paid at the reduced amount before the determination is made about whether the payment adjustment applies, or holding claims until the determination is made about whether the payment adjustment applies. As a result, we need to determine whether eligible professionals are successful electronic prescribers prior to 2012, based on a reporting period that also takes place prior to 2012. We believe that the proposed reporting period of the first six months of 2011 will allow sufficient time for eligible professionals to report the electronic prescribing measure, allow us to collect and analyze the data submitted by eligible professionals, and avoid retroactive adjustments of payments in 2012. Avoiding retroactive adjustments would not be possible if the determination of a successful electronic prescriber for purposes of the 2012 payment adjustment was based on reporting for the entire 2011 calendar year or a later portion of the 2011 calendar year. After the end of the reporting period, we must allow some time for claims for services furnished during the reporting period to be submitted and processed before it is available for analysis. Once we have completed our analysis we also need time to make the

necessary system changes to begin applying the payment adjustments to the appropriate individuals. All of this must occur prior to January 1, 2012.

Comment: One commenter suggested we be consistent with EHR Incentive Program submission guidelines by allowing electronic prescribing measure data to be submitted for up to two months after the close of the reporting period, rather than the proposed one month.

Response: As we explained previously, we need sufficient time following the close of the 6-month reporting period to determine whether an eligible professional is a successful electronic prescriber and must do so prior to 2012, when the eRx payment adjustment would be assessed (if applicable). Accordingly, we cannot allow claims to be submitted for up to two months after the close of the reporting period.

After considering the comments and for the reasons we explained previously, we are finalizing a 6-month reporting period, from January 1, 2011 through June 30, 2011, for the 2012 eRx payment adjustment.

(2) Criteria for Determining Applicability of the 2012 eRx Payment Adjustment to Individual Eligible Professionals

As we explained previously, section 1848(a)(5) of the Act requires a payment adjustment be applied with respect to covered professional services furnished by an eligible professional in 2012, if the eligible professional is not a successful electronic prescriber for the reporting period for the year. Section 1848(m)(3)(B) of the Act sets forth the requirements for being a successful electronic prescriber. As we discussed in section VII.F.2.b.(2). of this final rule with comment period, for the 2011 eRx Incentive Program, we decided to continue to require eligible professionals to report on the

electronic prescribing measure to determine whether an eligible professional is a successful electronic prescriber. Details about the electronic prescribing quality measure are discussed in section VII.F.2.b.(2).(C) and (D) of this final rule with comment period.

In addition, based on the authority under section 1848(m)(3)(D) of the Act to revise the criteria for submitting data on the electronic prescribing quality measure, we proposed that the 2012 eRx payment adjustment would not apply to the following:

(1) An eligible professional who is not a physician (includes MDs, DOs, and podiatrists), nurse practitioner, or physician assistant as of June 30, 2011.

(2) An eligible professional who does not have at least 100 cases (that is, claims for patient services) containing an encounter code that falls within the denominator of the electronic prescribing measure for dates of service between January 1, 2011 through June 30, 2011.

(3) An eligible professional who is a successful electronic prescriber for the January 1, 2011 through June 30, 2011 reporting period. Specifically, we proposed that to be a successful electronic prescriber for purposes of avoiding the 2012 eRx payment adjustment, the eligible professional must report that at least 1 prescription for Medicare Part B FFS patients created during an encounter that is represented by 1 of the codes in the denominator of the 2011 electronic prescribing measure was generated and transmitted electronically using a qualified eRx system at least 10 times during the 2012 eRx payment adjustment reporting period (that is, January 1, 2011 through June 30, 2011). (75 FR 40208).

The limitation with respect to the electronic prescribing measures required under section 1848(m)(2)(B)(i) of the Act also applies to the eRx payment adjustment.

Therefore, we proposed that if less than 10 percent of the eligible professional's estimated total allowed charges for the January 1, 2011 through June 30,2011 reporting period are comprised of services which appear in the denominator of the 2011 electronic prescribing measure, then the eligible professional would not be subject to the 2012 eRx payment adjustment (75 FR 40209). As with the 2011 eRx incentive payment, we proposed that the determination of whether an eligible professional is subject to the payment adjustment will be made at the individual professional level, based on the NPI and for each unique TIN/NPI combination.

The following is a summary of the comments received on the proposed criteria for determining the applicability of the 2012 eRx payment adjustment to individual eligible professionals and our responses.

Comment: A couple of commenters suggested that regardless of the payment adjustment exemption criteria, any eligible professional who qualifies for the incentive payment should be exempt from the payment adjustment. The commenters specifically requested an exemption for eligible professionals who are successful electronic prescribers for the 2011 eRx incentive.

Response: As discussed previously, section 1848(a)(5) of the Act requires that the PFS amount for covered professional services furnished by an eligible professional, who is not a successful electronic prescriber, must be reduced by 1 percent for services furnished during 2012. With regard to applying the required 2012 eRx payment adjustment, we believe it is necessary to reduce the PFS amount concurrently with claims submissions in 2012, and so we need to determine if the 2012 eRx payment adjustment is applicable to eligible professionals prior to 2012. This assessment would not be possible

if the successful electronic prescriber determination was based on eRx incentive payment eligibility criteria for 2011, given that we cannot determine successful electronic prescribers for purposes of the 2011 eRx incentive until 2012.

After considering the comments received, we are finalizing the criteria for determining applicability of the 2012 eRx payment adjustment to individual eligible professionals as proposed and previously described. As stated in the proposed rule (75 FR 40208 and 40209), we believe that that limiting the application of the payment adjustment to those professionals who generally have prescribing privileges and who have a sufficient number of denominator-eligible cases is appropriate. We also believe that the reporting threshold of 10 unique electronic prescribing events between January 1, 2011 and June 30, 2011 is achievable. As stated previously, although we proposed to allow reporting of the electronic prescribing measure via claims, a qualified registry, or a qualified EHR, we are finalizing only the claims-based reporting mechanism for purposes of the 2012 payment adjustment. It is not operationally feasible for us to accept the data submissions from the EHRs and registries in the timeframe needed for us to be able to have sufficient time to be analyze the data and make the determination whether an eligible professional is subject to the 2012 payment adjustment prior to January 1, 2012.

For purposes of determining whether an eligible professional is a physician (includes MDs, DOs, and podiatrists), nurse practitioner, or physician assistant we will use National Plan & Provider Enumeration System (NPPES) data. It is an eligible professional's responsibility to ensure that his or her primary taxonomy code in NPPES is accurate. Since there are concerns about the reliability of the specialty information

contained in NPPES, we are also establishing a G-code that eligible professionals can use to report to us that they do not have prescribing privileges. Eligible professionals who do not have prescribing privileges must report this G-code on at least one claim with dates of service between January 1, 2011 and June 30, 2011, and processed by no later than one month after the reporting period.

(3) Criteria for Determining Applicability of the 2012 eRx Payment Adjustment to Group Practices

As required by section 1848(m)(3)(C) of the Act, we are also required to establish and have in place a process under which eligible professionals in a group practice shall be treated as a successful electronic prescriber for purposes of the eRx payment adjustment. Thus, we proposed that for purposes of the 2012 eRx payment adjustment, a payment adjustment would not be applied to a group practice participating in the 2011 eRx GPRO if the group practice is participating in either the 2011 Physician Quality Reporting System GPRO I or the 2011 Physician Quality Reporting System GPRO II and meets the proposed 2011 criteria for successful electronic prescribing for the 2011 eRx incentive (75 FR 40209). For purposes of the 2012 eRx payment adjustment, however, we proposed that the 2011 eRx incentive criteria for successful electronic prescribing would need to be satisfied during the 2012 eRx payment adjustment reporting period of January 1, 2011 through June 30, 2011, for the same operational reasons that we proposed a 6-month reporting period for the payment adjustment for individual eligible professionals.

For purposes of determining whether the eRx payment adjustment applies to a group practice, we proposed to analyze each unique TIN/NPI combination so as not to

disadvantage eligible professionals who may have joined the group practice after January 1, 2011 (75 FR 40209).

In addition, in accordance with the limitation under section 1848(m)(2)(B)(i) of the Act, we proposed that the 2012 eRx payment adjustment would not apply to an eRx GPRO in which less than 10 percent of the group practice's estimated total allowed charges for the January 1, 2011 through June 30, 2011 reporting period are comprised of services which appear in the denominator of the 2011 electronic prescribing measure. To be consistent with how this limitation is applied to group practices for purposes of the incentive, we proposed to determine whether this limitation applies to a group practice for the payment adjustment at the TIN level.

For the same reasons that we proposed a 6-month reporting period for the 2012 eRx payment adjustment for group practices, we also proposed to use only claims processed by no later than 1 month after the reporting period in our analysis, consistent with our proposed approach for analyzing individual eligible professional claims. Similarly, we proposed that registries would need to submit eRx data for services furnished January 1, 2011 through June 30, 2011 to CMS between July 1, 2011 and August 19, 2011, so that we may include registry data in our analysis. We also proposed that group practices participating in the eRx group practice reporting option via EHR-based reporting would be required to submit eRx data for services furnished January 1, 2011 through June 30, 2011 to CMS between July 1, 2011 and August 19, 2011 (75 FR 40209).

The following is a summary of the comments received on the proposed criteria for determining applicability of the 2012 eRx payment adjustment to group practices,

including the proposed criteria for successful reporting of the electronic prescribing measure for group practices, and our proposed analytical approach.

Comment: One commenter suggested that we lower the reporting criteria for group practices if we finalize our proposal to use the 6-month reporting period beginning January 1, 2011 to determine whether a group practice is subject to the 2012 payment adjustment. The commenter noted that in determining the volume for the group incentive payment, we assume that not all eligible professionals in the practice would be electronically prescribing. The commenter believes that the same assumption should be applied for purposes of the payment adjustment determination.

Response: As we stated in the proposed rule (75 FR 40209), we do not believe that group practices would be disadvantaged by having to satisfy the criteria for being a successful e-prescriber for the 2011 eRx incentive in 6 months to avoid the 2012 eRx payment adjustment. When compared to the criteria for individual eligible professionals reporting the electronic prescribing measure for purposes of the payment adjustment, the criteria for being a successful electronic prescriber for the 2011 eRx payment adjustment for group practices enable group practices, on average, to avoid the incentive by electronically prescribing a fewer number of prescriptions per eligible professionals than what individual eligible professionals are required to do. Therefore, we are not lowering the reporting criteria for successful electronic prescribers for purposes of determining applicability of the 2012 eRx payment adjustment to group practices. By having the same reporting criteria for purposes of both the payment adjustment and incentive payment, group practices have the added advantage of knowing that they have successfully electronically prescribed for purposes of the 2011 incentive payment once

they have successfully electronically prescribed for purposes of the 2012 payment adjustment, since the reporting periods for the 2011 incentive and 2012 payment adjustment overlap.

After consideration of the comments received and for the reasons we discussed previously, we are finalizing the criteria for determining applicability of the 2012 eRx payment adjustment to group practices. However, for the reasons discussed previously with regard to the reporting mechanisms for submitting data on the electronic prescribing measure during 2011 for purposes of the 2012 payment adjustment, we are finalizing only the claims-based reporting mechanism. Thus, for the 2012 eRx payment adjustment, we are not finalizing eRx data submission by group practices via a qualified registry or qualified EHR.

In addition, while we had proposed to analyze each unique TIN/NPI combination to see whether the payment adjustment applies on an individual basis if the group practice fails to satisfy the criteria that would exempt the group practice from being subject to the 2012 eRx payment adjustment, we are unable to finalize this proposal as this would add significant time to our data analyses and could delay our ability to determine applicability of the 2012 payment adjustment in a timely fashion.

(4) Significant Hardship Exemption

Section 1848(a)(5)(B) of the Act provides that the Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment, if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship, such in the case of an eligible professional who practices in a rural area without

sufficient Internet access. Therefore, we proposed that in addition to meeting the criteria for a successful electronic prescriber, an eligible professional or group practice may also be exempt from application of the 2012 eRx payment adjustment, if, during the 2012 eRx payment adjustment reporting period (that is, January 1, 2011 through June 30, 2011), one of the following circumstances applies to the eligible professional or group practice:

- The eligible professional or group practice practices in a rural area with limited high speed internet access; or
- The eligible professional or group practice practices in an area with limited available pharmacies for electronic prescribing.

We proposed to add two additional "G" codes to the 2011 electronic prescribing measure's specifications describing these 2 circumstances. Eligible professionals or group practices to whom one or more of these circumstances apply would be required to report the appropriate G-code at least once between January 1, 2011 and June 30, 2011 using their selected 2011 eRx reporting mechanism. Reporting of one of these two G-codes prior to June 30, 2011 will indicate to us that the eligible professional or group practice would like to be considered for an exemption from the 2012 payment adjustment under the significant hardship exception (75 FR 40209).

The following is a summary on the comments we received regarding our proposal for the significant hardship exemption and our responses.

Comment: One commenter supported the proposed process for the significant hardship exemption and did not offer any other circumstances that should also be considered a significant hardship.

Response: We appreciate the commenter's supportive comments.

Comment: While our acknowledgement of hardship circumstances was appreciated, several commenters suggested we add more hardship exemption categories, or offered additional hardship circumstances for our consideration. Specifically, commenters requested that the following hardship circumstances be added to the payment adjustment exemption list: (1) physicians who are nearing the end of their careers, (2) physicians who are currently eligible for Social Security benefits or will be eligible for Social Security benefits by 2014, (3) physicians who plan on participating in the EHR incentive program beginning in 2012, 2013, or 2014, (4) DEA e-prescribers, (5) small practices (that is, 1 to 2 physicians), (6) practices located in Health Professional Shortage Areas (HPSAs), (7) physicians who cannot meet the requirements due to patient preference, and (8) hospital-based eligible professionals. Commenters stated that physicians nearing retirement age or in small practices may find it difficult to justify the cost of implementing these systems. Several commenters noted that many physicians have postponed purchasing electronic prescribing software in order to take advantage of the EHR incentives. Finally, commenters argued that physicians who electronically prescribe controlled substances should have additional time to comply with the eRx Incentive Program requirements as the DEA compliant electronic prescribing applications are not yet available.

Response: We appreciate the commenters' feedback and are actively working on G-codes for eligible professionals to report the significant hardship categories we proposed for the 2012 eRx payment adjustment. We do not believe, however, that any of the suggested additional hardship categories constitute a circumstance that limits an eligible professional's access to electronic prescribing in the way that the two hardship

exemptions we proposed do. We also believe that eligible professionals who are nearing retirement or are eligible for Social Security benefits still have the opportunity to purchase and use electronic prescribing technology even though they may not have a business case for doing so. With respect to the other hardship exemptions specifically requested by commenters (such as, hospital-based eligible professionals, DEA e-prescribers and physicians who cannot meet the requirements due to patient preferences), we believe that we have already taken these circumstances into account when we established the reporting threshold for the electronic prescribing and the other criteria that would subject an eligible professional to the eRx payment adjustment. Therefore, we are finalizing the two hardship exemption G-codes that we proposed.

Comment: A couple of commenters requested that we further define terms such as "rural areas," areas with "limited high speed internet access," and "limited availability of pharmacies."

Response: We are actively working to develop G-codes for eligible professionals to report the eRx hardship. Once we finalize the G-codes, we will provide additional guidance with regards to the hardship exemptions categories associated with the eRx payment adjustment along with education and outreach with regard to the 2012 payment adjustment under the eRx Incentive Program.

After considering the comments received, we are finalizing the following hardship exemptions for purposes of the 2012 eRx payment adjustment:

- Eligible professionals who practice in a rural area without sufficient high speed internet access; and

- Eligible professionals who practice in an area without sufficient available pharmacies for electronic prescribing.

We are creating G-codes to address these 2 situations. Since the hardship exception must be renewed on an annual basis, we have deleted the proposed language at §414.92(c)(2)(ii) that listed specific circumstances that constitute a "significant hardship." For future years and in future rulemaking, we will address the circumstances that will constitute a significant hardship for each year.

Eligible professionals for whom one or more of these circumstances apply must report the appropriate G-code at least once between January 1, 2011 and June 30, 2011 using claims. Group practices who wish to participate in the 2011 eRx GPRO and for whom one or more of these circumstances apply must request a hardship exemption at the time they self-nominate by indicating the appropriate G-code in their self-nomination letter to CMS. Reporting of one of these G-codes prior to June 30, 2011 will indicate to us that the eligible professional or group practice would like to be considered for an exemption from the eRx 2012 payment adjustment under the significant hardship exception.

d. The 2013 eRx Payment Adjustment

Section 1848(a)(5) of the Act also requires that with respect to covered professional services furnished by an eligible professional in 2013, if the eligible professional is not a successful electronic prescriber for the reporting period for the year, the fee schedule amount for such services furnished by such professional during 2013 shall be equal to 98.5 percent of the fee schedule amount that would otherwise apply to such PFS services. Under section 1848(m)(3)(C) of the Act, we are also required to

establish and have in place a process under which eligible professionals in a group practice shall be treated as a successful electronic prescriber for purposes of the eRx payment adjustment.

For purposes of the 2013 eRx payment adjustment, we proposed to use the proposed criteria for successful electronic prescriber for the proposed 2011 eRx incentive payment to determine whether an eligible professional or a group practice is a successful electronic prescriber for purposes of the 2013 eRx payment adjustment. In addition, we proposed that the reporting period for the 2013 eRx payment adjustment would be January 1, 2011 through December 31, 2011 (75 FR 40210). We believe that matching the criteria that will be applied for the 2013 eRx payment adjustment with the criteria that will be applied for the 2011 eRx incentive payment in an earlier year would be the most effective means of encouraging eligible professionals and group practices to adopt and use electronic prescribing systems since anyone who does not qualify for an incentive in 2011 would be subject to a payment adjustment in 2013.

The following is a summary of the comments received on our proposal for the 2013 eRx payment adjustment.

Comment: We received comments similar to the ones opposing the proposed 2012 eRx payment adjustment reporting period, with regard to the proposed 2013 eRx payment adjustment reporting period. One commenter suggested that the proposed reporting period for purposes of the 2013 eRx payment adjustment be changed so the 2012 and 2013 eRx payment adjustments do not overlap. Another commenter suggested that the 2013 payment adjustment be based on claims reported during the first half of

2012 to better reflect expected increases in eRx adoption, including increases due to the EHR Incentive Program.

Response: We understand the commenters' concerns that the reporting periods for purposes of the 2012 and 2013 eRx payment adjustments overlap. We note that section 1848(a)(5)(C)(D) gives us the authority to specify the reporting period with respect to a year. As such, we may consider revisiting in the 2012 PFS rulemaking process additional reporting periods in 2012 for purposes of the 2013 eRx payment adjustment since having multiple reporting periods for purposes of the payment adjustment will maximize opportunities for eligible professionals to avoid the 2013 payment adjustment.

After considering the comments received and for the reasons we previously explained, we are finalizing our proposal to use the 2011 eRx incentive payment criteria for successful electronic prescriber as described in section VII.F.2.b. of this final rule with comment period to determine whether an eligible professional or a group practice is a successful electronic prescriber for purposes of the 2013 eRx payment adjustment based on the January 1, 2011 through December 31, 2011 reporting period. However, we may consider revisiting the criteria for the 2013 payment adjustment in the context of 2012 reporting periods in the 2012 PFS proposed and final rules.

e. Public Reporting of Names of Successful Electronic Prescribers

Section 1848(m)(5)(G) of the Act requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submit data on quality measures for the Physician Quality Reporting System and the names of the eligible professionals (or group practices) who are successful electronic prescribers. As required by section 1848(m)(5)(G) of the

Act, we proposed to make public the names of eligible professionals and group practices who are successful electronic prescribers for the 2011 eRx Incentive Program on the Physician Compare Web site that we are required to establish by January 1, 2011 under section 10331 of the ACA.

The following is a summary of the comments received regarding public reporting of successful electronic prescribers.

Comment: A few commenters expressed concerns about posting the names of successful e-prescribers. One commenter was concerned that the public would not be able to correctly identify a successful e-prescriber as a professional who has met the reporting requirements for the eRx Incentive Program. One commenter was concerned that individuals using this information to make health care decisions may do so without fully understanding the methodology and the program requirements. The commenters suggested that CMS take appropriate measures to ensure the accuracy of the list of successful e-prescribers and to provide the appropriate disclaimers for the Web site listing.

Response: We will make every effort to ensure that the list of successful e-prescribers that we will post on the Physician Compare Web site is accurate. We also intend to include explanatory language with information on the intended uses and/or limitations of this data.

Based on the comments received, we are finalizing our proposal to post the names of eligible professionals and group practices who are successful electronic prescribers for purposes of the 2011 eRx incentive on the Physician Compare Web site. We anticipate that the names of individual eligible professionals and group practices who are successful

electronic prescribers for the 2011 eRx Incentive Program will be available in 2012 after the 2011 incentive payments are paid.

To comply with section 1848(m)(5)(G) of the Act, we specifically intend to post the names of individual eligible professionals who report the electronic prescribing measure at least 25 times during the 2011 reporting period for patient encounters included in the measure's denominator, without regard to whether the limitation under section 1848(m)(2)(B) of the Act applies to the eligible professional and without regard to whether the eligible professional actually qualifies to earn an incentive payment. In addition, since the Physician Quality Reporting System and the eRx Incentive Program are two separate programs and individual eligible professionals are not required to participate in both programs to earn an incentive under either program, we point out that it is possible for an eligible professional who participates in both incentive programs to be listed both as an individual eligible professional who satisfactorily submits data on quality measures for the Physician Quality Reporting System and is a successful electronic prescriber under the eRx Incentive Program. Likewise, if an eligible professional participated in both incentive programs but did not meet the respective requirements for both programs, he or she may be listed as an individual eligible professional who satisfactorily submits data on quality measures for the Physician Quality Reporting System only or as a successful electronic prescriber under the eRx Incentive Program only.

Similarly, for purposes of publicly reporting the names of group practices, on the Physician Compare Web site, we intend to post the names of group practices that report the electronic prescribing measure the required number of times during the 2011

reporting period for patient encounters included in the measure's denominator without regard to whether the limitation under section 1848(m)(2)(B) of the Act applies to the group practice or whether the group practice actually qualifies to earn an incentive payment. Although any group practice participating in the eRx Incentive Program under the group practice reporting option would also have to participate in a Physician Quality Reporting System group practice reporting option, the criteria for satisfactory reporting of Physician Quality Reporting System measures for group practices are different from the criteria for successful reporting of the electronic prescribing measure by group practices. Therefore, it is possible for a group practice to be listed as a group practice that satisfactorily submits data on quality measures for the Physician Quality Reporting System but not as a successful electronic prescriber under the eRx Incentive Program, or vice versa.

G. DMEPOS Provisions

1. Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP)

a. Legislative and Regulatory History of DMEPOS CBP

Medicare pays for most DMEPOS furnished after January 1, 1989 pursuant to fee schedule methodologies set forth in section 1834 of the Act, as added by section 4062 of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100-203). Specifically, sections 1834(a)(1)(A) and (B), and 1834 (h)(1)(A) of the Act provide that Medicare payment for these items is equal to 80 percent of the lesser of the actual charge for the item or the fee schedule amount for the item. We implemented this payment methodology at 42 CFR Part 414, Subpart D of our regulations. Sections 1834(a)(2) through (a)(5) and 1834(a)(7) of the Act, and implementing regulations at §414.200 through §414.232 (with the exception of §414.228), set forth separate payment categories of durable medical equipment (DME) and describe how the fee schedule for each of the following categories is established:

- Inexpensive or other routinely purchased items (section 1834(a)(2) of the Act and §414.220 of the regulations);
- Items requiring frequent and substantial servicing (sections 1834(a)(3) of the Act and §414.222 of the regulations);
- Customized items (section 1834(a)(4) of the Act and §414.224 of the regulations);
- Oxygen and oxygen equipment (section 1834(a)(5) of the Act and §414.226 of the regulations);

• Other items of DME (section 1834(a)(7) of the Act and §414.229 of the regulations).

For a detailed discussion of payment for DMEPOS under fee schedules, see the final rule published in the April 10, 2007 **Federal Register** (72 FR 17992).

Blood glucose testing strips or diabetic testing strips are covered under the Medicare DME benefit in accordance with section 1861(n) of the Act. Other supplies that are necessary for the effective use of DME are also covered under the Medicare DME benefit in accordance with longstanding program instructions at section 110.3 of chapter 15 of the Medicare Benefit Policy Manual.

Section 1847 of the Act, as amended by section 302(b)(1) of the MMA, requires the Secretary to establish and implement a DMEPOS CBP. Under the DMEPOS CBP, Medicare sets payment amounts for selected DMEPOS items and services furnished to beneficiaries in competitive bidding areas (CBAs) based on bids submitted by qualified suppliers and accepted by Medicare. For competitively bid items, these new payment amounts, referred to as "single payment amounts (SPA)," replace the fee schedule payment methodology. Section 1847(b)(5) of the Act provides that Medicare payment for these competitively bid items and services is made on an assignment-related basis equal to 80 percent of the applicable SPA, less any unmet Part B deductible described in section 1833(b) of the Act. Section 1847(b)(2)(A)(iii) of the Act prohibits the awarding of contracts to any entity unless the total amounts to be paid to contractors in a CBA are expected to be less than the total amounts that would otherwise be paid under the fee schedule methodologies set forth in section 1834(a) of the Act. This requirement guarantees savings to both the Medicare program and beneficiaries under the program.

The fee schedule methodologies will continue to set payment amounts for noncompetitively bid DMEPOS items and services. The program also includes provisions to ensure beneficiary access to quality DMEPOS items and services. Section 1847(b)(2)(A) and 1847(b)(4)(B) of the Act, respectively, limits participation in the program to suppliers who have met applicable quality and financial standards and requires the Secretary to maintain beneficiary access to multiple suppliers.

When first enacted by the Congress, section 1847(a)(1)(B) of the Act required the Secretary to phase in the DMEPOS CBP in a manner so that the competition under the program occurred in 10 of the largest metropolitan statistical areas (MSAs) in 2007. The program was to be expanded into 70 additional MSAs in 2009, and then into additional areas after 2009.

In the May 1, 2006 **Federal Register** (72 FR 25654), we issued a proposed rule that would implement the DMEPOS CBP for certain DMEPOS items and services and solicited public comment on our proposals. In the April 10, 2007 **Federal Register** (72 FR 17992), we issued a final rule addressing the comments on the proposed rule and establishing the regulatory framework for the DMEPOS CBP in accordance with section 1847 of the Act.

Consistent with the requirements of section 1847 of the Act and the competitive bidding regulations, we began implementation of the program by conducting the first round of competition in 10 of the largest MSAs in 2007. We limited competition during this first round of the program to DMEPOS items and services included in 10 selected product categories, including mail order diabetic supplies. The bidding window opened on May 15, 2007 and was extended to allow bidders adequate time to prepare and submit

their bids. We then evaluated each submission and awarded contracts consistent with the requirements of section 1847(b)(2) of the Act and §414.414. Following the bid evaluation process, we awarded over 329 contracts to qualified suppliers.

The DMEPOS CBP was effective on July 1, 2008. Beginning on that date, Medicare coverage for competitively bid DMEPOS items and services furnished in the first 10 CBAs was limited to items and services furnished by contract suppliers and/or grandfathered suppliers of oxygen and oxygen equipment and rented DME, unless an exemption applies as stated in the regulation. For further discussion of the DMEPOS CBP and the bid evaluation process, see the final rule published in the April 10, 2007 **Federal Register** (72 FR 17992).

On July 15, 2008, the MIPPA was enacted. Section 154 of the MIPPA amended section 1847 of the Act to make certain limited changes to the DMEPOS CBP. Section 154(a) of the MIPPA delayed competition under the program and amended section 1847(a)(1)(D)(i) of the Act to terminate the competitive bidding contracts effective June 30, 2008 and prohibit payment based on the contracts.

Section 154(a) of the MIPPA required the Secretary to conduct a second competition to select suppliers for Round 1 in 2009 ("Round 1 Rebid"). The Round 1 Rebid includes the "same items and services" and is to be conducted in the "same areas" as the 2007 Round 1 competition, with certain limited exceptions. Specifically, we were required to exclude the product category of negative pressure wound therapy (NPWT) items and services and the San Juan, Puerto Rico CBA from the Round 1 Rebid. In addition, section 154(a) of the MIPPA permanently excluded group 3 complex, rehabilitative wheelchairs from the DMEPOS CBP by amending the definition of "items

and services" in section 1847(a)(2) of the Act. Section 154(a) of the MIPPA delayed competition for Round 2 of the DMEPOS CBP from 2009 to 2011, and subsequent competitions under the program to after 2011. Finally, section 154(a) of the MIPPA specifically addresses the phase in of a competition for national mail order items and services by specifying that such competitions may be phased in after 2010.

b. Implementation of a National Mail Order DMEPOS Competitive Bidding Program (CBP) for Diabetic Testing Supplies

Section 1847(a)(2)(A) of the Act mandates competitive bidding programs for supplies used in conjunction with durable medical equipment, such as blood glucose monitors used by beneficiaries with diabetes to test their blood glucose levels. Replacement of supplies used with these monitors are referred to under the DMEPOS CBP as diabetic supplies or diabetic testing supplies such as blood glucose test strips and lancets. In the April 10, 2007 final rule (72 FR 17992) implementing the DMEPOS CBP, we established regulations to implement competitions on a regional or national level for certain items such as diabetic testing supplies that are furnished on a mail order basis. We explained our rationale for establishing a national DMEPOS CBP for items furnished on a mail order basis in the May 1, 2006 proposed rule (71 FR 25669) and April 10, 2007 final rule (72 FR 18018). In the case of diabetic supplies and other items furnished by local neighborhood pharmacies, establishing a competition for items furnished on a mail order basis would exempt local pharmacies from competing with national mail order suppliers while preserving the choice of the beneficiary to go to any local pharmacy to pick up their diabetic supplies. Manufacturers and suppliers have stated to CMS at different meetings on numerous occasions that the choice for beneficiaries to obtain

diabetic supplies from local pharmacies with licensed pharmacists in house who can provide instructions and guidance to beneficiaries related to their testing needs is important and needs to be preserved.

In the January 16, 2009 **Federal Register** (74 FR 2873), we published an interim final rule implementing certain changes to the DMEPOS CBP. Specifically, the rule implemented certain MIPPA provisions that delayed implementation of Round 1 of the program, required CMS to conduct a second Round 1 competition in 2009, and mandated certain changes for both the Round 1 Rebid and subsequent rounds of the program. In the January 16, 2009 interim final rule, we indicated that we would be considering alternatives for competition of diabetic testing supplies in future notice and comment rulemaking. We explained that we believed it was consistent with section 1847(a) to employ competitive bidding for diabetic suppliers in both the mail order and traditional retail markets, in part due to concerns raised about the bifurcation of the method of delivery of diabetic supplies and the difficulty in defining what constitutes "mail order" for purposes of competition.

In the July 13, 2010, proposed rule (75 FR 40211), we discussed alternatives for competition of diabetic testing supplies and proposed the implementation of a revised national mail order DMEPOS CBP for diabetic testing supplies. Under the proposed mail order DMEPOS CBP, we would award contracts to suppliers to furnish these items across the nation to beneficiaries who elect to have replacement diabetic testing supplies delivered to their residence. Suppliers wishing to furnish these items through mail order to Medicare beneficiaries would be required to submit bids to participate in the national mail order DMEPOS CBP for diabetic testing supplies. In addition, we proposed to

revise the national mail order program for diabetic testing supplies DMEPOS CBP by implementing the following changes:

• Revision of §414.402 to include definitions of: “National mail order DMEPOS CBP," “Mail order item,” and “Non-mail order item.” We proposed these new definitions to establish a clear distinction between mail order items and non-mail order items. These revised definitions would apply to all future competitions for mail order items and services.

• Addition of §414.411 to implement the special rule mandated by section 1847(b)(10)(A) of the Act for competitions for diabetic testing strips following the Round 1 Rebid. Section 1847(b)(10)(A) requires suppliers bidding in competitions to furnish diabetic testing strips after the Round 1 Rebid to demonstrate that their bid covers at least 50 percent of all types of diabetic testing strips furnished by suppliers. If the supplier is not able to satisfy this requirement, the Secretary must reject that bid.

• Revision of §414.422 to include an additional term in contracts of mail order suppliers of diabetic testing supplies following the Round 1 Rebid. The proposed term would prohibit suppliers from influencing or incentivizing beneficiaries to change their brand of glucose monitor and test strips.

(1) Future Competitions for Diabetic Testing Supplies

Section 1847(a)(1)(A) of the Act mandates the establishment of DMEPOS CBP for items described in section 1847(a)(2)(A) of the Act, including diabetic testing supplies. Section 1847(a)(1)(B)(ii) of the Act authorizes the phase in of items and services under these programs beginning with the highest cost and highest volume items and services or those items and services that are determined to have the largest savings

potential. Current Medicare claims data from fiscal year 2009 shows that over 62 percent of beneficiaries currently receive their replacement diabetic testing supplies from mail order suppliers. Mail order diabetic testing supplies account for approximately one billion dollars in allowed charges per year and are therefore high volume items. We believe that a national mail order DMEPOS CBP for diabetic testing supplies would result in large savings as a result of competition between entities that would factor into their bids savings from volume discount purchasing of quantities of supplies needed on a national rather than local basis. Therefore, we believe that implementing a national mail order DMEPOS CBP for diabetic testing supplies is the best option for meeting the requirements of the statute referenced above as long as certain refinements discussed below are made to the program to address concerns about the mail order/non-mail order bifurcation.

We have heard from industry groups and suppliers that furnish diabetic testing supplies on a national mail order basis of their concerns that national chain pharmacies that furnish diabetic testing supplies through both a national mail order business and local retail pharmacies will encourage beneficiaries to obtain these items from local retail locations by offering certain incentives to Medicare beneficiaries for switching from mail order to local retail. Based on our experience from Round 1, we believe DMEPOS CBP for mail order diabetic testing supplies would be subject to manipulation without a clearer definition of what we mean by mail order. We agree with the industry groups and suppliers that have indicated that this practice will harm businesses that only furnish diabetic testing supplies on a mail order basis. In order to address these concerns, we are proposing to add to §414.402 a definition of "National mail order DMEPOS CBP." We

proposed to define that term as a program whereby contracts are awarded to suppliers for the furnishing of mail order items across the nation. We believe that implementing a national competitive bidding program for diabetic supplies would preserve beneficiary choice to purchase testing supplies in person from any local pharmacy that is an enrolled Medicare supplier that furnishes diabetic supplies, while clarifying the definition of mail order will provide significant savings potential for beneficiaries and the program. Savings would be generated in the near future from national SPAs for supplies furnished on a mail order or home delivery basis and on a long term basis for all diabetic supplies as a result of the requirement of section 1834(a)(1)(F) of the Act (as amended by section 6410(b) of the ACA) to either competitively bid in all areas or adjust prices in all areas by January 1, 2016. We believe that more beneficiaries will elect to choose the mail order/home delivery option, thereby further increasing short term savings under the program. Even if this is not the case, and the percentage of beneficiaries choosing the mail order/home delivery option remains at the current rate of 62 percent, savings for the remaining 38 percent must be achieved by no later than January 1, 2016, as a result of the requirements of section 1834(a)(1)(F) of the Act.

We considered other alternatives for establishing DMEPOS CBP for diabetic testing supplies that would eliminate the mail order/non-mail order bifurcation and associated concerns. These alternatives include the following:

- A national competition among all types of suppliers for all replacement diabetic supplies. Under this alternative, all beneficiaries would receive their replacement diabetic supplies from contract suppliers responsible for furnishing diabetic supplies throughout the nation using any method of delivery as long as the supplies are

delivered on a timely basis.

• Competitions in regional CBAs among all types of suppliers for all replacement diabetic supplies. Under this alternative, all beneficiaries would receive their replacement diabetic supplies from contract suppliers responsible for furnishing diabetic supplies throughout a designated region of the country using any method of delivery to a beneficiary's home as long as the supplies are delivered on a timely basis.

• Competitions in local CBAs among all types of suppliers for all replacement diabetic supplies. Under this alternative, all beneficiaries would receive their replacement diabetic supplies from contract suppliers responsible for furnishing diabetic supplies throughout the local area using any method of delivery to a beneficiary's home as long as the supplies are delivered on a timely basis.

We believe that the first option to bid on a national basis for all diabetic supplies, would result in most beneficiaries using mail order and might generate more savings than a national competition for diabetic supplies furnished on a mail order basis only. However, this first option would likely eliminate the beneficiary choice to obtain replacement diabetic supplies on a non-mail order basis from any enrolled supplier that is a pharmacy or other local supplier storefront where a licensed pharmacist is on hand to offer guidance and consultation to the beneficiary. We believe the other two options would also diminish this choice. In addition, the alternatives of regional or local competitions are not likely to result in savings at or above the level that can be generated from a national competition for mail order supplies. Suppliers participating in a national program may be able to obtain volume purchasing discounts for the quantities of supplies needed nationwide. Therefore, we did not propose any of these alternatives but we

solicited public comment on alternatives for establishing DMEPOS CBP for diabetic testing supplies.

In §414.411, we proposed to establish a national mail order DMEPOS CBP with competitions taking place after 2010 for the purpose of awarding contracts to suppliers to furnish replacement diabetic testing supplies across the nation, with additional program refinements described below. We note that the decision to proceed with a national mail order competition after 2010 does not prevent us from phasing in competitions for non-mail order diabetic supplies or from conducting competitions for diabetic supplies in general in the future consistent with section 1847(a)(1) of the Act.

Comment: We received 31 comments in response to our proposed regulation to implement a national mail order DMEPOS CBP for diabetic testing supplies. There were several commenters that supported the proposal made by CMS and a few commenters that were opposed to our proposal. The commenters in favor of our proposal stated they wanted CMS to preserve the local storefront option for the beneficiary. A few commenters specifically stated that CMS should maintain retail pharmacies as a necessary safety valve, ensuring that beneficiaries will have immediate local access to their specific diabetic testing supplies. In addition, several commenters who supported our conducting separate auctions stated that our proposal to conduct one competition between mail order companies and those with a local storefront would not be fair because these companies have different business models, different overhead costs and different operational structures. Numerous commenters stated that beneficiaries get better service from a local storefront than they would get from a mail order company because local storefronts preserve a face-to-face pharmacy/patient relationship.

We also received several comments opposed to our proposal to conduct separate competitions because they believed that gives the local storefronts an unfair advantage because they are paid more than mail order companies for the same product. They suggest that CMS should conduct a competition for both mail order and non mail order under one program.

Response: We agree with those commenters who stated that we need to preserve beneficiary choice and access to local storefronts to get their diabetic testing supplies. We believe that our proposal preserves the beneficiaries' choice to go to their local pharmacy to pick up their diabetic supplies or request that they be sent through the mail by a national mail order DMEPOS contract supplier. Also, we believe that both mail order suppliers and storefront suppliers are able to provide the necessary services and education to their beneficiaries. Therefore, we believe our proposal to bid diabetic testing supplies when provided through the mail will preserve beneficiaries' choice while ensuring they receive quality services. We also agree that to bid storefronts and mail order companies in the same auction may make it difficult for small storefronts to compete against large mail order suppliers. We also believe the difference in payment between mail order companies and retail stores will not harm mail order companies because we expect that more beneficiaries will choose to obtain their test strips from mail order companies to lower their co-insurance payment, generating more business for mail order suppliers. In addition, non-mail order diabetic supplies were not included the first round of the competitive bidding program and the issue with regard to payment for these items under the program will be addressed in the future as additional items subject to the program are phased in.

Comment: One commenter stated that CMS should phase in a regional program, rather than moving immediately into a national program, since CMS and mail order suppliers are without sufficient knowledge base or experience with the operation of a large-scale competitive bidding program and its impact on beneficiaries' access to quality care.

Response: We disagree with this comment. We believe that the option to bid on a national basis for all mail order diabetic supplies would result in large savings because of the volume purchase power of bidders providing these items on a national basis. Currently our data shows that over 62 percent of Medicare beneficiaries receive their testing supplies through the mail, we see no real benefit of bidding on a regional basis because most mail order suppliers operate nationally. We also believe that we have experience conducting the DMEPOS CBP since we have successfully completed the bidding and contract offers for Round 1 Rebid and the program will begin January 1, 2011. We have established a process and will evaluate and monitor contract suppliers to ensure beneficiaries' have access to quality products.

Comment: One commenter stated that diabetic testing supplies should be excluded from DMEPOS CBP because CMS does not have any experience with this product category with respect to competitive bidding, as diabetic supplies were not included in any prior demonstration project. Several commenters suggested that CMS should not initiate the bidding process for the national mail order DMEPOS CBP until it has had sufficient time to evaluate the rebid of Round 1.

Response: Section 1847(a)(1)(A) of the Act mandates the establishment of DMEPOS CBP for items described in section 1847(a)(2)(A) of the Act, including

diabetic testing supplies. Section 1847(a)(1)(B)(ii) of the Act authorizes the phase in of items and services under these programs beginning with the highest cost and highest volume items and services or those items and services that are determined to have the largest savings potential. Current Medicare claims data identifies diabetic testing supplies as a high cost/high volume item. Mail order diabetic testing supplies account for approximately one billion dollars in allowed charges per year and the majority of these payments are for mail order diabetic testing supplies. In addition, CMS does have experience bidding these items as they were included in both Round 1 and the Round 1 rebid.

Comment: One commenter stated that section 1834(a)(1)(F) of the Act does not compel CMS to adjust prices for all items by January 1, 2016, or any other specific date. The commenter stated that CMS could elect to continue to exclude diabetic testing supplies provided through local retail storefronts.

Response: We are required by section 1834(a)(1)(F) of the Act to either competitively bid in all areas of the country or adjust prices for all phased in items in areas where competitive bidding programs are not implemented by January 1, 2016. We intend to address specific issues related to implementation of clauses (ii) and (iii) of section 1834(a)(1)(F) of the Act as part of separate rulemaking mandated by section 1834(a)(1)(G) of the Act.

After consideration of the public comments we received, we are not making any changes to this section of the proposed rule on the future competitions of diabetic testing supplies.

(2) Definition of Mail Order Item

We proposed to define "mail order item" in §414.402 to mean any item (for example, diabetic testing supplies) shipped or delivered to the beneficiary's home, regardless of the method of delivery. We also proposed to define "non-mail order item" as any item (for example, diabetic testing supplies) that a beneficiary or caregiver purchases at a local pharmacy or supplier storefront rather than having the item delivered to the beneficiary's home. For round 1 of the program, this means that beneficiaries that do not obtain their testing supplies through mail order may purchase these items at a local pharmacy or local storefront. Therefore, the only items excluded from the mail order definition and mail order competition would be those that a beneficiary or caregiver purchases at a local pharmacy or local supplier storefront and are not delivered to the beneficiary's home. These revised definitions of mail order item and non-mail order item are intended to clearly identify which items is truly mail order. In addition, we believe this definition will preserve the choice of the beneficiary to obtain replacement diabetic supplies in person from a local pharmacy and eliminate the circumvention of the mail order program.

As previously discussed, for Round 1 and the Round 1 Rebid of the DMEPOS CBP, we defined mail order contract supplier in our regulations at §414.402 to mean a contract supplier that furnishes items through the mail. We further defined mail order in program instructions to mean "items ordered remotely (that is, by telephone, e-mail, internet or mail) and delivered to beneficiary's residence by common carriers (for example, U.S. Postal Service, Federal Express, United Parcel Service) and does not include items obtained by beneficiaries from local storefronts." The intent of the Round

1 definition was to distinguish between mail order supplies (items shipped or delivered directly to the beneficiary's home, regardless of the method of delivery) and non-mail order supplies (items that a beneficiary or caregiver picks up in person at a local pharmacy or storefront). Manufacturers and suppliers of blood glucose monitors and test strips have expressed on numerous occasions the importance of maintaining the patient option of obtaining diabetic testing supplies from a local pharmacy that provides full time access to a licensed pharmacist who can provide instructions and guidance to the beneficiary or caregiver related to the use of the diabetic supplies (the pharmacy pickup option). This is the "non-mail order" option we attempted to separate from the mail order option with the Round 1 definition of mail order.

During implementation of Round 1 of the program, we discovered that suppliers that did not successfully compete and win a contract under the program tried to adopt certain approaches to circumvent the mail order definition. In the first round of competitive bidding, suppliers that lost their bid to be a contract supplier for mail order diabetic testing supplies considered ways to change their delivery methods to circumvent the mail order DMEPOS CBP. For example, some mail order suppliers considered purchasing a fleet of cars to deliver these items to the beneficiary's home so as not to be considered a mail order supplier. Other suppliers attempted to enter into special "private" arrangements with well known delivery services and claimed that because of such arrangements they should not be considered mail order suppliers. These alternative home delivery methods do not provide any benefits to the patient beyond what the traditional mail order home delivery method offers. They are simply ways to continue furnishing diabetic supplies on a home delivery basis after submitting a bid for mail order that does

not result in the award of a contract under the DMEPOS CBP. Without a clear distinction between mail order (home delivery option) and non-mail order (pharmacy pickup option), suppliers could continue to attempt to make arrangements as they did in the initial Round 1 competition to circumvent the DMEPOS CBP. We consider these practices to be inconsistent with the DMEPOS CBP statute and regulations currently in effect, and our proposal is intended to further clarify the existing definition of mail order. Such arrangements prevent beneficiaries and the Medicare program from realizing savings afforded by the mail order DMEPOS CBP and is unfair to winning suppliers who bid in good faith for a contract for furnishing supplies to the home delivery market.

This proposed definition of mail order item would not apply to the Round 1 Rebid competition because of the specific requirement of MIPPA to rebid Round 1 in 2009 for the same items and services included in the initial Round 1 competition. However, for a national competition, it is imperative that the new definition of mail order item be in place because of the implications such a program would have on the entire mail order delivery market in the United States. In these future competitions, we will continue to emphasize in our educational efforts the basic distinction between mail order (items shipped or delivered to the beneficiary's home, regardless of the method of delivery) and non-mail order (items that a beneficiary or caregiver picks up in person at a local pharmacy or storefront). In addition, we will continue to take appropriate and necessary action against suppliers that furnish mail order items and bill for them as if they were non-mail order items.

As previously mentioned, an alternative DMEPOS CBP for replacement diabetic supplies would be to hold a national competition among all types of suppliers for all

replacement diabetic supplies. One benefit to this approach is that it would eliminate the need to differentiate between mail order and non-mail order supplies; however, it would likely eliminate the pharmacy pickup choice since most local pharmacies would not be able to service the entire CBA if they did not also operate a national mail order service.

We solicited comment on our proposed definition of "mail order" and its impact on future rounds of bidding. We received several comments regarding the proposed definition of mail order both in favor of and against the definition.

Comment: Several commenters agreed with the proposed definition because they believe it will result in a clear distinction between mail order and non-mail order and reduce the ability of suppliers to game the program. A few commenters opposed the proposed change in definition stating that the definition is too broad and therefore, could be applied to any DMEPOS item delivered to a patient's home.

Response: We agree that it is important to revise the definition of mail order to make a clear distinction between mail order and non mail order. We believe we cannot make the necessary distinction between mail order and non-mail order under our current definition. With the revised definition, beneficiaries will have a clear choice to make; they or their caregiver can either go to a retail store or get their items shipped or delivered to their home by any means. If they choose to get their items delivered to their home they would have their supplies delivered by a DMEPOS contract supplier who meets our qualifications to be a mail order supplier of diabetic testing supplies. We agree that the definition is broad with respect to DMEPOS items in general. However, for the reasons previously stated, we believe it is necessary to have this specific definition of mail order item for diabetic testing supplies that includes any item shipped or delivered to the

beneficiary's home, regardless of the method of delivery. However, competitions for mail order items may not be necessary or appropriate for rented equipment or for items that require the presence of the supplier in the home for inspection, equipment set up, and other purposes. We believe that mail order competitions may be more appropriate for purchased items that do not require these in home services.

Comment: Several commenters advocated for exemption from bidding as a local storefront and from the program when providing diabetic testing supplies delivered to the patient's home. These commenters believe that this service is necessary for some beneficiaries who have difficulty getting to a pharmacy. The commenters stated that the proposed definition of mail order prevents them from continuing to service snow bird beneficiaries. The commenter supported the policy that independent pharmacies do not have to bid to continue to provide diabetic testing supplies to beneficiaries that come into their store, but they would also like to continue to provide supplies to these beneficiaries via mail when they temporarily relocate as a snowbird. Several commenters also stated that they would like CMS to exempt from competitive bidding companies that deliver diabetic testing supplies directly to a beneficiary's home using their specially trained employees.

Response: We disagree. We do not believe that such an exception is warranted because contract suppliers will be able to deliver these items to the beneficiary's home in these situations. If the beneficiary or their caregiver would normally pick up the beneficiary's supplies in person at a local pharmacy they may switch for any reason or any period of time and obtain these items from a contract mail order supplier. Delivery of the supplies from a local store is no different than delivery thru the mail or some other

means from a remote location. It would be unfair to exempt these companies from competitive bidding while still allowing them to provide these items when they deliver them to the patient's home. We believe that home delivery companies should have to bid in the DMEPOS CBP and be awarded a contract to continue to deliver these items to the home. We are not aware of what services are being provided by the specially trained employees that commenters refer to that are different than services that a mail order contract supplier would perform. The contract suppliers must meet all of the supplier and quality standards necessary for furnishing the items. The supplier of the glucose monitor is responsible for ensuring that the beneficiary is educated and trained on the use of their monitor. Since there are no in-home services necessary for furnishing replacement diabetic testing supplies, we do not understand the point these commenters are trying to make. We believe that mail order suppliers are qualified and capable of providing any education and services related to the furnishing of the replacement diabetic testing supplies. Finally, it important to note that our current rules provide great flexibility in arranging for the furnishing of replacement diabetic testing supplies. The program allows beneficiaries to receive a 3-month supply of diabetic test strips and beneficiaries can order and obtain their supplies 5 days in advance of the start of the next 3-month period.

Comment: Several commenters stated that mail order companies provide the same type of instruction and guidance that local pharmacies provide by offering hotlines, working with patients to educate and coach them on the use of glucose monitors, and continued patient counseling and monitoring.

Response: As previously discussed, we believe that mail order suppliers are qualified and capable of providing any necessary services related to the furnishing of

replacement diabetic testing supplies. The same supplier standards and quality standards that apply to local storefronts that furnish these items also apply to mail order suppliers. Local home delivery companies state that because they have local presence they can offer better service from specially trained employees to meet the needs of the beneficiaries. We believe that employees of mail order companies are also well trained and both companies train their employees to address beneficiaries' needs.

After consideration of the public comments received, we are finalizing our proposal without modification.

(3) Special Rule in Case of Competition for Diabetic Testing Strips

Following Round 1 Rebid of the program, any competition for diabetic testing strips, such as a national mail order program for diabetic testing supplies proposed in this rule, must include the special rule set forth in section 1847(b)(10)(A) of the Act. Under that section, a supplier must demonstrate that their bid to furnish diabetic testing strips covers the furnishing of a sufficient number of different types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, account for at least 50 percent of all such types of products on the market. Section 1847(a)(10)(A) of the Act also specifies that the volume for the different products may be determined in accordance with data (which may include market based data) recognized by the Secretary. When a beneficiary needs to obtain replacement test strips, they must obtain the specific brand of test strips products that work with their brand and model of blood glucose monitor. The test strips are not manufactured in a way that allows use of different brands of test strips in different brands of monitors. Therefore, when replacement test strips are furnished, the supplier must ensure that the specific brand and

model of test strips that the patient requires for use with their purchased monitor is furnished.

Section 1847(b)(10)(B) of the Act mandates the DHHS OIG conduct a study before 2011 to generate volume data for the various products that could be used for this purpose.

Under the DMEPOS CBP, bidding suppliers are required to provide information on the products they plan to furnish if awarded a contract. We proposed to use this information and information on the market share (volume) of the various diabetic testing strip products to educate suppliers on meeting the requirements of this special rule. In addition, it may be necessary to obtain additional information from suppliers such as invoices or purchase orders to verify that the requirements in the statute have been met.

We proposed that suppliers be required to demonstrate that their bids cover the minimum 50-percent threshold provided in the statute, but we invited comments on whether a higher threshold should be used. We have proposed the 50-percent threshold in part because we believe that all suppliers have an inherent incentive to furnish a wide variety of types of diabetic testing products to generate a wider customer referral base. The 50-percent threshold would ensure that beneficiaries have access to mail order delivery of the top-selling diabetic test strip products. In addition, as explained below, we proposed an "anti-switching provision" that we believe should obviate the need to establish a threshold of greater than 50 percent for the purpose of implementing this special rule because the contract suppliers would not be able to carry a limited variety of products and switch beneficiaries to those products.

For purposes of implementing the special rule in section 1847(b)(10)(A) of the Act, we proposed to define "diabetic testing strip product" as a specific brand and model of test strip, as that is the best way to distinguish among different products. Therefore, we plan to use market based data for specific brands and models of diabetic test strips to determine the relative market share or volume of the various products on the market that are available to Medicare beneficiaries. We plan to review a variety of data, including but not limited to data furnished in the OIG report, to determine the market share of the various products. The special rule mandated by section 1847(b)(10)(A) of the Act applies to all competitions for diabetic testing strips after the Round 1 Rebid of the DMEPOS CBP. Therefore, we would apply this rule to non-mail order competitions and local competitions conducted for diabetic testing strips after the Round 1 Rebid of the DMEPOS CBP.

Comment: Several commenters supported the requirement for suppliers to demonstrate that their bids cover 50 percent of the diabetic testing strips on the market. Other commenters noted problems associated with implementing the 50-percent rule. A few commenters stated that this rule provides an advantage to large manufacturers by encouraging suppliers to carry more of their products and disadvantages small manufacturers with limited product lines.

Response: This special rule is mandated by the statute which stipulates a supplier must demonstrate that its bid to furnish diabetic testing strips covers the furnishing of a sufficient number of different types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, to account for at least 50 percent of all such types of products on the market. Suppliers are able to decide from

which manufacturers to obtain their diabetic testing supplies from, but we are required to ensure that suppliers are in compliance with the special rule before awarding a contract to them under the DMEPOS CBP.

Comment: Several commenters are concerned that products developed between bidding cycles will be frozen out of the program for up to 3 years and suppliers could be discouraged from offering new products until the next bidding cycle or up to 3 years after the product's release.

Response: We disagree that the 50-percent rule creates a disincentive for manufacturers and innovators to develop new and progressive technology. This rule does not prevent suppliers from offering new products to their customers. In fact, suppliers may choose to offer new products in order to gain market share under the DMEPOS CBP. In addition, we believe that the anti-switching rule would create a strong incentive for contract suppliers to carry a wide range of products well beyond the 50-percent threshold in order to increase their volume of business. Contract supplier would have to carry the brand test strips that work with new products that are successfully marketed to Medicare beneficiaries.

Comment: Several commenters stated that the minimum 50-percent threshold required by the statute may be insufficient to ensure that suppliers carry a wide array of available products. Other commenters recommended that CMS require suppliers to carry a more clinically diverse array of products. Without this change they believe suppliers could limit the range of diabetic testing supplies by only offering the lowest cost versions of those supplies.

Response: We disagree. We believe that the 50-percent threshold is sufficient to ensure that contract suppliers offer the products that physicians and beneficiaries prefer because it will be extremely difficult for suppliers to limit the number of products they offer to the lowest cost versions unless those are also the top selling products. We believe that the top selling products are widely used because physicians and beneficiaries prefer them rather than because they are the cheapest products available. We do not believe that physicians and pharmacists would continue to recommend products to beneficiaries if they did not meet the needs of the specific beneficiaries. Likewise, we do not believe that beneficiaries who choose certain products would continue to use those products and make them top-selling products if they did not adequately meet their needs. Due to widespread manufacturer rebates, trade-ins, and other discounts, beneficiaries and other consumers are able to purchase new glucose monitor products at little or no cost. Therefore, beneficiaries who are unhappy with their choice of glucose monitor product, can easily switch to another brand of monitor. It would be extremely difficult for suppliers who only elect to furnish products that are not top-selling products to reach the 50-percent threshold.

Comment: One commenter stated that the 50-percent rule is a strong beneficiary protection and that the 50-percent rule will not work without enforcement of the anti-switching rule.

Response: We agree that the 50-percent threshold would ensure that beneficiaries have access to mail order delivery of the top-selling diabetic test strip brands and models. We also agree that the 50-percent rule would be more effective with implementation of the anti-switching rule.

Comment: One commenter recommended that when CMS determines the product list they should identify the brands and products that have been furnished through the mail. This is important because market share data for mail order and retail medical supply establishments are not the same.

Response: We agree. The DHHS OIG is conducting a study to generate volume data for various diabetic testing strip products furnished on a mail order basis. We will use this data in providing guidance to implement this special rule for mail order contract suppliers to ensure that their bids cover at least 50 percent of the volume of testing strip products currently furnished to beneficiaries via mail order. The OIG is required to complete their study before 2011 and will make their data available to the public.

Comment: A few commenters believe that the proposed rule does not indicate how CMS will determine compliance with the percentage standard. The commenters urge CMS to do more than analyze a supplier's bid to determine compliance. They suggest CMS develop mechanisms to "look back" at a supplier's actual performance over a period of time, preferably on a monthly basis for the first year of the program's operation. Also, CMS could review supplier's records, such as invoices and purchase orders, to verify compliance with the requirement.

Response: We agree with this comment and the need for CMS to ensure compliance with the special rule. Suppliers will be required to submit information to document that their bid covers at least 50 percent of the products available to beneficiaries. In addition, contract suppliers will be required to submit quarterly reports that include information on the items that the contract supplier has furnished for the quarter. These quarterly reports will indicate the approximate number of items furnished,

manufacturer, model and model number of the items furnished. The quarterly reports will enable us to monitor access to different products under the program.

Comment: One commenter stated that the 50-percent rule fails to meets the non-discrimination requirement.

Response: We disagree. The non-discrimination requirement does not conflict with the 50-percent rule. Contract suppliers must furnish the same products to Medicare patients that they furnish to their other customers and these products must make up at least 50 percent of the volume of items available. Neither requirement prevents the supplier from meeting the other requirement. The non-discrimination requirement will be fully enforced along with the special 50-percent rule.

Comment: A commenter recommended that CMS consult with patient advocates, providers, and industry experts to determine whether the methodology used by CMS for determining the different types and amounts of products on the market is consistent with what is actually available to Medicare beneficiaries today.

Response: We agree and will consider whether or not it is necessary to consult with patient advocates, providers, and industry experts to determine the types and volume products available to Medicare beneficiaries. The statute also mandates that the OIG conduct a study to generate volume data for various diabetic testing strip products that could be used to make this determination.

Comment: A commenter suggested that CMS should consider adopting a generic substitution requirement for diabetic testing supplies.

Response: This comment is outside the scope of this rulemaking..

After consideration of the public comments we received, we are finalizing our

proposal without modification.

(4) Anti-switching Rule in Case of Competition for Diabetic Test Strips

As previously noted, we believe that an anti-switching requirement will help ensure compliance with the 50-percent rule and creates an incentive for contract suppliers to offer a wide variety of testing strip products. Therefore, we proposed to prohibit suppliers awarded contracts for diabetic testing supplies from influencing or incentivizing the beneficiary by persuading, pressuring, or advising them to switch from their current brand or for new beneficiaries from their preferred brand of glucose monitor and testing supplies. The contract supplier may not furnish information about alternative brands to the beneficiary to influence the beneficiary's decision unless the beneficiary requests such information. We proposed that contract suppliers for diabetic testing supplies must furnish the brand of diabetic testing supplies that work with the home blood glucose monitor selected by the beneficiary. In the case where the beneficiary is receiving a monitor for the first time or a replacement monitor, the contract supplier would be subject to the requirements of §414.420 in order to protect beneficiaries from feeling forced or incentivized to use a particular type or brand of monitor. We continue to believe the proper role of the contract supplier is to furnish diabetic testing strips and other supplies to beneficiaries, not to interfere with the beneficiary's selection of the type of monitor and supplies. This requires the supplier to furnish the brand of testing supplies that work with the blood glucose monitor product that the beneficiary, and not the supplier of the testing supplies, selects. If the beneficiary needs a blood glucose monitor for the first time, or needs to replace their existing blood glucose monitor, and neither the beneficiary nor their physician has determined which brand or type of monitor to obtain, the beneficiary

may continue to ask for assistance from the supplier to select a monitor and the supplier should show them the full range of products. However, if the beneficiary has already selected a monitor and simply needs replacement diabetic testing supplies, the supplier must furnish the brands of testing supplies that work with the brand monitor that the beneficiary has selected. We believed that our proposal would preserve the integrity of the clinical decision regarding choice of glucose monitoring system and would result in contract suppliers offering a wide variety of diabetic testing supply products.

We proposed to amend §414.422 to add the anti-switching requirement to the terms of the contract for a supplier of diabetic testing supplies. A supplier would be in breach of their contract and subject to the sanctions set forth under §414.423(g), including termination, if they violate this term.

Comment: Numerous commenters stated that CMS should adopt a strong anti-switching rule and stated that this rule is an important improvement to the DMEPOS CBP and will protect beneficiaries' access to supplies.

Response: We agree that the anti-switching rule will help protect beneficiaries from being influenced or incentivized to use a particular type of brand of glucose monitor.

Comment: One commenter also recommended that the anti-switching rule should be actively monitored to ensure that beneficiaries are adequately protected.

Response: We agree. The anti-switching rule will be actively monitored by requiring contract suppliers to submit quarterly reports that include information of the items that the contract supplier has furnished for the quarter. We will be analyzing the quarterly reports to determine changes in the rates that various brands are provided. We

will also be monitoring beneficiary complaints to determine if this is an issue.

Comment: One commenter stated suppliers should be required to submit evidence to CMS such as copies of agreements with manufactures to demonstrate how they will obtain adequate quantities of testing supplies in order to furnish the supplies sought by beneficiaries in a timely manner. This is to prevent suppliers from influencing a beneficiary's choice of products by not being able to fill certain orders.

Response: We disagree. The anti-switching rule does not require the supplier to increase their capacity for furnishing sufficient quantities of all of the various products available. It is intended to prevent the supplier from actively influencing or incentivizing the beneficiary to switch to a different glucose monitor product. If the contract supplier does not stock a specific product or is out of inventory of a specific product they carry and which the beneficiary needs, the beneficiary can go to any other contract supplier to see if they carry the product they need in stock.

Comment: A few commenters were concerned about the anti-switching rule because they believe that this rule will prevent suppliers from consulting with beneficiaries regarding the various features of the different products and the selection of diabetic supplies that best meet the patient's needs.

Response: The anti-switching policy impacts those beneficiaries who are already using a specific monitor or whose physician ordered a specific brand. The anti-switching policy prevents suppliers from influencing or incentivizing beneficiaries to switch monitors. This policy has no impact on situations where the beneficiary has not yet selected a monitor or initiates discussions with the supplier about changing to a new type of monitor.

Comment: One commenter stated that the anti-switching rule prevents beneficiaries from having access to lower cost glucose monitors and test strips, unless they specifically request information about less costly alternatives from their supplier. In addition, the commenter stated that the DMEPOS CBP should provide incentives to use lower cost alternatives and not prohibit their use.

Response: We disagree. The purpose of this policy is to prevent beneficiaries from being influenced to switch from their current brand to a lower cost brand to increase a supplier's profit. The beneficiary's choice should not be influenced by the supplier's ability to obtain the product at a lower cost, rather than the product that the beneficiary prefers. This policy does not prevent a beneficiary from initiating a discussion with suppliers or their physician to determine the most appropriate brand. The contract supplier can discuss the features or how to operate the glucose monitor selected by the beneficiary, even if information is not requested by the beneficiary.

Comment: One commenter stated that CMS should enforce the anti-switching rule by prohibiting mail order suppliers from counseling patients on blood glucose monitors and supplies, pre-approving suppliers' marketing materials and establishing a hotline for beneficiaries.

Response: We disagree. As previously stated, the contract supplier can discuss the features or how to operate the glucose monitor selected by the beneficiary even if this information is not requested by the beneficiary. We established a 1-800 Medicare number which is a beneficiary dedicated hotline that beneficiaries are to call when they have questions or concerns related to their Medicare needs. In addition, the presence of local ombudsman will be available for beneficiaries and suppliers for their Medicare

related needs when the DMEPOS CBP is implemented.

Comment: One commenter recommended that CMS take steps to appropriately inform and educate beneficiaries in advance about their rights under the anti-switching provisions. The commenter also recommended that a special education effort be implemented during the new Round 1 Rebid and any future rounds of bidding aimed at eliminating any confusion that beneficiaries have regarding their ability to continue receiving their replacement supplies at their retail pharmacies.

Response: We agree. We have designed and will conduct an extensive beneficiary educational campaign on the Round 1 Rebid. In addition, for future rounds of competition we will continue to conduct future educational campaigns to educate beneficiaries on all aspects of the program, including the anti-switching provisions and the 50-percent rule.

After consideration of the public comments we received, we are finalizing our proposal without modification

c. Off-the-Shelf (OTS) Orthotics Exemption

In the April 10, 2007 final rule (72 FR 17992), we established §414.404(b)(1), which sets forth several exemptions to the DMEPOS CBP. These exceptions are applicable to providers, physicians, and treating practitioners that furnish certain DMEPOS items under Medicare Part B. The exempted items are limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps that are DME. For an explanation as to why these items were exempt see the DMEPOS Competitive Bidding final rule (CMS-1270-F) published April 10, 2007, (72 FR 17992). For the exemptions to apply, the items must be furnished by a physician or treating

practitioner to his or her own patients as part of his or her professional service. The items are to be billed under a billing number assigned to the physician, the treating practitioner (if possible), or a group practice to which the physician or treating practitioner has reassigned the right to receive Medicare payment.

The April 10, 2007 final rule also established an exemption for a physical therapist in private practice (as defined in §410.60(c)) or an occupational therapist in private practice (as defined in §410.59(c)) to furnish competitively bid OTS orthotics without submitting a bid and being awarded a contract under the DMEPOS CBP, provided that the items are furnished only to the therapist's own patients as part of a physical or occupational therapy service.

Section 154(d) of MIPPA amended section 1847(a) of the Act by adding paragraph (7), which expands the exemptions from the DMEPOS CBP for certain OTS orthotics to physicians or other practitioners (as defined by the Secretary) if furnished to their own patients as part of their professional service. Section 1847(a)(7) of the Act, as added by MIPPA, also expanded the exemption from the program to hospitals for certain OTS orthotics, crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps if these items are furnished to the hospital's own patients during an admission or on the date of discharge.

The DMEPOS CBP Round 1 Rebid interim final rule with comment period (IFC) included the expanded exemption for certain DMEPOS items as provided by MIPPA for hospitals. We noted in the IFC that we would address the expanded exemption of OTS orthotics for hospitals, physicians and other practitioners in future rulemaking.

We proposed to revise current provisions at §414.404(b)(1)(i) to incorporate the provision of section 1847(a)(7)(A)(i) and (ii) of the Act that exempts from the program OTS orthotics furnished by physicians and other practitioners to their own patients as part of their professional service or by hospitals to the hospital's own patients during an admission or on the date of discharge.

Comment: One commenter submitted a question requesting clarification on whether a supplier owned by a hospital or provider affiliated with a hospital would qualify for the hospital exemption.

Response: The OTS orthotics exemption for hospitals is limited to hospitals that furnish OTS orthotics to their own patients during an admission or on the date of discharge. The exemption for a hospital does not apply to suppliers or providers owned by or affiliated with a hospital. This exemption applies only to entities that meet the definition at section 1861(e) of the Act.

Comment: One commenter suggested that CMS include small independent pharmacies in the definition of "other practitioners" and exempt OTS orthotics furnished by small independent pharmacies from bidding and contract requirements under the DMEPOS CBP.

Response: We disagree. There are several factors we consider in determining which suppliers qualify for an exemption. As discussed in the April 10, 2007, **Federal Register** (72 FR 18029) we exempted physical and occupational therapists, from bidding in the DMEPOS CBP and being awarded a contract so that they could continue to provide competitively bid OTS orthotics to their own patients when these items are furnished as part of their professional service. MIPPA has extended this exemption to

include OTS orthotics furnished by physicians, certain other practitioners, and hospitals to their own patients. The MIPPA expanded exemption does not include OTS orthotics furnished to the general public by suppliers such as pharmacies. Therefore, we do not agree that this exemption should be applied to small independent pharmacies who sell these products to the general public and they are not furnished as an integral part of a treatment service furnished by the pharmacy. Also, the term treating practitioner is defined at §414.402 of the regulations and includes physician assistants, nurse practitioners, and clinical nurse specialists in accordance with the definition of these terms as defined at section 1861(aa)(5) of the Act. We do not believe that the statutory language that extended the OTS orthotic exemption to physicians, certain other practitioners, and hospitals was intended to extend the exemption to small independent pharmacies that provide products to the general public.

Comment*:* One commenter supported the OTS orthotics exemption for physicians, practitioners, and hospitals.

Response: We agree.

After consideration of the public comments we received, we are finalizing our proposal without modification.

d. Grandfathering Rules Resulting in Additional Payments to Contract Suppliers under the DMEPOS Competitive Bidding Program (CBP)

Section 1847(a)(4) of the Act requires that in the case of rented DME and oxygen and oxygen equipment, the Secretary shall establish a "grandfathering" process. This requirement was implemented through regulations at §414.408(j) that were published in the April 10, 2007 **Federal Register** (72 FR 17992). The grandfathering process allows

beneficiaries who were renting DME items or receiving oxygen and oxygen equipment prior to the start of a DMEPOS CBP from a supplier who did not win a contract to continue to rent the equipment from that noncontract supplier if that supplier chooses to become a grandfathered supplier. Under §414.408(i)(2), when the beneficiary decides to use a contract supplier instead of a grandfathered supplier to receive their oxygen equipment and supplies, the contract supplier receives a minimum of 10 monthly payments for taking over the furnishing of oxygen and oxygen equipment. When a beneficiary decides to use a contract supplier to furnish capped rental DME, section §414.408(h)(2) restarts the 13-month capped rental period. These rules were established, in part, based on advice from the Program Advisory and Oversight Committee (PAOC) and are intended to give bidding suppliers an assurance that they would be compensated in these situations and would not have to factor into their bids the cost of receiving as few as one monthly payment for beneficiaries near the end of the 13-month cap for capped rental items and 36-month cap for oxygen equipment.

At the time these rules were developed, the supplier was mandated by the statute to transfer title to the equipment to the beneficiary after the both the 13-month cap for capped rental items and the 36-month cap for oxygen equipment. Section 144(b) of the MIPPA repealed the transfer of title requirement for oxygen equipment, as established by DRA, replacing that requirement with the 36-month rental cap. Under the revised oxygen payment provisions, suppliers now get the equipment back when the beneficiary no longer needs it. Also, at the time these rules were developed, the beneficiary had the option to acquire standard power wheelchairs on a lump sum purchase basis, an option which greater than 95 percent of the beneficiaries selected, based upon historic claims

data. Therefore, those items generally would not be affected by the grandfathering rules. However, as discussed in section VI.V. of this final rule with comment period, section 3136 of the Affordable Care Act eliminates the lump sum purchase option for standard power wheelchairs. This new policy applies to items furnished under the DMEPOS CBP beginning with Round 2 of the program. Over 200,000 beneficiaries received standard power wheelchairs nationwide in 2009, and the Medicare allowed charges for these wheelchairs was over $650 million, including both rental and purchase options. Therefore, this large volume of capped rental items will be subject to the grandfathering rules effective with Round 2 of the DMEPOS CBP, thus increasing the overall magnitude of the effect these rules have on the program and beneficiaries.

In some cases, the grandfathering rules described above place a financial burden on beneficiaries who are near the end of the 13 or 36-month rental cap periods. If a beneficiary's existing supplier chooses not to be a grandfathered supplier, the beneficiary will be required to switch to a contract supplier in order for Medicare to continue to pay for the furnishing of the rental equipment. In such cases, the beneficiary will be responsible for additional co-insurance amounts. Based on experience from the initial Round 1 competition in 2008, we believe that most suppliers will choose to grandfather and therefore these rules will have no impact on these situations. However, in those limited situations in which the beneficiary does not use a grandfathered supplier and the beneficiary is near the end of the 13 or 36-month rental cap period, the impact on the beneficiary could be significant. As mentioned above, our current grandfathering rules will result in a limited number of beneficiaries facing additional co-insurance payments. To illustrate the impact some beneficiaries may face as a result of these rules, a

beneficiary who has already made 12 coinsurance payments for a capped rental item could make as many as 12 additional copayments as a result of restarting the capped rental period when they transition from a noncontract supplier to a contract supplier at the beginning of a DMEPOS CBP. In another example, a beneficiary who has already made 35 coinsurance payments for oxygen and oxygen equipment could make as many as 9 additional copayments as a result of the rule that provides a minimum of 10 monthly payments when they transition from a noncontract supplier to a contract supplier at the beginning of a DMEPOS CBP. As stated above, we expect that most noncontract suppliers will choose to become grandfathered suppliers, therefore limiting the number of instances where these rules would apply. However, in light of the beneficiary impact in the those extreme cases illustrated above, and in light of the recent legislative changes by the MIPPA and the Affordable Care Act as explained above, we are reevaluating whether or not changes to these grandfathering rules are necessary. As discussed above, as a result of the MIPPA, suppliers of oxygen equipment no longer lose title to the equipment after receiving the 36th payment and this may warrant reconsideration of the minimum number of payments they should receive as contract suppliers when a beneficiary transitions to them from a noncontract supplier at the beginning of a DMEPOS CBP. In addition, we believe it is important to reevaluate the policy that restarts the 13-month capped rental period in situations where a beneficiary transitions from a noncontract supplier to a contract supplier at the beginning of a DMEPOS CBP.

We received nine public comments on the grandfathering rules resulting in additional payments to contract suppliers under the DMEPOS CBP. In the proposed rule we solicited public comments on whether or not the current rules should be changed to

reduce the number of payments the contract supplier would receive in these situations above the 13 and 36-month limits set forth under the standard payment rules in section 1834(a) of the Act. We requested comments only and did not propose any regulation changes. Therefore, the comments received will be taken into consideration in future proposed rulemaking.

e. Appeals Process

The April 10, 2007 DMEPOS CBP final rule finalized §414.422(g)(1), which states that "any deviation from contract requirements, including a failure to comply with governmental agency or licensing organization requirements, constitutes a breach of contract." In the event we determine that a contract supplier's actions constitute a breach of contract, §414.422(g)(2) authorizes us to take one or more of the following actions:

- Require the contract supplier to submit a corrective action plan.
- Suspend the contract supplier's contract.
- Terminate the contract.
- Preclude the contract supplier from participating in the DMEPOS CBP.
- Revoke the supplier number of the contract supplier, or
- Avail itself of other remedies allowed by the statute.

We proposed to add a new §414.423 to establish an appeals process for contracts terminated under section 1847(a) and (b) of the Act. Proposed §414.423 would set forth policies and procedures relating to our determinations of a breach of contract and the appeals process for contract suppliers that are considered to be in breach of contract. In addition, we proposed to add new definitions to §414.402 that are used in the proposed §414.423.

Given the impact that termination has on a contract supplier, we believe it is appropriate for contract suppliers whose contract(s) may be terminated due to a breach of contract to have access to an appeals process that will reconsider that termination. In establishing this process we reviewed other appeals processes, such as the appeals process under Part D located at §423.641 through §423.668, Subpart N – Medicare Contract Determinations and Appeals, to consider essential steps to ensure suppliers have access to an appropriate review of certain CMS decisions. We proposed a simplified process that would not result in disruption to the program by having suppliers going in and out of the program. For this reason, we proposed a process for review and reconsideration before the contract is actually terminated. This proposal would avoid the necessity to reinstate retroactively suppliers because the contracts would generally not be terminated before the full review process has occurred. This would protect the supplier because we generally would not terminate a supplier until a final decision is made. Another feature of this process that may be beneficial to some suppliers is allowing them to submit a corrective action plan (CAP) depending upon the nature of the breach. We believe our proposal would allow most suppliers to correct identified deficiencies.

(1) Purpose and Definitions: (§414.402)

We are proposed to amend §414.402 to define the following terms:

- Affected party means a contract supplier that has been notified that their DMEPOS CBP contract will be terminated for a breach of contract.

- Breach of contract means any deviation from contract requirements, including a failure to comply with a governmental agency or licensing organization requirements.

- Corrective Action Plan (CAP) means a contract supplier's written document

with supporting information that describes the actions the contract supplier would take within a specified timeframe to remedy the breach of contract.

• Hearing Officer (HO) means an individual, who was not involved with the CBIC recommendation to terminate a DMEPOS Competitive Bidding Program contract, who is designated by CMS to review and make an unbiased and independent recommendation when there is an appeal of CMS's initial determination to terminate a DMEPOS Competitive Bidding Program contract.

• Parties to the hearing means the DMEPOS contract supplier and CMS.

(2) Applicability

The appeals process proposed in this regulation would allow contract suppliers the opportunity for a review of the following:

• A CMS determination under §414.422(g)(1) that the contract supplier breached its contract entered into as part of the DMEPOS CBP; and

• Certain agency actions taken under §414.422(g)(2).

The proposed appeals process would not apply to any other actions made by CMS, nor would the existence of other appeals processes preclude us from terminating a DMEPOS CBP contract. In other words, the proposed appeals process would be in addition to – and would not replace – existing CMS regulations regarding other appeals mechanisms. For example, a contract may be terminated because a supplier's National Supplier Clearinghouse (NSC) number has been revoked or inactivated. In this case, the supplier would not appeal the decision to inactive or revoke its number through this appeals process. Instead, the supplier would continue to appeal the inactivation or revocation of its supplier number through the NSC's appeals process. We would

postpone the contract termination decision until the supplier completes the NSC appeals process unless there are multiple findings of breach of contract.

Under our proposal, when we issue a termination decision, it would be final and binding unless a postponement of the termination decision is allowed by proposed §414.423.

(3) Contract Termination

We proposed that this appeals process applies in situations where the supplier has received a notice that we have determined that they are in breach of contract and that their contract is therefore subject to termination. A contract may be terminated for any violation of the terms of the contract. Examples of violations include, but are not limited to, situations where the contract supplier --

• Has committed or participated in false, fraudulent, or abusive activities affecting the Medicare program, including the submission of false or fraudulent data or claims;

• Experiences financial difficulties so that they are unable to effectively provide the necessary services to a Medicare beneficiary; or

• Fails to meet the non-discrimination policy and provides different items to beneficiaries located in a competitive bidding area (CBA) than it provides to its non-Medicare beneficiaries at §414.422(c).

(4) Notice of Termination

We proposed that the CBIC would work with suppliers to informally resolve performance deficiencies under its DMEPOS CBP contract prior to sending a recommendation to CMS that the supplier's contract be terminated. If the CBIC cannot informally resolve the supplier's deficiencies and recommends that we terminate the

supplier’s contract, we will review the CBIC's recommendation to terminate the supplier's contract. If we find that a breach occurred, we would begin the contract termination process by sending out a notice of termination to the supplier.

We also proposed requirements for the notice of termination so that suppliers are informed of the basis for CMS's action as well as their options to respond to this action. The notice would explain all actions we plan to take in response to the supplier's breach, such as the ability to submit a CAP or our determination to preclude a supplier from participating in future rounds of competitive bidding if found in breach of contract. If the supplier decides to appeal any of these decisions the supplier would submit an appeal in response to the notice to terminate. If we consider a supplier to be in breach of its contract, either in part or in whole, we would notify the contract supplier of the termination by certified mail. The notice would indicate that the contract supplier has been found to be in breach of contract and that the supplier's contract will be terminated within 45 days of the date of the notification of termination. The notice would be sent by the CBIC using certified mail on the same date that the notification is signed. The notification will be mailed on the date that it is signed. This is the same date as indicated on the notification.

Our proposal required the notice to include, at a minimum, the following information:

• The reasons for the termination in sufficient detail to allow the contract supplier to understand the nature of its breach of contract;

• Depending on the nature of the breach, whether the supplier may be allowed to submit a CAP in lieu of requesting a hearing by the HO;

- The right to request a hearing by the HO;
- The address to which the written request for a hearing must be mailed;
- The address to which the CAP must be mailed; and
- The effective date of the termination of the contract, if a CAP is not submitted or if a request for a hearing has not been filed timely.

We believe that this information will be sufficient to provide the supplier with the basis for CMS's action, as well as their options in responding to our decision.

In addition, our proposal required the notice to indicate any additional penalties that may result from the termination, such as, not being eligible to bid in future rounds of competitive bidding. An appeal of the termination would include the appeal of any other results from the termination that are permissible under § 414.423, such as preclusion from participation in future rounds of the DMEPOS CBP. We believe this information may help the supplier to decide whether to appeal the notice of termination.

(5) Corrective Action Plan

We proposed a process by which a contract supplier may be able to submit a CAP to address the breach of contract. Depending on the nature of the breach of contract, we proposed that the notice to the supplier would indicate whether a contract supplier would be allowed to provide the CBIC with a written CAP instead of submitting a request for a hearing by a HO. For example, under this proposal we would not allow a CAP if the supplier has been excluded from any federal program, debarred by any federal agency, or convicted of a healthcare-related crime. We may also not allow a CAP that would result in negative consequences to the beneficiaries or the program caused by delaying the termination of the contract.

We proposed the following timelines for situations where the contract supplier is allowed to provide a written CAP:

• If the supplier decides to submit a CAP, the CAP must be received by the CBIC within 30 days from the date on the notice of termination.

• If the supplier decides not to submit a CAP, the supplier retains the right to request a review by a HO within 30 days from the date of the notice of termination. While the CAP is being evaluated, the termination action would be postponed. We believe that 30 days is a sufficient amount of time for suppliers to prepare and submit a CAP and this would also ensure that there are no unnecessary delays in the appeals process.

We proposed to require the CAP to demonstrate that the contract supplier has a plan to remedy all of the deficiencies that were identified in its notice of termination and must specify the timeframes for correcting these deficiencies. The CBIC would review the CAP to ensure that the contract supplier would be taking the appropriate measures in a timely manner to remedy the breach of contract. What constitutes a timely manner is dependent on the type of deficiency that is being corrected. Once the nature of the deficiency is identified the CBIC and CMS would make a case-by-case determination concerning what constitutes a timely manner for correcting the deficiency. However, we expect most deficiencies to be corrected within 90 days or less. Further guidance of what constitutes a timely manner would be communicated to the contract supplier by the CBIC as part of the review process.

As part of the review process, the CBIC would provide guidance, in accordance with CMS instructions, regarding the type of documentation that the CAP and the follow

up report must provide to substantiate that the deficiencies have been corrected. To make a determination if a CAP would be considered acceptable, we would discuss any deficiencies related to the CAP with the supplier, and as a result of these discussions, the CBIC may allow a supplier to make revisions to its CAP during the review process. Suppliers will only revise their CAP one-time during the review process. The timeframe for the review process would vary upon the circumstances for each case. If the supplier does not submit an acceptable CAP during the review process, the supplier would receive a new notice that their CAP is not acceptable or has not been implemented consistent with the supplier's original submission and its contract would be terminated within 45 days. Every supplier that submits a CAP will have a one-time opportunity to revise their CAP based upon deficiencies identified by the CBIC. Failure to develop and implement an approved CAP would result in a new notice to the supplier of the termination of the DMEPOS CBP contract and provide notice that the supplier may request a hearing on this termination. We proposed that once an acceptable CAP has been completed the contract supplier must provide a follow-up report within 5 days of the agreed upon date for the completion of the CAP to verify that all of the deficiencies identified in the CAP have been corrected consistent with the timeframes specified in the CAP, as approved by the CMS. We believe that 5 days is a sufficient time for a supplier to submit a report to the CBIC outlining all steps that have been completed to correct the identified deficiencies.

(6) Right to Request a Hearing by the CBIC Hearing Officer (HO)

We proposed that a contract supplier that has received a notice that we consider the supplier in breach of contract has the right to request a hearing before a HO who was

not involved with the original breach of contract determination. We consider this process to be a reconsideration of the original decision, and, consistent with other Medicare appeals provisions, we believe it is important that an individual not involved in making the initial recommendation conduct the reconsideration of the initial decision. As mentioned previously, the HO would be an individual who is designated by CMS to review and to make an unbiased and independent recommendation of whether to terminate the supplier's DMEPOS CBP contract. The notice to the contract supplier would also identify the location to which a request for hearing must be sent.

We proposed that a contract supplier may appeal the notice of termination by submitting a written request to the CBIC for a hearing by a HO. The written request should include any evidence to support its appeal. The HO is not required to allow evidence submitted in addition to evidence beyond the evidence submitted along with the written request. The hearing request must be received by the CBIC within 30 days from the date of the termination letter. A request for a hearing must be sent to the address identified on the notice. Failure to request a hearing within the allotted 30 days would result in a termination of the supplier's contract, as of the effective date of termination identified in the notice to the supplier. There would be no extension to this 30-day timeframe. We believe suppliers have sufficient time to decide whether or not to request a hearing and the deficiencies identified in the notice may pose a risk to the DMEPOS CBP. The date the request is received by the CBIC determines if the hearing request was timely filed.

We would require that the request for hearing be filed by a supplier's authorized official, because an authorized official of the company signed the contract and this

ensures the validity of the request. The authorized official must be an official of the company who is identified on the supplier's CMS 855-S form as an authorized official of the supplier. A supplier may appoint someone other than the authorized official to be a representative for them at the hearing. However, the representative may not be an individual who has been disqualified or suspended from acting as a representative by the Secretary or otherwise prohibited by law. The request for a hearing must be filed with the CBIC at the address identified on the notice of termination.

(7) Scheduling of the Hearing

We proposed that within 30 days from the receipt of a supplier's timely hearing request the HO would contact the parties to schedule a hearing. The request for a hearing would result in the postponement of the date of the contract termination. The only exception to this rule is when a supplier has been excluded from any federal program, debarred by any federal agency, or convicted of a healthcare related crime; in that situation the supplier's contract would be terminated immediately. In the hearing request the contract supplier may ask for the hearing to be held in person or by telephone. The HO would send a notice to the parties to the hearing indicating the time and place for the hearing at least 30 days before the date of the hearing. The HO may, on his or her own motion, or at the request of a party, change the time and place for the hearing, but must give the parties to the hearing a 30 day notice of the change.

We proposed to require that the HO's notice scheduling the hearing must provide, at a minimum, the following information:

- Date, time, and location of the scheduled hearing;
- Description of the hearing procedure;

- Issues to be resolved;
- Requirement that the contract supplier bears the burden of proof to demonstrate that it is not in breach of contract; and
- Provide an opportunity for the supplier to submit additional evidence if requested by the HO.

We believe this information provides the supplier with sufficient information regarding the hearing date, time, and matters that would be addressed at that time. We solicited comment on the content of this notice and the procedures for scheduling a hearing.

(8) Burden of Proof

We proposed that the contract supplier would present to the HO the basis for its disagreement with the termination notice and would have the burden of proof to demonstrate to the HO with supporting evidence that it is not in breach of its contract and that the termination action is not appropriate. The supplier's supporting evidence must be submitted with its request for a hearing. The supporting evidence and the request for a hearing must be submitted together and received by the HO within 30 days from the date identified on the notice of termination. In the absence of good cause, the HO may not allow evidence to be submitted in addition to the evidence submitted along with the written request. We also have the opportunity to submit evidence to the HO within 30 days of receiving the notice announcing the hearing. The HO will share all evidence submitted, both from the supplier and CMS, in preparation for the hearing with all affected parties within 15 days prior to the scheduled date of the hearing.

(9) Role of the Hearing Officer (HO)

Our proposal requires that the HO conduct a thorough and independent review. Such a review requires the consideration of all information and documentation relevant to the hearing and submitted consistent with this proposal. Consistent with this goal, we propose that the HO is responsible for the all of following:

- Sharing all evidence submitted, from both the supplier and CMS, in preparation for the hearing with all affected parties within 15 days prior to the scheduled date of the hearing.
- Conducting the hearing and deciding the order in which the evidence and the arguments of the parties would be presented.
- Determining the rules on admissibility of the evidence.
- Examining the witnesses, in addition to the examinations conducted by CMS and the contract supplier.
- Determining the rules for requesting documents and other evidence from other parties.
- Ensuring a complete recording of the hearing is available and provided to all parties to the hearing and the CBIC.
- Preparing a file of the record of the hearing which includes all evidence submitted as well as any relevant documents identified by the HO and considered as part of the hearing.
- Complying with all applicable provisions of 42 USC Title 18 and related provisions of the Act, the applicable regulations issued by the Secretary, and manual instructions issued by CMS.

The HO would make a recommendation based on the information presented and submitted. The HO would issue a written recommendation to CMS within 30 days of the close of the hearing, unless the HO requests an extension from CMS and demonstrates to CMS that he or she needs an extension due to complexity of the matter or heavy work load. The HO's recommendation would include the rationale for his or her recommendation regarding the termination of the supplier's contract and the HO would submit this recommendation to CMS for its determination.

(10) CMS's Final Determination

We proposed that the HO's recommendation is submitted to CMS, and the agency would make the final determination regarding whether the supplier's contract would be terminated. Our determination would be based upon on the record of the hearing, evidence, and documents considered by the HO as part of the HO recommendation. Information submitted after the hearing would not be considered. Our decision would be made within 30 days of the receipt of the HO's recommendation. If our decision is to terminate the contract, the supplier would be notified of the effective date of termination by certified mail. Our decision regarding the termination of the contract is final and binding.

(11) Effective Date of the Contract Termination

We proposed that suppliers who submit a CAP or request a hearing would have the termination date identified on the notice delayed. The only exception to this rule is when a supplier has been excluded from any federal program, debarred by any federal agency, or convicted of a healthcare related crime; in that situation the contract would be terminated immediately. For terminations that do not meet these exceptions, the effective

date of a final termination would be determined as follows:

• The termination of a supplier's DMEPOS CBP contract is effective on the date specified in the initial notice of termination, which will be 45 days from the date of the notice, unless the supplier requests a hearing with the HO or the supplier submits a CAP.

• After reviewing the HO recommendation, if we terminate a supplier's contract the effective date of the termination would be the date specified in the post-hearing notice sent to the supplier indicating CMS's final determination to terminate the contract.

(12) Effect of Contract Termination

Under our proposal, once a supplier's contract is terminated for breach of contract under the DMEPOS CBP, the contract supplier is no longer a DMEPOS CBP contract supplier for any DMEPOS CBP product category for which it was awarded a contract. This termination applies to all areas and product categories because there is only one contract that encompasses all CBAs and product categories for which the supplier was awarded a contract. We would not make payment and would reject claims for DMEPOS competitive bid items and services furnished by a supplier whose contract has been terminated after the effective date of the termination for the remainder of the contract period.

We recognize that a supplier's termination would impact beneficiaries within the CBA. Therefore, we proposed that terminated suppliers must notify all beneficiaries within the CBA who are receiving rented competitively bid items of the termination of their contract status so that the beneficiaries can make arrangements to receive equipment and suppliers through other contract suppliers. After we have made our final determination and sent notification to the supplier, the supplier must notify beneficiaries

within 5 days of receipt of the contract supplier's final notice of termination. This notice must inform beneficiaries that they will have to select a new contract supplier to furnish their DMEPOS items in order for Medicare to pay for these items. For beneficiary protection, we also proposed that contract suppliers who fail to give proper notification to beneficiaries may be prevented from participating in future rounds of DMEPOS CBP. We also proposed that rental items may not be picked up from the beneficiary's home until after the last day of the rental month for which the supplier has already received payment. We proposed both of these policies to protect the beneficiary and to ensure that suppliers do not pick up equipment from a beneficiary for a time period for which they have already been paid to provide the service.

Comment: A commenter supported CMS's appeals process for contract suppliers whose competitive bidding contract was terminated due to breach of contract. The commenter stated that "including an appeals process under DMEPOS CBP protects contract providers from arbitrary or mistaken decisions by CMS or its contractors and preserves the continuity of care for the beneficiaries they are serving."

Response: We agree that the appeals process does provide protection for contract suppliers and preserves continuity of care for the beneficiaries they serve.

Comment: A commenter who was concerned with the timeline required for communication between terminated suppliers and beneficiaries. The commenter suggested that CMS lengthen the period of time to afford providers ample opportunity to develop, mail and disseminate this critical information.

Response: We agree and have increased the period of time from 5 to 15 days of receipt of contract suppliers' final notice of termination. We believe that 15 days would

be a good balance to ensure the beneficiaries receive information timely and suppliers will have enough time to notify the beneficiaries. Therefore, a contract supplier, whose contract was terminated, has 15 days from the receipt of the final notice of termination to notify each beneficiary currently renting a competitive bid item. This change will not impact any other of the timeframes or provisions described in this regulation. We also proposed that rental items may not be picked up from the beneficiary's home until after the last day of the rental month for which the supplier has already received payment. We proposed both of these policies to protect the beneficiary and to ensure that suppliers do not pick up equipment from a beneficiary for a time period for which they have already been paid to provide the service.

Comment: A commenter opposed the proposed appeals process because they believed, "the proposed process is biased and burdened with inherent CMS conflict of interests that disadvantage suppliers." This commenter recommended CMS adopt the appeals process used for DMEPOS claims which includes a hearing by an administrative law judge (ALJ) and the Departmental Appeals Board (DAB) or the process used under government contracting and FAR requirements." In addition, the commenter questioned whether the termination occurs at the supplier number level or the product category level. The commenter has questioned if a supplier has contracts for more than one of the product categories, and is determined to be in breach of contract in one category, does the termination apply to just that one product or to all? The commenter also stated that the process should include an appeal to a federal court.

Response: We disagree with this comment and feel that our process does provide for an independent and unbiased review by the CBIC hearing officer who was not involved in the original recommendation. It is not in the best interest of the program to

terminate contracts if the supplier has not breached their contract; therefore, this action will not be taken lightly. This process allows CMS contractor's hearing officers to conduct an independent review of the issues. Only after considering the HO's recommendation will CMS make a final determination regarding these issues. We believe this process provides suppliers with ample opportunities to have their positions reviewed and considered. Therefore, we are not including review by the ALJ or the DAB. Our process provides for different levels of review of breach of contract, one at the recommendation level, one at the CBIC hearing officer level, and one at the CMS Administrator level. We believe this process does provide for an extensive review by allowing for reconsideration before a contract is actually terminated, which may include the use of a corrective action plan. As stated in the final regulation, these contracts are not procurement contracts are not subject to the FAR requirements; therefore, the FAR is not applicable. The rule does not address federal court review that might otherwise exist. As we stated in the proposed rule §414.423(k)(4) CMS's decisions regarding contract terminations are final and binding. In response to the question regarding the scope of the termination, if a supplier is terminated due to a breach of contract all locations associated with that contract will be terminated, regardless of the competitive bid product category they provide. In addition, we have added clarifying language to §414.423(l)(1).

After consideration of the public comments we received, we are revising the time for the supplier to notify the beneficiary once the supplier has been notified of their contract termination. Therefore, we have revised §414.423(l)(2)(i) of the regulation to state that the supplier whose contract was terminated must notify the beneficiary within 15 days of receipt of the final notice of termination. In addition, we are clarifying the

regulation language by adding language to §414.423(l)(1) to state that "all locations of the contract supplier" may no longer furnish competitive bid items to beneficiaries within a CBA and be reimbursed by Medicare for these items after the effective date of the termination.

2. Changes to Payment Rules for Oxygen and Oxygen Equipment

a. Background

The general Medicare payment rules for DME are set forth in section 1834(a) of the Act and 42 CFR part 414, subpart D of our regulations. Section 1834(a)(1) of the Act and §414.210(a) of our regulations establish the Medicare payment for a DME item as equal to 80 percent of either the lower of the actual charge or the fee schedule amount for the item. The beneficiary coinsurance is equal to 20 percent of either the lower of the actual charge or the fee schedule amount for the item once the deductible is met.

The specific payment rules for oxygen and oxygen equipment under the existing fee schedules are set forth in section 1834(a)(5) of the Act and §414.226 of our regulations. Suppliers are paid a monthly payment amount for furnishing medically necessary oxygen contents (for both stationary and portable) and stationary oxygen equipment described under the class described in §414.226(c)(1)(i). Equipment in the stationary class includes stationary oxygen concentrators, which concentrate oxygen from room air; stationary liquid oxygen systems, which use oxygen stored as a very cold liquid in cylinders and tanks; and gaseous oxygen systems, which administer compressed oxygen directly from cylinders.

A monthly add-on payment is also made to suppliers furnishing medically necessary portable oxygen equipment falling under one of two classes described in

§414.226(c)(1)(ii) and (iii). Equipment in these classes includes traditional portable equipment, that is, portable liquid oxygen systems and portable gaseous oxygen systems, and oxygen generating portable equipment (OGPE), that is, portable oxygen concentrators and oxygen transfilling equipment used to fill portable tanks or cylinders in the home. Both the liquid and gaseous oxygen systems (for stationary and traditional portable systems) require on-going delivery of oxygen contents.

Section 1834(a)(5)(F) of the Act, as amended by section 144(b) of MIPPA, limits the monthly rental payments to suppliers for oxygen equipment to 36 months of continuous use, although monthly payments for furnishing gaseous or liquid oxygen contents continue after the 36-month equipment rental cap is reached for gaseous or liquid systems. In the CY 2009 PFS final rule with comment period (73 FR 69875 through 69876), we discussed section 144(b) of MIPPA and included a detailed discussion of how section 5101(b) of the DRA previously required suppliers to transfer title to oxygen equipment to the beneficiary at the end of the 36-month rental period. Section 144(b) of the MIPPA repealed this requirement to transfer title to the oxygen equipment to the beneficiary and allows suppliers to retain title to the oxygen equipment after 36 monthly rental payments are made for the equipment.

Section 414.210 establishes the requirements for the replacement of DME, including oxygen equipment. Section 414.210(f)(1) states that if an item of DME, which includes oxygen equipment, has been in continuous use by the patient for the equipment's reasonable useful lifetime or if the original equipment is lost, stolen, or irreparably damaged, the patient may elect to obtain a new piece of equipment. In such circumstances, §414.420(f)(2) authorizes payment for the new oxygen equipment in

accordance with §414.226(a). Section 414.210(f)(1) states that the reasonable useful lifetime for DME, which includes oxygen equipment, is determined through program instructions. In the absence of CMS program instructions, the carrier may determine the reasonable useful lifetime for equipment, but in no case can it be less than 5 years. Computation is based on when the equipment is delivered to the beneficiary, not the age of the equipment. If the beneficiary elects to obtain new oxygen equipment after the reasonable useful lifetime, the payment is made for a new 36-month rental period in accordance with §414.226(a).

We proposed to revise the payment rule for oxygen and oxygen equipment at §414.226(g)(1) to address situations where beneficiaries relocate outside the service area of a supplier during the 36-month rental payment cap period for the oxygen equipment.

Beneficiaries are experiencing great difficulties in finding suppliers willing to furnish oxygen equipment in situations where only a few months are left in the 36-month rental payment period at the time they relocate. For example, if a beneficiary is in the 30^{th} rental month, the new supplier would be entitled to only 6 months of rental payments and then would have to continue to furnish the oxygen and oxygen equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment. This creates a financial disincentive for oxygen suppliers to furnish oxygen and oxygen equipment to beneficiaries in these situations.

The proposed changes to the payment rules for oxygen and oxygen equipment would apply to oxygen and oxygen equipment furnished under Part B and would also apply to oxygen and oxygen equipment furnished under programs implemented in accordance with section 1847(a) of the Act.

b. Furnishing Oxygen Equipment after the 36-Month Rental Period (Cap)

In the CY 2010 PFS final rule with comment period (74 FR 61887 through 61890), we finalized §414.226(g)(1) which, in accordance with section 1834(a)(5)(F)(ii)(I) of the Act, requires the supplier that furnishes oxygen equipment during the 36-month rental period to continue furnishing the oxygen equipment after the 36-month rental period. The supplier is required to continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment. As we noted when finalizing this rule, section 1834(a)(5)(F)(ii)(I) does not provide any exceptions to this requirement. If the beneficiary relocates outside the supplier's normal service area at some time after the 36-month rental period but before the end of the reasonable useful lifetime of the equipment, the supplier must make arrangements for the beneficiary to continue receiving the equipment at his or her new place of residence. This responsibility for furnishing the equipment does not transfer to another supplier.

We revised §414.226(f) to conform our regulations to this new MIPPA requirement. We deleted the transfer of ownership requirement and added the new requirement that the supplier must continue furnishing the oxygen equipment after the 36-month rental period during any period of medical need for the remainder of the reasonable useful lifetime of the equipment. It is important to note that §414.226(g)(1)(ii) does not apply this same requirement in situations where the beneficiary relocates outside of the supplier's normal service area during the 36-month rental period.

c. Furnishing Oxygen Equipment during the 36-Month Rental Period (CAP)

Section §414.226(g)(1) contains the requirement that the supplier that furnishes oxygen and oxygen equipment for the first month of the 36th month of the rental cap period must continue to furnish the equipment for the entire 36-month period of continuous use, with limited exceptions. One exception at §414.226(g)(1)(ii) applies when a beneficiary permanently relocates his or her residence during the 36-month rental period outside of the current supplier's normal service area. This exception was proposed in the "Home Health Prospective Payment System Rate Update for Calendar Year 2007 and Deficit Reduction Act of 2005 Changes to Medicare Payment for Oxygen Equipment and Capped Rental Durable Medical Equipment; Proposed Rule" published in the August 3, 2006 **Federal Register** (71 FR 44094) and was intended to reduce the burden on the supplier in these situations. This approach is also consistent with the regulations addressing capped rental items described in §414.229. We addressed this issue in the context of other capped rental DME, not including oxygen and oxygen equipment, in the July 10, 1995 **Federal Register** (60 FR 35494) in response to comments. The discussion states that since the implementation of the capped rental payment methodology on January 1, 1989, we received no reports of beneficiaries having difficulty obtaining access to capped rental DME after relocating outside the supplier's service area. Since enactment of the capped rental DME payment category in section 4062 of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100-203), representatives of the DME industry indicated that suppliers would be able to accommodate beneficiaries in these situations, and this has proven to be true for capped rental items. In fact, we have found this to be the case to this day.

For this reason, we believed that beneficiaries would not encounter problems obtaining access to oxygen and oxygen equipment in similar situations, that is, following the 36-month cap imposed by section 144(b) of MIPPA. However, since the changes to the payment rules for oxygen and oxygen equipment mandated by the DRA became effective in 2006 and the 36-month rental cap imposed by MIPPA was reached for the first time in January 2009, we have received many reports of beneficiaries relocating prior to the end of the 36-month rental payment cap period and having difficulty finding an oxygen supplier in the new location. We have learned that many suppliers are unwilling to provide services in situations where there are a few number of months left in the 36-month rental payment period.

We do not believe that beneficiaries have encountered similar issues following the 36-month rental cap, which most likely is the result of different statutory requirements for these two periods (that is, during and after the 36-month rental period). Section 1834(a)(5)(F)(ii) of the Act requires the supplier that furnishes the oxygen equipment during the 36-month rental payment period to continue furnishing the equipment after the 36-month rental payment period. Consistent with this requirement, we established regulations at §414.226(f)(1) that require the supplier to furnish the equipment or make arrangements for furnishing the equipment in situations where the beneficiary relocates outside the supplier's normal service area. Since no such requirement currently applies in situations where the beneficiary relocates prior to the end of the 36-month rental payment period, and in fact current regulations at §414.226(g)(1)(ii) absolve the supplier of the obligation to continue furnishing oxygen equipment in these situations, beneficiaries are experiencing difficulties finding suppliers of oxygen equipment in their new locations

that are willing to accommodate them. As noted above, we have not seen this problem in the capped rental DME context. The requirement at §414.226(g)(1) to furnish oxygen equipment for the entire 36 month rental cap period was established in the course of implementing section 5101(b) of the DRA in order to safeguard the beneficiary from situations where suppliers might discontinue service and pick up oxygen equipment prior to the end of the 36-month rental cap in order to avoid losing title to the equipment. As mentioned earlier, the transfer of title of oxygen and oxygen equipment after the 36th paid rental month was repealed. The exception to this rule at §414.226(g)(1)(ii) was established based on our experience that suppliers of capped rental DME have accommodated beneficiaries in these situations, which, unfortunately, has not been our experience in the context of oxygen equipment.

In order to address this vulnerability facing beneficiaries as a result of regulations currently in effect, we proposed to revise the exception at §414.226(g)(1)(ii) to apply only to situations where the beneficiary relocates before the 18th paid rental month to an area that is outside the normal service area of the supplier that initially furnished the equipment. We proposed to revise the regulation to require the supplier that furnishes the oxygen equipment and receives payment for month 18 or later to either furnish the equipment for the remainder of the 36-month rental payment period or, in the case where the beneficiary has relocated outside the service area of the supplier, make arrangements for furnishing the oxygen equipment with another supplier for the remainder of the 36-month rental payment period. The supplier that is required to furnish the equipment on the basis of this requirement must also furnish the equipment after the 36-month rental

payment period in accordance with the requirements of section 1834(a)(5)(F)(ii) and §414.226(f).

The proposed revision would mean that a supplier does not have to continue to furnish the oxygen equipment if the beneficiary relocates outside the normal service area before the 18th paid rental month during a period of continuous use. Under the current rule, a supplier does not have to furnish the oxygen equipment if the beneficiary relocated before the 36th paid rental month during a period of continuous use. The current rule was established based on the long term, demonstrated ability of suppliers of capped rental DME to accommodate beneficiaries in situations where they relocate near the end of a capped rental payment period.

Comment: We received a total of 8 comments on our proposal to require oxygen suppliers to continue to furnish medically necessary oxygen equipment for the remainder of the reasonable useful lifetime of the equipment to beneficiaries who relocate on or after the 18th rental month. All the comments were opposed to the proposed requirement. Some of the commenters questioned whether the statute gives us the authority to establish this requirement before the 36th month rental payment. Others objected to the financial and coordination-of-benefits burden they believe that this requirement would cause for suppliers. Other objections were that the proposed requirement did not consider the effect on beneficiaries who relocate on a temporary basis during winter months ("snow birds"), or the access problems that it might cause in rural areas. Recommended alternatives included starting the rental period over at the time of relocation or keeping the current policy that only requires suppliers to continue furnishing oxygen equipment to beneficiaries who relocate outside of their service area if 36 rental amounts have already

been paid.

Response: In addition to considering the comments on the proposed rule, we analyzed complaint data from beneficiaries from January 2009 to September 2010 which is data collected by the regional offices. In the limited situations where beneficiaries receiving oxygen equipment for less than 36 months relocated during this time and initially had trouble locating an oxygen supplier in their new location, CMS caseworkers in the CMS Regional Offices and the Office of the Medicare Beneficiary Ombudsman were able to locate suppliers to serve each and every beneficiary, usually within a matter of a days. This means that, although supply arrangements and/or access to oxygen and oxygen equipment in these situations may have been briefly delayed, suppliers stepped forward to provide access to oxygen and oxygen equipment in these situations. Based on this information and certain comments received, we have decided not to finalize this proposed revision at this time. If in the future, beneficiaries' access to oxygen equipment becomes a problem following the relocation of beneficiaries, we may consider this proposal or similar proposals.

H. Provider and Supplier Enrollment Issue: Air Ambulance Provision

The National Transportation Safety Board (NTSB) is an independent Federal agency charged by the Congress with investigating transportation accidents, determining their probable cause, and making recommendations to prevent similar accidents from occurring. Based on information derived from testimony provided at the NTSB public hearing and investigations into recent helicopter air ambulance accidents, the NTSB made several specific recommendations to the Secretary on September 24, 2009.

Specifically, the NTSB recommended that the Secretary develop minimum safety accreditation standards for helicopter air ambulance operators that augment the operating standards of 14 CFR 135 by including for all flights with medical personnel on board: (a) scenario-based pilot training; (b) implementation of preflight risk evaluation programs; and (c) the installation of FAA-approved terrain awareness warning systems, night vision imaging systems, flight data recording systems for monitoring and autopilots if a second pilot is not used.

In response to the NTSB concerns, the Secretary noted that the recommendations to CMS were similar to those being made to the Federal Aviation Administration (FAA). While we have expertise to regulate health and safety requirements that suppliers and providers of healthcare should meet, we do not have the expertise to determine aircraft safety requirements. The Secretary stated that, "we believe the FAA should determine the minimum level of safety that HEMS operators should meet and CMS should adopt regulations that require any HEMS operator that enrolls in Medicare to meet those requirements." The Secretary also added that, "while we do not believe CMS should augment FAA regulations, we do believe that CMS' regulations should ensure that only

those HEMS operators that maintain the minimum level of requirements established by the FAA through its regulations are enrolled or maintain enrollment in the Medicare program." The FAA proposed Federal regulations to address the NTSB's concerns in their October 12, 2010 proposed rule (75 FR 62640) entitled "Air Ambulance and Commercial Helicopter Operations, Part 91 Helicopter Operations, and Part 135 Aircraft Operations; Safety Initiatives and Miscellaneous Amendments." .

In the April 21, 2006 **Federal Register**, we published the "Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment" final rule. This final rule implemented section 1866(j)(1)(A) of the Act. In this final rule, we required that all providers and suppliers (other than physicians or practitioners who have elected to "opt-out" of the Medicare program) must complete an enrollment form and submit specific information to CMS in order to obtain Medicare billing privileges. Section 424.515 required that ambulance service providers continue to resubmit enrollment information in accordance with §410.41(c)(2), which states, "Upon a carrier's request, complete and return the ambulance supplier form designated by CMS and provide the Medicare carrier with documentation of compliance with emergency vehicle and staff licensure and certification requirements in accordance with State and local laws." This final rule also established §424.510(d)(2)(iii) which states, "Submission of all documentation, including all applicable Federal and State licensure and regulatory requirements that apply to the specific provider or supplier type related to providing health care services, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the

Medicare program."

While the Airline Deregulation Act (Pub. L. 95-504) preempts a State, political subdivision of a State, or political authority of at least two States from enacting or enforcing a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation, air ambulances remain subject to Federal laws and regulations. In accordance with §424.516(a)(2), providers and suppliers must adhere to all Federal regulations and State laws and regulations, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare.

In §424.510(d)(iii), we proposed to clarify that ambulance suppliers and other providers and suppliers include documentation regarding all applicable Federal and State certifications. Accordingly we proposed to revise §424.510(d)(iii) from "Submission of all documentation, including all applicable Federal and State licenses and regulatory requirements that apply to the specific provider or supplier type that relate to providing health care service, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program," to "Submission of all documentation, including all applicable Federal and State licenses, certifications (including, but not limited to FAA certifications),and regulatory requirements that apply to the specific provider or supplier type that relate to providing health care service, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the

Medicare program." When revoked or suspended, we are requiring that the specific pilot certifications (for example, instrumentation and medical), and the airworthiness certifications be reported. We proposed to add new paragraph (e)(3) to clarify that Medicare enrolled providers and suppliers must report a revocation or suspension of a Federal or State license or certification, including but not limited to FAA certifications. The certifications, when revoked, that need to be reported are the specific pilot certifications, such as instrument and medical certified; as well as airworthiness certificates. This revision will clarify that fixed-wing ambulance operators and helicopter air ambulance operators are responsible for notifying the designated Medicare contractor for their State when FAA revokes or suspends any license or certification. Moreover, fixed-wing ambulance operators and helicopter air ambulance operators must maintain all requirements as specified in 14 CFR parts 91, 119, and 135.

We stated our belief that requiring fixed wing ambulance and helicopter air ambulance operators to notify their Medicare contractor of a suspension or revocation of a license or certification will ensure that any action taken by the FAA or other regulating authority will have a direct link to the operator’s ability to maintain their Medicare enrollment. We also stated that such a policy will help improve aircraft safety for operators that are enrolled in Medicare and providing services to Medicare beneficiaries. We believe that allowing providers and suppliers to self-report licensure or certification revocations and suspensions within a 30 day period via the Medicare enrollment application (such as, the Internet-based Provider Enrollment Chain and Ownership System (PECOS) or the paper CMS-855) promotes compliance with the Medicare reporting requirements found in §424.516. In addition, by reporting a licensure or

certification revocation or suspension within 30 days, the provider or supplier avoids the Medicare contractor bringing an action to revoke its Medicare billing privileges and establishing a Medicare enrollment bar, see §424.535(c). Thus, by complying with the reporting responsibilities found in §424.516 and voluntarily terminating from the Medicare program, the air ambulance supplier can submit an initial application to enroll in the Medicare program as soon as the licensure or certification revocation or suspension action is resolved with the applicable licensing or certification organization. If the supplier does not self-report a licensure, certification revocation or a suspension action, then the supplier's enrollment in the Medicare program will be automatically revoked for a period of one to three years.

In §424.502, we proposed to define the term, "voluntary termination" as it is currently used in the Medicare program and throughout this regulation in the context of the provider enrollment requirements: We proposed that the term, "voluntary termination" means an air ambulance supplier that submits written confirmation to CMS of its decision to discontinue enrollment in the Medicare program.

Furthermore, we stated our belief that an air ambulance supplier can make the decision to voluntarily terminate their business relationship with the Medicare program at any time, including when the provider or supplier makes the decision that they will no longer furnish services to Medicare beneficiaries. In those situations, where an air ambulance supplier does not meet their reporting responsibilities and notify the Medicare program of a Federal or State licensure or certification revocation or suspension within 30 days of the reportable event, we believe that it is appropriate that CMS or the Medicare contractor revoke the supplier's Medicare billing privileges using

§424.535(a)(1). We believe that this change will clarify that CMS or our Medicare contractor may revoke Medicare billing privileges when these types of suppliers do not report a revocation or suspension of a Federal or State license or certification.

Comment: Several comments received agreed with CMS' enrollment requirements and believe the FAA has the appropriate resources to develop, monitor, and enforce aviation or aviation safety related standards. The commenters believe that the sole authority of the FAA to regulate matters of aviation safety assures continuity in regulations and further believe any change to the authority would have serious consequences for safe operations since CMS lacks the expertise and resources to develop and enforce such standards.

Response: We agree with the commenters; and therefore, are finalizing the proposal without modification.

Comment: Several commenters believe CMS missed an opportunity through this proposed rule to improve system safety for Medicare beneficiaries through an accreditation process.

Response: Currently, we do not have the statutory authority to establish an accreditation program for fixed-wing air ambulance operators and air ambulance operators.

Comment: Several commenters noted that the preamble language might cause confusion as stated, "fixed-wing air ambulance operators and HEMS operators must maintain all requirements as specified in 14 CFR part 135."

Response: We are clarifying that all fixed-wing air ambulance operators and helicopter air ambulance operators must adhere to all applicable FAA regulations as

specified in 14 CFR parts 91, 119 and 135 or risk having their Medicare enrollment revoked or suspended.

I. Technical Corrections

1. Physical Therapy, Occupational Therapy and Speech-language Pathology

We proposed to revise §409.23(c) by making a minor technical correction to remove an extraneous cross-reference which was initially proposed in the CY 2008 PFS proposed rule (72 FR 38122, 72 FR 38193, and 72 FR 38221). This cross-reference refers the reader to "paragraph (c)(1)(ii) of this section," a paragraph also proposed in the CY 2008 PFS proposed rule, but never finalized. In the CY 2008 PFS final rule with comment period, we inadvertently neglected to remove the associated cross-reference from the regulations text. Therefore, we proposed to rectify that oversight by making an appropriate correction in the regulations text, along with other minor formatting revisions by making the following changes:

- To make a minor clarification to the section heading and introductory text of §409.23 (along with a conforming revision to the corresponding regulations text at §409.20(a)(3)) by revising the existing phrase "speech therapy" to read "speech-language pathology services," so that it more accurately reflects the currently used terminology for this type of therapeutic treatment.

- To make a minor wording change in the provision at §409.17(d) (which is incorporated by reference in §409.23(c)(2)), in order to clarify that the former provision’s reference to "hospital" policies and procedures can alternatively refer, depending on the particular context, to SNF policies and procedures.

We did not receive public comment on this proposal; and therefore, are finalizing

this proposal without modification.

2. Scope of Benefits

Currently, §410.3(b)(2) states that the specific rules on payment are set forth in subpart E of part 410. However, the specific payment rules are actually listed in subpart I of part 410. Therefore, we proposed correct this referencing error by making a technical correction to §410.3(b)(2).

We did not receive public comment on this proposal; and therefore, are finalizing this proposal without modification.

J. Physician Self-Referral Prohibition: Annual Update to the List of CPT/HCPCS Codes

1. General

Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain designated health services (DHS) to an entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare or billing the beneficiary or any other entity for Medicare DHS that are furnished as a result of a prohibited referral.

Section 1877(h)(6) of the Act and §411.351 of our regulations specify that the following services are DHS:

- Clinical laboratory services.
- Physical therapy services.
- Occupational therapy services.
- Outpatient speech-language pathology services.
- Radiology services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

2. Annual Update to the Code List

a. Background

In §411.351, we specify that the entire scope of four DHS categories is defined in a list of CPT/HCPCS codes (the Code List), which is updated annually to account for changes in the most recent CPT and HCPCS publications. The DHS categories defined and updated in this manner are:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.

The Code List also identifies those items and services that may qualify for either of the following two exceptions to the physician self-referral prohibition:

- Dialysis-related drugs furnished in or by an ESRD facility (§411.355(g)).
- Preventive screening tests, immunizations, or vaccines (§411.355(h)).

The Code List was last updated in Addendum I of the CY 2010 PFS final rule with comment period (74 FR 62177 through 62188) and revised in a subsequent correction notice (75 FR 26350).

b. Response to Comments

We received no public comments relating to the Code List that became effective January 1, 2010.

c. Revisions Effective for 2011

The updated, comprehensive Code List effective January 1, 2011 appears as Addendum J in this final rule with comment period and is available on our Web site at http://www.cms.gov/PhysicianSelfReferral/40_List_of_Codes.asp#TopOfPage. Additions and deletions to the Code List conform the Code List to the most recent publications of CPT and HCPCS and to changes in Medicare coverage policy and payment status.

Tables 98 and 99, identify the additions and deletions, respectively, to the comprehensive Code List that became effective January 1, 2010. Tables 98 and 99 also identify the additions and deletions to the list of codes used to identify the items and services that may qualify for the exception in §411.355(g) (regarding dialysis–related outpatient prescription drugs furnished in or by an ESRD facility) and in §411.355(h) (regarding preventive screening tests, immunizations, and vaccines).

In Table 98, we specify additions that reflect new CPT and HCPCS codes that become effective January 1, 2011, or that became effective since our last update. We also include additions that reflect changes in Medicare coverage policy or payment status that become effective January l, 2011, or that became effective since our last update.

Table 99 reflects the deletions necessary to conform the Code List to the most recent publications of the CPT and HCPCS and to changes in Medicare coverage policy and payment status. In addition, we are deleting CPT codes 94667 and 94668 (Chest wall manipulation) from the category of "physical therapy, occupational therapy, and outpatient speech-language pathology services" because these services are not generally considered to be physical therapy services. Also, we are deleting CPT code 77014 (CT

scan for therapy guide) from the category "radiology and certain other imaging services." This service is always integral to the performance of, and performed during, a non-radiological medical procedure. Therefore, under §411.351, this service is excluded from the definition of "radiology and certain other imaging services."

Lastly, we are deleting the drugs currently listed as qualifying for the exception for "EPO and other dialysis-related drugs" furnished in or by and ESRD facility. Beginning January 1, 2011, EPO and other dialysis-related drugs furnished by an ESRD facility (except drugs for which there are no injectable equivalents or other forms of administration) will be paid under the ESRD PPS promulgated in the final rule published on August 12, 2010 in the **Federal Register** (75 FR 49030). Drugs for which there are no injectable equivalents or other forms of administration will be payable under the ESRD PPS beginning January 1, 2014. The definition of DHS at §411.351 excludes services that are reimbursed by Medicare as part of a composite rate (unless the services are specifically identified as DHS and are themselves payable through a composite rate, such as home health and inpatient and outpatient hospital services). Accordingly, EPO and other dialysis-related outpatient prescription drugs furnished by an ESRD facility (except drugs for which there are no injectable equivalents or other forms of administration) will not be DHS beginning January 1, 2011. When dialysis-related drugs for which there are no injectable equivalents or other forms of administration are bundled into the ESRD PPS beginning January 1, 2014, and furnished by an ESRD facility, they will no longer meet the definition of DHS and, therefore, will not be subject to the physician self-referral prohibition. In the meantime, those drugs remain DHS. If we determine that any of those drugs may qualify for the exception for dialysis-related drugs

at 411.355(g), we will announce them through the annual update to the Code List that appears in the PFS final rule.

We will consider comments regarding the codes listed in Tables 98 and 99. Comments will be considered if we receive them by the date specified in the "DATES" section of this final rule with comment period. We will not consider any comment that advocates a substantive change to any of the DHS defined in §411.351.

TABLE 98: Additions to the Physician Self-Referral List of CPT[1/]HCPCS Codes

CLINICAL LABORATORY SERVICES	
0058T	Cryopreservation ovary tiss
0059T	Cryopreservation oocyte
G0432	EIA HIV-1/HIV-2 screen
G0433	ELISA HIV-1/HIV-2 screen
G0434	Drug screen multi drug class
G0435	Oral HIV-1/HIV-2 screen
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
95992	Canalith repositioning proc
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
72159	Mr angio spine w/o&w/dye
73225	Mr angio upr extr w/o&w/dye
74176	Ct angio abd & pelvis
74177	Ct angio abd&pelv w/contrast
74178	Ct angio abd & pelv 1+ regns
76881	Us xtr non-vasc complete
76882	Us xtr non-vasc lmtd
92132	Cmptr ophth dx img ant segmt
92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92227	Remote dx retinal imaging
92228	Remote retinal imaging mgmt
RADIATION THERAPY SERVICES AND SUPPLIES	

49327	Lap ins device for rt
49412	Ins device for rt guide open
57156	Ins vag brachytx device
A4650	Implant radiation dosimeter
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
[No additions]	
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
90662	Flu vacc prsv free inc antig
90670	Pneumococcal vacc 13 val im
G0432	EIA HIV-1/HIV-2 screen
G0433	ELISA HIV-1/HIV-2 screen
G0435	Oral HIV-1/HIV-2 screen
Q2035	Afluria vacc, 3 yrs & >, im
Q2036	Flulaval vacc, 3 yrs & >, im
Q2037	Fluvirin vacc, 3 yrs & >, im
Q2038	Fluzone vacc, 3 yrs & >, im
Q2039	NOS flu vacc, 3 yrs & >, im

[1]CPT codes and descriptions only are copyright 2010 AMA. All rights are reserved and applicable FARS/DFARS clauses apply.

TABLE 99: Deletions to the Physician Self-Referral List of CPT[1/]HCPCS Codes

CLINICAL LABORATORY SERVICES	
0104T	At rest cardio gas rebreathe
0140T	Exhaled breath condensate ph
G0430	Drug screen multi class
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
94667	Chest wall manipulation
94668	Chest wall manipulation
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
76150	X-ray exam, dry process
76880	Us exam, extremity
77014	Ct scan for therapy guide

RADIATION THERAPY SERVICES AND SUPPLIES	
[No deletions]	
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
J0630	Calcitonin salmon injection
J0636	Inj calcitriol per 0.1 mcg
J0882	Darbepoetin alfa, esrd use
J0895	Deferoxamine mesylate inj
J1270	Injection, doxercalciferol
J1750	Inj iron dextran
J1756	Iron sucrose injection
J1955	Inj levocarnitine per 1 gm
J2501	Paricalcitol
J2916	Na ferric gluconate complex
J2993	Reteplase injection
J2995	Inj streptokinase /250000 IU
J2997	Alteplase recombinant
J3364	Urokinase 5000 IU injection
P9041	Albumin (human), 5%, 50ml
P9045	Albumin (human), 5%, 250ml
P9046	Albumin (human), 25%, 20ml
P9047	Albumin (human), 25%, 50ml
Q0139	Ferumoxytol, esrd use
Q4081	Epoetin alfa, 100 units ESRD
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
90658	Flu vaccine, 3 yrs & >, im

[1] CPT codes and descriptions only are copyright 2010 AMA. All rights are reserved and applicable FARS/DFARS clauses apply.

VIII. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We utilize HCPCS codes for Medicare payment purposes. The HCPCS is a national drug coding system comprised of Level I (CPT) codes and Level II (HCPCS National Codes) that are intended to provide uniformity to coding procedures, services, and supplies across all types of medical providers and suppliers. Level I (CPT) codes are copyrighted by the AMA and consist of several categories, including Category I codes which are 5-digit numeric codes, and Category III codes which are temporary codes to track emerging technology, services, and procedures.

The AMA issues an annual update of the CPT code set each Fall, with January 1 as the effective date for implementing the updated CPT codes. The HCPCS, including both Level I and Level II codes, is similarly updated annually on a CY basis. Annual coding changes are not available to the public until the Fall immediately preceding the annual January update of the PFS. Because of the timing of the release of these new codes, it is impracticable for us to provide prior notice and solicit comment on these codes and the RVUs assigned to them in advance of publication of the final rule that implements the PFS. Yet, it is imperative that these coding changes be accounted for and

recognized timely under the PFS for payment because services represented by these codes will be provided to Medicare beneficiaries by physicians during the CY in which they become effective. Moreover, regulations implementing HIPAA (42 CFR parts 160 and 162) require that the HCPCS be used to report health care services, including services paid under the PFS. We also assign interim RVUs to any new codes based on a review of the AMA RUC recommendations for valuing these services. By reviewing these AMA RUC recommendations for the new codes, we are able to assign RVUs to services based on input from the medical community and to establish payment for them, on an interim basis, that corresponds to the relative resources associated with furnishing the services. We are also able to determine, on an interim final basis, whether the codes will be subject other payment policies. If we did not assign RVUs to new codes on an interim basis, the alternative would be to either not pay for these services during the initial CY or have each Medicare contractor establish a payment rate for these new codes. We believe both of these alternatives are contrary to the public interest, particularly since the AMA RUC process allows for an assessment of the valuation of these services by the medical community prior to our establishing payment for these codes on an interim basis. Therefore, we believe it would be contrary to the public interest to delay establishment of fee schedule payment amounts for these codes.

For the reasons outlined above in this section, we find good cause to waive the notice of proposed rulemaking for the interim RVUs for selected procedure codes identified in Addendum C and to establish RVUs for these codes on an interim final basis. We are providing a 60-day public comment period.

Section II.C. of this final rule with comment period discusses the identification

and review of potentially misvalued codes by the AMA RUC, as well as our review and decisions regarding the AMA RUC recommendations. Similar to the AMA RUC recommendations for new and revised codes discussed above, due to the timing of the AMA RUC recommendations for the potentially misvalued codes, it was impracticable for CMS to solicit public comment regarding specific proposals for revision prior to this final rule with comment period. We believe it is in the public interest to implement the revised RVUs for the codes that were identified as misvalued, and that have been reviewed and re-evaluated by the AMA RUC, on an interim final basis for CY 2011. The revisions of RVUs for these codes will establish a more appropriate payment that better corresponds to the relative resources associated with furnishing these services. A delay in implementing revised values for these misvalued codes would not only perpetuate the known misvaluation for these services, it would also perpetuate a distortion in the payment for other services under the PFS. Implementing the changes now allows for a more equitable distribution of payments across all PFS services. We believe a delay in implementation of these revisions would be contrary to the public interest, particularly since the AMA RUC process allows for an assessment of the valuation of these services by the medical community prior to the AMA RUC's recommendation to CMS. For the reasons described above, we find good cause to waive notice and comment procedures with respect to the misvalued codes identified in Tables 53, 54, and 55, and to revise RVUs for these codes on an interim final basis. We are providing a 60-day public comment period.

Furthermore, in this final rule with comment period, we are making a technical revision to §410.64 (Additional Preventive Services) to conform with section

1861(ddd)(1), as amended by section 4104 of the ACA. We are revising §410.64(a) by removing the words "not otherwise described in this subpart" and adding the words "not described in subparagraphs (1) or (3) of §410.2 of this subpart" in their place. This change reflects section 1861(ddd)(1) of the Act (as amended by section 4104(a)(2) of the ACA). While this change was not discussed in the CY 2011 PFS proposed rule (74 FR 40129), we are making this change pursuant to the "good cause" exception to APA notice and comment rulemaking. Under the good cause exception, public participation procedures are not required "when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefore in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest" (5 U.S.C. 553(b)). Section 410.64(a) previously reflected section 1861(ddd)(1) of the Act, which was subsequently amended. The revision to the regulations merely incorporates the new statutory language for consistency, and is not an interpretation or clarification. Therefore, we believe it is appropriate to waive advanced notice and public comment on this change for good cause, due to the technical nature of the revision to the regulations.

We ordinarily provide a 60-day delay in the effective date of the provisions of a rule in accordance with the Administrative Procedure Act (APA) (5 U.S.C. 553(d)), which requires a 30-day delayed effective date, and the Congressional Review Act (5 U.S.C. 801(a)(3)), which requires a 60-day delayed effective date for major rules. However, we can waive the delay in the effective date if the Secretary finds, for good cause, that the delay is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons in the rule issued (5 U.S.C.

553(d)(3); 5 U.S.C. 808(2)).

IX. Collection of Information Requirements

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

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

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

A. ICRs Regarding Diagnostic X-ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions (§410.32)

Section 410.32(d)(2)(i) requires the physician or qualified nonphysician practitioner (as defined in §410.32(a)(2)) who orders the service must maintain documentation of medical necessity in the beneficiary's medical record. In addition, both the medical record and the laboratory requisition (or order) would be required to be signed by the physician or qualified nonphysician practitioner (as defined in

§410.32(a)(2)) who orders the service. The burden associated with these requirements would be the time and effort necessary for a physician or qualified nonphysician practitioner to sign the medical record or laboratory requisition (or order). There is also a recordkeeping requirement associated with maintaining the documentation of medical necessity in the beneficiary medical record. While these recordkeeping and reporting requirements are subject to the PRA, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with the aforementioned information collection requirements is incurred by persons in the normal course of their activities and therefore considered to be usual and customary business practices.

B. ICRs Regarding General Exceptions to the Referral Prohibition Related to Both Ownership/Investment and Compensation (§411.355)

Section 411.355(b)(7)(i) states that with respect to magnetic resonance imaging, computed tomography, and positron emission tomography, the referring physician must provide written notice to the patient at the time of the referral that the patient may receive the same services from a person other than one described in §411.355(b)(1). The written notice must include a list of other suppliers (as defined in §400.202 of this title) that provide the services for which the individual is being referred. In response to public comments received, we are finalizing this provision to require that the list must include a minimum of 5 suppliers within a 25-mile radius of the referring physician's office location at the time of the referral, rather than the proposed 10 suppliers. The notice should be written in a manner sufficient to be reasonably understood by all patients and should include for each supplier on the list, at a minimum, the supplier's name, address,

and telephone number.

This rule finalizes section 411.355(b)(7)(ii) to state that if the referring physician makes a referral within an area with fewer than 5 other suppliers within the 25-mile radius of the physician's office location at the time of the referral, the physician shall list all of the other suppliers of the imaging service that are present within a 25-mile radius of the referring physician's office location. Provision of the written list of alternate suppliers will not be required if no other suppliers provide the services for which the individual is being referred within the 25-mile radius. These physicians must still disclose to the patient that the patient may receive these services from a person other than one described in §411.355(b)(1) in a manner sufficient to reasonably be understood by all patients.

The burden associated with the requirements contained in this section would be the time and effort necessary for a physician to develop a standard disclosure. There would also be burden associated with the time and effort necessary for a physician to provide the disclosure to the patient. Based upon public comments received, we have removed the requirement that a physician must obtain the patient’s signature on the disclosure and maintain a copy of this document in the medical record. Physicians must retain adequate assurance that the information was shared with the patient so that this information can be verified.

Our estimate that it would take 1 hour for a physician's office to develop a standard disclosure remains the same in this final rule with comment to account for physicians drafting the disclosure notice and listing the 5 alternate suppliers. Our estimate that 71,000 physicians will be required to comply with these requirements

remains unchanged from the proposed rule. The total burden associated with the development of the standard disclosure remains 71,000 hours at a cost of $1,042,280. Although the physician no longer must have the patient sign the disclosure and enter it into the medical record, we have not changed the estimate that it will take each physician 1 minute to provide the disclosure to the patient. Each provider will make approximately 106 disclosures. The total estimated annual for this requirement remains 125,433 hours at a cost of $10,536,400.

C. ICRs Regarding Appeals Process for Termination of Competitive Bidding Contract (§414.423)

Section 414.423(c)(1)(i) states that CMS has the option to allow a DMEPOS supplier to provide a written CAP to remedy the deficiencies identified in the notice, when CMS determines that the delay in the termination date caused by allowing a CAP will not cause harm to beneficiaries. As stated in §414.423(c)(2)(i) a CAP must be submitted within 30 calendar days from the date on the notification letter. If the supplier decides not to submit a CAP the supplier may within 30 days of the date on the termination letter request a hearing by a CBIC hearing officer.

The burden associated with this requirement is the time and effort necessary for a supplier that has received a termination notice to develop and submit a CAP. We estimate that 10 suppliers will need to comply with this requirement annually. Similarly, we estimate that it will take a supplier an average of 3 hours to develop a CAP. The total estimated annual burden associated with this requirement is 30 hours at a cost of $2,250.

Section 414.423(e)(2) requires that if CMS accepts the CAP, including supplier's designated timeframe for its completion, the supplier must provide a follow-up report

within 5 days after the supplier has fully implemented the CAP that verifies that all of the deficiencies identified in the CAP have been corrected in accordance with the timeframes accepted by CMS. The burden associated with this requirement is the time and effort necessary for a supplier to develop and submit a follow-up report. While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.3(h)(6). In accordance with 5 CFR 1320.3(h)(6), a request for facts or opinions addressed to a single person is not defined as information collection requirements and is therefore exempt from the PRA.

Section 414.423(f)(1) states that a supplier who has received a notice that CMS considers them in breach of contract or that their CAP is not acceptable has the right to request a hearing before a CBIC HO who was not involved with the original determination. Section 414.423(f)(2) further specifies that a supplier who wishes to appeal the termination notice must submit a written request to the CBIC. The request for a hearing must be received by the CBIC within 30 calendar days from the date of the notice to terminate.

The burden associated with this section is the time and effort necessary for a supplier to develop and submit a written request for a hearing by a CBIC Hearing Officer. We estimate that it will take a supplier 8 hours to develop and submit a request for a hearing. We believe 5 suppliers will be subject to this requirement on an annual basis. The total estimated annual burden associated with developing and submitting a written request for a hearing by a CBIC Hearing Officer is 40 hours at a cost of $3,000.

Section 414.423 requires a contract supplier whose contract has been terminated to notify all beneficiaries who are receiving rented competitive bid items or competitive

bid items received on a recurring basis, of the termination of their contract. The notice to the beneficiary from the supplier whose contract was terminated must be provided within 5 days of receipt of the notice of termination. The notification to the beneficiaries must inform the beneficiaries that they are going to have to select a new contract supplier for these items.

The burden associated with this section is the time and effort necessary for a supplier to develop and distribute notification of its termination to all beneficiaries receiving rented competitive bid items or competitive bid items received on a recurring basis. We estimate that it will take a supplier 3 hours to develop and distribute a notice announcing its termination to all of its beneficiaries receiving rented competitive bid items or competitive bid items received on a recurring basis. We believe 2 suppliers will be subject to this requirement on an annual basis. The total estimated annual burden associated with this requirement is 6 hours at a cost of $450.

D. ICRs Regarding Additional Provider and Supplier Requirements for Enrolling and Maintaining Active Enrollment Status in the Medicare Program (§424.516)

Section 424.516(e)(2) would require a provider or supplier to report a revocation or suspension to the applicable Medicare contractor within 30 days of any revocation or suspension of a Federal or State license or certification. Similarly, proposed §424.516(e)(2) states that within 30 days of a voluntary withdrawal or involuntary termination from the Medicare program, the provider or supplier must report a voluntary withdrawl or involuntary termination to the applicable Medicare contractor. The burden associated with the requirements in §424.516(e)(2) and (3) is the time and effort necessary for a provider or supplier to report the required information to the applicable

Medicare contractor. While these requirements are subject to the PRA, each submission will be evaluated on a case-by-case basis.

Table 100: Estimated Annual Recordkeeping and Reporting Burden

Regulation Section(s)	OMB Control No.	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting (in $)	Total Labor Cost of Reporting (in $)	Total Capital/Maintenance Costs (in $)	Total Cost (in $)
§411.355	0938-New	71,000	71,000	1	71,000	14.68	1,042,280	0	1,042,280
		71,000	7,454,760	0.0167	125,433	83.79	10,536,400*	0	10,536,400
§414.423	0938-New	10	10	3	30	75.00	2,250	0	2,250
		5	5	8	40	75.00	3000	0	3000
		2	2	3	6	75.00	450	0	450
Total		71,017	7,525,777		196,509				11,584,380

***** The annual cost burden for this provision was calculated by taking 106 disclosures per year per physician x $1.40 per disclosure = $148.40 a year per physician x 71,000 physicians = $10,536,400.

E. Additional Information Collection Requirements

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

1. Part B Drug Payment

The discussion of average sales price (ASP) issues in section VII.A.1 of this final rule with comment period does not contain any new information collection requirements with respect to payment for Medicare Part B drugs and biologicals under the ASP methodology. Drug manufacturers are required to submit ASP data to us on a quarterly basis. The ASP reporting requirements are set forth in section 1927(b) of the Act. The burden associated with this requirement is the time and effort required by manufacturers of Medicare Part B drugs and biologicals to calculate, record, and submit the required

data to CMS. While the burden associated with this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0921 with a June 31, 2012, expiration date.

2. The Physician Quality Reporting System (formerly the Physician Quality Reporting Initiative (PQRI))

Section VII.F.1. of this final rule with comment period discusses the background of the Physician Quality Reporting System, provides information about the measures and reporting mechanisms that will be available to eligible professionals and group practices who choose to participate in the 2011 Physician Quality Reporting System, and the criteria for satisfactory reporting in 2011.

With respect to satisfactory submission of data on quality measures by eligible professionals, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(c) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. Eligible professionals may choose whether to participate and, to the extent they satisfactorily submit data on quality measures for covered professional services, they can qualify to receive an incentive payment. To qualify to receive an incentive payment for 2011, the eligible professional (or group practice) must meet one of the criteria for satisfactory reporting described in section VII.F.1.e. or VII.F.1.f. of this final rule with comment period (or section VII.F.1.g. for group practices).

Because this is a voluntary program, it is difficult to accurately estimate how many eligible professionals will opt to participate in the Physician Quality Reporting System in CY 2011. Information from the "Physician Quality Reporting System 2007

Reporting Experience Report, "which is available on the Physician Quality Reporting System section of the CMS Web site at http://www.cms.hhs.gov/pqri, indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit Physician Quality Reporting System quality measures data via claims for the 2007 Physician Quality Reporting System. Therefore, for purposes of conducting a burden analysis for the 2011 Physician Quality Reporting System, we will assume that all eligible professionals who attempted to participate in the 2007 Physician Quality Reporting System will also attempt to participate in the 2011 Physician Quality Reporting System. Furthermore, we believe that the burden for eligible professionals who are participating in the Physician Quality Reporting System for the first time in 2011 will be considerably higher than the burden for eligible professionals who have participated in Physician Quality Reporting System in prior years.

For individual eligible professionals, the burden associated with the requirements of this reporting initiative is the time and effort associated with eligible professionals identifying applicable Physician Quality Reporting System quality measures for which they can report the necessary information, collecting the necessary information, and reporting the information needed to report the eligible professional's or group practice's measures. We believe it is difficult to accurately quantify the burden because eligible professionals may have different processes for integrating the Physician Quality Reporting System into their practice's work flows. Moreover, the time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them, and incorporate the use of quality data codes into the office work flows is expected to

vary along with the number of measures that are potentially applicable to a given professional's practice. Since eligible professionals are generally required to report on at least 3 measures to earn a Physician Quality Reporting System incentive, we will assume that each eligible professional who attempts to submit Physician Quality Reporting System quality measures data is attempting to earn a Physician Quality Reporting System incentive payment and reports on an average of 3 measures for this burden analysis.

Because we anticipate even greater participation in the 2011 Physician Quality Reporting System than in previous years, including participation by eligible professionals who are participating in the Physician Quality Reporting System for the first time in 2011, we will assign 5 hours as the amount of time needed for eligible professionals to review the 2011 Physician Quality Reporting System Measures List, review the various reporting options, select the most appropriate reporting option, identify the applicable measures or measures groups for which they can report the necessary information, review the measure specifications for the selected measures or measures groups, and incorporate reporting of the selected measures or measures groups into the office work flows. This estimate is based on our assumption that an eligible professional will need up to 2 hours to review the 2011 Physician Quality Reporting System Measures List, review the reporting options, and select a reporting option and measures on which to report and 3 hours to review the measure specifications for up to 3 selected measures or up to 1 selected measures group and to develop a mechanism for incorporating reporting of the selected measures or measures group into the office work flows.

Information from the PVRP, which was a predecessor to the Physician Quality Reporting System, indicated an average labor cost of $50 per hour. To account for salary

increases over time, we will use an average practice labor cost of $58 per hour in our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we estimate the cost for an eligible professional associated with preparing to report Physician Quality Reporting System quality measures would be approximately $290 per eligible professional ($58 per hour x 5 hours).

We continue to expect the ongoing costs associated with Physician Quality Reporting System participation to decline based on an eligible professional's familiarity with and understanding of the Physician Quality Reporting System, experience with participating in the Physician Quality Reporting System, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices.

We believe the burden associated with actually reporting the Physician Quality Reporting System quality measures will vary depending on the reporting mechanism selected by the eligible professional. For claims-based reporting, eligible professionals must gather the required information, select the appropriate QDCs, and include the appropriate QDCs on the claims they submit for payment. The Physician Quality Reporting System will collect QDCs as additional (optional) line items on the existing HIPAA transaction 837-P and/or CMS Form 1500 (OCN: 0938-0999). We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate changes to the 837-P or CMS Form 1500 for CY 2011.

Based on our experience with the PVRP, we continue to estimate that the time needed to perform all the steps necessary to report each measure (that is, reporting the relevant quality data code(s) for a measure) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/or measures, with the median time

being 1.75 minutes. At an average labor cost of $58 per hour per practice, the cost associated with this burden ranges from $0.24 in labor to about $11.60 in labor time for more complicated cases and/or measures, with the cost for the median practice being $1.69.

The total estimated annual burden for this requirement will also vary along with the volume of claims on which quality data is reported. In previous years, when we required reporting on 80 percent of eligible cases for claims-based reporting, we found that on average, the median number of reporting instances for each of the Physician Quality Reporting System measures was 9. Since we proposed to reduce the required reporting rate by over one-third to 50 percent, then for purposes of this burden analysis we will assume that an eligible professional will need to report each selected measure for 6 reporting instances. The actual number of cases on which an eligible professional would be required to report quality measures data will vary, however, with the eligible professional's patient population and the types of measures on which the eligible professional chooses to report (each measure's specifications includes a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual reporting burden per eligible professional associated with claims-based reporting to range from 4.5 minutes (0.25 minutes per measure X 3 measures X 6 cases per measure) to 180 minutes (12 minutes per measure X 3 measures X 6 cases per measure), with the burden to the median practice being 31.5 minutes (1.75 minutes per measure X 3 measures X 6 cases). We estimate the total annual reporting cost per eligible professional associated with claims-based reporting to range from $4.32 ($0.24 per measure X 3 measures X 6 cases

per measure) to $208.80 ($11.60 per measure X 3 measures X 6 cases per measure), with the cost to the median practice being $30.42 per eligible professional ($1.69 per measure X 3 measures X 6 cases per measure).

For registry-based reporting, there would be no additional time burden for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes and the registry would merely be re-packaging the data for use in the Physician Quality Reporting System. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2011 Physician Quality Reporting System. However, eligible professionals would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes per eligible professional.

Registries interested in submitting quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf in 2011 will need to complete a self-nomination process in order to be considered "qualified" to submit on behalf of eligible professionals unless the registry was qualified to submit on behalf of eligible professionals for prior years and did so successfully. We estimate that the self-nomination process for qualifying additional registries to submit on behalf of eligible professionals for the 2011 Physician Quality Reporting System involves approximately 1 hour per registry to draft the letter of intent for self-nomination. It is estimated that each self-nominated entity will also spend 2 hours for the interview with CMS officials and 2 hours calculating numerators, denominators, and measure results for

each measure the registry wishes to report using a CMS-provided measure flow. However, the time it takes to complete the measure flow could vary depending on the registry's experience and the number and type of measures for which the registry wishes to submit on behalf of eligible professionals. Additionally, part of the self-nomination process involves the completion of an XML submission by the registry, which is estimated to take approximately 5 hours, but may vary depending on the registry's experience. We estimate that the registry staff involved in the registry self-nomination process have an average labor cost of $50 per hour. Therefore, assuming the total burden hours per registry associated with the registry self-nomination process is 10 hours, we estimate the total cost to a registry associated with the registry self-nomination process to be approximately $500 ($50 per hour x 10 hours per registry).

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating quality measures results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measures results, and submit the measures results and numerator and denominator data on the quality measures on their participants' behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, we believe that registries already perform many of these activities for their participants. The number of measures that the registry intends to report to CMS and how

similar the registry's measures are to CMS' Physician Quality Reporting System measures will determine the time burden to the registry.

For EHR-based reporting, the eligible professional must have access to a CMS-specified identity management system, such as IACS, which we believe takes less than 1 hour to obtain. Once an eligible professional has an account for this CMS-specified identity management system, he or she must extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. With respect to our requirement for an eligible professional to submit a test file, we believe that doing so would take less than 1 hour. With respect to submitting the actual 2011 data file in 2012, we believe that this would take an eligible professional no more than 2 hours, depending on the number of patients on which the eligible professional is submitting. We believe that once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on Physician Quality Reporting System quality measures should be minimal. Because this manner of reporting quality data to CMS was new to the Physician Quality Reporting System for 2010 and no EHR data submissions have taken place yet, it is difficult to estimate how many eligible professionals will opt to participate in the Physician Quality Reporting System through the EHR mechanism in CY 2011.

An EHR vendor interested in having their product(s) be used by eligible professionals to submit Physician Quality Reporting System quality measures data to CMS was required to complete a self-nomination process in order for the vendor's product(s) to be considered "qualified" for 2011. It is difficult to accurately quantify the burden associated with the EHR self-nomination process as there is variation regarding

the technical capabilities and experience among vendors. For purposes of this burden analysis, however, we estimate that the time required for an EHR vendor to complete the self-nomination process will be similar to the time required for registries to self-nominate, that is approximately 10 hours at $50 per hour for a total of $500 per EHR vendor ($50 per hour x 10 hours per EHR vendor).

The burden associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2010 Physician Quality Reporting System quality measures will be dependent on the EHR vendor's familiarity with the Physician Quality Reporting System, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total burden hours to be 40 hours at a rate of $50 per hour for a total burden estimate of $2,000 ($50 per hour x 40 hours per vendor). However, given the variability in the capabilities of the vendors, those vendors with minimal experience would have a burden of approximately 200 hours at $50 per hour, for a total estimate of $10,000 per vendor ($50 per hour x 200 hours per EHR vendor).

With respect to the process for group practices to be treated as satisfactorily submitting quality measures data under the 2011 Physician Quality Reporting System discussed in section VII.F.1. of this final rule with comment, group practices interested in participating in the 2011 Physician Quality Reporting System through one of the group practice reporting options (GPRO I or GPRO II) will need to complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. Therefore, assuming 2 hours for a group practice to decide whether to participate as a

group or individually, approximately 2 hours per group practice to draft the letter of intent for self-nomination, gather the requested information, and provide this requested information, and an additional 2 hours undergoing the vetting process with CMS officials, we estimate a total of 6 hours associated with the self-nomination process. Assuming that the group practice staff involved in the group practice self-nomination process have the same average practice labor cost as the average practice labor cost estimates we used for individual eligible professionals of $58 per hour, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately $348 ($58 per hour x 6 hours per group practice).

The burden associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For practices participating under the GPRO I process, this would be the time associated with the physician group completing the data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938-0941, with an expiration date of December 31, 2011, for use in the Physician Group Practice, Medicare Care Management Performance (MCMP), and EHR demonstrations. Based on burden estimates for the PGP demonstration, which uses the same data submission methods, we estimate the burden associated with a physician group completing the data collection tool would be approximately 79 hours per physician group. Based on an average labor cost of $58 per physician group, we estimate the cost of data submission per physician group associated with participating in the Physician

Quality Reporting System GPRO I would be $4,582 ($58 per hour x 79 hours per group practice).

For group practices participating under the GPRO II process, the burden associated with submitting the Physician Quality Reporting System quality measures data would be the time associated with the group practice submitting the required data to CMS via claims or a registry. We would expect that data submission under GPRO II would take no more time than the time it would take an individual eligible professional to submit via claims or registry. We believe it would be appropriate to multiply the appropriate burden estimates for each reporting mechanism for individual eligible professionals by the number of eligible professionals in a group to obtain the burden estimates for data submission under GPRO II. For example, based on our estimate of 15.75 minutes per eligible professional under claims-based reporting, we would expect that a 2-person group would have a burden of 31.50 minutes for claims-based submission under GPRO II.

Eligible professionals who wish to qualify for the additional 0.5 percent incentive payment authorized under section 1848(m)(7) of the Act ("Additional Incentive Payments") for 2011 will need to more frequently than is required to qualify for or maintain board certification status participate in a qualified Maintenance of Certification Program for 2011 and successfully complete a qualified Maintenance of Certification Program practice assessment for 2011. We believe that a majority of the eligible professionals who would attempt to qualify for this additional 0.5 percent incentive payment would be those who are already enrolled and participating in a Maintenance of Certification Board. The amount of time that it would take for the eligible professional to

participate in the Maintenance of Certification Program more frequently than is required to qualify for or maintain board certification status would vary based on what each individual board determines constitutes "more frequently." The amount of time needed to complete a qualified Maintenance of Certification Program practice assessment is expected to be spread out over time since a quality improvement component is often required. Information from an informal poll of a few ABMS member boards indicates that the time an individual eligible professional spends to complete the practice assessment component of the Maintenance of Certification ranges from 8 to 12 hours.

We invited comments on this burden analysis, including the underlying assumptions used in developing our burden estimates and received no comments.

3. Electronic Prescribing (eRx) Incentive Program

We believe it is difficult to accurately estimate how many eligible professionals will opt to participate in the eRx Incentive Program in CY 2011. Information from the 2009 eRx Incentive Program indicates that nearly 90,000 eligible professionals participated in the first year of the program. We believe, however, that the number of participants will increase in light of the payment adjustment that will start in 2012. Therefore, for purposes of conducting a burden analysis for the 2011 eRx Incentive Program, we will assume that as many eligible professionals who attempted to participate in the 2007 Physician Quality Reporting System will attempt to participate in the 2011 eRx Incentive Program. As such, we can estimate that nearly 110,000 unique TIN/NPI combinations will participate in the 2011 eRx Incentive Program (see the "PQRI 2007 Reporting Experience Report," which is available on the Physician Quality Reporting System section of the CMS Web site at http://www.cms.hhs.gov/pqri).

Section VII.F.2 of this final rule with comment discusses the background of the eRx Incentive Program. Section VII.F.2.b.(2) of this final rule with comment provides information on how eligible professionals and group practices can qualify to be considered a successful electronic prescriber in 2011 in order to earn an incentive payment. For 2011, eligible professionals and group practices may choose whether to participate and, to the extent they meet-- (1) certain thresholds with respect to the volume of covered professional services furnished; and (2) the criteria to be considered a successful electronic prescriber described in section VII.F.2.b.(2) of this final rule with comment, they can qualify to receive an incentive payment for 2011 and/or avoid being subject to the payment adjustment that goes into effect in 2012.

For the 2011 eRx Incentive Program, as discussed in section VII.F.2. of this final rule with comment, each eligible professional will need to report the G-code indicating that at least one prescription generated during an encounter was electronically submitted at least 25 instances during the reporting period. We expect the ongoing costs associated with participation in the eRx Incentive Program to decline based on an eligible professional's familiarity with and understanding of the eRx Incentive Program, experience with participating in the eRx Incentive Program, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices.

Similar to the Physician Quality Reporting System, one factor in the burden to individual eligible professionals is the time and effort associated with individual eligible professionals reviewing the electronic prescribing measure to determine whether it is applicable to them, reviewing the available reporting options (for purposes of the 2011 incentive, this measure will be reportable through claims-based reporting, registry-based

reporting, or through EHRs) and selecting one, gathering the required information, and incorporating reporting of the measure into their office work flows. Since the eRx Incentive Program consists of only 1 measure to report, we estimate 2 hours as the amount of time needed for individual eligible professionals to prepare for participation in the eRx Incentive Program. At an average cost of approximately $58 per hour per practice, we estimate the total preparation costs to individual eligible professionals to be approximately $116 (2 hours X $58 per hour).

Another factor that influences the burden to eligible professionals is how they choose to report the electronic prescribing measure. For eligible professionals who choose to do so via claims, we estimate that the burden associated with the requirements of this incentive program is the time and effort associated with gathering the required information, selecting the appropriate quality data codes (QDCs), and including the appropriate QDCs on the claims they submit for payment. For claims-based reporting, the QDCs will be collected as additional (optional) line items on the existing HIPAA transaction 837-P and/or CMS Form 1500. We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate changes to the 837-P or CMS Form 1500 for CY 201.

Based on the information from the PVRP described above for the amount of time it takes a median practice to report one measure one time on claims (1.75 minutes) and our requirement that eligible professionals to report the measure 25 times for purposes of the incentive payment, we estimate the burden associated with claims-based data submission to be 43.75 minutes (1.75 minutes per case X 1 measure X 25 cases per measure). This equates to a cost of approximately $42.29 (1.75 minutes per case X 1

measure X 25 cases per measure X $58 per hour) per individual eligible professional. For purposes of the 2012 eRx payment adjustment, where an eligible professional is required to report the measure only 10 times, we estimate the burden associated with claims-based submission to be 17.5 minutes (1.75 minutes per case X 1 measure X 10 cases per measure). This equates to a cost of approximately $16.92 (1.75 minutes per case X 1 measure X 10 cases per measure X $58 per hour) per individual eligible professional.

Because registry-based reporting of the electronic prescribing measure to CMS was added to the eRx Incentive Program for 2010 and eligible professionals are not required to indicate to us how they plan to report the electronic prescribing measure each year, it is difficult to accurately estimate how many eligible professionals will opt to participate in the eRx Incentive Program through the registry-based reporting mechanism in CY 2011. We do not anticipate, however, any additional burden for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2011 eRx Incentive Program. However, eligible professionals would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

Based on our decision to consider only registries qualified to submit Physician Quality Reporting System quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2011 Physician Quality Reporting System to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2011 eRx Incentive Program, there would be no need for a registry to undergo a separate self-nomination process for the eRx Incentive Program and therefore, no additional burden associated with the registry self-nomination process.

There would also be a burden to the registry associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the electronic prescribing quality measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants behalf is expected to vary along with the number of eligible professionals reporting data to whom the measure applies. However, we believe that registries already perform many of these activities for their participants. Since the eRx Incentive Program consists of only one measure, we believe that the burden associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting, the eligible professional must extract the necessary clinical data from his or her EHR and submit the necessary data to the CMS-designated

clinical data warehouse. Because this manner of reporting quality data to CMS was first added to the eRx Incentive Program in 2010 and eligible professionals are not required to indicate to us how they intend to report the electronic prescribing measure, it is difficult to estimate how many eligible professionals will opt to participate in the eRx Incentive Program through the EHR-based reporting mechanism in CY 2011. We believe that once an eligible professional's EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on the electronic prescribing measure should be minimal.

Since we are considering only EHR products qualified for the 2010 Physician Quality Reporting System to be qualified for the 2011 eRx Incentive Program, there will be no need for EHR vendors to undergo a separate self-nomination process for the 2011 eRx Incentive Program and therefore, no additional burden associated with the self-nomination process.

There will also be a burden to the EHR vendor associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting the proposed 2011 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable eligible professionals to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2011 Physician Quality Reporting System will be qualified for the 2011 eRx Incentive Program and the

eRx Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable eligible professionals to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

Finally, with respect to the process for group practices to be treated as successful electronic prescribers under the 2011 eRx Incentive Program discussed in section VII.F.2. of this final rule with comment, group practices will have the same options as individual eligible professionals in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices would have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). There are only 2 differences between the requirements for an individual eligible professional and a group practice: (1) the fact that a group practice will have to self-nominate; and (2) the number of times that a group practice will be required to report the electronic prescribing measure.

We do not anticipate any additional burden associated with the group practice self-nomination practice since we are limiting the group practices to those selected to participate in the 2011 Physician Quality Reporting System GPRO I or Physician Quality Reporting System GPRO II. The practice only will need to indicate their desire to participate in the eRx GPRO at the same time they self-nominate for either Physician Quality Reporting System GPRO I or Physician Quality Reporting System GPRO II and indicate how they intend to report the electronic prescribing measure.

In terms of the burden to group practices associated with submission of the electronic prescribing measure, we believe that this would be similar to the burden to

individual eligible professionals for submitting the electronic prescribing measure. In fact, overall, there could be less burden associated with a practice participating as a group rather than as individual eligible professionals because the total number of reporting instances required by the group could be less than the total number of reporting instances that would be required if each member of the group separately reported the electronic prescribing measure. Thus, we believe that the burden to a group practice associated with reporting the electronic prescribing measure could range from almost no burden (for groups who choose to do so through a qualified EHR or registry) to 72.92 hours (1.75 minutes per measure x 1 measure x 2500 cases per measure) for a GPRO I group who chooses to report the electronic prescribing measures through claims submission. Consequently, the total estimated cost per group practice to report the electronic prescribing measure could be as high as $4,225 ($1.69 per measure x 1 measure x 2500 cases per measure).

As with individual eligible professionals, we believe that group practices that choose to participate in the 2011 eRx GPRO through registry-based reporting of the electronic prescribing measure would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2011 eRx Incentive Program beyond authorizing or instructing the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each group practice that wishes to authorize or instruct the registry to submit quality measures results

and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

For group practices that choose to participate in the 2011 eRx Incentive Program through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

We invited comments on this burden analysis, including the underlying assumptions used in developing our burden estimates and received none.

X. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XI. Regulatory Impact Analysis

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate, as discussed below in this section, that the PFS provisions included in this final rule with comment period will redistribute more than $100 million in 1 year. Therefore, we estimate that this rulemaking is "economically significant" as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that most hospitals and most other providers are small entities as that term is used in the RFA (including small businesses, nonprofit

organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $34.5 million in any 1 year) (for details see the SBA's Web site at http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf (refer to the 620000 series). Individuals and States are not included in the definition of a small entity. The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

For purposes of the RFA, physicians, NPPs, and suppliers including IDTFs are considered small businesses if they generate revenues of $10 million or less based on SBA size standards. Approximately 95 percent of physicians are considered to be small entities. There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS.

For purposes of the RFA approximately 85 percent of suppliers of DMEPOS are considered small businesses according to the SBA size standards. Our most recent claims information includes 47,000 entities billing Medicare for DMEPOS each year. Total annual estimated Medicare expenditures for DMEPOS suppliers are approximately $10.1 billion in CY 2009, for which $8.1 billion was fee-for-service (FFS) and $2 billion was

for managed care.

For purposes of the RFA, approximately 80 percent of clinical diagnostic laboratories are considered small businesses according to the SBA size standards.

Ambulance providers and suppliers for purposes of the RFA are also considered to be small entities.

In addition, most ESRD facilities are considered small entities for purposes of the RFA, either based on nonprofit status or by having revenues of $34.5 million or less in any year. We note that a considerable number of ESRD facilities are owned and operated by large dialysis organizations (LDOs) or regional chains, which would have total revenues more than $34.5 million in any year if revenues from all locations are combined. However, the claims data we use to estimate payments for this RFA and RIA does not identify which dialysis facilities are parts of an LDO, regional chain, or other type of ownership. Each individual dialysis facility has its own provider number and bills Medicare using this number. Therefore, we consider each ESRD facility to be a small entity for purposes of the RFA. We consider a substantial number of entities to be significantly affected if the final rule with comment period has an annual average impact on small entities of 3 to 5 percent or more. The majority of ESRD facilities will experience impacts of approximately 2 percent of total revenues. There are 976 nonprofit ESRD facilities with a combined increase of 2.1 percent in overall payments relative to current overall payments. We note that although the overall effect of the wage index changes is budget neutral, there are increases and decreases based on the location of individual facilities. The analysis and discussion provided in this section and elsewhere in this final rule with comment period complies with the RFA requirements.

Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this final rule with comment period constitutes our regulatory flexibility analysis for the remaining provisions and addresses comments received on these issues.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis, if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Any such regulatory impact analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We do not believe this final rule with comment period has impact on significant operations of a substantial number of small rural hospitals because most dialysis facilities are freestanding. While there are 180 rural hospital-based dialysis facilities, we do not know how many of them are based at hospitals with fewer than 100 beds. However, overall, the 180 rural hospital-based dialysis facilities will experience an estimated 2.1 percent increase in payments. As a result, this rule will not have a significant impact on small rural hospitals. Therefore, the Secretary has determined that this final rule with comment period will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2010, that threshold is approximately $135 million. This final rule with comment period will not mandate any requirements for State, local, or tribal

governments in the aggregate, or by the private sector, of $135 million. Medicare beneficiaries are considered to be part of the private sector and as a result a more detailed discussion is presented on the Impact of Beneficiaries in section XI.G. of this regulatory impact analysis.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have examined this final rule with comment period in accordance with Executive Order 13132 and have determined that this regulation would not have any substantial direct effect on State or local governments, preempt States, or otherwise have a Federalism implication.

We have prepared the following analysis, which together with the information provided in the rest of this preamble, meets all assessment requirements. The analysis explains the rationale for and purposes of this final rule with comment period; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we will use to minimize the burden on small entities. As indicated elsewhere in this rule, we are implementing a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections of this final rule with comment period. We are unaware of any relevant Federal rules that duplicate, overlap, or conflict with this final rule with comment period. The relevant sections of this rule contain a description of significant alternatives if applicable.

A. RVU Impacts

1. Resource-Based Work, PE, and Malpractice RVUs

Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve budget neutrality.

Our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2010 with final payment rates for CY 2011 using CY 2009 Medicare utilization for all years. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown in Table 101. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician furnishes. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the PFS. For instance, independent laboratories receive approximately 85 percent of their Medicare revenues from clinical laboratory services that are not paid under the PFS.

Table 101 shows only the payment impact on PFS services. We note that these impacts do not include the effect of the December 2010 and January 2011 conversion factor changes under current law. The following is an explanation of the information represented in Table 101:

- Column A (Specialty): The Medicare specialty code as reflected in our physician/supplier enrollment files.

- Column B (Allowed Charges): The aggregate estimated PFS allowed charges for the specialty based on CY 2009 utilization and CY 2010 rates. That is, allowed charges are the PFS amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services furnished by physicians, practitioners, and suppliers within a specialty to arrive at the total allowed charges for the specialty.

- Column C (Impact of Work and Malpractice (MP) RVU Changes): This column shows the estimated CY 2011 impact on total allowed charges of the changes in the work and malpractice RVUs, including the impact of changes due to new, revised, and potentially misvalued codes.

- Column D (Impact of PE RVU and Multiple Procedure Payment Reduction Changes - Full): This column shows the estimated CY 2011 impact on total allowed charges of the changes in the PE RVUs if there were no remaining transition to the full use of the new PPIS data. This column also includes the impact of the various MPPR and imaging equipment utilization polices, and the impact of changes due to new, revised, and potentially misvalued codes.

- Column E (Impact of PE RVU and Multiple Procedure Payment Reduction Changes - Tran): This column shows the estimated CY 2011 impact on total allowed charges of the changes in the PE RVUs under the second year of the 4-year transition to the full use of the new PPIS data. This column also includes the impact of the various

MPPR and imaging equipment utilization policies, and the impact of changes due to new, revised, and potentially misvalued codes.

- Column F (Impact of MEI Rebasing): This column shows the estimated CY 2011 impact on total allowed charges of the CY 2011 rescaling of the RVUs so that the proportions of total payments based on the work, PE, and malpractice RVUs match the proportions in the final revised and rebased MEI for CY 2011.

- Column G (Combined Impact - Full): This column shows the estimated CY 2011 combined impact on total allowed charges of all the changes in the previous columns if there were no remaining transition to the new PE RVUs using the PPIS data.

- Column H (Combined Impact - Tran): This column shows the estimated CY 2011 combined impact on total allowed charges of all the changes in the previous columns under the second year of the 4-year transition to the new PE RVUs using the PPIS data.

TABLE 101: CY 2011 PFS Final Rule Total Allowed Charge Estimated Impact for RVU, MPPR, and MEI Rebasing Changes*

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Specialty	**Allowed Charges (mil)**	**Impact of Work and MP RVU Changes**	**Impact of PE RVU and MPPR Changes**		**Impact of MEI Rebasing**	**Combined Impact**	
			Full	**Tran**		**Full**	**Tran**
TOTAL	$81,980	0%	0%	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$181	0%	0%	1%	4%	4%	5%
ANESTHESIOLOGY	$1,793	0%	4%	2%	-3%	2%	-1%
CARDIAC SURGERY	$382	0%	-1%	0%	0%	-1%	0%
CARDIOLOGY	$6,951	0%	-5%	-2%	1%	-5%	-2%
COLON AND RECTAL SURGERY	$138	0%	4%	2%	0%	5%	3%
CRITICAL CARE	$240	0%	3%	2%	-2%	1%	0%
DERMATOLOGY	$2,749	0%	2%	2%	3%	5%	4%
EMERGENCY MEDICINE	$2,600	0%	2%	1%	-3%	-2%	-3%
ENDOCRINOLOGY	$395	1%	4%	2%	0%	4%	2%
FAMILY PRACTICE	$5,512	0%	4%	2%	0%	4%	2%
GASTROENTEROLOGY	$1,800	0%	3%	1%	-1%	2%	1%

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Specialty	Allowed Charges (mil)	Impact of Work and MP RVU Changes	Impact of PE RVU and MPPR Changes		Impact of MEI Rebasing	Combined Impact	
			Full	Tran		Full	Tran
GENERAL PRACTICE	$728	0%	3%	1%	0%	3%	1%
GENERAL SURGERY	$2,286	0%	3%	1%	0%	3%	1%
GERIATRICS	$188	0%	5%	2%	-2%	4%	1%
HAND SURGERY	$103	0%	4%	2%	2%	6%	4%
HEMATOLOGY/ONCOLOGY	$1,912	0%	-4%	-2%	2%	-2%	0%
INFECTIOUS DISEASE	$584	0%	4%	2%	-2%	3%	0%
INTERNAL MEDICINE	$10,696	0%	3%	2%	-1%	3%	1%
INTERVENTIONAL PAIN MGMT	$390	-1%	3%	1%	1%	2%	0%
INTERVENTIONAL RADIOLOGY	$224	-2%	-8%	-4%	0%	-9%	-5%
MULTISPECIALTY CLINIC/OTHER	$46	0%	-7%	-5%	1%	-5%	-4%
NEPHROLOGY	$1,946	1%	1%	1%	-1%	1%	1%
NEUROLOGY	$1,457	0%	5%	2%	0%	5%	2%
NEUROSURGERY	$642	-2%	1%	0%	1%	0%	-1%
NUCLEAR MEDICINE	$59	0%	-7%	-4%	0%	-6%	-4%
OBSTETRICS/GYNECOLOGY	$670	0%	1%	1%	1%	2%	2%
OPHTHALMOLOGY	$5,287	-1%	4%	0%	1%	4%	0%
ORTHOPEDIC SURGERY	$3,432	0%	3%	1%	1%	4%	3%
OTOLARNGOLOGY	$941	0%	3%	2%	1%	5%	3%
PATHOLOGY	$1,069	-1%	-1%	0%	0%	-2%	-1%
PEDIATRICS	$68	0%	2%	1%	0%	2%	1%
PHYSICAL MEDICINE	$895	0%	4%	2%	-1%	4%	1%
PLASTIC SURGERY	$317	0%	4%	2%	1%	5%	3%
PSYCHIATRY	$1,149	1%	2%	1%	-3%	0%	-1%
PULMONARY DISEASE	$1,786	-1%	2%	1%	-1%	1%	-1%
RADIATION ONCOLOGY	$1,939	-2%	-9%	-3%	4%	-7%	-1%
RADIOLOGY	$5,052	-2%	-12%	-7%	-1%	-14%	-10%
RHEUMATOLOGY	$511	0%	1%	0%	2%	2%	2%
THORACIC SURGERY	$398	0%	-1%	0%	0%	-1%	0%
UROLOGY	$1,950	-1%	-6%	-3%	1%	-7%	-3%
VASCULAR SURGERY	$708	-1%	-3%	-2%	0%	-4%	-2%
AUDIOLOGIST	$54	0%	-6%	-1%	2%	-5%	0%
CHIROPRACTOR	$756	0%	4%	2%	-2%	2%	0%
CLINICAL PSYCHOLOGIST	$577	0%	-6%	-2%	-4%	-10%	-6%
CLINICAL SOCIAL WORKER	$390	0%	-5%	-2%	-4%	-9%	-5%
DIAGNOSTIC TESTING FACILITY	$909	0%	-27%	-16%	2%	-23%	-15%
INDEPENDENT LABORATORY	$1,039	-1%	-7%	-3%	5%	-4%	1%
NURSE ANES / ANES ASST	$726	0%	4%	2%	-4%	1%	-1%
NURSE PRACTITIONER	$1,212	0%	4%	2%	-1%	4%	1%
OPTOMETRY	$970	0%	4%	1%	1%	6%	2%

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Specialty	**Allowed Charges (mil)**	**Impact of Work and MP RVU Changes**	**Impact of PE RVU and MPPR Changes**		**Impact of MEI Rebasing**	**Combined Impact**	
			Full	**Tran**		**Full**	**Tran**
ORAL/MAXILLOFACIAL SURGERY	$40	0%	5%	3%	2%	7%	5%
PHYSICAL/OCCUPATIONAL THERAPY	$2,204	0%	0%	-3%	-2%	-1%	-5%
PHYSICIAN ASSISTANT	$893	0%	3%	2%	0%	3%	1%
PODIATRY	$1,801	0%	6%	3%	1%	7%	4%
PORTABLE X-RAY	$94	0%	2%	0%	6%	7%	6%
RADIATION THERAPY CENTERS	$71	0%	-13%	-5%	8%	-6%	3%
OTHER	$69	2%	3%	1%	0%	5%	3%

* Table 101 shows only the payment impact on PFS services. We note that these impacts do not include the effects of the December 2010 and January 2011 conversion factor changes under current law.

2. CY 2011 PFS Impact Discussion

a. Changes in RVUs

The most widespread specialty impacts of the RVU changes are generally related to several factors. First, as discussed in section II.A.2. of this final rule with comment period, we are currently implementing the second year of the 4-year transition to new PE RVUs using the new PPIS data that were adopted in the CY 2010 PFS final rule with comment period (74 FR 61751). The impacts of using the new PPIS data are generally consistent with the impacts discussed in the CY 2010 PFS final rule with comment period (74 FR 61983 through 61984).

The second general factor contributing to the CY 2011 impacts shown in Table 101 is the CY 2011 rescaling of the RVUs so that in the aggregate they match the work, PE, and malpractice proportions in the revised and rebased MEI for CY 2011. That is, as discussed in section II.E.5. of this final rule with comment period, the revised and rebased MEI has a greater proportion attributable to malpractice and PE and, correspondingly, a lesser proportion attributable to work. Specialties that have a high

proportion of total RVUs attributable to work, such as anesthesiology, are estimated to experience a decrease in aggregate payments as a result of this rescaling, while specialties that have a high proportion attributable to PE, such as radiation oncology, are estimated to experience an increase in aggregate payments. Malpractice generally represents a small proportion of total payments and the rescaling of the malpractice RVUs is not the primary driver of the specialty impacts. As discussed in section II.E.7. of this final rule with comment period, the rescaling of the RVUs to match the rebased MEI is budget neutral overall.

Finally, another significant factor contributing to the impacts shown in Table 101 (but on a specialty-specific rather than widespread level) is the final policies regarding new, revised, and potentially revised codes resulting from our CY 2011 acceptance of 70 percent of the AMA RUC work RVU recommendations and the majority of the direct PE input recommendations. We have incorporated alternative RVUs and direct PE inputs for some codes in accordance with our recommended policies. We note that some specialties, such as radiation oncology, ophthalmology, and IDTFs that commonly furnish potentially misvalued codes that have been examined by the AMA RUC and newly valued for CY 2011, experience decreases in aggregate payment as a result of these changes.

Table 101 also includes the impacts resulting from our regulatory change to expand the current 50 percent MPPR policy to therapy services, but at an MPPR rate of 25 percent on the PE component payment for therapy services. Under the PFS, we estimate that this change would primarily reduce payments to the specialties of physical therapy and occupational therapy. In order to maintain budget neutrality, we

redistributed the PFS savings back into other services paid under the PFS by increasing all PE RVUs by approximately 0.5 percent.

Because providers in settings outside of the PFS, such as outpatient hospital departments, are also paid using the PFS payment rates and policies for physical therapy services, we estimated that this will reduce (not redistribute) payments in those settings for therapy services by approximately 7 percent in CY 2011.

In addition, Table 101 includes the impacts resulting from the regulatory change to the scope of the current contiguous body area MPPR policy for imaging services from contiguous body areas to include noncontiguous body areas. We estimate that this change would primarily reduce payments to the specialties of IDTF and radiology. In order to maintain budget neutrality, we redistributed these savings back into other services paid under the PFS by increasing all PE RVUs by approximately 0.1 percent.

Table 101 also reflects the impacts resulting from certain ACA provisions, including reductions in payment under section 3135 of the ACA which amends section 1848(b)(4) of the Act to increase the equipment utilization rate assumption for expensive diagnostic imaging equipment, and, effective July 1, 2010, to increase the level of the MPPR for contiguous body areas from 25 percent to 50 percent. The expansion of the MPPR policy is further discussed in section II.C.4. of this final rule with comment period, while the discussions of the provisions of section 3135 of the ACA are found in sections VI.M. and II.A.3.a. of this final rule with comment period. As required by sections 1848(c)(2)(B)(v)(V) and (VI) of the Act (as added by sections 3135(a) and (b) of the ACA), these changes are not budget neutral and result in program savings.

We note that in section XI.D of this final rule with comment period, we provide discussions of the budget impacts of individual ACA provisions not elsewhere discussed in this section. Additionally, while column H in Table 101 illustrates the estimated combined CY 2011 impact on total allowed charges by specialty of all the final RVU and MPPR changes and the MEI rebasing, including several ACA provisions that directly affect the determination of PFS payments as discussed previously, we note that other ACA provisions discussed in section XI.D. of this final rule with comment period could also result in additional impacts on individual practitioners or specialties, depending on their practice patterns. Since the effects of a number of the ACA provisions are dependent on the practice patterns of practitioners, we would expect these impacts to be non-uniform among specialties. For example, as discussed further in section XI.D.19 of this final rule with comment period, section 1833(x) of the Act (as added by section 5501(a) of the ACA) provides for a 10 percent incentive payment for primary care services furnished by primary care practitioners. Accordingly, potentially eligible primary care specialties designated under the statute (including family practice and geriatric medicine), are expected to experience an estimated aggregate increase in payment of between 4 and 9 percent, which includes the estimated impacts under the PFS displayed in column H of Table 101 and the new primary care incentive payments. We note that in general the payment impact for an individual physician may be different from the average, based on the mix of services the physician furnishes and his or her eligibility for the primary care incentive payment program.

b. Combined Impact

Column H of Table 101 displays the estimated CY 2011 combined impact on total allowed charges by specialty of all the final RVU and MPPR changes. These impacts range from an increase of 6 percent for portable x-ray suppliers to a decrease of 15 percent for diagnostic testing facilities. There is generally a slightly positive net effect of our final policies on primary care specialties, such as family practice, internal medicine, and geriatrics. Again, these impacts are estimated prior to the application of the negative CY 2011 CF update applicable under the current statute.

Comment: One commenter requested that the specialty impact table incorporate the impact of payment changes for other Medicare Part B services that are not paid under the PFS.

Response: The purpose of Table 101 is to isolate the impacts by specialty for services paid under the PFS. To the extent that changes in payment for other Part B services are adopted in this final rule with comment period and have significant impacts upon providers, those impacts are discussed elsewhere in this section.

Table 102 shows the estimated impact on total payments for selected high-volume procedures of all of the changes discussed previously, including the effect of the CY 2011 negative PFS CF update. We selected these procedures because they are the most commonly furnished by a broad spectrum of physician specialties. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility PE, we refer readers to Addendum A of this final rule with comment period.

TABLE 102: Impact of Final Rule With Comment Period and Estimated Physician Update on CY 2011 Payment for Selected Procedures

CPT/ HCPCS Code	MOD	Short Descriptor	Facility			Nonfacility		
			CY 2010[1]	CY 2011[2]	Percent Change	CY 2010[1]	CY 2011[2]	Percent Change
11721		Debride nail, 6 or more	$20.72	$19.40	-7%	$31.23	$31.39	1%
17000		Destruct premalg lesion	$40.88	$41.60	2%	$57.91	$59.72	3%
27130		Total hip arthroplasty	$1,084.09	$1,083.40	0%	NA	NA	NA
27244		Treat thigh fracture	$918.31	$921.08	0%	NA	NA	NA
27447		Total knee arthroplasty	$1,159.32	$1,157.92	0%	NA	NA	NA
33533		CABG, arterial, single	$1,536.01	$1,491.74	-3%	NA	NA	NA
35301		Rechanneling of artery	$869.49	$848.34	-2%	NA	NA	NA
43239		Upper GI endoscopy, biopsy	$133.42	$131.44	-2%	$256.05	$260.07	2%
66821		After cataract laser surgery	$216.59	$223.57	3%	$228.80	$236.84	3%
66984		Cataract surg w/iol, 1 stage	$549.57	$558.41	2%	NA	NA	NA
67210		Treatment of retinal lesion	$479.17	$487.21	2%	$494.21	$503.29	2%
71010		Chest x-ray	NA	NA	NA	$18.17	$17.87	-2%
71010	26	Chest x-ray	$7.10	$6.64	-7%	$7.10	$6.64	-7%
77056		Mammogram, both breasts	NA	NA	NA	$82.61	$83.46	1%
77056	26	Mammogram, both breasts	$34.63	$32.67	-6%	$34.63	$32.67	-6%
77057		Mammogram, screening	NA	NA	NA	$61.60	$61.25	-1%
77057	26	Mammogram, screening	$27.82	$26.29	-6%	$27.82	$26.29	-6%
77427		Radiation tx management, x5	$153.00	$120.97	-26%	$153.00	$120.97	-26%
88305	26	Tissue exam by pathologist	$28.67	$27.31	-5%	$28.67	$27.31	-5%
90801		Psy dx interview	$100.21	$92.64	-8%	$120.93	$115.61	-5%
90862		Medication management	$35.77	$33.69	-6%	$44.28	$43.39	-2%
90935		Hemodialysis, one evaluation	$53.08	$56.15	5%	NA	NA	NA

CPT/ HCPCS Code	MOD	Short Descriptor	Facility			Nonfacility		
			CY 2010[1]	CY 2011[2]	Percent Change	CY 2010[1]	CY 2011[2]	Percent Change
92012		Eye exam established pat	$38.32	$38.28	0%	$58.48	$60.23	3%
92014		Eye exam & treatment	$58.48	$58.19	0%	$85.44	$87.28	2%
92980		Insert intracoronary stent	$689.80	$656.42	-5%	NA	NA	NA
93000		Electrocardiogram, complete	NA	NA	NA	$15.61	$15.06	-4%
93010		Electrocardiogram report	$7.10	$6.64	-7%	$7.10	$6.64	-7%
93015		Cardiovascular stress test	NA	$69.67	NA	$72.67	$69.67	-4%
93307	26	Echo exam of heart	$38.32	$35.73	-7%	$38.32	$35.73	-7%
93458	26	Left heart artery/ventricle angiography[3]	NA[4]	$240.41	NA	NA	$240.41	NA
98941		Chiropractic manipulation	$24.13	$23.22	-4%	$27.25	$26.80	-2%
99203		Office/outpatient visit, new	$57.34	$56.15	-2%	$76.93	$77.59	1%
99213		Office/outpatient visit, est	$38.04	$37.26	-2%	$51.38	$51.81	1%
99214		Office/outpatient visit, est	$58.48	$56.91	-3%	$76.93	$77.08	0%
99222		Initial hospital care	$101.62	$99.28	-2%	NA	NA	NA
99223		Initial hospital care	$149.60	$145.73	-3%	NA	NA	NA
99231		Subsequent hospital care	$29.81	$28.84	-3%	NA	NA	NA
99232		Subsequent hospital care	$53.93	$52.32	-3%	NA	NA	NA
99233		Subsequent hospital care	$77.50	$75.03	-3%	NA	NA	NA
99236		Observ/hosp same date	$166.06	$160.79	-3%	NA	NA	NA
99239		Hospital discharge day	$77.78	$76.31	-2%	NA	NA	NA
99283		Emergency dept visit	$48.26	$45.94	-5%	NA	NA	NA
99284		Emergency dept visit	$91.41	$86.77	-5%	NA	NA	NA
99291		Critical care, first hour	$170.04	$163.34	-4%	$203.25	$198.81	-2%
99292		Critical care, addl 30 min	$85.16	$81.92	-4%	$91.97	$89.33	-3%
99348		Home visit, est patient	NA	NA	NA	$63.59	$61.76	-3%
99350		Home visit, est patient	NA	NA	NA	$130.58	$127.61	-2%

CPT/ HCPCS Code	MOD	Short Descriptor	Facility			Nonfacility		
			CY 2010[1]	CY 2011[2]	Percent Change	CY 2010[1]	CY 2011[2]	Percent Change
G0008		Admin influenza virus vac	NA	NA	NA	$16.75	$17.35	3%

[1] Payments based upon corrected CY 2010 conversion factor of $28.3868 under the statute as of October 30, 2009 that would be in effect on December 31, 2010 under current law.
[2]Payments based upon the CY 2011 conversion factor of $25.5217.
[3]New code for CY 2011. No CY 2010 payment rate is provided as the code did not exist in CY 2010. Prior coding has been completely revised for this service.

B. Geographic Practice Cost Indices (GPCIs)

As discussed in section II.D. of this final rule with comment period, we are required to update the GPCI values at least every 3 years and phase in the adjustment over 2 years (if there has not been an adjustment in the past year). For CY 2011, we are finalizing new GPCIs for each Medicare locality. The updated GPCIs reflect the first year of the 2-year phase-in. The new GPCIs rely upon the 2010 HUD data for determining the relative cost differences in the office rent component of the PE GPCIs, as well as the 2006 through 2007 professional malpractice premium data for determining the malpractice GPCIs. The 2006 through 2008 Bureau of Labor and Statistics (BLS) Occupational Employment Statistics (OES) data were used as a replacement for 2000 Census data for determining the physician work GPCIs and the employee compensation component of the PE GPCIs. However, as discussed in section II.D. of this final rule with comment period, we are continuing to use the current cost share weights for determining the PE GPCI values and locality GAFs.

Additionally, the updated GPCIs reflect several provisions required by changes included in the ACA. Section 1848(e)(1)(H) of the Act (as added by section 3102(b) of the ACA) specifies that for CYs 2010 and 2011, the employee wage and rent portions of the PE GPCIs reflect only one-half of the relative cost differences for each locality compared to the national average and includes a "hold harmless" provision for any PFS locality that would receive a reduction to its PE GPCI resulting from the limited recognition of cost differences. Section 1848(e)(1)(E) of the Act (as amended by section 3102(a) of the ACA) extends the 1.000 work GPCI floor only through December 31, 2010. Therefore, the CY 2011 GPCIs reflect the sunset of the 1.000 work GPCI floor.

Section 1848(e)(1)(G) of the Act (as amended by section 134(b) of the MIPPA) established a permanent 1.500 work GPCI floor in Alaska, beginning January 1, 2009 and, therefore, the 1.500 work GPCI floor in Alaska will remain in place for CY 2011. Moreover, section 1848(e)(1)(I) of the Act (as added by section 10324(c) of the ACA) establishes a 1.000 PE GPCI floor for services furnished in frontier states effective January 1, 2011. We estimate the combined impact of these provisions on a fiscal year cash basis to be $580 million for FY 2011.

As required by the statute, the updated GPCIs would be phased in over a 2-year period. Addendum D to this final rule with comment period shows the estimated effects of the revised GPCIs on locality GAFs for the transitional year (CY 2011) by State and Medicare locality. The GAFs reflect the use of updated underlying GPCI data and the ACA provisions. The GAFs are a weighted composite of each area's work, PE, and malpractice GPCIs using the national GPCI cost share weights. While we do not actually use the GAFs in computing the PFS payment for a specific service, they are useful in comparing the estimated overall costs and payments for different localities. The actual effect on payment for any specific service would deviate from the estimated payment based on the GAF to the extent that the proportions of work, PE, and malpractice expense RVUs for the specific service differ from those of the GAF. The most significant changes would occur in 12 payment localities, where the GAF increases or decreases by more than 2 percent. The cumulative effects of all of the GPCI revisions, including the updated underlying GPCI data and provisions of the ACA, are reflected in the CY 2012 GPCI values that are displayed in Addendum E to this final rule with comment period.

C. Rebasing and Revising of the MEI

As discussed in section II.E.5. of this final rule with comment period, we finalized the rebasing and revision of the MEI for the CY 2011 PFS. Using the new 2006 MEI weights in place of the 2000 weights and implementing the revisions to the MEI results in a slightly higher projected MEI increase for CY 2011 than would have been the case without the rebasing and revision of the MEI. The MEI update for CY 2011 is 0.4 percent under the 2006-based MEI, while the MEI update for CY 2011 would have been 0.3 percent under the 2000-based MEI. After CY 2011, the 2006-based MEI updates are forecasted to be either the same or slightly lower (0.1 to 0.2 percentage point) than the forecasted 2000-based MEI updates.

D. The Affordable Care Act Provisions

1. Section 3002: Improvements to the Physician Quality Reporting System

For the impact of this provision see section XI.E.6. of this final rule with comment period.

2. Sections 3003 and 3007: Improvements to the Physician Feedback Program and Value-Based Payment Under the Physician Fee Schedule

As discussed in section VI.B. of this final rule with comment period, these provisions: (1) continue the confidential feedback program and requires the Secretary, beginning in 2012, to provide reports that compare patterns of resource use of individual physicians to other physicians; and (2) require the Secretary to apply a separate, budget-neutral, value-based payment modifier to the payment calculation for PFS services furnished by certain practitioners beginning in CY 2015. There is no budgetary impact associated with these provisions for CY 2011.

3. Section 3102: Extension of the Work Geographic Index Floor and Revisions to the Practice Expense Geographic Adjustment under the Medicare Physician Fee Schedule, and Protections for Frontier States as amended by Section 10324

For the impact of this provision see section XI.B. of this final rule with comment period.

4. Section 3103: Extension of Exceptions Process for Medicare Therapy Caps

This provision extends the exceptions process for therapy caps through December 31, 2010. Therapy caps are discussed in detail in section III.A.1. of this final rule with comment period. We estimate the impact on a fiscal year cash basis to be $1.16 billion for FY 2011.

5. Section 3104: Extension of Payment for Technical Component of Certain Physician Pathology Services

As discussed in section VI.E. of this final rule with comment period, this provision continues payment to independent laboratories for the TC of physician pathology services for fee-for-service Medicare beneficiaries who are inpatients or outpatients of a covered hospital through CY 2010. We estimate the impact on a fiscal year cash basis to be $80 million for FY 2011.

6. Sections 3105 and 10311: Extension of Ambulance Add-Ons

As discussed in section VI.F. of this final rule with comment period, these provisions require the extension of certain add-on payments for ground ambulance services, and the extension of certain rural area designations for purposes of air ambulance payment. As further discussed in section VI.F. of this final rule with comment period, we are amending the Medicare program regulations to conform the

regulations to these provisions of the ACA. These statutory provisions are essentially prescriptive and do not allow for discretionary alternatives on the part of the Secretary.

As discussed in the July 1, 2004 interim final rule (69 FR 40288), in determining the super-rural bonus amount under section 1834(l)(12) of Act, we followed the statutory guidance of using the data from the Comptroller General (GAO) of the U.S. We obtained the same data as the data that were used in the GAO's September 2003 Report titled "Ambulance Services: Medicare Payments Can Be Better Targeted to Trips in Less Densely Populated Rural Areas" (GAO report number GAO-03-986) and used the same general methodology in a regression analysis as was used in that report. The result was that the average cost per trip in the lowest quartile of rural county populations was 22.6 percent higher than the average cost per trip in the highest quartile. As required by section 1834(l)(12) of the Act, this percent increase is applied to the base rate for ground ambulance transports that originate in qualified rural areas, which were identified using the methodology set forth in the statute. Payments for ambulance services under Medicare are determined by the point of pick-up (by zip code area) where the beneficiary is loaded on board the ambulance. We determined that ground ambulance transports originating in 7,842 zip code areas (which were determined to be in "qualified rural areas") out of 42,879 zip code areas, according to the July 2010 zip code file, will realize increased base rate payments under this provision. However, the number and level of services that might occur in these areas for CY 2011 is unknown at this time. While many elements may factor into the final impact of sections 3105(a) through (c) and 10311(a) through (c) of the ACA, we estimate the impact of all these provisions to be $10 million for FY 2011.

7. Section 3107: Extension of Physician Fee Schedule Mental Health Add-On

As discussed in section VI.G. of this final rule with comment period, this provision extends application of the five percent increase in Medicare payment for specified mental health services only through CY 2010. We estimate the impact on a fiscal year cash basis to be $20 million for FY 2011.

8. Section 3108: Permitting Physician Assistants to Order Post-Hospital Extended Care Services

As discussed in section VI.H of this final rule with comment period, this provision adds PAs to the list of practitioners (that is, physicians, nurse practitioners (NPs), and clinical nurse specialists) that can perform the required initial certification and periodic recertifications under section 1814(a)(2)(B) of the Act with respect to the SNF level of care. There is no budgetary impact associated with this provision.

9. Section 3111: Payment for Bone Density Tests

As discussed in section VI.I. of this final rule with comment period, this provision requires payment for dual-energy x-ray absorptiometry (DXA) services furnished during CYs 2010 and 2011 at 70 percent of the Medicare rate paid in CY 2006, with the applicable geographic adjustment for CY 2011. We estimate the impact on a fiscal year cash basis to be $60 million for FY 2011.

10. Section 3114: Improved Access for Certified Nurse-Midwife Services

As discussed in section VI.J. of this final rule with comment period, this provision increased the amount of Medicare payment made under the PFS for certified nurse-midwife (CNM) services. There is no significant budgetary impact associated with this provision.

11. Section 3122: Extension of Medicare Reasonable Costs Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas

As discussed in section VI.K. of this final rule with comment period, this provision reinstitutes reasonable cost payment for clinical diagnostic laboratory tests performed by hospitals with fewer than 50 beds that are located in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010 through June 30, 2011. For some hospitals with cost reports that begin as late as June 30, 2011, this reinstitution of reasonable cost payment could affect services performed as late as June 29, 2012, because this is the date those cost reports will close.

12. Section 3134: Misvalued Codes Under the PFS

As discussed in section II.C. of this final rule with comment period, section 1848 (c) (2)(K) of the Act (as added by section 3134 of the ACA) requires the Secretary to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of those services identified as being potentially misvalued. The impacts of our CY 2011 policy changes under this provision are included in the discussion of RVU impacts in section XI.A. of this final rule and summarized by specialty in Table Q1 of this final rule with comment period.

13. Section 3135: Modification of Equipment Utilization Factor For Advanced Imaging Services

As discussed in section VI.M. of this final rule with comment period, for services furnished on or after July 1, 2010, section 1848(b)(4)(D) of the Act (as added by section 3135(b) of the ACA) adjusts the technical component MPPR for multiple imaging studies

provided in a single imaging session on contiguous body parts within families of codes from 25 percent to 50 percent as of July 1, 2010. For services furnished on or after January 1, 2011, section 1848(b)(4)(C) of the Act (as added by section 3135(a) of the ACA) increases the equipment utilization rate to 75 percent for expensive diagnostic imaging equipment, changing the CY 2011 utilization rate adopted in the CY 2010 PFS final rule with comment period to the 75 percent rate. We estimate the impact on a fiscal year cash basis to be savings to the Medicare program of $160 million for FY 2011.

14. Section 3136: Revisions in Payments for Power Wheelchairs

As discussed in section VI.N. of this final rule with comment period, this provision requires the Secretary to revise the capped rental fee schedule amounts for all power wheelchairs effective for power wheelchairs furnished on or after January 1, 2011. Under the monthly capped rental payment structure, the fee schedule will pay 15 percent (instead of 10 percent) of the purchase price for the first 3 months and 6 percent (instead of 7.5 percent) for the remaining rental months not to exceed 13 months. In addition, the lump sum (up front) purchase payment will be eliminated for standard power-driven wheelchairs. For complex rehabilitative power-driven wheelchairs, the provision permits payment to be made on a lump sum purchase method or a monthly rental method. These changes are prescriptive in the statute and do not allow for alternatives.

We expect the changes mandated by section 3136 of the ACA as a whole to achieve program savings as a result of total payments per standard power wheelchair being less than 100 percent of the purchase fee schedule amount. This decrease in expenditures is expected for two reasons. Primarily, the provision will eliminate the lump sum payment method for standard power-driven wheelchairs and instead payment

will be made under the monthly rental method resulting in lower aggregate payments because many beneficiaries who use standard power wheelchairs do not use them for as long as 13 months. In addition, we note that currently a significantly lower volume of power-driven wheelchairs are paid under the monthly payment method. The payment impact of increasing monthly rental payments in the initial 3 months will be offset both by the savings achieved from eliminating the lump sum payment method for standard power-driven wheelchairs and by decreasing payments for the remaining months of rental from 7.5 percent to 6 percent of the purchase price for all power-driven wheelchairs. We compared the estimates of current payments for power-driven wheelchairs to estimates of payments resulting from the changes required by section 3136 of the ACA which showed an estimated payment impact of a decrease in expenditures of approximately $780 million over a 5-year period. The FY 2011 cash savings was $120 million.

15. Section 3139: Payment for Biosimilar Biological Products

In Section VI.O. of this rule we discussed the provisions of the ACA that establish the definition of biosimilar, and reference biological product as well as the payment methodology for these products under Section 1847A of the Act. We noted that while these provisions are effective July 1, 2010, per statute, we do not expect to make payment for biosimilar products until after such products are approved by the FDA. We do not expect this provision to have any impact on spending.

16. Section 3401: Revisions of Certain Market Basket Updates and Incorporation of Productivity Adjustments

As discussed in section VI.P. of this final rule with comment period, section 3401 of the ACA amends section 1881(b)(14)(F) of the Act so that in CY 2011, there is a full

ESRD market basket update to the composite rate component of the blended payment amount under the new ESRD PPS. This provision is estimated to be a cost to the Medicare program of $40 million (does not include coinsurance).

Section 3401 of the ACA also incorporates a productivity adjustment into the update factors for certain payment systems. Specifically, section 3401 requires that in CY 2011 (and in subsequent years), update factors under the ASC payment system, the AFS, the CLFS, and the DMEPOS fee schedules be adjusted by the productivity adjustment. We estimate the impact to be savings to the Medicare program of $20 million, $30 million, $50 million, and $60 million for the ASC payment system, the AFS, the CLFS, and the DMEPOS fee schedules respectively, for FY 2011.

17. Section 4103: Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan

As discussed in section VI.Q. of this final rule with comment period, for services furnished on or after January 1, 2011, section 1861(s)(2)(FF) of the Act (as added by section 4103 of the ACA) provides Medicare coverage, with no coinsurance or deductible, for an annual wellness visit. The annual wellness visit entails the creation of a personalized prevention plan for an individual that ultimately will include a health risk assessment and also includes other elements, such as updating the family history, identifying providers that regularly provide medical care to the individual, body mass index measurement, development of a screening service schedule, and identification of risk factors. We estimate the impact on a fiscal year cash basis to be $110 million for FY 2011.

18. Section 4104: Removal of Barriers to Preventive Services in Medicare

As discussed in section VI.R. of this final rule with comment period, for services furnished on or after January 1, 2011, sections 1833(a)(1) and 1833(b)of the Act (as amended by section 4104 of the ACA) waive the deductible and coinsurance requirements for most preventive services, and waive the deductible for colorectal cancer screening tests that are reported with other codes. Services to which no coinsurance or deductible would be applied are the annual wellness visit, the initial preventive physical examination, and any covered preventive service if it is recommended with a grade of A or B by the United States Preventive Services Task Force. We estimate that this new benefit will result in an increase in Medicare payments. We estimate the impact on a fiscal year cash basis to be $110 million for FY 2011.

19. Section 5501: Expanding Access to Primary Care Services and General Surgery Services

As discussed in section VI.S. of this final rule with comment period, for services furnished on or after January 1, 2011 and before January 1, 2016, sections 1833(x) and (y) of the Act (as added by section 5501 of the ACA) provides for a 10 percent incentive payment applied to primary care services furnished by primary care practitioners, as well as a 10 percent incentive payment for major surgical procedures furnished by general surgeons practicing in geographic health professional shortage areas. Under the final CY 2011 policies, we estimate the impact on a fiscal year cash basis to be $240 million for section 1833(x) of the Act and $10 million for section 1833(y) of the Act for FY 2011.

20. Section 6003: Disclosure Requirements for In-office Ancillary Services Exception to the Prohibition of Physician Self-referral for Certain Imaging Services

In section VI.T of this final rule with comment period, we discuss our revisions to §411.355(b)(2) to include a new disclosure requirement created by section 6003 of the ACA and related to the in-office ancillary services exception to the physician self-referral prohibition. We are finalizing this provision with some modification, including reducing the number of required suppliers on the disclosure from 10 to 5 and removing the requirement that a record of the signed disclosure notification be maintained as a part of the patient's medical record. Physicians are now able to document the disclosure without the patient's signature.

Comment: Two commenters disagreed with the estimated impact in the proposed rule related to section 6003 of the ACA. The commenter noted that requiring physicians to list 10 suppliers is excessive and places an unnecessary administrative burden on the referring physicians. The commenters also expressed concern that it will take longer to create and maintain the disclosure notice than we proposed. The commenters did not provide alternative values for calculating the impact of this provision.

Response: We have addressed the commenters' concerns regarding the administrative burden related to this new disclosure requirement in the final rule by reducing the number of suppliers that must be listed from 10 to 5. In addition, we have removed the requirement that the disclosure notice be signed by the patient and a copy of this maintained in the medical record. We believe that our previous economic estimates are appropriate taking into account the public comments received in response to the estimated values included in the proposed rule and the changes that have been finalized in this rule.

We believe that the provisions in section VI.T. of this final rule with comment

period will have a minor economic impact on the affected physicians who self-refer for advanced imaging services under the in-office ancillary services exception. We did not receive any public comments addressing the estimated number of physicians impacted by this provision. The burden associated for these physicians remains de minimis as we have reduced the number of suppliers to be listed and have reduced the requirements for effective disclosure by eliminating the patient signature maintained as part of the medical record. We still believe physicians will incur a one-time cost associated with developing the disclosure notice.

21. Section 6404: Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months

As discussed in section VI.U. of this final rule with comment period, section 6404 of the ACA reduces the maximum time period for filing Medicare claims to no more than 12 months after the date of service. Under the new law, claims for services furnished on or after January 1, 2010, must be filed within 1 calendar year after the date of service. In addition, section 6404 of the ACA provides that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010. Section 6404 of the ACA also permits the Secretary to make certain exceptions to the 1-year filing deadline. This final rule with comment period would create three new exceptions to the 1-year filing deadline.

The budgetary impact related to this provision is significant as future payment of claims for services incurred will now be made at an earlier date, relative to the 12-month submission expiration. This is reflected by the Part A and Part B payment amounts of $60 and $50 million for FY 2011. However, for purposes of the RIA, the economic

impact of this provision is non-economically significant, as to the interest lost on money now required to pay claims prior to the 12-month submission expiration is minimal.

Providers and suppliers have established billing practices for the submission of claims for payment to the Medicare program. Although this final rule with comment period would require providers and suppliers to submit Medicare FFS claims within 12 months from the date of service, we believe providers and suppliers would easily revise their billing practices on a one-time basis, and suffer no economic impact. In fact, analysis of Medicare claims data shows that more than 99 percent of Part A and Part B claims are filed in 12 months or less. Lastly, providers, suppliers, or the small number of beneficiaries that occasionally submit claims may benefit from the availability of the three new exceptions to the timely filing rule. However, we believe the impact on program costs would be negligible.

We did not receive any comments on the RIA for this provision.

22. Section 6410 of Patient Accountability and Affordable Care Act and Section 154 of MIPPA: Adjustments to the Metropolitan Statistical Areas (MSA) for Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Acquisition Program

For the impact of this provision see section XI.E.7.c. of this final rule with comment period.

23. Section 10501(i)(3): Collection of HCPCS Data for the Development and Implementation of a Prospective Payment System for the Medicare FQHC Program

As discussed in section VI.W. of this final rule with comment period, section 10501(i)(3) of the ACA establishes a process by which we will collect claims level data,

using HCPCS codes, from FQHCs. This data will be used to determine the time, scope, and intensity of services provided by FQHCs in anticipation of the establishment of a prospective payment system to be implemented beginning in 2014. We further noted that the proposed new data collection effort would be for informational and data gathering purposes only, and would not be utilized to determine Medicare payment to the FQHC. Because this provision does not affect payment to FQHCs, there is no impact.

E. Other Provisions of the Final Rule

1. Part B Drug Payment: ASP Issues

Application of our policies for "Carry Over ASP" and "Partial Quarter ASP Data," as discussed in section VII.A. of this final rule with comment period, are dependent on the status and quality of quarterly manufacturer data submissions, so we cannot quantify associated savings.

Furthermore, we do not expect that our policy for determining the payment amount for drugs and biologicals that include intentional overfill, as discussed in section VII.A of this final rule with comment period, will impact payments made by the Medicare program.

Finally, as discussed in section VII.A of this final rule with comment period, we are not finalizing our price substitution policy at this time and as a result there is no impact to the program as no changes to policy are being made.

2. Ambulance Fee Schedule: Policy for Reporting Units when Billing for Ambulance Fractional Mileage

As discussed in section VII.B. of this final rule with comment period, we are implementing fractional mileage billing for all providers and suppliers of ambulance

services. Effective for dates of service on and after January 1, 2011, ambulance providers and suppliers (except for providers eligible to bill on the Form UB-04) will be required to report mileage rounded up to the nearest tenth of a mile, rather than the nearest whole mile, on all claims for mileage totaling up to 100 covered miles, and we will pay based on that amount. Implementation of the fractional mileage billing policy will be delayed until August 1, 2011 for ambulance providers submitting claims on the Form UB-04, unless updates to allow billing fractional units on the Form UB-04 are not completed by July 2011. In that case, implementation of the fractional mileage billing policy is delayed for ambulance providers eligible to bill on the Form UB-04 until January 1, 2012.

By requiring that providers and suppliers round up to the nearest tenth of a mile rather than the nearest whole mile, providers and suppliers will be submitting claims for anywhere between 0.1 and 0.9 of a mile less per claim and Medicare will pay based on that amount. In our analysis (using 2008 claim data) for the proposed rule, we indicated that Medicare could potentially save at least $45 million per year in payments for base mileage billed by suppliers, and perhaps as much as $80 million per year when considering other types of ambulance mileage payments such as those for rural mileage and those made to institutional providers. Further analysis has revealed that, once adjusted for other factors such as premium offsets and MA savings, the potential annual savings totals approximately $30 million for supplier-billed base mileage alone. We continue to anticipate that the total savings will likely increase when considering other ambulance mileage payments such as for rural mileage, institutional provider payments, etc. However, we were not able to further analyze the potential additional savings using

available data. Although implementation of the fractional mileage billing policy for institutional providers billing on paper claims is delayed in the final rule with comment period, the volume of institutional paper billers is insignificant – less than 1 percent of all institutional billers submits claims on the Form UB-04 – and therefore, will not significantly impact any potential savings.

3. Chiropractic Services Demonstration

As discussed in section VII.D. of this final rule with comment period, we are continuing the recoupment of the $50 million in expenditures from this demonstration in order to satisfy the budget neutrality requirement in section 651(f)(1)(b) of the MMA. We initiated this recoupment in CY 2010 and this will be the second year. As discussed in the CY 2010 PFS final rule with comment period, we finalized a policy to recoup $10 million each year through adjustments to the PFS for all chiropractors in CYs 2010 through 2014. To implement this required budget neutrality adjustment, we are recouping $10 million in CY 2011 by reducing the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942) by approximately 2 percent.

4. Renal Dialysis Services Furnished by ESRD Facilities

The ESRD related provisions are discussed in sections VI.P.1. and VII.E. of this final rule with comment period. To understand the impact of the changes affecting payments to different categories of ESRD facilities, it is necessary to compare estimated payments under the current year (CY 2010 payments) to estimated payments under the revisions to the composite rate payment system (CY 2011 payments) as discussed in section VII.E. of this final rule with comment period. To estimate the impact among

various classes of ESRD facilities, it is imperative that the estimates of current payments and estimates of proposed payments contain similar inputs. Therefore, we simulated payments only for those ESRD facilities for which we are able to calculate both current CY 2010 payments and proposed CY 2011 payments.

Also, as explained in the ESRD PPS final rule (74 FR 49162 through 49164), section 1881(b)(14)(E)(i) of the Act requires a 4-year transition (phase-in) from the current composite payment system to the ESRD PPS, and section 1881(b)(14)(E)(ii) allows ESRD facilities to make a one-time election to be excluded from the transition. As of January 1, 2011, ESRD facilities that elect to go through the transition would be paid a blended amount that will consist of 75 percent of the basic case-mix adjusted composite payment system and the remaining 25 percent would be based on the ESRD PPS payment. Therefore, these final rates listed in the impact table (Table Q3) reflect only the composite rate portion of the blended payment amounts for facilities going through the first year of the 4-year transition under the new ESRD PPS.

ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from the Healthcare Cost Report Information System (HCRIS). We also used the June 2010 update of CY 2009 National Claims History file as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. Since the December 2009 update of the CY 2009 National Claims History File is incomplete, we updated the data. The description of the updates for the separately billable drugs is described in section VII.E. of this final rule with comment period. To update the treatment counts we used the ratio of the June 2009 to the December 2008

updates of the CY 2008 National Claims History File figure for treatments. This was an increase of 12.4 percent. Due to data limitations, we are unable to estimate current and proposed payments for 32 of the 5431 ESRD facilities that bill for ESRD dialysis treatments.

Table 103 shows the impact of this year's changes to CY 2011 payments to hospital-based and independent ESRD facilities. The first column of Table 103 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments. The fourth column shows the effect of all changes to the ESRD wage index for CY 2011 as it affects the composite rate payments to ESRD facilities. The fourth column compares aggregate ESRD wage-adjusted composite rate payments in CY 2011 to aggregate ESRD wage-adjusted composite rate payments in CY 2010. In CY 2010, ESRD facilities receive 100 percent of the CBSA wage-adjusted composite rate. The overall effect to all ESRD providers in aggregate is zero because the CY 2011 ESRD wage index has been multiplied by a budget neutrality adjustment factor to comply with the statutory requirement that any wage index revisions be done in a manner that results in the same aggregate amount of expenditures as would have been made without any changes in the wage index. The fifth column shows the effect of changes to the ESRD wage index in CY 2011 and the effect of section 3401(h) of the ACA, which amends section 1881(b)(14)(F) of the Act to revise the ESRD market basket increase factor. Effective January 1, 2011, there is a full ESRD bundled market basket update to the composite rate component of the blended payment amount under the payment system. We apply a ESRD market basket increase factor of 2.5 percent for those facilities electing to go

through the ESRD PPS transition. The sixth column shows the overall effect of the changes in composite rate payments to ESRD providers, including the drug add-on. The overall effect is measured as the difference between the CY 2011 payment with all changes in this rule and current CY 2010 payment. This payment amount is computed by multiplying the wage-adjusted composite rate with the drug add-on for each provider times the number of dialysis treatments from the CY 2009 claims. The CY 2011 payment is the composite rate for each provider (with the 14.7 percent drug add-on) times dialysis treatments from CY 2009 claims. The CY 2010 current payment is the composite rate for each provider (with the current 15.0 percent drug add-on) times dialysis treatments from CY 2009 claims.

The overall impact to ESRD providers in aggregate is 2.2 percent as shown in Table 103. Most ESRD facilities will see an increase in payments as a result of the ACA provision. While section 3401(h) of the ACA modifies the ESRD bundled market basket, which we will be a 2.5 percent increase to the ESRD composite rate portion of the blended payment amount, this 2.5 percent increase does not apply to the drug add-on to the composite rate. For this reason, the impact of all changes in this final rule with comment period is a 2.2 percent increase for all ESRD providers. Overall, payments to ineligible professional independent ESRD facilities will increase by 2.2 percent and payments to hospital-based ESRD facilities will increase by 2.1 percent.

TABLE 103: Impact of CY 2011 Changes in Payments to Hospital-Based and Independent ESRD Facilities

[Percent change in composite rate payments to ESRD facilities]

1	2	3	4	5	6
	Number of facilities	**Number of Dialysis Treatments (in millions)**	**Effect of Changes in Wage Index [1/]**	**Effect of Changes in Wage Index and of Affordable Care Act provision/[2]**	**Overall Effect of Wage Index Affordable Care Act & Drug Add-on [3]/**
All Providers	5,399	38.6	0.0%	2.5%	2.2%
Independent	4,821	34.9	0.0%	2.5%	2.2%
Hospital Based	578	3.7	-0.1%	2.4%	2.1%
By Facility Size					
Less than 5000 treatments	2105	5.9	0.1%	2.5%	2.3%
5000 to 9999 treatments	2,049	14.8	0.1%	2.6%	2.3%
Greater than 9999 treatments	1,245	17.9	-0.1%	2.4%	2.2%
Type of Ownership					
Profit	4,423	31.8	0.0%	2.5%	2.3%
Nonprofit	976	6.7	-0.1%	2.4%	2.1%
By Geographic Location					
Rural	1,178	6.2	0.1%	2.6%	2.4%
Urban	4,221	32.4	0.0%	2.5%	2.2%
By Region					
New England	165	1.3	-0.6%	1.8%	1.6%
Middle Atlantic	603	4.8	-0.4%	2.1%	1.8%
East North Central	885	6.0	0.2%	2.7%	2.4%
West North Central	403	2.1	-0.1%	2.4%	2.2%
South Atlantic	1,211	8.8	0.0%	2.5%	2.2%
East South Central	422	2.9	0.2%	2.7%	2.4%
West South Central	729	5.6	0.4%	2.9%	2.6%
Mountain	323	1.8	0.2%	2.7%	2.4%
Pacific	619	5.0	0.1%	2.6%	2.4%
Puerto Rico & Virgin Islands	39	0.4	-2.4%	0.0%	-0.2%

Notes: Payments have been adjusted to reflect budget neutrality.
2010 includes the MIPPA 1% increase and site neutral rates.
2010 & 2011 are 100 percent new CBSA wage adjusted composite rate.

[1] This column shows the overall effect of wage index changes on ESRD providers. Composite rate payments are computed using the final CY 2011 wage indexes which are compared to composite rate payments using the current CY 2010 wage indexes.

[2] This column shows the effect of the changes in the Wage Indexes and the ACA provision which includes an ESRD Bundled Market Basket (2.5 percent) increase to the composite rate. This provision is effective January 1, 2011.

[3] This column shows the percent change between CY 2011 and CY 2010 composite rate payments to ESRD facilities. The CY 2011 payments include the CY 2011 wage adjusted composite rate, a 2.5% increase due to the ACA, effective January 1, 2011, and the drug add-on of 14.7%. The CY 2010 payments include the CY 2010 wage adjusted composite rate, a 1% increase and site neutral rates effective January 1, 2009 and the drug add-on of 15.0%. This column shows the effect of wage index, ACA, and drug add-on changes. While the ACA provision includes a 2.5% increase to the composite rate, this increase does not apply to the drug add-on to the composite rate. For this reason, the impact of all changes in this final rule with comment period is a 2.2% increase for all ESRD providers.

5. Section 131(b) of the MIPPA: Physician Payment, Efficiency, and Quality

Improvements - Physician Quality Reporting System

As discussed in section VII.F.1 of this final rule with comment period, we are finalizing several different reporting options for eligible professionals who wish to participate in the 2011 Physician Quality Reporting System. Although there may be some cost incurred in the Physician Quality Reporting System and their associated code sets, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and EHR-based reporting for the Physician Quality Reporting System, we do not anticipate a significant cost impact on the Medicare program.

Participation in the CY 2011 Physician Quality Reporting System by individual eligible professionals is voluntary and individual eligible professionals and group practices may have different processes for integrating the Physician Quality Reporting System into their practice's work flows. Given this variability and the multiple reporting options that we provide, it is difficult to accurately estimate the impact of the Physician Quality Reporting System on providers. Furthermore, we believe that costs for eligible professionals who are participating in the Physician Quality Reporting System for the first time in 2011 will be considerably higher than the cost for eligible professionals who participated in Physician Quality Reporting System in prior years. In addition, for many eligible professionals, the cost of participating in the Physician Quality Reporting System is offset by the incentive payment received.

With respect to the potential incentive payment that will be made for the 2011 Physician Quality Reporting System, we estimate this amount to be approximately $100 million. This estimate is derived from looking at our 2008 incentive payment of more than $95 million and then accounting for the fact that the 2008 incentive payment was 1.5

percent of an eligible professional's total estimated Medicare Part B PFS allowed charges for all covered professional services furnished during the 2008 reporting period. For 2011, the incentive payment is 1.0 percent of an eligible professional's total estimated Medicare Part B PFS allowed charges for all covered professional services furnished during the 2011 reporting period. Although we expect that the lower incentive payment amount for 2011 would reduce the total outlay by approximately one-third, we also expect more eligible professionals to participate in the 2011 Physician Quality Reporting System as there are more methods of data submission and additional alternative reporting periods and that some eligible professionals would qualify for the additional 0.5 percent incentive authorized under section 1848(m)(7) of the Act ("Additional Incentive Payment").

One factor that influences the cost to individual eligible professionals is the time and effort associated with individual eligible professionals identifying applicable Physician Quality Reporting System quality measures and reviewing and selecting a reporting option. This burden will vary with each individual eligible professional by the number of applicable measures, the eligible professional's familiarity, and understanding of the Physician Quality Reporting System I, experience with Physician Quality Reporting System participation, and the method(s) selected by the eligible professional for reporting of the measures, and incorporating the reporting of the measures into the office work flows. Information obtained from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the Physician Quality Reporting System and was the first step for the reporting of physician quality of care through certain quality metrics, indicated an average labor cost per practice of approximately $50 per hour. To

account for salary increases over time, we will use an average practice labor cost of $58 per hour for our estimates, based on an assumption of an average annual increase of approximately 3 percent. Therefore, assuming that it takes an individual eligible professional approximately 5 hours to review the PQRI quality measures, review the various reporting options, select the most appropriate reporting option, identify the applicable measures for which they can report the necessary information, and incorporate reporting of the selected measures into their office work flows, we estimate that the cost to eligible professionals associated with preparing to report Physician Quality Reporting System quality measures would be approximately $290 per individual eligible professional ($58 per hour x 5 hours).

Another factor that influences the cost to individual eligible professionals is how they choose to report the Physician Quality Reporting System measures (that is, whether they select the claims-based, registry-based or EHR-based reporting mechanism). For claims-based reporting, estimates from the PVRP indicate the time needed to perform all the steps necessary to report quality data codes (QDCs) for 1 measure on a claim ranges from 15 seconds (0.25 minutes) to 12 minutes for complicated cases or measures. In previous years, when we required reporting on 80 percent of eligible cases for claims-based reporting, we found that on average, the median number of reporting instances for each of the PQRI measures was 9. Since we reduced the required reporting rate by over one-third to 50 percent, then for purposes of this impact analysis we will assume that an eligible professional will need to report each selected measure for 6 reporting instances, or 6 cases. Assuming that an eligible professional, on average, will report 3 measures and that an eligible professional reports on an average of 6 reporting instances per

measure, we estimate that the cost to an individual eligible professional associated with claims-based reporting of Physician Quality Reporting System measures would range from approximately $4.35 (0.25 minutes per reporting instance x 6 reporting instances per measure x 3 measures x $58 per hour) to $208.80 (12 minutes per reporting instance x 6 reporting instances per measure x 3 measures x $58 per hour). If an eligible professional satisfactorily reports, these costs will more than likely be negated by the incentive earned. For the 2007 PQRI, which had a 1.5 percent incentive for a 6-month reporting period, the mean incentive amount was close to $700 for an individual eligible professional and the median incentive payment amount was over $300.

For registry-based reporting, individual eligible professionals must generally incur a cost to submit data to registries. Estimated fees for using a qualified registry range from no charge, or a nominal charge, for an individual eligible professional to use a registry to several thousand dollars, with a majority of registries charging fees ranging from $500 to$1,000. However, our impact analysis is limited to the incremental costs associated with Physician Quality Reporting System reporting, which we believe are minimal. Many eligible professionals who select registry-based reporting were already utilizing the registry for other purposes and would not need to report additional data to the registry specifically for Physician Quality Reporting System. The registries also often provide the eligible professional services above and beyond what is required for Physician Quality Reporting System.

For EHR-based reporting, an individual eligible professional generally will incur a cost associated with purchasing an EHR product. Although we do not believe that the majority of eligible professionals would purchase an EHR solely for the purpose of

participating in Physician Quality Reporting System, cost estimates for EHR adoption by eligible professionals from the EHR Incentive Program final rule (75 FR 44549) show that an individual eligible professional who chooses to do so would have to spend anywhere from $25,000 to $54,000 to purchase and implement an EHR and up to $18,000 annually for ongoing maintenance.

Although we believe that the majority of eligible professionals attempting to qualify for the additional 0.5 percent incentive payment authorized by section 1848(m)(7) of the Act would be those who are already required by their Boards to participate in a Maintenance of Certification Program, individual eligible professionals who wish to qualify for the additional 0.5 percent incentive payment and are not currently participating in a Maintenance of Certification Program would also have to incur a cost for participating in a Maintenance of Certification Program. The manner in which fees are charged for participating in a Maintenance of Certification Program vary by specialty. Some Boards charge a single fee for participation in the full cycle of Maintenance of Certification Program. Such fees appear to range anywhere from over $1,100 to nearly $1,800 per cycle. Some Boards have annual fees that are paid by their diplomates. On average, ABMS diplomates pay approximately $200.00 per year for participating in Maintenance of Certification Program. Some Boards have an additional fee for the Maintenance of Certification Program Part III secure examination, but most Boards do not have additional charges for participation in the Part IV practice/quality improvement activities.

With respect to the process for group practices to be treated as satisfactorily submitting quality measures data for the CY 2011 Physician Quality Reporting System

discussed in section VII.F.1 of this final rule with comment period, group practices interested in participating in the CY 2011 Physician Quality Reporting System through the group practice reporting option (GPRO) I or GPRO II may also incur a cost. However, for groups that satisfactorily report for 2011 Physician Quality Reporting System, we believe these costs would be completely offset by the incentive payment earned since the group practice would be eligible for an incentive payment equal to 1 percent of the entire group's total estimated Medicare Part B PFS allowed charges for covered professional services furnished during the reporting period.

One factor in the cost to group practices would be the costs associated with the self-nomination process. Similar to our estimates for staff involved with the claims-based reporting option for individual eligible professionals, we also estimate that the group practice staff involved in the group practice self-nomination process has an average labor cost of $58 per hour. Therefore, assuming 2 hours for a group practice to decide whether to participate individually or as a group and 4 hours for the self-nomination process, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately $348 ($58 per hour x 6 hours per group practice).

For groups participating under the GPRO I process, another factor in the cost to the group would be the time and effort associated with the group practice completing and submitting the proposed data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938-0941, with an expiration date of December 31, 2011. Based on the Physician Group Practice (PGP) demonstration's estimate that it takes

approximately 79 hours for a group practice to complete the data collection tool, which uses the same data submission methods as those we have finalized, we estimate the cost associated with a physician group completing the data collection tool would be approximately $4,582 ($58 per hour x 79 hours per group practice).

For group practices participating under the GPRO II process, the costs associated with submitting the Physician Quality Reporting System quality measures data will be the time associated with the group practice submitting the required data to CMS via claims or, if applicable, a registry. The costs for a group practice reporting to a registry is similar to the costs associated with registry reporting for an individual eligible professional, as the process is the same with the exception that more patients and more measures must be reported in GPRO II compared to an individual eligible professional. For similar reasons, the costs for a group practice reporting via claims should also be similar to the costs associated with claims-based reporting for an individual eligible professional. Overall, there is significantly less burden associated with a group practice participating in Physician Quality Reporting System via GPRO II than doing so as individual eligible professionals. Participation in GPRO II requires the group practice as a whole to report a fewer number of measures on a fewer number of people since eligible professionals within a group who share patients will not be required to separately report measures for those shared patients. Therefore, assuming that an average group practice will spend 20 hours for data submission, we estimate the cost of data submission under GPRO II would be approximately $1,160 (20 hours for data submission x $58 per hour). Smaller groups may need less time for data submission as they would be required to report fewer measures and presumably have a smaller patient population while larger

groups may need more time for data submission since they would be required to report more measures and presumably have a larger patient population.

In addition to costs incurred by eligible professionals and group practices, registries and EHR vendors may also incur some costs related to the Physician Quality Reporting System. Registries interested in becoming "qualified" to submit on behalf of individual eligible professionals would also have to incur a cost associated with the vetting process and with calculating quality measures results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. We estimate the registry self-nomination process will cost approximately $500 per registry ($50 per hour x 10 hours per registry). This cost estimate includes the cost of submitting the self-nomination letter to CMS and completing the CMS vetting process. Our estimate of $50 per hour average labor cost for registries is based on the assumption that registry staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer. Because we are finalizing new requirements for 2011, the 2010 qualified registries will incur similar costs associated with the self-nomination process. We do not believe that there are any additional costs for registries associated with a registry calculating quality measures results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. We believe that the majority of registries already perform these functions for their participants.

An EHR vendor interested in having its product(s) be used by individual eligible professionals to submit Physician Quality Reporting System measures to CMS for 2012 will have to complete a vetting process during 2011 and program its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2012 quality measures in 2013 as well. We specified that previously qualified vendors will need to only update their electronic measure specifications and data transmission schema during 2011 to incorporate any new EHR measures to maintain their qualification for the 2012 Physician Quality Reporting System. Therefore, for EHR vendors that were not previously qualified, the cost associated with completing the self-nomination process, including the vetting process with CMS officials, is estimated to be $500 ($50 per hour x 10 hours per EHR vendor). Our estimate of a $50 per hour average labor cost for EHR vendors is based on the assumption that vendor staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer. We believe that the cost associated with the time and effort needed for an EHR vendor to review the quality measures and other information and program the EHR product to enable individual eligible professionals to submit Physician Quality Reporting System quality measures data to the CMS-designated clinical warehouse will be dependent on the EHR vendor's familiarity with the Physician Quality Reporting System, the vendor's system's capabilities, as well as the vendor's programming capabilities. Some vendors already have the necessary capabilities and for such vendors, we estimate the total cost to be approximately $2,000 ($50 per hour x 40 hours per vendor). However, given the variability in the capabilities of the vendors, we

believe an estimate for those vendors with minimal experience would be approximately $10,000 per vendor ($50 per hour x 200 hours per EHR vendor).

6. Section 132 of the MIPPA: Incentives for Electronic Prescribing (eRx)- The eRx Incentive Program

Section VII.F.2. of this final rule with comment period describes the 2011 Electronic Prescribing (eRx) Incentive Program. To be considered a successful electronic prescriber in CY 2011, an individual eligible professional will need to meet the requirements described in section VII.F.2. of this final rule with comment period.

We estimate that the cost impact of the eRx Incentive Program on the Medicare program would be the cost incurred for maintaining the electronic prescribing measure and its associated code set, and for maintaining the existing clinical data warehouse to accommodate registry-based reporting and EHR-based reporting for the electronic prescribing measure. However, we do not believe that this provision has a significant cost impact on the Medicare program since much of this infrastructure has already been established for the Physician Quality Reporting System program.

Individual eligible professionals and group practices may have different processes for integrating the eRx Incentive Program into their practices' work flows. Given this variability and the multiple reporting options that we provide, it is difficult to accurately estimate the impact of the eRx Incentive Program on providers. Furthermore, we believe that costs for eligible professionals who are participating in the eRx Incentive Program for the first time in 2011 will be considerably higher than the cost for eligible professionals who participated in the eRx Incentive Program in prior years. In addition, for many eligible professionals (especially those who participated in the eRx Incentive

Program in prior years), the cost of participating in the eRx Incentive Program for 2011 will be offset by the incentive payment received. As a result of the payment adjustment that begins in 2012, the cost of not participating in the eRx Incentive Program for 2011 could be higher than the cost of participating in the form of reduced Medicare payments.

For the 2009 eRx Incentive Program, approximately $148 million in total incentives were paid to eligible professionals with a median incentive amount of about $1600. We estimate that the total incentive payments for the 2011 eRx Incentive Program (which will be paid in 2012) will be similar. We anticipate that despite a decrease in the incentive payment amount from 2 percent in 2010 to 1 percent of total estimated Medicare Part B allowed charges for covered professional services in 2011, more eligible professionals (and groups) will choose to participate in the 2011 eRx Incentive Program to avoid a prospective 1 percent payment penalty in 2012 for not demonstrating that they are successful electronic prescribers. Any eligible professional who wishes to participate in the eRx Incentive Program must have a qualified electronic prescribing system in order to participate. Therefore, a one-time potential cost to some individual eligible professionals would be the cost of purchasing and using an eRx system, which varies by the commercial software package selected, the level at which the professional currently employs information technology in his or her practice and the training needed. One study indicated that a midrange complete electronic medical record with electronic prescribing functionality costs $2,500 per license with an annual fee of $90 per license for quarterly updates of the drug database after setup costs while standalone prescribing, messaging, and problem list system may cost $1,200 per physician per year after setup costs. Hardware costs and setup fees substantially add to

the final cost of any software package. (Corley, S.T. (2003). "Electronic prescribing: a review of costs and benefits." Topics in Health Information Management 24(1):29-38.). These are the estimates that we intend to use for our impact analysis.

Similar to the Physician Quality Reporting System, one factor in the cost to individual eligible professionals is the time and effort associated with individual eligible professionals reviewing the electronic prescribing measure to determine whether it is applicable to them, reviewing the available reporting options and selecting one, gathering the required information, and incorporating reporting of the measure into their office work flows. Since the eRx Incentive Program consists of only 1 quality measure, we estimate 2 hours as the amount of time needed for individual eligible professionals to prepare for participation in the eRx Incentive Program. Information obtained from the PVRP, which was a predecessor to the Physician Quality Reporting System and was the first step for the reporting of physician quality of care through certain quality metrics, indicated an average labor cost per practice of approximately $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $58 per hour for our estimates, based on an assumption of an average annual increase of approximately 3 percent. At an average cost of approximately $58 per hour, we estimate the total preparation costs to individual eligible professionals to be approximately $116 ($58 per hour x 2 hours).

Another factor that influences the cost to individual eligible professionals is how they choose to report the electronic prescribing measure (that is, whether they select the claims-based, registry-based or EHR-based reporting mechanism). For claims-based reporting, there would be a cost associated with reporting the appropriate QDC on the

claims an individual eligible professional submits for payment. Based on the information from the PVRP described above for the amount of time it takes a median practice to report one measure one time (1.75 minutes) and the requirement to report 25 electronic prescribing events during 2011, we estimate the annual estimated cost per individual eligible professional to report the electronic prescribing measure via claims-submission to be $42.29 (1.75 minutes per case x1 measure x 25 cases per measure x $58 per hour). We believe that for most successful electronic prescribers who earn an incentive, these costs would be negated by the incentive payment received given that the median incentive for eligible professionals who qualified for a 2009 eRx incentive was around $1600.

For eligible professionals who select the registry-based reporting mechanism, we do not anticipate any additional cost for individual eligible professionals to report data to a registry, as individual eligible professionals opting for registry-based reporting are more than likely already reporting data to the registry. Little if any, additional data would need to be reported to the registry for purposes of participation in the CY 2011 eRx Incentive Program. Individual eligible professionals using registries for Physician Quality Reporting System will likely experience minimal, if any, increased costs charged by the registry to report this 1 additional measure.

For EHR-based reporting, the eligible professional must extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Once the EHR is programmed by the vendor to allow data submission to CMS, the cost to the individual eligible professional associated with the time and effort to submit data on the electronic prescribing measure should be minimal.

With respect to the process for group practices to be treated as successful electronic prescribers under the CY 2011 eRx Incentive Program discussed in section VII.F.2 of this final rule with comment period, group practices have the same option as individual eligible professionals in terms of the form and manner for reporting the eRx measure (that is, group practices have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). There are only 2 differences between the requirements for an individual eligible professional and a group practice: (1) the fact that a group practice would have to self-nominate; and (2) the number of times a group practice would be required to report the eRx measure. Overall, there could be less cost associated with a practice participating in the eRx Incentive Program as a group rather than the individual members of the group separately participating. We do not believe that there are any additional costs associated with the group practice self-nomination process since we are limiting the group practices to those selected to participate in the 2011 Physician Quality Reporting System GPRO I or Physician Quality Reporting System GPRO II. The practices only will need to indicate their desire to participate in the eRx GPRO at the time they self-nominate for either Physician Quality Reporting System GPRO I or Physician Quality Reporting System GPRO II.

The costs for a group practice reporting to an EHR or registry should be similar to the costs associated with registry and EHR reporting for an individual eligible professional, as the process is the same with the exception that more electronic prescribing events must be reported by the group. For similar reasons, the costs for a group practice reporting via claims should also be similar to the costs associated with claims-based reporting for an individual eligible professional. Therefore, we estimate

that the costs for group practices who are selected to participate in the CY 2011 eRx Incentive Program as a group would range from $126.88 (1.75 minutes per case x 1 measure x 75 cases per measure x $58 per hour) for the smallest groups participating under GPRO II to $4,229.17 (1.75 minutes per case x 2500 cases per measure x $58 per hour) for the groups participating under GPRO I.

We believe that the costs to individual eligible professionals and group practices associated with avoiding the eRx payment adjustment that goes into effect in 2012 would be similar to the costs of an eligible professional or group practice reporting the electronic prescribing measure for purposes of the 2011 eRx incentive. Specifically, we believe that the cost of reporting the eRx measure in one instance for purposes of the payment adjustment is identical to the cost of reporting the eRx measure for one instance on claims for purposes of the incentive payment. The only difference would be in the total costs for an individual eligible professional. Group practices are required to report the eRx measure for the same number of eRx events for both the 2011 incentive and the 2012 payment adjustment. Individual eligible professionals, however, are required to report the eRx measure only for 10 eRx events for purposes of the 2012 payment adjustment as opposed to 25 eRx events for purposes of the 2011 incentive.

Based on our decision to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participant's behalf for the 2011 Physician Quality Reporting System to be qualified to submit results and numerator and denominator data on the eRx measure for the CY 2011 eRx Incentive Program, we do not estimate any cost to the registry associated with becoming a registry qualified to submit the eRx measure for CY 2011.

The cost for the registry would be the time and effort associated with the registry calculating results for the eRx measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the eRx quality measure to CMS on behalf of their participants. We believe such costs will be minimal as registries would already be required to perform these activities for Physician Quality Reporting System.

Likewise, based on our decision to consider only EHR products qualified for the CY 2011 Physician Quality Reporting System to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the CY 2011 eRx Incentive Program, there would be no need for EHR vendors to undergo a separate self-nomination process for the eRx Incentive Program. Therefore, there will be no additional cost associated with the self-nomination process.

The cost to the EHR vendor associated with the EHR-based reporting requirements of this reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the individual eligible professional needs to submit to CMS for reporting the CY 2011 eRx measure. Since we determined that only EHR products qualified for the 2011 Physician Quality Reporting System will be qualified for the CY 2011 eRx Incentive Program, and the eRx Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable individual eligible professionals to submit data on the eRx measure to the CMS-designated clinical data warehouse will be minimal.

7. Durable Medical Equipment-Related Issues

a. Off-the-Shelf (OTS) Orthotics Exemption

In section VII.G. of this final rule with comment period, we are expanding the exemptions from the CBP for certain OTS orthotics to physicians, other practitioners (as defined by the Secretary), or by hospitals if furnished to their own patients as part of their professional service.

The exemption is a self-implementing mandate required by section 154(d) of MIPPA, which added section 1847(a)(7) of the Act. Section 1847(a)(7)(A) of the Act expanded the exemptions from the CBP for certain OTS orthotics to physicians, other practitioners (as defined by the Secretary), or hospitals if furnished to their own patients as part of their professional service. Section 1847(a)(7)(B) of the Act, as added by section 154(d) of MIPPA, also expanded the exemption from CBP for certain DME items (crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps) when furnished by hospitals to the hospital's own patients during an admission or on the date of discharge.

We believe this exemption will have a negligible impact on physicians, other practitioners, and hospitals. The exemption allows physicians, other practitioners, and hospitals to continue to provide these items to their own patients without submitting a bid and becoming a contract supplier. This exemption also allows continued access to these items for beneficiaries when these items are furnished by physicians, other practitioners, and hospitals to their own patients.

b. Changes to Payment for Oxygen Equipment

We are not finalizing our proposal pertaining to oxygen and oxygen equipment; and therefore, the impact analysis associated with this proposal is not being finalized.

c. Diabetic Testing Supplies

We are establishing requirements for conducting a national competition for furnishing diabetic testing supplies on a mail order basis. Specifically this final rule with comment period will establish 3 requirements: a new definition for what constitutes mail order; a rule that requires contract suppliers to provide at a minimum 50 percent of all of the different types of diabetic testing products on the market by brand and model name; and a prohibition against influencing and incentivizing beneficiaries to switch their brand of monitor and testing supplies.

Currently based on claims data from FY 2009 over 62 percent of beneficiaries receive their replacement diabetic testing supplies from mail order suppliers. The new mail order definition will not impact these beneficiaries because they can continue to obtain their items through mail order. The remaining 38 percent of beneficiaries may continue to obtain these items from a local pharmacy. We do not expect this rule to have any adverse affects on beneficiaries because the new definition of mail order item is reflective of the way that beneficiaries currently get their diabetic testing supplies. However, we believe that by clarifying this definition we will protect beneficiaries from paying higher co-payment amounts and we anticipate program savings that would have been eroded by suppliers circumventing our definition to continue to provide items, even if not awarded a contract under competitive bidding and to obtain the higher fee schedule payment amount. This definition is also consistent with the way that suppliers currently do business by either providing items through mail order or at a local storefront. For these reasons we believe this new definition will have minimal impact.

Also, we considered the option to not bifurcate bidding based on delivery method and to bid for diabetic testing supplies regardless of how the items were obtained. We rejected this approach because it would force companies with different business models to compete against each other, by requiring local pharmacies to compete with national mail order suppliers in order to win a contract to be able to furnish diabetic testing supplies.

In order to implement a national mail order competition for diabetic supplies, we are also implementing the special "50 percent rule" mandated by MIPPA. This final rule with comment period requires a bidder to demonstrate that its bid covers types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, cover 50 percent (or such higher percentage as the Secretary may specify) of all such types of products. The 50 percent threshold would ensure that beneficiaries have access to mail order delivery of the top-selling diabetic test strip products from every contract supplier. We plan to use the information that bidding suppliers provide on their bidding Form B where suppliers list the products they plan to furnish. We believe this requirement will have a minimal impact on suppliers because most suppliers currently provide a wide range of the brands and models in order to gain market share. The statute states that suppliers are required to carry at least 50 percent of all brands on the market. However, the Secretary can establish suppliers to carry a higher percentage of brands. We have adopted 50 percent criteria because we believe this is reflective of what suppliers are currently doing and ensures appropriate access for beneficiaries.

In addition to the 50 percent rule we are establishing an anti-switching

requirement. This provision would prevent contract suppliers from influencing or incentivizing beneficiaries by persuading, pressuring, or advising them to switch from their current brand to a brand provided by the supplier. We believe this requirement will protect the beneficiary and physician choice of glucose monitoring systems. The decision concerning the type of monitor and testing supplies that a beneficiary chooses should not be made by the supplier but rather by the beneficiary and their physician. We believe that this provision will have a minimal impact on suppliers because suppliers currently offer a variety of products and generally do not require beneficiaries to switch from the brands they are familiar with and customarily use.

d. Metropolitan Statistical Areas

In section VII.V. of this final rule with comment period, we implement section 6410 of the ACA regarding adjustments to the DMEPOS CBP. We believe that the provisions pertaining to subdividing metropolitan statistical areas (MSAs) with populations of at least 8,000,000 for the purpose of establishing competitive bidding areas (CBAs) under Round 2 of the DMEPOS CBP will have a positive impact on most suppliers, particularly small suppliers. The authority provided by section 1847(a)(1)(D)(ii)(II) of the Act will be used to create CBAs that are smaller than the highly and densely populated MSAs of: Chicago-Naperville-Joliet, IL-IN-WI; Los Angeles-Long Beach-Santa Ana, CA; and New York-Northern New Jersey-Long Island, NY-NJ-PA. This results in more manageable service areas for suppliers to navigate when furnishing items. More importantly, it ensures more timely delivery of items and services to beneficiaries located throughout each of the MSAs. It also benefits small suppliers because they will have smaller geographic areas to cover as contract suppliers than the

large MSAs, which in some cases, might prevent them from being considered for participation under the program. The larger suppliers will still have the opportunity to bid in all of the CBAs within each MSA. We expect that subdividing the large MSAs of Chicago, Los Angeles, and New York would not have a negative impact on program savings, as long as each CBA is large enough to be attractive to suppliers for bidding purposes.

Table 104 considers FY cash impact on the entire Medicare program, including Medicare Advantage for FYs 2011 thru 2015 of the provisions of this final rule with comment period related to the establishment of CBAs during Round 2 and prior to calendar year 2015. The FY–CY distinction is an important one when comparing savings. For example, the savings for the DMEPOS CBP will be for 9 months of FY 2013, but for 12 months of CY 2013. Table 104 considers the impact on program expenditures, and does not include beneficiary coinsurance. Finally, the estimates in Table 104 incorporate spillover effects from the competitive acquisition program onto the Medicare Advantage program. The expectation is that the 21 additional MSAs added to the DMEPOS CBP would lower prices for DME products in FFS would lead to lower prices in the Medicare Advantage market. The table below considers FY cash impact of the above provisions on the entire Medicare program, including Medicare Advantage for the FY.

Table 104: Impact of Adding 21 MSAs to Round 2 of the Medicare DMEPOS Competitive Bidding Program

FY	Cost (in $millions)
2011	0
2012	0
2013	-40

2014	-70
2015	-110

Subdividing the large MSAs of Chicago, Los Angeles, and New York is considered to have little to no fiscal impact. The exceptions to the DMEPOS CBP involving rural areas, MSAs with populations less than 250,000, and low population density areas in selected MSAs before 2015 are considered to have little to no impact because the baseline never considered these areas as subject to competitive bidding prices.

8. Air Ambulance

In section VII.H. of this final rule with comment period, we present our provision regarding air ambulance and provider and supplier enrollment. We note that this provision is an administrative initiative that may result in Medicare program savings but at this time those savings are inestimable. We believe the probable costs providers or suppliers will incur as a result of this rule to be negligible.

F. Alternatives Considered

This final rule with comment period contains a range of policies, including some provisions related to specific MIPPA and ACA provisions. The preceding preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, presents rationale for our final policies and, where relevant, alternatives that were considered.

G. Impact on Beneficiaries

There are a number of changes in this final rule with comment period that would have an effect on beneficiaries. In general, we believe that many of the proposed changes, including the refinements of the PQRI with its focus on measuring, submitting,

and analyzing quality data, the expansion of the list of Medicare-approved telehealth services, the incentive payments for primary care services furnished by primary care practitioners in any location and major surgical procedures furnished by general surgeons in HPSAs, the waiver of beneficiary cost-sharing for most preventive services, and the annual wellness visit provisions, will have a positive impact and improve the quality and value of care provided to Medicare beneficiaries.

The regulatory provisions may affect beneficiary liability in some cases. For example, the waiver of the deductible and coinsurance for the annual wellness visit, the IPPE, and preventive services with a grade of A or B from the USPSTF would reduce beneficiary liability for these services. Most changes in aggregate beneficiary liability due to a particular provision would be a function of the coinsurance (20 percent if applicable for the particular provision after the beneficiary has met the deductible). To illustrate this point, as shown in Table 102, the CY 2010 national payment amount in the nonfacility setting for CPT code 99203 (Office/outpatient visit, new) is $76.93 which means that in CY 2010 a beneficiary would be responsible for 20 percent of this amount, or $15.39. Based on this final rule with comment period, the CY 2011 national payment amount in the nonfacility setting for CPT code 99203, as shown in Table 102, is $77.59, which means that, in CY 2011, the beneficiary coinsurance for this service would be $15.52

Additionally, beneficiary liability would also be impacted by the effect of the aggregate cost (savings) of the provisions on the standard calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings).

Most policies discussed in this final rule with comment period that impact payment rates, such as the expansion of the MPPR to therapy services and the increased discount on the TC of multiple imaging procedures from 25 percent to 50 percent, would similarly impact beneficiaries' coinsurance.

H. Accounting Statement

As required by OMB Circular A-4 (available at http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf), in Table 105, we have prepared an accounting statement showing the estimated expenditures associated with this final rule with comment period. This estimate includes the estimated FY 2011 cash benefit impact associated with certain ACA and MIPPA provisions, and the CY 2011 incurred benefit impact associated with the estimated CY 2011 PFS conversion factor update based on the Mid-Session Review of the FY 2011 President's Budget baseline.

TABLE 105: Accounting Statement:
Classification of Estimated Expenditures

CATEGORY	TRANSFERS
CY 2011 Annualized Monetized Transfers	Estimated decrease in expenditures of $17.6 billion for PFS conversion factor update
From Whom To Whom?	Federal Government to physicians, other practitioners and providers and suppliers who receive payment under Medicare.
FY 2011 Annualized Monetized Transfers	Estimated increase in expenditures of $1.97 billion for Affordable Care Act provisions
From Whom To Whom?	Federal Government to providers

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

List of Subjects

42 CFR Part 405

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

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

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

42 CFR Part 411

Kidney diseases, Medicare, Physician Referral, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Part 414

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

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 405--FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. The authority for part 405 continues to read as follows:

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1886(k) of the Social Security Act (42 U.S.C. 1302, 1395x, 1395y(a), 1395hh, 1395kk, 1395rr and 1395ww(k)), and sec. 353 of the Public Health Service Act (42 U.S.C.263a).

Subpart X—Rural Health Clinic and Federally Qualified Health Center Services

2. A new §405.2449 is added to read as follows

§ 405.2449 Preventive services.

For services furnished on or after January 1, 2011, preventive services covered under the Medicare Federally qualified health center benefit are those preventive services defined in section 1861(ddd)(3) of the Act, and §410.2 of this chapter. Specifically, these include the following:

(a) The specific services currently listed in section 1861(ww)(2) of the Act, with the explicit exclusion of electrocardiograms.

(b) The Initial Preventive Physical Examination (IPPE) (as specified by section 1861(ww)(1) of the Act as added by section 611 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173) and §410.16 of this chapter); and

(c) The Personalized Prevention Plan Services (PPPS), also known as the "Annual Wellness Visit" (as specified by section 1861(hhh) of the Act as added by section 4103 of the Affordable Care Act (Pub. L. 111-148) and §410.15 of this chapter).

3. Section 405.2470 is amended by adding a new paragraph (d) to read as follows:

§ 405.2470 Reports and maintenance of records.

* * * * *

(d) Collection of additional claims data. Beginning January 1, 2011, a Medicare FQHC must report on its Medicare claims such information as the Secretary determines is needed to develop and implement a prospective payment system for FQHCs including, but not limited to all pertinent HCPCS (Healthcare Common Procedure Coding System) code(s) corresponding to the service(s) provided for each Medicare FQHC visit (as defined in §405.2463).

PART 409--HOSPITAL INSURANCE BENEFITS

4. The authority citation for part 409 continues to read as follows:

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

Subpart B--Inpatient Hospital Services and Inpatient Critical Access Hospital Services

§ 409.17 [Amended]

5. Amend §409.17(d) by removing the phrase "hospital policies and procedures." and adding in its place the phrase "the provider's policies and procedures.".

Subpart C--Posthospital SNF Care

6. Section 409.20 is amended by revising paragraph (a)(3) to read as follows:

§ 409.20 Coverage of services.

(a) * * *

(3) Physical therapy, occupational therapy, and speech-language pathology services.

* * * * *

7. Section 409.23 is revised to read as follows:

§ 409.23 Physical therapy, occupational therapy, and speech-language pathology services.

Medicare pays for physical therapy, occupational therapy, or speech-language pathology services as posthospital SNF care if they are furnished--

(a) By (or under arrangements made by) the facility and billed by (or through) the facility;

(b) By qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, or speech-language pathologists as defined in part 484 of this chapter; and

(c) In accordance with a plan that meets the requirements of §409.17(b) through (d) of this part.

PART 410--SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

8. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102, 1834, 1871, and 1893 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395hh, and 1395ddd).

Subpart A--General Provisions

9. Section 410.2 is amended by adding the definition of "Preventive services" in alphabetical order to read as follows:

§410.2 Definitions.

* * * * *

Preventive services means all of the following:

(1) The specific services listed in section 1861(ww)(2) of the Act, with the explicit exclusion of electrocardiograms;

(2) The Initial Preventive Physical Examination (IPPE) (as specified by section 1861(ww)(1) of the Act); and

(3) Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS) (as specified by section 1861(hhh)(1) of the Act).

§410.3 [Amended]

10. Amend §410.3(b)(2) by removing the reference "subpart E" and adding in its place the reference "subpart I."

Subpart B--Medical and Other Health Services

11. Section 410.15 is added to read as follows:

§410.15 Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage.

(a) Definitions. For purposes of this section--

Detection of any cognitive impairment means assessment of an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers or others.

Eligible beneficiary means an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period and who has not received either an initial preventive physical examination or an annual wellness visit providing a personalized prevention plan within the past 12 months.

Establishment of, or an update to the individual's medical and family history means, at minimum, the collection and documentation of the following:

(i) Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries and treatments.

(ii) Use or exposure to medications and supplements, including calcium and vitamins.

(iii) Medical events in the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the individual at increased risk.

First annual wellness visit providing personalized prevention plan services means the following services furnished to an eligible beneficiary by a health professional as those terms are defined in this section:

(i) Establishment of an individual's medical and family history.

(ii) Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.

(iii) Measurement of an individual's height, weight, body-mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements as deemed appropriate, based on the beneficiary's medical and family history.

(iv) Detection of any cognitive impairment that the individual may have, as that term is defined in this section.

(v) Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.

(vi) Review of the individual's functional ability and level of safety, based on direct observation or the use of appropriate screening questions or a screening questionnaire, which the health professional as defined in this section may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

(vii) Establishment of the following:

(A) A written screening schedule for the individual such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.

(B) A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under §410.16 of this subpart), and a list of treatment options and their associated risks and benefits.

(viii) Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

(ix) Voluntary advance care planning (as defined in this section) upon agreement with the individual.

(x) Any other element determined appropriate through the national coverage determination process.

Health professional means--

(i) A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act); or

(ii) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); or

(iii) A medical professional (including a health educator, a registered dietitian, or nutrition professional, or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in §410.32(b)(3)(ii)) of a physician as defined in paragraph (i) of this definition.

Review of the individual's functional ability and level of safety means, at minimum, assessment of the following topics:

(i) Hearing impairment.

(ii) Ability to successfully perform activities of daily living.

(iii) Fall risk.

(iv) Home safety.

Subsequent annual wellness visit providing personalized prevention plan services means the following services furnished to an eligible beneficiary by a health professional as those terms are defined in this section:

(i) An update of the individual's medical and family history.

(ii) An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual as that list was developed for the first annual wellness visit providing personalized prevention plan services.

(iii) Measurement of an individual's weight (or waist circumference), blood pressure and other routine measurements as deemed appropriate, based on the individual's medical and family history.

(iv) Detection of any cognitive impairment that the individual may have, as that term is defined in this section.

(v) An update to the following:

(A) The written screening schedule for the individual as that schedule is defined in paragraph (a) of this section for the first annual wellness visit providing personalized prevention plan services.

(B) The list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual as that list was developed at the first annual wellness visit providing personalized prevention plan services.

(vi) Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs as that advice and related services are defined in paragraph (a) of this section.

(vii) Voluntary advance care planning (as defined in paragraph (a) of this section) upon agreement with the individual.

(viii) Any other element determined appropriate through the national coverage determination process.

Voluntary advance care planning means, for purposes of this section, verbal or written information regarding the following areas:

(i) An individual's ability to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions.

(ii) Whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

(b) Conditions for coverage of annual wellness visits providing personalized prevention plan services. Medicare Part B pays for first and subsequent annual wellness visits providing personalized prevention plan services that are furnished to an eligible beneficiary, as described in this section, if they are furnished by a health professional, as defined in this section.

(c) Limitations on coverage of an annual wellness visit providing personalized prevention plan services. Payment may not be made for either a first or a subsequent annual wellness visit providing personalized prevention plan services that is performed for an individual who is--

(1) Not an eligible beneficiary as described in this section.

(2) An eligible beneficiary as described in this section and who has had either an initial preventive physical examination as specified in §410.16 of this subpart or either a first or a subsequent annual wellness visit providing personalized prevention plan services performed within the past 12 months.

(d) Effective date. Coverage for an annual wellness visit providing personalized prevention plan services is effective for services furnished on or after January 1, 2011.

12. Section 410.32 is amended by adding paragraph (b)(2)(vii) to read as follows:

§410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

* * * * *

(b) * * *

(2) * * *

(vii) Diagnostic tests performed by a certified nurse-midwife authorized to perform the tests under applicable State laws.

* * * * *

13. Section 410.64 is amended by revising paragraph (a) introductory text to read as follows:

§ 410.64 Additional Preventive Services

(a) Medicare Part B pays for additional preventive services not described in paragraph (1) or (3) of the definition of "preventive services" under §410.2, that identify medical conditions or risk factors for individuals if the Secretary determines through the national coverage determination process (as defined in section 1869(f)(1)(B) of the Act) that these services are all of the following:

* * * * *

14. Section 410.78 is amended by revising paragraph (b) introductory text to read as follows:

§410.78 Telehealth services.

* * * * *

(b) General rule. Medicare Part B pays for office or other outpatient visits, subsequent hospital care services (with the limitation of one telehealth visit every 3 days), subsequent nursing facility care services (not including the Federally-mandated periodic visits under §483.40(c) and with the limitation of one telehealth visit every 30 days), professional consultations, psychiatric diagnostic interview examination, neurobehavioral status exam, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one "hands on" visit per month to examine the access site), individual and group medical nutrition therapy services, individual and group kidney disease education services, individual and group diabetes self-management (DSMT) training services (except for one hour of in-person services to be furnished in the year following the initial DSMT service to ensure effective injection training), and individual and group health and behavior assessment and intervention services furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

Subpart I--Payment for SMI Benefits

15. Section 410.150 is amended by adding paragraph (b)(20) to read as follows:

§410.150 To whom payment is made.

* * * * *

(b) * * *

(20) To a certified nurse-midwife for professional services furnished by the certified nurse-midwife in all settings and for services and supplies furnished incident to those services. Payment is made only if no facility or other provider charges or is paid any amount for the furnishing of the professional services of the certified nurse-midwife.

16. Section 410.152 is amended by revising paragraph (l) to read as follows:

§410.152 Amount of payment.

* * * * *

(l) Amount of payment: Preventive services. Medicare Part B pays 100 percent of the Medicare payment amount established under the applicable payment methodology for the service setting for providers and suppliers for the following preventive services:

(1) Pneumococcal (as specified in paragraph (h) of this section), influenza, and hepatitis B vaccine and administration.

(2) Screening mammography.

(3) Screening pap tests and screening pelvic exam.

(4) Prostate cancer screening tests (excluding digital rectal examinations).

(5) Colorectal cancer screening tests (excluding barium enemas).

(6) Bone mass measurement.

(7) Medical nutrition therapy (MNT) services.

(8) Cardiovascular screening blood tests.

(9) Diabetes screening tests.

(10) Ultrasound screening for abdominal aortic aneurysm (AAA).

(11) Additional preventive services identified for coverage through the national coverage determination (NCD) process.

(12) Initial Preventive Physical Examination (IPPE).

(13) Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS).

16. Section 410.160 is amended by--

A. Revising paragraph (b)(2).

B. Adding paragraphs (b)(10) through (13).

The revisions and additions read as follows:

§410.160 Part B annual deductible.

* * * * *

(b) * * *

(2) Pneumococcal, influenza, and hepatitis b vaccines and their administration.

* * * * *

(10) Bone mass measurement.

(11) Medical nutrition therapy (MNT) services.

(12) Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS).

(13) Additional preventive services identified for coverage through the national coverage determination (NCD) process.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

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

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

Subpart A--General Exclusions and Exclusion of Particular Services

18. Section 411.15 is amended by--

A. Revising paragraph (a)(1).

B. Adding new paragraph (k)(16).

The revision and addition read as follows:

§411.15 Particular services excluded from coverage.

* * * * *

(a) * * *

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, ultrasound screening for abdominal aortic aneurysms (AAA), cardiovascular disease screening tests, diabetes screening tests, a screening electrocardiogram, initial preventive physical examinations that meet the criteria specified in paragraphs (k)(6) through (k)(15) of this section, additional preventive services that meet the criteria in §410.64 of this chapter, or annual wellness visits providing personalized prevention plan services.

* * * * *

(k) * * *

(16) In the case of an annual wellness visit providing a personalized prevention plan, subject to the conditions and limitations specified in §410.15 of this subpart.

* * * * *

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

19. Section 411.355 is amended by adding paragraph (b)(7) to read as follows:

§411.355 General exceptions to the referral prohibition related to both ownership/investment and compensation.

* * * * *

(b) * * *

(7) Disclosure requirement for certain imaging services.

(i) With respect to magnetic resonance imaging, computed tomography, and positron emission tomography services identified as "radiology and certain other imaging services" on the List of CPT/HCPCS Codes, the referring physician must provide written notice to the patient at the time of the referral that the patient may receive the same services from a person other than one described in paragraph (b)(1) of this section. Except as set forth in paragraph (b)(7)(ii) of this section, the written notice must include a list of at least 5 other suppliers (as defined in §400.202 of this chapter) that provide the services for which the individual is being referred and which are located within a 25-mile radius of the referring physician's office location at the time of the referral. The notice should be written in a manner sufficient to be reasonably understood by all patients and should include for each supplier on the list, at a minimum, the supplier's name, address, and telephone number.

(ii) If there are fewer than 5 other suppliers located within a 25-mile radius of the physician's office location at the time of the referral, the physician must list all of the other suppliers of the imaging service that are present within a 25-mile radius of the referring physician's office location. Provision of the written list of alternate suppliers will not be required if no other suppliers provide the services for which the individual is being referred within the 25-mile radius.

* * * * *

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

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

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Public Law 106–133 (113 Stat. 1501A–332).

Subpart E--Payments to Providers

21. Section 413.70 is amended by adding a sentence at the end of paragraph (b)(3)(ii)(B) to read as follows:

§413.70 Payment for services of a CAH.

* * * * *

(b) * * *

(3) * * *

(ii) * * *

(B) * * * Effective for primary care services furnished by primary care practitioners (as defined in §414.80(a)) and major surgical procedures furnished by general surgeons in health professional shortage areas (as defined in §414.2) furnished on or after January 1, 2011 and before January 1, 2016, incentive payments specified under §414.80 and §414.67(b), respectively, of this title must not be included in determining payment made under this paragraph.

* * * * *

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

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

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

Subpart A--General Provisions

23. Section 414.2 is amended by adding the definitions of "Health Professional Shortage Area" and "Major surgical procedure" in alphabetical order to read as follows:

§414.2 Definitions.

* * * * *

Health Professional Shortage Area (HPSA) means an area designated under section 332(a)(1)(A) of the Public Health Service Act as identified by the Secretary prior to the beginning of such year.

Major surgical procedure means a surgical procedure for which a 10-day or 90-day global period is used for payment under the physician fee schedule and section 1848(b) of the Act.

* * * * *

24. Section 414.26 is amended by--

A. Redesignating paragraph (c) as paragraph (d).

B. Adding a new paragraph (c).

The addition reads as follows:

§414.26 Determining the GAF.

* * * * *

(c) Adjusting the practice expense index to account for the Frontier State floor.

(1) General criteria. Effective on or after January 1, 2011, CMS will adjust the practice expense index for physicians' services furnished in qualifying States to recognize the practice expense index floor established for Frontier States. A qualifying State must meet the following criteria:

(i) At least 50 percent of counties located within the State have a population density less than 6 persons per square mile.

(ii) The State does not receive a non-labor related share adjustment determined by the Secretary to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(2) Amount of adjustment. The practice expense value applied for physicians' services furnished in a qualifying State will be not less than 1.00.

(3) Process for determining adjustment. (i) CMS will use the most recent population estimate data published by the U.S. Census Bureau to determine county definitions and population density. This analysis will be periodically revised, such as for updates to the decennial census data.

(ii) CMS will publish annually a listing of qualifying Frontier States receiving a practice expense index floor attributable to this provision.

* * * * *

Subpart B--Physicians and Other Practitioners

25. Section 414.54 is revised to read as follows:

§414.54 Payment for certified nurse-midwives' services.

(a) For services furnished after December 31, 1991, allowed amounts under the fee schedule established under section 1833(a)(1)(K) of the Act for the payment of certified nurse-midwife services may not exceed 65 percent of the physician fee schedule amount for the service.

(b) For certified nurse-midwife services furnished on or after January 1, 2011, allowed amounts may not exceed 100 percent of the physician fee schedule amount that would be paid to a physician for the services.

26. Section 414.65 is amended by revising paragraph (a)(1) introductory text to read as follows:

§414.65 Payment for telehealth services.

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, subsequent hospital care services (with the limitation of one telehealth subsequent

hospital care service every 3 days), subsequent nursing facility care services (not including the Federally-mandated periodic visits under §483.40(c) and with the limitation of one telehealth nursing facility care service every 30 days), professional consultations, psychiatric diagnostic interview examination, neurobehavioral status exam, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one "hands on" visit per month to examine the access site), individual and group medical nutrition therapy services, individual and group kidney disease education services, individual and group diabetes self-management training (DSMT) services (except for 1 hour of in-person DSMT services to be furnished in the year following the initial DSMT service to ensure effective injection training), and individual and group health and behavior assessment and intervention furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

* * * * *

27. Section 414.67 is revised to read as follows:

§414.67 Incentive payments for services furnished in Health Professional Shortage Areas.

(a) Health Professional Shortage Area (HPSA) physician bonus program. A HPSA physician incentive payment will be made subject to the following:

(1) HPSA bonuses are payable for services furnished by physicians as defined in section 1861(r) of the Act in areas designated as of December 31 of the prior year as geographic primary medical care HPSAs as defined in section 332(a)(1)(A) of the Public Health Service Act.

(2) HPSA bonuses are payable for services furnished by psychiatrists in areas designated as of December 31 of the prior year as geographic mental health HPSAs if the services are not already eligible for the bonus based on being in a geographic primary care HPSA.

(3) Physicians eligible for the HPSA physician bonus are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

(4) Physicians furnishing services in areas that are designated as geographic HPSAs prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA bonus payments are made must use the AQ modifier to receive the HPSA physician bonus payment.

(b) HPSA surgical incentive payment program. A HPSA surgical incentive payment will be made subject to the following:

(1) A major surgical procedure as defined in §414.2 of this part is furnished by a general surgeon on or after January 1, 2011 and before January 1, 2016 in an area recognized for the HPSA physician bonus program under paragraph (a)(1) of this section.

(2) Payment will be made on a quarterly basis in an amount equal to 10 percent of the Part B payment amount for major surgical procedures furnished as described in paragraph (b)(1) of this section, in addition to the amount the physician would otherwise be paid.

(3) Physicians furnishing services in areas that are designated as geographic HPSAs eligible for the HPSA physician bonus program under paragraph (a)(1) of this section prior to the beginning of the year but not included on the published list of zip

codes for which automated HPSA surgical incentive payments are made should report HCPCS modifier -AQ to receive the HPSA surgical incentive payment.

(4) The payment described in paragraph (b)(2) of this section is made to the surgeon or, where the surgeon has reassigned his or her benefits to a critical access hospital (CAH) paid under the optional method, to the CAH based on an institutional claim.

28. Section 414.80 is added to read as follows:

§414.80 Incentive payment for primary care services.

(a) Definitions. As defined in this section--

Eligible primary care practitioner means one of the following:

(i) A physician (as defined in section 1861(r)(1) of the Act) who meets all of the following criteria:

(A) Enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics.

(B) At least 60 percent of the physician's allowed charges under the physician fee schedule (excluding hospital inpatient care and emergency department visits) during a reference period specified by the Secretary are for primary care services.

(ii) A nurse practitioner, clinical nurse specialist, or physician assistant (as defined in section 1861(aa)(5) of the Act) who meets all of the following criteria:

(A) Enrolled in Medicare with a primary specialty designation of 50-nurse practitioner, 89-certified clinical nurse, or 97-physician assistant.

(B) At least 60 percent of the practitioner's allowed charges under the physician fee schedule (excluding hospital inpatient care and emergency department visits) during a

reference period specified by the Secretary are for primary care services.

Primary care services means--

(i) New and established patient office or other outpatient evaluation and management (E/M) visits;

(ii) Initial, subsequent, discharge, and other nursing facility E/M services;

(iii) New and established patient domiciliary, rest home (for example, boarding home), or custodial care E/M services;

(iv) Domiciliary, rest home (for example, assisted living facility), or home care plan oversight services; and

(v) New and established patient home E/M visits.

(b) Payment.

(1) For primary care services furnished by an eligible primary care practitioner on or after January 1, 2011 and before January 1, 2016, payment is made on a quarterly basis in an amount equal to 10 percent of the payment amount for the primary care services under Part B, in addition to the amount the primary care practitioner would otherwise be paid for the primary care services under Part B.

(2) The payment described in paragraph (b)(1) of this section is made to the eligible primary care practitioner or, where the physician has reassigned his or her benefits to a critical access hospital (CAH) paid under the optional method, to the CAH based on an institutional claim.

29. A new §414.90 is added to read as follows:

§414.90 Physician Quality Reporting System.

(a) Basis and scope. This section implements the following provisions of the

Act:

(1) 1848(a)--Payment Based on Fee Schedule.

(2) 1848(k)--Quality Reporting System.

(3) 1848(m)--Incentive Payments for Quality Reporting.

(b) Definitions. As used in this section, unless otherwise indicated—

Covered professional services means services for which payment is made under, or is based on, the Medicare physician fee schedule as provided under section 1848(k)(3) of the Act and which are furnished by an eligible professional.

Eligible professional means any of the following:

(i) A physician.

(ii) A practitioner described in section 1842(b)(18)(C) of the Act.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

Group practice means a single Taxpayer Identification Number (TIN) with two or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN.

Maintenance of Certification Program means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification Program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, and professionalism. Such a program

must include the following:

(i) The program requires the physician to maintain a valid unrestricted license in the United States.

(ii) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(iii) The program requires a physician to demonstrate, through a formalized secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

(iv) The program requires successful completion of a qualified maintenance of certification program practice assessment.

Maintenance of Certification Program Practice Assessment means an assessment of a physician's practice that--

(i) Includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

(ii) Includes a survey of patient experience with care; and

(iii) Requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under paragraph (h) of this section and then to remeasure to assess performance improvement after such intervention.

Measures group means a subset of four or more Physician Quality Reporting System measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.

Physician Quality Reporting System means the physician reporting system under section 1848(k) of the Act for the reporting by eligible professionals of data on quality measures and the incentive payment associated with this physician reporting system.

Performance rate means the percentage of a defined population who receives a particular process of care or achieve a particular outcome for a particular quality measure.

Reporting rate means the percentage of patients that the eligible professional indicated a quality action was or was not performed divided by the total number of patients in the denominator of the measure.

Qualified registry means a medical registry or a maintenance of certification program operated by a specialty body of the American Board of Medical Specialties that, with respect to a particular program year, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate its compliance with the Physician Quality Reporting System qualification requirements specified by CMS for that program year. The registry may act as a data submission vendor, which has the requisite legal authority to provide Physician Quality Reporting System data (as specified by CMS) on behalf of an eligible professional to CMS.

Qualified electronic health record product means an electronic health record vendor's product and version that, with respect to a particular program year, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate the product's compliance with the Physician Quality Reporting System qualification requirements specified by CMS for a program year. The requirements and process for an electronic health record product to be qualified for the purpose of the Physician Quality Reporting System is separate from the standards, implementation

specifications, and certification criteria established for the EHR Incentive Program specified in part 495.

(c) Incentive payments. With respect to covered professional services furnished during a reporting period by an eligible professional, if --

(1) There are any quality measures that have been established under the Physician Quality Reporting System that are applicable to any such services furnished by such professional (or in the case of a group practice under paragraph (g) of this section, such group practice) for such reporting period; and

(2) The eligible professional (or in the case of a group practice under paragraph (g) of this section, the group practice) satisfactorily submits (as determined under paragraph (f) of this section for eligible professionals and paragraph (g) of this section for group practices) to the Secretary data on such quality measures in accordance with the Physician Quality Reporting System for such reporting period, in addition to the amount otherwise paid under section 1848 of the Act, there also must be paid to the eligible professional (or to an employer or facility in the cases described in section 1842(b)(6)(A) of the Act or, in the case of a group practice) under paragraph (g) of this section, to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Act an amount equal to the applicable quality percent (as specified in paragraph (c)(3) of this section) of the eligible professional's (or, in the case of a group practice under paragraph (g) of this section, the group practice's) total estimated allowed charges for all covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (g) of this section, by the group practice) during the applicable reporting period. For purposes of

this paragraph,

(i) The eligible professional's (or, in the case of a group practice under paragraph (g) of this section, the group practice's) total estimated allowed charges for covered professional services furnished during a reporting period are determined based on claims processed in the National Claims History (NCH) no later than 2 months after the end of the applicable reporting period;

(ii) In the case of an eligible professional who furnishes covered professional services in more than one practice, incentive payments are separately determined for each practice based on claims submitted for the eligible professional for each practice;

(iii) Incentive payments earned by an eligible professional (or in the case of a group practice under paragraph (g) of this section, by a group practice) for a particular program year will be paid as a single consolidated payment to the TIN holder of record.

(3) Applicable quality percent. The applicable quality percent is as follows:

(i) For 2011, 1.0 percent; and

(ii) For 2012, 2013, and 2014, 0.5 percent;

(d) Additional incentive payment. (1) Through 2014, if an eligible professional meets the requirements described in paragraph (d)(2) of this section, the applicable percent for such year, as described in paragraphs (c)(3)(i) and (ii) of this section, must be increased by 0.5 percentage points.

(2) In order to qualify for the additional incentive payment described in paragraph (d)(1) of this section, an eligible professional must meet the following requirements:

(i) The eligible professional must--

(A) Satisfactorily submit data on quality measures for purposes of this section for a year; and

(B) Have such data submitted on their behalf through a Maintenance of Certification program (as defined in paragraph (b) of this section) that meets:

(1) The criteria for a registry (as specified by CMS)); or

(2) An alternative form and manner determined appropriate by the Secretary.

(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status--

(A) Participates in a maintenance of certification program (as defined in paragraph (b) of this section) for a year; and

(B) Successfully completes a qualified maintenance of certification program practice assessment (as defined in paragraph (b) of this section) for such year.

(iii) A Maintenance of Certification Program submits to the Secretary, on behalf of the eligible professional, information --

(A) In a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of paragraph (d)(2)(ii) of this section which may be in the form of a structural measure);

(B) If requested by the Secretary, on the survey of patient experience with care (as described in paragraph (b) of this section); and

(C) As the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

(e) Use of consensus-based quality measures. For each program year, CMS will

publish the final list of measures and the final detailed measure specifications for all quality measures selected for inclusion in the Physician Quality Reporting System quality measure set for a given program year on a CMS website by no later than December 31 of the prior year.

(1) General rule. Subject to paragraph (e)(2) of this section, for purposes of reporting data on quality measures for covered professional services furnished during a year, subject to paragraph (f) of this section, the quality measures specified under this paragraph must be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) of the Act.

(2) Exception. In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance.

(3) Opportunity to provide input on measures. For each quality measure adopted by the Secretary under this paragraph, the Secretary ensures that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of quality measures applicable to services they furnish.

(f) Requirements for individual eligible professionals to qualify to receive an incentive payment. In order to qualify to earn a Physician Quality Reporting System incentive payment for a particular program year, an individual eligible professional, as

identified by a unique TIN/NPI combination, must meet the criteria for satisfactory reporting specified by CMS for such year by reporting on either individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups identified by CMS during a reporting period specified in paragraph (f)(1) of this section and using one of the reporting mechanisms specified in paragraph (f)(2) of this section. Although an eligible professional may attempt to qualify for the Physician Quality Reporting System incentive payment by reporting on both individual Physician Quality Reporting System quality measures and measures groups, using more than one reporting mechanism (as specified in paragraph (f)(2) of this section), or reporting for more than one reporting period, he or she will receive only one Physician Quality Reporting System incentive payment per TIN/NPI combination for a program year.

(1) Reporting periods. For purposes of this paragraph, the reporting period with respect to program year 2011 is--

(i) The 12-month period from January 1 through December 31 of such program year; or

(ii) The 6-month period from July 1 through December 31 of such program year.

(2) Exceptions. In program year 2011, the 6-month reporting period is not available for EHR-based reporting of individual Physician Quality Reporting System quality measures or for reporting by group practices under the process described in paragraph (g) of this section.

(3) Reporting mechanisms. For program year 2011, an eligible professional who wishes to participate in the Physician Quality Reporting System must report information

on the individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups identified by CMS in the following manner:

(i) Reporting the individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups to CMS, by no later than 2 months after the end of the applicable reporting period, on the eligible professional's Medicare Part B claims for covered professional services furnished during the applicable reporting period.

(ii) Reporting the individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups to a qualified registry (as specified in paragraph (b) of this section) in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected registry will submit information, as required by CMS, for covered professional services furnished by the eligible professional during the applicable reporting period to CMS on the eligible professional's behalf; or

(iii) Reporting the individual Physician Quality Reporting System quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from a qualified EHR product (as defined in paragraph (b) of this section) by the deadline specified by CMS for covered professional services furnished by the eligible professional during the applicable reporting period. Prior to actual data submission for a given program year and by a date specified by CMS, the eligible professional must submit a test file containing real or dummy clinical quality data extracted from the qualified EHR product selected by the eligible professional using a secure data submission method, as required by CMS.

(g) Requirements for group practices to qualify to receive an incentive payment. A group practice (as defined in paragraph (b) of this section) will be treated as satisfactorily submitting data on quality measures under Physician Quality Reporting System for covered professional services for a reporting period, if, in lieu of reporting Physician Quality Reporting System measures, the group practice--

(1) Meets the participation requirements specified by CMS for the Physician Quality Reporting System group practice reporting option or is a group practice of any size (including solo practitioners) or comprised of multiple TINs participating in a Medicare approved demonstration project that is deemed to be participating in the Physician Quality Reporting System group practice reporting option;

(2) Is selected by CMS to participate in the Physician Quality Reporting System group practice reporting option;

(3) Reports measures specified by CMS in the form and manner, and at a time specified by CMS; and

(4) Meets other requirements for satisfactory reporting specified by CMS.

(5) No double payments. Payments to a group practice under this paragraph must be in lieu of the payments that would otherwise be made under the Physician Quality Reporting System to eligible professionals in the group practice for meeting the criteria for satisfactory reporting for individual eligible professionals.

(i) If an eligible professional, as identified by an individual NPI, has reassigned his or her Medicare billing rights to a TIN selected to participate in the Physician Quality Reporting System group practice reporting option for a program year, then for that program year the eligible professional must participate in the Physician Quality

Reporting System via the group practice reporting option. For any program year in which the TIN is selected to participate in the Physician Quality Reporting System group practice reporting option, the eligible professional cannot individually qualify for a Physician Quality Reporting System incentive payment by meeting the requirements specified in paragraph (f) of this section.

(ii) If, for the program year, the eligible professional participates in the Physician Quality Reporting System under another TIN that is not selected to participate in the Physician Quality Reporting System group practice reporting option for that program year, then the eligible professional may individually qualify for a Physician Quality Reporting System incentive by meeting the requirements specified in paragraph (f) of this section under that TIN.

(h) Limitations on review. Except as specified in paragraph (i) of this section, there is no administrative or judicial review under section 1869 or 1879 of the Act, or otherwise of--

(1) The determination of measures applicable to services furnished by eligible professionals under the Physician Quality Reporting System;

(2) The determination of the payment limitation; and

(3) The determination of any Physician Quality Reporting System incentive payment and the Physician Quality Reporting System payment adjustment.

(i) Informal review. Eligible professionals (or in the case of reporting under paragraph (g) of this section, group practices) may seek an informal review of the determination that an eligible professional (or in the case of reporting under paragraph (g) of this section, group practices) did not satisfactorily submit data on quality measures

under the Physician Quality Reporting System.

(1) To request an informal review, an eligible professional (or in the case of reporting under paragraph (g) of this section, group practices) must submit a request to CMS within 90 days of the release of the feedback reports. The request must be submitted in writing or via email and summarize the concern(s) and reasons for requesting an informal review and may also include information to assist in the review.

(2) CMS will provide a written response within 60 days of the receipt of the original request.

(i) All decisions based on the informal review will be final.

(ii) There will be no further review or appeal.

(j) Public reporting of an eligible professional's or group practice's Physician Quality Reporting System data. For each program year, CMS will post on a public website, in an easily understandable format, a list of the names of eligible professionals (or in the case of reporting under paragraph (g) of this section, group practices) who satisfactorily submitted Physician Quality Reporting System quality measures.

30. A new §414.92 is added to read as follows:

§ 414.92 Electronic Prescribing Incentive Program.

(a) Basis and scope. This section implements the following provisions of the Act:

(1) Section 1848(a)--Payment Based on Fee Schedule.

(2) Section 1848(m)--Incentive Payments for Quality Reporting.

(b) Definitions. As used in this section, unless otherwise indicated--

Covered professional services means services for which payment is made under,

or is based on, the Medicare physician fee schedule which are furnished by an eligible professional.

Electronic Prescribing Incentive Program means the incentive payment program established under section 1848(m) of the Act for the adoption and use of electronic prescribing technology by eligible professionals.

Eligible professional means any of the following healthcare professionals who have prescribing authority:

(i) A physician.

(ii) A practitioner described in section 1842(b)(18)(C) of the Act.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

Group practice means a group practice that is--

(i) Defined at §414.90(b), that is participating in the Physician Quality Reporting System; or

(ii) (A) In a Medicare approved demonstration project that is deemed to be participating in the Physician Quality Reporting System group practice reporting option; and

(B) Has indicated its desire to participate in the electronic prescribing group practice option.

Qualified electronic health record product means an electronic health record product and version that, with respect to a particular program year, is designated by CMS as a qualified electronic health record product for the purpose of the Physician Quality

Reporting System (as described in §414.90) and the product's vendor has indicated a desire to have the product qualified for purposes of the product's users to submit information related to the electronic prescribing measure.

Qualified registry means a medical registry or a Maintenance of Certification Program operated by a specialty body of the American Board of Medical Specialties that, with respect to a particular program year, is designated by CMS as a qualified registry for the purpose of the Physician Quality Reporting System (as described in §414.90) and that has indicated its desire to be qualified to submit the electronic prescribing measure on behalf of eligible professionals for the purposes of the Electronic Prescribing Incentive Program.

(c) Incentive payments and payment adjustments. (1) Incentive payments. Subject to paragraph (c)(3) of this section, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting period, in addition to the amount otherwise paid under section 1848 of the Act, there also must be paid to the eligible professional (or to an employer or facility in the cases described in section 1842(b)(6)(A) of the Act) or, in the case of a group practice under paragraph (e) of this section, to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Act an amount equal to the applicable electronic prescribing percent (as specified in paragraph (c)(1)(ii) of this section) of the eligible professional's (or, in the case of a group practice under paragraph (e) of this section, the group practice's) total estimated allowed charges for all covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph

(e) of this section, by the group practice) during the applicable reporting period.

(i) For purposes of paragraph (c)(1) of this section,

(A) The eligible professional's (or, in the case of a group practice under paragraph (e) of this section, the group practice's) total estimated allowed charges for covered professional services furnished during a reporting period are determined based on claims processed in the National Claims History (NCH) no later than 2 months after the end of the applicable reporting period;

(B) In the case of an eligible professional who furnishes covered professional services in more than one practice, incentive payments are separately determined for each practice based on claims submitted for the eligible professional for each practice;

(C) Incentive payments earned by an eligible professional (or in the case of a group practice under paragraph (e) of this section, by a group practice) for a particular program year will be paid as a single consolidated payment to the TIN holder of record.

(ii) Applicable electronic prescribing percent. The applicable electronic prescribing percent is as follows:

(A) For the 2011 and 2012 program years, 1.0 percent.

(B) For the 2013 program year, 0.5 percent.

(iii) Limitation with respect to electronic health record (EHR) incentive payments. The provisions of this paragraph do not apply to an eligible professional (or, in the case of a group practice under paragraph (e) of this section, a group practice) if, for the electronic health record reporting period the eligible professional (or group practice) receives an incentive payment under section 1848(o)(1)(A) of the Act with respect to a certified electronic health record technology (as defined in section 1848(o)(4) of the Act)

that has the capability of electronic prescribing.

(2) Incentive payment adjustment. Subject to paragraphs (c)(1)(ii) and (c)(3) of this section, with respect to covered professional services furnished by an eligible professional during 2012, 2013, or 2014, if the eligible professional (or in the case of a group practice under paragraph (e) of this section, the group practice) is not a successful electronic prescriber (as specified by CMS for purposes of the payment adjustment) for an applicable reporting period (as specified by CMS) the fee schedule amount for such services furnished by such professional (or group practice) during the program year (including the fee schedule amount for purposes of determining a payment based on such amount) is equal to the applicable percent (as specified in paragraph (c)(2)(i) of this section) of the fee schedule amount that would otherwise apply to such services under section 1848 of the Act.

(i) Applicable percent. The applicable percent is as follows:

(A) For 2012, 99 percent;

(B) For 2013, 98.5 percent; and

(C) For 2014, 98 percent.

(ii) Significant hardship exception. CMS may, on a case-by-case basis, exempt an eligible professional (or in the case of a group practice under paragraph (e) of this section, a group practice) from the application of the payment adjustment under paragraph (c)(2) of this section if, CMS determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship.

(3) Limitation with respect to electronic prescribing quality measures. The

provisions of paragraphs (c)(1) and (c)(2) of this section do not apply to an eligible professional (or, in the case of a group practice under paragraph (e) of this section, a group practice) if for the reporting period the allowed charges under section 1848 of the Act for all covered professional services furnished by the eligible professional (or group, as applicable) for the codes to which the electronic prescribing measure applies are less than 10 percent of the total of the allowed charges under section 1848 of the Act for all such covered professional services furnished by the eligible professional (or the group practice, as applicable).

(d) Requirements for individual eligible professionals to qualify to receive an incentive payment. In order to be considered a successful electronic prescriber and qualify to earn an electronic prescribing incentive payment (subject to paragraph (c)(3) of this section), an individual eligible professional, as identified by a unique TIN/NPI combination, must meet the criteria for successful electronic prescriber under section 1848(m)(3)(B) of the Act and as specified by CMS during the reporting period specified in paragraph (d)(1) of this section and using one of the reporting mechanisms specified in paragraph (d)(2) of this section. Although an eligible professional may attempt to qualify for the electronic prescribing incentive payment using more than one reporting mechanism (as specified in paragraph (d)(2) of this section), the eligible professional will receive only one electronic prescribing incentive payment per TIN/NPI combination for a program year.

(1) Reporting period. For purposes of this paragraph in 2011, the reporting period with respect to a program year is the entire calendar year.

(2) Reporting mechanisms. For program year 2011, an eligible professional who

wishes to participate in the Electronic Prescribing Incentive Program must report information on the electronic prescribing measure identified by CMS to--

(i) CMS, by no later than 2 months after the end of the applicable reporting period, on the eligible professional's Medicare Part B claims for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section;

(ii) A qualified registry (as defined in paragraph (b) of this section) in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected qualified registry will submit information, as required by CMS, for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section to CMS on the eligible professional's behalf; or

(iii) CMS by extracting clinical data using a secure data submission method, as required by CMS, from a qualified electronic health record product (as defined in paragraph (b) of this section) by the deadline specified by CMS for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section. Prior to actual data submission for a given program year and by a date specified by CMS, the eligible professional must submit a test file containing real or dummy clinical quality data extracted from the qualified electronic health record product selected by the eligible professional using a secure data submission method, as required by CMS.

(e) Requirements for group practices to qualify to receive an incentive payment. (1) A group practice (as defined in paragraph (b) of this section) will be treated as a

successful electronic prescriber for covered professional services for a reporting period if the group practice meets the criteria for successful electronic prescriber specified by CMS in the form and manner and at the time specified by CMS.

(2) No double payments. Payments to a group practice under this paragraph must be in lieu of the payments that would otherwise be made under the Electronic Prescribing Incentive Program to eligible professionals in the group practice for being a successful electronic prescriber.

(i) If an eligible professional, as identified by an individual NPI, has reassigned his or her Medicare billing rights to a TIN selected to participate in the electronic prescribing group practice reporting option for a program year, then for that program year the eligible professional must participate in the Electronic Prescribing Incentive Program via the group practice reporting option. For any program year in which the TIN is selected to participate in the Electronic Prescribing Incentive Program group practice reporting option, the eligible professional cannot individually qualify for an electronic prescribing incentive payment by meeting the requirements specified in paragraph (d) of this section.

(ii) If, for the program year, the eligible professional participates in the Electronic Prescribing Incentive Program under another TIN that is not selected to participate in the Electronic Prescribing Incentive Program group practice reporting option for that program year, then the eligible professional may individually qualify for an electronic prescribing incentive by meeting the requirements specified in paragraph (d) of this section under that TIN.

(f) Public reporting of an eligible professional's or group practice's Electronic

Prescribing Incentive Program data. For each program year, CMS will post on a public website, in an easily understandable format, a list of the names of eligible professionals (or in the case of reporting under paragraph (e) of this section, group practices) who are successful electronic prescribers.

Subpart D--Payment for Durable Medical Equipment and Prosthetic and Orthotic Devices

31. Section 414.202 is amended by adding the definition of "Complex rehabilitative power-driven wheelchair.

§414.202 Definitions.

* * * * *

Complex rehabilitative power-driven wheelchair means a power-driven wheelchair that is classified as--

(1) Group 2 power wheelchair with power options that can accommodate rehabilitative features (for example, tilt in space); or

(2) Group 3 power wheelchair.

* * * * *

32. Section 414.229 is amended by--

A. Revising paragraphs (a)(3), (d)(1), and (h).

B. Adding paragraphs (a)(4), (a)(5), and (b)(3).

The revisions and additions read as follows:

§414.229 Other durable medical equipment-capped rental items.

(a) * * *

(3) For power-driven wheelchairs furnished on or after January 1, 2006 through December 31, 2010, payment is made in accordance with the rules set forth in paragraphs (f) or (h) of this section.

(4) For power-driven wheelchairs that are not classified as complex rehabilitative power-driven wheelchairs, furnished on or after January 1, 2011, payment is made in accordance with the rules set forth in paragraph (f) of this section.

(5) For power-driven wheelchairs classified as complex rehabilitative power-driven wheelchairs, furnished on or after January 1, 2011, payment is made in accordance with the rules set forth in paragraphs (f) or (h) of this section.

(b) * * *

(3) For power-driven wheelchairs furnished on or after January 1, 2011, the monthly fee schedule amount for rental equipment equals 15 percent of the purchase price recognized as determined under paragraph (c) of this section for each of the first 3 months and 6 percent of the purchase price for each of the remaining months.

* * * * *

(d) * * *

(1) Suppliers must offer beneficiaries the option of purchasing power-driven wheelchairs at the time the supplier first furnishes the item. On or after January 1, 2011, this option is available only for complex rehabilitative power-driven wheelchairs. Payment must be on a lump-sum fee schedule purchase basis if the beneficiary chooses the purchase option. The purchase fee is the amount established in paragraph (c) of this section.

* * * * *

(h) Purchase of power-driven wheelchairs furnished on or after January 1, 2006. (1) Suppliers must offer beneficiaries the option to purchase power-driven wheelchairs at the time the equipment is initially furnished.

(2) Payment is made on a lump-sum purchase basis if the beneficiary chooses this option.

(3) On or after January 1, 2011, this option is available only for complex rehabilitative power-driven wheelchairs.

Subpart F--Competitive Bidding for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

33. Section 414.402 is amended by adding the definitions of "Affected party," "Breach of contract," "Corrective action plan (CAP)," "Hearing officer," "Mail order item," "National mail order DMEPOS competitive bidding program," "Non-mail order item" and "Parties to the hearing" in alphabetical order to read as follows:

§414.402 Definitions.

Affected party means a contract supplier that has been notified that their DMEPOS CBP contract will be terminated for a breach of contract.

* * * * *

Breach of contract means any deviation from contract requirements, including a failure to comply with a governmental agency or licensing organization requirements, constitutes a breach of contract.

* * * * *

Corrective action plan (CAP) means a contract supplier's written document with supporting information that describes the actions the contract supplier will take within a specified timeframe to remedy a breach of contract.

* * * * *

Hearing officer (HO) means an individual, who was not involved with the CBIC recommendation to terminate a DMEPOS Competitive Bidding Program contract, who is designated by CMS to review and make an unbiased and independent recommendation when there is an appeal of CMS's initial determination to terminate a DMEPOS Competitive Bidding Program contract.

* * * * *

Mail order item means any item (for example, diabetic testing supplies) shipped or delivered to the beneficiary's home, regardless of the method of delivery.

* * * * *

National mail order DMEPOS competitive bidding program means a program whereby contracts are awarded to suppliers for the furnishing of mail order items across the nation.

* * * * *

Non-mail order item means any item (for example, diabetic testing supplies) that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront.

Parties to the hearing means the DMEPOS contract supplier and CMS.

* * * * *

34. Section 414.404 is amended by revising paragraph (b)(1)(i) to read as follows:

§414.404 Scope and applicability

* * * * *

(b) * * *

(1) * * *

(i) The items furnished are limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps that are DME, and off-the-shelf (OTS) orthotics.

* * * * *

35. Section 414.408 is amended by-–

A. Revising paragraph (f)(1).

B. Redesignating paragraph (h)(2) through (h)(7) as paragraphs (h)(3) through (h)(8), respectively.

C. Adding new paragraph (h)(2).

D. In newly designated paragraphs (h)(3)(i) and (ii), remove the phrase "(h)(2)" and insert in its place the phrase "(h)(3)."

The revision and addition reads as follows:

§ 414.408 Payment rules.

* * * * *

(f) * * *

(1) The single payment amounts for new purchased durable medical equipment, including power wheelchairs that are purchased when the equipment is initially furnished and enteral nutrition equipment are calculated based on the bids submitted and accepted for these items. For contracts entered into beginning on or after January 1, 2011,

payment on a lump sum purchase basis is only available for power wheelchairs classified as complex rehabilitative power wheelchairs.

* * * * *

(h) * * *

(2) For contracts entered into beginning on or after January 1, 2011, the monthly fee schedule amount for rental of power wheelchairs equals 15 percent of the single payment amounts calculated for new durable medical equipment under paragraph (f)(1) of this section for each of the first 3 months, and 6 percent of the single payment amounts calculated for these items for each of the remaining months 4 through 13.

* * * * *

36. Section 414.410 is amended as follows:

A. Revising paragraphs (a)(2) and (a)(3).

B. Adding a new paragraph (a)(4).

The revisions and addition read as follows:

§414.410 Phase-in implementation of competitive bidding programs.

(a) * * *

(2) In CY 2011, in an additional 91 MSAs (the additional 70 MSAs selected by CMS as of June 1, 2008, and the next 21 largest MSAs by total population based on 2009 population estimates, and not already phased in as of June 1, 2008). CMS may subdivide any of the 91 MSAs with a population of greater than 8,000,000 into separate CBAs, thereby resulting in more than 91 CBAs.

(3) After CY 2011, additional CBAs (or, in the case of national mail order for items and services, after CY 2010).

(4) For competitions (other than for national mail order items and services) after CY 2011 and prior to CY 2015, the following areas are excluded:

(i) Rural areas.

(ii) MSAs not selected under paragraphs (a)(1) or (a)(2) of this section with a population of less than 250,000.

(iii) An area with low population density within an MSA not selected under paragraphs (a)(1) or (a)(2) of this section.

* * * * *

37. Section 414.411 is added to read as follows:

§414.411 Special rule in case of competitions for diabetic testing strips conducted on or after January 1, 2011.

(a) National mail order competitions. A supplier must demonstrate that their bid submitted as part of a national mail order competition for diabetic testing strips covers the furnishing of a sufficient number of different types of diabetic testing strip products that, in the aggregate, and taking into account volume for the different products, includes at least 50 percent of all the different types of products on the market. A type of diabetic testing strip means a specific brand and model of testing strips.

(b) Other competitions. CMS may apply this special rule to non-mail order or local competitions for diabetic testing strips.

38 Section 414.422 is amended by adding paragraph (e)(3) to read as follows:

§414.422 Term of contracts.

* * * * *

(e) * * *

(3) Contract suppliers for diabetic testing supplies must furnish the brand of diabetic testing supplies that work with the home blood glucose monitor selected by the beneficiary. The contract supplier is prohibited from influencing or incentivizing the beneficiary by persuading, pressuring, or advising them to switch from their current brand or for new beneficiaries from their preferred brand of glucose monitor and testing supplies. The contract supplier may not furnish information about alternative brands to the beneficiary unless the beneficiary requests such information.

* * * * *

39. Section 414.423 is added to read as follows:

§414.423 Appeals Process for Termination of Competitive Bidding Contract

This section implements an appeals process for suppliers that CMS has determined are in breach of their Medicare DMEPOS Competitive Bidding Program contracts and where CMS has taken action to terminate the supplier's contract. Except as specified in this regulation termination decisions made under this section are final and binding.

(a) Terminations for breach of contract. CMS may terminate a supplier's DMEPOS Competitive Bidding Program contract when it determines that the supplier has violated any of the terms of its contract.

(b) Notice of termination.

(1) CMS notification. If CMS determines a supplier to be in breach of its contract either in part or in whole, it will notify the Medicare DMEPOS supplier of the termination by certified mail.

(2) Content of the notice. The CMS notice will include the following:

(i) The reasons for the termination.

(ii) The right to request a hearing by a CBIC Hearing Officer, and depending on the nature of the breach, the supplier may also be allowed to submit a CAP in lieu of requesting a hearing by a CBIC Hearing Officer, as specified in paragraph (c)(1)(i) of this section.

(iii) The address to which the written request for a hearing must be mailed.

(iv) The address to which the CAP must be mailed, if applicable.

(v) Penalties that will accompany the termination, such as not being eligible to bid in future rounds of competitive bidding.

(vi) The effective date of termination is 45 days from the date of the notification letter unless a timely hearing request has been filed or a corrective action plan (CAP) has been submitted within 30 days of the date on the notification letter.

(c) Corrective action plan (CAP). (1) Option for corrective action plan (CAP).

(i) CMS has the option to allow a DMEPOS supplier to provide a written corrective action plan (CAP) to remedy the deficiencies identified in the notice, when CMS determines that the delay in the termination date caused by allowing a CAP will not cause harm to beneficiaries, for example, we would not allow a CAP if the supplier has been excluded from any Federal program, debarred by a Federal agency, or convicted of a healthcare-related crime.

(ii) If a supplier chooses not to submit a CAP or if CMS determines that a supplier's CAP is insufficient, the supplier may request a hearing on the termination.

(2) Submission of a CAP. (i) A corrective action plan must be submitted within 30 days from the date on the notification letter. If the supplier decides not to submit a

corrective action plan the supplier may within 30 days of the date on the termination letter request a hearing by a CBIC hearing officer.

(ii) Suppliers will only have the opportunity to submit a CAP when they are first notified that they have been determined to be in breach of contract. If the CAP is not acceptable or properly implemented, suppliers will receive a subsequent termination notice.

(d) The purpose of the corrective action plan. (1) For the supplier to eliminate all of the deficiencies that were identified in the notice to terminate its contract to avoid contract termination.

(2) To identify the timeframes by which the supplier will implement each of the components of the CAP.

(e) Review of the CAP. (1) The CBIC will review the CAP. Suppliers may only revise their CAP one-time during the review process based on the deficiencies identified by the CBIC. The CBIC will submit a recommendation to CMS concerning whether the CAP includes the steps necessary to remedy the contract deficiencies as identified in the notice of termination.

(2) If CMS accepts the CAP, including supplier's designated timeframe for its completion; the supplier must provide a follow-up report within 5 days after the supplier has fully implemented the CAP that verifies that all of the deficiencies identified in the CAP have been corrected in accordance with the timeframes accepted by CMS.

(3) If the supplier does not implement an acceptable CAP the supplier will receive a subsequent notice that their contract will be terminated within 45 days of the date on that notice.

(f) Right to request a hearing by the CBIC hearing officer (HO). (1) A supplier who has received a notice that CMS considers the supplier in breach of contract or that the supplier's CAP is not acceptable has the right to request a hearing before a HO who was not involved with the original determination.

(2) A supplier who wishes to appeal the termination notice must submit a written request to the CBIC. The request for a hearing must be received by the CBIC within 30 days from the date of the notice to terminate.

(3) A request for hearing must be in writing and submitted by an authorized official of the supplier.

(4) The appeals process for the Medicare DMEPOS Competitive Bidding Program is not to be used in place of other existing appeals processes that apply to other parts of the Medicare.

(5) If the supplier is given the opportunity to submit a CAP and a CAP is not submitted and the supplier fails to timely request a hearing, this will result in the termination of the supplier's DMEPOS Competitive Bidding Program contract effective 45 days from the date on the notice to terminate received by the supplier.

(g) The CBIC Hearing Officer schedules and conducts the hearing. (1) Within 30 days from the receipt of the supplier's timely request for a hearing the hearing officer will contact the parties to schedule the hearing.

(2) The hearing may be held in person or by telephone at the supplier's request.

(3) The scheduling notice to the parties must indicate the time and place for the hearing and must be sent to the supplier 30 days before the date of the hearing.

(4) The HO may, on his or her own motion, or at the request of a party, change the time and place for the hearing, but must give the parties to the hearing 30 days notice of the change.

(5) The HO's scheduling notice must provide the parties to the hearing and the CBIC the following information:

(i) Description of the hearing procedure.

(ii) The general and specific issues to be resolved.

(iii) The supplier has the burden to prove it is not in violation of the contract.

(iv) The opportunity for parties to the hearing to submit additional evidence to support their positions, if requested by the HO.

(v) All evidence submitted, both from the supplier and CMS, in preparation for the hearing with all affected parties within 15 days prior to the scheduled dated of the hearing.

(h) Burden of proof. (1) The burden of proof is on the Competitive Bidding Program contract supplier to demonstrate to the HO with convincing evidence that it has not breached its contract or that termination is not appropriate.

(2) The supplier's supporting evidence must be submitted with its request for a hearing.

(3) If the Medicare DMEPOS supplier fails to submit this evidence at the time of its submission, the Medicare DMEPOS supplier is precluded from introducing new evidence later during the hearing process, unless permitted by the hearing officer.

(4) CMS also has the opportunity to submit evidence to the HO within 10 days of receiving a notice announcing the hearing.

(5) The HO will share all evidence submitted by the supplier and/or CMS, with all parties to the hearing and the CBIC within 15 days prior to the scheduled date of the hearing.

(i) Role of the Hearing Officer. The HO will conduct a thorough and independent review of the evidence including the information and documentation submitted for the hearing and other information that the HO considers pertinent for the hearing. The role of the HO includes, at a minimum, the following:

(1) Conducts the hearing and decides the order in which the evidence and the arguments of the parties are presented;

(2) Determines the rules on admissibility of the evidence;

(3) Examines the witnesses, in addition to the examinations conducted by CMS and the contract supplier;

(4) The CBIC may assist CMS in the appeals process including being present at the hearing, testifying as a witness, or performing other, related ministerial duties.

(5) Determines the rules for requesting documents and other evidence from other parties;

(6) Ensures a complete record of the hearing is made available to all parties to the hearing;

(7) Prepares a file of the record of the hearing which includes all evidence submitted as well as any relevant documents identified by the HO and considered as part of the hearing; and

(8) Complies with all applicable provisions of 42 USC Title 18 and related provisions of the Act, the applicable regulations issued by the Secretary, and manual instructions issued by CMS.

(j) Hearing Officer recommendation. (1) The HO will issue a written recommendation to CMS within 30 days of the close of the hearing unless an extension has been granted by CMS because the HO has demonstrated that an extension is needed due to the complexity of the matter or heavy workload.

(2) The recommendation will explain the basis and the rationale for the HO's recommendation.

(3) The hearing officer must include the record of the hearing, along with all evidence and documents produced during the hearing along with its recommendation.

(k) CMS' final determination. (1) CMS' review of the HO recommendation will not allow the supplier to submit new information.

(2) After reviewing the HO recommendation, CMS' decision will be made within 30 days from the date of receipt of the HO's recommendation.

(3) A CMS decision to terminate will indicate the effective date of the termination.

(4) This decision is final and binding.

(l) Effect of contract termination. A contract supplier whose contract has been terminated--

(1) All locations included in the contract can no longer furnish competitive bid items to beneficiaries within a CBA and the supplier cannot be reimbursed by Medicare for these items after the effective date of the termination.

(2) Must notify all beneficiaries who are receiving rented competitive bid items or competitive bid items received on a recurring basis, of the termination of their contract.

(i) The notice to the beneficiary from the supplier whose contract was terminated must be provided within 15 days of receipt of the final notice of termination.

(ii) The notification to the beneficiaries must inform the beneficiaries that they are going to have to select a new contract supplier to furnish these items in order for Medicare to pay these items.

(m) Effective date of the contract termination. (1) A supplier's DMEPOS CBP contract is terminated effective on the termination date specified in the notice to the supplier, unless the supplier timely requests a hearing with the HO or the supplier has submitted a CAP under paragraph (c) of this section.

(2) If a supplier requests an HO review of the CMS decision to terminate its contract, and CMS based upon the HO's recommendation terminates the supplier's contract, the effective date of the termination will be the date specified in the post-hearing notice to the supplier indicating CMS's final determination to terminate the contract.

(3) For violations of the terms of the supplier's DMEPOS CBP contract that may harm beneficiaries, such as a supplier providing an inferior product that causes harm to the beneficiary, no delays of the effective date of the termination will be allowed.

Subpart H --Fee Schedule for Ambulance Services

39. Section 414.610 is amended as follows:

A. Revising paragraph (c)(1)(i).

B. Redesignating (c)(1)(ii) as (c)(1)(iii).

C. Adding a new paragraph (c)(1)(ii).

D. Revising paragraphs (c)(5)(ii), (f), and (h).

The revisions and addition read as follows:

§414.610 Basis of payments.

* * * * *

(c) * * *

(1) * * *

(i) For services furnished during the period July 1, 2004 through December 31, 2006, ambulance services originating in--

(A) Urban areas (both base rate and mileage) are paid based on a rate that is 1 percent higher than otherwise is applicable under this section; and

(B) Rural areas (both base rate and mileage) are paid based on a rate that is 2 percent higher than otherwise is applicable under this section.

(ii) For services furnished during the period July 1, 2008 through December 31, 2010, ambulance services originating in--

(A) Urban areas (both base rate and mileage) are paid based on a rate that is 2 percent higher than otherwise is applicable under this section;

(B) Rural areas (both base rate and mileage) are paid based on a rate that is 3 percent higher than otherwise is applicable under this section.

* * * * *

(5) * * *

(ii) For services furnished during the period July 1, 2004 through December 31, 2010, the payment amount for the ground ambulance base rate is increased by 22.6 percent where the point of pickup is in a rural area determined to be in the lowest 25 percent of rural population arrayed by population density. The amount of this increase is based on CMS's estimate of the ratio of the average cost per trip for the rural areas in the lowest quartile of population compared to the average cost per trip for the rural areas in the highest quartile of population. In making this estimate, CMS may use data provided by the GAO.

* * * * *

(f) Updates. The CF, the air ambulance base rates, and the mileage rates are updated annually by an inflation factor established by law. The inflation factor is based on the consumer price index for all urban consumers (CPI-U) (U.S. city average) for the 12-month period ending with June of the previous year and, for 2011 and each subsequent year, is reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

* * * * *

(h) Treatment of certain areas for payment for air ambulance services. Any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished on December 31, 2006, must be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008 through December 31, 2010.

40. Section 414.620 is revised to read as follows:

§414.620 Publication of the ambulance fee schedule.

(a) Changes in payment rates resulting from incorporation of the annual inflation factor and the productivity adjustment as described in §414.610(f) will be announced by CMS by instruction and on the CMS website.

(b) CMS will follow applicable rulemaking procedures in publishing revisions to the fee schedule for ambulance services that result from any factors other than those described in §414.610(f).

Subpart J--Submission of Manufacturer's Average Sales Price Data

41. Section 414.804 is amended by--

A. Redesignating paragraph (a)(6) as (a)(7).

B. Adding new paragraph (a)(6).

C. Reserving paragraph (b).

The addition reads as follows:

§414.804 Basis of payment.

(a) * * *

(6) The manufacturer's average sales price must be calculated based on the amount of product in a vial or other container as conspicuously reflected on the FDA approved label as defined by section 201(k) of the Food, Drug, and Cosmetic Act.

(b) [Reserved]

Subpart K--Payment for Drugs and Biologicals Under Part B

42. Section 414.902 is amended by adding the definitions of "Biosimilar biological product" and "Reference biological product" in alphabetical order to read as follows:

§414.902 Definitions.

* * * * *

Biosimilar biological product means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act (PHSA) as defined at section 1847A(c)(6)(H) of the Act.

* * * * *

Reference biological product means the biological product licensed under such section 351 of the PHSA that is referred to in the application of the biosimilar biological product as defined at section 1847A(c)(6)(I) of the Act.

* * * * *

43. Section 414.904 is amended by--

A. Adding paragraphs (a)(3), (i), and (j).

B. Revising paragraph (d)(3).

The revisions and additions read as follows:

§414.904 Average sales price as the basis for payment.

(a) * * *

(3) For purposes of this paragraph--

(i) CMS calculates an average sales price payment limit based on the amount of product included in a vial or other container as reflected on the FDA-approved label.

(ii) Additional product contained in the vial or other container does not represent a cost to providers and is not incorporated into the ASP payment limit.

(iii) No payment is made for amounts of product in excess of that reflected on the FDA-approved label.

* * * * *

(d) * * *

(3) Widely available market price and average manufacturer price. If the Inspector General finds that the average sales price exceeds the widely available market price or the average manufacturer price by 5 percent or more in CYs 2005 through 2011 the payment limit in the quarter following the transmittal of this information to the Secretary is the lesser of the widely available market price or 103 percent of the average manufacturer price.

* * * * *

(i) If manufacturer ASP data is not available prior to the publication deadline for quarterly payment limits and the unavailability of manufacturer ASP data significantly changes the quarterly payment limit for the billing code when compared to the prior quarter's billing code payment limit, the payment limit is calculated by carrying over the most recent available manufacturer ASP price from a previous quarter for an NDC in the billing code, adjusted by the weighted average of the change in the manufacturer ASPs for the NDCs that were reported for both the most recently available previous quarter and the current quarter.

(j) Biosimilar biological products. Effective July 1, 2010, the payment amount for a biosimilar biological drug product (as defined in §414.902 of this subpart) is the sum of the average sales price of all NDCs assigned to the biosimilar biological product as determined under section 1847A(b)(6) of the Act and 6 percent of the amount determined under section 1847A(b)(4) of the Act for the reference drug product (as defined in §414.902 of this subpart).

PART 415--SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

44. The authority citation for part 415 continues to read as follows:

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

Subpart C--Part B Carrier Payments for Physician Services to Beneficiaries in Providers

45. Section 415.130 is amended by revising paragraph (d) to read as follows:

§415.130 Conditions for payment: Physician pathology services.

* * * * *

(d) Physician pathology services furnished by an independent laboratory.

(1) The technical component of physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient on or before December 31, 2010, may be paid to the laboratory by the contractor under the physician fee schedule if the Medicare beneficiary is a patient of a covered hospital as defined in paragraph (a)(1) of this section.

(2) For services furnished after December 31, 2010, an independent laboratory may not bill the Medicare contractor for the technical component of physician pathology services furnished to a hospital inpatient or outpatient.

(3) For services furnished on or after January 1, 2008, the date of service policy in §414.510 of this chapter applies to the TC of specimens for physician pathology services.

PART 424--CONDITIONS FOR MEDICARE PAYMENT

46. The authority citation for part 424 continues to read as follows:

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

Subpart B--Certification and Plan of Treatment Requirements

47. Section 424.20 is amended by revising paragraph (e)(2) to read as follows:

§424.20 Requirements for posthospital SNF care.

* * * * *

(e) * * *

(2) A physician extender (that is, a nurse practitioner, a clinical nurse specialist, or a physician assistant as those terms are defined in section 1861(aa)(5) of the Act) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with a physician. For purposes of this section--

(i) Collaboration. (A) Collaboration means a process whereby a physician extender works with a doctor of medicine or osteopathy to deliver health care services.

(B) The services are delivered within the scope of the physician extender's professional expertise, with medical direction and appropriate supervision as provided for

in guidelines jointly developed by the physician extender and the physician or other mechanisms defined by Federal regulations and the law of the State in which the services are performed.

(ii) Types of employment relationships. (A) Direct employment relationship. A direct employment relationship with the facility is one in which the physician extender meets the common law definition of the facility's "employee," as specified in §404.1005, §404.1007, and §404.1009 of title 20 of the regulations. When a physician extender meets this definition with respect to an entity other than the facility itself, and that entity has an agreement with the facility for the provision of nursing services under § 409.21 of this subchapter, the facility is considered to have an indirect employment relationship with the physician extender.

(B) Indirect employment relationship. (1) When a physician extender meets the definition of a direct employment relationship in paragraph (e)(2)(ii)(A) of this section with respect to an entity other than the facility itself, and that entity has an agreement with the facility for the provision of nursing services under § 409.21 of this subchapter, the facility is considered to have an indirect employment relationship with the physician extender.

(2) An indirect employment relationship does not exist if the agreement between the entity and the facility involves only the performance of delegated physician tasks under §483.40(e) of this chapter.

* * * * *

Subpart C--Claims for Payment

48. Section 424.44 is amended by revising paragraphs (a), (b), and (e) to read as follows:

§424.44 Time limits for filing claims.

(a) Time limits. (1) Except as provided in paragraphs (b) and (e) of this section, for services furnished on or after January 1, 2010, the claim must be filed no later than the close of the period ending 1 calendar year after the date of service.

(2) Except as provided in paragraphs (b) and (e) of this section and except for services furnished during the last 3 months of 2009, for services furnished before January 1, 2010, the claim must be filed--

(i) On or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year; and

(ii) On or before December 31st of the second following year for services that were furnished during the last 3 months of the calendar year.

(3) For services furnished during the last 3 months of CY 2009 all claims must be filed no later than December 31, 2010.

(b) Exceptions to time limits. Exceptions to the time limits for filing claims include the following:

(1) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of HHS that was performing Medicare functions and acting within the scope of its authority.

(2) The time for filing a claim will be extended if CMS or one of its contractors

determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was not entitled to Medicare.

(ii) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(3) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was not entitled to Medicare.

(ii) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(iii) A State Medicaid agency recovered the Medicaid payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.

(4) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was enrolled in a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization.

(ii) The beneficiary was subsequently disenrolled from the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization

effective retroactively to or before the date of the furnished service.

(iii) The Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.

(5) Extension of time. (i) If CMS or one of its contractors determines that a failure to meet the deadline specified in paragraph (a) of this section was caused by error or misrepresentation of an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of HHS that was performing Medicare functions and acting within the scope of its authority, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which either the beneficiary or the provider or supplier received notification that the error or misrepresentation referenced in paragraph (b)(1) of this section was corrected. No extension of time will be granted for paragraph (b)(1) when the request for that exception is made to CMS or one of its contractors more than 4 years after the date of service.

(ii) If CMS or one of its contractors determines that both of the conditions are met in paragraph (b)(2) of this section but that all of the conditions in paragraph (b)(3) are not satisfied, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which either the beneficiary or the provider or supplier received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(iii) If CMS or one of its contractors determines that all of the conditions are met in paragraph (b)(3) of this section, the time to file a claim will be extended through the

last day of the sixth calendar month following the month in which the State Medicaid agency recovered the Medicaid payment for the furnished service from the provider or supplier.

(iv) If CMS or one of its contractors determines that all of the conditions are met in paragraph (b)(4) of this section, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from the provider or supplier.

* * * * *

(e) As specified in §424.520 and §424.521 of this subpart, there are restrictions on the ability of the following newly-enrolled suppliers to submit claims for items or services furnished prior to the effective date of their Medicare billing privileges:

(1) Physician or nonphysician practitioner organizations.

(2) Physicians.

(3) Nonphysician practitioners.

(4) Independent diagnostic testing facilities.

* * * * *

Subpart P--Requirements for Establishing and Maintaining Medicare Billing Privileges

49. Section 424.502 is amended by adding a definition of "Voluntary termination" to read as follows:

§424.502 Definitions.

* * * * *

Voluntary termination means that a provider or supplier, including an individual physician or nonphysician practitioner, submits written confirmation to CMS of its decision to discontinue enrollment in the Medicare program.

50. Section 424.510 is amended by revising paragraph (d)(2)(iii) to read as follows:

§424.510 Requirements for enrolling in the Medicare program.

(d) * * *

(2) * * *

(iii) Submission of all documentation, including--

(A) All applicable Federal and State licenses, certifications including, but not limited to Federal Aviation Administration; and

(B) Documentation associated with regulatory and statutory requirements necessary to establish a provider's or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program.

51. Section 424.516 is amended by adding a new paragraph (e)(3) to read as follows:

§424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.

(e) * * *

(3) Within 30 days of any revocation or suspension of a Federal or State license or certification including Federal Aviation Administration certifications, an air

ambulance supplier must report a revocation or suspension of its license or certification to the applicable Medicare contractor. The following FAA certifications must be reported:

(i) Specific pilot certifications including but not limited to instrument and medical certifications.

(ii) Airworthiness certification.

* * * * *

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

Dated: October 26, 2010.

_____

Donald M. Berwick,

Administrator

Centers for Medicare & Medicaid Services.

Approved: October 29, 2010.

_____

Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

BILLING CODE 4120-01-P

ADDENDUM A: EXPLANATION AND USE OF ADDENDA B AND C

The Addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in CY 2011. Addendum B contains the RVUs for work, nonfacility PE, facility PE, and malpractice expense, and other information for all services included in the PFS. Addendum C contains the list of HCPCS codes that have interim work, PE, and/or malpractice expense RVUs for CY 2011 and are open for comment on this final rule with comment period.

(1) Addendum B, CY 2011 Relative Value Units and Related Information Used in Determining Medicare Payments

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes or the alpha-numeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B.

Addendum B contains the following information for each CPT code and alpha-numeric HCPCS code, except for: alpha-numeric codes beginning with B (enteral and parenteral therapy); E (durable medical equipment); K (temporary codes for nonphysicians' services or items); or L (orthotics); and codes for anesthesiology. Please also note the following:

- An "NA" in the "Nonfacility PE RVUs" column of Addendum B means that CMS has not developed a PE RVU in the nonfacility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office). If there is an "NA" in the

nonfacility PE RVU column, and the contractor determines that this service can be performed in the nonfacility setting, the service will be paid at the facility PE RVU rate.

- Services that have an "NA" in the "Facility PE RVUs" column of Addendum B are typically not paid under the PFS when provided in a facility setting. These services (which include "incident to" services and the technical portion of diagnostic tests) are generally paid under either the hospital outpatient prospective payment system or bundled into the hospital inpatient prospective payment system payment. In some cases, these services may be paid in a facility setting at the PFS rate (for example, therapy services), but there would be no payment made to the practitioner under the PFS in these situations.

1. CPT/HCPCS code. This is the CPT or alpha-numeric HCPCS number for the service. Alpha-numeric HCPCS codes are included at the end of this Addendum.

2. Modifier. A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier-26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code. A code for: the global values (both professional and technical); modifier-26 (PC); and modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service. Modifier-53 is shown for a discontinued procedure, for example, a colonoscopy that is not completed. There will be RVUs for a code with this modifier.

3. Status indicator. This indicator shows whether the CPT/HCPCS code is included in the PFS and whether it is separately payable if the service is covered. An explanation of types of status indicators follows:

A = Active code. These codes are separately payable under the PFS if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service. Contractors remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payments for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (for example, a telephone call from a hospital nurse regarding care of a patient).

C = Contractors price the code. Contractors establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation, such as an operative report.

E = Excluded from the PFS by regulation. These codes are for items and services that CMS chose to exclude from the PFS by regulation. No RVUs are shown, and no payment may be made under the PFS for these codes. Payment for them, when covered, continues under reasonable charge procedures.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Codes not subject to a 90 day grace period.)

M = Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. CMS uses them to aid with performance measurement. No separate payment is made. These codes should be billed with a zero

(($0.00) charge and are denied) on the MPFSDB.

N = Non-covered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is contractor-priced.

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

X = Statutory exclusion. These codes represent an item or service that is not within the statutory definition of "physicians' services" for PFS payment purposes. No RVUs are shown for these codes, and no payment may be made under the PFS, (for example, ambulance services and clinical diagnostic laboratory services.)

4. Description of code. This is the code's short descriptor, which is an abbreviated version of the narrative description of the code.

5. Physician work RVUs. These are the RVUs for the physician work in CY 2011.

6. Fully implemented nonfacility PE RVUs. These are the fully implemented resource-based PE RVUs for nonfacility settings.

7. CY 2011 transitional nonfacility PE RVUs. These are the CY 2011 resource-based PE RVUs for nonfacility settings.

8. Fully implemented facility PE RVUs. These are the fully implemented

resource-based PE RVUs for facility settings.

9. CY 2011 Transitional facility PE RVUs. These are the CY 2011 resource-based PE RVUs for facility settings.

10. Malpractice expense RVUs. These are the RVUs for the malpractice expense for CY 2011.

Note: The BN reduction resulting from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

11. *Global period*. This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = Code describes a service furnished in uncomplicated maternity cases, including ante partum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the contractor (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and PE are associated with intra-service time and, in some instances, with the post-service time.)

(2) Addendum C, Codes with Interim RVUs

Addendum C, Codes with Interim RVUs, includes the columns and indicators described above for Addendum B, plus an additional column to indicate which

component, or components, of each code's RVUs are interim final for CY 2011 and, therefore, open for public comment: work, PE, and/or malpractice expense. This column, headed "RVUs Open for Comment" and located between the columns for the "Description" and "Physician Work RVUs," displays the indicators below.

W = Physician work RVUs are interim for CY 2011 and open for comment.

PE = Nonfacility and facility PE RVUs are interim for CY 2011 and open for comment.

MP = Malpractice expense RVUs are interim for CY 2011 and open for comment.

ADDENDUM B: CY 2011—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
0001F		I	Heart failure composite	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0005F		I	Osteoarthritis composite	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0012F		I	Cap bacterial assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0014F		I	Comp preop assess cat surg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0015F		I	Melan follow-up complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T		C	Extracorp shock wv tx ms nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0030T		C	Antiprothrombin antibody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0042T		C	Ct perfusion w/contrast cbf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0048T		C	Implant ventricular device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0050T		C	Removal circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0051T		C	Implant total heart system	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0052T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0053T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0054T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0055T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0058T		C	Cryopreservation ovary tiss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0059T		C	Cryopreservation oocyte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0073T		A	Delivery comp imrt	0.00	13.38	15.38	NA	NA	0.01	XXX
0075T		C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0075T	TC	C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0075T	26	C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0076T		C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0076T	TC	C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
0076T	26	C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0080T		C	Endovasc aort repr rad s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0081T		C	Endovasc visc extnsn s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0085T		N	Breath test heart reject	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0092T		C	Artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0095T		C	Artific diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0098T		C	Rev artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0099T		C	Implant corneal ring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0100T		C	Prosth retina receive&gen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0101T		C	Extracorp shockwv tx hi enrg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0102T		C	Extracorp shockwv tx anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0103T		C	Holotranscobalamin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0106T		C	Touch quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0107T		C	Vibrate quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0108T		C	Cool quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0109T		C	Heat quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0110T		C	Nos quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0111T		C	Rbc membranes fatty acids	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0123T		C	Scleral fistulization	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0124T		C	Conjunctival drug placement	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0126T		C	Chd risk imt study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0141T		I	Perq islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0142T		I	Open islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0143T		I	Laparoscopic islet transplnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0155T		C	Lap impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0156T		C	Lap remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
0157T		C	Open impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0158T		C	Open remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0159T		C	Cad breast mri	0.00	0.00	0.00	NA	NA	0.00	ZZZ
0159T	TC	C	Cad breast mri	0.00	0.00	0.00	NA	NA	0.00	ZZZ
0159T	26	C	Cad breast mri	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0163T		C	Lumb artif diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0164T		C	Remove lumb artif disc addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0165T		C	Revise lumb artif disc addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0166T		C	Tcath vsd close w/o bypass	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0167T		C	Tcath vsd close w/bypass	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0168T		C	Rhinophototx light app bilat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0169T		C	Place stereo cath brain	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0171T		C	Lumbar spine proces distract	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0172T		C	Lumbar spine process addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0173T		C	Iop monit io pressure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0174T		C	Cad cxr with interp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0175T		C	Cad cxr remote	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0178T		C	64 lead ecg w/i&r	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0179T		C	64 lead ecg w/tracing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0180T		C	64 lead ecg w/i&r only	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0181T		C	Corneal hysteresis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0182T		C	Hdr elect brachytherapy	0.00	0.00	0.00	NA	NA	0.00	XXX
0182T	TC	C	Hdr elect brachytherapy	0.00	0.00	0.00	NA	NA	0.00	XXX
0182T	26	C	Hdr elect brachytherapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0183T		C	Wound ultrasound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0184T		C	Exc rectal tumor endoscopic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0185T		C	Comptr probability analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0186T		C	Suprachoroidal drug delivery	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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0188T		N	Videoconf crit care 74 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0189T		N	Videoconf crit care addl 30	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0190T		C	Place intraoc radiation src	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0191T		C	Insert ant segment drain int	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0192T		C	Insert ant segment drain ext	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0195T		C	Arthrod presac interbody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0196T		C	Arthrod presac interbody eac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0197T		C	Intrafraction track motion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0198T		C	Ocular blood flow measure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0199T		C	Physiologic tremor record	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0200T		C	Perq sacral augmt unilat inj	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0201T		C	Perq sacral augmt bilat inj	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0202T		C	Post vert arthrplst 1 lumbar	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0205T		C	Inirs each vessel add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0206T		C	Remote algorithm analys ecg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0207T		C	Clear eyelid gland w/heat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0208T		C	Audiometry air only	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0209T		C	Audiometry air & bone	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0210T		C	Speech audiometry threshold	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0211T		C	Speech audiom thresh & recog	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0212T		C	Compre audiometry evaluation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0213T		C	Njx paravert w/us cer/thor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0214T		C	Njx paravert w/us cer/thor	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0215T		C	Njx paravert w/us cer/thor	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0216T		C	Njx paravert w/us lumb/sac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0217T		C	Njx paravert w/us lumb/sac	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0218T		C	Njx paravert w/us lumb/sac	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0219T		C	Plmt post facet implt cerv	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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0220T		C	Plmt post facet implt thor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0221T		C	Plmt post facet implt lumb	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0222T		C	Plmt post facet implt addl	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0223T		C	Acoustic ecg w/i&r	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0224T		C	Acoustic ecg 1+ analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0225T		C	Acoustic ecg analy & reprog	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0226T		C	Anoscopy hra w/spec collect	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0227T		C	Anoscopy hra w/biopsy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0228T		C	Njx tfrml eprl w/us cer/thor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0229T		C	Njx tfrml eprl w/us cer/thor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0230T		C	Njx tfrml eprl w/us lumb/sac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0231T		C	Njx tfrml eprl w/us lumb/sac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0232T		C	Njx platelet plasma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0233T		C	Skin glycation spectroscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0234T		C	Trluml perip athrc renal art	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0235T		C	Trluml perip athrc visceral	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0236T		C	Trluml perip athrc abd aorta	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0237T		C	Trluml perip athrc brchiocph	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0238T		C	Trluml perip athrc iliac art	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0239T		C	Bioimpedance spectroscopy	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0240T		C	Esoph motility 3d topography	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0240T	TC	C	Esoph motility 3d topography	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0240T	26	C	Esoph motility 3d topography	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0241T		C	Esoph motility w/stim/perf	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0241T	TC	C	Esoph motility w/stim/perf	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0241T	26	C	Esoph motility w/stim/perf	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0242T		C	Gi tract transit & pres meas	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0242T	TC	C	Gi tract transit & pres meas	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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0242T	26	C	Gi tract transit & pres meas	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0243T		C	Intm msr bronchodil wheeze	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0243T	TC	C	Intm msr bronchodil wheeze	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0243T	26	C	Intm msr bronchodil wheeze	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0244T		C	Cont msr bronchodil wheeze	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0244T	TC	C	Cont msr bronchodil wheeze	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0244T	26	C	Cont msr bronchodil wheeze	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0245T		C	Opn tx rib fx 1-2 ribs	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0246T		C	Opn tx rib fx 3-4 ribs	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0247T		C	Opn tx rib fx 5-6 ribs	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0248T		C	Opn tx rib fx 7+ ribs	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0249T		C	Ligation hemorrhoid w/us	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0250T		C	Insert bronchial valve	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0251T		C	Remov bronchial valve addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0252T		C	Bronchscpc rmvl bronch valve	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0253T		C	Insert aqueous drain device	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0254T		C	Evasc rpr iliac art bifur	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0255T		C	Evasc rpr iliac art bifr s&i	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0255T	TC	C	Evasc rpr iliac art bifr s&i	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0255T	26	C	Evasc rpr iliac art bifr s&i	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0256T		C	Evasc aortic hrt valve	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0257T		C	Opn tthrc aortic hrt valve	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0258T		C	Aortic hrt valv w/o card byp	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0259T		C	Aortic hrt valve w/card byp	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0260T		C	Hypthrm bdy neonate 28d/<	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0261T		C	Hypthrm head neonate 28d/<	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0501F		I	Prenatal flow sheet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0502F		I	Subsequent prenatal care	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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0503F		I	Postpartum care visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0516F		I	Anemia plan of care docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0519F		I	Pland chemo docd b/4 txmnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0525F		I	Initial visit for episode	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0528F		I	Rcmnd flw-up 10 yrs docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0535F		I	Dyspnea mngmnt plan docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0545F		I	Follow up care plan mdd docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1000F		I	Tobacco use assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10021		A	Fna w/o image	1.27	2.78	2.71	0.64	0.59	0.22	XXX
10022		A	Fna w/image	1.27	2.47	2.62	0.52	0.52	0.14	XXX
1003F		I	Level of activity assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10040		A	Acne surgery	1.21	1.65	1.60	1.29	1.23	0.18	010
1004F		I	Clin symp vol ovrld assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10060		A	Drainage of skin abscess	1.22	2.00	1.87	1.46	1.37	0.12	010
10061		A	Drainage of skin abscess	2.45	2.75	2.60	2.04	1.94	0.30	010
10080		A	Drainage of pilonidal cyst	1.22	3.62	3.49	1.58	1.47	0.20	010
10081		A	Drainage of pilonidal cyst	2.50	4.78	4.63	2.14	1.98	0.45	010
1008F		I	Gi/renal risk assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10120		A	Remove foreign body	1.25	2.66	2.55	1.34	1.26	0.16	010
10121		A	Remove foreign body	2.74	4.81	4.54	2.37	2.22	0.41	010
10140		A	Drainage of hematoma/fluid	1.58	2.93	2.76	1.69	1.64	0.20	010
1015F		I	Copd symptoms assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10160		A	Puncture drainage of lesion	1.25	2.36	2.27	1.41	1.36	0.16	010
10180		A	Complex drainage wound	2.30	4.35	4.13	2.50	2.39	0.48	010
1018F		I	Assess dyspnea not present	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1019F		I	Assess dyspnea present	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1022F		I	Pneumo imm status assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1026F		I	Co-morbid condition assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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1030F		I	Influenza imm status assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1034F		I	Current tobacco smoker	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1035F		I	Smokeless tobacco user	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1050F		I	History of mole changes	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1055F		I	Visual funct status assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1060F		I	Doc perm/cont/parox atr fib	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1061F		I	Doc lack perm+cont+parox fib	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1065F		I	Ischm stroke symp lt3 hrsb/4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1066F		I	Ischm stroke symp ge3 hrsb/4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1070F		I	Alarm symp assessed-absent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1071F		I	Alarm symp assessed-1+ prsnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11000		A	Debride infected skin	0.60	0.92	0.88	0.21	0.22	0.05	000
11001		A	Debride infected skin add-on	0.30	0.29	0.29	0.10	0.11	0.03	ZZZ
11004		A	Debride genitalia & perineum	10.80	NA	NA	4.73	4.55	1.89	000
11005		A	Debride abdom wall	14.24	NA	NA	6.32	5.89	2.96	000
11006		A	Debride genit/per/abdom wall	13.10	NA	NA	5.84	5.59	2.34	000
11008		A	Remove mesh from abd wall	5.00	NA	NA	2.21	2.07	1.05	ZZZ
11010		A	Debride skin at fx site	4.19	9.45	8.94	3.49	3.28	0.76	010
11011		A	Debride skin musc at fx site	4.94	9.62	9.33	3.11	2.92	0.98	000
11012		A	Deb skin bone at fx site	6.87	12.49	12.28	4.68	4.46	1.30	000
11042		A	Deb subq tissue 20 sq cm/<	0.80	2.13	1.66	0.62	0.50	0.10	000
11043		A	Deb musc/fascia 20 sq cm/<	2.00	3.30	3.30	1.28	1.28	0.33	000
11044		A	Deb bone 20 sq cm/<	3.60	4.34	4.34	2.03	2.03	0.62	000
11045		A	Deb subq tissue add-on	0.33	0.51	0.51	0.13	0.13	0.07	ZZZ
11046		A	Deb musc/fascia add-on	0.70	0.77	0.77	0.31	0.31	0.12	ZZZ
11047		A	Deb bone add-on	1.20	1.19	1.19	0.54	0.54	0.22	ZZZ
11055		R	Trim skin lesion	0.43	1.01	0.95	0.13	0.14	0.03	000
11056		R	Trim skin lesions 2 to 4	0.61	1.09	1.04	0.18	0.20	0.04	000

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11057		R	Trim skin lesions over 4	0.79	1.23	1.17	0.24	0.26	0.05	000
11100		A	Biopsy skin lesion	0.81	2.10	2.10	0.59	0.54	0.11	000
11101		A	Biopsy skin add-on	0.41	0.51	0.50	0.30	0.28	0.05	ZZZ
1118F		I	Gerd symps assessed 12 month	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11200		A	Removal of skin tags	0.82	1.61	1.53	1.22	1.15	0.11	010
11201		A	Remove skin tags add-on	0.29	0.24	0.22	0.18	0.17	0.04	ZZZ
11300		A	Shave skin lesion	0.51	1.45	1.42	0.33	0.30	0.07	000
11301		A	Shave skin lesion	0.85	1.78	1.75	0.59	0.54	0.11	000
11302		A	Shave skin lesion	1.05	2.08	2.05	0.75	0.68	0.14	000
11303		A	Shave skin lesion	1.24	2.45	2.40	0.87	0.79	0.18	000
11305		A	Shave skin lesion	0.67	1.32	1.27	0.26	0.27	0.05	000
11306		A	Shave skin lesion	0.99	1.71	1.67	0.52	0.51	0.11	000
11307		A	Shave skin lesion	1.14	2.04	2.00	0.68	0.65	0.14	000
11308		A	Shave skin lesion	1.41	2.15	2.08	0.70	0.68	0.14	000
11310		A	Shave skin lesion	0.73	1.66	1.64	0.49	0.45	0.10	000
11311		A	Shave skin lesion	1.05	1.95	1.92	0.74	0.69	0.14	000
11312		A	Shave skin lesion	1.20	2.27	2.23	0.86	0.79	0.18	000
11313		A	Shave skin lesion	1.62	2.69	2.64	1.14	1.04	0.24	000
1134F		I	Epsd bk pain for =< 6 wks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1135F		I	Epsd bk pain for > 6 wks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1136F		I	Epsd bk pain for <= 12 wks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1137F		I	Epsd bk pain for > 12 wks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.90	2.50	2.43	1.32	1.23	0.12	010
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.28	2.83	2.74	1.61	1.50	0.20	010
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.45	3.11	3.01	1.71	1.59	0.24	010
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.84	3.40	3.25	2.20	2.04	0.31	010
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.11	3.83	3.66	2.33	2.16	0.37	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	3.52	4.90	4.57	3.10	2.81	0.67	010

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11420		A	Exc h-f-nk-sp b9+marg 0.5 <	1.03	2.38	2.29	1.26	1.20	0.12	010
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.47	2.89	2.78	1.62	1.52	0.22	010
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.68	3.16	3.04	2.09	1.96	0.26	010
11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.06	3.51	3.38	2.30	2.15	0.33	010
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.48	3.90	3.75	2.46	2.30	0.41	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	4.09	4.95	4.69	3.38	3.11	0.71	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.05	2.66	2.59	1.82	1.72	0.16	010
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.53	3.12	3.02	2.14	2.02	0.24	010
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.77	3.45	3.33	2.29	2.16	0.29	010
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.34	3.86	3.71	2.63	2.46	0.38	010
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.19	4.57	4.37	3.12	2.90	0.52	010
11446		A	Exc face-mm b9+marg > 4 cm	4.80	5.95	5.52	4.21	3.82	0.80	010
11450		A	Removal sweat gland lesion	3.22	7.05	6.66	3.53	3.21	0.65	090
11451		A	Removal sweat gland lesion	4.43	8.44	8.13	4.18	3.84	0.90	090
11462		A	Removal sweat gland lesion	3.00	7.05	6.74	3.49	3.20	0.60	090
11463		A	Removal sweat gland lesion	4.43	8.65	8.42	4.33	4.00	0.88	090
11470		A	Removal sweat gland lesion	3.74	7.54	7.06	3.91	3.54	0.71	090
11471		A	Removal sweat gland lesion	4.89	8.92	8.44	4.51	4.09	0.91	090
1150F		I	Doc pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1151F		I	Doc no pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1152F		I	Doc advncd dis comfort 1st	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1153F		I	Doc advncd dis cmfrt not 1st	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1157F		I	Advnc care plan in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1158F		I	Advnc care plan tlk docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1159F		I	Med list docd in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.63	3.66	3.49	1.68	1.53	0.26	010
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	2.07	4.29	4.15	2.12	1.97	0.31	010
11602		A	Exc tr-ext mlg+marg 1.1-2 cm	2.27	4.66	4.54	2.35	2.18	0.34	010

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11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.82	5.07	4.88	2.68	2.45	0.42	010
11604		A	Exc tr-ext mlg+marg 3.1-4 cm	3.17	5.54	5.31	2.83	2.57	0.52	010
11606		A	Exc tr-ext mlg+marg > 4 cm	5.02	7.32	6.85	3.77	3.35	0.88	010
1160F		I	Rvw meds by rx/dr in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.64	3.72	3.57	1.73	1.58	0.26	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	2.08	4.34	4.20	2.15	2.00	0.31	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.41	4.76	4.64	2.44	2.28	0.37	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	3.11	5.27	5.07	2.86	2.62	0.49	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.62	5.77	5.52	3.09	2.82	0.60	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.61	6.67	6.36	3.55	3.27	0.80	010
11640		A	Exc face-mm malig+marg 0.5 <	1.67	3.89	3.76	1.84	1.70	0.26	010
11641		A	Exc face-mm malig+marg 0.6-1	2.17	4.48	4.38	2.26	2.13	0.33	010
11642		A	Exc face-mm malig+marg 1.1-2	2.62	4.98	4.87	2.60	2.44	0.39	010
11643		A	Exc face-mm malig+marg 2.1-3	3.42	5.51	5.32	3.08	2.85	0.54	010
11644		A	Exc face-mm malig+marg 3.1-4	4.34	6.65	6.39	3.67	3.40	0.71	010
11646		A	Exc face-mm mlg+marg > 4 cm	6.26	8.06	7.67	4.82	4.46	1.05	010
11719		R	Trim nail(s)	0.17	0.47	0.44	0.05	0.06	0.01	000
11720		A	Debride nail 1-5	0.32	0.58	0.55	0.10	0.10	0.03	000
11721		A	Debride nail 6 or more	0.54	0.67	0.65	0.16	0.18	0.04	000
11730		A	Removal of nail plate	1.10	1.66	1.59	0.34	0.36	0.08	000
11732		A	Remove nail plate add-on	0.57	0.68	0.65	0.17	0.19	0.04	ZZZ
11740		A	Drain blood from under nail	0.37	1.00	0.94	0.54	0.52	0.03	000
11750		A	Removal of nail bed	2.50	3.75	3.54	2.38	2.31	0.22	010
11752		A	Remove nail bed/finger tip	3.63	5.39	5.00	3.71	3.59	0.39	010
11755		A	Biopsy nail unit	1.31	2.49	2.40	0.94	0.94	0.11	000
11760		A	Repair of nail bed	1.63	4.71	4.32	2.03	1.95	0.26	010
11762		A	Reconstruction of nail bed	2.94	4.88	4.56	2.23	2.25	0.31	010
11765		A	Excision of nail fold toe	0.74	3.37	3.15	1.27	1.20	0.05	010

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11770		A	Removal of pilonidal lesion	2.66	4.77	4.51	2.26	2.07	0.52	010
11771		A	Removal of pilonidal lesion	6.09	9.28	8.61	5.47	5.00	1.24	090
11772		A	Removal of pilonidal lesion	7.35	10.92	10.30	7.83	7.27	1.47	090
1180F		I	Thromboemb risk assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11900		A	Injection into skin lesions	0.52	1.04	1.04	0.38	0.34	0.07	000
11901		A	Added skin lesions injection	0.80	1.18	1.16	0.59	0.54	0.11	000
11920		R	Correct skin color defects	1.61	3.13	3.21	1.59	1.48	0.31	000
11921		R	Correct skin color defects	1.93	3.60	3.62	1.85	1.71	0.37	000
11922		R	Correct skin color defects	0.49	1.23	1.20	0.35	0.32	0.08	ZZZ
11950		R	Therapy for contour defects	0.84	1.05	1.13	0.49	0.49	0.10	000
11951		R	Therapy for contour defects	1.19	1.51	1.50	0.75	0.69	0.24	000
11952		R	Therapy for contour defects	1.69	1.62	1.85	0.81	0.88	0.24	000
11954		R	Therapy for contour defects	1.85	2.57	2.50	1.39	1.24	0.35	000
11960		A	Insert tissue expander(s)	11.49	NA	NA	13.05	13.07	1.83	090
11970		A	Replace tissue expander	8.01	NA	NA	9.04	8.36	1.56	090
11971		A	Remove tissue expander(s)	3.41	9.50	9.48	5.37	5.10	0.64	090
11975		N	Insert contraceptive cap	1.48	2.14	2.12	0.65	0.65	0.10	XXX
11976		R	Removal of contraceptive cap	1.78	2.14	2.17	0.83	0.75	0.30	000
11977		N	Removal/reinsert contra cap	3.30	2.97	2.97	1.45	1.43	0.24	XXX
11980		A	Implant hormone pellet(s)	1.48	1.37	1.34	0.73	0.68	0.23	000
11981		A	Insert drug implant device	1.48	2.18	2.22	0.71	0.74	0.24	XXX
11982		A	Remove drug implant device	1.78	2.24	2.37	0.84	0.90	0.24	XXX
11983		A	Remove/insert drug implant	3.30	2.55	2.87	1.36	1.56	0.35	XXX
12001		A	Repair superficial wound(s)	0.84	1.52	1.84	0.38	0.64	0.14	000
12002		A	Repair superficial wound(s)	1.14	1.72	1.98	0.46	0.75	0.19	000
12004		A	Repair superficial wound(s)	1.44	1.92	2.25	0.55	0.85	0.24	000
12005		A	Repair superficial wound(s)	1.97	2.39	2.76	0.73	1.03	0.33	000
12006		A	Repair superficial wound(s)	2.39	2.87	3.31	0.91	1.27	0.41	000

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12007		A	Repair superficial wound(s)	2.90	3.20	3.72	1.07	1.50	0.50	000
1200F		I	Seizure type& frequ docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
12011		A	Repair superficial wound(s)	1.07	1.87	2.12	0.43	0.68	0.19	000
12013		A	Repair superficial wound(s)	1.22	1.88	2.21	0.46	0.77	0.20	000
12014		A	Repair superficial wound(s)	1.57	2.08	2.47	0.57	0.89	0.26	000
12015		A	Repair superficial wound(s)	1.98	2.46	2.96	0.67	1.03	0.33	000
12016		A	Repair superficial wound(s)	2.68	2.92	3.45	0.91	1.29	0.46	000
12017		A	Repair superficial wound(s)	3.18	NA	NA	0.76	1.34	0.56	000
12018		A	Repair superficial wound(s)	3.61	NA	NA	0.85	1.78	0.64	000
12020		A	Closure of split wound	2.67	4.93	4.73	2.47	2.34	0.42	010
12021		A	Closure of split wound	1.89	2.63	2.45	1.94	1.80	0.31	010
12031		A	Intmd wnd repair s/tr/ext	2.20	4.76	4.53	2.41	2.20	0.35	010
12032		A	Intmd wnd repair s/tr/ext	2.52	6.07	6.01	2.98	2.84	0.38	010
12034		A	Intmd wnd repair s/tr/ext	2.97	5.65	5.42	2.72	2.52	0.50	010
12035		A	Intmd wnd repair s/tr/ext	3.47	6.90	6.68	2.98	2.82	0.64	010
12036		A	Intmd wnd repair s/tr/ext	4.09	7.24	6.92	3.26	3.06	0.77	010
12037		A	Intmd wnd repair s/tr/ext	4.71	7.90	7.60	3.78	3.59	0.90	010
12041		A	Intmd wnd repair n-hf/genit	2.42	4.86	4.60	2.47	2.25	0.37	010
12042		A	Intmd wnd repair n-hg/genit	2.79	5.38	5.26	2.86	2.67	0.41	010
12044		A	Intmd wnd repair n-hg/genit	3.19	6.72	6.32	2.71	2.53	0.52	010
12045		A	Intmd wnd repair n-hg/genit	3.68	6.61	6.44	2.92	2.79	0.62	010
12046		A	Intmd wnd repair n-hg/genit	4.29	7.79	7.62	3.46	3.30	0.84	010
12047		A	Intmd wnd repair n-hg/genit	4.69	8.60	8.24	3.52	3.48	0.91	010
12051		A	Intmd wnd repair face/mm	2.52	5.04	4.91	2.63	2.45	0.39	010
12052		A	Intmd wnd repair face/mm	2.87	5.79	5.63	3.36	3.11	0.42	010
12053		A	Intmd wnd repair face/mm	3.17	6.45	6.19	2.89	2.69	0.50	010
12054		A	Intmd wnd repair face/mm	3.50	6.70	6.37	2.77	2.60	0.58	010
12055		A	Intmd wnd repair face/mm	4.47	7.83	7.35	2.98	2.80	0.73	010

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12056		A	Intmd wnd repair face/mm	5.28	9.98	9.02	4.87	4.14	0.67	010
12057		A	Intmd wnd repair face/mm	6.00	11.66	10.32	4.79	4.41	0.76	010
1205F		I	Epi etiol synd rvwd and docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1220F		I	Pt screened for depression	0.00	0.00	0.00	0.00	0.00	0.00	XXX
13100		A	Repair of wound or lesion	3.17	5.52	5.47	3.38	3.24	0.50	010
13101		A	Repair of wound or lesion	3.96	7.14	7.04	4.05	3.86	0.61	010
13102		A	Repair wound/lesion add-on	1.24	1.77	1.69	0.84	0.76	0.23	ZZZ
13120		A	Repair of wound or lesion	3.35	5.70	5.63	3.54	3.37	0.52	010
13121		A	Repair of wound or lesion	4.42	8.00	7.85	4.83	4.58	0.67	010
13122		A	Repair wound/lesion add-on	1.44	1.85	1.79	0.94	0.85	0.26	ZZZ
13131		A	Repair of wound or lesion	3.83	6.17	6.08	3.91	3.74	0.58	010
13132		A	Repair of wound or lesion	6.58	9.71	9.44	6.71	6.37	0.98	010
13133		A	Repair wound/lesion add-on	2.19	2.51	2.40	1.53	1.41	0.34	ZZZ
13150		A	Repair of wound or lesion	3.85	6.09	5.97	3.86	3.65	0.61	010
13151		A	Repair of wound or lesion	4.49	6.85	6.73	4.44	4.25	0.67	010
13152		A	Repair of wound or lesion	6.37	9.35	9.11	5.58	5.31	0.95	010
13153		A	Repair wound/lesion add-on	2.38	2.79	2.65	1.63	1.49	0.38	ZZZ
13160		A	Late closure of wound	12.04	NA	NA	10.04	9.45	2.23	090
14000		A	Skin tissue rearrangement	6.37	11.00	10.69	7.75	7.41	1.13	090
14001		A	Skin tissue rearrangement	8.78	13.56	13.17	9.63	9.26	1.53	090
1400F		I	Prkns diag rviewed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
14020		A	Skin tissue rearrangement	7.22	12.33	11.99	8.86	8.53	1.21	090
14021		A	Skin tissue rearrangement	9.72	14.81	14.39	10.73	10.39	1.55	090
14040		A	Skin tissue rearrangement	8.60	12.97	12.59	9.49	9.16	1.32	090
14041		A	Skin tissue rearrangement	10.83	15.86	15.46	11.44	11.06	1.62	090
14060		A	Skin tissue rearrangement	9.23	12.69	12.23	9.97	9.54	1.41	090
14061		A	Skin tissue rearrangement	11.48	17.19	16.76	12.31	11.91	1.71	090
14301		A	Skin tissue rearrangement	12.65	17.55	17.55	12.30	12.30	2.13	090

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14302		A	Skin tissue rearrange add-on	3.73	2.55	2.55	2.55	2.55	0.62	ZZZ
14350		A	Skin tissue rearrangement	11.05	NA	NA	8.71	8.61	1.55	090
15002		A	Wound prep trk/arm/leg	3.65	5.85	5.50	2.60	2.37	0.65	000
15003		A	Wound prep addl 100 cm	0.80	1.23	1.17	0.42	0.38	0.16	ZZZ
15004		A	Wound prep f/n/hf/g	4.58	6.51	6.27	3.00	2.82	0.67	000
15005		A	Wnd prep f/n/hf/g addl cm	1.60	1.74	1.63	0.86	0.76	0.31	ZZZ
15040		A	Harvest cultured skin graft	2.00	5.05	5.01	1.46	1.38	0.37	000
15050		A	Skin pinch graft	5.57	10.51	9.81	7.12	6.67	0.90	090
15100		A	Skin splt grft trnk/arm/leg	9.90	13.66	13.30	9.80	9.26	1.94	090
15101		A	Skin splt grft t/a/l add-on	1.72	3.34	3.37	1.28	1.23	0.34	ZZZ
15110		A	Epidrm autogrft trnk/arm/leg	10.97	12.19	11.67	9.12	8.51	2.15	090
15111		A	Epidrm autogrft t/a/l add-on	1.85	1.22	1.23	0.90	0.88	0.38	ZZZ
15115		A	Epidrm a-grft face/nck/hf/g	11.28	12.90	12.06	9.87	9.17	1.85	090
15116		A	Epidrm a-grft f/n/hf/g addl	2.50	2.24	1.98	1.81	1.55	0.49	ZZZ
15120		A	Skn splt a-grft fac/nck/hf/g	11.16	15.60	14.69	10.93	10.17	1.93	090
15121		A	Skn splt a-grft f/n/hf/g add	2.67	4.71	4.60	2.02	1.88	0.50	ZZZ
15130		A	Derm autograft trnk/arm/leg	7.53	11.04	10.66	8.03	7.56	1.48	090
15131		A	Derm autograft t/a/l add-on	1.50	1.31	1.17	1.08	0.91	0.31	ZZZ
15135		A	Derm autograft face/nck/hf/g	11.03	13.33	12.46	10.31	9.62	1.87	090
15136		A	Derm autograft f/n/hf/g add	1.50	1.18	0.99	1.00	0.80	0.10	ZZZ
15150		A	Cult epiderm grft t/arm/leg	9.39	8.97	8.84	7.32	7.17	1.98	090
15151		A	Cult epiderm grft t/a/l addl	2.00	1.67	1.46	1.41	1.17	0.42	ZZZ
15152		A	Cult epiderm graft t/a/l +%	2.50	1.38	1.56	1.12	1.27	0.49	ZZZ
15155		A	Cult epiderm graft f/n/hf/g	10.14	6.92	7.93	5.57	6.55	0.76	090
15156		A	Cult epidrm grft f/n/hfg add	2.75	1.47	1.62	1.20	1.35	0.58	ZZZ
15157		A	Cult epiderm grft f/n/hfg +%	3.00	1.20	1.60	0.90	1.25	0.22	ZZZ
15170		A	Acell graft trunk/arms/legs	5.99	6.09	5.58	4.27	3.81	1.09	090
15171		A	Acell graft t/arm/leg add-on	1.55	0.98	0.90	0.81	0.75	0.31	ZZZ

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15175		A	Acellular graft f/n/hf/g	7.99	6.23	6.05	4.53	4.39	1.05	090
15176		A	Acell graft f/n/hf/g add-on	2.45	1.58	1.47	1.27	1.19	0.39	ZZZ
15200		A	Skin full graft trunk	9.15	13.90	13.10	9.61	8.85	1.64	090
15201		A	Skin full graft trunk add-on	1.32	2.81	2.75	0.90	0.80	0.26	ZZZ
15220		A	Skin full graft sclp/arm/leg	8.09	13.52	13.01	9.29	8.83	1.39	090
15221		A	Skin full graft add-on	1.19	2.62	2.59	0.80	0.74	0.23	ZZZ
15240		A	Skin full grft face/genit/hf	10.41	15.82	15.08	12.31	11.57	1.70	090
15241		A	Skin full graft add-on	1.86	3.34	3.21	1.30	1.19	0.33	ZZZ
15260		A	Skin full graft een & lips	11.64	16.83	16.07	12.89	12.20	1.77	090
15261		A	Skin full graft add-on	2.23	3.85	3.70	1.78	1.67	0.37	ZZZ
15300		A	Apply skinallogrft t/arm/lg	4.65	5.06	4.64	3.37	3.07	0.86	090
15301		A	Apply sknallogrft t/a/l addl	1.00	0.68	0.64	0.51	0.48	0.20	ZZZ
15320		A	Apply skin allogrft f/n/hf/g	5.36	4.98	4.79	3.18	3.08	0.73	090
15321		A	Aply sknallogrft f/n/hfg add	1.50	1.04	0.96	0.81	0.75	0.30	ZZZ
15330		A	Aply acell alogrft t/arm/leg	3.99	5.11	4.69	3.37	3.07	0.76	090
15331		A	Aply acell grft t/a/l add-on	1.00	0.75	0.68	0.59	0.53	0.20	ZZZ
15335		A	Apply acell graft f/n/hf/g	4.50	4.45	4.27	2.80	2.71	0.50	090
15336		A	Aply acell grft f/n/hf/g add	1.43	1.33	1.07	1.03	0.80	0.10	ZZZ
15340		A	Apply cult skin substitute	3.82	4.92	4.77	3.57	3.43	0.52	010
15341		A	Apply cult skin sub add-on	0.50	0.82	0.79	0.20	0.20	0.07	ZZZ
15360		A	Apply cult derm sub t/a/l	4.02	5.87	5.77	4.35	4.23	0.60	090
15361		A	Aply cult derm sub t/a/l add	1.15	0.50	0.58	0.35	0.40	0.20	ZZZ
15365		A	Apply cult derm sub f/n/hf/g	4.30	5.33	5.22	3.92	3.82	0.41	090
15366		A	Apply cult derm f/hf/g add	1.45	0.76	0.76	0.53	0.54	0.16	ZZZ
15400		A	Apply skin xenograft t/a/l	4.47	7.12	6.62	5.53	5.24	0.69	090
15401		A	Apply skn xenogrft t/a/l add	1.00	1.37	1.43	0.51	0.48	0.22	ZZZ
15420		A	Apply skin xgraft f/n/hf/g	4.98	7.32	7.14	5.81	5.63	0.67	090
15421		A	Apply skn xgrft f/n/hf/g add	1.50	1.69	1.59	0.83	0.74	0.30	ZZZ

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15430		A	Apply acellular xenograft	6.20	9.05	8.50	8.33	7.86	1.05	090
15431		C	Apply acellular xgraft add	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
15570		A	Form skin pedicle flap	10.21	14.44	13.78	9.67	9.00	2.06	090
15572		A	Form skin pedicle flap	10.12	14.40	13.46	10.64	9.73	1.82	090
15574		A	Form skin pedicle flap	10.70	14.86	14.04	10.89	10.11	1.82	090
15576		A	Form skin pedicle flap	9.37	13.32	12.68	9.67	9.01	1.53	090
15600		A	Skin graft	2.01	6.99	7.07	3.78	3.63	0.38	090
15610		A	Skin graft	2.52	7.38	6.96	4.25	4.07	0.45	090
15620		A	Skin graft	3.75	8.51	8.41	5.41	5.11	0.61	090
15630		A	Skin graft	4.08	8.89	8.77	5.78	5.54	0.65	090
15650		A	Transfer skin pedicle flap	4.77	9.41	9.37	6.08	5.89	0.77	090
15731		A	Forehead flap w/vasc pedicle	14.38	17.64	16.69	14.44	13.49	2.40	090
15732		A	Muscle-skin graft head/neck	19.90	21.93	20.64	17.57	15.98	3.53	090
15734		A	Muscle-skin graft trunk	19.86	21.72	20.94	16.90	15.95	3.98	090
15736		A	Muscle-skin graft arm	17.04	19.70	19.02	14.92	13.87	3.35	090
15738		A	Muscle-skin graft leg	19.04	19.76	19.11	15.25	14.31	3.80	090
15740		A	Island pedicle flap graft	11.80	17.12	16.48	12.82	12.17	1.77	090
15750		A	Neurovascular pedicle graft	12.96	NA	NA	12.53	11.76	2.28	090
15756		A	Free myo/skin flap microvasc	36.94	NA	NA	29.02	26.64	6.34	090
15757		A	Free skin flap microvasc	37.15	NA	NA	28.48	26.16	5.91	090
15758		A	Free fascial flap microvasc	36.90	NA	NA	28.29	26.11	5.91	090
15760		A	Composite skin graft	9.86	14.22	13.50	10.30	9.61	1.58	090
15770		A	Derma-fat-fascia graft	8.96	NA	NA	9.82	9.09	1.63	090
15775		R	Hair transplant punch grafts	3.95	3.84	4.18	2.00	1.98	0.29	000
15776		R	Hair transplant punch grafts	5.53	6.64	6.42	3.38	3.17	0.38	000
15780		A	Abrasion treatment of skin	8.73	14.19	14.09	8.63	8.65	1.20	090
15781		A	Abrasion treatment of skin	5.02	10.46	10.10	7.20	6.93	0.76	090
15782		A	Abrasion treatment of skin	4.44	10.83	11.08	6.40	6.61	0.62	090

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15783		A	Abrasion treatment of skin	4.41	9.33	9.19	6.32	6.00	0.62	090
15786		A	Abrasion lesion single	2.08	4.72	4.64	1.75	1.68	0.33	010
15787		A	Abrasion lesions add-on	0.33	1.01	1.02	0.16	0.15	0.04	ZZZ
15788		R	Chemical peel face epiderm	2.09	11.13	10.62	5.07	4.79	0.35	090
15789		R	Chemical peel face dermal	4.91	10.76	10.79	7.14	6.94	0.68	090
15792		R	Chemical peel nonfacial	1.86	10.60	10.39	5.64	5.56	0.30	090
15793		A	Chemical peel nonfacial	3.96	9.99	9.66	6.51	6.20	0.56	090
15819		A	Plastic surgery neck	10.65	NA	NA	7.61	8.17	2.09	090
15820		A	Revision of lower eyelid	6.27	9.47	8.85	8.01	7.36	1.24	090
15821		A	Revision of lower eyelid	6.84	10.06	9.28	8.41	7.62	1.33	090
15822		A	Revision of upper eyelid	4.62	7.76	7.24	6.32	5.79	0.81	090
15823		A	Revision of upper eyelid	6.81	10.15	9.79	8.49	8.16	1.26	090
15824		R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15825		R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15826		R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15828		R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15830		R	Exc skin abd	17.11	NA	NA	15.13	13.81	3.38	090
15832		A	Excise excessive skin tissue	12.85	NA	NA	13.28	11.75	2.57	090
15833		A	Excise excessive skin tissue	11.90	NA	NA	12.59	11.29	2.32	090
15834		A	Excise excessive skin tissue	12.17	NA	NA	12.79	11.12	2.39	090
15835		A	Excise excessive skin tissue	12.99	NA	NA	13.35	11.63	2.55	090
15836		A	Excise excessive skin tissue	10.61	NA	NA	8.54	8.53	2.08	090
15837		A	Excise excessive skin tissue	9.55	14.51	12.66	10.04	8.94	2.01	090
15838		A	Excise excessive skin tissue	8.25	NA	NA	8.21	7.66	1.06	090
15839		A	Excise excessive skin tissue	10.50	13.50	12.77	9.54	8.92	1.93	090
15840		A	Graft for face nerve palsy	14.99	NA	NA	13.88	12.75	2.39	090
15841		A	Graft for face nerve palsy	25.99	NA	NA	22.89	20.42	3.35	090

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15842		A	Flap for face nerve palsy	41.01	NA	NA	29.43	28.39	5.27	090
15845		A	Skin and muscle repair face	14.32	NA	NA	14.23	12.63	1.83	090
15847		C	Exc skin abd add-on	0.00	0.00	0.00	0.00	0.00	0.00	YYY
15850		B	Removal of sutures	0.78	1.61	1.68	0.34	0.34	0.05	XXX
15851		A	Removal of sutures	0.86	1.85	1.78	0.42	0.37	0.12	000
15852		A	Dressing change not for burn	0.86	NA	NA	0.42	0.39	0.14	000
15860		A	Test for blood flow in graft	1.95	NA	NA	0.91	0.90	0.38	000
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15920		A	Removal of tail bone ulcer	8.29	NA	NA	8.22	7.57	1.71	090
15922		A	Removal of tail bone ulcer	10.38	NA	NA	11.56	10.22	2.02	090
15931		A	Remove sacrum pressure sore	10.07	NA	NA	8.08	7.52	2.06	090
15933		A	Remove sacrum pressure sore	11.77	NA	NA	10.93	10.18	2.40	090
15934		A	Remove sacrum pressure sore	13.68	NA	NA	11.55	10.61	2.77	090
15935		A	Remove sacrum pressure sore	15.78	NA	NA	13.98	13.09	3.18	090
15936		A	Remove sacrum pressure sore	13.16	NA	NA	11.15	10.30	2.66	090
15937		A	Remove sacrum pressure sore	15.14	NA	NA	13.40	12.38	3.06	090
15940		A	Remove hip pressure sore	10.20	NA	NA	8.67	7.99	2.06	090
15941		A	Remove hip pressure sore	12.41	NA	NA	12.12	11.39	2.47	090
15944		A	Remove hip pressure sore	12.44	NA	NA	12.18	11.20	2.50	090
15945		A	Remove hip pressure sore	13.75	NA	NA	13.62	12.52	2.73	090
15946		A	Remove hip pressure sore	24.12	NA	NA	20.95	19.29	4.81	090
15950		A	Remove thigh pressure sore	8.03	NA	NA	7.41	7.04	1.59	090
15951		A	Remove thigh pressure sore	11.58	NA	NA	13.10	11.24	2.27	090
15952		A	Remove thigh pressure sore	12.31	NA	NA	9.56	9.58	2.62	090
15953		A	Remove thigh pressure sore	13.57	NA	NA	10.50	10.67	2.66	090

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15956		A	Remove thigh pressure sore	16.79	NA	NA	14.93	13.69	3.41	090
15958		A	Remove thigh pressure sore	16.75	NA	NA	15.71	14.45	3.38	090
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	YYY
16000		A	Initial treatment of burn(s)	0.89	1.03	0.98	0.39	0.34	0.12	000
16020		A	Dress/debrid p-thick burn s	0.80	1.57	1.48	0.82	0.76	0.11	000
16025		A	Dress/debrid p-thick burn m	1.85	2.27	2.14	1.34	1.23	0.31	000
16030		A	Dress/debrid p-thick burn l	2.08	2.87	2.72	1.53	1.41	0.37	000
16035		A	Incision of burn scab initi	3.74	NA	NA	1.58	1.62	0.62	000
16036		A	Escharotomy addl incision	1.50	NA	NA	0.67	0.65	0.27	ZZZ
17000		A	Destruct premalg lesion	0.65	1.64	1.61	0.94	0.90	0.08	010
17003		A	Destruct premalg les 2-14	0.07	0.12	0.13	0.05	0.05	0.01	ZZZ
17004		A	Destroy premlg lesions 15+	1.85	2.93	2.95	1.86	1.83	0.27	010
17106		A	Destruction of skin lesions	3.69	5.87	5.78	4.04	3.93	0.53	090
17107		A	Destruction of skin lesions	4.79	7.40	7.47	4.96	5.00	0.73	090
17108		A	Destruction of skin lesions	7.49	10.10	9.74	6.88	6.68	1.30	090
17110		A	Destruct b9 lesion 1-14	0.70	2.41	2.42	1.28	1.24	0.08	010
17111		A	Destruct lesion 15 or more	0.97	2.73	2.72	1.47	1.42	0.12	010
17250		A	Chemical cautery tissue	0.50	1.69	1.63	0.51	0.49	0.07	000
17260		A	Destruction of skin lesions	0.96	1.70	1.69	0.97	0.92	0.12	010
17261		A	Destruction of skin lesions	1.22	2.80	2.79	1.39	1.33	0.18	010
17262		A	Destruction of skin lesions	1.63	3.24	3.21	1.69	1.61	0.23	010
17263		A	Destruction of skin lesions	1.84	3.52	3.49	1.84	1.74	0.26	010
17264		A	Destruction of skin lesions	1.99	3.74	3.70	1.92	1.82	0.29	010
17266		A	Destruction of skin lesions	2.39	4.11	4.05	2.18	2.04	0.34	010
17270		A	Destruction of skin lesions	1.37	2.84	2.79	1.47	1.39	0.20	010
17271		A	Destruction of skin lesions	1.54	3.06	3.02	1.62	1.54	0.23	010
17272		A	Destruction of skin lesions	1.82	3.42	3.38	1.83	1.74	0.26	010
17273		A	Destruction of skin lesions	2.10	3.73	3.69	2.02	1.91	0.30	010

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17274		A	Destruction of skin lesions	2.64	4.22	4.17	2.37	2.25	0.37	010
17276		A	Destruction of skin lesions	3.25	4.68	4.58	2.73	2.57	0.48	010
17280		A	Destruction of skin lesions	1.22	2.72	2.69	1.36	1.29	0.18	010
17281		A	Destruction of skin lesions	1.77	3.19	3.15	1.79	1.70	0.26	010
17282		A	Destruction of skin lesions	2.09	3.67	3.61	2.03	1.92	0.30	010
17283		A	Destruction of skin lesions	2.69	4.23	4.15	2.44	2.30	0.38	010
17284		A	Destruction of skin lesions	3.26	4.75	4.66	2.81	2.66	0.45	010
17286		A	Destruction of skin lesions	4.48	5.62	5.44	3.58	3.38	0.67	010
17311		A	Mohs 1 stage h/n/hf/g	6.20	12.21	12.64	4.67	4.34	0.87	000
17312		A	Mohs addl stage	3.30	7.67	8.01	2.48	2.31	0.45	ZZZ
17313		A	Mohs 1 stage t/a/l	5.56	11.23	11.64	4.19	3.90	0.77	000
17314		A	Mohs addl stage t/a/l	3.06	7.11	7.43	2.30	2.14	0.42	ZZZ
17315		A	Mohs surg addl block	0.87	1.36	1.38	0.66	0.61	0.11	ZZZ
17340		A	Cryotherapy of skin	0.77	0.65	0.58	0.59	0.52	0.10	010
17360		A	Skin peel therapy	1.46	2.21	2.19	1.38	1.31	0.22	010
17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	000
17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
19000		A	Drainage of breast lesion	0.84	2.15	2.26	0.33	0.35	0.11	000
19001		A	Drain breast lesion add-on	0.42	0.29	0.31	0.16	0.17	0.05	ZZZ
19020		A	Incision of breast lesion	3.83	8.89	8.45	4.32	3.98	0.77	090
19030		A	Injection for breast x-ray	1.53	2.83	3.09	0.57	0.64	0.14	000
19100		A	Bx breast percut w/o image	1.27	2.77	2.66	0.55	0.50	0.26	000
19101		A	Biopsy of breast open	3.23	5.90	5.65	2.62	2.44	0.67	010
19102		A	Bx breast percut w/image	2.00	3.73	4.06	0.76	0.83	0.22	000
19103		A	Bx breast percut w/device	3.69	11.15	11.97	1.44	1.51	0.48	000
19105		A	Cryosurg ablate fa each	3.69	49.38	56.05	1.62	1.61	0.39	000
19110		A	Nipple exploration	4.44	8.74	8.19	4.69	4.30	0.92	090
19112		A	Excise breast duct fistula	3.81	8.61	8.12	4.52	4.15	0.80	090

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19120		A	Removal of breast lesion	5.92	7.17	6.65	4.98	4.55	1.25	090
19125		A	Excision breast lesion	6.69	7.83	7.23	5.41	4.93	1.41	090
19126		A	Excision addl breast lesion	2.93	NA	NA	1.27	1.16	0.62	ZZZ
19260		A	Removal of chest wall lesion	17.78	NA	NA	14.21	13.62	3.95	090
19271		A	Revision of chest wall	22.19	NA	NA	20.98	20.72	5.04	090
19272		A	Extensive chest wall surgery	25.17	NA	NA	22.11	21.98	5.95	090
19290		A	Place needle wire breast	1.27	3.08	3.31	0.48	0.53	0.12	000
19291		A	Place needle wire breast	0.63	1.22	1.32	0.24	0.26	0.05	ZZZ
19295		A	Place breast clip percut	0.00	2.45	2.67	NA	NA	0.01	ZZZ
19296		A	Place po breast cath for rad	3.63	108.67	112.34	1.89	1.76	0.73	000
19297		A	Place breast cath for rad	1.72	NA	NA	0.75	0.69	0.35	ZZZ
19298		A	Place breast rad tube/caths	6.00	24.98	29.07	2.87	2.83	0.76	000
19300		A	Removal of breast tissue	5.31	8.56	8.23	5.55	5.09	1.13	090
19301		A	Partical mastectomy	10.13	NA	NA	7.04	6.26	2.15	090
19302		A	P-mastectomy w/ln removal	13.99	NA	NA	9.36	8.60	2.97	090
19303		A	Mast simple complete	15.85	NA	NA	10.70	9.47	3.37	090
19304		A	Mast subq	7.95	NA	NA	7.34	6.71	1.67	090
19305		A	Mast radical	17.46	NA	NA	12.34	11.23	3.72	090
19306		A	Mast rad urban type	18.13	NA	NA	13.47	12.16	3.86	090
19307		A	Mast mod rad	18.23	NA	NA	13.27	12.07	3.86	090
19316		A	Suspension of breast	11.09	NA	NA	10.21	9.50	2.19	090
19318		A	Reduction of large breast	16.03	NA	NA	14.90	13.87	3.15	090
19324		A	Enlarge breast	6.80	NA	NA	6.17	5.86	1.45	090
19325		A	Enlarge breast with implant	8.64	NA	NA	9.45	8.75	1.68	090
19328		A	Removal of breast implant	6.48	NA	NA	7.34	6.79	1.28	090
19330		A	Removal of implant material	8.54	NA	NA	9.09	8.38	1.66	090
19340		A	Immediate breast prosthesis	13.99	NA	NA	14.10	8.97	2.74	090
19342		A	Delayed breast prosthesis	12.63	NA	NA	13.28	12.25	2.43	090

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19350		A	Breast reconstruction	9.11	13.85	13.60	9.72	9.06	1.78	090
19355		A	Correct inverted nipple(s)	8.52	10.13	10.14	6.52	6.24	1.82	090
19357		A	Breast reconstruction	18.50	NA	NA	23.79	21.54	3.61	090
19361		A	Breast reconstr w/lat flap	23.36	NA	NA	24.43	22.01	4.59	090
19364		A	Breast reconstruction	42.58	NA	NA	34.56	31.69	8.23	090
19366		A	Breast reconstruction	21.84	NA	NA	15.73	14.41	4.45	090
19367		A	Breast reconstruction	26.80	NA	NA	23.29	21.48	5.26	090
19368		A	Breast reconstruction	33.90	NA	NA	28.12	25.63	6.65	090
19369		A	Breast reconstruction	31.31	NA	NA	26.25	23.66	6.14	090
19370		A	Surgery of breast capsule	9.17	NA	NA	10.04	9.27	1.79	090
19371		A	Removal of breast capsule	10.62	NA	NA	11.38	10.51	2.06	090
19380		A	Revise breast reconstruction	10.41	NA	NA	11.22	10.37	2.02	090
19396		A	Design custom breast implant	2.17	5.14	4.44	1.59	1.40	0.45	000
19499		C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
20005		A	I&d abscess subfascial	3.58	4.64	4.54	2.66	2.62	0.58	010
2001F		I	Weight record	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2002F		I	Clin sign vol ovrld assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2004F		I	Initial exam involved joints	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20100		A	Explore wound neck	10.38	NA	NA	5.76	5.15	1.96	010
20101		A	Explore wound chest	3.23	7.91	7.74	2.04	1.98	0.69	010
20102		A	Explore wound abdomen	3.98	9.29	8.97	2.80	2.58	0.80	010
20103		A	Explore wound extremity	5.34	10.62	10.21	4.15	3.93	0.99	010
20150		A	Excise epiphyseal bar	14.75	NA	NA	12.58	11.30	2.92	090
2018F		I	Hydration status assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20200		A	Muscle biopsy	1.46	4.12	3.96	1.03	0.97	0.33	000
20205		A	Deep muscle biopsy	2.35	5.28	5.00	1.68	1.55	0.56	000
20206		A	Needle biopsy muscle	0.99	5.66	6.21	0.63	0.69	0.10	000
2020F		I	Dilated fundus eval done	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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20220		A	Bone biopsy trocar/needle	1.27	2.95	3.42	0.74	0.82	0.11	000
20225		A	Bone biopsy trocar/needle	1.87	13.33	15.89	1.14	1.25	0.23	000
20240		A	Bone biopsy excisional	3.28	NA	NA	2.85	2.77	0.52	010
20245		A	Bone biopsy excisional	8.95	NA	NA	8.34	7.87	1.64	010
20250		A	Open bone biopsy	5.19	NA	NA	4.98	4.69	1.22	010
20251		A	Open bone biopsy	5.72	NA	NA	5.28	5.10	1.32	010
2029F		I	Complete phys skin exam done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2030F		I	H2o stat docd normal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2031F		I	H2o stat docd dehydrated	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2044F		I	Doc mntl tst b/4 bk trxmnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20500		A	Injection of sinus tract	1.28	1.67	1.80	1.10	1.20	0.12	010
20501		A	Inject sinus tract for x-ray	0.76	2.53	2.80	0.28	0.32	0.07	000
2050F		I	Wound char size etc docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20520		A	Removal of foreign body	1.90	3.62	3.45	2.10	1.99	0.30	010
20525		A	Removal of foreign body	3.54	9.68	9.50	3.25	3.07	0.64	010
20526		A	Ther injection carp tunnel	0.94	1.13	1.10	0.63	0.59	0.14	000
20550		A	Inj tendon sheath/ligament	0.75	0.85	0.83	0.40	0.37	0.08	000
20551		A	Inj tendon origin/insertion	0.75	0.91	0.85	0.45	0.41	0.08	000
20552		A	Inj trigger point 1/2 muscl	0.66	0.86	0.81	0.40	0.35	0.07	000
20553		A	Inject trigger points =/> 3	0.75	1.00	0.93	0.45	0.39	0.07	000
20555		A	Place ndl musc/tis for rt	6.00	NA	NA	2.83	2.85	0.86	000
20600		A	Drain/inject joint/bursa	0.66	0.86	0.84	0.42	0.41	0.07	000
20605		A	Drain/inject joint/bursa	0.68	0.98	0.94	0.46	0.44	0.08	000
2060F		I	Pt talk eval hlthwkr re mdd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20610		A	Drain/inject joint/bursa	0.79	1.43	1.36	0.58	0.55	0.12	000
20612		A	Aspirate/inj ganglion cyst	0.70	0.97	0.91	0.46	0.44	0.08	000
20615		A	Treatment of bone cyst	2.33	3.78	3.69	2.08	2.00	0.29	010
20650		A	Insert and remove bone pin	2.28	3.31	3.15	1.96	1.89	0.29	010

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20660		A	Apply rem fixation device	4.00	NA	NA	2.22	2.10	1.10	000
20661		A	Application of head brace	5.26	NA	NA	7.77	7.36	1.64	090
20662		A	Application of pelvis brace	6.38	NA	NA	4.74	5.62	0.61	090
20663		A	Application of thigh brace	5.74	NA	NA	6.98	6.46	1.14	090
20664		A	Application of halo	10.06	NA	NA	10.63	10.16	3.60	090
20665		A	Removal of fixation device	1.36	1.57	1.75	1.17	1.25	0.11	010
20670		A	Removal of support implant	1.79	8.81	9.16	2.30	2.24	0.30	010
20680		A	Removal of support implant	5.96	11.16	10.67	5.75	5.36	1.06	090
20690		A	Apply bone fixation device	8.78	NA	NA	7.27	6.41	1.62	090
20692		A	Apply bone fixation device	16.27	NA	NA	14.38	12.53	2.80	090
20693		A	Adjust bone fixation device	6.06	NA	NA	6.39	6.17	1.07	090
20694		A	Remove bone fixation device	4.28	7.41	7.26	5.01	4.78	0.76	090
20696		A	Comp multiplane ext fixation	17.56	NA	NA	15.51	12.69	1.25	090
20697		A	Comp ext fixate strut change	0.00	58.00	49.48	NA	NA	0.01	000
20802		A	Replantation arm complete	42.62	NA	NA	23.11	22.13	3.04	090
20805		A	Replant forearm complete	51.46	NA	NA	18.05	22.27	10.12	090
20808		A	Replantation hand complete	63.09	NA	NA	50.32	47.23	12.40	090
20816		A	Replantation digit complete	31.95	NA	NA	26.94	27.23	3.98	090
20822		A	Replantation digit complete	26.66	NA	NA	24.09	23.89	5.26	090
20824		A	Replantation thumb complete	31.95	NA	NA	24.13	25.62	6.27	090
20827		A	Replantation thumb complete	27.48	NA	NA	24.69	25.07	5.40	090
20838		A	Replantation foot complete	42.88	NA	NA	23.52	23.67	3.06	090
20900		A	Removal of bone for graft	3.00	8.62	8.50	2.77	3.25	0.56	000
20902		A	Removal of bone for graft	4.58	NA	NA	3.75	4.17	0.87	000
20910		A	Remove cartilage for graft	5.53	NA	NA	6.31	6.16	0.71	090
20912		A	Remove cartilage for graft	6.54	NA	NA	7.25	6.83	0.99	090
20920		A	Removal of fascia for graft	5.51	NA	NA	5.89	5.61	0.69	090
20922		A	Removal of fascia for graft	6.93	9.01	9.28	6.22	6.28	1.28	090

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20924		A	Removal of tendon for graft	6.68	NA	NA	7.21	6.88	1.20	090
20926		A	Removal of tissue for graft	5.79	NA	NA	5.98	5.82	1.17	090
20930		B	Sp bone algrft morsel add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931		A	Sp bone algrft struct add-on	1.81	NA	NA	1.03	0.99	0.56	ZZZ
20936		B	Sp bone agrft local add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20937		A	Sp bone agrft morsel add-on	2.79	NA	NA	1.62	1.57	0.68	ZZZ
20938		A	Sp bone agrft struct add-on	3.02	NA	NA	1.74	1.68	0.83	ZZZ
20950		A	Fluid pressure muscle	1.26	5.61	5.68	1.22	1.16	0.23	000
20955		A	Fibula bone graft microvasc	40.26	NA	NA	30.96	28.58	6.65	090
20956		A	Iliac bone graft microvasc	41.18	NA	NA	30.65	28.73	8.11	090
20957		A	Mt bone graft microvasc	42.61	NA	NA	28.63	24.93	8.39	090
20962		A	Other bone graft microvasc	39.21	NA	NA	33.18	30.44	7.71	090
20969		A	Bone/skin graft microvasc	45.43	NA	NA	33.82	31.18	6.65	090
20970		A	Bone/skin graft iliac crest	44.58	NA	NA	31.43	29.98	8.79	090
20972		A	Bone/skin graft metatarsal	44.51	NA	NA	17.74	19.73	3.42	090
20973		A	Bone/skin graft great toe	47.27	NA	NA	34.61	28.49	3.37	090
20974		A	Electrical bone stimulation	0.62	1.43	1.29	0.72	0.68	0.12	000
20975		A	Electrical bone stimulation	2.60	NA	NA	2.09	2.01	0.58	000
20979		A	Us bone stimulation	0.62	0.84	0.82	0.29	0.29	0.08	000
20982		A	Ablate bone tumor(s) perq	7.27	88.94	97.51	3.06	3.31	0.80	000
20985		A	Cptr-asst dir ms px	2.50	NA	NA	1.50	1.40	0.49	ZZZ
20999		C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21010		A	Incision of jaw joint	11.04	NA	NA	9.56	8.81	1.41	090
21011		A	Exc face les sc < 2 cm	2.99	6.26	6.26	3.95	3.95	0.45	090
21012		A	Exc face les sbq 2+ cm	4.45	NA	NA	5.04	5.04	0.72	090
21013		A	Exc face tum deep < 2 cm	5.42	8.74	8.74	5.65	5.65	0.81	090
21014		A	Exc face tum deep 2+ cm	7.13	NA	NA	7.46	7.46	1.15	090
21015		A	Resect face tum < 2 cm	9.89	NA	NA	9.50	7.59	1.86	090

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21016		A	Resect face tum + cm	15.26	NA	NA	13.07	13.07	2.91	090
21025		A	Excision of bone lower jaw	10.03	15.17	14.42	11.30	10.50	1.44	090
21026		A	Excision of facial bone(s)	5.70	11.75	11.13	8.41	7.93	0.83	090
21029		A	Contour of face bone lesion	8.39	13.21	12.48	9.56	8.92	1.64	090
21030		A	Excise max/zygoma b9 tumor	4.91	9.71	9.14	6.87	6.39	0.76	090
21031		A	Remove exostosis mandible	3.30	7.80	7.44	5.06	4.72	0.41	090
21032		A	Remove exostosis maxilla	3.34	7.96	7.59	4.94	4.59	0.42	090
21034		A	Excise max/zygoma mlg tumor	17.38	20.61	19.31	16.06	14.81	2.43	090
21040		A	Excise mandible lesion	4.91	9.84	9.26	6.95	6.40	0.75	090
21044		A	Removal of jaw bone lesion	12.80	NA	NA	12.37	11.48	1.78	090
21045		A	Extensive jaw surgery	18.37	NA	NA	16.73	15.41	2.51	090
21046		A	Remove mandible cyst complex	14.21	NA	NA	17.41	16.03	1.82	090
21047		A	Excise lwr jaw cyst w/repair	20.07	NA	NA	17.23	15.66	2.58	090
21048		A	Remove maxilla cyst complex	14.71	NA	NA	17.81	16.18	1.89	090
21049		A	Excis uppr jaw cyst w/repair	19.32	NA	NA	15.84	14.98	2.46	090
21050		A	Removal of jaw joint	11.76	NA	NA	12.47	11.80	2.30	090
21060		A	Remove jaw joint cartilage	11.07	NA	NA	11.70	10.69	2.34	090
21070		A	Remove coronoid process	8.62	NA	NA	9.13	8.67	1.10	090
21073		A	Mnpj of tmj w/anesth	3.45	7.65	7.15	3.70	3.29	0.68	090
21076		A	Prepare face/oral prosthesis	13.40	15.05	13.32	10.49	9.15	1.70	010
21077		A	Prepare face/oral prosthesis	33.70	37.54	32.77	26.53	23.45	4.32	090
21079		A	Prepare face/oral prosthesis	22.31	25.78	22.91	17.72	15.55	2.87	090
21080		A	Prepare face/oral prosthesis	25.06	29.04	26.00	19.63	17.28	3.22	090
21081		A	Prepare face/oral prosthesis	22.85	26.89	24.03	17.87	15.79	2.95	090
21082		A	Prepare face/oral prosthesis	20.84	26.31	23.23	17.57	15.30	2.66	090
21083		A	Prepare face/oral prosthesis	19.27	25.66	22.76	16.40	14.24	1.37	090
21084		A	Prepare face/oral prosthesis	22.48	28.80	25.82	18.79	16.52	2.89	090
21085		A	Prepare face/oral prosthesis	8.99	12.65	10.86	7.23	6.38	3.34	010

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21086		A	Prepare face/oral prosthesis	24.88	28.05	23.92	19.38	16.89	3.19	090
21087		A	Prepare face/oral prosthesis	24.88	27.83	23.82	19.03	16.73	3.19	090
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21100		A	Maxillofacial fixation	4.73	11.85	13.68	4.71	5.47	0.64	090
21110		A	Interdental fixation	5.99	16.72	15.79	13.08	12.29	0.76	090
21116		A	Injection jaw joint x-ray	0.81	3.33	3.42	0.38	0.35	0.05	000
21120		A	Reconstruction of chin	5.10	13.03	12.58	9.48	8.97	1.00	090
21121		A	Reconstruction of chin	7.81	15.07	14.11	11.23	10.49	0.54	090
21122		A	Reconstruction of chin	8.71	NA	NA	11.79	11.17	0.61	090
21123		A	Reconstruction of chin	11.34	NA	NA	15.56	13.47	0.80	090
21125		A	Augmentation lower jaw bone	10.80	74.31	76.24	11.48	10.33	2.13	090
21127		A	Augmentation lower jaw bone	12.44	96.47	94.88	13.23	11.88	1.59	090
21137		A	Reduction of forehead	10.24	NA	NA	9.26	8.91	2.00	090
21138		A	Reduction of forehead	12.87	NA	NA	12.35	11.43	1.82	090
21139		A	Reduction of forehead	15.02	NA	NA	14.19	12.93	1.06	090
21141		A	Reconstruct midface lefort	19.57	NA	NA	18.24	17.08	3.84	090
21142		A	Reconstruct midface lefort	20.28	NA	NA	18.59	16.55	3.99	090
21143		A	Reconstruct midface lefort	21.05	NA	NA	19.75	17.73	4.48	090
21145		A	Reconstruct midface lefort	23.94	NA	NA	20.42	18.35	1.68	090
21146		A	Reconstruct midface lefort	24.87	NA	NA	23.22	20.73	4.89	090
21147		A	Reconstruct midface lefort	26.47	NA	NA	21.01	19.86	1.87	090
21150		A	Reconstruct midface lefort	25.96	NA	NA	22.77	20.50	1.83	090
21151		A	Reconstruct midface lefort	29.02	NA	NA	24.56	25.08	3.73	090
21154		A	Reconstruct midface lefort	31.29	NA	NA	31.32	27.36	4.01	090
21155		A	Reconstruct midface lefort	35.22	NA	NA	28.65	26.13	2.50	090
21159		A	Reconstruct midface lefort	43.14	NA	NA	39.89	33.83	5.51	090
21160		A	Reconstruct midface lefort	47.19	NA	NA	28.85	28.59	3.35	090

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21172		A	Reconstruct orbit/forehead	28.20	NA	NA	23.96	20.84	3.61	090
21175		A	Reconstruct orbit/forehead	33.56	NA	NA	28.82	25.18	12.00	090
21179		A	Reconstruct entire forehead	22.65	NA	NA	20.18	17.92	4.45	090
21180		A	Reconstruct entire forehead	25.58	NA	NA	22.40	20.14	3.29	090
21181		A	Contour cranial bone lesion	10.28	NA	NA	10.58	9.39	1.30	090
21182		A	Reconstruct cranial bone	32.58	NA	NA	22.72	21.85	4.17	090
21183		A	Reconstruct cranial bone	35.70	NA	NA	24.56	23.92	7.01	090
21184		A	Reconstruct cranial bone	38.62	NA	NA	30.61	27.12	7.60	090
21188		A	Reconstruction of midface	23.15	NA	NA	22.24	21.42	2.97	090
21193		A	Reconst lwr jaw w/o graft	18.90	NA	NA	17.94	15.76	4.03	090
21194		A	Reconst lwr jaw w/graft	21.82	NA	NA	17.60	16.59	2.80	090
21195		A	Reconst lwr jaw w/o fixation	19.16	NA	NA	19.43	18.03	2.44	090
21196		A	Reconst lwr jaw w/fixation	20.83	NA	NA	21.81	19.87	2.66	090
21198		A	Reconstr lwr jaw segment	15.71	NA	NA	17.62	16.37	2.17	090
21199		A	Reconstr lwr jaw w/advance	16.73	NA	NA	12.33	11.30	2.15	090
21206		A	Reconstruct upper jaw bone	15.59	NA	NA	19.51	17.19	3.08	090
21208		A	Augmentation of facial bones	11.42	41.16	39.37	11.50	11.10	2.24	090
21209		A	Reduction of facial bones	7.82	15.72	15.17	10.70	10.07	1.53	090
21210		A	Face bone graft	11.69	53.00	50.23	12.87	11.54	1.51	090
21215		A	Lower jaw bone graft	12.23	101.33	96.04	13.13	11.79	2.39	090
21230		A	Rib cartilage graft	11.17	NA	NA	10.25	9.58	2.19	090
21235		A	Ear cartilage graft	7.50	13.33	12.87	8.79	8.30	1.10	090
21240		A	Reconstruction of jaw joint	16.07	NA	NA	15.62	14.24	2.04	090
21242		A	Reconstruction of jaw joint	14.59	NA	NA	14.26	13.21	1.87	090
21243		A	Reconstruction of jaw joint	24.53	NA	NA	23.27	21.16	3.15	090
21244		A	Reconstruction of lower jaw	13.62	NA	NA	16.81	15.69	1.93	090
21245		A	Reconstruction of jaw	13.12	19.10	18.42	12.55	11.93	1.67	090
21246		A	Reconstruction of jaw	12.92	NA	NA	10.80	10.11	1.64	090

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21247		A	Reconstruct lower jaw bone	24.37	NA	NA	19.78	18.85	4.81	090
21248		A	Reconstruction of jaw	12.74	18.63	17.23	12.91	11.61	1.63	090
21249		A	Reconstruction of jaw	18.77	24.40	22.30	17.91	15.67	2.39	090
21255		A	Reconstruct lower jaw bone	18.46	NA	NA	19.82	19.88	2.35	090
21256		A	Reconstruction of orbit	17.66	NA	NA	16.57	14.97	2.25	090
21260		A	Revise eye sockets	17.90	NA	NA	21.79	19.95	1.26	090
21261		A	Revise eye sockets	34.07	NA	NA	23.67	24.31	6.71	090
21263		A	Revise eye sockets	31.01	NA	NA	22.32	22.38	2.20	090
21267		A	Revise eye sockets	20.69	NA	NA	24.13	22.54	4.07	090
21268		A	Revise eye sockets	27.07	NA	NA	20.59	21.74	5.32	090
21270		A	Augmentation cheek bone	10.63	17.28	15.69	10.62	9.30	1.51	090
21275		A	Revision orbitofacial bones	11.76	NA	NA	11.84	10.62	2.30	090
21280		A	Revision of eyelid	7.13	NA	NA	8.90	8.04	1.40	090
21282		A	Revision of eyelid	4.27	NA	NA	6.36	5.85	0.77	090
21295		A	Revision of jaw muscle/bone	1.90	NA	NA	2.90	2.92	0.37	090
21296		A	Revision of jaw muscle/bone	4.78	NA	NA	5.93	6.39	0.61	090
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21310		A	Treatment of nose fracture	0.58	2.74	2.60	0.16	0.16	0.10	000
21315		A	Treatment of nose fracture	1.83	6.04	5.80	2.45	2.33	0.29	010
21320		A	Treatment of nose fracture	1.88	5.52	5.32	2.00	1.89	0.27	010
21325		A	Treatment of nose fracture	4.18	NA	NA	9.16	9.06	0.67	090
21330		A	Treatment of nose fracture	5.79	NA	NA	10.54	10.27	0.73	090
21335		A	Treatment of nose fracture	9.02	NA	NA	11.88	11.40	1.22	090
21336		A	Treat nasal septal fracture	6.77	NA	NA	11.93	11.44	0.91	090
21337		A	Treat nasal septal fracture	3.39	8.12	7.81	5.01	4.71	0.52	090
21338		A	Treat nasoethmoid fracture	6.87	NA	NA	14.27	13.80	1.36	090
21339		A	Treat nasoethmoid fracture	8.50	NA	NA	13.43	13.57	1.66	090
21340		A	Treatment of nose fracture	11.49	NA	NA	10.16	9.98	1.48	090

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21343		A	Treatment of sinus fracture	14.32	NA	NA	17.14	16.85	2.82	090
21344		A	Treatment of sinus fracture	21.57	NA	NA	22.09	19.96	7.73	090
21345		A	Treat nose/jaw fracture	9.06	13.11	12.87	8.77	8.57	1.17	090
21346		A	Treat nose/jaw fracture	11.45	NA	NA	14.83	14.53	1.48	090
21347		A	Treat nose/jaw fracture	13.53	NA	NA	18.47	17.29	1.71	090
21348		A	Treat nose/jaw fracture	17.52	NA	NA	16.57	14.45	2.24	090
21355		A	Treat cheek bone fracture	4.45	8.48	8.04	5.16	4.73	0.56	010
21356		A	Treat cheek bone fracture	4.83	9.31	8.96	5.85	5.53	0.71	010
21360		A	Treat cheek bone fracture	7.19	NA	NA	8.15	7.54	0.91	090
21365		A	Treat cheek bone fracture	16.77	NA	NA	14.67	13.40	2.80	090
21366		A	Treat cheek bone fracture	18.60	NA	NA	17.36	15.13	3.67	090
21385		A	Treat eye socket fracture	9.57	NA	NA	10.20	9.79	1.22	090
21386		A	Treat eye socket fracture	9.57	NA	NA	8.49	8.19	1.87	090
21387		A	Treat eye socket fracture	10.11	NA	NA	10.50	10.03	1.97	090
21390		A	Treat eye socket fracture	11.23	NA	NA	11.31	10.25	1.89	090
21395		A	Treat eye socket fracture	14.70	NA	NA	13.74	12.13	1.87	090
21400		A	Treat eye socket fracture	1.50	3.80	3.61	2.79	2.63	0.27	090
21401		A	Treat eye socket fracture	3.68	9.57	9.52	4.62	4.43	0.72	090
21406		A	Treat eye socket fracture	7.42	NA	NA	8.73	7.82	0.95	090
21407		A	Treat eye socket fracture	9.02	NA	NA	9.22	8.51	1.59	090
21408		A	Treat eye socket fracture	12.78	NA	NA	12.60	11.34	2.51	090
21421		A	Treat mouth roof fracture	6.02	15.28	14.72	11.98	11.48	1.18	090
21422		A	Treat mouth roof fracture	8.73	NA	NA	10.30	9.67	1.13	090
21423		A	Treat mouth roof fracture	10.85	NA	NA	12.40	11.25	2.13	090
21431		A	Treat craniofacial fracture	7.90	NA	NA	12.54	12.41	1.55	090
21432		A	Treat craniofacial fracture	8.82	NA	NA	11.34	10.16	1.71	090
21433		A	Treat craniofacial fracture	26.29	NA	NA	18.97	18.40	5.17	090
21435		A	Treat craniofacial fracture	20.26	NA	NA	16.23	15.61	2.59	090

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21436		A	Treat craniofacial fracture	30.30	NA	NA	27.36	24.32	5.96	090
21440		A	Treat dental ridge fracture	3.44	12.58	12.09	9.59	9.25	0.67	090
21445		A	Treat dental ridge fracture	6.26	15.57	15.05	11.53	11.07	0.80	090
21450		A	Treat lower jaw fracture	3.71	13.28	12.63	9.94	9.59	0.65	090
21451		A	Treat lower jaw fracture	5.65	16.64	15.66	12.74	12.08	0.72	090
21452		A	Treat lower jaw fracture	2.40	13.41	14.19	7.23	7.11	0.48	090
21453		A	Treat lower jaw fracture	6.64	19.17	18.03	15.51	14.77	1.05	090
21454		A	Treat lower jaw fracture	7.36	NA	NA	8.76	8.06	0.92	090
21461		A	Treat lower jaw fracture	9.31	51.81	48.72	17.56	16.70	1.40	090
21462		A	Treat lower jaw fracture	11.01	53.30	50.61	18.76	17.63	1.41	090
21465		A	Treat lower jaw fracture	13.12	NA	NA	13.76	12.31	2.58	090
21470		A	Treat lower jaw fracture	17.54	NA	NA	16.70	15.15	2.89	090
21480		A	Reset dislocated jaw	0.61	2.02	1.97	0.26	0.24	0.10	000
21485		A	Reset dislocated jaw	4.77	15.28	14.42	11.96	11.32	0.61	090
21490		A	Repair dislocated jaw	12.95	NA	NA	12.89	11.97	2.55	090
21495		A	Treat hyoid bone fracture	6.79	NA	NA	13.84	13.04	0.86	090
21497		A	Interdental wiring	4.64	14.72	14.31	11.71	11.37	0.90	090
21499		C	Head surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21501		A	Drain neck/chest lesion	3.98	8.63	8.31	4.88	4.67	0.75	090
21502		A	Drain chest lesion	7.55	NA	NA	5.73	5.87	1.60	090
21510		A	Drainage of bone lesion	6.20	NA	NA	6.35	6.18	1.45	090
21550		A	Biopsy of neck/chest	2.11	5.21	5.11	2.30	2.24	0.30	010
21552		A	Exc neck les sc 3+ cm	6.49	NA	NA	5.64	5.64	1.28	090
21554		A	Exc neck tum deep 5+ cm	11.13	NA	NA	8.79	8.79	2.08	090
21555		A	Exc neck les sc < 3 cm	3.96	7.45	7.25	4.38	4.29	0.77	090
21556		A	Exc neck tum deep < 5 cm	7.66	NA	NA	6.93	6.05	1.44	090
21557		A	Resect neck tum < 5 cm	14.75	NA	NA	11.40	8.73	2.78	090
21558		A	Resect neck tum 5+ cm	21.58	NA	NA	15.25	15.25	4.07	090

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21600		A	Partial removal of rib	7.26	NA	NA	8.12	7.70	1.56	090
21610		A	Partial removal of rib	15.91	NA	NA	14.07	12.49	5.70	090
21615		A	Removal of rib	10.45	NA	NA	6.52	6.67	2.46	090
21616		A	Removal of rib and nerves	12.69	NA	NA	6.95	8.19	3.03	090
21620		A	Partial removal of sternum	7.28	NA	NA	6.74	6.58	1.62	090
21627		A	Sternal debridement	7.30	NA	NA	7.36	7.27	1.64	090
21630		A	Extensive sternum surgery	19.18	NA	NA	14.91	14.29	4.03	090
21632		A	Extensive sternum surgery	19.68	NA	NA	12.86	12.70	4.93	090
21685		A	Hyoid myotomy & suspension	15.26	NA	NA	13.55	12.49	1.96	090
21700		A	Revision of neck muscle	6.31	NA	NA	4.71	4.88	1.49	090
21705		A	Revision of neck muscle/rib	9.92	NA	NA	4.73	5.69	2.34	090
21720		A	Revision of neck muscle	5.80	NA	NA	5.87	5.33	2.06	090
21725		A	Revision of neck muscle	7.19	NA	NA	7.45	7.02	1.41	090
21740		A	Reconstruction of sternum	17.57	NA	NA	9.36	9.80	3.46	090
21742		C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21743		C	Repair sternum/nuss w/scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21750		A	Repair of sternum separation	11.40	NA	NA	6.68	6.86	2.70	090
21800		A	Treatment of rib fracture	1.01	1.91	1.78	2.00	1.85	0.18	090
21805		A	Treatment of rib fracture	2.88	NA	NA	4.22	4.15	0.67	090
21810		A	Treatment of rib fracture(s)	7.03	NA	NA	7.26	6.65	1.63	090
21820		A	Treat sternum fracture	1.36	2.50	2.33	2.59	2.40	0.26	090
21825		A	Treat sternum fracture	7.76	NA	NA	7.13	7.10	1.82	090
21899		C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21920		A	Biopsy soft tissue of back	2.11	5.14	5.08	2.42	2.30	0.34	010
21925		A	Biopsy soft tissue of back	4.63	7.37	6.97	4.84	4.50	0.92	090
21930		A	Exc back les sc < 3 cm	4.94	7.79	7.56	4.78	4.68	1.02	090
21931		A	Exc back les sc 3+ cm	6.88	NA	NA	5.70	5.70	1.41	090
21932		A	Exc back tum deep < 5 cm	9.82	NA	NA	8.08	8.08	2.08	090

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21933		A	Exc back tum deep 5+ cm	11.13	NA	NA	8.53	8.53	2.35	090
21935		A	Resect back tum < 5 cm	15.72	NA	NA	11.71	11.41	3.20	090
21936		A	Resect back tum 5+ cm	22.55	NA	NA	15.50	15.50	4.59	090
22010		A	I&d p-spine c/t/cerv-thor	12.75	NA	NA	12.01	11.36	3.29	090
22015		A	I&d p-spine l/s/ls	12.64	NA	NA	11.79	11.25	3.07	090
22100		A	Remove part of neck vertebra	11.00	NA	NA	11.33	10.61	3.95	090
22101		A	Remove part thorax vertebra	11.08	NA	NA	10.06	9.98	3.97	090
22102		A	Remove part lumbar vertebra	11.08	NA	NA	10.76	10.30	2.66	090
22103		A	Remove extra spine segment	2.34	NA	NA	1.36	1.32	0.64	ZZZ
22110		A	Remove part of neck vertebra	14.00	NA	NA	13.10	12.41	5.02	090
22112		A	Remove part thorax vertebra	14.07	NA	NA	12.93	11.88	5.04	090
22114		A	Remove part lumbar vertebra	14.07	NA	NA	12.80	12.16	2.77	090
22116		A	Remove extra spine segment	2.32	NA	NA	1.33	1.27	0.60	ZZZ
22206		A	Cut spine 3 col thor	37.18	NA	NA	26.43	24.70	7.31	090
22207		A	Cut spine 3 col lumb	36.68	NA	NA	26.12	24.44	9.18	090
22208		A	Cut spine 3 col addl seg	9.66	NA	NA	5.63	5.27	2.58	ZZZ
22210		A	Revision of neck spine	25.38	NA	NA	20.74	19.73	6.74	090
22212		A	Revision of thorax spine	20.99	NA	NA	18.01	17.03	4.96	090
22214		A	Revision of lumbar spine	21.02	NA	NA	17.97	17.13	5.11	090
22216		A	Revise extra spine segment	6.03	NA	NA	3.51	3.39	1.51	ZZZ
22220		A	Revision of neck spine	22.94	NA	NA	19.04	17.84	6.41	090
22222		A	Revision of thorax spine	23.09	NA	NA	19.34	16.16	4.54	090
22224		A	Revision of lumbar spine	23.09	NA	NA	18.88	17.79	5.36	090
22226		A	Revise extra spine segment	6.03	NA	NA	3.48	3.35	1.58	ZZZ
22305		A	Treat spine process fracture	2.13	3.07	2.89	2.60	2.44	0.41	090
22310		A	Treat spine fracture	3.89	4.37	4.03	3.72	3.41	0.77	090
22315		A	Treat spine fracture	10.11	13.56	12.81	10.46	9.83	2.54	090
22318		A	Treat odontoid fx w/o graft	22.72	NA	NA	18.27	17.43	7.66	090

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22319		A	Treat odontoid fx w/graft	25.33	NA	NA	20.11	18.84	9.09	090
22325		A	Treat spine fracture	19.87	NA	NA	17.16	16.24	5.68	090
22326		A	Treat neck spine fracture	20.84	NA	NA	17.16	16.29	6.29	090
22327		A	Treat thorax spine fracture	20.77	NA	NA	17.89	16.74	5.61	090
22328		A	Treat each add spine fx	4.60	NA	NA	2.62	2.52	1.36	ZZZ
22505		A	Manipulation of spine	1.87	NA	NA	1.43	1.31	0.29	010
22520		A	Percut vertebroplasty thor	9.22	53.30	55.57	4.80	5.15	1.06	010
22521		A	Percut vertebroplasty lumb	8.65	53.07	54.94	4.60	4.93	1.00	010
22522		A	Percut vertebroplasty addl	4.30	NA	NA	1.89	1.97	0.54	ZZZ
22523		A	Percut kyphoplasty thor	9.26	NA	NA	6.13	6.22	1.82	010
22524		A	Percut kyphoplasty lumbar	8.86	NA	NA	5.97	6.04	1.74	010
22525		A	Percut kyphoplasty add-on	4.47	NA	NA	2.33	2.35	0.95	ZZZ
22526		N	Idet single level	6.10	59.00	55.12	3.49	2.93	0.54	010
22527		N	Idet 1 or more levels	3.03	50.65	46.41	1.33	1.02	0.24	ZZZ
22532		A	Lat thorax spine fusion	25.99	NA	NA	19.90	18.82	7.55	090
22533		A	Lat lumbar spine fusion	24.79	NA	NA	19.23	18.19	6.37	090
22534		A	Lat thor/lumb addl seg	5.99	NA	NA	3.43	3.31	1.59	ZZZ
22548		A	Neck spine fusion	27.06	NA	NA	21.81	20.34	9.70	090
22551		A	Neck spine fuse&remove addl	25.00	NA	NA	18.65	18.65	7.55	090
22552		A	Addl neck spine fusion	6.50	NA	NA	3.65	3.65	1.78	ZZZ
22554		A	Neck spine fusion	17.69	NA	NA	14.70	14.28	5.46	090
22556		A	Thorax spine fusion	24.70	NA	NA	18.63	17.77	6.61	090
22558		A	Lumbar spine fusion	23.53	NA	NA	17.15	16.19	5.65	090
22585		A	Additional spinal fusion	5.52	NA	NA	3.10	3.00	1.59	ZZZ
22590		A	Spine & skull spinal fusion	21.76	NA	NA	18.25	17.38	7.03	090
22595		A	Neck spinal fusion	20.64	NA	NA	17.55	16.69	6.56	090
22600		A	Neck spine fusion	17.40	NA	NA	15.53	14.77	5.31	090
22610		A	Thorax spine fusion	17.28	NA	NA	15.34	14.59	4.85	090

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22612		A	Lumbar spine fusion	23.53	NA	NA	18.04	17.22	6.22	090
22614		A	Spine fusion extra segment	6.43	NA	NA	3.69	3.57	1.77	ZZZ
22630		A	Lumbar spine fusion	22.09	NA	NA	17.67	16.91	6.26	090
22632		A	Spine fusion extra segment	5.22	NA	NA	2.99	2.88	1.49	ZZZ
22800		A	Fusion of spine	19.50	NA	NA	16.06	15.37	4.89	090
22802		A	Fusion of spine	32.11	NA	NA	23.65	22.65	7.50	090
22804		A	Fusion of spine	37.50	NA	NA	26.91	25.73	8.51	090
22808		A	Fusion of spine	27.51	NA	NA	20.21	19.34	7.25	090
22810		A	Fusion of spine	31.50	NA	NA	21.71	20.78	7.92	090
22812		A	Fusion of spine	34.25	NA	NA	25.84	24.09	6.74	090
22818		A	Kyphectomy 1-2 segments	34.33	NA	NA	24.84	23.27	6.75	090
22819		A	Kyphectomy 3 or more	39.38	NA	NA	28.70	26.88	14.12	090
22830		A	Exploration of spinal fusion	11.22	NA	NA	9.99	9.58	2.89	090
22840		A	Insert spine fixation device	12.52	NA	NA	7.16	6.94	3.48	ZZZ
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
22842		A	Insert spine fixation device	12.56	NA	NA	7.21	6.98	3.44	ZZZ
22843		A	Insert spine fixation device	13.44	NA	NA	7.77	7.46	3.49	ZZZ
22844		A	Insert spine fixation device	16.42	NA	NA	9.62	9.35	3.68	ZZZ
22845		A	Insert spine fixation device	11.94	NA	NA	6.76	6.53	3.65	ZZZ
22846		A	Insert spine fixation device	12.40	NA	NA	7.02	6.79	3.76	ZZZ
22847		A	Insert spine fixation device	13.78	NA	NA	7.71	7.51	4.94	ZZZ
22848		A	Insert pelv fixation device	5.99	NA	NA	3.52	3.41	1.39	ZZZ
22849		A	Reinsert spinal fixation	19.17	NA	NA	14.65	14.05	5.13	090
22850		A	Remove spine fixation device	9.82	NA	NA	8.99	8.61	2.61	090
22851		A	Apply spine prosth device	6.70	NA	NA	3.82	3.68	1.89	ZZZ
22852		A	Remove spine fixation device	9.37	NA	NA	8.72	8.34	2.40	090
22855		A	Remove spine fixation device	15.86	NA	NA	12.79	12.24	4.74	090
22856		A	Cerv artific diskectomy	24.05	NA	NA	18.16	17.47	7.27	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
22857		R	Lumbar artif diskectomy	27.13	NA	NA	16.18	16.54	5.77	090
22861		A	Revise cerv artific disc	33.36	NA	NA	17.43	17.05	9.10	090
22862		R	Revise lumbar artif disc	32.63	NA	NA	17.61	17.24	6.41	090
22864		A	Remove cerv artif disc	29.40	NA	NA	21.76	18.45	8.03	090
22865		R	Remove lumb artif disc	31.75	NA	NA	21.16	21.76	6.23	090
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
22900		A	Exc back tum deep < 5 cm	8.32	NA	NA	6.61	5.49	1.71	090
22901		A	Exc back tum deep 5+ cm	10.11	NA	NA	7.39	7.39	2.09	090
22902		A	Exc abd les sc < 3 cm	4.42	7.75	7.75	4.95	4.95	0.71	090
22903		A	Exc abd les sc > 3 cm	6.39	NA	NA	5.57	5.57	1.21	090
22904		A	Resect abd tum < 5 cm	16.69	NA	NA	10.40	10.40	3.54	090
22905		A	Resect abd tum > 5 cm	21.58	NA	NA	13.67	13.67	4.59	090
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23000		A	Removal of calcium deposits	4.48	11.36	10.67	5.58	5.25	0.86	090
23020		A	Release shoulder joint	9.36	NA	NA	9.25	8.87	1.79	090
23030		A	Drain shoulder lesion	3.47	8.59	8.30	3.47	3.31	0.68	010
23031		A	Drain shoulder bursa	2.79	8.70	8.27	3.12	2.93	0.53	010
23035		A	Drain shoulder bone lesion	9.16	NA	NA	9.21	8.92	1.79	090
23040		A	Exploratory shoulder surgery	9.75	NA	NA	9.74	9.29	1.90	090
23044		A	Exploratory shoulder surgery	7.59	NA	NA	7.82	7.52	1.49	090
23065		A	Biopsy shoulder tissues	2.30	3.71	3.59	2.36	2.24	0.38	010
23066		A	Biopsy shoulder tissues	4.30	10.50	9.98	5.15	4.87	0.84	090
23071		A	Exc shoulder les sc > 3 cm	5.91	NA	NA	5.36	5.36	1.21	090
23073		A	Exc shoulder tum deep > 5 cm	10.13	NA	NA	8.51	8.51	2.04	090
23075		A	Exc shoulder les sc < 3 cm	4.21	8.49	6.53	4.53	3.37	0.86	090
23076		A	Exc shoulder tum deep < 5 cm	7.41	NA	NA	7.02	6.85	1.51	090
23077		A	Resect shoulder tum < 5 cm	17.66	NA	NA	13.15	12.71	3.59	090
23078		A	Resect shoulder tum > 5 cm	22.55	NA	NA	14.10	14.10	4.81	090

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23100		A	Biopsy of shoulder joint	6.20	NA	NA	7.37	6.94	1.22	090
23101		A	Shoulder joint surgery	5.72	NA	NA	6.45	6.19	1.13	090
23105		A	Remove shoulder joint lining	8.48	NA	NA	8.77	8.39	1.66	090
23106		A	Incision of collarbone joint	6.13	NA	NA	7.33	6.80	1.21	090
23107		A	Explore treat shoulder joint	8.87	NA	NA	9.02	8.62	1.71	090
23120		A	Partial removal collar bone	7.39	NA	NA	8.45	8.02	1.45	090
23125		A	Removal of collar bone	9.64	NA	NA	9.57	9.02	1.89	090
23130		A	Remove shoulder bone part	7.77	NA	NA	8.76	8.35	1.52	090
23140		A	Removal of bone lesion	7.12	NA	NA	7.01	6.58	1.41	090
23145		A	Removal of bone lesion	9.40	NA	NA	9.43	8.95	1.85	090
23146		A	Removal of bone lesion	8.08	NA	NA	8.75	8.10	1.59	090
23150		A	Removal of humerus lesion	8.91	NA	NA	8.91	8.49	1.71	090
23155		A	Removal of humerus lesion	10.86	NA	NA	10.63	10.08	2.13	090
23156		A	Removal of humerus lesion	9.11	NA	NA	9.25	8.77	1.79	090
23170		A	Remove collar bone lesion	7.21	NA	NA	7.97	7.24	1.41	090
23172		A	Remove shoulder blade lesion	7.31	NA	NA	8.03	7.46	1.45	090
23174		A	Remove humerus lesion	10.05	NA	NA	10.51	9.99	1.97	090
23180		A	Remove collar bone lesion	8.99	NA	NA	9.13	8.98	1.81	090
23182		A	Remove shoulder blade lesion	8.61	NA	NA	9.39	9.02	1.68	090
23184		A	Remove humerus lesion	9.90	NA	NA	9.99	9.72	1.90	090
23190		A	Partial removal of scapula	7.47	NA	NA	8.02	7.49	1.48	090
23195		A	Removal of head of humerus	10.36	NA	NA	10.11	9.57	2.02	090
23200		A	Resect clavicle tumor	22.71	NA	NA	18.41	14.25	4.47	090
23210		A	Resect scapula tumor	27.21	NA	NA	21.11	15.92	5.35	090
23220		A	Resect prox humerus tumor	30.21	NA	NA	22.58	17.36	5.95	090
23330		A	Remove shoulder foreign body	1.90	4.54	4.38	2.18	2.10	0.35	010
23331		A	Remove shoulder foreign body	7.63	NA	NA	8.40	8.02	1.49	090
23332		A	Remove shoulder foreign body	12.37	NA	NA	11.52	11.01	2.39	090

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23350		A	Injection for shoulder x-ray	1.00	2.98	3.27	0.40	0.43	0.10	000
23395		A	Muscle transfer shoulder/arm	18.54	NA	NA	16.30	15.51	3.59	090
23397		A	Muscle transfers	16.76	NA	NA	14.16	13.48	3.30	090
23400		A	Fixation of shoulder blade	13.87	NA	NA	12.43	11.87	2.73	090
23405		A	Incision of tendon & muscle	8.54	NA	NA	8.41	8.09	1.66	090
23406		A	Incise tendon(s) & muscle(s)	11.01	NA	NA	10.02	9.62	2.16	090
23410		A	Repair rotator cuff acute	11.39	NA	NA	10.86	10.46	2.21	090
23412		A	Repair rotator cuff chronic	11.93	NA	NA	11.18	10.80	2.31	090
23415		A	Release of shoulder ligament	9.23	NA	NA	9.64	9.21	1.81	090
23420		A	Repair of shoulder	13.54	NA	NA	12.73	12.23	2.65	090
23430		A	Repair biceps tendon	10.17	NA	NA	10.07	9.51	1.97	090
23440		A	Remove/transplant tendon	10.64	NA	NA	9.79	9.39	2.06	090
23450		A	Repair shoulder capsule	13.70	NA	NA	11.92	11.37	2.70	090
23455		A	Repair shoulder capsule	14.67	NA	NA	12.52	11.98	2.85	090
23460		A	Repair shoulder capsule	15.82	NA	NA	13.71	13.10	3.12	090
23462		A	Repair shoulder capsule	15.72	NA	NA	13.32	12.66	3.11	090
23465		A	Repair shoulder capsule	16.30	NA	NA	13.92	13.27	3.20	090
23466		A	Repair shoulder capsule	15.80	NA	NA	14.51	13.82	3.11	090
23470		A	Reconstruct shoulder joint	17.89	NA	NA	14.81	14.18	3.50	090
23472		A	Reconstruct shoulder joint	22.65	NA	NA	17.83	17.01	4.41	090
23480		A	Revision of collar bone	11.54	NA	NA	10.71	10.18	2.25	090
23485		A	Revision of collar bone	13.91	NA	NA	12.05	11.52	2.72	090
23490		A	Reinforce clavicle	12.16	NA	NA	12.13	10.97	2.39	090
23491		A	Reinforce shoulder bones	14.54	NA	NA	12.89	12.30	2.87	090
23500		A	Treat clavicle fracture	2.21	3.67	3.49	3.77	3.52	0.41	090
23505		A	Treat clavicle fracture	3.83	5.67	5.38	5.14	4.85	0.72	090
23515		A	Treat clavicle fracture	9.69	NA	NA	10.10	9.40	1.89	090
23520		A	Treat clavicle dislocation	2.29	3.98	3.70	4.08	3.77	0.43	090

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23525		A	Treat clavicle dislocation	3.79	6.92	6.01	5.85	5.15	0.73	090
23530		A	Treat clavicle dislocation	7.48	NA	NA	8.02	7.22	1.48	090
23532		A	Treat clavicle dislocation	8.20	NA	NA	8.71	8.28	1.60	090
23540		A	Treat clavicle dislocation	2.36	3.63	3.46	3.72	3.46	0.42	090
23545		A	Treat clavicle dislocation	3.43	5.42	5.10	4.60	4.33	0.60	090
23550		A	Treat clavicle dislocation	7.59	NA	NA	7.88	7.55	1.47	090
23552		A	Treat clavicle dislocation	8.82	NA	NA	9.04	8.62	1.70	090
23570		A	Treat shoulder blade fx	2.36	3.91	3.71	4.10	3.85	0.43	090
23575		A	Treat shoulder blade fx	4.23	6.64	6.19	5.95	5.53	0.83	090
23585		A	Treat scapula fracture	14.23	NA	NA	12.40	11.48	2.76	090
23600		A	Treat humerus fracture	3.11	5.68	5.42	5.11	4.79	0.60	090
23605		A	Treat humerus fracture	5.06	7.57	7.23	6.51	6.19	0.98	090
23615		A	Treat humerus fracture	12.30	NA	NA	11.71	11.07	2.39	090
23616		A	Treat humerus fracture	18.37	NA	NA	15.31	14.87	3.57	090
23620		A	Treat humerus fracture	2.55	4.76	4.51	4.40	4.12	0.49	090
23625		A	Treat humerus fracture	4.10	6.22	5.92	5.50	5.23	0.77	090
23630		A	Treat humerus fracture	10.57	NA	NA	10.67	9.88	2.06	090
23650		A	Treat shoulder dislocation	3.53	4.58	4.35	3.93	3.67	0.61	090
23655		A	Treat shoulder dislocation	4.76	NA	NA	6.01	5.59	0.88	090
23660		A	Treat shoulder dislocation	7.66	NA	NA	8.16	7.75	1.49	090
23665		A	Treat dislocation/fracture	4.66	6.83	6.49	6.04	5.74	0.88	090
23670		A	Treat dislocation/fracture	12.28	NA	NA	11.45	10.57	2.39	090
23675		A	Treat dislocation/fracture	6.27	8.67	8.20	7.33	6.94	1.20	090
23680		A	Treat dislocation/fracture	13.15	NA	NA	12.00	11.22	2.57	090
23700		A	Fixation of shoulder	2.57	NA	NA	2.70	2.58	0.49	010
23800		A	Fusion of shoulder joint	14.73	NA	NA	13.06	12.41	2.92	090
23802		A	Fusion of shoulder joint	18.42	NA	NA	16.40	15.14	3.61	090
23900		A	Amputation of arm & girdle	20.72	NA	NA	16.89	15.02	4.09	090

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23920		A	Amputation at shoulder joint	16.23	NA	NA	14.33	12.92	3.19	090
23921		A	Amputation follow-up surgery	5.72	NA	NA	6.97	5.75	1.36	090
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23930		A	Drainage of arm lesion	2.99	6.69	6.62	2.83	2.71	0.61	010
23931		A	Drainage of arm bursa	1.84	6.03	5.90	2.52	2.41	0.34	010
23935		A	Drain arm/elbow bone lesion	6.38	NA	NA	7.43	6.97	1.24	090
24000		A	Exploratory elbow surgery	6.08	NA	NA	6.91	6.55	1.17	090
24006		A	Release elbow joint	9.74	NA	NA	9.66	9.16	1.82	090
24065		A	Biopsy arm/elbow soft tissue	2.13	5.05	4.93	2.57	2.45	0.34	010
24066		A	Biopsy arm/elbow soft tissue	5.35	11.45	10.91	5.74	5.35	1.07	090
24071		A	Exc arm/elbow les sc 3+ cm	5.70	NA	NA	5.31	5.31	1.15	090
24073		A	Ex arm/elbow tum deep > 5 cm	10.13	NA	NA	8.60	8.60	2.01	090
24075		A	Exc arm/elbow les sc < 3 cm	4.24	9.14	8.99	4.66	4.39	0.84	090
24076		A	Ex arm/elbow tum deep < 5 cm	7.41	NA	NA	7.17	6.50	1.48	090
24077		A	Resect arm/elbow tum < 5 cm	15.72	NA	NA	12.15	10.51	3.18	090
24079		A	Resect arm/elbow tum > 5 cm	20.61	NA	NA	13.25	13.25	4.37	090
24100		A	Biopsy elbow joint lining	5.07	NA	NA	6.25	5.84	1.00	090
24101		A	Explore/treat elbow joint	6.30	NA	NA	7.31	6.97	1.21	090
24102		A	Remove elbow joint lining	8.26	NA	NA	8.48	8.04	1.55	090
24105		A	Removal of elbow bursa	3.78	NA	NA	5.76	5.44	0.72	090
24110		A	Remove humerus lesion	7.58	NA	NA	8.34	7.91	1.49	090
24115		A	Remove/graft bone lesion	10.12	NA	NA	9.86	9.28	1.98	090
24116		A	Remove/graft bone lesion	12.23	NA	NA	11.12	10.55	2.40	090
24120		A	Remove elbow lesion	6.82	NA	NA	7.56	7.13	1.29	090
24125		A	Remove/graft bone lesion	8.14	NA	NA	8.67	8.13	1.59	090
24126		A	Remove/graft bone lesion	8.62	NA	NA	8.96	8.50	1.68	090
24130		A	Removal of head of radius	6.42	NA	NA	7.39	7.05	1.20	090
24134		A	Removal of arm bone lesion	10.22	NA	NA	10.03	9.64	2.00	090

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24136		A	Remove radius bone lesion	8.40	NA	NA	8.69	7.79	1.64	090
24138		A	Remove elbow bone lesion	8.50	NA	NA	9.80	9.29	1.66	090
24140		A	Partial removal of arm bone	9.55	NA	NA	9.63	9.36	1.78	090
24145		A	Partial removal of radius	7.81	NA	NA	8.22	8.05	1.53	090
24147		A	Partial removal of elbow	7.84	NA	NA	9.12	8.85	1.51	090
24149		A	Radical resection of elbow	16.22	NA	NA	15.93	14.90	2.97	090
24150		A	Resect distal humerus tumor	23.46	NA	NA	18.75	15.03	4.62	090
24152		A	Resect radius tumor	19.99	NA	NA	16.67	12.76	3.92	090
24155		A	Removal of elbow joint	12.09	NA	NA	11.03	10.41	2.38	090
24160		A	Remove elbow joint implant	8.00	NA	NA	8.55	8.11	1.49	090
24164		A	Remove radius head implant	6.43	NA	NA	7.05	6.73	1.26	090
24200		A	Removal of arm foreign body	1.81	3.86	3.69	2.03	1.89	0.31	010
24201		A	Removal of arm foreign body	4.70	10.54	10.34	5.21	4.98	0.92	090
24220		A	Injection for elbow x-ray	1.31	3.00	3.32	0.58	0.59	0.12	000
24300		A	Manipulate elbow w/anesth	4.04	NA	NA	7.23	6.87	0.72	090
24301		A	Muscle/tendon transfer	10.38	NA	NA	9.94	9.51	2.02	090
24305		A	Arm tendon lengthening	7.62	NA	NA	8.26	7.85	1.36	090
24310		A	Revision of arm tendon	6.12	NA	NA	6.84	6.52	1.18	090
24320		A	Repair of arm tendon	10.86	NA	NA	10.29	9.71	2.13	090
24330		A	Revision of arm muscles	9.79	NA	NA	9.65	9.19	1.91	090
24331		A	Revision of arm muscles	10.95	NA	NA	11.25	10.37	2.16	090
24332		A	Tenolysis triceps	7.91	NA	NA	8.69	8.25	1.55	090
24340		A	Repair of biceps tendon	8.08	NA	NA	8.56	8.17	1.58	090
24341		A	Repair arm tendon/muscle	9.49	NA	NA	10.82	10.17	1.85	090
24342		A	Repair of ruptured tendon	10.86	NA	NA	10.28	9.83	2.06	090
24343		A	Repr elbow lat ligmnt w/tiss	9.16	NA	NA	10.09	9.62	1.67	090
24344		A	Reconstruct elbow lat ligmnt	15.21	NA	NA	14.56	13.79	3.00	090
24345		A	Repr elbw med ligmnt w/tissu	9.16	NA	NA	9.99	9.49	1.67	090

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24346		A	Reconstruct elbow med ligmnt	15.21	NA	NA	14.56	13.83	3.00	090
24357		A	Repair elbow perc	5.44	NA	NA	6.71	6.42	1.03	090
24358		A	Repair elbow w/deb open	6.66	NA	NA	7.65	7.27	1.25	090
24359		A	Repair elbow deb/attch open	8.98	NA	NA	9.04	8.45	1.67	090
24360		A	Reconstruct elbow joint	12.67	NA	NA	11.69	11.15	2.47	090
24361		A	Reconstruct elbow joint	14.41	NA	NA	12.84	12.29	2.84	090
24362		A	Reconstruct elbow joint	15.32	NA	NA	13.39	12.73	3.03	090
24363		A	Replace elbow joint	22.65	NA	NA	18.19	17.10	4.20	090
24365		A	Reconstruct head of radius	8.62	NA	NA	8.69	8.31	1.68	090
24366		A	Reconstruct head of radius	9.36	NA	NA	9.20	8.76	1.77	090
24400		A	Revision of humerus	11.33	NA	NA	10.88	10.41	2.19	090
24410		A	Revision of humerus	15.11	NA	NA	13.53	12.67	2.99	090
24420		A	Revision of humerus	13.73	NA	NA	13.13	12.50	2.70	090
24430		A	Repair of humerus	15.25	NA	NA	13.52	12.71	2.95	090
24435		A	Repair humerus with graft	14.99	NA	NA	14.32	13.52	2.92	090
24470		A	Revision of elbow joint	8.93	NA	NA	9.25	8.24	1.77	090
24495		A	Decompression of forearm	8.41	NA	NA	9.07	8.98	1.79	090
24498		A	Reinforce humerus	12.28	NA	NA	11.20	10.71	2.40	090
24500		A	Treat humerus fracture	3.41	6.23	5.92	5.36	5.02	0.64	090
24505		A	Treat humerus fracture	5.39	8.18	7.81	6.88	6.54	1.05	090
24515		A	Treat humerus fracture	12.12	NA	NA	11.67	11.11	2.34	090
24516		A	Treat humerus fracture	12.19	NA	NA	11.12	10.63	2.38	090
24530		A	Treat humerus fracture	3.69	6.63	6.30	5.65	5.31	0.69	090
24535		A	Treat humerus fracture	7.11	9.62	9.20	8.33	7.94	1.37	090
24538		A	Treat humerus fracture	9.77	NA	NA	10.39	9.96	1.91	090
24545		A	Treat humerus fracture	13.15	NA	NA	12.09	11.32	2.55	090
24546		A	Treat humerus fracture	14.91	NA	NA	13.33	12.77	2.89	090
24560		A	Treat humerus fracture	2.98	5.68	5.41	4.78	4.46	0.56	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
24565		A	Treat humerus fracture	5.78	8.68	8.02	7.47	6.86	1.14	090
24566		A	Treat humerus fracture	9.06	NA	NA	10.39	9.85	1.79	090
24575		A	Treat humerus fracture	9.71	NA	NA	10.19	9.74	1.87	090
24576		A	Treat humerus fracture	3.06	6.18	5.85	5.24	4.90	0.58	090
24577		A	Treat humerus fracture	6.01	8.88	8.27	7.61	7.04	1.18	090
24579		A	Treat humerus fracture	11.44	NA	NA	11.25	10.68	2.20	090
24582		A	Treat humerus fracture	10.14	NA	NA	11.79	11.08	1.98	090
24586		A	Treat elbow fracture	15.78	NA	NA	13.70	13.08	3.04	090
24587		A	Treat elbow fracture	15.79	NA	NA	13.84	13.12	2.92	090
24600		A	Treat elbow dislocation	4.37	5.26	5.10	4.48	4.24	0.76	090
24605		A	Treat elbow dislocation	5.64	NA	NA	7.05	6.66	1.09	090
24615		A	Treat elbow dislocation	9.83	NA	NA	9.54	9.10	1.83	090
24620		A	Treat elbow fracture	7.22	NA	NA	7.79	7.42	1.36	090
24635		A	Treat elbow fracture	8.80	NA	NA	9.51	10.02	1.67	090
24640		A	Treat elbow dislocation	1.25	2.36	2.14	1.18	1.08	0.23	010
24650		A	Treat radius fracture	2.31	4.78	4.55	4.20	3.91	0.42	090
24655		A	Treat radius fracture	4.62	7.12	6.86	6.10	5.83	0.86	090
24665		A	Treat radius fracture	8.36	NA	NA	9.40	8.94	1.59	090
24666		A	Treat radius fracture	9.86	NA	NA	10.08	9.60	1.86	090
24670		A	Treat ulnar fracture	2.69	5.19	4.95	4.42	4.15	0.50	090
24675		A	Treat ulnar fracture	4.91	7.48	7.16	6.41	6.11	0.92	090
24685		A	Treat ulnar fracture	8.37	NA	NA	9.39	8.94	1.62	090
24800		A	Fusion of elbow joint	11.41	NA	NA	11.06	10.11	2.24	090
24802		A	Fusion/graft of elbow joint	14.32	NA	NA	12.80	12.13	2.82	090
24900		A	Amputation of upper arm	10.18	NA	NA	9.63	9.01	2.01	090
24920		A	Amputation of upper arm	10.13	NA	NA	9.71	8.96	1.98	090
24925		A	Amputation follow-up surgery	7.30	NA	NA	8.02	7.60	1.44	090
24930		A	Amputation follow-up surgery	10.83	NA	NA	10.13	9.38	2.13	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
24931		A	Amputate upper arm & implant	13.44	NA	NA	8.42	8.18	0.95	090
24935		A	Revision of amputation	16.45	NA	NA	7.58	8.56	3.23	090
24940		C	Revision of upper arm	0.00	0.00	0.00	0.00	0.00	0.00	090
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
25000		A	Incision of tendon sheath	3.55	NA	NA	5.68	5.75	0.64	090
25001		A	Incise flexor carpi radialis	3.79	NA	NA	5.69	5.33	0.67	090
25020		A	Decompress forearm 1 space	6.06	NA	NA	9.89	9.60	1.06	090
25023		A	Decompress forearm 1 space	13.83	NA	NA	16.21	15.61	2.73	090
25024		A	Decompress forearm 2 spaces	10.79	NA	NA	10.27	9.76	2.12	090
25025		A	Decompress forearm 2 spaces	17.94	NA	NA	15.28	14.03	3.53	090
25028		A	Drainage of forearm lesion	5.39	NA	NA	8.82	8.57	1.03	090
25031		A	Drainage of forearm bursa	4.26	NA	NA	5.14	5.44	0.83	090
25035		A	Treat forearm bone lesion	7.65	NA	NA	8.19	8.80	1.48	090
25040		A	Explore/treat wrist joint	7.50	NA	NA	7.85	7.61	1.36	090
25065		A	Biopsy forearm soft tissues	2.04	5.12	5.00	2.58	2.49	0.33	010
25066		A	Biopsy forearm soft tissues	4.27	NA	NA	5.48	5.62	0.80	090
25071		A	Exc forearm les sc > 3 cm	5.91	NA	NA	5.71	5.71	1.17	090
25073		A	Exc forearm tum deep 3+ cm	7.13	NA	NA	7.50	7.50	1.36	090
25075		A	Exc forearm les sc < 3 cm	3.96	9.20	9.20	4.66	4.77	0.76	090
25076		A	Exc forearm tum deep < 3 cm	6.74	NA	NA	7.27	7.03	1.28	090
25077		A	Resect forearm/wrist tum<3cm	12.93	NA	NA	10.93	10.24	2.61	090
25078		A	Resect forearm/wrist tum3+cm	17.69	NA	NA	11.98	11.98	3.78	090
25085		A	Incision of wrist capsule	5.64	NA	NA	6.62	6.57	1.10	090
25100		A	Biopsy of wrist joint	4.02	NA	NA	5.36	5.23	0.77	090
25101		A	Explore/treat wrist joint	4.83	NA	NA	6.20	6.03	0.90	090
25105		A	Remove wrist joint lining	6.02	NA	NA	7.18	7.05	1.10	090
25107		A	Remove wrist joint cartilage	7.70	NA	NA	9.26	8.91	1.36	090
25109		A	Excise tendon forearm/wrist	6.94	NA	NA	7.84	7.28	1.24	090

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25110		A	Remove wrist tendon lesion	4.04	NA	NA	5.22	5.39	0.75	090
25111		A	Remove wrist tendon lesion	3.53	NA	NA	5.19	5.01	0.67	090
25112		A	Reremove wrist tendon lesion	4.67	NA	NA	5.87	5.63	0.87	090
25115		A	Remove wrist/forearm lesion	10.09	NA	NA	10.83	11.04	1.79	090
25116		A	Remove wrist/forearm lesion	7.56	NA	NA	8.95	9.38	1.33	090
25118		A	Excise wrist tendon sheath	4.51	NA	NA	5.97	5.80	0.80	090
25119		A	Partial removal of ulna	6.21	NA	NA	7.29	7.20	1.22	090
25120		A	Removal of forearm lesion	6.27	NA	NA	7.32	7.91	1.17	090
25125		A	Remove/graft forearm lesion	7.67	NA	NA	8.39	8.95	1.51	090
25126		A	Remove/graft forearm lesion	7.74	NA	NA	8.43	8.94	1.52	090
25130		A	Removal of wrist lesion	5.43	NA	NA	6.88	6.66	0.99	090
25135		A	Remove & graft wrist lesion	7.08	NA	NA	8.03	7.84	1.39	090
25136		A	Remove & graft wrist lesion	6.14	NA	NA	7.21	7.01	1.21	090
25145		A	Remove forearm bone lesion	6.54	NA	NA	7.46	8.04	1.28	090
25150		A	Partial removal of ulna	7.38	NA	NA	8.04	7.91	1.36	090
25151		A	Partial removal of radius	7.68	NA	NA	8.18	8.71	1.51	090
25170		A	Resect radius/ulnar tumor	22.21	NA	NA	17.89	14.89	4.36	090
25210		A	Removal of wrist bone	6.12	NA	NA	7.32	7.08	1.07	090
25215		A	Removal of wrist bones	8.14	NA	NA	8.86	8.64	1.40	090
25230		A	Partial removal of radius	5.37	NA	NA	6.52	6.31	0.90	090
25240		A	Partial removal of ulna	5.31	NA	NA	6.45	6.40	0.91	090
25246		A	Injection for wrist x-ray	1.45	2.94	3.24	0.59	0.63	0.14	000
25248		A	Remove forearm foreign body	5.31	NA	NA	5.82	6.09	1.05	090
25250		A	Removal of wrist prosthesis	6.77	NA	NA	7.58	7.23	1.32	090
25251		A	Removal of wrist prosthesis	9.82	NA	NA	9.66	9.21	1.93	090
25259		A	Manipulate wrist w/anesthes	4.04	NA	NA	7.31	6.94	0.72	090
25260		A	Repair forearm tendon/muscle	8.04	NA	NA	9.25	9.65	1.48	090
25263		A	Repair forearm tendon/muscle	8.04	NA	NA	8.95	9.48	1.58	090

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25265		A	Repair forearm tendon/muscle	10.10	NA	NA	10.18	10.64	1.97	090
25270		A	Repair forearm tendon/muscle	6.17	NA	NA	7.29	7.85	1.15	090
25272		A	Repair forearm tendon/muscle	7.21	NA	NA	7.94	8.51	1.32	090
25274		A	Repair forearm tendon/muscle	8.94	NA	NA	9.15	9.69	1.77	090
25275		A	Repair forearm tendon sheath	8.96	NA	NA	9.32	8.93	1.77	090
25280		A	Revise wrist/forearm tendon	7.39	NA	NA	8.09	8.61	1.28	090
25290		A	Incise wrist/forearm tendon	5.43	NA	NA	6.53	7.68	0.98	090
25295		A	Release wrist/forearm tendon	6.72	NA	NA	7.65	8.18	1.18	090
25300		A	Fusion of tendons at wrist	9.02	NA	NA	9.52	9.20	1.78	090
25301		A	Fusion of tendons at wrist	8.59	NA	NA	9.01	8.69	1.56	090
25310		A	Transplant forearm tendon	8.08	NA	NA	8.94	9.36	1.39	090
25312		A	Transplant forearm tendon	9.82	NA	NA	9.84	10.26	1.78	090
25315		A	Revise palsy hand tendon(s)	10.68	NA	NA	10.19	10.69	2.09	090
25316		A	Revise palsy hand tendon(s)	12.90	NA	NA	11.84	12.10	1.60	090
25320		A	Repair/revise wrist joint	12.75	NA	NA	14.46	13.64	2.25	090
25332		A	Revise wrist joint	11.74	NA	NA	11.35	10.74	2.17	090
25335		A	Realignment of hand	13.39	NA	NA	8.62	10.04	0.95	090
25337		A	Reconstruct ulna/radioulnar	11.73	NA	NA	12.81	12.22	2.01	090
25350		A	Revision of radius	9.09	NA	NA	9.35	9.86	1.60	090
25355		A	Revision of radius	10.53	NA	NA	10.21	10.70	2.06	090
25360		A	Revision of ulna	8.74	NA	NA	9.04	9.61	1.64	090
25365		A	Revise radius & ulna	12.91	NA	NA	11.86	12.13	2.54	090
25370		A	Revise radius or ulna	14.10	NA	NA	13.15	13.35	2.77	090
25375		A	Revise radius & ulna	13.55	NA	NA	12.24	12.65	0.95	090
25390		A	Shorten radius or ulna	10.70	NA	NA	10.41	10.81	1.87	090
25391		A	Lengthen radius or ulna	14.28	NA	NA	12.68	12.98	2.82	090
25392		A	Shorten radius & ulna	14.58	NA	NA	12.86	13.18	2.89	090
25393		A	Lengthen radius & ulna	16.56	NA	NA	15.48	15.06	3.27	090

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25394		A	Repair carpal bone shorten	10.85	NA	NA	10.36	9.84	2.13	090
25400		A	Repair radius or ulna	11.28	NA	NA	10.65	11.13	2.06	090
25405		A	Repair/graft radius or ulna	15.01	NA	NA	13.26	13.58	2.73	090
25415		A	Repair radius & ulna	13.80	NA	NA	12.89	13.18	2.72	090
25420		A	Repair/graft radius & ulna	17.04	NA	NA	14.58	14.90	3.37	090
25425		A	Repair/graft radius or ulna	13.72	NA	NA	12.34	13.45	2.70	090
25426		A	Repair/graft radius & ulna	16.45	NA	NA	13.98	13.18	3.23	090
25430		A	Vasc graft into carpal bone	9.71	NA	NA	10.10	9.50	1.21	090
25431		A	Repair nonunion carpal bone	10.89	NA	NA	10.47	9.86	2.15	090
25440		A	Repair/graft wrist bone	10.68	NA	NA	10.30	9.93	1.89	090
25441		A	Reconstruct wrist joint	13.29	NA	NA	13.19	12.14	1.64	090
25442		A	Reconstruct wrist joint	11.12	NA	NA	11.08	10.50	1.39	090
25443		A	Reconstruct wrist joint	10.66	NA	NA	10.49	10.05	2.09	090
25444		A	Reconstruct wrist joint	11.42	NA	NA	11.87	10.92	0.80	090
25445		A	Reconstruct wrist joint	9.88	NA	NA	9.82	9.32	1.79	090
25446		A	Wrist replacement	17.30	NA	NA	14.94	14.10	2.95	090
25447		A	Repair wrist joint(s)	11.14	NA	NA	11.59	10.88	1.96	090
25449		A	Remove wrist joint implant	14.94	NA	NA	13.51	12.69	2.95	090
25450		A	Revision of wrist joint	8.06	NA	NA	6.05	6.83	1.58	090
25455		A	Revision of wrist joint	9.71	NA	NA	7.00	7.75	0.68	090
25490		A	Reinforce radius	9.73	NA	NA	8.85	9.56	1.25	090
25491		A	Reinforce ulna	10.15	NA	NA	9.88	10.39	1.98	090
25492		A	Reinforce radius and ulna	12.66	NA	NA	11.82	12.13	2.47	090
25500		A	Treat fracture of radius	2.60	4.75	4.45	4.14	3.82	0.45	090
25505		A	Treat fracture of radius	5.45	8.14	7.79	7.01	6.67	1.03	090
25515		A	Treat fracture of radius	8.80	NA	NA	9.37	8.91	1.67	090
25520		A	Treat fracture of radius	6.50	8.88	8.20	8.08	7.42	1.28	090
25525		A	Treat fracture of radius	10.55	NA	NA	10.76	10.45	2.01	090

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25526		A	Treat fracture of radius	13.15	NA	NA	12.72	12.60	2.59	090
25530		A	Treat fracture of ulna	2.24	4.86	4.62	4.19	3.91	0.41	090
25535		A	Treat fracture of ulna	5.36	7.92	7.51	6.94	6.57	1.02	090
25545		A	Treat fracture of ulna	7.94	NA	NA	8.99	8.63	1.51	090
25560		A	Treat fracture radius & ulna	2.59	4.83	4.55	4.13	3.80	0.48	090
25565		A	Treat fracture radius & ulna	5.85	8.30	7.95	6.97	6.64	1.10	090
25574		A	Treat fracture radius & ulna	8.80	NA	NA	9.44	8.94	1.70	090
25575		A	Treat fracture radius/ulna	12.29	NA	NA	12.13	11.52	2.34	090
25600		A	Treat fracture radius/ulna	2.78	5.14	4.90	4.46	4.16	0.52	090
25605		A	Treat fracture radius/ulna	7.25	9.66	9.14	8.68	8.17	1.39	090
25606		A	Treat fx distal radial	8.31	NA	NA	9.70	9.39	1.60	090
25607		A	Treat fx rad extra-articul	9.56	NA	NA	10.45	9.77	1.82	090
25608		A	Treat fx rad intra-articul	11.07	NA	NA	11.37	10.63	2.06	090
25609		A	Treat fx radial 3+ frag	14.38	NA	NA	14.20	13.24	2.69	090
25622		A	Treat wrist bone fracture	2.79	5.46	5.18	4.73	4.39	0.52	090
25624		A	Treat wrist bone fracture	4.77	7.73	7.45	6.60	6.31	0.88	090
25628		A	Treat wrist bone fracture	9.67	NA	NA	10.03	9.50	1.74	090
25630		A	Treat wrist bone fracture	3.03	5.25	5.00	4.58	4.24	0.56	090
25635		A	Treat wrist bone fracture	4.61	7.75	7.20	6.66	5.98	0.90	090
25645		A	Treat wrist bone fracture	7.42	NA	NA	7.98	7.60	1.47	090
25650		A	Treat wrist bone fracture	3.23	5.46	5.18	4.93	4.55	0.60	090
25651		A	Pin ulnar styloid fracture	5.82	NA	NA	7.45	7.00	1.10	090
25652		A	Treat fracture ulnar styloid	8.06	NA	NA	8.97	8.49	1.47	090
25660		A	Treat wrist dislocation	4.98	NA	NA	5.93	5.69	0.90	090
25670		A	Treat wrist dislocation	8.09	NA	NA	8.33	8.01	1.49	090
25671		A	Pin radioulnar dislocation	6.46	NA	NA	8.00	7.54	1.26	090
25675		A	Treat wrist dislocation	4.89	6.85	6.53	5.84	5.54	0.87	090
25676		A	Treat wrist dislocation	8.29	NA	NA	8.94	8.50	1.53	090

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25680		A	Treat wrist fracture	6.23	NA	NA	6.36	5.99	1.07	090
25685		A	Treat wrist fracture	10.09	NA	NA	9.83	9.30	1.97	090
25690		A	Treat wrist dislocation	5.72	NA	NA	7.30	6.80	1.14	090
25695		A	Treat wrist dislocation	8.51	NA	NA	8.63	8.24	1.66	090
25800		A	Fusion of wrist joint	10.07	NA	NA	9.95	9.61	1.81	090
25805		A	Fusion/graft of wrist joint	11.73	NA	NA	11.14	10.84	2.30	090
25810		A	Fusion/graft of wrist joint	11.95	NA	NA	11.87	11.28	2.12	090
25820		A	Fusion of hand bones	7.64	NA	NA	9.20	8.80	1.37	090
25825		A	Fuse hand bones with graft	9.69	NA	NA	11.12	10.60	1.68	090
25830		A	Fusion radioulnar jnt/ulna	10.88	NA	NA	15.00	14.66	2.15	090
25900		A	Amputation of forearm	9.61	NA	NA	9.76	9.96	1.82	090
25905		A	Amputation of forearm	9.59	NA	NA	9.40	9.60	1.89	090
25907		A	Amputation follow-up surgery	8.09	NA	NA	8.50	8.76	1.59	090
25909		A	Amputation follow-up surgery	9.31	NA	NA	9.23	9.48	1.83	090
25915		A	Amputation of forearm	17.52	NA	NA	10.17	12.60	3.10	090
25920		A	Amputate hand at wrist	9.03	NA	NA	9.84	9.34	1.78	090
25922		A	Amputate hand at wrist	7.65	NA	NA	6.22	6.84	0.53	090
25924		A	Amputation follow-up surgery	8.81	NA	NA	7.66	8.14	1.71	090
25927		A	Amputation of hand	9.09	NA	NA	12.92	12.30	1.79	090
25929		A	Amputation follow-up surgery	7.82	NA	NA	8.94	7.82	1.53	090
25931		A	Amputation follow-up surgery	8.04	NA	NA	10.00	10.47	1.70	090
25999		C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26010		A	Drainage of finger abscess	1.59	5.52	5.47	2.16	2.04	0.27	010
26011		A	Drainage of finger abscess	2.24	8.50	8.46	2.84	2.70	0.39	010
26020		A	Drain hand tendon sheath	5.08	NA	NA	6.84	6.47	0.92	090
26025		A	Drainage of palm bursa	5.08	NA	NA	6.48	6.11	0.91	090
26030		A	Drainage of palm bursa(s)	6.25	NA	NA	7.25	6.85	1.15	090
26034		A	Treat hand bone lesion	6.63	NA	NA	8.06	7.64	1.22	090

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26035		A	Decompress fingers/hand	11.37	NA	NA	11.87	10.97	2.23	090
26037		A	Decompress fingers/hand	7.57	NA	NA	8.03	7.58	1.44	090
26040		A	Release palm contracture	3.46	NA	NA	5.16	4.88	0.56	090
26045		A	Release palm contracture	5.73	NA	NA	7.00	6.67	1.09	090
26055		A	Incise finger tendon sheath	3.11	12.31	12.47	5.42	5.09	0.56	090
26060		A	Incision of finger tendon	2.91	NA	NA	4.45	4.22	0.54	090
26070		A	Explore/treat hand joint	3.81	NA	NA	4.68	4.33	0.65	090
26075		A	Explore/treat finger joint	3.91	NA	NA	4.95	4.65	0.67	090
26080		A	Explore/treat finger joint	4.47	NA	NA	6.24	5.89	0.77	090
26100		A	Biopsy hand joint lining	3.79	NA	NA	5.29	4.95	0.73	090
26105		A	Biopsy finger joint lining	3.83	NA	NA	5.31	5.03	0.75	090
26110		A	Biopsy finger joint lining	3.65	NA	NA	5.21	4.91	0.64	090
26111		A	Exc hand les sc > 1.5 cm	5.42	NA	NA	6.09	6.09	0.99	090
26113		A	Exc hand tum deep > 1.5 cm	7.13	NA	NA	8.00	8.00	1.25	090
26115		A	Exc hand les sc < 1.5 cm	3.96	9.92	11.43	5.17	5.28	0.71	090
26116		A	Exc hand tum deep < 1.5 cm	6.74	NA	NA	7.75	7.29	1.20	090
26117		A	Exc hand tum ra < 3 cm	10.13	NA	NA	10.52	9.29	1.85	090
26118		A	Exc hand tum ra > 3 cm	14.81	NA	NA	14.28	14.28	2.93	090
26121		A	Release palm contracture	7.73	NA	NA	8.66	8.21	1.40	090
26123		A	Release palm contracture	10.88	NA	NA	12.07	11.29	1.91	090
26125		A	Release palm contracture	4.60	NA	NA	2.95	2.78	0.81	ZZZ
26130		A	Remove wrist joint lining	5.59	NA	NA	7.05	6.62	1.06	090
26135		A	Revise finger joint each	7.13	NA	NA	8.00	7.58	1.26	090
26140		A	Revise finger joint each	6.34	NA	NA	7.52	7.13	1.14	090
26145		A	Tendon excision palm/finger	6.49	NA	NA	7.55	7.16	1.18	090
26160		A	Remove tendon sheath lesion	3.57	12.27	12.16	5.61	5.27	0.65	090
26170		A	Removal of palm tendon each	4.91	NA	NA	6.27	5.94	0.86	090
26180		A	Removal of finger tendon	5.35	NA	NA	6.77	6.47	0.90	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
26185		A	Remove finger bone	6.52	NA	NA	8.41	7.90	1.28	090
26200		A	Remove hand bone lesion	5.65	NA	NA	6.68	6.36	1.03	090
26205		A	Remove/graft bone lesion	7.93	NA	NA	8.36	8.01	1.56	090
26210		A	Removal of finger lesion	5.32	NA	NA	6.83	6.47	0.95	090
26215		A	Remove/graft finger lesion	7.27	NA	NA	7.96	7.55	1.44	090
26230		A	Partial removal of hand bone	6.47	NA	NA	7.22	6.88	1.13	090
26235		A	Partial removal finger bone	6.33	NA	NA	7.29	6.89	1.10	090
26236		A	Partial removal finger bone	5.46	NA	NA	6.64	6.31	0.98	090
26250		A	Extensive hand surgery	15.21	NA	NA	13.81	10.66	3.00	090
26260		A	Resect prox finger tumor	11.16	NA	NA	11.54	9.29	2.19	090
26262		A	Resect distal finger tumor	8.29	NA	NA	8.90	7.49	1.62	090
26320		A	Removal of implant from hand	4.10	NA	NA	5.48	5.18	0.71	090
26340		A	Manipulate finger w/anesth	2.80	NA	NA	6.43	6.08	0.52	090
26350		A	Repair finger/hand tendon	6.21	NA	NA	13.12	13.17	1.13	090
26352		A	Repair/graft hand tendon	7.87	NA	NA	14.08	14.00	1.55	090
26356		A	Repair finger/hand tendon	10.62	NA	NA	19.20	18.76	1.91	090
26357		A	Repair finger/hand tendon	8.77	NA	NA	14.61	14.54	1.71	090
26358		A	Repair/graft hand tendon	9.36	NA	NA	15.80	15.51	1.85	090
26370		A	Repair finger/hand tendon	7.28	NA	NA	13.41	13.44	1.36	090
26372		A	Repair/graft hand tendon	9.01	NA	NA	14.76	14.80	1.78	090
26373		A	Repair finger/hand tendon	8.41	NA	NA	14.40	14.39	1.64	090
26390		A	Revise hand/finger tendon	9.43	NA	NA	13.01	12.76	1.86	090
26392		A	Repair/graft hand tendon	10.50	NA	NA	15.65	15.48	2.06	090
26410		A	Repair hand tendon	4.77	NA	NA	10.57	10.64	0.87	090
26412		A	Repair/graft hand tendon	6.48	NA	NA	12.12	12.10	1.15	090
26415		A	Excision hand/finger tendon	8.51	NA	NA	10.28	10.45	1.17	090
26416		A	Graft hand or finger tendon	9.56	NA	NA	14.37	12.74	1.87	090
26418		A	Repair finger tendon	4.47	NA	NA	11.21	11.24	0.81	090

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26420		A	Repair/graft finger tendon	6.94	NA	NA	12.09	12.17	1.37	090
26426		A	Repair finger/hand tendon	6.32	NA	NA	7.42	8.15	1.14	090
26428		A	Repair/graft finger tendon	7.40	NA	NA	12.92	12.85	1.47	090
26432		A	Repair finger tendon	4.16	NA	NA	9.40	9.40	0.73	090
26433		A	Repair finger tendon	4.70	NA	NA	9.71	9.73	0.86	090
26434		A	Repair/graft finger tendon	6.26	NA	NA	11.11	11.00	1.24	090
26437		A	Realignment of tendons	5.99	NA	NA	10.96	10.86	1.03	090
26440		A	Release palm/finger tendon	5.16	NA	NA	11.73	11.84	0.90	090
26442		A	Release palm & finger tendon	9.75	NA	NA	16.56	16.19	1.74	090
26445		A	Release hand/finger tendon	4.45	NA	NA	11.29	11.43	0.77	090
26449		A	Release forearm/hand tendon	8.59	NA	NA	10.68	11.19	1.51	090
26450		A	Incision of palm tendon	3.79	NA	NA	7.22	7.13	0.68	090
26455		A	Incision of finger tendon	3.76	NA	NA	7.23	7.11	0.69	090
26460		A	Incise hand/finger tendon	3.58	NA	NA	7.17	7.04	0.62	090
26471		A	Fusion of finger tendons	5.90	NA	NA	10.87	10.74	1.03	090
26474		A	Fusion of finger tendons	5.49	NA	NA	10.88	10.67	1.07	090
26476		A	Tendon lengthening	5.35	NA	NA	10.78	10.46	1.06	090
26477		A	Tendon shortening	5.32	NA	NA	10.50	10.40	1.02	090
26478		A	Lengthening of hand tendon	5.97	NA	NA	10.90	10.91	1.09	090
26479		A	Shortening of hand tendon	5.91	NA	NA	10.90	10.84	1.17	090
26480		A	Transplant hand tendon	6.90	NA	NA	13.58	13.56	1.21	090
26483		A	Transplant/graft hand tendon	8.48	NA	NA	14.33	14.32	1.56	090
26485		A	Transplant palm tendon	7.89	NA	NA	14.04	14.05	1.40	090
26489		A	Transplant/graft palm tendon	9.86	NA	NA	15.27	14.41	1.93	090
26490		A	Revise thumb tendon	8.60	NA	NA	12.91	12.61	1.68	090
26492		A	Tendon transfer with graft	9.84	NA	NA	13.84	13.60	1.93	090
26494		A	Hand tendon/muscle transfer	8.66	NA	NA	12.80	12.63	1.68	090
26496		A	Revise thumb tendon	9.78	NA	NA	13.57	13.27	1.64	090

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26497		A	Finger tendon transfer	9.76	NA	NA	13.46	13.25	1.91	090
26498		A	Finger tendon transfer	14.21	NA	NA	16.45	16.12	2.80	090
26499		A	Revision of finger	9.17	NA	NA	13.11	12.89	1.81	090
26500		A	Hand tendon reconstruction	6.13	NA	NA	10.91	10.80	1.14	090
26502		A	Hand tendon reconstruction	7.31	NA	NA	12.14	11.81	1.45	090
26508		A	Release thumb contracture	6.18	NA	NA	11.06	10.86	1.10	090
26510		A	Thumb tendon transfer	5.60	NA	NA	10.58	10.56	0.98	090
26516		A	Fusion of knuckle joint	7.32	NA	NA	11.69	11.56	1.29	090
26517		A	Fusion of knuckle joints	9.08	NA	NA	13.05	12.91	1.79	090
26518		A	Fusion of knuckle joints	9.27	NA	NA	13.39	13.11	1.82	090
26520		A	Release knuckle contracture	5.47	NA	NA	12.27	12.34	0.99	090
26525		A	Release finger contracture	5.50	NA	NA	12.27	12.36	0.95	090
26530		A	Revise knuckle joint	6.88	NA	NA	7.85	7.42	1.22	090
26531		A	Revise knuckle with implant	8.13	NA	NA	9.05	8.54	1.39	090
26535		A	Revise finger joint	5.41	NA	NA	6.08	5.55	0.83	090
26536		A	Revise/implant finger joint	6.56	NA	NA	12.93	12.23	1.13	090
26540		A	Repair hand joint	6.60	NA	NA	11.28	11.19	1.18	090
26541		A	Repair hand joint with graft	8.81	NA	NA	12.82	12.70	1.52	090
26542		A	Repair hand joint with graft	6.95	NA	NA	11.55	11.44	1.25	090
26545		A	Reconstruct finger joint	7.11	NA	NA	11.87	11.68	1.26	090
26546		A	Repair nonunion hand	10.83	NA	NA	16.17	15.73	1.85	090
26548		A	Reconstruct finger joint	8.22	NA	NA	12.53	12.32	1.49	090
26550		A	Construct thumb replacement	21.68	NA	NA	22.52	19.73	4.25	090
26551		A	Great toe-hand transfer	48.48	NA	NA	28.89	30.88	9.53	090
26553		A	Single transfer toe-hand	48.17	NA	NA	44.78	35.27	3.42	090
26554		A	Double transfer toe-hand	57.01	NA	NA	32.96	34.22	4.05	090
26555		A	Positional change of finger	17.08	NA	NA	19.76	19.31	3.37	090
26556		A	Toe joint transfer	49.75	NA	NA	32.53	29.48	3.95	090

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26560		A	Repair of web finger	5.52	NA	NA	10.58	10.18	1.09	090
26561		A	Repair of web finger	11.10	NA	NA	15.02	13.92	2.35	090
26562		A	Repair of web finger	16.68	NA	NA	19.39	18.69	1.18	090
26565		A	Correct metacarpal flaw	6.91	NA	NA	11.40	11.30	1.36	090
26567		A	Correct finger deformity	6.99	NA	NA	11.43	11.35	1.24	090
26568		A	Lengthen metacarpal/finger	9.27	NA	NA	14.91	14.77	1.82	090
26580		A	Repair hand deformity	19.75	NA	NA	15.21	15.89	3.88	090
26587		A	Reconstruct extra finger	14.50	NA	NA	14.82	12.52	3.10	090
26590		A	Repair finger deformity	18.67	NA	NA	15.18	14.40	3.69	090
26591		A	Repair muscles of hand	3.38	NA	NA	8.49	8.58	0.61	090
26593		A	Release muscles of hand	5.50	NA	NA	10.87	10.76	0.92	090
26596		A	Excision constricting tissue	9.14	NA	NA	11.34	10.64	1.81	090
26600		A	Treat metacarpal fracture	2.60	5.37	5.01	4.91	4.48	0.48	090
26605		A	Treat metacarpal fracture	3.03	5.73	5.45	4.95	4.66	0.56	090
26607		A	Treat metacarpal fracture	5.48	NA	NA	6.96	6.38	1.06	090
26608		A	Treat metacarpal fracture	5.55	NA	NA	7.51	7.17	1.03	090
26615		A	Treat metacarpal fracture	7.07	NA	NA	8.75	8.03	1.29	090
26641		A	Treat thumb dislocation	4.13	5.44	5.35	4.66	4.52	0.72	090
26645		A	Treat thumb fracture	4.58	7.01	6.49	6.05	5.55	0.88	090
26650		A	Treat thumb fracture	5.35	NA	NA	7.71	7.40	1.02	090
26665		A	Treat thumb fracture	7.94	NA	NA	9.19	8.61	1.47	090
26670		A	Treat hand dislocation	3.83	5.06	4.82	4.27	3.96	0.67	090
26675		A	Treat hand dislocation	4.83	7.49	6.95	6.48	5.97	0.95	090
26676		A	Pin hand dislocation	5.74	NA	NA	7.92	7.61	1.06	090
26685		A	Treat hand dislocation	7.07	NA	NA	8.66	8.11	1.39	090
26686		A	Treat hand dislocation	8.17	NA	NA	8.71	8.28	1.60	090
26700		A	Treat knuckle dislocation	3.83	4.68	4.43	4.19	3.87	0.65	090
26705		A	Treat knuckle dislocation	4.38	7.05	6.52	6.07	5.56	0.81	090

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26706		A	Pin knuckle dislocation	5.31	NA	NA	6.80	6.34	0.95	090
26715		A	Treat knuckle dislocation	7.03	NA	NA	8.62	7.99	1.30	090
26720		A	Treat finger fracture each	1.76	3.57	3.39	3.20	2.98	0.33	090
26725		A	Treat finger fracture each	3.48	5.70	5.46	4.81	4.52	0.64	090
26727		A	Treat finger fracture each	5.42	NA	NA	7.46	7.12	0.99	090
26735		A	Treat finger fracture each	7.42	NA	NA	8.94	8.23	1.37	090
26740		A	Treat finger fracture each	2.07	4.21	3.96	3.82	3.57	0.35	090
26742		A	Treat finger fracture each	3.99	5.92	5.71	5.01	4.77	0.72	090
26746		A	Treat finger fracture each	9.80	NA	NA	10.54	9.55	1.78	090
26750		A	Treat finger fracture each	1.80	3.12	2.97	3.14	2.91	0.33	090
26755		A	Treat finger fracture each	3.23	5.20	5.00	4.12	3.89	0.58	090
26756		A	Pin finger fracture each	4.58	NA	NA	6.89	6.58	0.83	090
26765		A	Treat finger fracture each	5.86	NA	NA	7.91	7.19	1.09	090
26770		A	Treat finger dislocation	3.15	4.10	3.90	3.59	3.32	0.54	090
26775		A	Treat finger dislocation	3.90	6.48	6.18	5.50	5.14	0.69	090
26776		A	Pin finger dislocation	4.99	NA	NA	7.13	6.82	0.91	090
26785		A	Treat finger dislocation	6.60	NA	NA	8.41	7.61	1.21	090
26820		A	Thumb fusion with graft	8.45	NA	NA	12.68	12.57	1.66	090
26841		A	Fusion of thumb	7.35	NA	NA	12.37	12.27	1.39	090
26842		A	Thumb fusion with graft	8.49	NA	NA	12.73	12.63	1.66	090
26843		A	Fusion of hand joint	7.78	NA	NA	12.02	11.89	1.53	090
26844		A	Fusion/graft of hand joint	8.98	NA	NA	12.99	12.85	1.78	090
26850		A	Fusion of knuckle	7.14	NA	NA	11.69	11.58	1.24	090
26852		A	Fusion of knuckle with graft	8.71	NA	NA	12.96	12.72	1.47	090
26860		A	Fusion of finger joint	4.88	NA	NA	10.49	10.43	0.84	090
26861		A	Fusion of finger jnt add-on	1.74	NA	NA	1.10	1.04	0.31	ZZZ
26862		A	Fusion/graft of finger joint	7.56	NA	NA	12.20	12.01	1.30	090
26863		A	Fuse/graft added joint	3.89	NA	NA	2.33	2.26	0.75	ZZZ

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26910		A	Amputate metacarpal bone	7.79	NA	NA	11.59	11.37	1.49	090
26951		A	Amputation of finger/thumb	6.04	NA	NA	11.67	11.26	1.14	090
26952		A	Amputation of finger/thumb	6.48	NA	NA	11.08	10.99	1.21	090
26989		C	Hand/finger surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26990		A	Drainage of pelvis lesion	7.95	NA	NA	8.95	8.53	1.58	090
26991		A	Drainage of pelvis bursa	7.06	12.23	11.86	7.18	6.76	1.39	090
26992		A	Drainage of bone lesion	13.48	NA	NA	12.53	11.93	2.66	090
27000		A	Incision of hip tendon	5.74	NA	NA	6.07	5.96	1.07	090
27001		A	Incision of hip tendon	7.14	NA	NA	7.50	7.16	1.40	090
27003		A	Incision of hip tendon	7.81	NA	NA	8.33	7.84	1.53	090
27005		A	Incision of hip tendon	10.07	NA	NA	9.61	9.17	1.97	090
27006		A	Incision of hip tendons	10.11	NA	NA	9.90	9.42	1.96	090
27025		A	Incision of hip/thigh fascia	12.89	NA	NA	11.82	11.07	2.57	090
27027		A	Buttock fasciotomy	13.04	NA	NA	11.45	10.40	0.91	090
27030		A	Drainage of hip joint	13.65	NA	NA	11.57	11.14	2.66	090
27033		A	Exploration of hip joint	14.11	NA	NA	12.24	11.69	2.77	090
27035		A	Denervation of hip joint	17.37	NA	NA	14.53	12.73	3.42	090
27036		A	Excision of hip joint/muscle	14.38	NA	NA	12.91	12.27	2.78	090
27040		A	Biopsy of soft tissues	2.92	6.38	6.41	2.45	2.44	0.48	010
27041		A	Biopsy of soft tissues	10.18	NA	NA	8.00	7.82	1.81	090
27043		A	Exc hip pelvis les sc > 3 cm	6.88	NA	NA	5.70	5.70	1.41	090
27045		A	Exc hip/pelv tum deep > 5 cm	11.13	NA	NA	8.82	8.82	2.25	090
27047		A	Exc hip/pelvis les sc < 3 cm	4.94	7.74	8.19	4.78	5.22	1.02	090
27048		A	Exc hip/pelv tum deep < 5 cm	8.85	NA	NA	7.53	6.69	1.81	090
27049		A	Resect hip/pelv tum < 5 cm	21.55	NA	NA	14.95	12.68	4.32	090
27050		A	Biopsy of sacroiliac joint	4.74	NA	NA	6.17	5.29	0.92	090
27052		A	Biopsy of hip joint	7.42	NA	NA	8.18	7.65	1.47	090
27054		A	Removal of hip joint lining	9.21	NA	NA	9.34	8.88	1.81	090

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27057		A	Buttock fasciotomy w/dbrdmt	14.91	NA	NA	12.57	11.42	1.06	090
27059		A	Resect hip/pelv tum > 5 cm	29.35	NA	NA	19.25	19.25	5.77	090
27060		A	Removal of ischial bursa	5.87	NA	NA	6.73	6.03	1.17	090
27062		A	Remove femur lesion/bursa	5.75	NA	NA	6.64	6.30	1.13	090
27065		A	Remove hip bone les super	6.55	NA	NA	7.14	6.82	1.28	090
27066		A	Remove hip bone les deep	11.20	NA	NA	10.81	10.26	2.20	090
27067		A	Remove/graft hip bone lesion	14.72	NA	NA	13.30	12.66	2.91	090
27070		A	Part remove hip bone super	11.56	NA	NA	11.52	10.99	2.27	090
27071		A	Part removal hip bone deep	12.39	NA	NA	12.28	11.76	2.43	090
27075		A	Resect hip tumor	32.71	NA	NA	23.28	22.60	6.42	090
27076		A	Resect hip tum incl acetabul	40.21	NA	NA	28.22	22.53	7.92	090
27077		A	Resect hip tum w/innom bone	45.21	NA	NA	31.77	28.73	8.89	090
27078		A	Rsect hip tum incl femur	32.21	NA	NA	23.99	17.89	6.33	090
27080		A	Removal of tail bone	6.89	NA	NA	6.86	6.39	1.41	090
27086		A	Remove hip foreign body	1.92	4.91	4.86	2.12	2.05	0.31	010
27087		A	Remove hip foreign body	8.83	NA	NA	8.14	7.83	1.70	090
27090		A	Removal of hip prosthesis	11.69	NA	NA	10.79	10.30	2.28	090
27091		A	Removal of hip prosthesis	24.35	NA	NA	18.96	17.88	4.79	090
27093		A	Injection for hip x-ray	1.30	4.03	4.15	0.66	0.64	0.14	000
27095		A	Injection for hip x-ray	1.50	5.07	5.16	0.78	0.73	0.18	000
27096		A	Inject sacroiliac joint	1.40	4.15	3.92	0.68	0.56	0.12	000
27097		A	Revision of hip tendon	9.27	NA	NA	9.20	8.54	1.82	090
27098		A	Transfer tendon to pelvis	9.32	NA	NA	9.48	8.24	1.83	090
27100		A	Transfer of abdominal muscle	11.35	NA	NA	11.03	10.46	2.23	090
27105		A	Transfer of spinal muscle	12.04	NA	NA	11.44	10.89	2.35	090
27110		A	Transfer of iliopsoas muscle	13.77	NA	NA	12.47	11.70	2.72	090
27111		A	Transfer of iliopsoas muscle	12.60	NA	NA	11.77	10.58	2.46	090
27120		A	Reconstruction of hip socket	19.25	NA	NA	15.99	14.97	3.79	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27122		A	Reconstruction of hip socket	16.09	NA	NA	13.76	13.11	3.15	090
27125		A	Partial hip replacement	16.64	NA	NA	14.08	13.30	3.27	090
27130		A	Total hip arthroplasty	21.79	NA	NA	17.26	16.38	4.28	090
27132		A	Total hip arthroplasty	25.69	NA	NA	19.77	18.81	5.05	090
27134		A	Revise hip joint replacement	30.28	NA	NA	21.71	20.77	5.95	090
27137		A	Revise hip joint replacement	22.70	NA	NA	17.27	16.48	4.45	090
27138		A	Revise hip joint replacement	23.70	NA	NA	17.87	17.04	4.66	090
27140		A	Transplant femur ridge	12.78	NA	NA	11.40	10.93	2.51	090
27146		A	Incision of hip bone	18.92	NA	NA	15.93	14.83	3.73	090
27147		A	Revision of hip bone	22.07	NA	NA	17.81	16.82	4.33	090
27151		A	Incision of hip bones	24.12	NA	NA	19.04	17.00	4.75	090
27156		A	Revision of hip bones	26.23	NA	NA	20.30	19.05	5.15	090
27158		A	Revision of pelvis	21.04	NA	NA	16.97	15.75	4.14	090
27161		A	Incision of neck of femur	17.89	NA	NA	15.00	14.33	3.50	090
27165		A	Incision/fixation of femur	20.29	NA	NA	16.99	16.05	3.98	090
27170		A	Repair/graft femur head/neck	17.61	NA	NA	14.28	13.58	3.46	090
27175		A	Treat slipped epiphysis	9.38	NA	NA	8.69	8.23	1.85	090
27176		A	Treat slipped epiphysis	12.92	NA	NA	11.97	11.30	2.55	090
27177		A	Treat slipped epiphysis	16.09	NA	NA	14.12	13.37	3.16	090
27178		A	Treat slipped epiphysis	12.92	NA	NA	11.97	11.21	2.55	090
27179		A	Revise head/neck of femur	13.97	NA	NA	12.48	11.83	2.74	090
27181		A	Treat slipped epiphysis	16.18	NA	NA	14.29	13.40	3.19	090
27185		A	Revision of femur epiphysis	9.79	NA	NA	6.81	7.08	0.69	090
27187		A	Reinforce hip bones	14.23	NA	NA	12.61	12.06	2.80	090
27193		A	Treat pelvic ring fracture	6.09	6.67	6.31	6.84	6.46	1.20	090
27194		A	Treat pelvic ring fracture	10.20	NA	NA	8.55	8.38	1.66	090
27200		A	Treat tail bone fracture	1.92	2.97	2.78	3.17	2.94	0.35	090
27202		A	Treat tail bone fracture	7.31	NA	NA	7.86	8.79	1.45	090

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27215		I	Treat pelvic fracture(s)	10.45	NA	NA	6.58	7.40	0.73	090
27216		I	Treat pelvic ring fracture	15.73	NA	NA	9.53	10.60	1.13	090
27217		I	Treat pelvic ring fracture	14.65	NA	NA	9.05	10.23	1.05	090
27218		I	Treat pelvic ring fracture	20.93	NA	NA	11.82	13.06	1.49	090
27220		A	Treat hip socket fracture	6.83	7.55	7.14	7.42	7.02	1.33	090
27222		A	Treat hip socket fracture	14.11	NA	NA	12.27	11.73	2.76	090
27226		A	Treat hip wall fracture	15.57	NA	NA	13.18	12.13	3.07	090
27227		A	Treat hip fracture(s)	25.41	NA	NA	19.72	18.71	5.00	090
27228		A	Treat hip fracture(s)	29.33	NA	NA	22.01	20.97	5.77	090
27230		A	Treat thigh fracture	5.81	7.03	6.69	6.94	6.55	1.14	090
27232		A	Treat thigh fracture	11.72	NA	NA	8.89	8.49	2.24	090
27235		A	Treat thigh fracture	13.00	NA	NA	11.68	11.13	2.55	090
27236		A	Treat thigh fracture	17.61	NA	NA	14.84	14.01	3.46	090
27238		A	Treat thigh fracture	5.75	NA	NA	6.66	6.33	1.13	090
27240		A	Treat thigh fracture	13.81	NA	NA	12.05	11.46	2.69	090
27244		A	Treat thigh fracture	18.18	NA	NA	15.21	14.35	3.56	090
27245		A	Treat thigh fracture	18.18	NA	NA	15.24	14.74	3.56	090
27246		A	Treat thigh fracture	4.83	5.60	5.33	5.65	5.37	0.92	090
27248		A	Treat thigh fracture	10.78	NA	NA	9.34	9.01	2.12	090
27250		A	Treat hip dislocation	3.82	NA	NA	0.98	1.54	0.67	000
27252		A	Treat hip dislocation	11.03	NA	NA	9.37	8.92	2.13	090
27253		A	Treat hip dislocation	13.58	NA	NA	11.92	11.39	2.66	090
27254		A	Treat hip dislocation	18.94	NA	NA	15.32	14.58	3.72	090
27256		A	Treat hip dislocation	4.28	3.54	3.43	1.79	1.86	0.75	010
27257		A	Treat hip dislocation	5.38	NA	NA	3.59	3.41	0.98	010
27258		A	Treat hip dislocation	16.18	NA	NA	13.92	13.17	3.19	090
27259		A	Treat hip dislocation	23.26	NA	NA	18.86	17.80	4.56	090
27265		A	Treat hip dislocation	5.24	NA	NA	5.31	5.16	0.92	090

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27266		A	Treat hip dislocation	7.78	NA	NA	7.99	7.59	1.52	090
27267		A	Cltx thigh fx	5.50	NA	NA	6.26	5.77	1.09	090
27268		A	Cltx thigh fx w/mnpj	7.12	NA	NA	7.47	6.78	1.40	090
27269		A	Optx thigh fx	18.89	NA	NA	14.59	13.39	3.69	090
27275		A	Manipulation of hip joint	2.32	NA	NA	2.54	2.45	0.39	010
27280		A	Fusion of sacroiliac joint	14.64	NA	NA	13.11	12.48	3.03	090
27282		A	Fusion of pubic bones	11.85	NA	NA	11.33	10.15	2.31	090
27284		A	Fusion of hip joint	25.06	NA	NA	18.84	16.67	4.94	090
27286		A	Fusion of hip joint	25.17	NA	NA	19.67	18.72	4.96	090
27290		A	Amputation of leg at hip	24.55	NA	NA	19.51	17.74	4.83	090
27295		A	Amputation of leg at hip	19.66	NA	NA	14.48	13.70	4.01	090
27299		C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27301		A	Drain thigh/knee lesion	6.78	11.42	11.08	6.74	6.38	1.37	090
27303		A	Drainage of bone lesion	8.63	NA	NA	8.69	8.28	1.68	090
27305		A	Incise thigh tendon & fascia	6.18	NA	NA	6.80	6.36	1.22	090
27306		A	Incision of thigh tendon	4.74	NA	NA	5.37	5.22	0.92	090
27307		A	Incision of thigh tendons	6.06	NA	NA	6.95	6.47	1.20	090
27310		A	Exploration of knee joint	10.00	NA	NA	9.82	9.31	1.96	090
27323		A	Biopsy thigh soft tissues	2.33	5.23	5.08	2.60	2.50	0.41	010
27324		A	Biopsy thigh soft tissues	5.04	NA	NA	5.54	5.22	1.05	090
27325		A	Neurectomy hamstring	7.20	NA	NA	7.89	7.18	1.41	090
27326		A	Neurectomy popliteal	6.47	NA	NA	7.46	6.80	1.26	090
27327		A	Exc thigh/knee les sc < 3 cm	3.96	8.48	7.95	4.44	4.47	0.80	090
27328		A	Exc thigh/knee tum deep <5cm	8.85	NA	NA	7.79	6.50	1.81	090
27329		A	Resect thigh/knee tum < 5 cm	15.72	NA	NA	12.32	11.60	3.18	090
27330		A	Biopsy knee joint lining	5.11	NA	NA	6.13	5.70	0.95	090
27331		A	Explore/treat knee joint	6.02	NA	NA	6.88	6.56	1.18	090
27332		A	Removal of knee cartilage	8.46	NA	NA	8.91	8.49	1.64	090

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27333		A	Removal of knee cartilage	7.55	NA	NA	8.32	7.90	1.49	090
27334		A	Remove knee joint lining	9.19	NA	NA	9.34	8.85	1.81	090
27335		A	Remove knee joint lining	10.55	NA	NA	10.12	9.67	2.06	090
27337		A	Exc thigh/knee les sc 3+ cm	5.91	NA	NA	5.40	5.40	1.21	090
27339		A	Exc thigh/knee tum deep 5+cm	11.13	NA	NA	9.13	9.13	2.25	090
27340		A	Removal of kneecap bursa	4.32	NA	NA	5.79	5.49	0.84	090
27345		A	Removal of knee cyst	6.09	NA	NA	6.94	6.65	1.20	090
27347		A	Remove knee cyst	6.73	NA	NA	7.60	7.15	1.32	090
27350		A	Removal of kneecap	8.66	NA	NA	9.01	8.59	1.68	090
27355		A	Remove femur lesion	8.00	NA	NA	8.31	7.96	1.58	090
27356		A	Remove femur lesion/graft	10.09	NA	NA	9.85	9.40	1.97	090
27357		A	Remove femur lesion/graft	11.16	NA	NA	10.90	10.38	2.20	090
27358		A	Remove femur lesion/fixation	4.73	NA	NA	2.83	2.73	0.91	ZZZ
27360		A	Partial removal leg bone(s)	11.46	NA	NA	11.60	11.09	2.25	090
27364		A	Resect thigh/knee tum 5+ cm	24.49	NA	NA	17.30	17.30	4.96	090
27365		A	Resect femur/knee tumor	32.21	NA	NA	23.83	18.80	6.34	090
27370		A	Injection for knee x-ray	0.96	3.85	3.85	0.51	0.48	0.12	000
27372		A	Removal of foreign body	5.21	11.41	11.10	5.79	5.53	1.03	090
27380		A	Repair of kneecap tendon	7.45	NA	NA	8.61	8.28	1.47	090
27381		A	Repair/graft kneecap tendon	10.76	NA	NA	10.84	10.42	2.12	090
27385		A	Repair of thigh muscle	8.11	NA	NA	9.04	8.68	1.59	090
27386		A	Repair/graft of thigh muscle	11.13	NA	NA	11.38	10.91	2.19	090
27390		A	Incision of thigh tendon	5.53	NA	NA	6.63	6.27	1.09	090
27391		A	Incision of thigh tendons	7.49	NA	NA	8.13	7.72	1.48	090
27392		A	Incision of thigh tendons	9.63	NA	NA	9.67	9.07	1.89	090
27393		A	Lengthening of thigh tendon	6.59	NA	NA	7.09	6.81	1.29	090
27394		A	Lengthening of thigh tendons	8.79	NA	NA	8.77	8.42	1.70	090
27395		A	Lengthening of thigh tendons	12.24	NA	NA	11.56	11.01	2.40	090

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27396		A	Transplant of thigh tendon	8.15	NA	NA	8.53	8.14	1.60	090
27397		A	Transplants of thigh tendons	12.66	NA	NA	12.18	11.49	2.47	090
27400		A	Revise thigh muscles/tendons	9.33	NA	NA	9.49	8.99	1.83	090
27403		A	Repair of knee cartilage	8.62	NA	NA	8.74	8.36	1.67	090
27405		A	Repair of knee ligament	9.08	NA	NA	9.25	8.83	1.79	090
27407		A	Repair of knee ligament	10.85	NA	NA	10.62	9.81	2.13	090
27409		A	Repair of knee ligaments	13.71	NA	NA	12.44	11.82	2.70	090
27412		A	Autochondrocyte implant knee	24.74	NA	NA	19.95	18.86	4.88	090
27415		A	Osteochondral knee allograft	20.00	NA	NA	17.29	16.25	3.92	090
27416		A	Osteochondral knee autograft	14.16	NA	NA	12.41	11.55	2.78	090
27418		A	Repair degenerated kneecap	11.60	NA	NA	10.91	10.45	2.25	090
27420		A	Revision of unstable kneecap	10.26	NA	NA	9.95	9.51	2.00	090
27422		A	Revision of unstable kneecap	10.21	NA	NA	9.92	9.48	1.98	090
27424		A	Revision/removal of kneecap	10.24	NA	NA	9.86	9.47	2.00	090
27425		A	Lat retinacular release open	5.39	NA	NA	6.77	6.44	1.06	090
27427		A	Reconstruction knee	9.79	NA	NA	9.64	9.21	1.91	090
27428		A	Reconstruction knee	15.58	NA	NA	14.59	13.83	3.08	090
27429		A	Reconstruction knee	17.54	NA	NA	16.13	15.34	3.46	090
27430		A	Revision of thigh muscles	10.16	NA	NA	9.88	9.43	1.98	090
27435		A	Incision of knee joint	10.88	NA	NA	10.96	10.40	2.15	090
27437		A	Revise kneecap	8.93	NA	NA	8.98	8.55	1.77	090
27438		A	Revise kneecap with implant	11.89	NA	NA	10.88	10.35	2.32	090
27440		A	Revision of knee joint	11.09	NA	NA	10.53	9.61	2.17	090
27441		A	Revision of knee joint	11.54	NA	NA	10.80	9.82	2.25	090
27442		A	Revision of knee joint	12.37	NA	NA	11.19	10.62	2.42	090
27443		A	Revision of knee joint	11.41	NA	NA	10.72	10.19	2.24	090
27445		A	Revision of knee joint	18.66	NA	NA	15.25	14.55	3.69	090
27446		A	Revision of knee joint	16.38	NA	NA	13.54	12.98	3.22	090

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27447		A	Total knee arthroplasty	23.25	NA	NA	18.45	17.56	4.56	090
27448		A	Incision of thigh	11.60	NA	NA	10.55	10.07	2.28	090
27450		A	Incision of thigh	14.61	NA	NA	12.81	12.28	2.89	090
27454		A	Realignment of thigh bone	19.17	NA	NA	16.08	15.00	3.78	090
27455		A	Realignment of knee	13.36	NA	NA	12.18	11.59	2.62	090
27457		A	Realignment of knee	14.03	NA	NA	12.05	11.51	2.76	090
27465		A	Shortening of thigh bone	18.60	NA	NA	15.39	14.25	3.68	090
27466		A	Lengthening of thigh bone	17.28	NA	NA	14.53	13.93	3.41	090
27468		A	Shorten/lengthen thighs	19.97	NA	NA	16.44	15.46	3.92	090
27470		A	Repair of thigh	17.14	NA	NA	14.81	14.11	3.38	090
27472		A	Repair/graft of thigh	18.72	NA	NA	15.52	14.85	3.69	090
27475		A	Surgery to stop leg growth	8.93	NA	NA	6.34	7.21	1.77	090
27477		A	Surgery to stop leg growth	10.14	NA	NA	9.72	9.24	1.98	090
27479		A	Surgery to stop leg growth	13.16	NA	NA	11.78	11.24	0.92	090
27485		A	Surgery to stop leg growth	9.13	NA	NA	9.04	8.63	1.81	090
27486		A	Revise/replace knee joint	21.12	NA	NA	17.04	16.23	4.14	090
27487		A	Revise/replace knee joint	27.11	NA	NA	20.59	19.64	5.32	090
27488		A	Removal of knee prosthesis	17.60	NA	NA	14.97	14.22	3.46	090
27495		A	Reinforce thigh	16.54	NA	NA	14.02	13.39	3.25	090
27496		A	Decompression of thigh/knee	6.78	NA	NA	7.96	7.15	1.33	090
27497		A	Decompression of thigh/knee	7.79	NA	NA	7.98	7.12	1.53	090
27498		A	Decompression of thigh/knee	8.66	NA	NA	9.09	7.87	1.68	090
27499		A	Decompression of thigh/knee	9.43	NA	NA	9.55	8.52	1.86	090
27500		A	Treatment of thigh fracture	6.30	7.76	7.36	6.70	6.30	1.22	090
27501		A	Treatment of thigh fracture	6.45	7.21	6.87	7.09	6.70	1.26	090
27502		A	Treatment of thigh fracture	11.36	NA	NA	9.69	9.31	2.19	090
27503		A	Treatment of thigh fracture	11.27	NA	NA	10.53	9.99	2.20	090
27506		A	Treatment of thigh fracture	19.65	NA	NA	16.66	15.78	3.86	090

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27507		A	Treatment of thigh fracture	14.48	NA	NA	11.90	11.39	2.85	090
27508		A	Treatment of thigh fracture	6.20	8.02	7.65	7.17	6.80	1.20	090
27509		A	Treatment of thigh fracture	8.14	NA	NA	9.41	9.03	1.59	090
27510		A	Treatment of thigh fracture	9.80	NA	NA	8.84	8.54	1.87	090
27511		A	Treatment of thigh fracture	15.11	NA	NA	11.95	11.62	2.97	090
27513		A	Treatment of thigh fracture	19.25	NA	NA	14.41	14.08	3.79	090
27514		A	Treatment of thigh fracture	14.60	NA	NA	11.63	11.68	2.87	090
27516		A	Treat thigh fx growth plate	5.59	8.22	7.71	7.35	6.87	1.10	090
27517		A	Treat thigh fx growth plate	9.12	NA	NA	9.47	8.98	1.79	090
27519		A	Treat thigh fx growth plate	13.25	NA	NA	10.91	10.81	2.61	090
27520		A	Treat kneecap fracture	3.04	5.73	5.46	4.96	4.64	0.58	090
27524		A	Treat kneecap fracture	10.37	NA	NA	10.04	9.59	2.02	090
27530		A	Treat knee fracture	4.09	6.75	6.43	6.00	5.66	0.77	090
27532		A	Treat knee fracture	7.55	9.20	8.75	8.16	7.74	1.48	090
27535		A	Treat knee fracture	13.41	NA	NA	10.93	10.61	2.62	090
27536		A	Treat knee fracture	17.39	NA	NA	14.94	14.16	3.42	090
27538		A	Treat knee fracture(s)	5.09	7.77	7.39	6.94	6.55	0.99	090
27540		A	Treat knee fracture	11.30	NA	NA	10.76	10.40	2.21	090
27550		A	Treat knee dislocation	5.98	7.47	7.13	6.48	6.14	1.10	090
27552		A	Treat knee dislocation	8.18	NA	NA	8.83	8.37	1.60	090
27556		A	Treat knee dislocation	13.00	NA	NA	10.76	10.67	2.57	090
27557		A	Treat knee dislocation	15.90	NA	NA	12.50	12.36	3.14	090
27558		A	Treat knee dislocation	18.39	NA	NA	13.99	13.61	3.61	090
27560		A	Treat kneecap dislocation	3.99	6.36	5.97	5.64	5.12	0.76	090
27562		A	Treat kneecap dislocation	5.98	NA	NA	7.13	6.55	1.18	090
27566		A	Treat kneecap dislocation	12.71	NA	NA	11.40	10.90	2.50	090
27570		A	Fixation of knee joint	1.79	NA	NA	2.31	2.19	0.34	010
27580		A	Fusion of knee	21.10	NA	NA	17.90	17.11	4.14	090

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27590		A	Amputate leg at thigh	13.47	NA	NA	8.44	8.11	2.95	090
27591		A	Amputate leg at thigh	13.94	NA	NA	10.17	9.95	2.91	090
27592		A	Amputate leg at thigh	10.98	NA	NA	7.82	7.51	2.34	090
27594		A	Amputation follow-up surgery	7.29	NA	NA	6.45	6.26	1.55	090
27596		A	Amputation follow-up surgery	11.29	NA	NA	8.37	8.07	2.39	090
27598		A	Amputate lower leg at knee	11.22	NA	NA	8.85	8.51	2.32	090
27599		C	Leg surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27600		A	Decompression of lower leg	6.03	NA	NA	5.14	5.09	1.26	090
27601		A	Decompression of lower leg	6.05	NA	NA	6.00	5.79	1.26	090
27602		A	Decompression of lower leg	7.82	NA	NA	5.68	5.65	1.74	090
27603		A	Drain lower leg lesion	5.23	9.64	9.21	5.54	5.23	1.00	090
27604		A	Drain lower leg bursa	4.59	8.63	8.14	4.70	4.50	0.77	090
27605		A	Incision of achilles tendon	2.92	6.55	6.81	2.20	2.27	0.34	010
27606		A	Incision of achilles tendon	4.18	NA	NA	3.68	3.59	0.72	010
27607		A	Treat lower leg bone lesion	8.62	NA	NA	8.14	7.75	1.58	090
27610		A	Explore/treat ankle joint	9.13	NA	NA	8.75	8.35	1.63	090
27612		A	Exploration of ankle joint	8.15	NA	NA	7.37	7.10	1.15	090
27613		A	Biopsy lower leg soft tissue	2.22	4.92	4.77	2.39	2.31	0.31	010
27614		A	Biopsy lower leg soft tissue	5.80	10.13	9.66	5.30	5.14	1.03	090
27615		A	Resect leg/ankle tum < 5 cm	15.72	NA	NA	12.26	11.03	3.14	090
27616		A	Resect leg/ankle tum 5+ cm	19.63	NA	NA	14.66	14.66	3.90	090
27618		A	Exc leg/ankle tum < 3 cm	3.96	8.36	8.07	4.39	4.59	0.73	090
27619		A	Exc leg/ankle tum deep <5 cm	6.91	NA	NA	6.34	6.52	1.22	090
27620		A	Explore/treat ankle joint	6.15	NA	NA	6.44	6.21	1.05	090
27625		A	Remove ankle joint lining	8.49	NA	NA	7.34	7.18	1.26	090
27626		A	Remove ankle joint lining	9.10	NA	NA	8.13	7.85	1.52	090
27630		A	Removal of tendon lesion	4.94	10.64	10.09	5.18	5.01	0.77	090
27632		A	Exc leg/ankle les sc 3+ cm	5.91	NA	NA	5.36	5.36	1.13	090

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27634		A	Exc leg/ankle tum deep 5+ cm	10.13	NA	NA	8.16	8.16	1.79	090
27635		A	Remove lower leg bone lesion	8.03	NA	NA	8.16	7.81	1.49	090
27637		A	Remove/graft leg bone lesion	10.31	NA	NA	10.41	9.86	2.01	090
27638		A	Remove/graft leg bone lesion	10.99	NA	NA	9.93	9.59	2.16	090
27640		A	Partial removal of tibia	12.24	NA	NA	10.74	10.52	2.20	090
27641		A	Partial removal of fibula	9.84	NA	NA	8.49	8.37	1.67	090
27645		A	Resect tibia tumor	27.21	NA	NA	21.11	16.76	5.35	090
27646		A	Resect fibula tumor	23.21	NA	NA	18.71	14.80	4.56	090
27647		A	Resect talus/calcaneus tum	20.26	NA	NA	10.89	9.53	2.02	090
27648		A	Injection for ankle x-ray	0.96	3.63	3.65	0.49	0.46	0.12	000
27650		A	Repair achilles tendon	9.21	NA	NA	9.18	8.84	1.51	090
27652		A	Repair/graft achilles tendon	10.78	NA	NA	8.61	8.54	1.51	090
27654		A	Repair of achilles tendon	10.53	NA	NA	9.18	8.81	1.51	090
27656		A	Repair leg fascia defect	4.71	12.67	11.33	6.06	5.31	0.91	090
27658		A	Repair of leg tendon each	5.12	NA	NA	5.30	5.15	0.77	090
27659		A	Repair of leg tendon each	7.10	NA	NA	6.45	6.25	0.99	090
27664		A	Repair of leg tendon each	4.73	NA	NA	5.39	5.17	0.75	090
27665		A	Repair of leg tendon each	5.57	NA	NA	5.73	5.60	0.88	090
27675		A	Repair lower leg tendons	7.35	NA	NA	6.18	6.11	1.02	090
27676		A	Repair lower leg tendons	8.73	NA	NA	8.13	7.83	1.70	090
27680		A	Release of lower leg tendon	5.88	NA	NA	6.07	5.80	0.98	090
27681		A	Release of lower leg tendons	7.05	NA	NA	7.77	7.14	1.39	090
27685		A	Revision of lower leg tendon	6.69	11.87	11.06	6.25	6.09	0.91	090
27686		A	Revise lower leg tendons	7.75	NA	NA	7.49	7.26	1.29	090
27687		A	Revision of calf tendon	6.41	NA	NA	6.22	6.00	0.99	090
27690		A	Revise lower leg tendon	9.17	NA	NA	8.56	8.11	1.32	090
27691		A	Revise lower leg tendon	10.49	NA	NA	10.19	9.70	1.82	090
27692		A	Revise additional leg tendon	1.87	NA	NA	1.06	1.01	0.34	ZZZ

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27695		A	Repair of ankle ligament	6.70	NA	NA	6.51	6.42	1.07	090
27696		A	Repair of ankle ligaments	8.58	NA	NA	7.03	6.91	1.15	090
27698		A	Repair of ankle ligament	9.61	NA	NA	8.12	7.87	1.51	090
27700		A	Revision of ankle joint	9.66	NA	NA	6.81	6.70	1.20	090
27702		A	Reconstruct ankle joint	14.42	NA	NA	12.18	11.82	2.65	090
27703		A	Reconstruction ankle joint	16.94	NA	NA	13.78	13.35	3.18	090
27704		A	Removal of ankle implant	7.81	NA	NA	8.00	7.52	1.41	090
27705		A	Incision of tibia	10.86	NA	NA	9.95	9.51	2.01	090
27707		A	Incision of fibula	4.78	NA	NA	6.36	6.03	0.90	090
27709		A	Incision of tibia & fibula	17.48	NA	NA	14.66	13.32	3.37	090
27712		A	Realignment of lower leg	15.87	NA	NA	14.11	13.35	3.14	090
27715		A	Revision of lower leg	15.50	NA	NA	13.03	12.59	3.07	090
27720		A	Repair of tibia	12.36	NA	NA	11.42	10.95	2.39	090
27722		A	Repair/graft of tibia	12.45	NA	NA	11.69	11.00	2.43	090
27724		A	Repair/graft of tibia	19.31	NA	NA	15.12	14.45	3.79	090
27725		A	Repair of lower leg	17.41	NA	NA	15.70	14.78	3.44	090
27726		A	Repair fibula nonunion	14.34	NA	NA	12.13	10.92	2.77	090
27727		A	Repair of lower leg	14.84	NA	NA	13.27	11.71	2.93	090
27730		A	Repair of tibia epiphysis	7.70	NA	NA	8.19	7.77	1.52	090
27732		A	Repair of fibula epiphysis	5.46	NA	NA	6.68	5.88	1.07	090
27734		A	Repair lower leg epiphyses	8.83	NA	NA	8.94	7.79	0.62	090
27740		A	Repair of leg epiphyses	9.61	NA	NA	6.76	7.11	1.89	090
27742		A	Repair of leg epiphyses	10.63	NA	NA	9.01	8.11	2.08	090
27745		A	Reinforce tibia	10.49	NA	NA	9.93	9.53	2.04	090
27750		A	Treatment of tibia fracture	3.37	6.03	5.74	5.25	4.95	0.64	090
27752		A	Treatment of tibia fracture	6.27	8.38	7.99	7.25	6.89	1.21	090
27756		A	Treatment of tibia fracture	7.45	NA	NA	8.15	7.77	1.45	090
27758		A	Treatment of tibia fracture	12.54	NA	NA	11.66	11.08	2.44	090

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27759		A	Treatment of tibia fracture	14.45	NA	NA	12.65	12.08	2.84	090
27760		A	Cltx medial ankle fx	3.21	5.89	5.63	5.09	4.79	0.58	090
27762		A	Cltx med ankle fx w/mnpj	5.47	7.60	7.33	6.47	6.23	1.00	090
27766		A	Optx medial ankle fx	7.89	NA	NA	8.77	8.38	1.51	090
27767		A	Cltx post ankle fx	2.64	5.07	4.67	5.12	4.71	0.50	090
27768		A	Cltx post ankle fx w/mnpj	5.14	NA	NA	6.81	6.13	1.02	090
27769		A	Optx post ankle fx	10.14	NA	NA	9.85	8.84	1.98	090
27780		A	Treatment of fibula fracture	2.83	5.47	5.17	4.72	4.40	0.53	090
27781		A	Treatment of fibula fracture	4.59	6.98	6.64	6.13	5.80	0.87	090
27784		A	Treatment of fibula fracture	9.67	NA	NA	9.88	9.19	1.87	090
27786		A	Treatment of ankle fracture	3.02	5.61	5.36	4.79	4.49	0.54	090
27788		A	Treatment of ankle fracture	4.64	6.89	6.61	5.90	5.63	0.84	090
27792		A	Treatment of ankle fracture	9.71	NA	NA	9.79	9.19	1.83	090
27808		A	Treatment of ankle fracture	3.03	6.07	5.79	5.14	4.85	0.56	090
27810		A	Treatment of ankle fracture	5.32	7.44	7.19	6.29	6.06	1.00	090
27814		A	Treatment of ankle fracture	10.62	NA	NA	10.44	9.98	2.04	090
27816		A	Treatment of ankle fracture	3.07	5.62	5.30	4.72	4.41	0.54	090
27818		A	Treatment of ankle fracture	5.69	7.33	7.12	6.02	5.84	1.05	090
27822		A	Treatment of ankle fracture	11.21	NA	NA	11.75	11.40	2.16	090
27823		A	Treatment of ankle fracture	13.16	NA	NA	12.91	12.47	2.54	090
27824		A	Treat lower leg fracture	3.31	5.20	4.95	4.95	4.66	0.61	090
27825		A	Treat lower leg fracture	6.69	8.17	7.83	6.77	6.48	1.28	090
27826		A	Treat lower leg fracture	11.10	NA	NA	11.77	11.13	2.13	090
27827		A	Treat lower leg fracture	14.79	NA	NA	14.74	14.17	2.89	090
27828		A	Treat lower leg fracture	18.43	NA	NA	16.87	16.12	3.59	090
27829		A	Treat lower leg joint	8.80	NA	NA	9.88	9.28	1.68	090
27830		A	Treat lower leg dislocation	3.96	6.40	5.85	5.67	5.16	0.76	090
27831		A	Treat lower leg dislocation	4.73	NA	NA	6.13	5.65	0.91	090

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27832		A	Treat lower leg dislocation	10.17	NA	NA	10.35	9.41	1.98	090
27840		A	Treat ankle dislocation	4.77	NA	NA	4.96	4.70	0.83	090
27842		A	Treat ankle dislocation	6.46	NA	NA	7.07	6.61	1.21	090
27846		A	Treat ankle dislocation	10.28	NA	NA	9.67	9.30	1.94	090
27848		A	Treat ankle dislocation	11.68	NA	NA	10.54	10.28	2.24	090
27860		A	Fixation of ankle joint	2.39	NA	NA	2.37	2.33	0.39	010
27870		A	Fusion of ankle joint open	15.41	NA	NA	12.97	12.45	2.80	090
27871		A	Fusion of tibiofibular joint	9.54	NA	NA	9.30	8.90	1.85	090
27880		A	Amputation of lower leg	15.37	NA	NA	9.54	9.07	3.31	090
27881		A	Amputation of lower leg	13.47	NA	NA	10.28	10.01	2.80	090
27882		A	Amputation of lower leg	9.79	NA	NA	6.71	6.66	2.15	090
27884		A	Amputation follow-up surgery	8.76	NA	NA	7.03	6.80	1.86	090
27886		A	Amputation follow-up surgery	10.02	NA	NA	7.93	7.69	2.13	090
27888		A	Amputation of foot at ankle	10.37	NA	NA	8.18	8.15	1.93	090
27889		A	Amputation of foot at ankle	10.86	NA	NA	7.07	7.05	2.40	090
27892		A	Decompression of leg	7.94	NA	NA	7.03	6.67	1.63	090
27893		A	Decompression of leg	7.90	NA	NA	8.63	7.62	1.67	090
27894		A	Decompression of leg	12.67	NA	NA	10.48	10.01	2.66	090
27899		C	Leg/ankle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
28001		A	Drainage of bursa of foot	2.78	5.00	4.75	1.98	2.02	0.23	010
28002		A	Treatment of foot infection	5.93	8.56	8.08	4.59	4.52	0.67	010
28003		A	Treatment of foot infection	9.06	9.83	9.42	5.77	5.81	1.06	090
28005		A	Treat foot bone lesion	9.44	NA	NA	7.14	7.06	1.02	090
28008		A	Incision of foot fascia	4.59	7.65	7.27	3.68	3.68	0.41	090
28010		A	Incision of toe tendon	2.97	3.65	3.48	2.99	2.92	0.27	090
28011		A	Incision of toe tendons	4.28	5.07	4.79	4.05	3.93	0.49	090
28020		A	Exploration of foot joint	5.15	9.89	9.19	4.85	4.70	0.67	090
28022		A	Exploration of foot joint	4.81	8.76	8.28	4.19	4.20	0.49	090

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28024		A	Exploration of toe joint	4.52	8.29	7.89	3.93	3.99	0.42	090
28035		A	Decompression of tibia nerve	5.23	9.50	9.00	4.65	4.61	0.65	090
28039		A	Exc foot/toe tum sc > 1.5 cm	5.42	8.38	8.38	4.05	4.05	0.54	090
28041		A	Exc foot/toe tum deep 1.5cm+	7.13	NA	NA	5.30	5.30	0.73	090
28043		A	Exc foot/toe tum sc < 1.5 cm	3.96	7.53	6.52	3.53	3.49	0.39	090
28045		A	Exc foot/toe tum deep <1.5cm	5.45	8.90	8.45	4.55	4.32	0.56	090
28046		A	Resect foot/toe tumor < 3 cm	12.38	NA	NA	8.56	7.94	1.66	090
28047		A	Resect foot/toe tumor > 3 cm	17.45	NA	NA	8.56	8.56	1.33	090
28050		A	Biopsy of foot joint lining	4.39	7.72	7.73	3.56	3.83	0.39	090
28052		A	Biopsy of foot joint lining	4.06	8.07	7.61	3.67	3.67	0.49	090
28054		A	Biopsy of toe joint lining	3.57	7.14	7.08	3.12	3.32	0.27	090
28055		A	Neurectomy foot	6.29	NA	NA	4.42	4.38	0.53	090
28060		A	Partial removal foot fascia	5.40	9.20	8.65	4.60	4.52	0.54	090
28062		A	Removal of foot fascia	6.69	9.96	9.52	4.82	4.78	0.60	090
28070		A	Removal of foot joint lining	5.24	9.92	9.02	4.79	4.57	0.56	090
28072		A	Removal of foot joint lining	4.72	9.81	9.20	4.69	4.67	0.64	090
28080		A	Removal of foot lesion	4.86	9.87	9.16	5.40	5.16	0.48	090
28086		A	Excise foot tendon sheath	4.92	10.27	9.81	5.03	4.93	0.72	090
28088		A	Excise foot tendon sheath	3.98	9.85	9.04	4.58	4.39	0.54	090
28090		A	Removal of foot lesion	4.55	8.74	8.21	4.10	4.03	0.48	090
28092		A	Removal of toe lesions	3.78	8.34	7.86	3.86	3.82	0.39	090
28100		A	Removal of ankle/heel lesion	5.83	10.84	10.36	5.43	5.31	0.76	090
28102		A	Remove/graft foot lesion	7.92	NA	NA	8.53	7.81	0.61	090
28103		A	Remove/graft foot lesion	6.67	NA	NA	4.46	4.92	0.50	090
28104		A	Removal of foot lesion	5.26	9.23	8.70	4.41	4.38	0.54	090
28106		A	Remove/graft foot lesion	7.35	NA	NA	4.83	5.07	0.56	090
28107		A	Remove/graft foot lesion	5.73	9.00	9.11	4.18	4.48	0.42	090
28108		A	Removal of toe lesions	4.30	8.12	7.61	3.80	3.75	0.38	090

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28110		A	Part removal of metatarsal	4.22	8.87	8.34	3.90	3.84	0.41	090
28111		A	Part removal of metatarsal	5.15	9.22	8.82	4.20	4.15	0.60	090
28112		A	Part removal of metatarsal	4.63	9.33	8.81	4.22	4.15	0.52	090
28113		A	Part removal of metatarsal	6.11	10.80	10.12	5.96	5.75	0.62	090
28114		A	Removal of metatarsal heads	12.00	18.04	16.92	11.29	10.78	1.64	090
28116		A	Revision of foot	9.14	12.22	11.36	6.89	6.64	0.95	090
28118		A	Removal of heel bone	6.13	10.48	9.85	5.35	5.23	0.75	090
28119		A	Removal of heel spur	5.56	9.29	8.72	4.58	4.49	0.53	090
28120		A	Part removal of ankle/heel	8.27	12.11	10.84	6.97	6.00	1.14	090
28122		A	Partial removal of foot bone	7.72	10.72	10.25	6.16	6.09	0.81	090
28124		A	Partial removal of toe	5.00	8.57	8.10	4.34	4.31	0.42	090
28126		A	Partial removal of toe	3.64	7.58	7.12	3.36	3.35	0.34	090
28130		A	Removal of ankle bone	9.50	NA	NA	10.29	8.95	1.86	090
28140		A	Removal of metatarsal	7.14	9.89	9.60	5.24	5.25	0.90	090
28150		A	Removal of toe	4.23	8.12	7.66	3.80	3.76	0.42	090
28153		A	Partial removal of toe	3.80	7.99	7.45	3.70	3.58	0.37	090
28160		A	Partial removal of toe	3.88	8.14	7.62	3.76	3.73	0.38	090
28171		A	Resect tarsal tumor	16.41	NA	NA	7.71	7.08	1.25	090
28173		A	Resect metatarsal tumor	14.16	NA	NA	7.48	6.68	1.56	090
28175		A	Resect phalanx of toe tumor	8.29	NA	NA	5.58	5.02	0.80	090
28190		A	Removal of foot foreign body	2.01	5.22	4.94	1.76	1.72	0.20	010
28192		A	Removal of foot foreign body	4.78	8.62	8.16	4.10	4.05	0.49	090
28193		A	Removal of foot foreign body	5.90	9.22	8.76	4.55	4.52	0.56	090
28200		A	Repair of foot tendon	4.74	8.80	8.28	4.11	4.07	0.45	090
28202		A	Repair/graft of foot tendon	7.07	9.52	9.38	4.75	4.87	0.64	090
28208		A	Repair of foot tendon	4.51	8.76	8.15	4.17	4.05	0.49	090
28210		A	Repair/graft of foot tendon	6.52	9.64	9.20	4.93	4.88	0.64	090
28220		A	Release of foot tendon	4.67	8.08	7.63	3.84	3.84	0.41	090

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28222		A	Release of foot tendons	5.76	8.78	8.29	4.19	4.24	0.50	090
28225		A	Release of foot tendon	3.78	7.57	7.09	3.39	3.35	0.35	090
28226		A	Release of foot tendons	4.67	8.93	8.35	4.21	4.19	0.35	090
28230		A	Incision of foot tendon(s)	4.36	7.89	7.47	3.59	3.66	0.39	090
28232		A	Incision of toe tendon	3.51	7.63	7.18	3.43	3.44	0.34	090
28234		A	Incision of foot tendon	3.54	8.21	7.69	3.99	3.91	0.35	090
28238		A	Revision of foot tendon	7.96	11.13	10.49	5.81	5.68	0.86	090
28240		A	Release of big toe	4.48	7.98	7.61	3.67	3.74	0.43	090
28250		A	Revision of foot fascia	6.06	10.12	9.40	5.15	5.01	0.76	090
28260		A	Release of midfoot joint	8.19	11.52	10.53	6.35	6.05	1.03	090
28261		A	Revision of foot tendon	13.11	14.13	13.28	8.39	8.26	1.28	090
28262		A	Revision of foot and ankle	17.21	21.08	19.70	13.53	12.97	3.00	090
28264		A	Release of midfoot joint	10.65	16.99	14.65	10.21	9.16	0.81	090
28270		A	Release of foot contracture	4.93	9.08	8.42	4.51	4.41	0.50	090
28272		A	Release of toe joint each	3.92	7.30	6.90	3.28	3.28	0.31	090
28280		A	Fusion of toes	5.33	9.34	8.94	4.52	4.58	0.60	090
28285		A	Repair of hammertoe	4.76	8.68	8.12	4.32	4.21	0.45	090
28286		A	Repair of hammertoe	4.70	8.31	7.81	3.86	3.81	0.39	090
28288		A	Partial removal of foot bone	6.02	11.34	10.45	6.21	5.99	0.67	090
28289		A	Repair hallux rigidus	8.31	12.46	11.71	7.09	6.87	1.00	090
28290		A	Correction of bunion	5.83	10.81	10.05	5.25	5.16	0.69	090
28292		A	Correction of bunion	9.05	13.40	12.54	7.97	7.66	0.87	090
28293		A	Correction of bunion	11.48	18.25	17.27	8.66	8.42	0.95	090
28294		A	Correction of bunion	8.75	11.65	11.24	5.80	5.82	0.92	090
28296		A	Correction of bunion	8.35	11.92	11.42	6.38	6.31	0.76	090
28297		A	Correction of bunion	9.43	13.65	12.95	6.97	6.91	1.18	090
28298		A	Correction of bunion	8.13	12.26	11.47	6.06	5.93	0.87	090
28299		A	Correction of bunion	11.57	13.75	13.05	7.45	7.32	1.14	090

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28300		A	Incision of heel bone	9.73	NA	NA	8.45	8.15	1.60	090
28302		A	Incision of ankle bone	9.74	NA	NA	9.67	8.71	1.91	090
28304		A	Incision of midfoot bones	9.41	13.28	12.29	7.16	6.87	1.21	090
28305		A	Incise/graft midfoot bones	10.77	NA	NA	7.67	7.72	0.81	090
28306		A	Incision of metatarsal	6.00	11.41	10.63	5.33	5.14	0.83	090
28307		A	Incision of metatarsal	6.50	12.54	12.46	5.94	5.95	1.28	090
28308		A	Incision of metatarsal	5.48	10.44	9.71	5.05	4.86	0.61	090
28309		A	Incision of metatarsals	14.16	NA	NA	10.60	10.00	2.09	090
28310		A	Revision of big toe	5.57	9.82	9.20	4.44	4.33	0.54	090
28312		A	Revision of toe	4.69	9.61	8.99	4.20	4.16	0.50	090
28313		A	Repair deformity of toe	5.15	9.81	9.14	4.90	4.93	0.69	090
28315		A	Removal of sesamoid bone	5.00	8.51	7.99	4.08	4.01	0.49	090
28320		A	Repair of foot bones	9.37	NA	NA	7.50	7.37	1.39	090
28322		A	Repair of metatarsals	8.53	13.41	12.56	7.43	7.16	1.30	090
28340		A	Resect enlarged toe tissue	7.15	9.38	9.21	4.60	4.74	0.54	090
28341		A	Resect enlarged toe	8.72	10.45	10.12	5.27	5.36	0.67	090
28344		A	Repair extra toe(s)	4.40	7.85	8.12	3.64	3.95	0.34	090
28345		A	Repair webbed toe(s)	6.09	8.83	8.93	4.28	4.66	0.45	090
28360		A	Reconstruct cleft foot	14.92	NA	NA	14.52	12.56	3.18	090
28400		A	Treatment of heel fracture	2.31	4.55	4.36	3.96	3.78	0.37	090
28405		A	Treatment of heel fracture	4.74	6.22	5.84	5.20	4.96	0.65	090
28406		A	Treatment of heel fracture	6.56	NA	NA	7.85	7.57	1.17	090
28415		A	Treat heel fracture	16.19	NA	NA	14.43	14.04	2.82	090
28420		A	Treat/graft heel fracture	17.52	NA	NA	16.53	15.16	3.45	090
28430		A	Treatment of ankle fracture	2.22	4.27	4.06	3.54	3.33	0.35	090
28435		A	Treatment of ankle fracture	3.54	6.29	5.56	5.23	4.68	0.69	090
28436		A	Treatment of ankle fracture	4.90	NA	NA	7.33	6.86	0.98	090
28445		A	Treat ankle fracture	15.76	NA	NA	13.13	12.68	2.77	090

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28446		A	Osteochondral talus autogrft	17.71	NA	NA	15.51	14.32	3.49	090
28450		A	Treat midfoot fracture each	2.03	3.94	3.77	3.28	3.12	0.30	090
28455		A	Treat midfoot fracture each	3.24	4.99	4.70	4.15	3.99	0.43	090
28456		A	Treat midfoot fracture	2.86	NA	NA	6.10	5.34	0.56	090
28465		A	Treat midfoot fracture each	8.80	NA	NA	8.07	7.78	1.26	090
28470		A	Treat metatarsal fracture	2.03	3.82	3.67	3.23	3.08	0.33	090
28475		A	Treat metatarsal fracture	3.01	4.14	4.01	3.33	3.30	0.38	090
28476		A	Treat metatarsal fracture	3.60	NA	NA	6.07	5.82	0.53	090
28485		A	Treat metatarsal fracture	7.44	NA	NA	7.43	7.11	0.95	090
28490		A	Treat big toe fracture	1.17	2.83	2.67	2.27	2.15	0.16	090
28495		A	Treat big toe fracture	1.68	3.32	3.11	2.52	2.43	0.20	090
28496		A	Treat big toe fracture	2.48	9.87	9.46	4.03	3.84	0.35	090
28505		A	Treat big toe fracture	7.44	11.39	10.79	6.54	6.10	0.92	090
28510		A	Treatment of toe fracture	1.17	2.26	2.12	2.16	2.04	0.14	090
28515		A	Treatment of toe fracture	1.56	2.93	2.76	2.40	2.32	0.18	090
28525		A	Treat toe fracture	5.62	10.47	9.94	5.59	5.24	0.71	090
28530		A	Treat sesamoid bone fracture	1.11	2.18	2.04	1.80	1.73	0.11	090
28531		A	Treat sesamoid bone fracture	2.57	7.23	7.35	2.61	2.59	0.50	090
28540		A	Treat foot dislocation	2.19	3.53	3.34	2.96	2.87	0.22	090
28545		A	Treat foot dislocation	2.60	5.50	4.72	4.55	3.97	0.50	090
28546		A	Treat foot dislocation	3.40	12.58	10.98	5.87	5.27	0.67	090
28555		A	Repair foot dislocation	9.65	14.66	13.90	8.69	8.22	1.60	090
28570		A	Treat foot dislocation	1.76	2.86	2.85	2.20	2.27	0.12	090
28575		A	Treat foot dislocation	3.49	6.48	5.86	5.50	5.05	0.68	090
28576		A	Treat foot dislocation	4.60	NA	NA	6.17	5.46	0.90	090
28585		A	Repair foot dislocation	11.13	14.52	13.71	8.76	8.55	1.64	090
28600		A	Treat foot dislocation	2.02	4.13	3.86	3.25	3.12	0.29	090
28605		A	Treat foot dislocation	2.89	4.98	4.63	4.21	3.98	0.56	090

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28606		A	Treat foot dislocation	5.09	NA	NA	5.72	5.45	0.84	090
28615		A	Repair foot dislocation	10.70	NA	NA	11.07	10.55	1.77	090
28630		A	Treat toe dislocation	1.75	2.54	2.34	1.26	1.21	0.23	010
28635		A	Treat toe dislocation	1.96	3.11	2.90	1.83	1.76	0.22	010
28636		A	Treat toe dislocation	2.77	4.44	4.69	1.99	2.29	0.39	010
28645		A	Repair toe dislocation	7.44	10.85	10.00	6.01	5.65	0.80	090
28660		A	Treat toe dislocation	1.28	1.84	1.71	1.11	1.04	0.20	010
28665		A	Treat toe dislocation	1.97	2.39	2.25	1.74	1.70	0.24	010
28666		A	Treat toe dislocation	2.66	NA	NA	3.10	2.78	0.52	010
28675		A	Repair of toe dislocation	5.62	10.69	10.25	5.79	5.50	0.75	090
28705		A	Fusion of foot bones	20.33	NA	NA	14.96	14.46	3.45	090
28715		A	Fusion of foot bones	14.60	NA	NA	12.01	11.53	2.47	090
28725		A	Fusion of foot bones	12.18	NA	NA	9.61	9.24	1.87	090
28730		A	Fusion of foot bones	12.42	NA	NA	10.91	10.39	1.91	090
28735		A	Fusion of foot bones	12.23	NA	NA	9.74	9.35	1.78	090
28737		A	Revision of foot bones	11.03	NA	NA	7.78	7.77	1.28	090
28740		A	Fusion of foot bones	9.29	14.68	13.95	8.20	7.87	1.36	090
28750		A	Fusion of big toe joint	8.57	14.57	14.04	8.08	7.81	1.30	090
28755		A	Fusion of big toe joint	4.88	9.40	8.94	4.33	4.29	0.52	090
28760		A	Fusion of big toe joint	9.14	13.41	12.48	7.21	6.92	1.05	090
28800		A	Amputation of midfoot	8.79	NA	NA	6.57	6.50	1.30	090
28805		A	Amputation thru metatarsal	12.71	NA	NA	7.83	7.56	2.13	090
28810		A	Amputation toe & metatarsal	6.64	NA	NA	5.38	5.26	1.18	090
28820		A	Amputation of toe	5.00	9.68	9.46	4.58	4.50	0.73	090
28825		A	Partial amputation of toe	6.01	10.33	9.90	5.35	5.11	0.84	090
28890		A	High energy eswt plantar f	3.45	6.24	6.06	3.03	2.85	0.35	090
28899		C	Foot/toes surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29000		A	Application of body cast	2.25	7.00	5.96	2.77	2.47	0.18	000

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29010		A	Application of body cast	2.06	6.89	5.66	2.66	2.31	0.39	000
29015		A	Application of body cast	2.41	4.13	4.01	1.92	1.85	0.41	000
29020		A	Application of body cast	2.11	3.90	3.92	1.53	1.59	0.08	000
29025		A	Application of body cast	2.40	4.27	4.32	1.99	2.06	0.48	000
29035		A	Application of body cast	1.77	5.24	4.98	2.16	2.03	0.34	000
29040		A	Application of body cast	2.22	4.45	4.15	1.99	1.89	0.42	000
29044		A	Application of body cast	2.12	5.74	5.29	2.47	2.30	0.41	000
29046		A	Application of body cast	2.41	4.55	4.83	2.06	2.25	0.48	000
29049		A	Application of figure eight	0.89	1.81	1.59	1.02	0.85	0.18	000
29055		A	Application of shoulder cast	1.78	4.30	3.99	1.99	1.85	0.35	000
29058		A	Application of shoulder cast	1.31	1.23	1.39	0.79	0.80	0.23	000
29065		A	Application of long arm cast	0.87	1.75	1.67	1.00	0.94	0.16	000
29075		A	Application of forearm cast	0.77	1.69	1.61	0.94	0.88	0.14	000
29085		A	Apply hand/wrist cast	0.87	1.74	1.65	0.99	0.91	0.14	000
29086		A	Apply finger cast	0.62	1.56	1.42	0.81	0.74	0.08	000
29105		A	Apply long arm splint	0.87	1.49	1.44	0.75	0.70	0.14	000
29125		A	Apply forearm splint	0.59	1.33	1.26	0.61	0.56	0.10	000
29126		A	Apply forearm splint	0.77	1.42	1.35	0.70	0.65	0.11	000
29130		A	Application of finger splint	0.50	0.61	0.58	0.28	0.26	0.07	000
29131		A	Application of finger splint	0.55	0.88	0.83	0.37	0.34	0.08	000
29200		A	Strapping of chest	0.65	0.86	0.81	0.49	0.46	0.05	000
29240		A	Strapping of shoulder	0.71	0.88	0.87	0.52	0.49	0.05	000
29260		A	Strapping of elbow or wrist	0.55	0.90	0.86	0.51	0.47	0.05	000
29280		A	Strapping of hand or finger	0.51	0.92	0.88	0.52	0.48	0.04	000
29305		A	Application of hip cast	2.03	4.73	4.43	2.31	2.19	0.39	000
29325		A	Application of hip casts	2.32	5.16	4.84	2.55	2.42	0.45	000
29345		A	Application of long leg cast	1.40	2.30	2.19	1.34	1.28	0.27	000
29355		A	Application of long leg cast	1.53	2.33	2.19	1.39	1.32	0.29	000

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29358		A	Apply long leg cast brace	1.43	2.95	2.75	1.40	1.31	0.29	000
29365		A	Application of long leg cast	1.18	2.18	2.07	1.22	1.16	0.23	000
29405		A	Apply short leg cast	0.86	1.61	1.54	0.90	0.86	0.12	000
29425		A	Apply short leg cast	1.01	1.63	1.56	0.88	0.86	0.12	000
29435		A	Apply short leg cast	1.18	2.05	1.97	1.11	1.08	0.23	000
29440		A	Addition of walker to cast	0.57	0.66	0.73	0.25	0.28	0.08	000
29445		A	Apply rigid leg cast	1.78	2.08	2.03	1.20	1.16	0.24	000
29450		A	Application of leg cast	2.08	1.92	1.89	1.07	1.10	0.22	000
29505		A	Application long leg splint	0.69	1.46	1.40	0.64	0.60	0.11	000
29515		A	Application lower leg splint	0.73	1.29	1.21	0.63	0.60	0.10	000
29520		A	Strapping of hip	0.54	0.86	0.84	0.47	0.47	0.04	000
29530		A	Strapping of knee	0.57	0.90	0.86	0.50	0.46	0.05	000
29540		A	Strapping of ankle and/or ft	0.32	0.63	0.62	0.32	0.35	0.03	000
29550		A	Strapping of toes	0.15	0.62	0.62	0.27	0.31	0.01	000
29580		A	Application of paste boot	0.55	0.92	0.89	0.44	0.43	0.07	000
29581		A	Apply multlay comprs lwr leg	0.60	2.04	2.04	0.27	0.27	0.07	000
29590		A	Application of foot splint	0.76	0.74	0.71	0.31	0.32	0.05	000
29700		A	Removal/revision of cast	0.57	1.25	1.20	0.36	0.35	0.10	000
29705		A	Removal/revision of cast	0.76	1.07	1.02	0.53	0.50	0.12	000
29710		A	Removal/revision of cast	1.34	2.02	1.87	0.93	0.85	0.27	000
29715		A	Removal/revision of cast	0.94	1.32	1.38	0.53	0.54	0.12	000
29720		A	Repair of body cast	0.68	1.61	1.52	0.51	0.48	0.12	000
29730		A	Windowing of cast	0.75	1.03	0.98	0.49	0.46	0.11	000
29740		A	Wedging of cast	1.12	1.30	1.29	0.60	0.59	0.18	000
29750		A	Wedging of clubfoot cast	1.26	1.47	1.40	0.78	0.74	0.26	000
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29800		A	Jaw arthroscopy/surgery	6.84	NA	NA	7.48	7.12	1.33	090
29804		A	Jaw arthroscopy/surgery	8.87	NA	NA	9.17	8.51	1.74	090

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29805		A	Shoulder arthroscopy dx	6.03	NA	NA	6.80	6.50	1.18	090
29806		A	Shoulder arthroscopy/surgery	15.14	NA	NA	13.60	13.01	2.97	090
29807		A	Shoulder arthroscopy/surgery	14.67	NA	NA	13.47	12.84	2.87	090
29819		A	Shoulder arthroscopy/surgery	7.79	NA	NA	8.16	7.81	1.52	090
29820		A	Shoulder arthroscopy/surgery	7.21	NA	NA	7.45	7.15	1.40	090
29821		A	Shoulder arthroscopy/surgery	7.89	NA	NA	8.15	7.81	1.55	090
29822		A	Shoulder arthroscopy/surgery	7.60	NA	NA	7.99	7.67	1.49	090
29823		A	Shoulder arthroscopy/surgery	8.36	NA	NA	8.66	8.32	1.63	090
29824		A	Shoulder arthroscopy/surgery	8.98	NA	NA	9.35	8.93	1.77	090
29825		A	Shoulder arthroscopy/surgery	7.79	NA	NA	8.11	7.77	1.52	090
29826		A	Shoulder arthroscopy/surgery	9.16	NA	NA	8.91	8.56	1.79	090
29827		A	Arthroscop rotator cuff repr	15.59	NA	NA	13.56	13.03	3.07	090
29828		A	Arthroscopy biceps tenodesis	13.16	NA	NA	11.86	11.14	2.58	090
29830		A	Elbow arthroscopy	5.88	NA	NA	6.47	6.18	1.17	090
29834		A	Elbow arthroscopy/surgery	6.42	NA	NA	7.01	6.71	1.22	090
29835		A	Elbow arthroscopy/surgery	6.62	NA	NA	7.17	6.85	1.29	090
29836		A	Elbow arthroscopy/surgery	7.72	NA	NA	8.12	7.78	1.52	090
29837		A	Elbow arthroscopy/surgery	7.01	NA	NA	7.39	7.07	1.36	090
29838		A	Elbow arthroscopy/surgery	7.88	NA	NA	8.26	7.89	1.49	090
29840		A	Wrist arthroscopy	5.68	NA	NA	6.60	6.31	1.13	090
29843		A	Wrist arthroscopy/surgery	6.15	NA	NA	7.00	6.69	1.21	090
29844		A	Wrist arthroscopy/surgery	6.51	NA	NA	7.20	6.80	1.18	090
29845		A	Wrist arthroscopy/surgery	7.69	NA	NA	8.18	7.67	1.37	090
29846		A	Wrist arthroscopy/surgery	6.89	NA	NA	7.47	7.09	1.22	090
29847		A	Wrist arthroscopy/surgery	7.22	NA	NA	7.52	7.21	1.41	090
29848		A	Wrist endoscopy/surgery	6.39	NA	NA	7.67	7.19	1.17	090
29850		A	Knee arthroscopy/surgery	8.27	NA	NA	8.68	7.58	1.62	090
29851		A	Knee arthroscopy/surgery	13.26	NA	NA	12.04	11.47	2.61	090

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29855		A	Tibial arthroscopy/surgery	10.76	NA	NA	10.59	10.12	2.12	090
29856		A	Tibial arthroscopy/surgery	14.28	NA	NA	12.76	12.20	2.82	090
29860		A	Hip arthroscopy dx	9.00	NA	NA	9.11	8.52	1.78	090
29861		A	Hip arthro w/fb removal	10.10	NA	NA	9.77	9.17	1.97	090
29862		A	Hip arthr0 w/debridement	11.17	NA	NA	11.08	10.48	2.19	090
29863		A	Hip arthr0 w/synovectomy	11.17	NA	NA	11.03	10.40	2.20	090
29866		A	Autgrft implnt knee w/scope	14.67	NA	NA	13.82	13.13	2.91	090
29867		A	Allgrft implnt knee w/scope	18.39	NA	NA	16.33	15.37	3.61	090
29868		A	Meniscal trnspl knee w/scpe	25.10	NA	NA	20.34	19.20	4.94	090
29870		A	Knee arthroscopy dx	5.19	10.83	10.83	6.04	5.75	1.02	090
29871		A	Knee arthroscopy/drainage	6.69	NA	NA	7.30	6.95	1.30	090
29873		A	Knee arthroscopy/surgery	6.24	NA	NA	8.05	7.67	1.22	090
29874		A	Knee arthroscopy/surgery	7.19	NA	NA	7.48	7.13	1.40	090
29875		A	Knee arthroscopy/surgery	6.45	NA	NA	7.04	6.73	1.26	090
29876		A	Knee arthroscopy/surgery	8.87	NA	NA	9.00	8.53	1.74	090
29877		A	Knee arthroscopy/surgery	8.30	NA	NA	8.66	8.21	1.62	090
29879		A	Knee arthroscopy/surgery	8.99	NA	NA	9.05	8.60	1.77	090
29880		A	Knee arthroscopy/surgery	9.45	NA	NA	9.35	8.87	1.85	090
29881		A	Knee arthroscopy/surgery	8.71	NA	NA	8.91	8.45	1.70	090
29882		A	Knee arthroscopy/surgery	9.60	NA	NA	9.41	8.90	1.89	090
29883		A	Knee arthroscopy/surgery	11.77	NA	NA	11.01	10.54	2.30	090
29884		A	Knee arthroscopy/surgery	8.28	NA	NA	8.63	8.18	1.62	090
29885		A	Knee arthroscopy/surgery	10.21	NA	NA	10.24	9.70	2.00	090
29886		A	Knee arthroscopy/surgery	8.49	NA	NA	8.81	8.34	1.66	090
29887		A	Knee arthroscopy/surgery	10.16	NA	NA	10.15	9.62	1.98	090
29888		A	Knee arthroscopy/surgery	14.30	NA	NA	12.53	11.95	2.80	090
29889		A	Knee arthroscopy/surgery	17.41	NA	NA	15.67	14.92	3.41	090
29891		A	Ankle arthroscopy/surgery	9.67	NA	NA	9.26	8.91	1.64	090

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29892		A	Ankle arthroscopy/surgery	10.27	NA	NA	6.18	7.21	2.01	090
29893		A	Scope plantar fasciotomy	6.32	11.04	10.44	5.79	5.61	0.50	090
29894		A	Ankle arthroscopy/surgery	7.35	NA	NA	6.89	6.52	1.22	090
29895		A	Ankle arthroscopy/surgery	7.13	NA	NA	6.41	6.17	1.13	090
29897		A	Ankle arthroscopy/surgery	7.32	NA	NA	6.75	6.57	1.24	090
29898		A	Ankle arthroscopy/surgery	8.49	NA	NA	7.27	7.03	1.29	090
29899		A	Ankle arthroscopy/surgery	15.41	NA	NA	12.98	12.47	2.87	090
29900		A	Mcp joint arthroscopy dx	5.88	NA	NA	7.59	6.86	0.41	090
29901		A	Mcp joint arthroscopy surg	6.59	NA	NA	7.90	7.20	1.29	090
29902		A	Mcp joint arthroscopy surg	7.16	NA	NA	5.76	6.27	2.57	090
29904		A	Subtalar arthro w/fb rmvl	8.65	NA	NA	8.68	8.09	1.68	090
29905		A	Subtalar arthro w/exc	9.18	NA	NA	9.58	8.92	1.81	090
29906		A	Subtalar arthro w/deb	9.65	NA	NA	10.10	9.42	1.89	090
29907		A	Subtalar arthro w/fusion	12.18	NA	NA	11.62	10.83	2.39	090
29914		A	Hip arthro w/femoroplasty	14.67	NA	NA	12.79	12.79	2.91	090
29915		A	Hip arthro acetabuloplasty	15.00	NA	NA	12.99	12.99	2.95	090
29916		A	Hip arthro w/labral repair	15.00	NA	NA	12.99	12.99	2.95	090
29999		C	Arthroscopy of joint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
30000		A	Drainage of nose lesion	1.48	5.16	5.06	1.91	1.80	0.22	010
30020		A	Drainage of nose lesion	1.48	5.27	5.01	1.95	1.84	0.20	010
3006F		I	Cxr doc rev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3008F		I	Body mass index docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30100		A	Intranasal biopsy	0.94	3.18	3.07	1.03	0.99	0.11	000
30110		A	Removal of nose polyp(s)	1.68	5.00	4.78	2.07	1.96	0.23	010
30115		A	Removal of nose polyp(s)	4.44	NA	NA	8.01	7.66	0.56	090
30117		A	Removal of intranasal lesion	3.26	22.18	21.35	6.49	6.22	0.41	090
30118		A	Removal of intranasal lesion	9.92	NA	NA	12.05	11.43	1.30	090
3011F		I	Lipid panel doc rev	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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30120		A	Revision of nose	5.39	9.32	9.01	7.02	6.88	0.84	090
30124		A	Removal of nose lesion	3.20	NA	NA	4.68	4.43	0.41	090
30125		A	Removal of nose lesion	7.30	NA	NA	10.23	9.80	0.92	090
30130		A	Excise inferior turbinate	3.47	NA	NA	7.49	7.21	0.43	090
30140		A	Resect inferior turbinate	3.57	NA	NA	9.17	8.80	0.45	090
30150		A	Partial removal of nose	9.55	NA	NA	12.37	12.03	1.41	090
3015F		I	Cerv cancer screen docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30160		A	Removal of nose	9.99	NA	NA	12.29	11.81	1.28	090
3018F		I	Pre-prxd rsk et al docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30200		A	Injection treatment of nose	0.78	2.53	2.43	0.95	0.90	0.10	000
30210		A	Nasal sinus therapy	1.13	3.23	3.09	1.75	1.67	0.14	010
30220		A	Insert nasal septal button	1.59	7.24	6.92	2.02	1.92	0.22	010
30300		A	Remove nasal foreign body	1.09	5.54	5.43	2.53	2.41	0.14	010
30310		A	Remove nasal foreign body	2.01	NA	NA	3.91	3.77	0.26	010
30320		A	Remove nasal foreign body	4.64	NA	NA	8.40	8.07	0.60	090
3035F		I	O2 saturation<=88% /pao<=55	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3037F		I	O2 saturation> 88% /pao>55	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30400		R	Reconstruction of nose	10.86	NA	NA	18.23	17.92	1.39	090
3040F		I	Fev<40% predicted value	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30410		R	Reconstruction of nose	14.00	NA	NA	20.08	19.68	1.79	090
30420		R	Reconstruction of nose	16.90	NA	NA	22.28	21.30	2.39	090
3042F		I	Fev>=40% predicted value	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30430		R	Revision of nose	8.24	NA	NA	16.68	16.89	1.62	090
30435		R	Revision of nose	12.73	NA	NA	22.28	21.16	1.63	090
30450		R	Revision of nose	19.66	NA	NA	23.42	23.11	2.51	090
30460		A	Revision of nose	10.32	NA	NA	10.65	10.28	2.01	090
30462		A	Revision of nose	20.28	NA	NA	23.50	21.85	3.99	090
30465		A	Repair nasal stenosis	12.36	NA	NA	15.74	14.90	1.74	090

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30520		A	Repair of nasal septum	7.01	NA	NA	11.00	10.26	0.90	090
30540		A	Repair nasal defect	7.92	NA	NA	11.90	11.10	1.02	090
30545		A	Repair nasal defect	11.62	NA	NA	12.29	13.12	0.81	090
30560		A	Release of nasal adhesions	1.31	6.57	6.42	2.68	2.60	0.18	010
30580		A	Repair upper jaw fistula	6.88	11.45	10.74	7.58	6.93	0.87	090
30600		A	Repair mouth/nose fistula	6.16	10.36	9.93	6.18	5.87	0.77	090
30620		A	Intranasal reconstruction	6.16	NA	NA	11.65	11.22	0.88	090
30630		A	Repair nasal septum defect	7.29	NA	NA	10.68	10.16	0.99	090
3073F		I	Pre-surg eye measures docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30801		A	Ablate inf turbinate superf	1.14	5.46	5.35	2.81	2.68	0.14	010
30802		A	Ablate inf turbinate submuc	2.08	6.33	6.15	3.41	3.23	0.27	010
3088F		I	Mdd mild	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3089F		I	Mdd moderate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30901		A	Control of nosebleed	1.10	1.55	1.57	0.47	0.43	0.16	000
30903		A	Control of nosebleed	1.54	4.23	4.02	0.70	0.63	0.23	000
30905		A	Control of nosebleed	1.97	5.16	4.91	0.84	0.79	0.30	000
30906		A	Repeat control of nosebleed	2.45	5.58	5.36	1.30	1.22	0.33	000
3090F		I	Mdd severe w/o psych	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30915		A	Ligation nasal sinus artery	7.44	NA	NA	9.12	8.61	0.99	090
3091F		I	Mdd severe w/psych	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30920		A	Ligation upper jaw artery	11.14	NA	NA	12.82	11.98	1.45	090
30930		A	Ther fx nasal inf turbinate	1.31	NA	NA	2.25	2.13	0.18	010
3093F		I	Doc new diag 1st/addl mdd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31000		A	Irrigation maxillary sinus	1.20	4.05	3.93	1.82	1.75	0.14	010
31002		A	Irrigation sphenoid sinus	1.96	NA	NA	3.78	3.68	0.26	010
31020		A	Exploration maxillary sinus	3.07	10.83	10.65	7.21	6.95	0.39	090
31030		A	Exploration maxillary sinus	6.01	13.74	13.45	9.00	8.55	0.75	090

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31032		A	Explore sinus remove polyps	6.69	NA	NA	9.74	9.25	0.87	090
31040		A	Exploration behind upper jaw	9.77	NA	NA	11.56	10.92	1.39	090
31050		A	Exploration sphenoid sinus	5.37	NA	NA	8.60	8.33	0.68	090
31051		A	Sphenoid sinus surgery	7.25	NA	NA	11.35	10.81	0.91	090
31070		A	Exploration of frontal sinus	4.40	NA	NA	8.25	7.90	0.58	090
31075		A	Exploration of frontal sinus	9.51	NA	NA	12.98	12.37	1.22	090
31080		A	Removal of frontal sinus	12.74	NA	NA	16.92	15.70	1.63	090
31081		A	Removal of frontal sinus	14.19	NA	NA	24.18	21.39	5.08	090
31084		A	Removal of frontal sinus	14.95	NA	NA	18.22	17.59	1.91	090
31085		A	Removal of frontal sinus	15.64	NA	NA	18.63	18.18	5.61	090
31086		A	Removal of frontal sinus	14.36	NA	NA	17.87	16.87	1.85	090
31087		A	Removal of frontal sinus	14.57	NA	NA	16.51	15.74	1.86	090
31090		A	Exploration of sinuses	11.17	NA	NA	18.29	17.28	1.47	090
31200		A	Removal of ethmoid sinus	5.14	NA	NA	10.62	10.20	0.73	090
31201		A	Removal of ethmoid sinus	8.60	NA	NA	12.55	11.87	1.14	090
31205		A	Removal of ethmoid sinus	10.58	NA	NA	14.61	13.67	1.59	090
31225		A	Removal of upper jaw	26.70	NA	NA	26.80	24.67	3.54	090
31230		A	Removal of upper jaw	30.82	NA	NA	28.87	26.50	3.95	090
31231		A	Nasal endoscopy dx	1.10	4.48	4.39	1.13	1.06	0.12	000
31233		A	Nasal/sinus endoscopy dx	2.18	5.50	5.36	1.76	1.65	0.29	000
31235		A	Nasal/sinus endoscopy dx	2.64	6.00	5.91	2.00	1.88	0.33	000
31237		A	Nasal/sinus endoscopy surg	2.98	6.40	6.25	2.24	2.08	0.38	000
31238		A	Nasal/sinus endoscopy surg	3.26	6.37	6.22	2.40	2.24	0.41	000
31239		A	Nasal/sinus endoscopy surg	9.33	NA	NA	10.11	9.37	1.24	010
31240		A	Nasal/sinus endoscopy surg	2.61	NA	NA	2.02	1.89	0.34	000
31254		A	Revision of ethmoid sinus	4.64	NA	NA	3.23	3.00	0.60	000
31255		A	Removal of ethmoid sinus	6.95	NA	NA	4.58	4.25	0.88	000
31256		A	Exploration maxillary sinus	3.29	NA	NA	2.42	2.26	0.41	000

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31267		A	Endoscopy maxillary sinus	5.45	NA	NA	3.70	3.43	0.69	000
31276		A	Sinus endoscopy surgical	8.84	NA	NA	5.69	5.27	1.14	000
31287		A	Nasal/sinus endoscopy surg	3.91	NA	NA	2.79	2.59	0.50	000
31288		A	Nasal/sinus endoscopy surg	4.57	NA	NA	3.18	2.96	0.60	000
31290		A	Nasal/sinus endoscopy surg	18.61	NA	NA	14.46	13.47	2.63	010
31291		A	Nasal/sinus endoscopy surg	19.56	NA	NA	15.18	14.11	3.14	010
31292		A	Nasal/sinus endoscopy surg	15.90	NA	NA	12.81	11.94	2.04	010
31293		A	Nasal/sinus endoscopy surg	17.47	NA	NA	13.81	12.85	2.23	010
31294		A	Nasal/sinus endoscopy surg	20.31	NA	NA	15.48	14.38	2.61	010
31295		A	Sinus endo w/balloon dil	2.70	57.07	57.07	2.12	2.12	0.35	000
31296		A	Sinus endo w/balloon dil	3.29	108.70	108.70	2.47	2.47	0.42	000
31297		A	Sinus endo w/balloon dil	2.64	108.37	108.37	2.08	2.08	0.34	000
31299		C	Sinus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31300		A	Removal of larynx lesion	15.91	NA	NA	20.57	19.46	2.02	090
3130F		I	Upper gi endoscopy performed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
31320		A	Diagnostic incision larynx	5.73	NA	NA	13.28	12.83	0.72	090
3132F		I	Doc ref upper gi endoscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
31360		A	Removal of larynx	29.91	NA	NA	29.89	27.04	3.91	090
31365		A	Removal of larynx	38.81	NA	NA	35.10	31.68	5.07	090
31367		A	Partial removal of larynx	30.57	NA	NA	32.90	30.46	3.97	090
31368		A	Partial removal of larynx	34.19	NA	NA	36.20	33.61	4.37	090
31370		A	Partial removal of larynx	27.57	NA	NA	32.12	29.95	3.53	090
31375		A	Partial removal of larynx	26.07	NA	NA	30.60	28.46	3.35	090
31380		A	Partial removal of larynx	25.57	NA	NA	30.30	28.16	3.29	090
31382		A	Partial removal of larynx	28.57	NA	NA	32.71	30.32	3.68	090
31390		A	Removal of larynx & pharynx	42.51	NA	NA	38.98	35.65	5.83	090
31395		A	Reconstruct larynx & pharynx	43.80	NA	NA	42.76	39.26	5.62	090
31400		A	Revision of larynx	11.60	NA	NA	17.19	16.55	1.49	090

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3140F		I	Upper gi endo shows barrtts	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3141F		I	Upper gi endo not barrtts	0.00	0.00	0.00	0.00	0.00	0.00	XXX
31420		A	Removal of epiglottis	11.43	NA	NA	12.64	11.90	1.47	090
3142F		I	Barium swallow test ordered	0.00	0.00	0.00	0.00	0.00	0.00	XXX
31500		A	Insert emergency airway	2.33	NA	NA	0.64	0.60	0.31	000
31502		A	Change of windpipe airway	0.65	NA	NA	0.34	0.32	0.07	000
31505		A	Diagnostic laryngoscopy	0.61	1.79	1.77	0.81	0.77	0.07	000
3150F		I	Forceps esoph biopsy done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
31510		A	Laryngoscopy with biopsy	1.92	4.15	4.07	1.55	1.45	0.26	000
31511		A	Remove foreign body larynx	2.16	3.85	3.76	1.42	1.37	0.31	000
31512		A	Removal of larynx lesion	2.07	3.95	3.84	1.70	1.58	0.27	000
31513		A	Injection into vocal cord	2.10	NA	NA	1.72	1.61	0.27	000
31515		A	Laryngoscopy for aspiration	1.80	4.16	4.12	1.32	1.25	0.24	000
31520		A	Dx laryngoscopy newborn	2.56	NA	NA	1.99	1.80	0.33	000
31525		A	Dx laryngoscopy excl nb	2.63	4.62	4.46	1.95	1.83	0.34	000
31526		A	Dx laryngoscopy w/oper scope	2.57	NA	NA	1.99	1.86	0.33	000
31527		A	Laryngoscopy for treatment	3.27	NA	NA	2.41	2.19	0.41	000
31528		A	Laryngoscopy and dilation	2.37	NA	NA	1.82	1.69	0.31	000
31529		A	Laryngoscopy and dilation	2.68	NA	NA	2.00	1.87	0.34	000
31530		A	Laryngoscopy w/fb removal	3.38	NA	NA	2.33	2.16	0.43	000
31531		A	Laryngoscopy w/fb & op scope	3.58	NA	NA	2.57	2.40	0.45	000
31535		A	Laryngoscopy w/biopsy	3.16	NA	NA	2.33	2.17	0.41	000
31536		A	Laryngoscopy w/bx & op scope	3.55	NA	NA	2.58	2.40	0.45	000
31540		A	Laryngoscopy w/exc of tumor	4.12	NA	NA	2.90	2.70	0.53	000
31541		A	Larynscop w/tumr exc + scope	4.52	NA	NA	3.14	2.93	0.58	000
31545		A	Remove vc lesion w/scope	6.30	NA	NA	4.22	3.89	0.80	000
31546		A	Remove vc lesion scope/graft	9.73	NA	NA	6.27	5.67	1.25	000
31560		A	Laryngoscop w/arytenoidectom	5.45	NA	NA	3.66	3.38	0.69	000

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31561		A	Larynscop remve cart + scop	5.99	NA	NA	3.97	3.66	0.76	000
31570		A	Laryngoscope w/vc inj	3.86	5.90	5.81	2.72	2.53	0.53	000
31571		A	Laryngoscop w/vc inj + scope	4.26	NA	NA	2.98	2.77	0.54	000
31575		A	Diagnostic laryngoscopy	1.10	2.21	2.18	1.11	1.06	0.12	000
31576		A	Laryngoscopy with biopsy	1.97	4.52	4.45	1.60	1.50	0.24	000
31577		A	Remove foreign body larynx	2.47	4.52	4.39	1.78	1.68	0.33	000
31578		A	Removal of larynx lesion	2.84	5.30	5.16	2.16	1.96	0.35	000
31579		A	Diagnostic laryngoscopy	2.26	3.85	3.83	1.81	1.69	0.30	XXX
31580		A	Revision of larynx	14.66	NA	NA	20.63	19.45	1.87	090
31582		A	Revision of larynx	23.22	NA	NA	31.48	30.26	2.99	090
31584		A	Treat larynx fracture	20.47	NA	NA	23.03	21.75	2.62	090
31587		A	Revision of larynx	15.27	NA	NA	13.62	12.44	1.94	090
31588		A	Revision of larynx	14.99	NA	NA	17.96	16.94	1.93	090
31590		A	Reinnervate larynx	7.85	NA	NA	17.94	17.54	1.02	090
31595		A	Larynx nerve surgery	8.84	NA	NA	13.23	12.71	1.14	090
31599		C	Larynx surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31600		A	Incision of windpipe	7.17	NA	NA	3.66	3.44	1.26	000
31601		A	Incision of windpipe	4.44	NA	NA	3.06	2.84	0.56	000
31603		A	Incision of windpipe	4.14	NA	NA	2.02	1.87	0.69	000
31605		A	Incision of windpipe	3.57	NA	NA	1.34	1.26	0.62	000
31610		A	Incision of windpipe	9.38	NA	NA	10.99	10.38	1.32	090
31611		A	Surgery/speech prosthesis	6.00	NA	NA	9.60	9.16	0.76	090
31612		A	Puncture/clear windpipe	0.91	1.44	1.38	0.44	0.40	0.11	000
31613		A	Repair windpipe opening	4.71	NA	NA	8.16	7.84	0.72	090
31614		A	Repair windpipe opening	8.63	NA	NA	13.10	12.35	1.18	090
31615		A	Visualization of windpipe	2.09	3.12	3.05	1.58	1.48	0.26	000
31620		A	Endobronchial us add-on	1.40	6.28	6.69	0.50	0.50	0.12	ZZZ
31622		A	Dx bronchoscope/wash	2.78	5.84	6.14	1.27	1.23	0.34	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
31623		A	Dx bronchoscope/brush	2.88	6.29	6.80	1.25	1.20	0.26	000
31624		A	Dx bronchoscope/lavage	2.88	5.75	6.14	1.27	1.22	0.26	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	5.91	6.30	1.43	1.38	0.31	000
31626		A	Bronchoscopy w/markers	4.16	8.59	8.59	1.73	1.73	0.31	000
31627		A	Navigational bronchoscopy	2.00	35.43	35.43	0.88	0.88	0.14	ZZZ
31628		A	Bronchoscopy/lung bx each	3.80	6.80	7.58	1.57	1.50	0.30	000
31629		A	Bronchoscopy/needle bx each	4.09	12.45	13.74	1.69	1.61	0.34	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	NA	1.76	1.75	0.49	000
31631		A	Bronchoscopy dilate w/stent	4.36	NA	NA	1.98	1.94	0.60	000
31632		A	Bronchoscopy/lung bx addl	1.03	0.99	1.00	0.37	0.35	0.07	ZZZ
31633		A	Bronchoscopy/needle bx addl	1.32	1.14	1.16	0.47	0.45	0.10	ZZZ
31634		A	Bronch w/balloon occlusion	4.00	48.98	48.98	1.76	1.76	0.33	000
31635		A	Bronchoscopy w/fb removal	3.67	5.79	6.18	1.59	1.55	0.39	000
31636		A	Bronchoscopy bronch stents	4.30	NA	NA	1.82	1.83	0.56	000
31637		A	Bronchoscopy stent add-on	1.58	NA	NA	0.61	0.59	0.11	ZZZ
31638		A	Bronchoscopy revise stent	4.88	NA	NA	2.15	2.12	0.65	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	NA	2.17	2.15	0.64	000
31641		A	Bronchoscopy treat blockage	5.02	NA	NA	2.18	2.09	0.58	000
31643		A	Diag bronchoscope/catheter	3.49	NA	NA	1.45	1.40	0.29	000
31645		A	Bronchoscopy clear airways	3.16	5.17	5.49	1.36	1.31	0.29	000
31646		A	Bronchoscopy reclear airway	2.72	4.87	5.17	1.20	1.15	0.26	000
31656		A	Bronchoscopy inj for x-ray	2.17	6.07	6.74	0.93	0.92	0.16	000
31715		A	Injection for bronchus x-ray	1.11	NA	NA	0.37	0.39	0.08	000
31717		A	Bronchial brush biopsy	2.12	5.43	6.14	1.03	0.97	0.16	000
31720		A	Clearance of airways	1.06	NA	NA	0.41	0.38	0.08	000
31725		A	Clearance of airways	1.96	NA	NA	0.73	0.65	0.20	000
31730		A	Intro windpipe wire/tube	2.85	29.77	26.77	1.20	1.13	0.45	000
31750		A	Repair of windpipe	15.39	NA	NA	23.74	22.68	2.27	090

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31755		A	Repair of windpipe	17.54	NA	NA	32.42	31.20	2.24	090
31760		A	Repair of windpipe	23.48	NA	NA	12.37	12.79	5.47	090
31766		A	Reconstruction of windpipe	31.67	NA	NA	14.67	15.01	7.39	090
31770		A	Repair/graft of bronchus	23.54	NA	NA	11.19	11.44	5.49	090
31775		A	Reconstruct bronchus	24.59	NA	NA	10.49	11.10	5.74	090
31780		A	Reconstruct windpipe	19.84	NA	NA	13.54	12.75	3.22	090
31781		A	Reconstruct windpipe	24.85	NA	NA	11.21	12.17	5.80	090
31785		A	Remove windpipe lesion	18.35	NA	NA	12.19	11.38	2.61	090
31786		A	Remove windpipe lesion	25.42	NA	NA	12.19	13.04	5.95	090
31800		A	Repair of windpipe injury	8.18	NA	NA	12.03	11.49	1.05	090
31805		A	Repair of windpipe injury	13.42	NA	NA	7.95	8.19	3.15	090
31820		A	Closure of windpipe lesion	4.64	7.89	7.53	4.77	4.48	0.67	090
31825		A	Repair of windpipe defect	7.07	10.28	9.80	6.73	6.33	0.99	090
31830		A	Revise windpipe scar	4.62	8.00	7.63	5.13	4.85	0.71	090
31899		C	Airways surgical procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
3200F		I	Barium swallow test not req	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32035		A	Exploration of chest	11.29	NA	NA	8.00	7.81	2.57	090
32036		A	Exploration of chest	12.30	NA	NA	8.28	8.21	2.89	090
32095		A	Biopsy through chest wall	10.14	NA	NA	6.60	6.59	2.34	090
32100		A	Exploration/biopsy of chest	16.16	NA	NA	8.95	9.09	3.79	090
32110		A	Explore/repair chest	25.28	NA	NA	13.30	13.10	5.73	090
32120		A	Re-exploration of chest	14.39	NA	NA	8.65	8.70	3.40	090
32124		A	Explore chest free adhesions	15.45	NA	NA	9.03	9.01	3.67	090
32140		A	Removal of lung lesion(s)	16.66	NA	NA	9.38	9.43	3.88	090
32141		A	Remove/treat lung lesions	27.18	NA	NA	13.02	12.76	6.38	090
32150		A	Removal of lung lesion(s)	16.82	NA	NA	9.60	9.55	3.92	090
32151		A	Remove lung foreign body	16.94	NA	NA	9.43	9.74	3.97	090
32160		A	Open chest heart massage	13.10	NA	NA	7.53	7.39	2.99	090

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32200		A	Drain open lung lesion	18.68	NA	NA	11.45	11.27	4.28	090
32201		A	Drain percut lung lesion	3.99	21.28	22.93	1.49	1.66	0.38	000
32215		A	Treat chest lining	13.05	NA	NA	8.07	8.15	3.04	090
32220		A	Release of lung	26.65	NA	NA	15.22	15.41	6.29	090
32225		A	Partial release of lung	16.75	NA	NA	9.52	9.54	3.91	090
3230F		I	Note hring tst w/in 6 mon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32310		A	Removal of chest lining	15.28	NA	NA	8.82	8.90	3.61	090
32320		A	Free/remove chest lining	27.25	NA	NA	14.95	14.96	6.31	090
32400		A	Needle biopsy chest lining	1.76	2.31	2.49	0.65	0.69	0.18	000
32402		A	Open biopsy chest lining	8.97	NA	NA	6.06	6.11	2.02	090
32405		A	Biopsy lung or mediastinum	1.93	0.71	0.81	0.71	0.80	0.18	000
32420		A	Puncture/clear lung	2.18	NA	NA	0.82	0.88	0.24	000
32421		A	Thoracentesis for aspiration	1.54	2.66	2.90	0.59	0.60	0.14	000
32422		A	Thoracentesis w/tube insert	2.19	3.14	3.40	1.20	1.27	0.22	000
32440		A	Removal of lung	27.28	NA	NA	13.89	14.26	6.34	090
32442		A	Sleeve pneumonectomy	56.47	NA	NA	23.22	22.80	4.24	090
32445		A	Removal of lung	63.84	NA	NA	28.23	27.39	14.91	090
32480		A	Partial removal of lung	25.82	NA	NA	13.16	13.44	6.04	090
32482		A	Bilobectomy	27.44	NA	NA	14.32	14.59	6.41	090
32484		A	Segmentectomy	25.38	NA	NA	12.39	12.64	5.89	090
32486		A	Sleeve lobectomy	42.88	NA	NA	18.67	18.64	10.12	090
32488		A	Completion pneumonectomy	42.99	NA	NA	19.86	19.60	10.09	090
32491		R	Lung volume reduction	25.24	NA	NA	13.53	14.05	5.87	090
32500		A	Partial removal of lung	24.64	NA	NA	13.18	13.50	5.79	090
32501		A	Repair bronchus add-on	4.68	NA	NA	1.70	1.77	1.09	ZZZ
32503		A	Resect apical lung tumor	31.74	NA	NA	15.61	15.99	7.48	090
32504		A	Resect apical lung tum/chest	36.54	NA	NA	16.88	17.75	8.50	090
32540		A	Removal of lung lesion	30.35	NA	NA	14.85	14.72	7.09	090

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32550		A	Insert pleural cath	4.17	17.51	18.65	1.86	1.94	0.69	000
32551		A	Insertion of chest tube	3.29	NA	NA	1.30	1.34	0.52	000
32552		A	Remove lung catheter	2.53	2.43	2.43	1.76	1.76	0.60	010
32553		A	Ins mark thor for rt perq	3.80	13.63	13.63	1.54	1.54	0.88	000
32560		A	Treat pleurodesis w/agent	1.54	5.21	5.89	0.57	0.68	0.27	000
32561		A	Lyse chest fibrin init day	1.39	1.21	1.21	0.51	0.51	0.24	000
32562		A	Lyse chest fibrin subq day	1.24	1.08	1.08	0.46	0.46	0.23	000
32601		A	Thoracoscopy diagnostic	5.45	NA	NA	2.64	2.70	1.26	000
32602		A	Thoracoscopy diagnostic	5.95	NA	NA	2.83	2.89	1.36	000
32603		A	Thoracoscopy diagnostic	7.80	NA	NA	3.43	3.56	1.94	000
32604		A	Thoracoscopy diagnostic	8.77	NA	NA	3.77	3.97	2.04	000
32605		A	Thoracoscopy diagnostic	6.92	NA	NA	3.12	3.20	1.62	000
32606		A	Thoracoscopy diagnostic	8.39	NA	NA	3.72	3.83	1.93	000
32650		A	Thoracoscopy surgical	10.83	NA	NA	6.81	6.97	2.47	090
32651		A	Thoracoscopy surgical	18.78	NA	NA	10.11	9.89	4.30	090
32652		A	Thoracoscopy surgical	29.13	NA	NA	14.43	14.23	6.71	090
32653		A	Thoracoscopy surgical	18.17	NA	NA	9.63	9.49	4.11	090
32654		A	Thoracoscopy surgical	20.52	NA	NA	10.46	10.31	4.64	090
32655		A	Thoracoscopy surgical	16.17	NA	NA	9.03	8.98	3.76	090
32656		A	Thoracoscopy surgical	13.26	NA	NA	7.83	8.00	3.00	090
32657		A	Thoracoscopy surgical	12.93	NA	NA	7.81	7.98	3.03	090
32658		A	Thoracoscopy surgical	11.71	NA	NA	7.02	7.35	2.74	090
32659		A	Thoracoscopy surgical	11.94	NA	NA	7.37	7.61	2.80	090
32660		A	Thoracoscopy surgical	17.77	NA	NA	9.35	9.71	4.44	090
32661		A	Thoracoscopy surgical	13.33	NA	NA	7.59	7.91	3.12	090
32662		A	Thoracoscopy surgical	14.99	NA	NA	8.52	8.82	3.49	090
32663		A	Thoracoscopy surgical	24.64	NA	NA	12.02	12.29	5.73	090
32664		A	Thoracoscopy surgical	14.28	NA	NA	7.93	8.16	3.35	090

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32665		A	Thoracoscopy surgical	21.53	NA	NA	10.68	10.75	4.59	090
3268F		I	Psa/t/glsc docd b/4 txmnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32800		A	Repair lung hernia	15.71	NA	NA	9.02	9.05	3.68	090
32810		A	Close chest after drainage	14.95	NA	NA	8.69	8.88	3.50	090
32815		A	Close bronchial fistula	50.03	NA	NA	23.31	22.44	11.87	090
32820		A	Reconstruct injured chest	22.51	NA	NA	12.33	12.92	5.27	090
32850		X	Donor pneumonectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32851		A	Lung transplant single	41.61	NA	NA	26.31	27.34	9.78	090
32852		A	Lung transplant with bypass	45.48	NA	NA	29.61	30.99	10.63	090
32853		A	Lung transplant double	50.78	NA	NA	29.61	30.85	11.99	090
32854		A	Lung transplant with bypass	54.74	NA	NA	33.44	34.83	12.87	090
32855		C	Prepare donor lung single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32856		C	Prepare donor lung double	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32900		A	Removal of rib(s)	23.81	NA	NA	13.12	12.75	5.47	090
32905		A	Revise & repair chest wall	23.29	NA	NA	11.64	11.94	5.43	090
32906		A	Revise & repair chest wall	29.30	NA	NA	13.76	14.20	6.86	090
3290F		I	Pt=d(rh)- and unsensitized	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3291F		I	Pt=d(rh)+ or sensitized	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3292F		I	Hiv tstng asked/docd/revwd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3293F		I	Abo rh blood typing docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32940		A	Revision of lung	21.34	NA	NA	11.04	11.13	5.00	090
3294F		I	Grp b strep screening docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32960		A	Therapeutic pneumothorax	1.84	1.76	1.92	0.83	0.86	0.42	000
32997		A	Total lung lavage	7.31	NA	NA	2.43	2.36	0.91	000
32998		A	Perq rf ablate tx pul tumor	5.68	74.39	79.04	2.22	2.55	0.60	000
32999		C	Chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
33010		A	Drainage of heart sac	2.24	NA	NA	0.84	1.03	0.45	000
33011		A	Repeat drainage of heart sac	2.24	NA	NA	0.87	1.00	0.49	000

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33015		A	Incision of heart sac	8.52	NA	NA	4.80	5.64	1.67	090
33020		A	Incision of heart sac	14.95	NA	NA	8.21	8.28	3.50	090
33025		A	Incision of heart sac	13.70	NA	NA	7.36	7.52	3.25	090
33030		A	Partial removal of heart sac	22.39	NA	NA	11.60	11.71	5.31	090
33031		A	Partial removal of heart sac	25.38	NA	NA	12.13	12.40	6.10	090
33050		A	Removal of heart sac lesion	16.97	NA	NA	9.66	9.64	3.97	090
33120		A	Removal of heart lesion	27.45	NA	NA	13.32	13.68	6.56	090
33130		A	Removal of heart lesion	24.17	NA	NA	11.95	12.27	6.03	090
33140		A	Heart revascularize (tmr)	28.34	NA	NA	13.06	13.45	7.06	090
33141		A	Heart tmr w/other procedure	2.54	NA	NA	0.93	1.09	0.61	ZZZ
3317F		I	Path rpt malig cancer docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3318F		I	Path rpt malig cancer docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33202		A	Insert epicard eltrd open	13.20	NA	NA	7.11	7.43	3.15	090
33203		A	Insert epicard eltrd endo	13.97	NA	NA	6.99	7.71	3.27	090
33206		A	Insertion of heart pacemaker	7.39	NA	NA	4.36	5.22	1.62	090
33207		A	Insertion of heart pacemaker	8.05	NA	NA	4.41	5.34	1.77	090
33208		A	Insertion of heart pacemaker	8.77	NA	NA	4.68	5.69	1.91	090
33210		A	Insertion of heart electrode	3.30	NA	NA	1.28	1.61	0.71	000
33211		A	Insertion of heart electrode	3.39	NA	NA	1.30	1.56	0.75	000
33212		A	Insertion of pulse generator	5.52	NA	NA	3.17	3.81	1.21	090
33213		A	Insertion of pulse generator	6.37	NA	NA	3.49	4.26	1.40	090
33214		A	Upgrade of pacemaker system	7.84	NA	NA	4.60	5.48	1.70	090
33215		A	Reposition pacing-defib lead	4.92	NA	NA	2.89	3.52	1.07	090
33216		A	Insert 1 electrode pm-defib	5.87	NA	NA	3.75	4.61	1.28	090
33217		A	Insert 2 electrode pm-defib	5.84	NA	NA	3.77	4.57	1.28	090
33218		A	Repair lead pace-defib one	6.07	NA	NA	4.05	4.87	1.32	090
33220		A	Repair lead pace-defib dual	6.15	NA	NA	4.04	4.88	1.33	090
33222		A	Revise pocket pacemaker	5.10	NA	NA	3.85	4.55	1.14	090

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33223		A	Revise pocket for defib	6.55	NA	NA	4.02	4.94	1.45	090
33224		A	Insert pacing lead & connect	9.04	NA	NA	3.88	4.83	1.98	000
33225		A	L ventric pacing lead add-on	8.33	NA	NA	3.27	4.14	1.82	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	NA	3.77	4.68	1.90	000
33233		A	Removal of pacemaker system	3.39	NA	NA	2.73	3.34	0.73	090
33234		A	Removal of pacemaker system	7.91	NA	NA	4.55	5.54	1.74	090
33235		A	Removal pacemaker electrode	10.15	NA	NA	6.15	7.43	2.24	090
33236		A	Remove electrode/thoracotomy	12.73	NA	NA	7.89	8.19	3.18	090
33237		A	Remove electrode/thoracotomy	13.84	NA	NA	7.61	8.73	3.23	090
33238		A	Remove electrode/thoracotomy	15.40	NA	NA	9.37	9.61	3.68	090
33240		A	Insert pulse generator	7.64	NA	NA	4.13	5.17	1.66	090
33241		A	Remove pulse generator	3.29	NA	NA	2.43	3.03	0.71	090
33243		A	Remove eltrd/thoracotomy	23.57	NA	NA	12.12	13.06	5.55	090
33244		A	Remove eltrd transven	13.99	NA	NA	7.80	9.61	3.10	090
33249		A	Eltrd/insert pace-defib	15.17	NA	NA	7.94	9.88	3.31	090
3324F		I	Mri ct scan ord rvwd rqstd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33250		A	Ablate heart dysrhythm focus	25.90	NA	NA	12.56	12.97	6.45	090
33251		A	Ablate heart dysrhythm focus	28.92	NA	NA	14.16	14.33	6.99	090
33254		A	Ablate atria lmtd	23.71	NA	NA	12.26	12.50	5.91	090
33255		A	Ablate atria w/o bypass ext	29.04	NA	NA	14.03	14.83	7.24	090
33256		A	Ablate atria w/bypass exten	34.90	NA	NA	16.15	17.11	8.73	090
33257		A	Ablate atria lmtd add-on	9.63	NA	NA	5.85	6.02	2.31	ZZZ
33258		A	Ablate atria x10sv add-on	11.00	NA	NA	6.37	6.57	2.62	ZZZ
33259		A	Ablate atria w/bypass add-on	14.14	NA	NA	8.24	8.53	3.42	ZZZ
3325F		I	Preop asses 4 cataract surg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33261		A	Ablate heart dysrhythm focus	28.92	NA	NA	13.48	13.91	7.21	090
33265		A	Ablate atria lmtd endo	23.71	NA	NA	11.88	12.27	5.64	090
33266		A	Ablate atria x10sv endo	33.04	NA	NA	15.29	15.89	7.96	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33282		A	Implant pat-active ht record	4.80	NA	NA	3.45	4.26	1.05	090
33284		A	Remove pat-active ht record	3.14	NA	NA	2.81	3.46	0.68	090
33300		A	Repair of heart wound	44.97	NA	NA	19.25	18.60	10.71	090
33305		A	Repair of heart wound	76.93	NA	NA	30.61	29.61	18.39	090
3330F		I	Imaging study ordered (bkp)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33310		A	Exploratory heart surgery	20.34	NA	NA	10.49	10.77	4.48	090
33315		A	Exploratory heart surgery	26.17	NA	NA	12.74	13.19	6.27	090
3331F		I	Bk imaging tst not ordered	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33320		A	Repair major blood vessel(s)	18.54	NA	NA	9.56	9.82	4.29	090
33321		A	Repair major vessel	20.81	NA	NA	10.60	10.82	4.86	090
33322		A	Repair major blood vessel(s)	24.42	NA	NA	12.31	12.62	5.85	090
33330		A	Insert major vessel graft	25.29	NA	NA	12.22	12.27	6.31	090
33332		A	Insert major vessel graft	24.56	NA	NA	11.80	12.38	6.11	090
33335		A	Insert major vessel graft	33.91	NA	NA	15.64	16.03	8.16	090
33400		A	Repair of aortic valve	41.50	NA	NA	18.58	19.20	9.87	090
33401		A	Valvuloplasty open	24.63	NA	NA	12.38	14.20	5.36	090
33403		A	Valvuloplasty w/cp bypass	25.61	NA	NA	13.29	14.19	6.38	090
33404		A	Prepare heart-aorta conduit	31.37	NA	NA	14.75	15.54	7.32	090
33405		A	Replacement of aortic valve	41.32	NA	NA	18.91	19.74	9.90	090
33406		A	Replacement of aortic valve	52.68	NA	NA	22.74	23.45	12.74	090
33410		A	Replacement of aortic valve	46.41	NA	NA	20.72	21.13	11.12	090
33411		A	Replacement of aortic valve	62.07	NA	NA	26.37	26.58	14.90	090
33412		A	Replacement of aortic valve	43.94	NA	NA	20.21	21.36	10.97	090
33413		A	Replacement of aortic valve	59.87	NA	NA	25.08	26.09	13.99	090
33414		A	Repair of aortic valve	39.37	NA	NA	17.00	17.87	9.82	090
33415		A	Revision subvalvular tissue	37.27	NA	NA	16.36	16.43	8.50	090
33416		A	Revise ventricle muscle	36.56	NA	NA	17.14	17.27	8.79	090
33417		A	Repair of aortic valve	29.33	NA	NA	14.62	15.19	7.02	090

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33420		A	Revision of mitral valve	25.79	NA	NA	15.77	13.70	3.53	090
33422		A	Revision of mitral valve	29.73	NA	NA	14.45	15.01	7.40	090
33425		A	Repair of mitral valve	49.96	NA	NA	22.02	21.72	11.96	090
33426		A	Repair of mitral valve	43.28	NA	NA	19.69	20.29	10.39	090
33427		A	Repair of mitral valve	44.83	NA	NA	19.58	20.54	10.76	090
33430		A	Replacement of mitral valve	50.93	NA	NA	23.15	23.44	12.24	090
33460		A	Revision of tricuspid valve	44.70	NA	NA	18.40	18.62	11.15	090
33463		A	Valvuloplasty tricuspid	57.08	NA	NA	24.26	23.89	13.76	090
33464		A	Valvuloplasty tricuspid	44.62	NA	NA	20.07	19.94	10.71	090
33465		A	Replace tricuspid valve	50.72	NA	NA	21.85	21.63	12.26	090
33468		A	Revision of tricuspid valve	32.94	NA	NA	15.09	16.45	8.23	090
33470		A	Revision of pulmonary valve	21.54	NA	NA	12.51	12.16	5.04	090
33471		A	Valvotomy pulmonary valve	22.96	NA	NA	13.09	12.80	1.62	090
33472		A	Revision of pulmonary valve	23.06	NA	NA	11.09	11.89	1.63	090
33474		A	Revision of pulmonary valve	39.40	NA	NA	17.32	16.77	9.21	090
33475		A	Replacement pulmonary valve	42.40	NA	NA	18.78	19.19	10.58	090
33476		A	Revision of heart chamber	26.57	NA	NA	13.33	13.37	6.63	090
33478		A	Revision of heart chamber	27.54	NA	NA	13.53	14.08	6.87	090
33496		A	Repair prosth valve clot	29.84	NA	NA	14.21	14.68	6.97	090
33500		A	Repair heart vessel fistula	27.94	NA	NA	13.28	13.78	6.97	090
33501		A	Repair heart vessel fistula	19.51	NA	NA	9.91	10.16	4.88	090
33502		A	Coronary artery correction	21.85	NA	NA	11.54	11.93	5.45	090
33503		A	Coronary artery graft	22.51	NA	NA	11.57	13.55	4.92	090
33504		A	Coronary artery graft	25.46	NA	NA	12.85	13.15	6.34	090
33505		A	Repair artery w/tunnel	38.40	NA	NA	15.38	15.72	9.57	090
33506		A	Repair artery translocation	37.85	NA	NA	22.95	20.09	8.85	090
33507		A	Repair art intramural	31.40	NA	NA	13.48	14.32	7.33	090
33508		A	Endoscopic vein harvest	0.31	NA	NA	0.11	0.12	0.07	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33510		A	Cabg vein single	34.98	NA	NA	16.30	17.04	8.39	090
33511		A	Cabg vein two	38.45	NA	NA	17.75	18.51	9.23	090
33512		A	Cabg vein three	43.98	NA	NA	19.81	20.52	10.58	090
33513		A	Cabg vein four	45.37	NA	NA	20.18	20.61	10.95	090
33514		A	Cabg vein five	48.08	NA	NA	21.07	21.84	11.52	090
33516		A	Cabg vein six or more	49.76	NA	NA	21.77	22.71	12.40	090
33517		A	Cabg artery-vein single	3.61	NA	NA	1.32	1.34	0.86	ZZZ
33518		A	Cabg artery-vein two	7.93	NA	NA	2.90	2.89	1.90	ZZZ
33519		A	Cabg artery-vein three	10.49	NA	NA	3.84	3.87	2.51	ZZZ
3351F		I	Neg scrn dep symp by deptool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33521		A	Cabg artery-vein four	12.59	NA	NA	4.62	4.69	3.04	ZZZ
33522		A	Cabg artery-vein five	14.14	NA	NA	5.19	5.32	3.42	ZZZ
33523		A	Cabg art-vein six or more	16.08	NA	NA	5.86	6.04	3.86	ZZZ
3352F		I	No sig dep symp by dep tool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33530		A	Coronary artery bypass/reop	10.13	NA	NA	3.69	3.66	2.42	ZZZ
33533		A	Cabg arterial single	33.75	NA	NA	15.67	16.59	8.11	090
33534		A	Cabg arterial two	39.88	NA	NA	18.26	19.14	9.56	090
33535		A	Cabg arterial three	44.75	NA	NA	20.04	20.91	10.73	090
33536		A	Cabg arterial four or more	48.43	NA	NA	21.42	22.05	11.68	090
3353F		I	Mild-mod dep symp by deptool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33542		A	Removal of heart lesion	48.21	NA	NA	21.14	20.91	11.61	090
33545		A	Repair of heart damage	57.06	NA	NA	24.26	24.18	13.65	090
33548		A	Restore/remodel ventricle	54.14	NA	NA	24.05	24.86	13.08	090
3354F		I	Clin sig dep sym by dep tool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33572		A	Open coronary endarterectomy	4.44	NA	NA	1.62	1.69	1.07	ZZZ
33600		A	Closure of valve	30.31	NA	NA	14.70	15.02	7.06	090
33602		A	Closure of valve	29.34	NA	NA	14.35	14.37	6.23	090
33606		A	Anastomosis/artery-aorta	31.53	NA	NA	17.05	16.53	6.71	090

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33608		A	Repair anomaly w/conduit	31.88	NA	NA	15.25	16.04	7.44	090
33610		A	Repair by enlargement	31.40	NA	NA	14.92	15.52	7.33	090
33611		A	Repair double ventricle	35.57	NA	NA	15.42	16.11	8.88	090
33612		A	Repair double ventricle	36.57	NA	NA	15.60	16.25	7.96	090
33615		A	Repair modified fontan	35.89	NA	NA	16.28	17.33	8.39	090
33617		A	Repair single ventricle	39.09	NA	NA	17.45	17.80	9.14	090
33619		A	Repair single ventricle	48.76	NA	NA	25.83	23.73	11.39	090
33620		A	Apply r&l pulm art bands	30.00	NA	NA	13.45	13.45	7.48	090
33621		A	Transthor cath for stent	16.18	NA	NA	7.42	7.42	3.75	090
33622		A	Redo compl cardiac anomaly	64.00	NA	NA	28.32	28.32	14.94	090
33641		A	Repair heart septum defect	29.58	NA	NA	13.82	13.76	7.10	090
33645		A	Revision of heart veins	28.10	NA	NA	13.24	13.79	7.01	090
33647		A	Repair heart septum defects	29.53	NA	NA	14.42	15.37	7.36	090
33660		A	Repair of heart defects	31.83	NA	NA	20.12	17.63	7.94	090
33665		A	Repair of heart defects	34.85	NA	NA	15.17	15.81	8.72	090
33670		A	Repair of heart chambers	36.63	NA	NA	14.84	15.51	9.15	090
33675		A	Close mult vsd	35.95	NA	NA	15.43	16.06	8.96	090
33676		A	Close mult vsd w/resection	36.95	NA	NA	18.64	18.20	2.62	090
33677		A	Cl mult vsd w/rem pul band	38.45	NA	NA	13.42	15.85	2.73	090
33681		A	Repair heart septum defect	32.34	NA	NA	16.22	16.53	7.78	090
33684		A	Repair heart septum defect	34.37	NA	NA	15.00	15.64	8.58	090
33688		A	Repair heart septum defect	34.75	NA	NA	14.27	14.62	8.68	090
33690		A	Reinforce pulmonary artery	20.36	NA	NA	13.26	12.34	4.75	090
33692		A	Repair of heart defects	31.54	NA	NA	16.34	15.97	2.23	090
33694		A	Repair of heart defects	35.57	NA	NA	15.26	16.25	8.88	090
33697		A	Repair of heart defects	37.57	NA	NA	16.42	18.60	8.18	090
33702		A	Repair of heart defects	27.24	NA	NA	13.26	13.58	6.79	090
33710		A	Repair of heart defects	30.41	NA	NA	14.23	17.10	7.10	090

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33720		A	Repair of heart defect	27.26	NA	NA	13.13	13.77	6.37	090
33722		A	Repair of heart defect	29.21	NA	NA	15.31	14.59	7.28	090
33724		A	Repair venous anomaly	27.63	NA	NA	12.59	13.55	6.44	090
33726		A	Repair pul venous stenosis	37.12	NA	NA	19.38	18.61	9.26	090
33730		A	Repair heart-vein defect(s)	36.14	NA	NA	16.11	16.00	9.03	090
33732		A	Repair heart-vein defect	28.96	NA	NA	14.22	14.75	7.22	090
33735		A	Revision of heart chamber	22.20	NA	NA	11.71	11.97	5.55	090
33736		A	Revision of heart chamber	24.32	NA	NA	12.45	12.92	6.06	090
33737		A	Revision of heart chamber	22.47	NA	NA	11.46	11.94	5.26	090
33750		A	Major vessel shunt	22.22	NA	NA	9.54	12.15	7.96	090
33755		A	Major vessel shunt	22.60	NA	NA	11.97	12.01	4.93	090
33762		A	Major vessel shunt	22.60	NA	NA	12.40	12.24	1.60	090
33764		A	Major vessel shunt & graft	22.60	NA	NA	13.22	12.40	4.82	090
33766		A	Major vessel shunt	23.57	NA	NA	11.20	12.60	5.12	090
33767		A	Major vessel shunt	25.30	NA	NA	11.93	12.10	6.31	090
33768		A	Cavopulmonary shunting	8.00	NA	NA	3.52	3.41	0.56	ZZZ
33770		A	Repair great vessels defect	39.07	NA	NA	16.01	16.85	9.14	090
33771		A	Repair great vessels defect	40.63	NA	NA	19.37	18.49	2.89	090
33774		A	Repair great vessels defect	31.73	NA	NA	15.24	15.95	7.92	090
33775		A	Repair great vessels defect	32.99	NA	NA	17.69	17.53	2.32	090
33776		A	Repair great vessels defect	34.75	NA	NA	18.80	18.61	2.44	090
33777		A	Repair great vessels defect	34.17	NA	NA	12.35	14.86	2.42	090
33778		A	Repair great vessels defect	42.75	NA	NA	21.70	21.23	3.04	090
33779		A	Repair great vessels defect	43.23	NA	NA	20.79	20.17	3.08	090
33780		A	Repair great vessels defect	43.90	NA	NA	21.28	21.16	3.12	090
33781		A	Repair great vessels defect	43.21	NA	NA	20.50	19.60	3.08	090
33782		A	Nikaidoh proc	60.08	NA	NA	24.13	24.13	14.04	090
33783		A	Nikaidoh proc w/ostia implt	65.08	NA	NA	25.90	25.90	15.21	090

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33786		A	Repair arterial trunk	41.87	NA	NA	17.34	18.35	2.97	090
33788		A	Revision of pulmonary artery	27.42	NA	NA	12.54	13.31	1.93	090
33800		A	Aortic suspension	17.28	NA	NA	8.52	8.63	4.30	090
33802		A	Repair vessel defect	18.37	NA	NA	12.01	11.06	4.59	090
33803		A	Repair vessel defect	20.31	NA	NA	9.72	9.82	5.07	090
33813		A	Repair septal defect	21.36	NA	NA	12.39	13.08	5.00	090
33814		A	Repair septal defect	26.57	NA	NA	13.24	13.78	6.63	090
33820		A	Revise major vessel	16.69	NA	NA	8.75	9.20	4.17	090
33822		A	Revise major vessel	17.71	NA	NA	10.14	10.13	1.25	090
33824		A	Revise major vessel	20.23	NA	NA	11.86	11.60	4.73	090
33840		A	Remove aorta constriction	21.34	NA	NA	13.30	12.15	5.32	090
33845		A	Remove aorta constriction	22.93	NA	NA	11.96	13.07	5.72	090
33851		A	Remove aorta constriction	21.98	NA	NA	18.50	15.17	5.47	090
33852		A	Repair septal defect	24.41	NA	NA	11.82	12.46	6.08	090
33853		A	Repair septal defect	32.51	NA	NA	15.31	16.78	8.12	090
33860		A	Ascending aortic graft	59.46	NA	NA	25.09	25.17	14.22	090
33863		A	Ascending aortic graft	58.79	NA	NA	24.02	24.63	14.04	090
33864		A	Ascending aortic graft	60.08	NA	NA	24.42	25.40	14.29	090
33870		A	Transverse aortic arch graft	46.06	NA	NA	20.09	20.96	10.97	090
33875		A	Thoracic aortic graft	35.78	NA	NA	17.19	17.15	8.53	090
33877		A	Thoracoabdominal graft	69.03	NA	NA	26.65	26.29	16.31	090
33880		A	Endovasc taa repr incl subcl	34.58	NA	NA	13.65	14.38	7.70	090
33881		A	Endovasc taa repr w/o subcl	29.58	NA	NA	12.01	12.58	6.59	090
33883		A	Insert endovasc prosth taa	21.09	NA	NA	9.15	9.55	4.69	090
33884		A	Endovasc prosth taa add-on	8.20	NA	NA	2.77	2.84	1.83	ZZZ
33886		A	Endovasc prosth delayed	18.09	NA	NA	7.98	8.30	4.29	090
33889		A	Artery transpose/endovas taa	15.92	NA	NA	5.48	5.51	3.78	000
33891		A	Car-car bp grft/endovas taa	20.00	NA	NA	5.96	6.38	4.74	000

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33910		A	Remove lung artery emboli	29.71	NA	NA	14.31	14.65	7.40	090
33915		A	Remove lung artery emboli	24.95	NA	NA	11.15	11.45	5.43	090
33916		A	Surgery of great vessel	28.42	NA	NA	13.31	14.99	7.09	090
33917		A	Repair pulmonary artery	25.30	NA	NA	12.92	14.15	5.91	090
33920		A	Repair pulmonary atresia	32.74	NA	NA	14.56	15.21	8.16	090
33922		A	Transect pulmonary artery	24.22	NA	NA	12.07	12.47	6.04	090
33924		A	Remove pulmonary shunt	5.49	NA	NA	1.92	2.00	1.28	ZZZ
33925		A	Rpr pul art unifocal w/o cpb	31.30	NA	NA	13.59	14.66	7.31	090
33926		A	Repr pul art unifocal w/cpb	44.73	NA	NA	26.84	22.00	11.15	090
33930		X	Removal of donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33933		C	Prepare donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33935		R	Transplantation heart/lung	62.01	NA	NA	28.00	29.37	15.47	090
33940		X	Removal of donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33944		C	Prepare donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33945		R	Transplantation of heart	89.50	NA	NA	37.49	37.17	21.29	090
33960		A	External circulation assist	19.33	NA	NA	7.13	7.11	3.82	000
33961		A	External circulation assist	10.91	NA	NA	4.01	4.14	1.66	ZZZ
33967		A	Insert ia percut device	4.84	NA	NA	1.88	2.35	1.07	000
33968		A	Remove aortic assist device	0.64	NA	NA	0.25	0.29	0.14	000
33970		A	Aortic circulation assist	6.74	NA	NA	2.50	2.85	1.56	000
33971		A	Aortic circulation assist	11.99	NA	NA	6.73	7.23	2.80	090
33973		A	Insert balloon device	9.75	NA	NA	3.67	4.19	2.25	000
33974		A	Remove intra-aortic balloon	15.03	NA	NA	7.93	8.98	3.76	090
33975		A	Implant ventricular device	20.97	NA	NA	7.65	8.02	4.98	XXX
33976		A	Implant ventricular device	22.97	NA	NA	8.15	9.00	5.73	XXX
33977		A	Remove ventricular device	20.28	NA	NA	11.42	11.98	4.81	090
33978		A	Remove ventricular device	22.72	NA	NA	12.48	12.80	5.68	090
33979		A	Insert intracorporeal device	45.93	NA	NA	16.48	17.38	10.97	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33980		A	Remove intracorporeal device	65.20	NA	NA	29.84	30.70	15.70	090
33981		C	Replace vad pump ext	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33982		C	Replace vad intra w/o bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33983		C	Replace vad intra w/bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33999		C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
34001		A	Removal of artery clot	17.88	NA	NA	8.85	8.63	4.06	090
34051		A	Removal of artery clot	16.99	NA	NA	9.11	9.20	4.24	090
34101		A	Removal of artery clot	10.93	NA	NA	5.68	5.71	2.46	090
34111		A	Removal of arm artery clot	10.93	NA	NA	5.69	5.72	2.43	090
34151		A	Removal of artery clot	26.52	NA	NA	11.80	11.63	5.96	090
34201		A	Removal of artery clot	19.48	NA	NA	8.80	8.40	4.47	090
34203		A	Removal of leg artery clot	17.86	NA	NA	8.46	8.55	4.10	090
34401		A	Removal of vein clot	26.52	NA	NA	14.59	13.96	5.65	090
34421		A	Removal of vein clot	13.37	NA	NA	6.86	6.89	2.96	090
34451		A	Removal of vein clot	28.52	NA	NA	10.36	11.42	6.76	090
34471		A	Removal of vein clot	21.11	NA	NA	12.23	10.45	4.49	090
34490		A	Removal of vein clot	10.91	NA	NA	6.05	5.97	2.42	090
34501		A	Repair valve femoral vein	16.85	NA	NA	7.51	8.27	3.99	090
34502		A	Reconstruct vena cava	28.07	NA	NA	13.17	13.50	5.88	090
3450F		I	Dyspnea scrnd no-mild dysp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34510		A	Transposition of vein valve	19.91	NA	NA	11.72	10.67	4.22	090
3451F		I	Dyspnea scrnd mod-high dysp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34520		A	Cross-over vein graft	19.18	NA	NA	7.69	8.38	4.54	090
3452F		I	Dyspnea not screened	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34530		A	Leg vein fusion	17.93	NA	NA	7.62	8.33	3.82	090
34800		A	Endovas aaa repr w/sm tube	21.54	NA	NA	9.05	9.56	4.56	090
34802		A	Endovas aaa repr w/2-p part	23.79	NA	NA	10.13	10.54	5.08	090
34803		A	Endovas aaa repr w/3-p part	24.82	NA	NA	10.22	10.57	5.32	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
34804		A	Endovas aaa repr w/1-p part	23.79	NA	NA	10.12	10.53	5.13	090
34805		A	Endovas aaa repr w/long tube	22.67	NA	NA	9.62	9.81	5.02	090
34806		A	Aneurysm press sensor add-on	2.06	NA	NA	0.70	0.74	0.45	ZZZ
34808		A	Endovas iliac a device addon	4.12	NA	NA	1.42	1.44	0.90	ZZZ
34812		A	Xpose for endoprosth femorl	6.74	NA	NA	2.34	2.34	1.55	000
34813		A	Femoral endovas graft add-on	4.79	NA	NA	1.61	1.62	1.10	ZZZ
34820		A	Xpose for endoprosth iliac	9.74	NA	NA	3.35	3.40	2.17	000
34825		A	Endovasc extend prosth init	12.80	NA	NA	6.28	6.56	2.74	090
34826		A	Endovasc exten prosth addl	4.12	NA	NA	1.44	1.49	0.88	ZZZ
34830		A	Open aortic tube prosth repr	35.23	NA	NA	12.45	13.50	8.34	090
34831		A	Open aortoiliac prosth repr	37.98	NA	NA	13.27	13.91	9.00	090
34832		A	Open aortofemor prosth repr	37.98	NA	NA	13.27	14.39	9.00	090
34833		A	Xpose for endoprosth iliac	11.98	NA	NA	4.39	4.50	2.78	000
34834		A	Xpose endoprosth brachial	5.34	NA	NA	2.05	2.13	1.24	000
34900		A	Endovasc iliac repr w/graft	16.85	NA	NA	7.63	7.96	3.57	090
3491F		I	Hiv unsure baby of hiv+moms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3497F		I	Cd4+ cell percentage <15%	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3498F		I	Cd4+ cell % >=15% (hiv)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35001		A	Repair defect of artery	20.81	NA	NA	9.72	10.04	4.81	090
35002		A	Repair artery rupture neck	22.23	NA	NA	8.56	9.56	4.74	090
35005		A	Repair defect of artery	19.29	NA	NA	11.57	10.79	4.56	090
35011		A	Repair defect of artery	18.58	NA	NA	8.69	8.66	4.21	090
35013		A	Repair artery rupture arm	23.23	NA	NA	11.14	10.86	5.27	090
35021		A	Repair defect of artery	22.17	NA	NA	8.77	9.97	5.19	090
35022		A	Repair artery rupture chest	25.70	NA	NA	12.15	12.04	6.00	090
35045		A	Repair defect of arm artery	18.01	NA	NA	9.18	8.83	3.99	090
35081		A	Repair defect of artery	33.53	NA	NA	14.43	14.20	7.75	090
35082		A	Repair artery rupture aorta	42.09	NA	NA	17.73	17.46	9.64	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
35091		A	Repair defect of artery	35.35	NA	NA	13.38	13.67	8.18	090
35092		A	Repair artery rupture aorta	50.97	NA	NA	19.71	19.70	11.76	090
35102		A	Repair defect of artery	36.53	NA	NA	15.07	14.96	8.43	090
35103		A	Repair artery rupture groin	43.62	NA	NA	17.35	17.39	9.97	090
3510F		I	Doc tb scrng-rslts interpd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35111		A	Repair defect of artery	26.28	NA	NA	14.49	13.07	5.59	090
35112		A	Repair artery rupture spleen	32.57	NA	NA	17.39	15.66	6.93	090
35121		A	Repair defect of artery	31.52	NA	NA	13.64	13.42	7.24	090
35122		A	Repair artery rupture belly	37.89	NA	NA	13.25	14.56	8.07	090
35131		A	Repair defect of artery	26.40	NA	NA	11.59	11.67	6.08	090
35132		A	Repair artery rupture groin	32.57	NA	NA	11.66	12.62	7.43	090
3513F		I	Hep b scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35141		A	Repair defect of artery	20.91	NA	NA	9.33	9.39	4.82	090
35142		A	Repair artery rupture thigh	25.16	NA	NA	11.01	11.13	5.77	090
3514F		I	Hep c scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35151		A	Repair defect of artery	23.72	NA	NA	10.39	10.46	5.46	090
35152		A	Repair artery rupture knee	27.66	NA	NA	10.19	11.19	6.56	090
3515F		I	Pt has docd immun to hep c	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35180		A	Repair blood vessel lesion	15.10	NA	NA	11.40	10.13	3.57	090
35182		A	Repair blood vessel lesion	31.71	NA	NA	14.79	15.02	6.75	090
35184		A	Repair blood vessel lesion	18.82	NA	NA	9.32	9.10	4.01	090
35188		A	Repair blood vessel lesion	15.16	NA	NA	6.46	7.33	3.23	090
35189		A	Repair blood vessel lesion	29.98	NA	NA	16.26	14.75	7.48	090
35190		A	Repair blood vessel lesion	13.42	NA	NA	7.14	7.08	3.06	090
35201		A	Repair blood vessel lesion	16.93	NA	NA	8.80	8.70	3.75	090
35206		A	Repair blood vessel lesion	13.84	NA	NA	7.40	7.23	3.06	090
35207		A	Repair blood vessel lesion	10.94	NA	NA	9.89	9.23	1.93	090
35211		A	Repair blood vessel lesion	24.58	NA	NA	12.05	12.31	5.89	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
35216		A	Repair blood vessel lesion	36.61	NA	NA	17.94	16.99	8.62	090
35221		A	Repair blood vessel lesion	26.62	NA	NA	12.27	11.77	5.81	090
35226		A	Repair blood vessel lesion	15.30	NA	NA	7.39	7.59	3.52	090
35231		A	Repair blood vessel lesion	21.16	NA	NA	11.52	11.19	4.16	090
35236		A	Repair blood vessel lesion	18.02	NA	NA	8.72	8.65	3.98	090
35241		A	Repair blood vessel lesion	25.58	NA	NA	13.28	13.19	6.29	090
35246		A	Repair blood vessel lesion	28.23	NA	NA	10.48	12.05	6.68	090
35251		A	Repair blood vessel lesion	31.91	NA	NA	13.98	13.46	6.98	090
35256		A	Repair blood vessel lesion	19.06	NA	NA	8.63	8.72	4.35	090
35261		A	Repair blood vessel lesion	18.96	NA	NA	9.55	9.44	4.63	090
35266		A	Repair blood vessel lesion	15.83	NA	NA	7.75	7.71	3.61	090
35271		A	Repair blood vessel lesion	24.58	NA	NA	12.06	12.29	6.12	090
35276		A	Repair blood vessel lesion	25.83	NA	NA	12.60	12.81	6.03	090
35281		A	Repair blood vessel lesion	30.06	NA	NA	13.73	13.35	6.78	090
35286		A	Repair blood vessel lesion	17.19	NA	NA	8.42	8.50	3.95	090
35301		A	Rechanneling of artery	19.61	NA	NA	9.07	9.08	4.55	090
35302		A	Rechanneling of artery	21.35	NA	NA	9.42	9.19	4.92	090
35303		A	Rechanneling of artery	23.60	NA	NA	10.44	10.09	5.42	090
35304		A	Rechanneling of artery	24.60	NA	NA	10.51	10.27	5.64	090
35305		A	Rechanneling of artery	23.60	NA	NA	10.31	10.00	5.42	090
35306		A	Rechanneling of artery	9.25	NA	NA	4.04	3.51	2.19	ZZZ
35311		A	Rechanneling of artery	28.60	NA	NA	12.27	12.50	6.68	090
35321		A	Rechanneling of artery	16.59	NA	NA	7.86	7.87	3.76	090
35331		A	Rechanneling of artery	27.72	NA	NA	12.17	12.32	6.42	090
35341		A	Rechanneling of artery	26.21	NA	NA	10.93	11.19	6.04	090
35351		A	Rechanneling of artery	24.61	NA	NA	10.53	10.49	5.64	090
35355		A	Rechanneling of artery	19.86	NA	NA	8.57	8.64	4.55	090
35361		A	Rechanneling of artery	30.24	NA	NA	10.97	11.94	7.17	090

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35363		A	Rechanneling of artery	32.35	NA	NA	14.32	14.63	7.55	090
35371		A	Rechanneling of artery	15.31	NA	NA	7.27	7.27	3.52	090
35372		A	Rechanneling of artery	18.58	NA	NA	8.30	8.35	4.25	090
35390		A	Reoperation carotid add-on	3.19	NA	NA	1.11	1.13	0.73	ZZZ
35400		A	Angioscopy	3.00	NA	NA	1.01	1.06	0.68	ZZZ
35450		A	Repair arterial blockage	10.05	NA	NA	3.82	3.93	2.24	000
35452		A	Repair arterial blockage	6.90	NA	NA	2.79	2.82	1.58	000
35458		A	Repair arterial blockage	9.48	NA	NA	3.80	3.79	2.13	000
35460		A	Repair venous blockage	6.03	NA	NA	2.54	2.48	1.32	000
35471		A	Repair arterial blockage	10.05	61.23	75.23	3.99	4.80	1.98	000
35472		A	Repair arterial blockage	6.90	47.73	54.85	2.80	3.11	1.44	000
35475		R	Repair arterial blockage	9.48	54.18	57.58	3.77	4.09	1.52	000
35476		A	Repair venous blockage	6.03	42.38	44.97	2.52	2.71	0.83	000
35500		A	Harvest vein for bypass	6.44	NA	NA	2.22	2.22	1.49	ZZZ
35501		A	Artery bypass graft	29.09	NA	NA	14.28	13.94	6.68	090
35506		A	Artery bypass graft	25.33	NA	NA	10.73	11.04	6.00	090
35508		A	Artery bypass graft	26.09	NA	NA	12.33	12.16	6.50	090
35509		A	Artery bypass graft	28.09	NA	NA	12.03	12.47	6.65	090
3550F		I	Low rsk thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35510		A	Artery bypass graft	24.39	NA	NA	8.96	9.86	5.77	090
35511		A	Artery bypass graft	22.20	NA	NA	12.98	11.67	5.27	090
35512		A	Artery bypass graft	23.89	NA	NA	8.81	9.57	5.66	090
35515		A	Artery bypass graft	26.09	NA	NA	9.97	10.17	6.18	090
35516		A	Artery bypass graft	24.21	NA	NA	8.86	9.07	5.73	090
35518		A	Artery bypass graft	22.65	NA	NA	8.30	9.33	5.36	090
3551F		I	Intrmed rsk thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35521		A	Artery bypass graft	24.13	NA	NA	13.70	12.21	5.72	090
35522		A	Artery bypass graft	23.15	NA	NA	10.18	10.25	5.47	090

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35523		A	Artery bypass graft	24.13	NA	NA	10.87	11.19	5.47	090
35525		A	Artery bypass graft	21.69	NA	NA	9.80	9.71	4.82	090
35526		A	Artery bypass graft	31.55	NA	NA	11.39	12.81	7.88	090
3552F		I	Hgh risk for thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35531		A	Artery bypass graft	39.11	NA	NA	16.23	16.14	8.89	090
35533		A	Artery bypass graft	29.92	NA	NA	16.23	14.66	7.09	090
35535		A	Artery bypass graft	38.13	NA	NA	13.36	15.00	2.70	090
35536		A	Artery bypass graft	33.73	NA	NA	12.01	12.85	8.00	090
35537		A	Artery bypass graft	41.88	NA	NA	21.58	19.29	9.91	090
35538		A	Artery bypass graft	47.03	NA	NA	23.88	21.52	11.14	090
35539		A	Artery bypass graft	44.11	NA	NA	15.18	16.03	10.46	090
35540		A	Artery bypass graft	49.33	NA	NA	20.98	20.01	11.33	090
35548		A	Artery bypass graft	22.68	NA	NA	8.70	9.51	5.38	090
35549		A	Artery bypass graft	24.45	NA	NA	16.12	13.81	5.20	090
35551		A	Artery bypass graft	27.83	NA	NA	15.30	14.19	5.93	090
35556		A	Artery bypass graft	26.75	NA	NA	11.67	11.51	6.12	090
35558		A	Artery bypass graft	23.13	NA	NA	10.84	10.70	5.32	090
3555F		I	Pt inr measurement performed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35560		A	Artery bypass graft	34.03	NA	NA	12.09	13.27	8.07	090
35563		A	Artery bypass graft	26.12	NA	NA	9.74	10.46	6.18	090
35565		A	Artery bypass graft	25.13	NA	NA	11.05	11.11	5.73	090
35566		A	Artery bypass graft	32.35	NA	NA	13.52	13.35	7.48	090
35570		A	Artery bypass graft	29.15	NA	NA	10.78	12.10	2.06	090
35571		A	Artery bypass graft	25.52	NA	NA	10.97	11.09	5.88	090
35572		A	Harvest femoropopliteal vein	6.81	NA	NA	2.48	2.55	1.59	ZZZ
35583		A	Vein bypass graft	27.75	NA	NA	12.03	11.81	6.34	090
35585		A	Vein bypass graft	32.35	NA	NA	13.82	13.64	7.39	090
35587		A	Vein bypass graft	26.21	NA	NA	11.71	11.71	6.03	090

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35600		A	Harvest art for cabg add-on	4.94	NA	NA	1.85	1.93	1.20	ZZZ
35601		A	Artery bypass graft	27.09	NA	NA	13.27	12.83	6.33	090
35606		A	Artery bypass graft	22.46	NA	NA	9.63	9.74	5.24	090
35612		A	Artery bypass graft	16.82	NA	NA	6.95	7.82	3.99	090
35616		A	Artery bypass graft	21.82	NA	NA	12.05	10.71	4.64	090
35621		A	Artery bypass graft	21.03	NA	NA	9.11	9.17	4.86	090
35623		A	Bypass graft not vein	25.92	NA	NA	14.48	12.93	6.12	090
35626		A	Artery bypass graft	29.14	NA	NA	12.90	13.25	6.97	090
35631		A	Artery bypass graft	36.03	NA	NA	14.15	14.35	8.41	090
35632		A	Artery bypass graft	36.13	NA	NA	12.77	14.33	2.57	090
35633		A	Artery bypass graft	39.11	NA	NA	15.07	16.05	2.77	090
35634		A	Artery bypass graft	35.33	NA	NA	13.58	14.60	2.50	090
35636		A	Artery bypass graft	31.75	NA	NA	17.03	15.29	7.52	090
35637		A	Artery bypass graft	33.05	NA	NA	14.03	13.78	7.63	090
35638		A	Artery bypass graft	33.60	NA	NA	14.49	14.27	7.81	090
35642		A	Artery bypass graft	18.94	NA	NA	11.94	10.93	4.48	090
35645		A	Artery bypass graft	18.43	NA	NA	10.91	9.72	4.60	090
35646		A	Artery bypass graft	32.98	NA	NA	13.93	14.04	7.58	090
35647		A	Artery bypass graft	29.73	NA	NA	12.96	12.96	6.89	090
35650		A	Artery bypass graft	20.16	NA	NA	9.29	9.20	4.59	090
35651		A	Artery bypass graft	26.08	NA	NA	9.72	10.81	5.57	090
35654		A	Artery bypass graft	26.28	NA	NA	11.35	11.38	6.06	090
35656		A	Artery bypass graft	20.47	NA	NA	9.27	9.27	4.70	090
35661		A	Artery bypass graft	20.35	NA	NA	9.51	9.55	4.69	090
35663		A	Artery bypass graft	23.93	NA	NA	10.28	10.49	5.46	090
35665		A	Artery bypass graft	22.35	NA	NA	9.86	9.95	5.11	090
35666		A	Artery bypass graft	23.66	NA	NA	11.29	11.36	5.43	090
35671		A	Artery bypass graft	20.77	NA	NA	10.00	10.10	4.77	090

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35681		A	Composite bypass graft	1.60	NA	NA	0.56	0.56	0.37	ZZZ
35682		A	Composite bypass graft	7.19	NA	NA	2.38	2.42	1.66	ZZZ
35683		A	Composite bypass graft	8.49	NA	NA	2.53	2.71	2.00	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	NA	1.38	1.38	0.92	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	NA	1.13	1.17	0.75	ZZZ
35691		A	Arterial transposition	18.41	NA	NA	7.25	7.97	4.36	090
35693		A	Arterial transposition	15.73	NA	NA	7.04	7.78	3.73	090
35694		A	Arterial transposition	19.28	NA	NA	8.56	8.62	4.56	090
35695		A	Arterial transposition	20.06	NA	NA	7.75	8.42	4.75	090
35697		A	Reimplant artery each	3.00	NA	NA	1.02	1.04	0.69	ZZZ
35700		A	Reoperation bypass graft	3.08	NA	NA	1.07	1.08	0.71	ZZZ
35701		A	Exploration carotid artery	9.19	NA	NA	6.57	6.18	1.79	090
35721		A	Exploration femoral artery	7.72	NA	NA	4.74	4.84	1.74	090
3572F		I	Pt consid poss risk fx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3573F		I	Pt not consid poss risk fx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35741		A	Exploration popliteal artery	8.69	NA	NA	5.32	5.23	1.93	090
35761		A	Exploration of artery/vein	5.93	NA	NA	4.83	4.67	1.29	090
35800		A	Explore neck vessels	8.07	NA	NA	5.59	5.40	1.70	090
35820		A	Explore chest vessels	36.89	NA	NA	16.03	15.52	8.81	090
35840		A	Explore abdominal vessels	10.96	NA	NA	6.77	6.49	2.35	090
35860		A	Explore limb vessels	6.80	NA	NA	4.44	4.45	1.55	090
35870		A	Repair vessel graft defect	24.50	NA	NA	13.85	12.32	5.80	090
35875		A	Removal of clot in graft	10.72	NA	NA	5.73	5.71	2.43	090
35876		A	Removal of clot in graft	17.82	NA	NA	8.14	8.12	4.07	090
35879		A	Revise graft w/vein	17.41	NA	NA	8.07	8.08	4.01	090
35881		A	Revise graft w/vein	19.35	NA	NA	8.69	8.82	4.48	090
35883		A	Revise graft w/nonauto graft	23.15	NA	NA	10.03	9.75	5.32	090
35884		A	Revise graft w/vein	24.65	NA	NA	8.97	9.30	5.83	090

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35901		A	Excision graft neck	8.38	NA	NA	5.61	5.62	1.90	090
35903		A	Excision graft extremity	9.53	NA	NA	6.17	6.20	2.15	090
35905		A	Excision graft thorax	33.52	NA	NA	11.94	12.98	7.94	090
35907		A	Excision graft abdomen	37.27	NA	NA	15.24	15.13	8.57	090
36000		A	Place needle in vein	0.18	0.49	0.54	0.08	0.08	0.03	XXX
36002		A	Pseudoaneurysm injection trt	1.96	2.45	2.71	0.95	1.04	0.30	000
36005		A	Injection ext venography	0.95	8.58	9.23	0.35	0.40	0.14	000
36010		A	Place catheter in vein	2.43	12.00	13.98	0.88	0.96	0.35	XXX
36011		A	Place catheter in vein	3.14	21.61	23.92	1.18	1.25	0.43	XXX
36012		A	Place catheter in vein	3.51	21.25	22.64	1.30	1.45	0.52	XXX
36013		A	Place catheter in artery	2.52	19.58	21.31	0.95	1.01	0.45	XXX
36014		A	Place catheter in artery	3.02	20.58	22.10	1.12	1.28	0.33	XXX
36015		A	Place catheter in artery	3.51	21.91	23.78	1.30	1.47	0.37	XXX
36100		A	Establish access to artery	3.02	10.84	12.19	1.14	1.29	0.67	XXX
36120		A	Establish access to artery	2.01	10.43	11.15	0.72	0.76	0.33	XXX
36140		A	Establish access to artery	2.01	10.65	12.00	0.73	0.81	0.39	XXX
36147		A	Access av dial grft for eval	3.72	20.20	20.20	1.43	1.43	0.50	XXX
36148		A	Access av dial grft for proc	1.00	6.57	6.57	0.37	0.37	0.12	ZZZ
36160		A	Establish access to aorta	2.52	11.15	12.70	0.90	1.06	0.38	XXX
36200		A	Place catheter in aorta	3.02	14.31	15.87	1.07	1.18	0.60	XXX
36215		A	Place catheter in artery	4.67	26.62	29.12	1.81	2.06	0.81	XXX
36216		A	Place catheter in artery	5.27	29.41	31.88	2.09	2.34	0.92	XXX
36217		A	Place catheter in artery	6.29	50.83	54.84	2.54	2.80	1.06	XXX
36218		A	Place catheter in artery	1.01	4.18	4.59	0.41	0.44	0.16	ZZZ
36245		A	Place catheter in artery	4.67	26.55	30.98	1.79	2.15	0.87	XXX
36246		A	Place catheter in artery	5.27	27.34	30.63	1.93	2.22	0.98	XXX
36247		A	Place catheter in artery	6.29	45.26	50.53	2.29	2.62	1.18	XXX
36248		A	Place catheter in artery	1.01	3.21	3.66	0.36	0.42	0.16	ZZZ

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36260		A	Insertion of infusion pump	9.91	NA	NA	7.20	6.55	2.12	090
36261		A	Revision of infusion pump	5.63	NA	NA	5.01	4.61	1.33	090
36262		A	Removal of infusion pump	4.11	NA	NA	4.07	3.74	0.87	090
36299		C	Vessel injection procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
36400		A	Bl draw < 3 yrs fem/jugular	0.38	0.52	0.43	0.08	0.09	0.05	XXX
36405		A	Bl draw < 3 yrs scalp vein	0.31	0.35	0.36	0.13	0.12	0.05	XXX
36406		A	Bl draw < 3 yrs other vein	0.18	0.28	0.30	0.07	0.07	0.03	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.27	0.33	0.08	0.07	0.03	XXX
36415		X	Routine venipuncture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36416		B	Capillary blood draw	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36420		A	Vein access cutdown < 1 yr	1.01	NA	NA	0.24	0.27	0.12	XXX
36425		A	Vein access cutdown > 1 yr	0.76	NA	NA	0.34	0.31	0.11	XXX
36430		A	Blood transfusion service	0.00	0.90	1.03	NA	NA	0.01	XXX
36440		A	Bl push transfuse 2 yr or <	1.03	NA	NA	0.50	0.43	0.24	XXX
36450		A	Bl exchange/transfuse nb	2.23	NA	NA	1.09	1.04	0.11	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	NA	0.85	0.99	0.14	XXX
36460		A	Transfusion service fetal	6.58	NA	NA	3.07	2.72	1.40	XXX
36468		R	Injection(s) spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36469		R	Injection(s) spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36470		A	Injection therapy of vein	1.10	2.92	2.95	0.85	0.83	0.22	010
36471		A	Injection therapy of veins	1.65	3.23	3.28	1.10	1.08	0.33	010
36475		A	Endovenous rf 1st vein	6.72	43.94	46.52	2.78	2.74	1.41	000
36476		A	Endovenous rf vein add-on	3.38	7.60	7.83	1.24	1.22	0.72	ZZZ
36478		A	Endovenous laser 1st vein	6.72	31.43	35.16	2.73	2.77	1.32	000
36479		A	Endovenous laser vein addon	3.38	7.81	8.25	1.29	1.26	0.65	ZZZ
36481		A	Insertion of catheter vein	6.98	53.67	29.60	3.01	3.01	0.88	000
36500		A	Insertion of catheter vein	3.51	NA	NA	1.36	1.49	0.53	000
3650F		I	Eeg ordered rvwd reqstd	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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36510		A	Insertion of catheter vein	1.09	1.52	1.82	0.53	0.50	0.24	000
36511		A	Apheresis wbc	1.74	NA	NA	0.89	0.83	0.27	000
36512		A	Apheresis rbc	1.74	NA	NA	0.88	0.84	0.16	000
36513		A	Apheresis platelets	1.74	NA	NA	0.98	0.91	0.34	000
36514		A	Apheresis plasma	1.74	12.18	13.39	0.80	0.77	0.27	000
36515		A	Apheresis adsorp/reinfuse	1.74	50.32	55.40	0.88	0.78	0.24	000
36516		A	Apheresis selective	1.22	54.37	61.86	0.56	0.53	0.35	000
36522		A	Photopheresis	1.67	34.95	38.52	1.20	1.20	0.16	000
36555		A	Insert non-tunnel cv cath	2.68	4.68	5.09	0.67	0.74	0.22	000
36556		A	Insert non-tunnel cv cath	2.50	3.93	4.14	0.85	0.81	0.31	000
36557		A	Insert tunneled cv cath	5.14	22.72	21.68	3.60	3.38	1.09	010
36558		A	Insert tunneled cv cath	4.84	16.89	18.46	2.81	2.95	0.72	010
36560		A	Insert tunneled cv cath	6.29	32.00	30.73	4.11	3.83	0.58	010
36561		A	Insert tunneled cv cath	6.04	26.85	28.07	3.60	3.54	1.10	010
36563		A	Insert tunneled cv cath	6.24	30.48	29.88	3.88	3.66	1.30	010
36565		A	Insert tunneled cv cath	6.04	21.59	22.57	3.35	3.32	1.29	010
36566		A	Insert tunneled cv cath	6.54	141.04	125.28	3.72	3.59	1.26	010
36568		A	Insert picc cath	1.92	5.88	6.76	0.75	0.77	0.18	000
36569		A	Insert picc cath	1.82	4.97	5.68	0.74	0.79	0.18	000
36570		A	Insert picvad cath	5.36	24.28	27.68	3.00	3.22	0.49	010
36571		A	Insert picvad cath	5.34	30.41	31.51	3.35	3.26	1.02	010
36575		A	Repair tunneled cv cath	0.67	3.86	4.06	0.30	0.30	0.10	000
36576		A	Repair tunneled cv cath	3.24	7.14	7.35	2.06	2.06	0.56	010
36578		A	Replace tunneled cv cath	3.54	10.52	11.18	2.38	2.48	0.53	010
36580		A	Replace cvad cath	1.31	4.59	5.18	0.54	0.55	0.16	000
36581		A	Replace tunneled cv cath	3.48	17.59	18.90	1.97	2.13	0.43	010
36582		A	Replace tunneled cv cath	5.24	25.57	26.68	3.12	3.18	0.88	010
36583		A	Replace tunneled cv cath	5.29	32.42	30.14	3.68	3.44	1.14	010

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36584		A	Replace picc cath	1.20	4.36	5.08	0.66	0.72	0.11	000
36585		A	Replace picvad cath	4.84	25.72	27.46	2.87	3.01	0.67	010
36589		A	Removal tunneled cv cath	2.28	2.28	2.36	1.55	1.58	0.37	010
36590		A	Removal tunneled cv cath	3.35	4.67	4.54	2.22	2.15	0.62	010
36591		T	Draw blood off venous device	0.00	0.61	0.67	NA	NA	0.01	XXX
36592		T	Collect blood from picc	0.00	0.69	0.75	NA	NA	0.01	XXX
36593		A	Declot vascular device	0.00	0.82	0.85	NA	NA	0.01	XXX
36595		A	Mech remov tunneled cv cath	3.59	11.92	13.58	1.53	1.69	0.39	000
36596		A	Mech remov tunneled cv cath	0.75	2.89	3.19	0.48	0.52	0.10	000
36597		A	Reposition venous catheter	1.21	2.21	2.42	0.49	0.54	0.11	000
36598		T	Inj w/fluor eval cv device	0.74	2.32	2.56	0.27	0.67	0.07	000
36600		A	Withdrawal of arterial blood	0.32	0.53	0.56	0.11	0.11	0.03	XXX
36620		A	Insertion catheter artery	1.15	NA	NA	0.29	0.25	0.10	000
36625		A	Insertion catheter artery	2.11	NA	NA	0.71	0.70	0.42	000
36640		A	Insertion catheter artery	2.10	NA	NA	1.40	1.29	0.42	000
36660		A	Insertion catheter artery	1.40	NA	NA	0.68	0.54	0.34	000
36680		A	Insert needle bone cavity	1.20	NA	NA	0.35	0.37	0.22	000
36800		A	Insertion of cannula	2.43	NA	NA	2.02	2.01	0.42	000
36810		A	Insertion of cannula	3.96	NA	NA	1.80	1.75	0.73	000
36815		A	Insertion of cannula	2.62	NA	NA	1.46	1.43	0.56	000
36818		A	Av fuse uppr arm cephalic	11.89	NA	NA	6.37	6.28	2.65	090
36819		A	Av fuse uppr arm basilic	14.47	NA	NA	7.23	7.08	3.25	090
36820		A	Av fusion/forearm vein	14.47	NA	NA	7.52	7.27	3.23	090
36821		A	Av fusion direct any site	12.11	NA	NA	6.79	6.45	2.70	090
36822		A	Insertion of cannula(s)	5.57	NA	NA	4.71	4.81	1.29	090
36823		A	Insertion of cannula(s)	22.98	NA	NA	12.46	11.96	5.00	090
36825		A	Artery-vein autograft	15.13	NA	NA	7.83	6.73	3.37	090
36830		A	Artery-vein nonautograft	12.03	NA	NA	5.80	5.70	2.70	090

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36831		A	Open thrombect av fistula	8.04	NA	NA	4.45	4.36	1.79	090
36832		A	Av fistula revision open	10.53	NA	NA	5.28	5.17	2.34	090
36833		A	Av fistula revision	11.98	NA	NA	5.85	5.72	2.69	090
36835		A	Artery to vein shunt	7.51	NA	NA	5.94	5.53	1.78	090
36838		A	Dist revas ligation hemo	21.69	NA	NA	9.47	9.55	4.93	090
36860		A	External cannula declotting	2.01	3.80	3.73	1.05	0.94	0.26	000
36861		A	Cannula declotting	2.52	NA	NA	1.62	1.63	0.48	000
36870		A	Percut thrombect av fistula	5.20	46.44	49.97	3.12	3.36	0.68	090
3700F		I	Psych disorders assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
37140		A	Revision of circulation	25.23	NA	NA	14.17	12.93	5.36	090
37145		A	Revision of circulation	26.24	NA	NA	14.51	13.73	5.70	090
37160		A	Revision of circulation	23.24	NA	NA	13.30	12.04	4.96	090
37180		A	Revision of circulation	26.24	NA	NA	14.61	13.12	5.59	090
37181		A	Splice spleen/kidney veins	28.37	NA	NA	15.54	14.14	6.03	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	NA	6.34	7.34	1.62	000
37183		A	Remove hepatic shunt (tips)	7.99	152.24	152.24	3.01	3.53	0.73	000
37184		A	Prim art mech thrombectomy	8.66	54.65	61.25	3.56	3.91	1.51	000
37185		A	Prim art m-thrombect add-on	3.28	17.49	19.69	1.20	1.32	0.61	ZZZ
37186		A	Sec art m-thrombect add-on	4.92	34.36	40.61	1.81	2.09	0.95	ZZZ
37187		A	Venous mech thrombectomy	8.03	52.29	58.83	3.19	3.58	1.13	000
37188		A	Venous m-thrombectomy add-on	5.71	44.92	50.94	2.39	2.70	0.69	000
37195		C	Thrombolytic therapy stroke	0.00	0.00	0.00	0.00	0.00	0.00	XXX
37200		A	Transcatheter biopsy	4.55	NA	NA	1.64	1.90	0.42	000
37201		A	Transcatheter therapy infuse	4.99	NA	NA	2.49	2.76	0.76	000
37202		A	Transcatheter therapy infuse	5.67	NA	NA	2.97	3.50	1.18	000
37203		A	Transcatheter retrieval	5.02	31.63	34.51	2.08	2.37	0.68	000
37204		A	Transcatheter occlusion	18.11	NA	NA	6.52	7.35	2.21	000
37205		A	Transcath iv stent percut	8.27	108.43	118.66	3.05	3.64	1.56	000

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37206		A	Transcath iv stent/perc addl	4.12	65.91	72.34	1.49	1.71	0.81	ZZZ
37207		A	Transcath iv stent open	8.27	NA	NA	3.23	3.27	1.86	000
37208		A	Transcath iv stent/open addl	4.12	NA	NA	1.42	1.43	0.92	ZZZ
37209		A	Change iv cath at thromb tx	2.27	NA	NA	0.80	0.90	0.33	000
3720F		I	Cognit impairment assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
37210		A	Embolization uterine fibroid	10.60	88.63	95.23	4.00	4.68	1.02	000
37215		R	Transcath stent cca w/eps	19.68	NA	NA	8.94	10.51	4.18	090
37216		N	Transcath stent cca w/o eps	18.95	NA	NA	10.10	10.04	1.33	090
37220		A	Iliac revasc	8.15	83.88	83.88	3.03	3.03	1.67	000
37221		A	Iliac revasc w/stent	10.00	126.56	126.56	3.75	3.75	1.89	000
37222		A	Iliac revasc add-on	3.73	22.52	22.52	1.34	1.34	0.76	ZZZ
37223		A	Iliac revasc w/stent add-on	4.25	132.39	132.39	1.53	1.53	0.84	ZZZ
37224		A	Fem/popl revas w/tla	9.00	101.76	101.76	3.34	3.34	1.81	000
37225		A	Fem/popl revas w/ather	12.00	303.34	303.34	4.55	4.55	2.51	000
37226		A	Fem/popl revasc w/stent	10.49	254.28	254.28	3.93	3.93	1.29	000
37227		A	Fem/popl revasc stnt & ather	14.50	412.19	412.19	5.48	5.48	3.04	000
37228		A	Tib/per revasc w/tla	11.00	146.98	146.98	4.04	4.04	2.25	000
37229		A	Tib/per revasc w/ather	14.05	298.12	298.12	5.30	5.30	2.97	000
37230		A	Tib/per revasc w/stent	13.80	231.18	231.18	5.13	5.13	2.61	000
37231		A	Tib/per revasc stent & ather	15.00	379.46	379.46	5.57	5.57	2.84	000
37232		A	Tib/per revasc add-on	4.00	31.17	31.17	1.43	1.43	0.81	ZZZ
37233		A	Tibper revasc w/ather add-on	6.50	36.11	36.11	2.41	2.41	1.37	ZZZ
37234		A	Revsc opn/prq tib/pero stent	5.50	108.02	108.02	1.98	1.98	1.09	ZZZ
37235		A	Tib/per revasc stnt & ather	7.80	113.10	113.10	2.81	2.81	1.55	ZZZ
37250		A	Iv us first vessel add-on	2.10	NA	NA	0.74	0.85	0.45	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	NA	0.53	0.58	0.35	ZZZ
37500		A	Endoscopy ligate perf veins	11.67	NA	NA	7.15	7.18	2.62	090
37501		C	Vascular endoscopy procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
37565		A	Ligation of neck vein	12.05	NA	NA	7.67	7.19	2.57	090
37600		A	Ligation of neck artery	12.42	NA	NA	7.14	6.91	2.54	090
37605		A	Ligation of neck artery	14.28	NA	NA	7.54	7.39	3.38	090
37606		A	Ligation of neck artery	8.81	NA	NA	4.33	4.88	1.87	090
37607		A	Ligation of a-v fistula	6.25	NA	NA	4.10	4.03	1.37	090
37609		A	Temporal artery procedure	3.05	5.62	5.44	2.67	2.50	0.64	010
37615		A	Ligation of neck artery	7.80	NA	NA	6.99	6.09	1.64	090
37616		A	Ligation of chest artery	18.97	NA	NA	10.40	10.30	4.05	090
37617		A	Ligation of abdomen artery	23.79	NA	NA	11.75	11.10	5.01	090
37618		A	Ligation of extremity artery	6.03	NA	NA	4.52	4.40	1.32	090
37620		A	Revision of major vein	11.57	NA	NA	6.01	6.55	1.70	090
37650		A	Revision of major vein	8.49	NA	NA	4.08	4.74	1.87	090
37660		A	Revision of major vein	22.28	NA	NA	12.25	11.15	4.74	090
37700		A	Revise leg vein	3.82	NA	NA	3.16	3.13	0.84	090
37718		A	Ligate/strip short leg vein	7.13	NA	NA	4.86	4.75	1.56	090
37722		A	Ligate/strip long leg vein	8.16	NA	NA	5.13	5.00	1.81	090
37735		A	Removal of leg veins/lesion	10.90	NA	NA	6.16	6.14	2.39	090
37760		A	Ligate leg veins radical	10.78	NA	NA	7.47	6.74	2.28	090
37761		A	Ligate leg veins open	9.13	NA	NA	6.21	6.21	1.96	090
37765		A	Stab phleb veins xtr 10-20	7.71	10.69	10.69	4.68	4.75	1.56	090
37766		A	Phleb veins - extrem 20+	9.66	12.11	12.11	5.44	5.51	2.01	090
37780		A	Revision of leg vein	3.93	NA	NA	3.25	3.24	0.86	090
37785		A	Ligate/divide/excise vein	3.93	5.98	6.04	3.27	3.25	0.86	090
37788		A	Revascularization penis	23.33	NA	NA	12.86	13.74	4.97	090
37790		A	Penile venous occlusion	8.43	NA	NA	5.02	5.28	0.81	090
37799		C	Vascular surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38100		A	Removal of spleen total	19.55	NA	NA	10.78	9.67	4.07	090
38101		A	Removal of spleen partial	19.55	NA	NA	11.07	9.85	4.16	090

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38102		A	Removal of spleen total	4.79	NA	NA	2.09	1.91	0.99	ZZZ
38115		A	Repair of ruptured spleen	21.88	NA	NA	11.83	10.60	4.28	090
38120		A	Laparoscopy splenectomy	17.07	NA	NA	10.74	9.82	3.60	090
38129		C	Laparoscope proc spleen	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38200		A	Injection for spleen x-ray	2.64	NA	NA	1.15	1.18	0.62	000
38204		B	Bl donor search management	2.00	NA	NA	0.88	0.85	0.14	XXX
38205		R	Harvest allogenic stem cells	1.50	NA	NA	0.81	0.77	0.08	000
38206		R	Harvest auto stem cells	1.50	NA	NA	0.82	0.78	0.11	000
38207		I	Cryopreserve stem cells	0.89	NA	NA	0.39	0.47	0.05	XXX
38208		I	Thaw preserved stem cells	0.56	NA	NA	0.25	0.29	0.04	XXX
38209		I	Wash harvest stem cells	0.24	NA	NA	0.11	0.13	0.01	XXX
38210		I	T-cell depletion of harvest	1.57	NA	NA	0.69	0.82	0.10	XXX
38211		I	Tumor cell deplete of harvst	1.42	NA	NA	0.63	0.75	0.10	XXX
38212		I	Rbc depletion of harvest	0.94	NA	NA	0.41	0.49	0.05	XXX
38213		I	Platelet deplete of harvest	0.24	NA	NA	0.11	0.13	0.01	XXX
38214		I	Volume deplete of harvest	0.81	NA	NA	0.36	0.42	0.05	XXX
38215		I	Harvest stem cell concentrte	0.94	NA	NA	0.41	0.49	0.05	XXX
38220		A	Bone marrow aspiration	1.08	2.94	3.28	0.63	0.62	0.11	XXX
38221		A	Bone marrow biopsy	1.37	2.96	3.37	0.79	0.78	0.08	XXX
38230		R	Bone marrow collection	4.85	NA	NA	4.45	4.17	1.10	010
38240		R	Bone marrow/stem transplant	2.24	NA	NA	1.35	1.30	0.16	XXX
38241		R	Bone marrow/stem transplant	2.24	NA	NA	1.34	1.30	0.14	XXX
38242		A	Lymphocyte infuse transplant	1.71	NA	NA	1.06	1.00	0.10	000
38300		A	Drainage lymph node lesion	2.36	5.30	5.26	2.70	2.62	0.41	010
38305		A	Drainage lymph node lesion	6.68	NA	NA	5.71	5.49	1.33	090
38308		A	Incision of lymph channels	6.81	NA	NA	5.17	4.83	1.45	090
38380		A	Thoracic duct procedure	8.46	NA	NA	8.09	7.30	1.09	090
38381		A	Thoracic duct procedure	13.38	NA	NA	7.66	7.80	3.14	090

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38382		A	Thoracic duct procedure	10.65	NA	NA	7.08	6.96	2.25	090
38500		A	Biopsy/removal lymph nodes	3.79	5.15	4.88	2.98	2.77	0.77	010
38505		A	Needle biopsy lymph nodes	1.14	2.33	2.45	0.84	0.89	0.12	000
38510		A	Biopsy/removal lymph nodes	6.74	7.63	7.19	4.80	4.42	1.21	010
38520		A	Biopsy/removal lymph nodes	7.03	NA	NA	5.53	5.19	1.41	090
38525		A	Biopsy/removal lymph nodes	6.43	NA	NA	5.13	4.71	1.36	090
38530		A	Biopsy/removal lymph nodes	8.34	NA	NA	6.27	5.80	1.82	090
38542		A	Explore deep node(s) neck	7.95	NA	NA	6.52	6.03	1.33	090
38550		A	Removal neck/armpit lesion	7.11	NA	NA	6.39	5.80	1.52	090
38555		A	Removal neck/armpit lesion	15.59	NA	NA	11.12	10.46	3.34	090
38562		A	Removal pelvic lymph nodes	11.06	NA	NA	7.67	7.48	1.96	090
38564		A	Removal abdomen lymph nodes	11.38	NA	NA	7.35	6.95	2.24	090
38570		A	Laparoscopy lymph node biop	9.34	NA	NA	5.15	5.17	1.37	010
38571		A	Laparoscopy lymphadenectomy	14.76	NA	NA	7.08	7.81	1.48	010
38572		A	Laparoscopy lymphadenectomy	16.94	NA	NA	8.92	8.46	2.39	010
38589		C	Laparoscope proc lymphatic	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38700		A	Removal of lymph nodes neck	12.81	NA	NA	10.18	9.18	1.77	090
38720		A	Removal of lymph nodes neck	21.95	NA	NA	15.95	14.35	3.38	090
38724		A	Removal of lymph nodes neck	23.95	NA	NA	17.66	15.66	3.34	090
38740		A	Remove armpit lymph nodes	10.70	NA	NA	7.55	6.93	2.25	090
38745		A	Remove armpit lymph nodes	13.87	NA	NA	9.25	8.46	2.95	090
38746		A	Remove thoracic lymph nodes	4.88	NA	NA	1.80	1.86	1.14	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	NA	2.10	1.94	1.03	ZZZ
38760		A	Remove groin lymph nodes	13.62	NA	NA	8.73	8.16	2.78	090
38765		A	Remove groin lymph nodes	21.91	NA	NA	12.34	11.64	4.22	090
38770		A	Remove pelvis lymph nodes	14.06	NA	NA	7.87	8.10	1.77	090
38780		A	Remove abdomen lymph nodes	17.70	NA	NA	10.27	10.36	2.55	090
38790		A	Inject for lymphatic x-ray	1.29	NA	NA	0.96	0.95	0.24	000

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38792		A	Identify sentinel node	0.52	NA	NA	0.59	0.59	0.08	000
38794		A	Access thoracic lymph duct	4.62	NA	NA	3.43	3.80	0.42	090
38900		A	Io map of sent lymph node	2.50	1.02	1.02	1.02	1.02	0.53	ZZZ
38999		C	Blood/lymph system procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39000		A	Exploration of chest	7.57	NA	NA	5.80	5.70	1.67	090
39010		A	Exploration of chest	13.19	NA	NA	7.62	7.89	3.12	090
39200		A	Removal chest lesion	15.09	NA	NA	8.03	8.18	3.53	090
39220		A	Removal chest lesion	19.55	NA	NA	10.49	10.61	4.43	090
39400		A	Visualization of chest	8.05	NA	NA	5.34	5.41	1.87	010
39499		C	Chest procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39501		A	Repair diaphragm laceration	13.98	NA	NA	8.48	8.03	2.95	090
39503		A	Repair of diaphragm hernia	108.91	NA	NA	52.18	46.00	23.18	090
39540		A	Repair of diaphragm hernia	14.57	NA	NA	8.44	7.90	3.11	090
39541		A	Repair of diaphragm hernia	15.75	NA	NA	9.23	8.59	3.40	090
39545		A	Revision of diaphragm	14.67	NA	NA	8.78	8.86	3.41	090
39560		A	Resect diaphragm simple	13.06	NA	NA	7.88	7.57	2.78	090
39561		A	Resect diaphragm complex	19.99	NA	NA	13.04	12.44	4.37	090
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4014F		I	Written discharge instr prvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4016F		I	Anti-inflm/anlgsc agent rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4017F		I	Gi prophylaxis for nsaid rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4018F		I	Therapy exercise joint rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4019F		I	Doc recpt counsl vit d/calc+	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4030F		I	Oxygen therapy rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4033F		I	Pulmonary rehab rec	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4035F		I	Influenza imm rec	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40490		A	Biopsy of lip	1.22	2.40	2.41	0.89	0.83	0.18	000
40500		A	Partial excision of lip	4.47	10.04	9.69	5.99	5.68	0.67	090

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40510		A	Partial excision of lip	4.82	9.02	8.66	5.40	5.04	0.71	090
40520		A	Partial excision of lip	4.79	9.22	8.96	5.49	5.15	0.75	090
40525		A	Reconstruct lip with flap	7.72	NA	NA	7.99	7.54	1.26	090
40527		A	Reconstruct lip with flap	9.32	NA	NA	8.66	8.39	1.20	090
4052F		I	Hemodialysis via av fistula	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40530		A	Partial removal of lip	5.54	9.90	9.60	6.02	5.69	0.86	090
4053F		I	Hemodialysis via av graft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4054F		I	Hemodialysis via catheter	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4055F		I	Pt rcvng periton dialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4056F		I	Approp oral rehyd recommd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4058F		I	Ped gastro ed given caregvr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4060F		I	Psych svcs provided	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4062F		I	Pt referral psych docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4063F		I	Antidepres rxthxpy not rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4064F		I	Antidepressant rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40650		A	Repair lip	3.78	8.04	7.79	4.33	4.13	0.65	090
40652		A	Repair lip	4.43	9.28	9.06	5.52	5.25	0.76	090
40654		A	Repair lip	5.48	10.62	10.36	6.55	6.24	0.92	090
4065F		I	Antipsychotic rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4066F		I	Ect provided	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4067F		I	Pt referral for ect docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40700		A	Repair cleft lip/nasal	14.17	NA	NA	14.38	12.56	1.82	090
40701		A	Repair cleft lip/nasal	17.23	NA	NA	13.91	13.59	2.20	090
40702		A	Repair cleft lip/nasal	14.27	NA	NA	9.14	9.18	1.02	090
40720		A	Repair cleft lip/nasal	14.72	NA	NA	12.13	11.61	2.91	090
40761		A	Repair cleft lip/nasal	15.84	NA	NA	14.92	13.52	3.12	090
4077F		I	Doc t-pa admin considered	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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40800		A	Drainage of mouth lesion	1.23	4.79	4.61	2.54	2.41	0.18	010
40801		A	Drainage of mouth lesion	2.63	6.39	6.09	3.75	3.52	0.37	010
40804		A	Removal foreign body mouth	1.30	4.95	4.71	2.51	2.39	0.16	010
40805		A	Removal foreign body mouth	2.79	6.57	6.29	3.73	3.53	0.35	010
40806		A	Incision of lip fold	0.31	2.72	2.74	0.52	0.57	0.04	000
40808		A	Biopsy of mouth lesion	1.01	4.41	4.26	2.14	2.05	0.12	010
40810		A	Excision of mouth lesion	1.36	4.63	4.44	2.36	2.23	0.18	010
40812		A	Excise/repair mouth lesion	2.37	5.91	5.63	3.34	3.11	0.31	010
40814		A	Excise/repair mouth lesion	3.52	7.58	7.18	5.31	4.98	0.48	090
40816		A	Excision of mouth lesion	3.77	7.87	7.47	5.42	5.10	0.52	090
40818		A	Excise oral mucosa for graft	2.83	7.27	7.14	4.88	4.82	0.37	090
40819		A	Excise lip or cheek fold	2.51	6.32	6.05	4.28	4.06	0.33	090
40820		A	Treatment of mouth lesion	1.34	6.33	6.23	3.66	3.58	0.18	010
40830		A	Repair mouth laceration	1.82	5.29	5.08	2.72	2.60	0.31	010
40831		A	Repair mouth laceration	2.57	6.95	6.60	3.78	3.63	0.42	010
40840		R	Reconstruction of mouth	9.15	15.74	14.13	9.91	8.74	1.18	090
40842		R	Reconstruction of mouth	9.15	14.12	13.11	9.46	8.31	1.18	090
40843		R	Reconstruction of mouth	12.79	17.26	16.01	10.06	9.12	2.51	090
40844		R	Reconstruction of mouth	16.80	22.39	21.03	16.06	14.41	3.31	090
40845		R	Reconstruction of mouth	19.36	22.64	21.40	15.94	14.84	2.47	090
40899		C	Mouth surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41000		A	Drainage of mouth lesion	1.35	3.33	3.19	1.89	1.78	0.18	010
41005		A	Drainage of mouth lesion	1.31	5.10	5.07	2.41	2.31	0.16	010
41006		A	Drainage of mouth lesion	3.34	7.09	6.76	4.33	3.97	0.42	090
41007		A	Drainage of mouth lesion	3.20	7.14	6.90	3.97	3.78	0.41	090
41008		A	Drainage of mouth lesion	3.46	7.38	6.98	4.32	4.01	0.43	090
41009		A	Drainage of mouth lesion	3.71	7.83	7.39	4.73	4.41	0.48	090
41010		A	Incision of tongue fold	1.11	4.91	4.77	2.10	2.02	0.14	010

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41015		A	Drainage of mouth lesion	4.08	8.80	8.10	5.93	5.44	0.52	090
41016		A	Drainage of mouth lesion	4.19	8.43	7.99	5.95	5.55	0.53	090
41017		A	Drainage of mouth lesion	4.19	8.55	8.09	5.98	5.59	0.53	090
41018		A	Drainage of mouth lesion	5.22	9.04	8.60	6.35	5.99	0.67	090
41019		A	Place needles h&n for rt	8.84	NA	NA	4.28	4.31	0.72	000
41100		A	Biopsy of tongue	1.42	3.46	3.33	1.71	1.63	0.20	010
41105		A	Biopsy of tongue	1.47	3.48	3.33	1.78	1.66	0.20	010
41108		A	Biopsy of floor of mouth	1.10	3.21	3.08	1.54	1.45	0.14	010
41110		A	Excision of tongue lesion	1.56	4.65	4.45	2.29	2.16	0.22	010
41112		A	Excision of tongue lesion	2.83	6.86	6.54	4.53	4.27	0.37	090
41113		A	Excision of tongue lesion	3.29	7.27	6.91	4.84	4.54	0.42	090
41114		A	Excision of tongue lesion	8.82	NA	NA	9.65	8.94	1.17	090
41115		A	Excision of tongue fold	1.79	5.28	5.12	2.61	2.42	0.23	010
41116		A	Excision of mouth lesion	2.52	7.11	6.77	3.89	3.68	0.34	090
41120		A	Partial removal of tongue	11.14	NA	NA	19.34	18.69	1.48	090
41130		A	Partial removal of tongue	15.74	NA	NA	22.06	20.92	2.08	090
41135		A	Tongue and neck surgery	30.14	NA	NA	32.02	29.90	4.03	090
41140		A	Removal of tongue	29.15	NA	NA	34.19	32.40	3.75	090
41145		A	Tongue removal neck surgery	37.93	NA	NA	42.14	39.43	4.86	090
41150		A	Tongue mouth jaw surgery	29.86	NA	NA	33.20	31.27	3.95	090
41153		A	Tongue mouth neck surgery	33.59	NA	NA	35.13	32.74	4.40	090
41155		A	Tongue jaw & neck surgery	44.30	NA	NA	41.68	38.17	5.91	090
41250		A	Repair tongue laceration	1.96	5.23	4.76	2.26	2.04	0.33	010
41251		A	Repair tongue laceration	2.32	5.46	4.75	2.53	2.29	0.30	010
41252		A	Repair tongue laceration	3.02	5.99	5.65	3.01	2.81	0.48	010
4133F		I	Antihist/decong rx/recom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4134F		I	No antihist/decong rx/recom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4135F		I	Systemic corticosteroids rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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4136F		I	Syst corticosteroids not rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41500		A	Fixation of tongue	3.80	NA	NA	9.40	9.08	0.49	090
41510		A	Tongue to lip surgery	3.51	NA	NA	6.61	7.33	0.43	090
41512		A	Tongue suspension	6.86	NA	NA	11.76	11.09	0.49	090
41520		A	Reconstruction tongue fold	2.83	7.28	6.98	4.59	4.35	0.35	090
41530		A	Tongue base vol reduction	4.51	91.00	90.45	7.62	7.24	0.31	010
4155F		I	Hep a vac series prev recvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4157F		I	Hep b vac series prev recvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41599		C	Tongue and mouth surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4163F		I	Pt couns 4 txmnt opt prost	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4167F		I	Hd bed tilted 1st day vent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4168F		I	Pt care icu&vent w/in 24hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4169F		I	No pt care icu/vent in 24hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4174F		I	Couns potent glauc impct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4176F		I	Talk re uv light pt/crgvr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4178F		I	Antid glbln rcvd w/in 26wks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41800		A	Drainage of gum lesion	1.27	6.19	5.69	2.81	2.57	0.22	010
41805		A	Removal foreign body gum	1.34	5.73	5.51	3.58	3.44	0.18	010
41806		A	Removal foreign body jawbone	2.79	7.70	7.12	4.80	4.45	0.54	010
4181F		I	Conformal radn thxpy rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41820		R	Excision gum each quadrant	0.00	0.00	0.00	0.00	0.00	0.00	000
41821		R	Excision of gum flap	0.00	0.00	0.00	0.00	0.00	0.00	000
41822		R	Excision of gum lesion	2.41	5.93	5.67	2.89	2.56	0.31	010
41823		R	Excision of gum lesion	3.77	8.51	8.20	5.59	5.23	0.48	090
41825		A	Excision of gum lesion	1.41	4.64	4.49	2.11	2.09	0.20	010
41826		A	Excision of gum lesion	2.41	6.59	6.03	3.73	3.40	0.31	010
41827		A	Excision of gum lesion	3.83	8.79	8.34	5.08	4.71	0.49	090
41828		R	Excision of gum lesion	3.14	5.66	5.29	3.04	2.76	0.39	010

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4182F		I	No conformal radn thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41830		R	Removal of gum tissue	3.45	7.82	7.41	4.76	4.38	0.43	010
41850		R	Treatment of gum lesion	0.00	0.00	0.00	0.00	0.00	0.00	000
4185F		I	Continuous ppi or h2ra rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4186F		I	No cont ppi or h2ra rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41870		R	Gum graft	0.00	0.00	0.00	0.00	0.00	0.00	000
41872		R	Repair gum	3.01	7.40	7.19	4.52	4.32	0.60	090
41874		R	Repair tooth socket	3.19	7.50	7.13	4.19	3.88	0.39	090
4188F		I	Approp ace/arb tstng done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41899		C	Dental surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4189F		I	Approp digoxin tstng done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4190F		I	Approp diuretic tstng done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4191F		I	Approp anticonvuls tstng	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42000		A	Drainage mouth roof lesion	1.28	3.26	3.17	1.76	1.64	0.16	010
42100		A	Biopsy roof of mouth	1.36	2.99	2.86	1.82	1.71	0.18	010
42104		A	Excision lesion mouth roof	1.69	4.60	4.33	2.37	2.20	0.23	010
42106		A	Excision lesion mouth roof	2.15	5.73	5.42	3.02	2.86	0.29	010
42107		A	Excision lesion mouth roof	4.56	8.78	8.32	5.48	5.11	0.58	090
4210F		I	Ace/arb thxpy for >= 6 mons	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42120		A	Remove palate/lesion	11.86	NA	NA	17.06	16.05	1.56	090
42140		A	Excision of uvula	1.70	5.78	5.55	2.86	2.73	0.23	090
42145		A	Repair palate pharynx/uvula	9.78	NA	NA	10.79	10.05	1.25	090
42160		A	Treatment mouth roof lesion	1.85	4.93	4.88	2.44	2.38	0.24	010
42180		A	Repair palate	2.55	4.01	4.02	2.39	2.40	0.33	010
42182		A	Repair palate	3.87	5.51	5.23	3.61	3.43	0.49	010
42200		A	Reconstruct cleft palate	12.53	NA	NA	12.28	11.72	1.60	090
42205		A	Reconstruct cleft palate	13.66	NA	NA	14.46	12.89	1.77	090
4220F		I	Digoxin thxpy for >= 6 mons	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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42210		A	Reconstruct cleft palate	15.03	NA	NA	13.77	13.35	2.96	090
42215		A	Reconstruct cleft palate	8.99	NA	NA	11.52	10.62	1.78	090
4221F		I	Diuretic thxpy for >= 6 mons	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42220		A	Reconstruct cleft palate	7.16	NA	NA	8.37	7.97	0.50	090
42225		A	Reconstruct cleft palate	9.77	NA	NA	15.96	16.18	1.25	090
42226		A	Lengthening of palate	10.35	NA	NA	15.81	15.59	1.32	090
42227		A	Lengthening of palate	9.90	NA	NA	14.63	14.87	1.26	090
42235		A	Repair palate	8.01	NA	NA	13.51	13.03	1.03	090
42260		A	Repair nose to lip fistula	10.22	13.50	12.77	9.01	8.38	1.30	090
42280		A	Preparation palate mold	1.59	3.09	2.88	1.58	1.36	0.34	010
42281		A	Insertion palate prosthesis	1.98	4.03	3.81	2.44	2.30	0.26	010
42299		C	Palate/uvula surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42300		A	Drainage of salivary gland	1.98	4.14	3.94	2.47	2.32	0.27	010
42305		A	Drainage of salivary gland	6.31	NA	NA	6.10	5.71	0.86	090
4230F		I	Anticonv thxpy for >= 6 mons	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42310		A	Drainage of salivary gland	1.61	3.14	2.98	2.04	1.91	0.22	010
42320		A	Drainage of salivary gland	2.40	4.95	4.70	2.75	2.58	0.31	010
42330		A	Removal of salivary stone	2.26	4.52	4.32	2.55	2.38	0.30	010
42335		A	Removal of salivary stone	3.41	7.55	7.19	4.13	3.89	0.42	090
42340		A	Removal of salivary stone	4.72	8.81	8.40	5.08	4.78	0.61	090
42400		A	Biopsy of salivary gland	0.78	2.33	2.32	0.82	0.82	0.08	000
42405		A	Biopsy of salivary gland	3.34	5.27	5.10	3.18	2.99	0.42	010
42408		A	Excision of salivary cyst	4.66	8.68	8.21	4.94	4.57	0.60	090
42409		A	Drainage of salivary cyst	2.91	6.91	6.57	3.61	3.41	0.37	090
4240F		I	Instr xrcz 4bk pn >12 weeks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42410		A	Excise parotid gland/lesion	9.57	NA	NA	8.21	7.62	1.44	090
42415		A	Excise parotid gland/lesion	18.12	NA	NA	13.86	12.79	2.42	090
42420		A	Excise parotid gland/lesion	21.00	NA	NA	15.59	14.35	2.82	090

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42425		A	Excise parotid gland/lesion	13.42	NA	NA	10.67	9.93	1.83	090
42426		A	Excise parotid gland/lesion	22.66	NA	NA	16.19	14.96	3.11	090
4242F		I	Sprvsd xrcz bk pn >12 weeks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42440		A	Excise submaxillary gland	7.13	NA	NA	6.37	5.91	0.95	090
42450		A	Excise sublingual gland	4.74	8.44	8.05	5.71	5.38	0.64	090
42500		A	Repair salivary duct	4.42	8.19	7.81	5.54	5.23	0.60	090
42505		A	Repair salivary duct	6.32	9.85	9.36	6.88	6.47	0.80	090
42507		A	Parotid duct diversion	6.25	NA	NA	8.79	8.37	0.80	090
42508		A	Parotid duct diversion	9.33	NA	NA	10.74	10.60	1.20	090
42509		A	Parotid duct diversion	11.76	NA	NA	10.17	10.49	2.30	090
42510		A	Parotid duct diversion	8.35	NA	NA	10.03	9.47	1.07	090
42550		A	Injection for salivary x-ray	1.25	2.43	2.76	0.47	0.53	0.11	000
42600		A	Closure of salivary fistula	4.94	9.13	8.76	5.24	4.97	0.64	090
4260F		I	Wound srfc culturetech used	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4261F		I	Tech other than surfc cultr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42650		A	Dilation of salivary duct	0.77	1.68	1.60	0.94	0.89	0.10	000
4265F		I	Wet-dry dressings rx recmd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42660		A	Dilation of salivary duct	1.13	1.97	1.87	1.13	1.06	0.14	000
42665		A	Ligation of salivary duct	2.63	6.62	6.30	3.44	3.25	0.34	090
4266F		I	No wet-dry drssings rx recmd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4268F		I	Pt ed re comp thxpy rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4269F		I	Appropos mthd offloading rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42700		A	Drainage of tonsil abscess	1.67	3.86	3.70	2.28	2.18	0.23	010
42720		A	Drainage of throat abscess	6.31	6.88	6.43	5.07	4.67	0.83	010
42725		A	Drainage of throat abscess	12.41	NA	NA	11.14	10.30	1.59	090
4275F		I	Hep b vac inj admin/rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4279F		I	Pcp prophylaxis rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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42800		A	Biopsy of throat	1.44	3.22	3.07	1.84	1.74	0.20	010
42802		A	Biopsy of throat	1.59	5.22	5.23	2.31	2.25	0.22	010
42804		A	Biopsy of upper nose/throat	1.29	4.53	4.48	2.05	1.99	0.16	010
42806		A	Biopsy of upper nose/throat	1.63	4.87	4.82	2.24	2.17	0.22	010
42808		A	Excise pharynx lesion	2.35	4.31	4.12	2.39	2.25	0.30	010
42809		A	Remove pharynx foreign body	1.86	3.06	2.92	1.91	1.78	0.27	010
42810		A	Excision of neck cyst	3.38	8.06	7.73	5.13	4.82	0.42	090
42815		A	Excision of neck cyst	7.31	NA	NA	8.87	8.35	1.00	090
42820		A	Remove tonsils and adenoids	4.22	NA	NA	4.25	3.98	0.53	090
42821		A	Remove tonsils and adenoids	4.36	NA	NA	4.44	4.17	0.56	090
42825		A	Removal of tonsils	3.51	NA	NA	4.16	3.93	0.43	090
42826		A	Removal of tonsils	3.45	NA	NA	3.90	3.68	0.43	090
42830		A	Removal of adenoids	2.65	NA	NA	3.42	3.24	0.34	090
42831		A	Removal of adenoids	2.81	NA	NA	3.74	3.55	0.35	090
42835		A	Removal of adenoids	2.38	NA	NA	2.59	2.67	0.30	090
42836		A	Removal of adenoids	3.26	NA	NA	3.78	3.59	0.41	090
42842		A	Extensive surgery of throat	12.23	NA	NA	16.84	15.73	1.58	090
42844		A	Extensive surgery of throat	17.78	NA	NA	22.09	20.83	2.27	090
42845		A	Extensive surgery of throat	32.56	NA	NA	31.94	29.68	4.17	090
42860		A	Excision of tonsil tags	2.30	NA	NA	3.22	3.06	0.30	090
42870		A	Excision of lingual tonsil	5.52	NA	NA	11.47	11.07	0.71	090
42890		A	Partial removal of pharynx	19.13	NA	NA	21.96	20.34	2.51	090
42892		A	Revision of pharyngeal walls	26.03	NA	NA	28.45	25.95	3.41	090
42894		A	Revision of pharyngeal walls	33.92	NA	NA	34.69	31.90	4.41	090
42900		A	Repair throat wound	5.29	NA	NA	4.58	4.26	0.68	010
42950		A	Reconstruction of throat	8.27	NA	NA	14.81	14.34	1.14	090
42953		A	Repair throat esophagus	9.45	NA	NA	18.27	18.11	1.30	090
42955		A	Surgical opening of throat	8.01	NA	NA	14.03	13.36	1.03	090

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42960		A	Control throat bleeding	2.38	NA	NA	2.54	2.39	0.31	010
42961		A	Control throat bleeding	5.77	NA	NA	6.52	6.13	0.73	090
42962		A	Control throat bleeding	7.40	NA	NA	7.69	7.22	0.95	090
42970		A	Control nose/throat bleeding	5.82	NA	NA	5.58	5.15	0.84	090
42971		A	Control nose/throat bleeding	6.60	NA	NA	6.76	6.30	0.84	090
42972		A	Control nose/throat bleeding	7.59	NA	NA	7.34	6.82	0.98	090
42999		C	Throat surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4300F		I	Pt rcvng warf thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4301F		I	Pt not rcvng warf thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43020		A	Incision of esophagus	8.23	NA	NA	7.49	6.64	1.06	090
43030		A	Throat muscle surgery	7.99	NA	NA	6.90	6.47	1.17	090
43045		A	Incision of esophagus	21.88	NA	NA	12.24	12.41	5.11	090
4305F		I	Pt ed re ft care inspct rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4306F		I	Pt tlk psych & rx opd addic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43100		A	Excision of esophagus lesion	9.66	NA	NA	8.60	7.82	1.24	090
43101		A	Excision of esophagus lesion	17.07	NA	NA	9.29	9.41	3.99	090
43107		A	Removal of esophagus	44.18	NA	NA	22.77	22.18	9.85	090
43108		A	Removal of esophagus	82.87	NA	NA	40.35	34.99	17.63	090
43112		A	Removal of esophagus	47.48	NA	NA	22.69	22.61	10.74	090
43113		A	Removal of esophagus	80.06	NA	NA	40.50	36.60	17.04	090
43116		A	Partial removal of esophagus	92.99	NA	NA	58.63	47.62	11.91	090
43117		A	Partial removal of esophagus	43.65	NA	NA	20.91	20.64	9.85	090
43118		A	Partial removal of esophagus	67.07	NA	NA	33.45	29.34	14.27	090
43121		A	Partial removal of esophagus	51.43	NA	NA	23.19	22.50	12.00	090
43122		A	Partial removal of esophagus	44.18	NA	NA	22.75	21.64	9.61	090
43123		A	Partial removal of esophagus	83.12	NA	NA	41.83	35.91	17.67	090
43124		A	Removal of esophagus	69.09	NA	NA	36.58	32.29	16.15	090
43130		A	Removal of esophagus pouch	12.53	NA	NA	9.67	9.09	1.98	090

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43135		A	Removal of esophagus pouch	26.17	NA	NA	13.21	12.68	5.96	090
43200		A	Esophagus endoscopy	1.59	4.55	4.59	1.39	1.32	0.23	000
43201		A	Esoph scope w/submucous inj	2.09	6.22	6.37	1.50	1.49	0.30	000
43202		A	Esophagus endoscopy biopsy	1.89	6.07	6.21	1.33	1.28	0.29	000
43204		A	Esoph scope w/sclerosis inj	3.76	NA	NA	2.29	2.33	0.58	000
43205		A	Esophagus endoscopy/ligation	3.78	NA	NA	2.41	2.40	0.56	000
4320F		I	Pt talk psychsoc&rx oh dpnd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43215		A	Esophagus endoscopy	2.60	NA	NA	1.68	1.63	0.41	000
43216		A	Esophagus endoscopy/lesion	2.40	3.66	3.39	1.59	1.55	0.35	000
43217		A	Esophagus endoscopy	2.90	7.67	7.83	1.81	1.74	0.49	000
43219		A	Esophagus endoscopy	2.80	NA	NA	1.87	1.88	0.48	000
43220		A	Esoph endoscopy dilation	2.10	NA	NA	1.45	1.41	0.31	000
43226		A	Esoph endoscopy dilation	2.34	NA	NA	1.56	1.54	0.37	000
43227		A	Esoph endoscopy repair	3.59	NA	NA	2.23	2.19	0.54	000
43228		A	Esoph endoscopy ablation	3.76	NA	NA	2.39	2.36	0.58	000
43231		A	Esoph endoscopy w/us exam	3.19	NA	NA	2.07	2.06	0.48	000
43232		A	Esoph endoscopy w/us fn bx	4.47	NA	NA	2.74	2.73	0.69	000
43234		A	Upper gi endoscopy exam	2.01	5.79	5.96	1.33	1.28	0.34	000
43235		A	Uppr gi endoscopy diagnosis	2.39	5.74	6.03	1.62	1.61	0.37	000
43236		A	Uppr gi scope w/submuc inj	2.92	7.14	7.56	1.93	1.93	0.42	000
43237		A	Endoscopic us exam esoph	3.98	NA	NA	2.50	2.51	0.60	000
43238		A	Uppr gi endoscopy w/us fn bx	5.02	NA	NA	3.04	3.07	0.75	000
43239		A	Upper gi endoscopy biopsy	2.87	6.60	6.90	1.88	1.86	0.42	000
43240		A	Esoph endoscope w/drain cyst	6.85	NA	NA	4.08	4.06	1.03	000
43241		A	Upper gi endoscopy with tube	2.59	NA	NA	1.72	1.70	0.39	000
43242		A	Uppr gi endoscopy w/us fn bx	7.30	NA	NA	4.38	4.37	1.07	000
43243		A	Upper gi endoscopy & inject	4.56	NA	NA	2.81	2.81	0.68	000
43244		A	Upper gi endoscopy/ligation	5.04	NA	NA	3.12	3.12	0.73	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
43245		A	Uppr gi scope dilate strictr	3.18	NA	NA	2.01	1.97	0.50	000
43246		A	Place gastrostomy tube	4.32	NA	NA	2.59	2.56	0.69	000
43247		A	Operative upper gi endoscopy	3.38	NA	NA	2.15	2.13	0.52	000
43248		A	Uppr gi endoscopy/guide wire	3.15	NA	NA	2.06	2.07	0.45	000
43249		A	Esoph endoscopy dilation	2.90	NA	NA	1.91	1.91	0.42	000
4324F		I	Pt queried prkns complic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43250		A	Upper gi endoscopy/tumor	3.20	NA	NA	2.00	1.96	0.52	000
43251		A	Operative upper gi endoscopy	3.69	NA	NA	2.33	2.31	0.56	000
43255		A	Operative upper gi endoscopy	4.81	NA	NA	2.99	2.99	0.71	000
43256		A	Uppr gi endoscopy w/stent	4.34	NA	NA	2.65	2.65	0.68	000
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	NA	3.47	3.27	0.80	000
43258		A	Operative upper gi endoscopy	4.54	NA	NA	2.82	2.81	0.68	000
43259		A	Endoscopic ultrasound exam	5.19	NA	NA	3.20	3.20	0.75	000
4325F		I	Med txmnt options rvwd w/pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43260		A	Endo cholangiopancreatograph	5.95	NA	NA	3.61	3.62	0.87	000
43261		A	Endo cholangiopancreatograph	6.26	NA	NA	3.80	3.80	0.91	000
43262		A	Endo cholangiopancreatograph	7.38	NA	NA	4.42	4.42	1.09	000
43263		A	Endo cholangiopancreatograph	7.28	NA	NA	4.29	4.35	1.07	000
43264		A	Endo cholangiopancreatograph	8.89	NA	NA	5.26	5.27	1.30	000
43265		A	Endo cholangiopancreatograph	10.00	NA	NA	5.87	5.88	1.48	000
43267		A	Endo cholangiopancreatograph	7.38	NA	NA	4.37	4.37	1.09	000
43268		A	Endo cholangiopancreatograph	7.38	NA	NA	4.58	4.59	1.09	000
43269		A	Endo cholangiopancreatograph	8.20	NA	NA	4.87	4.87	1.21	000
4326F		I	Pt asked re symp auto dysfxn	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43271		A	Endo cholangiopancreatograph	7.38	NA	NA	4.41	4.41	1.09	000
43272		A	Endo cholangiopancreatograph	7.38	NA	NA	4.45	4.42	1.09	000
43273		A	Endoscopic pancreatoscopy	2.24	NA	NA	1.25	1.29	0.33	ZZZ
43279		A	Lap myotomy heller	22.10	NA	NA	12.06	11.01	4.70	090

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43280		A	Laparoscopy fundoplasty	18.10	NA	NA	10.44	9.56	3.84	090
43281		A	Lap paraesophag hern repair	26.60	NA	NA	14.16	14.16	5.65	090
43282		A	Lap paraesoph her rpr w/mesh	30.10	NA	NA	15.67	15.67	6.37	090
43283		A	Lap esoph lengthening	2.95	NA	NA	1.29	1.29	0.60	ZZZ
43289		C	Laparoscope proc esoph	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4328F		I	Pt asked re sleep disturb	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43300		A	Repair of esophagus	9.33	NA	NA	8.60	7.88	1.20	090
43305		A	Repair esophagus and fistula	18.10	NA	NA	13.62	12.49	2.31	090
4330F		I	Cnslng epi spec sfty issues	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43310		A	Repair of esophagus	26.26	NA	NA	12.49	12.83	6.12	090
43312		A	Repair esophagus and fistula	29.25	NA	NA	12.35	13.23	6.84	090
43313		A	Esophagoplasty congenital	48.45	NA	NA	26.11	23.68	11.33	090
43314		A	Tracheo-esophagoplasty cong	53.43	NA	NA	23.24	24.88	6.86	090
43320		A	Fuse esophagus & stomach	23.31	NA	NA	13.41	12.58	4.97	090
43325		A	Revise esophagus & stomach	22.60	NA	NA	12.41	11.59	4.82	090
43327		A	Esoph fundoplasty lap	13.35	NA	NA	8.16	8.16	2.84	090
43328		A	Esoph fundoplasty thor	19.91	NA	NA	10.87	10.87	4.97	090
43330		A	Esophagomyotomy abdominal	22.19	NA	NA	12.46	11.48	4.77	090
43331		A	Esophagomyotomy thoracic	23.06	NA	NA	12.31	12.41	5.39	090
43332		A	Transab esoph hiat hern rpr	19.62	NA	NA	11.07	11.07	4.17	090
43333		A	Transab esoph hiat hern rpr	21.46	NA	NA	11.85	11.85	4.54	090
43334		A	Transthor diaphrag hern rpr	22.12	NA	NA	11.44	11.44	4.70	090
43335		A	Transthor diaphrag hern rpr	23.97	NA	NA	12.18	12.18	5.07	090
43336		A	Thorabd diaphr hern repair	25.81	NA	NA	13.52	13.52	5.84	090
43337		A	Thorabd diaphr hern repair	27.65	NA	NA	15.40	15.40	6.26	090
43338		A	Esoph lengthening	2.21	NA	NA	1.30	1.30	0.50	ZZZ
43340		A	Fuse esophagus & intestine	22.99	NA	NA	13.27	12.22	4.89	090
43341		A	Fuse esophagus & intestine	24.23	NA	NA	14.86	14.17	5.66	090

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43350		A	Surgical opening esophagus	19.49	NA	NA	14.48	12.43	4.14	090
43351		A	Surgical opening esophagus	22.05	NA	NA	12.01	12.23	5.15	090
43352		A	Surgical opening esophagus	17.81	NA	NA	10.20	10.31	4.16	090
43360		A	Gastrointestinal repair	40.11	NA	NA	18.79	19.03	9.38	090
43361		A	Gastrointestinal repair	45.68	NA	NA	20.62	20.91	9.72	090
43400		A	Ligate esophagus veins	25.60	NA	NA	14.41	15.67	3.76	090
43401		A	Esophagus surgery for veins	26.49	NA	NA	12.55	12.38	5.64	090
43405		A	Ligate/staple esophagus	24.73	NA	NA	15.95	14.58	5.27	090
4340F		I	Cnslng chldbrng women epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43410		A	Repair esophagus wound	16.41	NA	NA	11.43	10.66	3.83	090
43415		A	Repair esophagus wound	28.91	NA	NA	16.36	15.72	6.59	090
43420		A	Repair esophagus opening	16.78	NA	NA	12.81	11.26	2.15	090
43425		A	Repair esophagus opening	25.04	NA	NA	15.22	14.46	5.34	090
43450		A	Dilate esophagus	1.38	2.90	3.06	1.08	1.08	0.22	000
43453		A	Dilate esophagus	1.51	6.58	7.02	1.15	1.16	0.23	000
43456		A	Dilate esophagus	2.57	13.84	14.78	1.73	1.71	0.38	000
43458		A	Dilate esophagus	3.06	7.68	7.97	1.98	1.94	0.45	000
43460		A	Pressure treatment esophagus	3.79	NA	NA	2.44	2.32	0.54	000
43496		C	Free jejunum flap microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
43499		C	Esophagus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43500		A	Surgical opening of stomach	12.79	NA	NA	7.94	7.25	2.70	090
43501		A	Surgical repair of stomach	22.60	NA	NA	12.81	11.60	4.77	090
43502		A	Surgical repair of stomach	25.69	NA	NA	14.40	12.97	5.46	090
43510		A	Surgical opening of stomach	15.14	NA	NA	11.40	10.33	2.21	090
43520		A	Incision of pyloric muscle	11.29	NA	NA	6.83	6.54	2.50	090
43605		A	Biopsy of stomach	13.72	NA	NA	8.67	7.71	2.87	090
43610		A	Excision of stomach lesion	16.34	NA	NA	9.52	8.62	3.45	090
43611		A	Excision of stomach lesion	20.38	NA	NA	11.79	10.72	4.29	090

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43620		A	Removal of stomach	34.04	NA	NA	17.62	16.04	7.24	090
43621		A	Removal of stomach	39.53	NA	NA	19.95	17.90	8.39	090
43622		A	Removal of stomach	40.03	NA	NA	20.37	18.20	8.53	090
43631		A	Removal of stomach partial	24.51	NA	NA	13.66	12.41	5.19	090
43632		A	Removal of stomach partial	35.14	NA	NA	18.22	16.03	7.40	090
43633		A	Removal of stomach partial	33.14	NA	NA	17.38	15.38	6.98	090
43634		A	Removal of stomach partial	36.64	NA	NA	19.18	16.96	7.79	090
43635		A	Removal of stomach partial	2.06	NA	NA	0.89	0.81	0.42	ZZZ
43640		A	Vagotomy & pylorus repair	19.56	NA	NA	11.57	10.44	4.11	090
43641		A	Vagotomy & pylorus repair	19.81	NA	NA	11.83	10.57	4.21	090
43644		A	Lap gastric bypass/roux-en-y	29.40	NA	NA	16.19	14.75	6.21	090
43645		A	Lap gastr bypass incl smll i	31.53	NA	NA	17.14	15.57	6.72	090
43647		C	Lap impl electrode antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43648		C	Lap revise/remv eltrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43651		A	Laparoscopy vagus nerve	10.13	NA	NA	7.17	6.56	2.16	090
43652		A	Laparoscopy vagus nerve	12.13	NA	NA	8.04	7.33	2.58	090
43653		A	Laparoscopy gastrostomy	8.48	NA	NA	6.66	6.09	1.81	090
43659		C	Laparoscope proc stom	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43752		A	Nasal/orogastric w/stent	0.81	NA	NA	0.32	0.33	0.08	000
43753		A	Tx gastro intub w/asp	0.45	NA	NA	0.13	0.13	0.03	000
43754		A	Dx gastr intub w/asp spec	0.45	1.84	1.84	0.44	0.44	0.04	000
43755		A	Dx gastr intub w/asp specs	0.94	2.53	2.53	0.68	0.68	0.08	000
43756		A	Dx duod intub w/asp spec	0.77	5.62	5.62	0.71	0.71	0.05	000
43757		A	Dx duod intub w/asp specs	1.26	6.95	6.95	0.87	0.87	0.08	000
43760		A	Change gastrostomy tube	0.90	12.32	10.90	0.42	0.43	0.14	000
43761		A	Reposition gastrostomy tube	2.01	1.22	1.30	0.83	0.88	0.24	000
43770		A	Lap place gastr adj device	18.00	NA	NA	11.55	10.54	3.80	090
43771		A	Lap revise gastr adj device	20.79	NA	NA	12.80	11.63	4.43	090

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43772		A	Lap rmvl gastr adj device	15.70	NA	NA	9.51	8.70	3.35	090
43773		A	Lap replace gastr adj device	20.79	NA	NA	12.77	11.63	4.43	090
43774		A	Lap rmvl gastr adj all parts	15.76	NA	NA	9.52	8.73	3.35	090
43775		N	Lap sleeve gastrectomy	21.56	NA	NA	12.14	12.14	4.59	XXX
43800		A	Reconstruction of pylorus	15.43	NA	NA	9.01	8.23	3.30	090
43810		A	Fusion of stomach and bowel	16.88	NA	NA	9.88	8.89	3.59	090
43820		A	Fusion of stomach and bowel	22.53	NA	NA	12.79	11.31	4.75	090
43825		A	Fusion of stomach and bowel	21.76	NA	NA	12.72	11.41	4.63	090
43830		A	Place gastrostomy tube	10.85	NA	NA	7.71	7.07	2.23	090
43831		A	Place gastrostomy tube	8.49	NA	NA	7.32	6.74	1.81	090
43832		A	Place gastrostomy tube	17.34	NA	NA	10.41	9.67	3.57	090
43840		A	Repair of stomach lesion	22.83	NA	NA	12.95	11.47	4.81	090
43842		N	V-band gastroplasty	21.03	NA	NA	11.67	11.26	1.49	090
43843		A	Gastroplasty w/o v-band	21.21	NA	NA	12.49	11.18	4.51	090
43845		A	Gastroplasty duodenal switch	33.30	NA	NA	18.37	16.42	7.05	090
43846		A	Gastric bypass for obesity	27.41	NA	NA	15.57	14.12	5.79	090
43847		A	Gastric bypass incl small i	30.28	NA	NA	17.12	15.23	6.44	090
43848		A	Revision gastroplasty	32.75	NA	NA	18.09	16.34	6.93	090
43850		A	Revise stomach-bowel fusion	27.58	NA	NA	15.22	13.59	5.87	090
43855		A	Revise stomach-bowel fusion	28.69	NA	NA	15.71	14.17	6.10	090
43860		A	Revise stomach-bowel fusion	27.89	NA	NA	15.08	13.69	5.87	090
43865		A	Revise stomach-bowel fusion	29.05	NA	NA	15.86	14.28	6.18	090
43870		A	Repair stomach opening	11.44	NA	NA	7.43	6.75	2.35	090
43880		A	Repair stomach-bowel fistula	27.18	NA	NA	14.84	13.46	5.69	090
43881		C	Impl/redo electrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43882		C	Revise/remove electrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43886		A	Revise gastric port open	4.64	NA	NA	5.06	4.63	0.99	090
43887		A	Remove gastric port open	4.32	NA	NA	4.41	4.07	0.91	090

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43888		A	Change gastric port open	6.44	NA	NA	5.81	5.33	1.37	090
43999		C	Stomach surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44005		A	Freeing of bowel adhesion	18.46	NA	NA	10.40	9.43	3.83	090
4400F		I	Rehab thxpy options w/pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44010		A	Incision of small bowel	14.26	NA	NA	8.62	7.82	3.00	090
44015		A	Insert needle cath bowel	2.62	NA	NA	1.10	1.03	0.56	ZZZ
44020		A	Explore small intestine	16.22	NA	NA	9.47	8.56	3.40	090
44021		A	Decompress small bowel	16.31	NA	NA	9.59	8.72	3.44	090
44025		A	Incision of large bowel	16.51	NA	NA	9.60	8.69	3.42	090
44050		A	Reduce bowel obstruction	15.52	NA	NA	9.16	8.31	3.23	090
44055		A	Correct malrotation of bowel	25.63	NA	NA	13.69	12.34	5.40	090
44100		A	Biopsy of bowel	2.01	NA	NA	1.09	1.10	0.31	000
44110		A	Excise intestine lesion(s)	14.04	NA	NA	8.42	7.65	2.89	090
44111		A	Excision of bowel lesion(s)	16.52	NA	NA	9.49	8.60	3.44	090
44120		A	Removal of small intestine	20.82	NA	NA	11.44	10.29	4.32	090
44121		A	Removal of small intestine	4.44	NA	NA	1.93	1.76	0.90	ZZZ
44125		A	Removal of small intestine	20.03	NA	NA	11.25	10.16	4.06	090
44126		A	Enterectomy w/o taper cong	42.23	NA	NA	22.56	20.09	8.98	090
44127		A	Enterectomy w/taper cong	49.30	NA	NA	25.55	22.80	10.48	090
44128		A	Enterectomy cong add-on	4.44	NA	NA	1.94	1.77	0.92	ZZZ
44130		A	Bowel to bowel fusion	22.11	NA	NA	12.62	11.13	4.55	090
44132		R	Enterectomy cadaver donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44133		R	Enterectomy live donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44135		R	Intestine transplnt cadaver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44136		R	Intestine transplant live	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44139		A	Mobilization of colon	2.23	NA	NA	0.97	0.88	0.43	ZZZ
44140		A	Partial removal of colon	22.59	NA	NA	12.89	11.69	4.63	090

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44141		A	Partial removal of colon	29.91	NA	NA	18.48	16.48	6.17	090
44143		A	Partial removal of colon	27.79	NA	NA	16.30	14.76	5.73	090
44144		A	Partial removal of colon	29.91	NA	NA	16.93	15.10	6.17	090
44145		A	Partial removal of colon	28.58	NA	NA	15.51	14.03	5.65	090
44146		A	Partial removal of colon	35.30	NA	NA	21.23	19.04	6.86	090
44147		A	Partial removal of colon	33.69	NA	NA	17.78	15.51	6.76	090
44150		A	Removal of colon	30.18	NA	NA	19.64	17.71	6.11	090
44151		A	Removal of colon/ileostomy	34.92	NA	NA	21.70	19.58	7.43	090
44155		A	Removal of colon/ileostomy	34.42	NA	NA	21.44	19.21	6.45	090
44156		A	Removal of colon/ileostomy	37.42	NA	NA	23.63	21.25	7.97	090
44157		A	Colectomy w/ileoanal anast	35.70	NA	NA	21.80	19.70	7.60	090
44158		A	Colectomy w/neo-rectum pouch	36.70	NA	NA	22.08	19.98	7.81	090
44160		A	Removal of colon	20.89	NA	NA	12.03	10.85	4.25	090
44180		A	Lap enterolysis	15.27	NA	NA	9.05	8.28	3.16	090
44186		A	Lap jejunostomy	10.38	NA	NA	6.85	6.35	2.21	090
44187		A	Lap ileo/jejuno-stomy	17.40	NA	NA	12.29	11.21	3.30	090
44188		A	Lap colostomy	19.35	NA	NA	13.42	12.23	3.83	090
44202		A	Lap enterectomy	23.39	NA	NA	13.28	12.04	4.83	090
44203		A	Lap resect s/intestine addl	4.44	NA	NA	1.92	1.74	0.92	ZZZ
44204		A	Laparo partial colectomy	26.42	NA	NA	14.55	13.13	5.21	090
44205		A	Lap colectomy part w/ileum	22.95	NA	NA	12.77	11.54	4.49	090
44206		A	Lap part colectomy w/stoma	29.79	NA	NA	16.86	15.23	6.04	090
44207		A	L colectomy/coloproctostomy	31.92	NA	NA	16.86	15.14	6.17	090
44208		A	L colectomy/coloproctostomy	33.99	NA	NA	19.35	17.46	6.38	090
44210		A	Laparo total proctocolectomy	30.09	NA	NA	17.95	16.20	5.80	090
44211		A	Lap colectomy w/proctectomy	37.08	NA	NA	22.46	20.00	7.90	090
44212		A	Laparo total proctocolectomy	34.58	NA	NA	20.78	18.80	6.36	090
44213		A	Lap mobil splenic fl add-on	3.50	NA	NA	1.52	1.38	0.67	ZZZ

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44227		A	Lap close enterostomy	28.62	NA	NA	15.65	14.14	5.83	090
44238		C	Laparoscope proc intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44300		A	Open bowel to skin	13.75	NA	NA	8.52	7.77	2.91	090
44310		A	Ileostomy/jejunostomy	17.59	NA	NA	10.20	9.24	3.45	090
44312		A	Revision of ileostomy	9.43	NA	NA	6.47	6.06	1.71	090
44314		A	Revision of ileostomy	16.74	NA	NA	10.22	9.39	3.15	090
44316		A	Devise bowel pouch	23.59	NA	NA	13.61	12.22	5.02	090
44320		A	Colostomy	19.91	NA	NA	11.96	10.82	4.06	090
44322		A	Colostomy with biopsies	13.32	NA	NA	13.43	12.28	2.84	090
44340		A	Revision of colostomy	9.28	NA	NA	7.38	6.68	1.87	090
44345		A	Revision of colostomy	17.22	NA	NA	10.84	9.81	3.44	090
44346		A	Revision of colostomy	19.63	NA	NA	11.91	10.72	3.87	090
44360		A	Small bowel endoscopy	2.59	NA	NA	1.76	1.77	0.38	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	NA	1.92	1.92	0.41	000
44363		A	Small bowel endoscopy	3.49	NA	NA	2.24	2.20	0.52	000
44364		A	Small bowel endoscopy	3.73	NA	NA	2.38	2.38	0.54	000
44365		A	Small bowel endoscopy	3.31	NA	NA	2.15	2.14	0.49	000
44366		A	Small bowel endoscopy	4.40	NA	NA	2.78	2.78	0.64	000
44369		A	Small bowel endoscopy	4.51	NA	NA	2.84	2.83	0.65	000
44370		A	Small bowel endoscopy/stent	4.79	NA	NA	3.18	3.15	0.69	000
44372		A	Small bowel endoscopy	4.40	NA	NA	2.64	2.59	0.69	000
44373		A	Small bowel endoscopy	3.49	NA	NA	2.16	2.16	0.53	000
44376		A	Small bowel endoscopy	5.25	NA	NA	3.10	3.08	0.81	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	NA	3.33	3.33	0.81	000
44378		A	Small bowel endoscopy	7.12	NA	NA	4.27	4.25	1.05	000
44379		A	S bowel endoscope w/stent	7.46	NA	NA	4.69	4.61	1.09	000
44380		A	Small bowel endoscopy	1.05	NA	NA	0.84	0.86	0.14	000
44382		A	Small bowel endoscopy	1.27	NA	NA	1.01	1.01	0.20	000

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44383		A	Ileoscopy w/stent	2.94	NA	NA	1.62	1.79	0.33	000
44385		A	Endoscopy of bowel pouch	1.82	5.37	5.39	1.11	1.08	0.26	000
44386		A	Endoscopy bowel pouch/biop	2.12	7.66	7.85	1.38	1.31	0.33	000
44388		A	Colonoscopy	2.82	6.97	7.03	1.75	1.70	0.45	000
44389		A	Colonoscopy with biopsy	3.13	7.93	8.17	1.97	1.93	0.49	000
44390		A	Colonoscopy for foreign body	3.82	9.19	9.33	2.45	2.32	0.56	000
44391		A	Colonoscopy for bleeding	4.31	9.55	10.06	2.62	2.59	0.65	000
44392		A	Colonoscopy & polypectomy	3.81	8.41	8.49	2.21	2.13	0.62	000
44393		A	Colonoscopy lesion removal	4.83	9.32	9.39	2.85	2.76	0.76	000
44394		A	Colonoscopy w/snare	4.42	9.53	9.81	2.63	2.58	0.69	000
44397		A	Colonoscopy w/stent	4.70	NA	NA	2.94	2.89	0.68	000
44500		A	Intro gastrointestinal tube	0.49	NA	NA	0.19	0.21	0.04	000
44602		A	Suture small intestine	24.72	NA	NA	12.45	10.90	5.09	090
44603		A	Suture small intestine	28.16	NA	NA	14.59	12.79	5.74	090
44604		A	Suture large intestine	18.16	NA	NA	9.77	8.83	3.71	090
44605		A	Repair of bowel lesion	22.08	NA	NA	12.54	11.34	4.55	090
44615		A	Intestinal stricturoplasty	18.16	NA	NA	10.36	9.39	3.72	090
44620		A	Repair bowel opening	14.43	NA	NA	8.72	7.83	2.82	090
44625		A	Repair bowel opening	17.28	NA	NA	9.95	8.93	3.35	090
44626		A	Repair bowel opening	27.90	NA	NA	14.56	13.15	5.69	090
44640		A	Repair bowel-skin fistula	24.20	NA	NA	12.97	11.73	4.88	090
44650		A	Repair bowel fistula	25.12	NA	NA	13.23	12.08	5.05	090
44660		A	Repair bowel-bladder fistula	23.91	NA	NA	12.16	11.93	3.84	090
44661		A	Repair bowel-bladder fistula	27.35	NA	NA	13.99	13.04	5.09	090
44680		A	Surgical revision intestine	17.96	NA	NA	10.27	9.29	3.83	090
44700		A	Suspend bowel w/prosthesis	17.48	NA	NA	9.98	9.00	3.03	090
44701		A	Intraop colon lavage add-on	3.10	NA	NA	1.34	1.21	0.58	ZZZ
44715		C	Prepare donor intestine	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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44720		A	Prep donor intestine/venous	5.00	NA	NA	2.18	2.13	0.35	XXX
44721		A	Prep donor intestine/artery	7.00	NA	NA	3.08	2.82	1.49	XXX
44799		C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44800		A	Excision of bowel pouch	12.05	NA	NA	8.24	7.56	2.43	090
44820		A	Excision of mesentery lesion	13.73	NA	NA	8.49	7.78	2.82	090
44850		A	Repair of mesentery	12.11	NA	NA	7.76	7.00	2.51	090
44899		C	Bowel surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44900		A	Drain app abscess open	12.57	NA	NA	7.90	7.12	2.63	090
44901		A	Drain app abscess percut	3.37	21.51	24.14	1.26	1.39	0.35	000
44950		A	Appendectomy	10.60	NA	NA	6.34	5.79	2.23	090
44955		A	Appendectomy add-on	1.53	NA	NA	0.68	0.62	0.31	ZZZ
44960		A	Appendectomy	14.50	NA	NA	8.54	7.71	3.07	090
44970		A	Laparoscopy appendectomy	9.45	NA	NA	6.44	5.86	1.97	090
44979		C	Laparoscope proc app	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45000		A	Drainage of pelvic abscess	6.30	NA	NA	5.15	4.74	1.09	090
45005		A	Drainage of rectal abscess	2.02	5.31	5.08	2.25	2.10	0.38	010
45020		A	Drainage of rectal abscess	8.56	NA	NA	6.70	6.02	1.62	090
45100		A	Biopsy of rectum	4.04	NA	NA	4.07	3.73	0.72	090
45108		A	Removal of anorectal lesion	5.12	NA	NA	4.70	4.25	1.09	090
45110		A	Removal of rectum	30.76	NA	NA	18.89	17.06	5.81	090
45111		A	Partial removal of rectum	18.01	NA	NA	11.10	10.03	3.54	090
45112		A	Removal of rectum	33.18	NA	NA	17.42	15.61	6.07	090
45113		A	Partial proctectomy	33.22	NA	NA	18.99	17.08	7.06	090
45114		A	Partial removal of rectum	30.79	NA	NA	16.98	15.09	6.56	090
45116		A	Partial removal of rectum	27.72	NA	NA	15.62	13.78	3.95	090
45119		A	Remove rectum w/reservoir	33.48	NA	NA	19.30	17.17	5.85	090
45120		A	Removal of rectum	26.40	NA	NA	15.47	13.91	5.62	090
45121		A	Removal of rectum and colon	29.08	NA	NA	16.64	14.91	6.18	090

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45123		A	Partial proctectomy	18.86	NA	NA	11.50	10.16	3.16	090
45126		A	Pelvic exenteration	49.10	NA	NA	26.72	24.96	10.44	090
45130		A	Excision of rectal prolapse	18.50	NA	NA	11.07	9.81	3.12	090
45135		A	Excision of rectal prolapse	22.36	NA	NA	13.95	12.35	4.75	090
45136		A	Excise ileoanal reservior	30.82	NA	NA	19.04	17.17	4.40	090
45150		A	Excision of rectal stricture	5.85	NA	NA	5.16	4.74	0.83	090
45160		A	Excision of rectal lesion	16.33	NA	NA	10.30	9.36	3.48	090
45171		A	Exc rect tum transanal part	8.13	NA	NA	8.06	8.06	1.51	090
45172		A	Exc rect tum transanal full	12.13	NA	NA	9.80	9.80	2.23	090
45190		A	Destruction rectal tumor	10.42	NA	NA	8.26	7.45	1.86	090
45300		A	Proctosigmoidoscopy dx	0.80	2.59	2.43	0.68	0.60	0.12	000
45303		A	Proctosigmoidoscopy dilate	1.50	24.73	24.19	1.00	0.86	0.26	000
45305		A	Proctosigmoidoscopy w/bx	1.25	4.08	3.90	0.90	0.81	0.23	000
45307		A	Proctosigmoidoscopy fb	1.70	4.24	4.01	1.07	0.93	0.33	000
45308		A	Proctosigmoidoscopy removal	1.40	4.37	4.01	0.98	0.85	0.26	000
45309		A	Proctosigmoidoscopy removal	1.50	4.45	4.28	1.03	0.97	0.27	000
45315		A	Proctosigmoidoscopy removal	1.80	4.86	4.57	1.14	1.07	0.33	000
45317		A	Proctosigmoidoscopy bleed	2.00	4.44	4.13	1.23	1.08	0.33	000
45320		A	Proctosigmoidoscopy ablate	1.78	4.26	4.19	1.15	1.08	0.31	000
45321		A	Proctosigmoidoscopy volvul	1.75	NA	NA	1.17	1.07	0.33	000
45327		A	Proctosigmoidoscopy w/stent	2.00	NA	NA	1.45	1.32	0.42	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.93	2.96	0.80	0.77	0.14	000
45331		A	Sigmoidoscopy and biopsy	1.15	3.57	3.73	0.94	0.93	0.18	000
45332		A	Sigmoidoscopy w/fb removal	1.79	6.25	6.38	1.27	1.23	0.29	000
45333		A	Sigmoidoscopy & polypectomy	1.79	6.37	6.47	1.24	1.21	0.29	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	NA	1.80	1.80	0.39	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	5.81	5.77	1.09	1.07	0.23	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	NA	1.56	1.52	0.38	000

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45338		A	Sigmoidoscopy w/tumr remove	2.34	6.47	6.68	1.56	1.54	0.35	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	6.28	6.25	2.00	1.98	0.48	000
45340		A	Sig w/balloon dilation	1.89	11.33	11.23	1.31	1.27	0.30	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	NA	1.74	1.73	0.38	000
45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	NA	2.57	2.55	0.60	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	NA	1.90	1.88	0.43	000
45355		A	Surgical colonoscopy	3.51	NA	NA	2.10	1.99	0.58	000
45378		A	Diagnostic colonoscopy	3.69	7.15	7.41	2.27	2.23	0.58	000
45378	53	A	Diagnostic colonoscopy	0.96	2.93	2.96	0.80	0.77	0.14	000
45379		A	Colonoscopy w/fb removal	4.68	9.27	9.50	2.83	2.74	0.72	000
45380		A	Colonoscopy and biopsy	4.43	8.51	8.86	2.73	2.70	0.67	000
45381		A	Colonoscopy submucous inj	4.19	8.39	8.76	2.60	2.58	0.62	000
45382		A	Colonoscopy/control bleeding	5.68	11.16	11.76	3.44	3.43	0.84	000
45383		A	Lesion removal colonoscopy	5.86	9.79	9.99	3.39	3.29	0.91	000
45384		A	Lesion remove colonoscopy	4.69	8.19	8.39	2.77	2.71	0.73	000
45385		A	Lesion removal colonoscopy	5.30	9.27	9.63	3.19	3.15	0.80	000
45386		A	Colonoscopy dilate stricture	4.57	13.60	14.23	2.74	2.69	0.72	000
45387		A	Colonoscopy w/stent	5.90	NA	NA	3.64	3.58	0.88	000
45391		A	Colonoscopy w/endoscope us	5.09	NA	NA	3.10	3.08	0.73	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	NA	3.90	3.86	1.02	000
45395		A	Lap removal of rectum	33.00	NA	NA	20.67	18.73	5.98	090
45397		A	Lap remove rectum w/pouch	36.50	NA	NA	22.03	19.73	6.00	090
45400		A	Laparoscopic proc	19.44	NA	NA	11.55	10.40	3.56	090
45402		A	Lap proctopexy w/sig resect	26.51	NA	NA	14.64	13.12	4.81	090
45499		C	Laparoscope proc rectum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45500		A	Repair of rectum	7.73	NA	NA	6.62	5.95	1.21	090
45505		A	Repair of rectum	8.36	NA	NA	7.63	6.81	1.51	090
45520		A	Treatment of rectal prolapse	0.55	3.75	3.43	0.57	0.52	0.07	000

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45540		A	Correct rectal prolapse	18.12	NA	NA	10.43	9.37	3.11	090
45541		A	Correct rectal prolapse	14.85	NA	NA	10.31	9.23	2.58	090
45550		A	Repair rectum/remove sigmoid	24.80	NA	NA	14.66	13.09	4.47	090
45560		A	Repair of rectocele	11.50	NA	NA	7.56	7.18	1.79	090
45562		A	Exploration/repair of rectum	17.98	NA	NA	11.89	10.92	3.37	090
45563		A	Exploration/repair of rectum	26.38	NA	NA	17.05	15.30	5.62	090
45800		A	Repair rect/bladder fistula	20.31	NA	NA	11.96	11.54	3.38	090
45805		A	Repair fistula w/colostomy	23.32	NA	NA	15.22	13.69	4.97	090
45820		A	Repair rectourethral fistula	20.37	NA	NA	12.48	11.75	1.96	090
45825		A	Repair fistula w/colostomy	24.17	NA	NA	15.55	14.46	3.45	090
45900		A	Reduction of rectal prolapse	2.99	NA	NA	2.44	2.23	0.56	010
45905		A	Dilation of anal sphincter	2.35	NA	NA	2.23	2.09	0.41	010
45910		A	Dilation of rectal narrowing	2.85	NA	NA	2.45	2.34	0.48	010
45915		A	Remove rectal obstruction	3.19	5.73	5.45	2.94	2.73	0.52	010
45990		A	Surg dx exam anorectal	1.80	NA	NA	1.10	1.02	0.31	000
45999		C	Rectum surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
46020		A	Placement of seton	3.00	4.52	4.09	3.37	3.04	0.54	010
46030		A	Removal of rectal marker	1.26	2.56	2.35	1.19	1.08	0.23	010
46040		A	Incision of rectal abscess	5.37	9.00	8.35	5.73	5.28	1.05	090
46045		A	Incision of rectal abscess	5.87	NA	NA	5.72	5.15	1.17	090
46050		A	Incision of anal abscess	1.24	4.24	3.96	1.40	1.28	0.24	010
46060		A	Incision of rectal abscess	6.37	NA	NA	6.46	5.80	1.18	090
46070		A	Incision of anal septum	2.79	NA	NA	3.83	3.50	0.20	090
46080		A	Incision of anal sphincter	2.52	4.22	3.89	1.74	1.58	0.49	010
46083		A	Incise external hemorrhoid	1.45	3.33	3.33	1.45	1.38	0.24	010
46200		A	Removal of anal fissure	3.59	8.49	7.72	5.24	4.79	0.62	090
46220		A	Excise anal ext tag/papilla	1.61	4.05	3.76	1.61	1.47	0.30	010
46221		A	Ligation of hemorrhoid(s)	2.36	5.00	4.62	2.84	2.62	0.41	010

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46230		A	Removal of anal tags	2.62	4.83	4.50	2.04	1.85	0.48	010
46250		A	Remove ext hem groups 2+	4.25	8.25	7.70	4.19	3.84	0.81	090
46255		A	Remove int/ext hem 1 group	4.96	8.64	8.15	4.50	4.13	0.95	090
46257		A	Remove in/ex hem grp & fiss	5.76	NA	NA	5.61	5.04	1.07	090
46258		A	Remove in/ex hem grp w/fistu	6.41	NA	NA	6.09	5.46	1.37	090
46260		A	Remove in/ex hem groups 2+	6.73	NA	NA	6.02	5.41	1.26	090
46261		A	Remove in/ex hem grps & fiss	7.76	NA	NA	6.51	5.84	1.39	090
46262		A	Remove in/ex hem grps w/fist	7.91	NA	NA	7.01	6.31	1.44	090
46270		A	Remove anal fist subq	4.92	8.77	8.09	5.61	5.07	0.98	090
46275		A	Remove anal fist inter	5.42	9.13	8.33	5.77	5.20	0.98	090
46280		A	Remove anal fist complex	6.39	NA	NA	6.29	5.64	1.13	090
46285		A	Remove anal fist 2 stage	5.42	9.09	8.14	5.80	5.17	0.91	090
46288		A	Repair anal fistula	7.81	NA	NA	7.04	6.31	1.33	090
46320		A	Removal of hemorrhoid clot	1.64	3.35	3.11	1.35	1.23	0.30	010
46500		A	Injection into hemorrhoid(s)	1.69	4.81	4.39	1.84	1.68	0.29	010
46505		A	Chemodenervation anal musc	3.18	4.60	4.29	3.33	3.04	0.58	010
46600		A	Diagnostic anoscopy	0.55	1.86	1.80	0.57	0.51	0.08	000
46604		A	Anoscopy and dilation	1.03	15.93	14.94	0.77	0.72	0.16	000
46606		A	Anoscopy and biopsy	1.20	4.95	4.84	0.87	0.78	0.23	000
46608		A	Anoscopy remove for body	1.30	5.11	4.93	0.86	0.80	0.24	000
46610		A	Anoscopy remove lesion	1.28	4.97	4.84	0.91	0.83	0.24	000
46611		A	Anoscopy	1.30	3.57	3.43	0.93	0.85	0.23	000
46612		A	Anoscopy remove lesions	1.50	5.78	5.69	1.01	0.97	0.31	000
46614		A	Anoscopy control bleeding	1.00	2.50	2.49	0.78	0.76	0.14	000
46615		A	Anoscopy	1.50	2.40	2.37	1.01	0.97	0.29	000
46700		A	Repair of anal stricture	9.81	NA	NA	7.96	7.08	1.63	090
46705		A	Repair of anal stricture	7.43	NA	NA	6.23	6.02	0.52	090
46706		A	Repr of anal fistula w/glue	2.44	NA	NA	2.09	1.95	0.42	010

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46707		A	Repair anorectal fist w/plug	6.39	NA	NA	6.52	6.52	0.90	090
46710		A	Repr per/vag pouch sngl proc	17.14	NA	NA	11.59	10.81	3.67	090
46712		A	Repr per/vag pouch dbl proc	36.45	NA	NA	22.21	19.99	2.58	090
46715		A	Rep perf anoper fistu	7.62	NA	NA	6.38	5.87	0.53	090
46716		A	Rep perf anoper/vestib fistu	17.54	NA	NA	13.80	14.51	1.24	090
46730		A	Construction of absent anus	30.65	NA	NA	19.25	18.50	2.17	090
46735		A	Construction of absent anus	36.14	NA	NA	21.67	20.80	2.57	090
46740		A	Construction of absent anus	33.90	NA	NA	22.59	20.28	7.21	090
46742		A	Repair of imperforated anus	40.14	NA	NA	25.22	22.99	8.54	090
46744		A	Repair of cloacal anomaly	58.94	NA	NA	35.38	30.59	8.41	090
46746		A	Repair of cloacal anomaly	65.44	NA	NA	34.70	33.69	4.63	090
46748		A	Repair of cloacal anomaly	71.42	NA	NA	33.57	33.79	5.07	090
46750		A	Repair of anal sphincter	12.15	NA	NA	8.64	7.87	1.97	090
46751		A	Repair of anal sphincter	9.30	NA	NA	6.98	6.92	1.56	090
46753		A	Reconstruction of anus	8.89	NA	NA	7.00	6.31	1.51	090
46754		A	Removal of suture from anus	3.01	5.22	4.88	3.40	3.02	0.42	010
46760		A	Repair of anal sphincter	17.45	NA	NA	12.54	11.16	2.47	090
46761		A	Repair of anal sphincter	15.29	NA	NA	10.19	9.13	2.42	090
46762		A	Implant artificial sphincter	14.82	NA	NA	10.48	9.46	2.12	090
46900		A	Destruction anal lesion(s)	1.91	4.76	4.47	1.90	1.77	0.30	010
46910		A	Destruction anal lesion(s)	1.91	4.90	4.70	1.71	1.59	0.34	010
46916		A	Cryosurgery anal lesion(s)	1.91	4.56	4.53	2.16	2.05	0.27	010
46917		A	Laser surgery anal lesions	1.91	10.96	10.89	1.74	1.62	0.33	010
46922		A	Excision of anal lesion(s)	1.91	5.39	5.08	1.75	1.60	0.35	010
46924		A	Destruction anal lesion(s)	2.81	12.04	11.73	2.25	2.06	0.45	010
46930		A	Destroy internal hemorrhoids	1.61	3.94	4.14	2.41	2.49	0.26	090
46940		A	Treatment of anal fissure	2.35	3.94	3.59	1.65	1.49	0.37	010
46942		A	Treatment of anal fissure	2.07	3.85	3.50	1.52	1.37	0.33	010

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46945		A	Remove by ligat int hem grp	2.21	6.17	5.76	3.93	3.70	0.38	090
46946		A	Remove by ligat int hem grps	2.63	5.87	5.62	3.49	3.33	0.43	090
46947		A	Hemorrhoidopexy by stapling	5.57	NA	NA	4.68	4.23	1.09	090
46999		C	Anus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47000		A	Needle biopsy of liver	1.90	8.20	8.09	0.74	0.82	0.20	000
47001		A	Needle biopsy liver add-on	1.90	NA	NA	0.82	0.75	0.38	ZZZ
47010		A	Open drainage liver lesion	19.40	NA	NA	12.19	11.36	3.95	090
47011		A	Percut drain liver lesion	3.69	NA	NA	1.36	1.54	0.35	000
47015		A	Inject/aspirate liver cyst	18.50	NA	NA	12.17	10.98	3.92	090
47100		A	Wedge biopsy of liver	12.91	NA	NA	9.48	8.67	2.69	090
47120		A	Partial removal of liver	39.01	NA	NA	22.18	20.23	8.24	090
47122		A	Extensive removal of liver	59.48	NA	NA	30.30	27.65	12.62	090
47125		A	Partial removal of liver	53.04	NA	NA	27.49	25.09	11.18	090
47130		A	Partial removal of liver	57.19	NA	NA	29.16	26.67	12.02	090
47133		X	Removal of donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47135		R	Transplantation of liver	83.64	NA	NA	44.88	40.79	17.67	090
47136		R	Transplantation of liver	70.74	NA	NA	37.60	34.87	15.06	090
47140		A	Partial removal donor liver	59.40	NA	NA	34.45	31.12	12.64	090
47141		A	Partial removal donor liver	71.50	NA	NA	38.50	35.66	5.07	090
47142		A	Partial removal donor liver	79.44	NA	NA	44.07	39.87	16.89	090
47143		C	Prep donor liver whole	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47144		C	Prep donor liver 3-segment	0.00	0.00	0.00	0.00	0.00	0.00	090
47145		C	Prep donor liver lobe split	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47146		A	Prep donor liver/venous	6.00	NA	NA	2.62	2.38	1.28	XXX
47147		A	Prep donor liver/arterial	7.00	NA	NA	3.06	2.78	1.48	XXX
47300		A	Surgery for liver lesion	18.14	NA	NA	11.86	10.71	3.83	090
47350		A	Repair liver wound	22.49	NA	NA	13.72	12.50	4.69	090
47360		A	Repair liver wound	31.31	NA	NA	18.05	16.30	6.65	090

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47361		A	Repair liver wound	52.60	NA	NA	26.72	24.42	10.67	090
47362		A	Repair liver wound	23.54	NA	NA	14.66	13.13	4.93	090
47370		A	Laparo ablate liver tumor rf	20.80	NA	NA	11.93	10.91	4.21	090
47371		A	Laparo ablate liver cryosurg	20.80	NA	NA	12.25	11.39	4.43	090
47379		C	Laparoscope procedure liver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47380		A	Open ablate liver tumor rf	24.56	NA	NA	13.38	12.35	4.94	090
47381		A	Open ablate liver tumor cryo	24.88	NA	NA	11.36	11.58	5.30	090
47382		A	Percut ablate liver rf	15.22	120.12	120.12	6.22	7.17	1.48	010
47399		C	Liver surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47400		A	Incision of liver duct	36.36	NA	NA	20.26	18.33	7.73	090
47420		A	Incision of bile duct	22.03	NA	NA	13.34	12.14	4.66	090
47425		A	Incision of bile duct	22.31	NA	NA	13.69	12.35	4.75	090
47460		A	Incise bile duct sphincter	20.52	NA	NA	12.91	12.10	4.36	090
47480		A	Incision of gallbladder	13.25	NA	NA	9.90	9.03	2.74	090
47490		A	Incision of gallbladder	4.76	NA	NA	4.32	5.57	0.43	010
47500		A	Injection for liver x-rays	1.96	NA	NA	0.71	0.82	0.20	000
47505		A	Injection for liver x-rays	0.76	NA	NA	0.28	0.32	0.07	000
47510		A	Insert catheter bile duct	8.03	NA	NA	4.88	5.46	0.80	090
47511		A	Insert bile duct drain	10.77	NA	NA	5.16	5.89	1.02	090
47525		A	Change bile duct catheter	1.54	12.36	13.52	0.81	1.23	0.14	000
47530		A	Revise/reinsert bile tube	6.05	33.64	36.11	3.65	4.09	0.61	090
47550		A	Bile duct endoscopy add-on	3.02	NA	NA	1.32	1.21	0.62	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	NA	2.60	2.94	0.62	000
47553		A	Biliary endoscopy thru skin	6.34	NA	NA	2.34	2.63	0.62	000
47554		A	Biliary endoscopy thru skin	9.05	NA	NA	4.07	4.16	1.51	000
47555		A	Biliary endoscopy thru skin	7.55	NA	NA	2.72	3.14	0.71	000
47556		A	Biliary endoscopy thru skin	8.55	NA	NA	3.10	3.57	0.80	000
47560		A	Laparoscopy w/cholangio	4.88	NA	NA	2.13	1.96	1.05	000

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47561		A	Laparo w/cholangio/biopsy	5.17	NA	NA	2.55	2.34	1.10	000
47562		A	Laparoscopic cholecystectomy	11.76	NA	NA	8.08	7.32	2.47	090
47563		A	Laparo cholecystectomy/graph	12.11	NA	NA	7.86	7.17	2.57	090
47564		A	Laparo cholecystectomy/explr	14.24	NA	NA	8.49	7.77	3.03	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	NA	7.86	7.18	2.66	090
47579		C	Laparoscope proc biliary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47600		A	Removal of gallbladder	17.48	NA	NA	11.15	9.98	3.69	090
47605		A	Removal of gallbladder	15.98	NA	NA	9.92	9.02	3.40	090
47610		A	Removal of gallbladder	20.92	NA	NA	12.08	10.96	4.44	090
47612		A	Removal of gallbladder	21.21	NA	NA	12.15	11.02	4.49	090
47620		A	Removal of gallbladder	23.07	NA	NA	13.18	11.90	4.93	090
47630		A	Remove bile duct stone	9.65	NA	NA	5.27	5.71	1.21	090
47700		A	Exploration of bile ducts	16.50	NA	NA	11.28	10.34	3.52	090
47701		A	Bile duct revision	28.73	NA	NA	16.91	16.21	6.10	090
47711		A	Excision of bile duct tumor	25.90	NA	NA	15.17	13.78	5.47	090
47712		A	Excision of bile duct tumor	33.72	NA	NA	18.82	16.96	7.18	090
47715		A	Excision of bile duct cyst	21.55	NA	NA	13.50	12.14	4.59	090
47720		A	Fuse gallbladder & bowel	18.34	NA	NA	11.91	10.81	3.87	090
47721		A	Fuse upper gi structures	21.99	NA	NA	13.70	12.33	4.69	090
47740		A	Fuse gallbladder & bowel	21.23	NA	NA	13.36	12.00	4.51	090
47741		A	Fuse gallbladder & bowel	24.21	NA	NA	14.67	13.22	5.15	090
47760		A	Fuse bile ducts and bowel	38.32	NA	NA	21.00	18.53	8.09	090
47765		A	Fuse liver ducts & bowel	52.19	NA	NA	27.60	23.85	11.11	090
47780		A	Fuse bile ducts and bowel	42.32	NA	NA	22.63	19.92	8.96	090
47785		A	Fuse bile ducts and bowel	56.19	NA	NA	28.92	25.19	11.96	090
47800		A	Reconstruction of bile ducts	26.17	NA	NA	15.49	13.99	5.58	090
47801		A	Placement bile duct support	17.60	NA	NA	10.00	10.40	2.43	090
47802		A	Fuse liver duct & intestine	24.93	NA	NA	15.27	13.79	5.31	090

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47900		A	Suture bile duct injury	22.44	NA	NA	13.49	12.29	4.71	090
47999		C	Bile tract surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
48000		A	Drainage of abdomen	31.95	NA	NA	16.98	15.69	6.17	090
48001		A	Placement of drain pancreas	39.69	NA	NA	20.93	18.88	8.46	090
48020		A	Removal of pancreatic stone	19.09	NA	NA	11.93	10.83	4.07	090
48100		A	Biopsy of pancreas open	14.46	NA	NA	9.00	8.20	2.99	090
48102		A	Needle biopsy pancreas	4.70	10.25	10.82	1.98	2.25	0.43	010
48105		A	Resect/debride pancreas	49.26	NA	NA	25.85	23.20	10.28	090
48120		A	Removal of pancreas lesion	18.41	NA	NA	10.73	9.73	3.90	090
48140		A	Partial removal of pancreas	26.32	NA	NA	14.77	13.39	5.57	090
48145		A	Partial removal of pancreas	27.39	NA	NA	15.56	13.96	5.81	090
48146		A	Pancreatectomy	30.60	NA	NA	18.92	17.00	6.50	090
48148		A	Removal of pancreatic duct	20.39	NA	NA	12.50	11.23	4.33	090
48150		A	Partial removal of pancreas	52.84	NA	NA	28.53	26.02	11.20	090
48152		A	Pancreatectomy	48.65	NA	NA	27.23	24.63	10.36	090
48153		A	Pancreatectomy	52.79	NA	NA	28.51	25.96	11.19	090
48154		A	Pancreatectomy	48.88	NA	NA	27.33	24.63	10.40	090
48155		A	Removal of pancreas	29.45	NA	NA	18.34	16.69	6.26	090
48160		N	Pancreas removal/transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48400		A	Injection intraop add-on	1.95	NA	NA	0.85	0.86	0.29	ZZZ
48500		A	Surgery of pancreatic cyst	18.16	NA	NA	12.23	11.03	3.86	090
48510		A	Drain pancreatic pseudocyst	17.19	NA	NA	11.56	10.53	3.59	090
48511		A	Drain pancreatic pseudocyst	3.99	21.85	23.46	1.48	1.68	0.38	000
48520		A	Fuse pancreas cyst and bowel	18.15	NA	NA	10.64	9.67	3.83	090
48540		A	Fuse pancreas cyst and bowel	21.94	NA	NA	11.97	10.95	4.66	090
48545		A	Pancreatorrhaphy	22.23	NA	NA	13.18	11.76	4.74	090
48547		A	Duodenal exclusion	30.38	NA	NA	16.74	14.98	6.45	090
48548		A	Fuse pancreas and bowel	28.09	NA	NA	15.64	14.21	5.96	090

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48550		X	Donor pancreatectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48551		C	Prep donor pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	NA	1.88	1.73	0.90	XXX
48554		R	Transpl allograft pancreas	37.80	NA	NA	30.15	27.65	7.88	090
48556		A	Removal allograft pancreas	19.47	NA	NA	14.12	12.84	4.14	090
48999		C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49000		A	Exploration of abdomen	12.54	NA	NA	7.85	7.26	2.57	090
49002		A	Reopening of abdomen	17.63	NA	NA	9.96	8.85	3.65	090
49010		A	Exploration behind abdomen	16.06	NA	NA	8.90	8.38	3.19	090
49020		A	Drain abdominal abscess	26.67	NA	NA	15.41	14.06	5.40	090
49021		A	Drain abdominal abscess	3.37	21.10	22.81	1.24	1.41	0.31	000
49040		A	Drain open abdom abscess	16.52	NA	NA	9.99	9.12	3.38	090
49041		A	Drain percut abdom abscess	3.99	21.53	22.93	1.46	1.66	0.38	000
49060		A	Drain open retrop abscess	18.53	NA	NA	10.59	9.94	3.68	090
49061		A	Drain percut retroper absc	3.69	21.18	22.69	1.36	1.54	0.34	000
49062		A	Drain to peritoneal cavity	12.22	NA	NA	7.50	7.08	2.46	090
49080		A	Puncture peritoneal cavity	1.35	2.97	3.35	0.53	0.58	0.12	000
49081		A	Removal of abdominal fluid	1.26	3.32	3.40	0.57	0.58	0.16	000
49180		A	Biopsy abdominal mass	1.73	2.64	2.96	0.64	0.72	0.16	000
49203		A	Exc abd tum 5 cm or less	20.13	NA	NA	11.59	10.74	3.92	090
49204		A	Exc abd tum over 5 cm	26.13	NA	NA	14.20	13.12	5.07	090
49205		A	Exc abd tum over 10 cm	30.13	NA	NA	15.97	14.72	6.02	090
49215		A	Excise sacral spine tumor	37.81	NA	NA	20.79	18.77	7.52	090
49220		A	Multiple surgery abdomen	15.79	NA	NA	9.77	8.96	3.38	090
49250		A	Excision of umbilicus	9.01	NA	NA	6.52	6.00	1.83	090
49255		A	Removal of omentum	12.56	NA	NA	8.38	7.74	2.54	090
49320		A	Diag laparo separate proc	5.14	NA	NA	3.57	3.35	1.03	010
49321		A	Laparoscopy biopsy	5.44	NA	NA	3.77	3.51	1.13	010

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49322		A	Laparoscopy aspiration	6.01	NA	NA	3.89	3.67	1.15	010
49323		A	Laparo drain lymphocele	10.23	NA	NA	6.91	6.38	2.13	090
49324		A	Lap insert tunnel ip cath	6.32	NA	NA	4.13	3.82	1.33	010
49325		A	Lap revision perm ip cath	6.82	NA	NA	4.32	3.99	1.47	010
49326		A	Lap w/omentopexy add-on	3.50	NA	NA	1.47	1.32	0.73	ZZZ
49327		A	Lap ins device for rt	2.38	NA	NA	1.04	1.04	0.48	ZZZ
49329		C	Laparo proc abdm/per/oment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49400		A	Air injection into abdomen	1.88	1.81	2.53	0.70	0.77	0.24	000
49402		A	Remove foreign body adbomen	14.09	NA	NA	8.57	7.81	2.89	090
49411		A	Ins mark abd/pel for rt perq	3.82	11.25	11.25	1.66	1.66	0.35	000
49412		A	Ins device for rt guide open	1.50	NA	NA	0.63	0.63	0.30	ZZZ
49418		A	Insert tun ip cath perc	4.21	40.03	40.03	2.07	2.07	0.62	000
49419		A	Insert tun ip cath w/port	7.08	NA	NA	4.81	4.61	1.22	090
49421		A	Ins tun ip cath for dial opn	4.21	NA	NA	1.91	2.90	0.83	000
49422		A	Remove tunneled ip cath	6.29	NA	NA	3.84	3.63	1.29	010
49423		A	Exchange drainage catheter	1.46	14.18	15.28	0.56	0.65	0.12	000
49424		A	Assess cyst contrast inject	0.76	3.34	3.66	0.31	0.35	0.07	000
49425		A	Insert abdomen-venous drain	12.22	NA	NA	7.57	7.21	2.66	090
49426		A	Revise abdomen-venous shunt	10.41	NA	NA	6.47	6.16	2.06	090
49427		A	Injection abdominal shunt	0.89	NA	NA	0.34	0.38	0.10	000
49428		A	Ligation of shunt	6.87	NA	NA	4.52	4.36	1.47	010
49429		A	Removal of shunt	7.44	NA	NA	4.65	4.32	1.59	010
49435		A	Insert subq exten to ip cath	2.25	NA	NA	0.89	0.81	0.45	ZZZ
49436		A	Embedded ip cath exit-site	2.72	NA	NA	2.22	2.10	0.58	010
49440		A	Place gastrostomy tube perc	4.18	25.13	27.53	2.01	2.17	0.48	010
49441		A	Place duod/jej tube perc	4.77	28.30	30.37	2.29	2.45	0.54	010
49442		A	Place cecostomy tube perc	4.00	21.78	25.57	2.02	2.05	0.37	010
49446		A	Change g-tube to g-j perc	3.31	24.26	26.15	1.22	1.39	0.31	000

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49450		A	Replace g/c tube perc	1.36	17.15	19.76	0.52	0.55	0.12	000
49451		A	Replace duod/jej tube perc	1.84	18.30	19.47	0.69	0.78	0.20	000
49452		A	Replace g-j tube perc	2.86	21.94	23.61	1.06	1.21	0.27	000
49460		A	Fix g/colon tube w/device	0.96	19.55	22.38	0.38	0.40	0.10	000
49465		A	Fluoro exam of g/colon tube	0.62	4.14	4.44	0.23	0.26	0.05	000
49491		A	Rpr hern preemie reduc	12.53	NA	NA	8.39	7.57	2.66	090
49492		A	Rpr ing hern premie blocked	15.43	NA	NA	9.75	8.86	3.29	090
49495		A	Rpr ing hernia baby reduc	6.20	NA	NA	4.64	4.13	1.32	090
49496		A	Rpr ing hernia baby blocked	9.42	NA	NA	6.80	6.17	2.20	090
49500		A	Rpr ing hernia init reduce	5.84	NA	NA	3.96	4.01	1.24	090
49501		A	Rpr ing hernia init blocked	9.36	NA	NA	6.62	6.02	1.98	090
49505		A	Prp i/hern init reduc >5 yr	7.96	NA	NA	5.82	5.33	1.66	090
49507		A	Prp i/hern init block >5 yr	10.05	NA	NA	6.80	6.21	2.12	090
49520		A	Rerepair ing hernia reduce	9.99	NA	NA	6.70	6.13	2.09	090
49521		A	Rerepair ing hernia blocked	12.44	NA	NA	7.73	7.07	2.61	090
49525		A	Repair ing hernia sliding	8.93	NA	NA	6.23	5.70	1.86	090
49540		A	Repair lumbar hernia	10.74	NA	NA	7.17	6.51	2.25	090
49550		A	Rpr rem hernia init reduce	8.99	NA	NA	6.24	5.71	1.89	090
49553		A	Rpr fem hernia init blocked	9.92	NA	NA	6.76	6.16	2.09	090
49555		A	Rerepair fem hernia reduce	9.39	NA	NA	6.40	5.87	1.97	090
49557		A	Rerepair fem hernia blocked	11.62	NA	NA	7.49	6.84	2.44	090
49560		A	Rpr ventral hern init reduc	11.92	NA	NA	7.56	6.91	2.47	090
49561		A	Rpr ventral hern init block	15.38	NA	NA	9.13	8.29	3.23	090
49565		A	Rerepair ventrl hern reduce	12.37	NA	NA	7.93	7.22	2.59	090
49566		A	Rerepair ventrl hern block	15.53	NA	NA	9.24	8.39	3.29	090
49568		A	Hernia repair w/mesh	4.88	NA	NA	2.13	1.94	1.03	ZZZ
49570		A	Rpr epigastric hern reduce	6.05	NA	NA	4.98	4.57	1.28	090
49572		A	Rpr epigastric hern blocked	7.87	NA	NA	5.78	5.24	1.64	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
49580		A	Rpr umbil hern reduc < 5 yr	4.47	NA	NA	4.39	3.99	0.95	090
49582		A	Rpr umbil hern block < 5 yr	7.13	NA	NA	5.64	5.13	1.52	090
49585		A	Rpr umbil hern reduc > 5 yr	6.59	NA	NA	5.20	4.77	1.37	090
49587		A	Rpr umbil hern block > 5 yr	8.04	NA	NA	5.83	5.33	1.68	090
49590		A	Repair spigelian hernia	8.90	NA	NA	6.24	5.70	1.87	090
49600		A	Repair umbilical lesion	11.55	NA	NA	7.71	7.18	2.44	090
49605		A	Repair umbilical lesion	87.09	NA	NA	42.20	39.18	18.54	090
49606		A	Repair umbilical lesion	19.00	NA	NA	10.75	9.80	4.05	090
49610		A	Repair umbilical lesion	10.91	NA	NA	7.21	6.66	2.31	090
49611		A	Repair umbilical lesion	9.34	NA	NA	6.03	6.15	0.65	090
49650		A	Lap ing hernia repair init	6.36	NA	NA	4.99	4.58	1.33	090
49651		A	Lap ing hernia repair recur	8.38	NA	NA	6.38	5.81	1.78	090
49652		A	Lap vent/abd hernia repair	12.88	NA	NA	8.14	7.42	0.90	090
49653		A	Lap vent/abd hern proc comp	16.21	NA	NA	10.12	9.20	1.15	090
49654		A	Lap inc hernia repair	15.03	NA	NA	9.11	8.27	1.06	090
49655		A	Lap inc hern repair comp	18.11	NA	NA	10.93	9.93	1.28	090
49656		A	Lap inc hernia repair recur	15.08	NA	NA	9.15	8.30	1.07	090
49657		A	Lap inc hern recur comp	22.11	NA	NA	12.70	11.48	1.56	090
49659		C	Laparo proc hernia repair	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49900		A	Repair of abdominal wall	12.41	NA	NA	9.30	8.60	2.54	090
49904		A	Omental flap extra-abdom	22.35	NA	NA	15.87	15.84	4.74	090
49905		A	Omental flap intra-abdom	6.54	NA	NA	2.81	2.60	1.24	ZZZ
49906		C	Free omental flap microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
49999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50010		A	Exploration of kidney	12.28	NA	NA	7.79	7.94	1.79	090
50020		A	Renal abscess open drain	18.08	NA	NA	10.81	10.81	2.40	090
50021		A	Renal abscess percut drain	3.37	22.57	24.30	1.23	1.40	0.31	000
50040		A	Drainage of kidney	16.68	NA	NA	8.81	9.81	1.68	090

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50045		A	Exploration of kidney	16.82	NA	NA	8.93	9.83	1.62	090
5005F		I	Pt counsld on exam for moles	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50060		A	Removal of kidney stone	20.95	NA	NA	10.55	11.78	2.01	090
50065		A	Incision of kidney	22.32	NA	NA	11.09	12.12	2.16	090
50070		A	Incision of kidney	21.85	NA	NA	10.91	12.26	2.12	090
50075		A	Removal of kidney stone	27.09	NA	NA	13.19	14.80	2.62	090
50080		A	Removal of kidney stone	15.74	NA	NA	8.27	9.27	1.55	090
50081		A	Removal of kidney stone	23.50	NA	NA	11.79	13.19	2.31	090
50100		A	Revise kidney blood vessels	17.45	NA	NA	7.25	8.35	3.72	090
50120		A	Exploration of kidney	17.21	NA	NA	9.01	9.95	1.66	090
50125		A	Explore and drain kidney	17.82	NA	NA	11.11	11.11	1.71	090
50130		A	Removal of kidney stone	18.82	NA	NA	9.76	10.89	1.82	090
50135		A	Exploration of kidney	20.59	NA	NA	10.41	11.56	1.98	090
50200		A	Renal biopsy perq	2.63	14.16	14.16	1.29	1.42	0.31	000
50205		A	Renal biopsy open	12.29	NA	NA	7.64	7.23	2.39	090
5020F		I	Txmnts 2 main dr by 1 mon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50220		A	Remove kidney open	18.68	NA	NA	9.89	10.70	2.24	090
50225		A	Removal kidney open complex	21.88	NA	NA	11.07	12.06	2.38	090
50230		A	Removal kidney open radical	23.81	NA	NA	11.52	12.79	2.44	090
50234		A	Removal of kidney & ureter	24.05	NA	NA	11.88	13.16	2.43	090
50236		A	Removal of kidney & ureter	26.94	NA	NA	13.55	15.15	2.63	090
50240		A	Partial removal of kidney	24.21	NA	NA	12.35	13.72	2.42	090
50250		A	Cryoablate renal mass open	22.22	NA	NA	11.40	12.86	2.17	090
50280		A	Removal of kidney lesion	17.09	NA	NA	9.24	10.08	1.86	090
50290		A	Removal of kidney lesion	16.15	NA	NA	10.38	9.89	1.56	090
50300		X	Remove cadaver donor kidney	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50320		A	Remove kidney living donor	22.43	NA	NA	15.49	15.40	3.87	090
50323		C	Prep cadaver renal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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50325		C	Prep donor renal graft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50327		A	Prep renal graft/venous	4.00	NA	NA	1.70	1.61	0.77	XXX
50328		A	Prep renal graft/arterial	3.50	NA	NA	1.48	1.41	0.67	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	NA	1.37	1.42	0.48	XXX
50340		A	Removal of kidney	14.04	NA	NA	11.05	10.10	3.00	090
50360		A	Transplantation of kidney	40.90	NA	NA	27.22	24.92	8.28	090
50365		A	Transplantation of kidney	46.13	NA	NA	29.82	27.52	9.82	090
50370		A	Remove transplanted kidney	18.88	NA	NA	13.01	11.98	3.75	090
50380		A	Reimplantation of kidney	30.11	NA	NA	22.85	22.02	6.40	090
50382		A	Change ureter stent percut	5.50	28.06	31.83	2.07	2.38	0.52	000
50384		A	Remove ureter stent percut	5.00	22.03	26.14	1.86	2.15	0.48	000
50385		A	Change stent via transureth	4.44	28.19	32.12	1.98	2.31	0.42	000
50386		A	Remove stent via transureth	3.30	18.15	20.49	1.56	1.81	0.31	000
50387		A	Change ext/int ureter stent	2.00	13.51	15.35	0.73	0.85	0.20	000
50389		A	Remove renal tube w/fluoro	1.10	7.09	8.56	0.41	0.47	0.10	000
50390		A	Drainage of kidney lesion	1.96	NA	NA	0.72	0.82	0.18	000
50391		A	Instll rx agnt into rnal tub	1.96	1.43	1.66	0.79	0.88	0.20	000
50392		A	Insert kidney drain	3.37	NA	NA	1.56	1.77	0.31	000
50393		A	Insert ureteral tube	4.15	NA	NA	1.84	2.10	0.38	000
50394		A	Injection for kidney x-ray	0.76	1.99	2.27	0.61	0.68	0.07	000
50395		A	Create passage to kidney	3.37	NA	NA	1.59	1.80	0.33	000
50396		A	Measure kidney pressure	2.09	NA	NA	1.10	1.26	0.20	000
50398		A	Change kidney tube	1.46	12.74	14.30	0.57	0.65	0.12	000
50400		A	Revision of kidney/ureter	21.27	NA	NA	10.73	11.86	2.09	090
50405		A	Revision of kidney/ureter	25.86	NA	NA	12.71	14.14	2.50	090
50500		A	Repair of kidney wound	21.22	NA	NA	12.04	11.66	4.51	090
50520		A	Close kidney-skin fistula	18.88	NA	NA	9.74	10.72	1.83	090
50525		A	Repair renal-abdomen fistula	24.39	NA	NA	14.20	13.94	5.19	090

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50526		A	Repair renal-abdomen fistula	26.31	NA	NA	14.24	13.77	1.86	090
50540		A	Revision of horseshoe kidney	21.10	NA	NA	10.61	11.50	2.02	090
50541		A	Laparo ablate renal cyst	16.86	NA	NA	8.56	9.51	1.70	090
50542		A	Laparo ablate renal mass	21.36	NA	NA	10.92	12.17	2.09	090
50543		A	Laparo partial nephrectomy	27.41	NA	NA	13.74	15.32	2.72	090
50544		A	Laparoscopy pyeloplasty	23.37	NA	NA	11.10	12.42	2.31	090
50545		A	Laparo radical nephrectomy	25.06	NA	NA	12.00	13.40	2.54	090
50546		A	Laparoscopic nephrectomy	21.87	NA	NA	11.24	12.42	2.30	090
50547		A	Laparo removal donor kidney	26.34	NA	NA	16.40	15.91	4.82	090
50548		A	Laparo remove w/ureter	25.36	NA	NA	11.91	13.34	2.50	090
50549		C	Laparoscope proc renal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50551		A	Kidney endoscopy	5.59	4.28	4.95	2.58	2.89	0.54	000
50553		A	Kidney endoscopy	5.98	4.56	5.14	2.69	3.01	0.65	000
50555		A	Kidney endoscopy & biopsy	6.52	4.79	5.50	2.94	3.30	0.62	000
50557		A	Kidney endoscopy & treatment	6.61	4.88	5.63	2.97	3.34	0.64	000
50561		A	Kidney endoscopy & treatment	7.58	5.48	6.30	3.36	3.78	0.75	000
50562		A	Renal scope w/tumor resect	10.90	NA	NA	5.18	5.87	1.06	090
50570		A	Kidney endoscopy	9.53	NA	NA	4.09	4.62	0.91	000
50572		A	Kidney endoscopy	10.33	NA	NA	4.40	4.99	1.00	000
50574		A	Kidney endoscopy & biopsy	11.00	NA	NA	4.67	5.27	1.07	000
50575		A	Kidney endoscopy	13.96	NA	NA	5.83	6.60	1.36	000
50576		A	Kidney endoscopy & treatment	10.97	NA	NA	4.66	5.27	1.06	000
50580		A	Kidney endoscopy & treatment	11.84	NA	NA	5.00	5.59	1.15	000
50590		A	Fragmenting of kidney stone	9.77	11.28	15.39	5.83	6.50	0.95	090
50592		A	Perc rf ablate renal tumor	6.80	76.66	94.45	3.17	3.57	0.64	010
50593		A	Perc cryo ablate renal tum	9.13	115.70	130.21	4.23	4.32	0.86	010
50600		A	Exploration of ureter	17.17	NA	NA	8.77	9.69	1.66	090
50605		A	Insert ureteral support	16.79	NA	NA	9.42	9.53	2.65	090

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5060F		I	Fndngs mammo 2pt w/in 3 days	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50610		A	Removal of ureter stone	17.25	NA	NA	8.87	9.90	1.66	090
50620		A	Removal of ureter stone	16.43	NA	NA	8.55	9.54	1.59	090
5062F		I	Mammo result com to pt 5 day	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50630		A	Removal of ureter stone	16.21	NA	NA	8.46	9.23	1.56	090
50650		A	Removal of ureter	18.82	NA	NA	9.78	10.83	1.89	090
50660		A	Removal of ureter	21.02	NA	NA	10.58	11.71	2.02	090
50684		A	Injection for ureter x-ray	0.76	2.15	3.63	0.62	0.68	0.07	000
50686		A	Measure ureter pressure	1.51	2.63	2.63	1.03	1.12	0.22	000
50688		A	Change of ureter tube/stent	1.20	NA	NA	0.99	1.12	0.11	010
50690		A	Injection for ureter x-ray	1.16	1.48	1.71	0.76	0.85	0.10	000
50700		A	Revision of ureter	16.69	NA	NA	8.88	9.81	1.62	090
50715		A	Release of ureter	20.64	NA	NA	11.64	11.32	3.00	090
50722		A	Release of ureter	17.95	NA	NA	10.55	10.06	3.04	090
50725		A	Release/revise ureter	20.20	NA	NA	12.15	12.01	1.94	090
50727		A	Revise ureter	8.28	NA	NA	5.68	6.24	0.84	090
50728		A	Revise ureter	12.18	NA	NA	7.10	7.70	1.18	090
50740		A	Fusion of ureter & kidney	20.07	NA	NA	11.45	11.25	4.28	090
50750		A	Fusion of ureter & kidney	21.22	NA	NA	10.66	11.98	2.04	090
50760		A	Fusion of ureters	20.07	NA	NA	10.62	11.24	2.66	090
50770		A	Splicing of ureters	21.22	NA	NA	10.66	11.30	2.04	090
50780		A	Reimplant ureter in bladder	19.95	NA	NA	10.38	11.26	2.31	090
50782		A	Reimplant ureter in bladder	19.66	NA	NA	10.04	10.89	4.18	090
50783		A	Reimplant ureter in bladder	20.70	NA	NA	12.37	11.98	2.00	090
50785		A	Reimplant ureter in bladder	22.23	NA	NA	11.20	12.37	2.24	090
50800		A	Implant ureter in bowel	16.41	NA	NA	9.12	10.00	1.74	090
50810		A	Fusion of ureter & bowel	22.61	NA	NA	11.88	12.15	4.82	090
50815		A	Urine shunt to intestine	22.26	NA	NA	11.52	12.77	2.16	090

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50820		A	Construct bowel bladder	24.07	NA	NA	12.25	13.24	2.65	090
50825		A	Construct bowel bladder	30.68	NA	NA	15.05	16.59	3.16	090
50830		A	Revise urine flow	33.77	NA	NA	16.05	17.51	3.29	090
50840		A	Replace ureter by bowel	22.39	NA	NA	11.57	12.88	2.17	090
50845		A	Appendico-vesicostomy	22.46	NA	NA	12.04	13.38	2.17	090
50860		A	Transplant ureter to skin	17.08	NA	NA	9.03	9.98	1.64	090
50900		A	Repair of ureter	15.04	NA	NA	8.52	9.08	1.47	090
50920		A	Closure ureter/skin fistula	15.81	NA	NA	8.53	9.48	1.53	090
50930		A	Closure ureter/bowel fistula	20.19	NA	NA	10.25	10.75	4.29	090
50940		A	Release of ureter	15.93	NA	NA	8.58	9.42	1.55	090
50945		A	Laparoscopy ureterolithotomy	17.97	NA	NA	8.93	9.95	1.74	090
50947		A	Laparo new ureter/bladder	25.78	NA	NA	12.45	13.73	2.50	090
50948		A	Laparo new ureter/bladder	23.82	NA	NA	11.43	12.86	2.30	090
50949		C	Laparoscope proc ureter	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50951		A	Endoscopy of ureter	5.83	4.48	5.18	2.68	3.02	0.56	000
50953		A	Endoscopy of ureter	6.23	4.69	5.41	3.16	3.55	0.61	000
50955		A	Ureter endoscopy & biopsy	6.74	4.94	5.94	3.37	3.81	0.65	000
50957		A	Ureter endoscopy & treatment	6.78	4.99	5.73	3.04	3.42	0.65	000
50961		A	Ureter endoscopy & treatment	6.04	4.56	5.26	2.75	3.10	0.58	000
50970		A	Ureter endoscopy	7.13	NA	NA	3.14	3.55	0.68	000
50972		A	Ureter endoscopy & catheter	6.88	NA	NA	3.05	3.42	0.67	000
50974		A	Ureter endoscopy & biopsy	9.16	NA	NA	3.94	4.46	0.88	000
50976		A	Ureter endoscopy & treatment	9.03	NA	NA	3.89	4.38	0.87	000
50980		A	Ureter endoscopy & treatment	6.84	NA	NA	3.03	3.43	0.65	000
5100F		I	Rsk fx ref w/n 24 hrs xray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
51020		A	Incise & treat bladder	7.69	NA	NA	5.22	5.81	0.77	090
51030		A	Incise & treat bladder	7.81	NA	NA	5.17	5.59	0.75	090
51040		A	Incise & drain bladder	4.49	NA	NA	3.48	3.92	0.43	090

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51045		A	Incise bladder/drain ureter	7.81	NA	NA	5.59	5.88	1.06	090
51050		A	Removal of bladder stone	7.97	NA	NA	5.07	5.65	0.77	090
51060		A	Removal of ureter stone	9.95	NA	NA	6.08	6.80	0.98	090
51065		A	Remove ureter calculus	9.95	NA	NA	6.00	6.68	0.98	090
51080		A	Drainage of bladder abscess	6.71	NA	NA	4.56	5.03	0.65	090
51100		A	Drain bladder by needle	0.78	0.95	1.02	0.31	0.33	0.08	000
51101		A	Drain bladder by trocar/cath	1.02	2.46	2.71	0.45	0.46	0.12	000
51102		A	Drain bl w/cath insertion	2.70	3.51	4.03	1.31	1.50	0.29	000
51500		A	Removal of bladder cyst	11.05	NA	NA	7.95	7.59	1.07	090
51520		A	Removal of bladder lesion	10.21	NA	NA	6.19	6.73	0.99	090
51525		A	Removal of bladder lesion	15.42	NA	NA	8.28	9.21	1.56	090
51530		A	Removal of bladder lesion	13.71	NA	NA	8.01	8.49	1.64	090
51535		A	Repair of ureter lesion	13.90	NA	NA	7.62	8.31	1.33	090
51550		A	Partial removal of bladder	17.23	NA	NA	9.23	9.92	2.13	090
51555		A	Partial removal of bladder	23.18	NA	NA	11.75	12.77	2.59	090
51565		A	Revise bladder & ureter(s)	23.68	NA	NA	12.12	13.19	2.42	090
51570		A	Removal of bladder	27.46	NA	NA	13.55	14.67	2.80	090
51575		A	Removal of bladder & nodes	34.18	NA	NA	16.17	18.04	3.34	090
51580		A	Remove bladder/revise tract	35.37	NA	NA	17.03	19.07	3.44	090
51585		A	Removal of bladder & nodes	39.64	NA	NA	18.71	20.95	3.84	090
51590		A	Remove bladder/revise tract	36.33	NA	NA	17.03	18.92	3.67	090
51595		A	Remove bladder/revise tract	41.32	NA	NA	19.20	21.40	4.10	090
51596		A	Remove bladder/create pouch	44.26	NA	NA	20.79	23.20	4.33	090
51597		A	Removal of pelvic structures	42.86	NA	NA	20.45	22.42	4.52	090
51600		A	Injection for bladder x-ray	0.88	4.23	4.83	0.34	0.38	0.08	000
51605		A	Preparation for bladder xray	0.64	NA	NA	0.42	0.47	0.05	000
51610		A	Injection for bladder x-ray	1.05	1.88	2.17	0.71	0.78	0.10	000
51700		A	Irrigation of bladder	0.88	1.40	1.63	0.36	0.39	0.08	000

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51701		A	Insert bladder catheter	0.50	1.00	1.21	0.26	0.28	0.05	000
51702		A	Insert temp bladder cath	0.50	1.43	1.73	0.33	0.36	0.05	000
51703		A	Insert bladder cath complex	1.47	2.08	2.51	0.79	0.87	0.14	000
51705		A	Change of bladder tube	1.05	1.85	2.20	0.81	0.90	0.10	010
51710		A	Change of bladder tube	1.52	2.48	3.01	1.11	1.24	0.14	010
51715		A	Endoscopic injection/implant	3.73	4.18	4.74	1.80	1.95	0.39	000
51720		A	Treatment of bladder lesion	1.50	1.49	1.77	0.72	0.83	0.14	000
51725		A	Simple cystometrogram	1.51	3.64	4.59	NA	NA	0.13	000
51725	TC	A	Simple cystometrogram	0.00	3.01	3.93	NA	NA	0.01	000
51725	26	A	Simple cystometrogram	1.51	0.63	0.66	0.63	0.66	0.12	000
51726		A	Complex cystometrogram	1.71	5.72	7.22	NA	NA	0.17	000
51726	TC	A	Complex cystometrogram	0.00	5.01	6.46	NA	NA	0.03	000
51726	26	A	Complex cystometrogram	1.71	0.71	0.76	0.71	0.76	0.14	000
51727		A	Cystometrogram w/up	2.11	6.71	6.71	NA	NA	0.23	000
51727	TC	A	Cystometrogram w/up	0.00	5.81	5.81	NA	NA	0.01	000
51727	26	A	Cystometrogram w/up	2.11	0.90	0.90	0.90	0.90	0.22	000
51728		A	Cystometrogram w/vp	2.11	6.66	6.66	NA	NA	0.19	000
51728	TC	A	Cystometrogram w/vp	0.00	5.79	5.79	NA	NA	0.01	000
51728	26	A	Cystometrogram w/vp	2.11	0.87	0.87	0.87	0.87	0.18	000
51729		A	Cystometrogram w/vp&up	2.51	7.06	7.06	NA	NA	0.25	000
51729	TC	A	Cystometrogram w/vp&up	0.00	5.99	5.99	NA	NA	0.01	000
51729	26	A	Cystometrogram w/vp&up	2.51	1.07	1.07	1.07	1.07	0.24	000
51736		A	Urine flow measurement	0.17	0.66	0.85	NA	NA	0.02	XXX
51736	TC	A	Urine flow measurement	0.00	0.59	0.67	NA	NA	0.01	XXX
51736	26	A	Urine flow measurement	0.17	0.07	0.18	0.07	0.18	0.01	XXX
51741		A	Electro-uroflowmetry first	0.17	0.76	1.09	NA	NA	0.02	XXX
51741	TC	A	Electro-uroflowmetry first	0.00	0.69	0.78	NA	NA	0.01	XXX
51741	26	A	Electro-uroflowmetry first	0.17	0.07	0.31	0.07	0.31	0.01	XXX

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51784		A	Anal/urinary muscle study	1.53	3.92	4.42	NA	NA	0.13	000
51784	TC	A	Anal/urinary muscle study	0.00	3.28	3.75	NA	NA	0.01	000
51784	26	A	Anal/urinary muscle study	1.53	0.64	0.67	0.64	0.67	0.12	000
51785		A	Anal/urinary muscle study	1.53	4.52	5.02	NA	NA	0.13	000
51785	TC	A	Anal/urinary muscle study	0.00	3.87	4.34	NA	NA	0.01	000
51785	26	A	Anal/urinary muscle study	1.53	0.65	0.68	0.65	0.68	0.12	000
51792		A	Urinary reflex study	1.10	4.99	5.68	NA	NA	0.11	000
51792	TC	A	Urinary reflex study	0.00	4.51	5.18	NA	NA	0.01	000
51792	26	A	Urinary reflex study	1.10	0.48	0.50	0.48	0.50	0.10	000
51797		A	Intraabdominal pressure test	0.80	2.28	3.13	NA	NA	0.06	ZZZ
51797	TC	A	Intraabdominal pressure test	0.00	1.95	2.74	NA	NA	0.01	ZZZ
51797	26	A	Intraabdominal pressure test	0.80	0.33	0.39	0.33	0.39	0.05	ZZZ
51798		A	Us urine capacity measure	0.00	0.51	0.57	NA	NA	0.01	XXX
51800		A	Revision of bladder/urethra	18.89	NA	NA	9.95	10.99	1.94	090
51820		A	Revision of urinary tract	19.59	NA	NA	10.33	10.94	1.89	090
51840		A	Attach bladder/urethra	11.36	NA	NA	6.82	7.05	1.49	090
51841		A	Attach bladder/urethra	13.68	NA	NA	7.96	8.17	1.83	090
51845		A	Repair bladder neck	10.15	NA	NA	6.08	6.56	1.20	090
51860		A	Repair of bladder wound	12.60	NA	NA	7.72	7.97	1.85	090
51865		A	Repair of bladder wound	15.80	NA	NA	8.76	9.42	1.91	090
51880		A	Repair of bladder opening	7.87	NA	NA	5.00	5.36	0.99	090
51900		A	Repair bladder/vagina lesion	14.63	NA	NA	8.38	8.89	1.41	090
51920		A	Close bladder-uterus fistula	13.41	NA	NA	7.66	8.22	1.29	090
51925		A	Hysterectomy/bladder repair	17.53	NA	NA	11.70	11.34	2.96	090
51940		A	Correction of bladder defect	30.66	NA	NA	14.71	15.56	2.97	090
51960		A	Revision of bladder & bowel	25.40	NA	NA	12.91	14.32	2.65	090
51980		A	Construct bladder opening	12.57	NA	NA	7.12	7.87	1.22	090
51990		A	Laparo urethral suspension	13.36	NA	NA	7.48	7.67	1.77	090

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51992		A	Laparo sling operation	14.87	NA	NA	8.55	8.43	2.23	090
51999		C	Laparoscope proc bla	0.00	0.00	0.00	0.00	0.00	0.00	YYY
52000		A	Cystoscopy	2.23	3.31	3.85	1.25	1.38	0.23	000
52001		A	Cystoscopy removal of clots	5.44	4.71	5.52	2.52	2.82	0.53	000
52005		A	Cystoscopy & ureter catheter	2.37	5.11	6.03	1.31	1.46	0.24	000
52007		A	Cystoscopy and biopsy	3.02	9.57	12.19	1.56	1.75	0.30	000
5200F		I	Eval appros surg thxpy epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
52010		A	Cystoscopy & duct catheter	3.02	7.22	8.64	1.56	1.66	0.30	000
52204		A	Cystoscopy w/biopsy(s)	2.59	7.39	9.69	1.33	1.47	0.26	000
52214		A	Cystoscopy and treatment	3.70	13.91	14.67	1.76	2.32	0.35	000
52224		A	Cystoscopy and treatment	3.14	13.20	18.93	1.54	1.73	0.31	000
52234		A	Cystoscopy and treatment	4.62	NA	NA	2.19	2.47	0.43	000
52235		A	Cystoscopy and treatment	5.44	NA	NA	2.55	2.87	0.53	000
52240		A	Cystoscopy and treatment	9.71	NA	NA	4.23	4.77	0.95	000
52250		A	Cystoscopy and radiotracer	4.49	NA	NA	2.24	2.50	0.45	000
52260		A	Cystoscopy and treatment	3.91	NA	NA	1.91	2.12	0.39	000
52265		A	Cystoscopy and treatment	2.94	7.02	8.94	1.58	1.67	0.35	000
52270		A	Cystoscopy & revise urethra	3.36	6.27	8.04	1.67	1.88	0.33	000
52275		A	Cystoscopy & revise urethra	4.69	8.32	10.81	2.19	2.47	0.45	000
52276		A	Cystoscopy and treatment	4.99	NA	NA	2.36	2.66	0.49	000
52277		A	Cystoscopy and treatment	6.16	NA	NA	2.88	3.20	0.60	000
52281		A	Cystoscopy and treatment	2.60	4.57	5.80	1.40	1.61	0.27	000
52282		A	Cystoscopy implant stent	6.39	NA	NA	2.93	3.26	0.65	000
52283		A	Cystoscopy and treatment	3.73	3.85	4.43	1.87	2.06	0.37	000
52285		A	Cystoscopy and treatment	3.60	4.01	4.63	1.82	2.01	0.37	000
52290		A	Cystoscopy and treatment	4.58	NA	NA	2.19	2.46	0.43	000
52300		A	Cystoscopy and treatment	5.30	NA	NA	2.56	2.82	0.56	000
52301		A	Cystoscopy and treatment	5.50	NA	NA	2.60	2.94	0.53	000

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52305		A	Cystoscopy and treatment	5.30	NA	NA	2.42	2.72	0.52	000
52310		A	Cystoscopy and treatment	2.81	3.64	4.39	1.38	1.55	0.29	000
52315		A	Cystoscopy and treatment	5.20	6.02	7.42	2.40	2.70	0.50	000
52317		A	Remove bladder stone	6.71	15.18	19.81	2.91	3.29	0.65	000
52318		A	Remove bladder stone	9.18	NA	NA	3.94	4.45	0.88	000
52320		A	Cystoscopy and treatment	4.69	NA	NA	2.14	2.41	0.45	000
52325		A	Cystoscopy stone removal	6.15	NA	NA	2.73	3.07	0.60	000
52327		A	Cystoscopy inject material	5.18	NA	NA	2.06	2.33	0.52	000
52330		A	Cystoscopy and treatment	5.03	8.37	14.37	2.27	2.56	0.49	000
52332		A	Cystoscopy and treatment	1.47	10.39	11.72	0.95	1.39	0.15	000
52334		A	Create passage to kidney	4.82	NA	NA	2.28	2.56	0.48	000
52341		A	Cysto w/ureter stricture tx	5.35	NA	NA	2.64	3.01	0.52	000
52342		A	Cysto w/up stricture tx	5.85	NA	NA	2.84	3.23	0.56	000
52343		A	Cysto w/renal stricture tx	6.55	NA	NA	3.12	3.55	0.64	000
52344		A	Cysto/uretero stricture tx	7.05	NA	NA	3.46	3.92	0.68	000
52345		A	Cysto/uretero w/up stricture	7.55	NA	NA	3.66	4.15	0.72	000
52346		A	Cystouretero w/renal strict	8.58	NA	NA	4.05	4.61	0.83	000
52351		A	Cystouretero & or pyeloscope	5.85	NA	NA	2.85	3.20	0.56	000
52352		A	Cystouretero w/stone remove	6.87	NA	NA	3.34	3.75	0.67	000
52353		A	Cystouretero w/lithotripsy	7.96	NA	NA	3.76	4.24	0.76	000
52354		A	Cystouretero w/biopsy	7.33	NA	NA	3.52	3.96	0.71	000
52355		A	Cystouretero w/excise tumor	8.81	NA	NA	4.10	4.62	0.86	000
52400		A	Cystouretero w/congen repr	8.69	NA	NA	4.52	5.13	0.84	090
52402		A	Cystourethro cut ejacul duct	5.27	NA	NA	2.12	2.40	0.50	000
52450		A	Incision of prostate	7.78	NA	NA	5.19	5.77	0.75	090
52500		A	Revision of bladder neck	8.14	NA	NA	5.33	5.96	0.77	090
52601		A	Prostatectomy (turp)	15.26	NA	NA	8.09	8.72	1.49	090
52630		A	Remove prostate regrowth	7.73	NA	NA	4.56	5.05	0.75	090

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52640		A	Relieve bladder contracture	4.79	NA	NA	3.33	3.82	0.45	090
52647		A	Laser surgery of prostate	11.30	37.09	48.90	6.57	7.31	1.10	090
52648		A	Laser surgery of prostate	12.15	37.66	49.44	6.91	7.68	1.20	090
52649		A	Prostate laser enucleation	17.29	NA	NA	8.96	10.52	1.67	090
52700		A	Drainage of prostate abscess	7.49	NA	NA	4.68	5.10	0.72	090
53000		A	Incision of urethra	2.33	NA	NA	1.75	1.97	0.24	010
53010		A	Incision of urethra	4.45	NA	NA	3.67	4.10	0.42	090
53020		A	Incision of urethra	1.77	NA	NA	0.91	1.02	0.18	000
53025		A	Incision of urethra	1.13	NA	NA	0.84	0.81	0.07	000
53040		A	Drainage of urethra abscess	6.55	NA	NA	4.28	4.75	0.64	090
53060		A	Drainage of urethra abscess	2.68	2.41	2.45	1.90	1.86	0.43	010
53080		A	Drainage of urinary leakage	6.92	NA	NA	4.67	5.45	0.67	090
53085		A	Drainage of urinary leakage	11.18	NA	NA	6.73	6.85	1.45	090
53200		A	Biopsy of urethra	2.59	1.69	1.86	1.33	1.44	0.27	000
53210		A	Removal of urethra	13.72	NA	NA	7.72	8.47	1.32	090
53215		A	Removal of urethra	16.85	NA	NA	8.80	9.86	1.63	090
53220		A	Treatment of urethra lesion	7.63	NA	NA	4.96	5.44	0.73	090
53230		A	Removal of urethra lesion	10.44	NA	NA	6.31	6.90	1.17	090
53235		A	Removal of urethra lesion	10.99	NA	NA	6.47	7.31	1.06	090
53240		A	Surgery for urethra pouch	7.08	NA	NA	4.63	5.23	0.68	090
53250		A	Removal of urethra gland	6.52	NA	NA	4.85	5.16	1.41	090
53260		A	Treatment of urethra lesion	3.03	2.51	2.74	1.95	2.06	0.35	010
53265		A	Treatment of urethra lesion	3.17	2.81	3.19	1.97	2.14	0.34	010
53270		A	Removal of urethra gland	3.14	2.66	2.79	2.12	2.15	0.53	010
53275		A	Repair of urethra defect	4.57	NA	NA	2.67	3.01	0.45	010
53400		A	Revise urethra stage 1	14.13	NA	NA	8.03	8.89	1.41	090
53405		A	Revise urethra stage 2	15.66	NA	NA	8.46	9.52	1.52	090
53410		A	Reconstruction of urethra	17.68	NA	NA	9.40	10.49	1.71	090

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53415		A	Reconstruction of urethra	20.70	NA	NA	10.50	11.71	2.04	090
53420		A	Reconstruct urethra stage 1	15.17	NA	NA	8.06	8.36	1.48	090
53425		A	Reconstruct urethra stage 2	17.07	NA	NA	8.81	9.94	1.64	090
53430		A	Reconstruction of urethra	17.43	NA	NA	9.24	9.89	1.97	090
53431		A	Reconstruct urethra/bladder	21.18	NA	NA	10.71	11.94	2.04	090
53440		A	Male sling procedure	15.54	NA	NA	8.88	9.82	1.52	090
53442		A	Remove/revise male sling	13.49	NA	NA	8.13	8.96	1.30	090
53444		A	Insert tandem cuff	14.19	NA	NA	7.72	8.66	1.37	090
53445		A	Insert uro/ves nck sphincter	15.39	NA	NA	8.82	9.93	1.51	090
53446		A	Remove uro sphincter	11.02	NA	NA	6.71	7.53	1.09	090
53447		A	Remove/replace ur sphincter	14.28	NA	NA	8.05	9.06	1.40	090
53448		A	Remov/replc ur sphinctr comp	23.44	NA	NA	11.93	13.37	2.25	090
53449		A	Repair uro sphincter	10.56	NA	NA	6.32	7.09	1.05	090
53450		A	Revision of urethra	6.77	NA	NA	4.50	5.04	0.65	090
53460		A	Revision of urethra	7.75	NA	NA	4.88	5.47	0.73	090
53500		A	Urethrlys transvag w/ scope	13.00	NA	NA	7.63	8.29	1.49	090
53502		A	Repair of urethra injury	8.26	NA	NA	5.17	5.70	0.80	090
53505		A	Repair of urethra injury	8.26	NA	NA	5.15	5.77	0.80	090
53510		A	Repair of urethra injury	10.96	NA	NA	6.46	7.24	1.06	090
53515		A	Repair of urethra injury	14.22	NA	NA	7.75	8.61	1.37	090
53520		A	Repair of urethra defect	9.48	NA	NA	5.88	6.57	0.91	090
53600		A	Dilate urethra stricture	1.21	1.07	1.25	0.56	0.63	0.11	000
53601		A	Dilate urethra stricture	0.98	1.24	1.45	0.50	0.56	0.08	000
53605		A	Dilate urethra stricture	1.28	NA	NA	0.51	0.57	0.12	000
53620		A	Dilate urethra stricture	1.62	1.56	1.88	0.80	0.89	0.16	000
53621		A	Dilate urethra stricture	1.35	1.64	1.98	0.65	0.73	0.12	000
53660		A	Dilation of urethra	0.71	1.21	1.42	0.44	0.48	0.07	000
53661		A	Dilation of urethra	0.72	1.17	1.38	0.40	0.44	0.07	000

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53665		A	Dilation of urethra	0.76	NA	NA	0.31	0.33	0.08	000
53850		A	Prostatic microwave thermotx	10.08	43.43	58.37	5.61	6.25	0.99	090
53852		A	Prostatic rf thermotx	10.83	40.95	55.07	6.35	7.06	1.06	090
53855		A	Insert prost urethral stent	1.64	19.37	19.37	0.65	0.65	0.16	000
53860		A	Transurethral rf treatment	3.97	38.52	38.52	2.24	2.24	0.68	090
53899		C	Urology surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54000		A	Slitting of prepuce	1.59	2.45	2.93	1.39	1.54	0.14	010
54001		A	Slitting of prepuce	2.24	2.81	3.31	1.59	1.76	0.23	010
54015		A	Drain penis lesion	5.36	NA	NA	3.10	3.49	0.56	010
54050		A	Destruction penis lesion(s)	1.29	2.40	2.44	1.67	1.65	0.16	010
54055		A	Destruction penis lesion(s)	1.25	2.01	2.16	1.32	1.36	0.14	010
54056		A	Cryosurgery penis lesion(s)	1.29	2.72	2.69	1.87	1.81	0.18	010
54057		A	Laser surg penis lesion(s)	1.29	2.47	2.76	1.33	1.42	0.12	010
54060		A	Excision of penis lesion(s)	1.98	2.94	3.38	1.62	1.75	0.22	010
54065		A	Destruction penis lesion(s)	2.47	3.65	3.74	2.38	2.32	0.31	010
54100		A	Biopsy of penis	1.90	3.62	3.79	1.69	1.62	0.24	000
54105		A	Biopsy of penis	3.54	3.70	4.37	2.34	2.64	0.35	010
54110		A	Treatment of penis lesion	10.92	NA	NA	6.31	7.03	1.06	090
54111		A	Treat penis lesion graft	14.42	NA	NA	7.69	8.63	1.40	090
54112		A	Treat penis lesion graft	16.98	NA	NA	8.92	10.05	1.63	090
54115		A	Treatment of penis lesion	6.95	5.47	6.15	4.75	5.28	0.67	090
54120		A	Partial removal of penis	11.01	NA	NA	6.43	7.18	1.09	090
54125		A	Removal of penis	14.56	NA	NA	7.88	8.77	1.48	090
54130		A	Remove penis & nodes	21.84	NA	NA	11.13	12.47	2.12	090
54135		A	Remove penis & nodes	28.17	NA	NA	13.62	15.29	2.73	090
54150		A	Circumcision w/regionl block	1.90	2.34	2.84	0.80	0.86	0.23	000
54160		A	Circumcision neonate	2.53	3.46	4.14	1.44	1.62	0.24	010
54161		A	Circum 28 days or older	3.32	NA	NA	2.11	2.35	0.34	010

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54162		A	Lysis penil circumic lesion	3.32	3.73	4.44	2.18	2.39	0.33	010
54163		A	Repair of circumcision	3.32	NA	NA	2.72	3.03	0.33	010
54164		A	Frenulotomy of penis	2.82	NA	NA	2.50	2.79	0.29	010
54200		A	Treatment of penis lesion	1.11	1.83	2.12	1.21	1.36	0.10	010
54205		A	Treatment of penis lesion	8.97	NA	NA	5.72	6.49	0.86	090
54220		A	Treatment of penis lesion	2.42	3.07	3.66	1.29	1.44	0.26	000
54230		A	Prepare penis study	1.34	1.30	1.48	0.86	0.96	0.12	000
54231		A	Dynamic cavernosometry	2.04	1.80	2.04	1.17	1.32	0.20	000
54235		A	Penile injection	1.19	1.29	1.45	0.85	0.94	0.11	000
54240		A	Penis study	1.31	1.43	1.60	NA	NA	0.09	000
54240	TC	A	Penis study	0.00	0.92	1.03	NA	NA	0.01	000
54240	26	A	Penis study	1.31	0.51	0.57	0.51	0.57	0.08	000
54250		A	Penis study	2.22	1.17	1.33	NA	NA	0.15	000
54250	TC	A	Penis study	0.00	0.29	0.34	NA	NA	0.01	000
54250	26	A	Penis study	2.22	0.88	0.99	0.88	0.99	0.14	000
54300		A	Revision of penis	11.20	NA	NA	6.53	7.41	1.09	090
54304		A	Revision of penis	13.28	NA	NA	7.43	8.46	1.28	090
54308		A	Reconstruction of urethra	12.62	NA	NA	7.89	8.49	1.22	090
54312		A	Reconstruction of urethra	14.51	NA	NA	8.96	9.67	1.40	090
54316		A	Reconstruction of urethra	18.05	NA	NA	10.56	11.34	1.74	090
54318		A	Reconstruction of urethra	12.43	NA	NA	7.97	8.53	0.87	090
54322		A	Reconstruction of urethra	13.98	NA	NA	7.59	8.64	1.36	090
54324		A	Reconstruction of urethra	17.55	NA	NA	9.22	10.51	1.68	090
54326		A	Reconstruction of urethra	17.02	NA	NA	9.11	9.77	1.64	090
54328		A	Revise penis/urethra	16.89	NA	NA	9.06	10.11	1.63	090
54332		A	Revise penis/urethra	18.37	NA	NA	9.65	10.91	1.78	090
54336		A	Revise penis/urethra	21.62	NA	NA	12.48	12.34	2.09	090
54340		A	Secondary urethral surgery	9.71	NA	NA	6.02	6.64	0.92	090

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54344		A	Secondary urethral surgery	17.06	NA	NA	10.12	10.89	1.64	090
54348		A	Secondary urethral surgery	18.32	NA	NA	16.82	14.68	1.29	090
54352		A	Reconstruct urethra/penis	26.13	NA	NA	22.83	19.83	2.54	090
54360		A	Penis plastic surgery	12.78	NA	NA	7.12	8.10	1.24	090
54380		A	Repair penis	14.18	NA	NA	7.89	8.97	1.37	090
54385		A	Repair penis	16.56	NA	NA	9.07	11.07	2.42	090
54390		A	Repair penis and bladder	22.77	NA	NA	12.79	12.46	2.20	090
54400		A	Insert semi-rigid prosthesis	9.17	NA	NA	5.45	6.15	0.88	090
54401		A	Insert self-contd prosthesis	10.44	NA	NA	7.63	8.56	1.03	090
54405		A	Insert multi-comp penis pros	14.52	NA	NA	7.84	8.78	1.41	090
54406		A	Remove muti-comp penis pros	12.89	NA	NA	7.28	8.15	1.25	090
54408		A	Repair multi-comp penis pros	13.91	NA	NA	7.93	8.83	1.37	090
54410		A	Remove/replace penis prosth	15.18	NA	NA	8.57	9.62	1.48	090
54411		A	Remov/replc penis pros comp	18.35	NA	NA	10.02	11.16	1.78	090
54415		A	Remove self-contd penis pros	8.88	NA	NA	5.70	6.37	0.86	090
54416		A	Remv/repl penis contain pros	12.08	NA	NA	7.54	8.39	1.18	090
54417		A	Remv/replc penis pros compl	16.10	NA	NA	8.72	9.73	1.56	090
54420		A	Revision of penis	12.39	NA	NA	7.07	7.98	1.21	090
54430		A	Revision of penis	11.06	NA	NA	6.61	7.45	1.07	090
54435		A	Revision of penis	6.81	NA	NA	4.69	5.27	0.65	090
54440		C	Repair of penis	0.00	0.00	0.00	0.00	0.00	0.00	090
54450		A	Preputial stretching	1.12	0.80	0.95	0.47	0.54	0.10	000
54500		A	Biopsy of testis	1.31	NA	NA	0.75	0.85	0.12	000
54505		A	Biopsy of testis	3.50	NA	NA	2.29	2.60	0.34	010
54512		A	Excise lesion testis	9.33	NA	NA	5.52	6.10	0.92	090
54520		A	Removal of testis	5.30	NA	NA	3.68	4.04	0.61	090
54522		A	Orchiectomy partial	10.25	NA	NA	6.04	6.50	1.00	090
54530		A	Removal of testis	8.46	NA	NA	5.47	6.11	0.87	090

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54535		A	Extensive testis surgery	13.19	NA	NA	7.36	8.01	1.28	090
54550		A	Exploration for testis	8.41	NA	NA	5.17	5.71	0.81	090
54560		A	Exploration for testis	12.10	NA	NA	6.86	7.25	1.18	090
54600		A	Reduce testis torsion	7.64	NA	NA	4.86	5.42	0.73	090
54620		A	Suspension of testis	5.21	NA	NA	3.07	3.47	0.50	010
54640		A	Suspension of testis	7.73	NA	NA	5.48	5.88	0.87	090
54650		A	Orchiopexy (fowler-stephens)	12.39	NA	NA	7.26	7.95	1.21	090
54660		A	Revision of testis	5.74	NA	NA	4.12	4.56	0.54	090
54670		A	Repair testis injury	6.65	NA	NA	4.53	5.03	0.64	090
54680		A	Relocation of testis(es)	14.04	NA	NA	7.70	8.42	1.36	090
54690		A	Laparoscopy orchiectomy	11.70	NA	NA	6.46	6.66	2.47	090
54692		A	Laparoscopy orchiopexy	13.74	NA	NA	7.23	8.13	1.32	090
54699		C	Laparoscope proc testis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54700		A	Drainage of scrotum	3.47	NA	NA	2.40	2.62	0.39	010
54800		A	Biopsy of epididymis	2.33	NA	NA	2.07	1.82	0.33	000
54830		A	Remove epididymis lesion	6.01	NA	NA	4.26	4.71	0.62	090
54840		A	Remove epididymis lesion	5.27	NA	NA	3.59	4.03	0.52	090
54860		A	Removal of epididymis	6.95	NA	NA	4.61	5.13	0.68	090
54861		A	Removal of epididymis	9.70	NA	NA	5.92	6.59	0.92	090
54865		A	Explore epididymis	5.77	NA	NA	4.13	4.57	0.56	090
54900		A	Fusion of spermatic ducts	14.20	NA	NA	7.90	8.03	1.02	090
54901		A	Fusion of spermatic ducts	19.10	NA	NA	11.17	11.87	1.36	090
55000		A	Drainage of hydrocele	1.43	1.79	2.07	0.92	1.00	0.14	000
55040		A	Removal of hydrocele	5.45	NA	NA	3.86	4.26	0.61	090
55041		A	Removal of hydroceles	8.54	NA	NA	5.52	6.09	0.90	090
55060		A	Repair of hydrocele	6.15	NA	NA	4.33	4.76	0.67	090
55100		A	Drainage of scrotum abscess	2.45	3.42	3.88	2.12	2.28	0.30	010
55110		A	Explore scrotum	6.33	NA	NA	4.39	4.81	0.68	090

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55120		A	Removal of scrotum lesion	5.72	NA	NA	4.10	4.51	0.61	090
55150		A	Removal of scrotum	8.14	NA	NA	5.41	5.94	0.86	090
55175		A	Revision of scrotum	5.87	NA	NA	4.19	4.63	0.60	090
55180		A	Revision of scrotum	11.78	NA	NA	7.32	7.98	1.29	090
55200		A	Incision of sperm duct	4.55	7.35	9.22	3.13	3.43	0.43	090
55250		A	Removal of sperm duct(s)	3.37	7.32	8.98	2.96	3.25	0.33	090
55300		A	Prepare sperm duct x-ray	3.50	NA	NA	1.68	1.73	0.34	000
55400		A	Repair of sperm duct	8.61	NA	NA	5.15	5.81	0.83	090
55450		A	Ligation of sperm duct	4.43	5.38	6.47	2.68	2.94	0.42	010
55500		A	Removal of hydrocele	6.22	NA	NA	4.67	4.80	0.88	090
55520		A	Removal of sperm cord lesion	6.66	NA	NA	5.38	5.00	1.36	090
55530		A	Revise spermatic cord veins	5.75	NA	NA	3.98	4.41	0.62	090
55535		A	Revise spermatic cord veins	7.19	NA	NA	4.69	5.17	0.69	090
55540		A	Revise hernia & sperm veins	8.30	NA	NA	6.11	5.68	1.64	090
55550		A	Laparo ligate spermatic vein	7.20	NA	NA	4.62	5.02	0.69	090
55559		C	Laparo proc spermatic cord	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55600		A	Incise sperm duct pouch	7.01	NA	NA	4.62	5.17	0.68	090
55605		A	Incise sperm duct pouch	8.76	NA	NA	6.21	6.24	0.84	090
55650		A	Remove sperm duct pouch	12.65	NA	NA	7.16	7.88	1.22	090
55680		A	Remove sperm pouch lesion	5.67	NA	NA	3.88	4.17	0.54	090
55700		A	Biopsy of prostate	2.58	3.37	4.04	1.28	1.39	0.26	000
55705		A	Biopsy of prostate	4.61	NA	NA	2.75	3.11	0.45	010
55706		A	Prostate saturation sampling	6.28	NA	NA	4.01	4.69	0.43	010
55720		A	Drainage of prostate abscess	7.73	NA	NA	4.75	5.29	0.73	090
55725		A	Drainage of prostate abscess	10.05	NA	NA	6.33	6.96	0.98	090
55801		A	Removal of prostate	19.80	NA	NA	10.41	11.49	1.91	090
55810		A	Extensive prostate surgery	24.29	NA	NA	12.08	13.39	2.47	090
55812		A	Extensive prostate surgery	29.89	NA	NA	14.59	16.28	2.91	090

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55815		A	Extensive prostate surgery	32.95	NA	NA	15.80	17.67	3.19	090
55821		A	Removal of prostate	15.76	NA	NA	8.40	9.37	1.55	090
55831		A	Removal of prostate	17.19	NA	NA	8.95	10.01	1.66	090
55840		A	Extensive prostate surgery	24.63	NA	NA	12.35	13.80	2.40	090
55842		A	Extensive prostate surgery	26.49	NA	NA	13.08	14.65	2.59	090
55845		A	Extensive prostate surgery	30.67	NA	NA	14.54	16.26	3.03	090
55860		A	Surgical exposure prostate	15.84	NA	NA	8.32	9.33	1.52	090
55862		A	Extensive prostate surgery	20.04	NA	NA	10.27	11.56	1.93	090
55865		A	Extensive prostate surgery	24.57	NA	NA	12.31	13.83	2.38	090
55866		A	Laparo radical prostatectomy	32.06	NA	NA	16.00	17.65	3.18	090
55870		A	Electroejaculation	2.58	2.24	2.51	1.35	1.54	0.26	000
55873		A	Cryoablate prostate	13.60	172.34	172.34	7.50	10.58	1.36	090
55875		A	Transperi needle place pros	13.46	NA	NA	7.62	8.50	1.29	090
55876		A	Place rt device/marker pros	1.73	1.98	2.27	1.05	1.20	0.16	000
55899		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55920		A	Place needles pelvic for rt	8.31	NA	NA	4.10	4.15	0.80	000
55970		N	Sex transformation m to f	0.00	0.00	0.00	0.00	0.00	0.00	XXX
55980		N	Sex transformation f to m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
56405		A	I & d of vulva/perineum	1.49	1.50	1.50	1.48	1.45	0.26	010
56420		A	Drainage of gland abscess	1.44	1.88	1.99	1.05	1.05	0.24	010
56440		A	Surgery for vulva lesion	2.89	NA	NA	2.12	2.06	0.49	010
56441		A	Lysis of labial lesion(s)	2.02	1.93	2.04	1.78	1.84	0.29	010
56442		A	Hymenotomy	0.68	NA	NA	0.64	0.64	0.11	000
56501		A	Destroy vulva lesions sim	1.58	2.00	2.03	1.57	1.55	0.27	010
56515		A	Destroy vulva lesion/s compl	3.08	3.10	3.06	2.43	2.32	0.50	010
56605		A	Biopsy of vulva/perineum	1.10	1.15	1.17	0.56	0.52	0.18	000
56606		A	Biopsy of vulva/perineum	0.55	0.47	0.48	0.26	0.24	0.08	ZZZ
56620		A	Partial removal of vulva	7.53	NA	NA	6.29	6.06	1.26	090

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56625		A	Complete removal of vulva	9.68	NA	NA	6.86	6.53	1.62	090
56630		A	Extensive vulva surgery	14.80	NA	NA	9.47	8.83	2.55	090
56631		A	Extensive vulva surgery	18.99	NA	NA	11.79	10.98	3.20	090
56632		A	Extensive vulva surgery	21.86	NA	NA	14.10	13.01	3.69	090
56633		A	Extensive vulva surgery	19.62	NA	NA	11.96	11.10	3.31	090
56634		A	Extensive vulva surgery	20.66	NA	NA	12.79	11.83	3.49	090
56637		A	Extensive vulva surgery	24.75	NA	NA	14.49	13.42	4.17	090
56640		A	Extensive vulva surgery	24.78	NA	NA	13.71	12.80	4.17	090
56700		A	Partial removal of hymen	2.84	NA	NA	2.29	2.25	0.48	010
56740		A	Remove vagina gland lesion	4.88	NA	NA	3.28	3.13	0.83	010
56800		A	Repair of vagina	3.93	NA	NA	2.67	2.62	0.64	010
56805		A	Repair clitoris	19.88	NA	NA	11.34	10.84	3.37	090
56810		A	Repair of perineum	4.29	NA	NA	2.85	2.75	0.69	010
56820		A	Exam of vulva w/scope	1.50	1.52	1.52	0.83	0.77	0.26	000
56821		A	Exam/biopsy of vulva w/scope	2.05	1.95	1.97	1.08	1.02	0.34	000
57000		A	Exploration of vagina	3.02	NA	NA	2.17	2.14	0.50	010
57010		A	Drainage of pelvic abscess	6.84	NA	NA	5.08	4.90	1.15	090
57020		A	Drainage of pelvic fluid	1.50	1.05	1.03	0.73	0.67	0.26	000
57022		A	I & d vaginal hematoma pp	2.73	NA	NA	1.88	1.81	0.45	010
57023		A	I & d vag hematoma non-ob	5.18	NA	NA	3.35	3.22	0.87	010
57061		A	Destroy vag lesions simple	1.30	1.80	1.85	1.39	1.38	0.22	010
57065		A	Destroy vag lesions complex	2.66	2.58	2.58	2.03	1.98	0.43	010
57100		A	Biopsy of vagina	1.20	1.20	1.21	0.60	0.55	0.20	000
57105		A	Biopsy of vagina	1.74	1.93	1.98	1.67	1.68	0.29	010
57106		A	Remove vagina wall partial	7.50	NA	NA	5.74	5.54	1.21	090
57107		A	Remove vagina tissue part	24.56	NA	NA	13.92	13.00	4.14	090
57109		A	Vaginectomy partial w/nodes	28.40	NA	NA	15.62	14.47	4.79	090
57110		A	Remove vagina wall complete	15.48	NA	NA	9.12	8.67	2.58	090

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57111		A	Remove vagina tissue compl	28.40	NA	NA	15.62	14.75	4.79	090
57112		A	Vaginectomy w/nodes compl	30.52	NA	NA	9.63	12.01	2.42	090
57120		A	Closure of vagina	8.28	NA	NA	5.73	5.57	1.36	090
57130		A	Remove vagina lesion	2.46	2.40	2.44	1.91	1.89	0.41	010
57135		A	Remove vagina lesion	2.70	2.53	2.56	2.02	1.99	0.43	010
57150		A	Treat vagina infection	0.55	0.69	0.79	0.25	0.24	0.08	000
57155		A	Insert uteri tandems/ovoids	3.37	6.05	6.05	1.69	1.69	0.30	000
57156		A	Ins vag brachytx device	1.87	2.41	2.41	1.01	1.01	0.16	000
57160		A	Insert pessary/other device	0.89	1.21	1.24	0.41	0.38	0.14	000
57170		A	Fitting of diaphragm/cap	0.91	0.75	0.87	0.41	0.38	0.14	000
57180		A	Treat vaginal bleeding	1.63	2.20	2.29	1.25	1.26	0.27	010
57200		A	Repair of vagina	4.42	NA	NA	3.77	3.72	0.71	090
57210		A	Repair vagina/perineum	5.71	NA	NA	4.33	4.26	0.91	090
57220		A	Revision of urethra	4.85	NA	NA	3.92	3.87	0.80	090
57230		A	Repair of urethral lesion	6.30	NA	NA	4.55	4.55	1.06	090
57240		A	Repair bladder & vagina	11.50	NA	NA	6.91	6.69	1.63	090
57250		A	Repair rectum & vagina	11.50	NA	NA	7.08	6.53	1.86	090
57260		A	Repair of vagina	14.44	NA	NA	8.43	7.79	2.34	090
57265		A	Extensive repair of vagina	15.94	NA	NA	9.10	8.56	2.57	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	NA	2.18	2.14	0.72	ZZZ
57268		A	Repair of bowel bulge	7.57	NA	NA	5.67	5.53	1.22	090
57270		A	Repair of bowel pouch	13.67	NA	NA	8.21	7.83	2.24	090
57280		A	Suspension of vagina	16.72	NA	NA	9.45	9.19	2.59	090
57282		A	Colpopexy extraperitoneal	7.97	NA	NA	5.80	5.74	1.24	090
57283		A	Colpopexy intraperitoneal	11.66	NA	NA	7.26	7.00	1.91	090
57284		A	Repair paravag defect open	14.33	NA	NA	8.07	8.02	2.16	090
57285		A	Repair paravag defect vag	11.60	NA	NA	6.97	6.78	1.79	090
57287		A	Revise/remove sling repair	11.15	NA	NA	7.53	7.85	1.47	090

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57288		A	Repair bladder defect	12.13	NA	NA	7.19	7.53	1.59	090
57289		A	Repair bladder & vagina	12.80	NA	NA	7.32	7.73	1.24	090
57291		A	Construction of vagina	8.64	NA	NA	9.10	7.54	1.47	090
57292		A	Construct vagina with graft	14.01	NA	NA	8.41	8.16	2.34	090
57295		A	Revise vag graft via vagina	7.82	NA	NA	5.32	5.35	1.20	090
57296		A	Revise vag graft open abd	16.56	NA	NA	9.49	8.98	2.78	090
57300		A	Repair rectum-vagina fistula	8.71	NA	NA	6.50	6.03	1.52	090
57305		A	Repair rectum-vagina fistula	15.35	NA	NA	9.64	8.78	2.96	090
57307		A	Fistula repair & colostomy	17.17	NA	NA	11.04	9.94	3.67	090
57308		A	Fistula repair transperine	10.59	NA	NA	7.43	6.84	1.79	090
57310		A	Repair urethrovaginal lesion	7.65	NA	NA	5.05	5.50	0.73	090
57311		A	Repair urethrovaginal lesion	8.91	NA	NA	5.55	6.04	0.86	090
57320		A	Repair bladder-vagina lesion	8.88	NA	NA	5.79	6.13	1.05	090
57330		A	Repair bladder-vagina lesion	13.21	NA	NA	7.20	7.76	1.28	090
57335		A	Repair vagina	20.02	NA	NA	11.72	11.32	3.38	090
57400		A	Dilation of vagina	2.27	NA	NA	1.37	1.34	0.38	000
57410		A	Pelvic examination	1.75	NA	NA	1.19	1.14	0.29	000
57415		A	Remove vaginal foreign body	2.49	NA	NA	1.90	1.89	0.37	010
57420		A	Exam of vagina w/scope	1.60	1.56	1.57	0.87	0.81	0.26	000
57421		A	Exam/biopsy of vag w/scope	2.20	2.05	2.05	1.16	1.08	0.37	000
57423		A	Repair paravag defect lap	16.08	NA	NA	8.96	8.67	2.72	090
57425		A	Laparoscopy surg colpopexy	17.03	NA	NA	9.66	9.21	2.66	090
57426		A	Revise prosth vag graft lap	14.30	NA	NA	8.42	8.42	2.40	090
57452		A	Exam of cervix w/scope	1.50	1.47	1.48	1.02	0.98	0.24	000
57454		A	Bx/curett of cervix w/scope	2.33	1.87	1.84	1.41	1.34	0.38	000
57455		A	Biopsy of cervix w/scope	1.99	1.92	1.92	1.05	0.98	0.33	000
57456		A	Endocerv curettage w/scope	1.85	1.84	1.85	0.98	0.92	0.31	000
57460		A	Bx of cervix w/scope leep	2.83	4.91	5.32	1.64	1.56	0.48	000

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57461		A	Conz of cervix w/scope leep	3.43	5.30	5.69	1.72	1.60	0.58	000
57500		A	Biopsy of cervix	1.20	2.29	2.46	0.88	0.84	0.20	000
57505		A	Endocervical curettage	1.19	1.59	1.63	1.33	1.33	0.20	010
57510		A	Cauterization of cervix	1.90	1.69	1.69	1.27	1.22	0.31	010
57511		A	Cryocautery of cervix	1.95	2.03	2.04	1.68	1.65	0.33	010
57513		A	Laser surgery of cervix	1.95	1.98	1.98	1.68	1.66	0.33	010
57520		A	Conization of cervix	4.11	4.23	4.29	3.35	3.30	0.68	090
57522		A	Conization of cervix	3.67	3.52	3.53	2.99	2.93	0.62	090
57530		A	Removal of cervix	5.27	NA	NA	4.17	4.09	0.87	090
57531		A	Removal of cervix radical	29.95	NA	NA	17.28	15.89	5.05	090
57540		A	Removal of residual cervix	13.29	NA	NA	8.09	7.65	2.23	090
57545		A	Remove cervix/repair pelvis	14.10	NA	NA	8.46	8.01	2.35	090
57550		A	Removal of residual cervix	6.34	NA	NA	4.84	4.73	1.07	090
57555		A	Remove cervix/repair vagina	9.94	NA	NA	6.55	6.26	1.66	090
57556		A	Remove cervix repair bowel	9.36	NA	NA	6.15	6.05	1.45	090
57558		A	D&c of cervical stump	1.72	1.70	1.71	1.40	1.37	0.29	010
57700		A	Revision of cervix	4.35	NA	NA	4.18	4.16	0.72	090
57720		A	Revision of cervix	4.61	NA	NA	3.83	3.77	0.76	090
57800		A	Dilation of cervical canal	0.77	0.88	0.89	0.56	0.55	0.12	000
58100		A	Biopsy of uterus lining	1.53	1.46	1.47	0.88	0.83	0.26	000
58110		A	Bx done w/colposcopy add-on	0.77	0.55	0.54	0.36	0.33	0.12	ZZZ
58120		A	Dilation and curettage	3.59	3.44	3.34	2.37	2.26	0.61	010
58140		A	Myomectomy abdom method	15.79	NA	NA	9.28	8.70	2.80	090
58145		A	Myomectomy vag method	8.91	NA	NA	6.00	5.76	1.49	090
58146		A	Myomectomy abdom complex	20.34	NA	NA	11.30	10.66	3.44	090
58150		A	Total hysterectomy	17.31	NA	NA	9.97	9.31	2.93	090
58152		A	Total hysterectomy	21.86	NA	NA	12.25	11.51	3.73	090
58180		A	Partial hysterectomy	16.60	NA	NA	9.60	9.02	2.80	090

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58200		A	Extensive hysterectomy	23.10	NA	NA	12.91	11.97	3.88	090
58210		A	Extensive hysterectomy	30.91	NA	NA	17.23	15.89	5.26	090
58240		A	Removal of pelvis contents	49.33	NA	NA	26.97	24.96	8.31	090
58260		A	Vaginal hysterectomy	14.15	NA	NA	8.53	8.08	2.38	090
58262		A	Vag hyst including t/o	15.94	NA	NA	9.34	8.83	2.69	090
58263		A	Vag hyst w/t/o & vag repair	17.23	NA	NA	9.94	9.40	2.91	090
58267		A	Vag hyst w/urinary repair	18.36	NA	NA	10.54	9.94	3.11	090
58270		A	Vag hyst w/enterocele repair	15.30	NA	NA	8.86	8.38	2.57	090
58275		A	Hysterectomy/revise vagina	17.03	NA	NA	9.90	9.36	2.89	090
58280		A	Hysterectomy/revise vagina	18.33	NA	NA	10.54	9.92	3.07	090
58285		A	Extensive hysterectomy	23.38	NA	NA	12.58	11.78	3.92	090
58290		A	Vag hyst complex	20.27	NA	NA	11.27	10.61	3.42	090
58291		A	Vag hyst incl t/o complex	22.06	NA	NA	12.11	11.43	3.72	090
58292		A	Vag hyst t/o & repair compl	23.35	NA	NA	12.70	11.94	3.92	090
58293		A	Vag hyst w/uro repair compl	24.33	NA	NA	13.16	12.32	4.10	090
58294		A	Vag hyst w/enterocele compl	21.55	NA	NA	11.86	11.11	3.65	090
58300		N	Insert intrauterine device	1.01	0.94	1.05	0.44	0.44	0.07	XXX
58301		A	Remove intrauterine device	1.27	1.33	1.35	0.59	0.54	0.22	000
58321		A	Artificial insemination	0.92	1.18	1.24	0.42	0.40	0.05	000
58322		A	Artificial insemination	1.10	1.25	1.29	0.51	0.47	0.18	000
58323		A	Sperm washing	0.23	0.19	0.25	0.11	0.10	0.04	000
58340		A	Catheter for hysterography	0.88	2.34	2.63	0.72	0.73	0.12	000
58345		A	Reopen fallopian tube	4.70	NA	NA	2.96	2.86	0.77	010
58346		A	Insert heyman uteri capsule	7.56	NA	NA	4.77	4.77	0.62	090
58350		A	Reopen fallopian tube	1.06	1.58	1.64	1.10	1.10	0.18	010
58353		A	Endometr ablate thermal	3.60	23.90	27.71	2.41	2.34	0.61	010
58356		A	Endometrial cryoablation	6.41	45.31	51.65	3.07	2.87	1.07	010
58400		A	Suspension of uterus	7.14	NA	NA	4.95	4.92	1.07	090

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58410		A	Suspension of uterus	13.80	NA	NA	8.26	7.80	2.31	090
58520		A	Repair of ruptured uterus	13.48	NA	NA	8.11	7.62	2.89	090
58540		A	Revision of uterus	15.71	NA	NA	9.21	8.66	2.65	090
58541		A	Lsh uterus 250 g or less	14.70	NA	NA	9.01	8.43	2.46	090
58542		A	Lsh w/t/o ut 250 g or less	16.56	NA	NA	9.88	9.22	2.80	090
58543		A	Lsh uterus above 250 g	16.87	NA	NA	10.04	9.34	2.85	090
58544		A	Lsh w/t/o uterus above 250 g	18.37	NA	NA	10.73	9.93	3.11	090
58545		A	Laparoscopic myomectomy	15.55	NA	NA	8.93	8.40	2.66	090
58546		A	Laparo-myomectomy complex	19.94	NA	NA	10.93	10.27	3.38	090
58548		A	Lap radical hyst	31.63	NA	NA	17.88	16.16	5.31	090
58550		A	Laparo-asst vag hysterectomy	15.10	NA	NA	9.09	8.62	2.55	090
58552		A	Laparo-vag hyst incl t/o	16.91	NA	NA	9.92	9.37	2.87	090
58553		A	Laparo-vag hyst complex	20.06	NA	NA	11.04	10.34	3.40	090
58554		A	Laparo-vag hyst w/t/o compl	23.11	NA	NA	12.90	12.06	3.92	090
58555		A	Hysteroscopy dx sep proc	3.33	4.97	4.12	1.88	1.77	0.56	000
58558		A	Hysteroscopy biopsy	4.74	6.09	5.08	2.56	2.42	0.80	000
58559		A	Hysteroscopy lysis	6.16	NA	NA	3.22	3.03	1.05	000
58560		A	Hysteroscopy resect septum	6.99	NA	NA	3.61	3.40	1.18	000
58561		A	Hysteroscopy remove myoma	9.99	NA	NA	5.01	4.69	1.67	000
58562		A	Hysteroscopy remove fb	5.20	6.02	5.04	2.74	2.59	0.87	000
58563		A	Hysteroscopy ablation	6.16	39.21	45.03	3.22	3.04	1.05	000
58565		A	Hysteroscopy sterilization	7.12	43.93	48.55	4.77	4.60	1.20	090
58570		A	Tlh uterus 250 g or less	15.88	NA	NA	9.60	8.94	2.69	090
58571		A	Tlh w/t/o 250 g or less	17.69	NA	NA	10.61	9.77	3.00	090
58572		A	Tlh uterus over 250 g	20.09	NA	NA	11.60	10.69	3.40	090
58573		A	Tlh w/t/o uterus over 250 g	23.11	NA	NA	13.16	12.02	3.88	090
58578		C	Laparo proc uterus	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58579		C	Hysteroscope procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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58600		A	Division of fallopian tube	5.91	NA	NA	4.09	3.92	1.00	090
58605		A	Division of fallopian tube	5.28	NA	NA	3.75	3.63	0.88	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	NA	0.68	0.62	0.24	ZZZ
58615		A	Occlude fallopian tube(s)	3.94	NA	NA	2.75	2.73	0.67	010
58660		A	Laparoscopy lysis	11.59	NA	NA	6.76	6.36	2.04	090
58661		A	Laparoscopy remove adnexa	11.35	NA	NA	6.23	5.85	1.93	010
58662		A	Laparoscopy excise lesions	12.15	NA	NA	7.13	6.75	2.06	090
58670		A	Laparoscopy tubal cautery	5.91	NA	NA	4.11	3.96	1.00	090
58671		A	Laparoscopy tubal block	5.91	NA	NA	4.10	3.95	1.00	090
58672		A	Laparoscopy fimbrioplasty	12.91	NA	NA	7.26	6.84	2.17	090
58673		A	Laparoscopy salpingostomy	14.04	NA	NA	7.89	7.46	2.35	090
58679		C	Laparo proc oviduct-ovary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58700		A	Removal of fallopian tube	12.95	NA	NA	8.13	7.61	2.40	090
58720		A	Removal of ovary/tube(s)	12.16	NA	NA	7.53	7.11	2.15	090
58740		A	Adhesiolysis tube ovary	14.90	NA	NA	8.94	8.49	2.63	090
58750		A	Repair oviduct	15.64	NA	NA	9.08	8.60	2.63	090
58752		A	Revise ovarian tube(s)	15.64	NA	NA	8.85	8.60	1.10	090
58760		A	Fimbrioplasty	13.93	NA	NA	8.28	7.91	2.34	090
58770		A	Create new tubal opening	14.77	NA	NA	8.61	7.91	2.47	090
58800		A	Drainage of ovarian cyst(s)	4.62	4.09	4.14	3.57	3.52	0.76	090
58805		A	Drainage of ovarian cyst(s)	6.42	NA	NA	4.54	4.48	1.09	090
58820		A	Drain ovary abscess open	4.70	NA	NA	4.62	4.21	0.77	090
58822		A	Drain ovary abscess percut	11.81	NA	NA	7.39	7.17	2.51	090
58823		A	Drain pelvic abscess percut	3.37	21.62	23.22	1.27	1.40	0.38	000
58825		A	Transposition ovary(s)	11.78	NA	NA	7.59	7.08	1.97	090
58900		A	Biopsy of ovary(s)	6.59	NA	NA	5.45	4.97	1.40	090
58920		A	Partial removal of ovary(s)	11.95	NA	NA	7.26	6.84	2.00	090
58925		A	Removal of ovarian cyst(s)	12.43	NA	NA	7.74	7.28	2.23	090

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58940		A	Removal of ovary(s)	8.22	NA	NA	5.87	5.49	1.53	090
58943		A	Removal of ovary(s)	19.52	NA	NA	11.24	10.44	3.52	090
58950		A	Resect ovarian malignancy	18.37	NA	NA	11.13	10.37	3.25	090
58951		A	Resect ovarian malignancy	24.26	NA	NA	13.70	12.66	4.17	090
58952		A	Resect ovarian malignancy	27.29	NA	NA	15.53	14.35	4.73	090
58953		A	Tah rad dissect for debulk	34.13	NA	NA	18.85	17.38	5.87	090
58954		A	Tah rad debulk/lymph remove	37.13	NA	NA	20.28	18.71	6.34	090
58956		A	Bso omentectomy w/tah	22.80	NA	NA	13.35	12.43	3.98	090
58957		A	Resect recurrent gyn mal	26.22	NA	NA	15.06	13.71	4.79	090
58958		A	Resect recur gyn mal w/lym	29.22	NA	NA	16.42	15.01	4.93	090
58960		A	Exploration of abdomen	15.79	NA	NA	9.54	8.96	2.76	090
58970		A	Retrieval of oocyte	3.52	2.58	2.52	1.99	1.84	0.26	000
58974		C	Transfer of embryo	0.00	0.00	0.00	0.00	0.00	0.00	000
58976		A	Transfer of embryo	3.82	3.01	3.05	2.08	2.07	0.27	000
58999		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59000		A	Amniocentesis diagnostic	1.30	2.01	2.13	0.79	0.76	0.37	000
59001		A	Amniocentesis therapeutic	3.00	NA	NA	1.64	1.63	0.86	000
59012		A	Fetal cord puncture prenatal	3.44	NA	NA	1.80	1.69	0.99	000
59015		A	Chorion biopsy	2.20	1.86	1.84	1.22	1.16	0.62	000
59020		A	Fetal contract stress test	0.66	1.23	1.22	NA	NA	0.17	000
59020	TC	A	Fetal contract stress test	0.00	0.92	0.94	NA	NA	0.01	000
59020	26	A	Fetal contract stress test	0.66	0.31	0.28	0.31	0.28	0.16	000
59025		A	Fetal non-stress test	0.53	0.75	0.73	NA	NA	0.13	000
59025	TC	A	Fetal non-stress test	0.00	0.50	0.50	NA	NA	0.01	000
59025	26	A	Fetal non-stress test	0.53	0.25	0.23	0.25	0.23	0.12	000
59030		A	Fetal scalp blood sample	1.99	NA	NA	0.88	0.83	0.12	000
59050		A	Fetal monitor w/report	0.89	NA	NA	0.42	0.38	0.26	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	NA	0.35	0.31	0.22	XXX

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59070		A	Transabdom amnioinfus w/us	5.24	5.75	5.82	2.71	2.65	1.51	000
59072		A	Umbilical cord occlud w/us	8.99	NA	NA	4.36	4.22	2.58	000
59074		A	Fetal fluid drainage w/us	5.24	5.92	5.58	3.01	2.76	1.51	000
59076		A	Fetal shunt placement w/us	8.99	NA	NA	4.36	4.05	2.58	000
59100		A	Remove uterus lesion	13.37	NA	NA	8.21	7.73	3.83	090
59120		A	Treat ectopic pregnancy	12.67	NA	NA	7.89	7.51	3.65	090
59121		A	Treat ectopic pregnancy	12.74	NA	NA	7.83	7.46	3.67	090
59130		A	Treat ectopic pregnancy	15.08	NA	NA	8.92	8.40	1.07	090
59135		A	Treat ectopic pregnancy	14.92	NA	NA	8.65	8.58	1.06	090
59136		A	Treat ectopic pregnancy	14.25	NA	NA	8.47	8.00	4.09	090
59140		A	Treat ectopic pregnancy	5.94	NA	NA	4.48	4.28	0.41	090
59150		A	Treat ectopic pregnancy	12.29	NA	NA	7.62	7.24	3.53	090
59151		A	Treat ectopic pregnancy	12.11	NA	NA	7.25	6.90	3.48	090
59160		A	D & c after delivery	2.76	2.57	2.72	1.73	1.76	0.77	010
59200		A	Insert cervical dilator	0.79	1.11	1.17	0.37	0.34	0.23	000
59300		A	Episiotomy or vaginal repair	2.41	2.65	2.65	1.44	1.33	0.68	000
59320		A	Revision of cervix	2.48	NA	NA	1.48	1.41	0.69	000
59325		A	Revision of cervix	4.06	NA	NA	2.21	2.09	0.29	000
59350		A	Repair of uterus	4.94	NA	NA	2.31	2.05	1.41	000
59400		A	Obstetrical care	28.69	NA	NA	20.68	19.40	7.97	MMM
59409		A	Obstetrical care	12.82	NA	NA	6.02	5.65	3.54	MMM
59410		A	Obstetrical care	16.07	NA	NA	8.03	7.40	4.44	MMM
59412		A	Antepartum manipulation	1.53	NA	NA	0.88	0.87	0.43	MMM
59414		A	Deliver placenta	1.44	NA	NA	0.67	0.65	0.45	MMM
59425		A	Antepartum care only	5.63	5.34	5.31	2.62	2.43	1.55	MMM
59426		A	Antepartum care only	9.96	9.73	9.67	4.64	4.30	2.69	MMM
59430		A	Care after delivery	2.20	2.27	1.84	1.03	1.00	0.60	MMM
59510		A	Cesarean delivery	31.80	NA	NA	22.68	21.59	9.04	MMM

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59514		A	Cesarean delivery only	14.39	NA	NA	6.77	6.53	4.07	MMM
59515		A	Cesarean delivery	19.15	NA	NA	10.07	9.25	5.42	MMM
59525		A	Remove uterus after cesarean	8.53	NA	NA	3.98	3.67	2.43	ZZZ
59610		A	Vbac delivery	30.22	NA	NA	21.32	20.17	8.68	MMM
59612		A	Vbac delivery only	14.35	NA	NA	6.70	6.35	4.11	MMM
59614		A	Vbac care after delivery	17.60	NA	NA	8.66	7.92	5.04	MMM
59618		A	Attempted vbac delivery	32.26	NA	NA	22.83	22.08	9.26	MMM
59620		A	Attempted vbac delivery only	14.86	NA	NA	6.93	6.92	4.26	MMM
59622		A	Attempted vbac after care	19.63	NA	NA	10.32	9.78	5.64	MMM
59812		A	Treatment of miscarriage	4.44	3.86	3.78	3.25	3.13	1.25	090
59820		A	Care of miscarriage	4.84	5.08	5.12	4.47	4.40	1.39	090
59821		A	Treatment of miscarriage	5.09	4.88	4.89	4.21	4.12	1.47	090
59830		A	Treat uterus infection	6.59	NA	NA	4.74	4.61	1.89	090
59840		R	Abortion	3.01	2.67	2.61	2.42	2.38	0.80	010
59841		R	Abortion	5.65	4.28	4.15	3.69	3.52	1.62	010
59850		R	Abortion	5.90	NA	NA	3.96	3.95	0.41	090
59851		R	Abortion	5.92	NA	NA	4.44	4.34	1.68	090
59852		R	Abortion	8.23	NA	NA	6.02	6.03	0.58	090
59855		R	Abortion	6.43	NA	NA	4.33	4.18	1.85	090
59856		R	Abortion	7.79	NA	NA	4.83	4.63	2.23	090
59857		R	Abortion	9.33	NA	NA	5.44	5.40	0.65	090
59866		R	Abortion (mpr)	3.99	NA	NA	2.16	2.08	0.29	000
59870		A	Evacuate mole of uterus	6.57	NA	NA	5.73	5.71	1.89	090
59871		A	Remove cerclage suture	2.13	NA	NA	1.34	1.29	0.61	000
59897		C	Fetal invas px w/us	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59898		C	Laparo proc ob care/deliver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59899		C	Maternity care procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60000		A	Drain thyroid/tongue cyst	1.81	2.86	2.74	2.37	2.28	0.24	010

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6005F		I	Care level rationale doc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
60100		A	Biopsy of thyroid	1.56	1.48	1.58	0.61	0.65	0.16	000
60200		A	Remove thyroid lesion	10.02	NA	NA	8.26	7.67	1.70	090
60210		A	Partial thyroid excision	11.23	NA	NA	8.14	7.45	2.06	090
60212		A	Partial thyroid excision	16.43	NA	NA	11.42	10.31	3.06	090
60220		A	Partial removal of thyroid	12.37	NA	NA	8.91	8.14	2.15	090
60225		A	Partial removal of thyroid	14.79	NA	NA	10.72	9.83	2.63	090
60240		A	Removal of thyroid	16.22	NA	NA	10.32	9.44	2.95	090
60252		A	Removal of thyroid	22.01	NA	NA	14.15	12.92	3.87	090
60254		A	Extensive thyroid surgery	28.42	NA	NA	18.44	16.84	4.52	090
60260		A	Repeat thyroid surgery	18.26	NA	NA	11.93	10.89	3.12	090
60270		A	Removal of thyroid	23.20	NA	NA	14.04	13.17	4.37	090
60271		A	Removal of thyroid	17.62	NA	NA	11.44	10.55	3.00	090
60280		A	Remove thyroid duct lesion	6.16	NA	NA	6.53	6.09	0.84	090
60281		A	Remove thyroid duct lesion	8.82	NA	NA	8.22	7.49	1.14	090
60300		A	Aspir/inj thyroid cyst	0.97	2.18	2.19	0.38	0.39	0.11	000
6040F		I	Appro rad ds dvcs techs docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
60500		A	Explore parathyroid glands	16.78	NA	NA	10.83	9.87	3.23	090
60502		A	Re-explore parathyroids	21.15	NA	NA	13.42	12.25	4.14	090
60505		A	Explore parathyroid glands	23.06	NA	NA	14.75	13.62	4.32	090
60512		A	Autotransplant parathyroid	4.44	NA	NA	2.10	1.90	0.83	ZZZ
60520		A	Removal of thymus gland	17.16	NA	NA	10.54	9.88	3.46	090
60521		A	Removal of thymus gland	19.18	NA	NA	10.41	10.66	4.52	090
60522		A	Removal of thymus gland	23.48	NA	NA	12.52	12.70	5.45	090
60540		A	Explore adrenal gland	18.02	NA	NA	10.23	10.26	3.03	090
60545		A	Explore adrenal gland	20.93	NA	NA	11.61	11.35	3.68	090
60600		A	Remove carotid body lesion	25.09	NA	NA	12.93	12.50	5.30	090
60605		A	Remove carotid body lesion	31.96	NA	NA	18.79	16.84	4.10	090

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60650		A	Laparoscopy adrenalectomy	20.73	NA	NA	11.14	10.74	3.73	090
60659		C	Laparo proc endocrine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60699		C	Endocrine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
6070F		I	Pt asked/cnsld aed effects	0.00	0.00	0.00	0.00	0.00	0.00	XXX
6080F		I	Pt/caregiver queried falls	0.00	0.00	0.00	0.00	0.00	0.00	XXX
6090F		I	Pt/caregiver counsel safety	0.00	0.00	0.00	0.00	0.00	0.00	XXX
61000		A	Remove cranial cavity fluid	1.58	NA	NA	1.53	1.46	0.14	000
61001		A	Remove cranial cavity fluid	1.49	NA	NA	1.32	1.36	0.53	000
61020		A	Remove brain cavity fluid	1.51	NA	NA	2.09	1.99	0.50	000
61026		A	Injection into brain canal	1.69	NA	NA	1.70	1.68	0.38	000
61050		A	Remove brain canal fluid	1.51	NA	NA	1.38	1.43	0.12	000
61055		A	Injection into brain canal	2.10	NA	NA	1.55	1.62	0.29	000
61070		A	Brain canal shunt procedure	0.89	NA	NA	1.39	1.36	0.20	000
61105		A	Twist drill hole	5.45	NA	NA	6.33	5.91	1.91	090
61107		A	Drill skull for implantation	4.99	NA	NA	2.77	2.67	1.78	000
61108		A	Drill skull for drainage	11.64	NA	NA	11.22	10.56	4.13	090
61120		A	Burr hole for puncture	9.60	NA	NA	9.20	8.63	3.45	090
61140		A	Pierce skull for biopsy	17.23	NA	NA	14.22	13.53	6.10	090
61150		A	Pierce skull for drainage	18.90	NA	NA	14.88	14.04	6.76	090
61151		A	Pierce skull for drainage	13.49	NA	NA	11.38	10.64	4.83	090
61154		A	Pierce skull & remove clot	17.07	NA	NA	14.64	13.86	6.08	090
61156		A	Pierce skull for drainage	17.45	NA	NA	13.49	12.93	6.25	090
61210		A	Pierce skull implant device	5.83	NA	NA	3.23	3.12	2.08	000
61215		A	Insert brain-fluid device	5.85	NA	NA	7.00	6.62	2.06	090
61250		A	Pierce skull & explore	11.49	NA	NA	10.26	9.55	4.11	090
61253		A	Pierce skull & explore	13.49	NA	NA	10.18	9.60	1.71	090
61304		A	Open skull for exploration	23.41	NA	NA	17.59	16.70	8.13	090
61305		A	Open skull for exploration	28.64	NA	NA	21.34	20.23	10.25	090

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61312		A	Open skull for drainage	30.17	NA	NA	21.35	20.27	10.77	090
61313		A	Open skull for drainage	28.09	NA	NA	21.22	20.13	10.01	090
61314		A	Open skull for drainage	25.90	NA	NA	19.54	18.51	9.25	090
61315		A	Open skull for drainage	29.65	NA	NA	21.63	20.64	10.63	090
61316		A	Implt cran bone flap to abdo	1.39	NA	NA	0.77	0.73	0.49	ZZZ
61320		A	Open skull for drainage	27.42	NA	NA	19.80	18.97	9.67	090
61321		A	Open skull for drainage	30.53	NA	NA	22.39	20.91	10.95	090
61322		A	Decompressive craniotomy	34.26	NA	NA	24.65	23.03	12.21	090
61323		A	Decompressive lobectomy	35.06	NA	NA	24.33	22.78	12.43	090
61330		A	Decompress eye socket	25.30	NA	NA	19.41	17.55	9.07	090
61332		A	Explore/biopsy eye socket	28.60	NA	NA	20.69	18.96	10.24	090
61333		A	Explore orbit/remove lesion	29.27	NA	NA	23.27	20.52	10.48	090
61334		A	Explore orbit/remove object	19.60	NA	NA	14.29	12.88	7.01	090
61340		A	Subtemporal decompression	20.11	NA	NA	15.95	14.98	7.21	090
61343		A	Incise skull (press relief)	31.86	NA	NA	22.61	21.56	11.33	090
61345		A	Relieve cranial pressure	29.23	NA	NA	21.46	20.40	10.47	090
61440		A	Incise skull for surgery	28.66	NA	NA	21.14	20.01	10.25	090
61450		A	Incise skull for surgery	27.69	NA	NA	20.06	18.93	9.91	090
61458		A	Incise skull for brain wound	28.84	NA	NA	21.05	20.09	10.23	090
61460		A	Incise skull for surgery	30.24	NA	NA	22.03	20.54	10.82	090
61470		A	Incise skull for surgery	27.62	NA	NA	20.03	18.99	9.89	090
61480		A	Incise skull for surgery	28.05	NA	NA	14.48	14.77	1.97	090
61490		A	Incise skull for surgery	27.22	NA	NA	19.80	18.88	9.76	090
61500		A	Removal of skull lesion	19.18	NA	NA	15.33	14.41	5.77	090
61501		A	Remove infected skull bone	16.35	NA	NA	13.71	12.84	4.66	090
61510		A	Removal of brain lesion	30.83	NA	NA	23.45	22.35	10.99	090
61512		A	Remove brain lining lesion	37.14	NA	NA	26.01	24.86	13.25	090
61514		A	Removal of brain abscess	27.23	NA	NA	19.88	19.05	9.70	090

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61516		A	Removal of brain lesion	26.58	NA	NA	19.64	18.71	9.21	090
61517		A	Implt brain chemotx add-on	1.38	NA	NA	0.76	0.73	0.49	ZZZ
61518		A	Removal of brain lesion	39.89	NA	NA	28.45	27.10	14.27	090
61519		A	Remove brain lining lesion	43.43	NA	NA	29.60	28.23	15.45	090
61520		A	Removal of brain lesion	57.09	NA	NA	37.88	36.12	17.93	090
61521		A	Removal of brain lesion	46.99	NA	NA	31.85	30.17	16.83	090
61522		A	Removal of brain abscess	31.54	NA	NA	22.76	21.68	11.30	090
61524		A	Removal of brain lesion	29.89	NA	NA	21.83	20.59	10.71	090
61526		A	Removal of brain lesion	54.08	NA	NA	36.25	33.64	19.37	090
61530		A	Removal of brain lesion	45.56	NA	NA	30.60	28.63	16.34	090
61531		A	Implant brain electrodes	16.41	NA	NA	14.19	13.46	5.88	090
61533		A	Implant brain electrodes	21.46	NA	NA	16.49	15.64	7.67	090
61534		A	Removal of brain lesion	23.01	NA	NA	17.98	17.07	8.24	090
61535		A	Remove brain electrodes	13.15	NA	NA	11.93	11.30	4.71	090
61536		A	Removal of brain lesion	37.72	NA	NA	26.21	25.05	13.51	090
61537		A	Removal of brain tissue	36.45	NA	NA	24.62	22.89	12.98	090
61538		A	Removal of brain tissue	39.45	NA	NA	26.64	24.63	14.15	090
61539		A	Removal of brain tissue	34.28	NA	NA	24.29	22.90	12.28	090
61540		A	Removal of brain tissue	31.43	NA	NA	22.79	21.73	11.26	090
61541		A	Incision of brain tissue	30.94	NA	NA	22.42	21.23	11.08	090
61542		A	Removal of brain tissue	33.16	NA	NA	20.48	20.97	11.87	090
61543		A	Removal of brain tissue	31.31	NA	NA	22.63	21.14	11.20	090
61544		A	Remove & treat brain lesion	27.36	NA	NA	19.88	17.23	9.80	090
61545		A	Excision of brain tumor	46.43	NA	NA	32.54	30.77	16.62	090
61546		A	Removal of pituitary gland	33.44	NA	NA	23.82	22.55	11.96	090
61548		A	Removal of pituitary gland	23.37	NA	NA	16.88	15.98	6.65	090
61550		A	Release of skull seams	15.59	NA	NA	10.56	10.62	1.10	090
61552		A	Release of skull seams	20.40	NA	NA	11.44	12.81	1.45	090

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61556		A	Incise skull/sutures	24.09	NA	NA	15.89	15.71	8.64	090
61557		A	Incise skull/sutures	23.31	NA	NA	18.61	17.84	8.35	090
61558		A	Excision of skull/sutures	26.50	NA	NA	14.27	16.24	9.49	090
61559		A	Excision of skull/sutures	34.02	NA	NA	25.45	24.42	2.40	090
61563		A	Excision of skull tumor	28.44	NA	NA	20.74	19.75	10.19	090
61564		A	Excision of skull tumor	34.74	NA	NA	25.00	23.86	12.43	090
61566		A	Removal of brain tissue	32.45	NA	NA	23.36	22.39	11.61	090
61567		A	Incision of brain tissue	37.00	NA	NA	26.63	25.59	13.27	090
61570		A	Remove foreign body brain	26.51	NA	NA	19.94	18.70	9.49	090
61571		A	Incise skull for brain wound	28.42	NA	NA	21.01	20.04	10.17	090
61575		A	Skull base/brainstem surgery	36.56	NA	NA	25.56	23.60	13.09	090
61576		A	Skull base/brainstem surgery	55.31	NA	NA	43.73	42.30	7.09	090
61580		A	Craniofacial approach skull	34.51	NA	NA	34.41	31.96	5.88	090
61581		A	Craniofacial approach skull	39.13	NA	NA	38.59	35.60	5.02	090
61582		A	Craniofacial approach skull	35.14	NA	NA	42.59	39.77	12.59	090
61583		A	Craniofacial approach skull	38.50	NA	NA	34.95	33.43	12.91	090
61584		A	Orbitocranial approach/skull	37.70	NA	NA	34.64	33.06	12.67	090
61585		A	Orbitocranial approach/skull	42.57	NA	NA	38.81	35.18	15.25	090
61586		A	Resect nasopharynx skull	27.48	NA	NA	35.11	31.28	9.85	090
61590		A	Infratemporal approach/skull	47.04	NA	NA	38.58	35.68	8.43	090
61591		A	Infratemporal approach/skull	47.02	NA	NA	38.23	35.69	9.57	090
61592		A	Orbitocranial approach/skull	43.08	NA	NA	36.93	35.42	14.48	090
61595		A	Transtemporal approach/skull	33.74	NA	NA	30.77	28.97	7.13	090
61596		A	Transcochlear approach/skull	39.43	NA	NA	31.60	29.64	5.05	090
61597		A	Transcondylar approach/skull	40.82	NA	NA	31.25	30.02	14.63	090
61598		A	Transpetrosal approach/skull	36.53	NA	NA	34.82	30.95	13.08	090
61600		A	Resect/excise cranial lesion	30.01	NA	NA	28.86	26.82	6.21	090
61601		A	Resect/excise cranial lesion	31.14	NA	NA	29.86	28.39	10.14	090

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61605		A	Resect/excise cranial lesion	32.57	NA	NA	29.75	27.60	4.94	090
61606		A	Resect/excise cranial lesion	42.05	NA	NA	33.80	32.64	13.65	090
61607		A	Resect/excise cranial lesion	40.93	NA	NA	31.97	29.99	14.65	090
61608		A	Resect/excise cranial lesion	45.54	NA	NA	36.04	34.42	15.35	090
61609		A	Transect artery sinus	9.88	NA	NA	4.35	4.45	3.54	ZZZ
61610		A	Transect artery sinus	29.63	NA	NA	16.57	15.74	10.62	ZZZ
61611		A	Transect artery sinus	7.41	NA	NA	3.26	3.57	0.52	ZZZ
61612		A	Transect artery sinus	27.84	NA	NA	12.25	12.84	1.96	ZZZ
61613		A	Remove aneurysm sinus	45.03	NA	NA	36.99	34.81	16.13	090
61615		A	Resect/excise lesion skull	35.77	NA	NA	29.59	28.45	4.59	090
61616		A	Resect/excise lesion skull	46.74	NA	NA	38.32	36.35	14.38	090
61618		A	Repair dura	18.69	NA	NA	14.72	13.86	5.74	090
61619		A	Repair dura	22.10	NA	NA	16.62	15.58	6.31	090
61623		A	Endovasc tempory vessel occl	9.95	NA	NA	4.48	4.70	1.85	000
61624		A	Transcath occlusion cns	20.12	NA	NA	8.79	9.14	3.76	000
61626		A	Transcath occlusion non-cns	16.60	NA	NA	6.44	7.10	2.13	000
61630		R	Intracranial angioplasty	22.07	NA	NA	11.23	11.64	4.17	XXX
61635		R	Intracran angioplsty w/stent	24.28	NA	NA	12.14	12.60	4.06	XXX
61640		N	Dilate ic vasospasm init	12.32	NA	NA	5.42	5.25	0.87	000
61641		N	Dilate ic vasospasm add-on	4.33	NA	NA	1.91	1.85	0.31	ZZZ
61642		N	Dilate ic vasospasm add-on	8.66	NA	NA	3.81	3.69	0.61	ZZZ
61680		A	Intracranial vessel surgery	32.55	NA	NA	23.52	22.49	11.65	090
61682		A	Intracranial vessel surgery	63.41	NA	NA	39.78	38.15	22.71	090
61684		A	Intracranial vessel surgery	41.64	NA	NA	28.86	27.12	14.91	090
61686		A	Intracranial vessel surgery	67.50	NA	NA	43.76	41.84	24.19	090
61690		A	Intracranial vessel surgery	31.34	NA	NA	22.97	21.74	11.23	090
61692		A	Intracranial vessel surgery	54.59	NA	NA	35.98	34.11	19.56	090
61697		A	Brain aneurysm repr complx	63.40	NA	NA	41.17	38.76	22.47	090

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61698		A	Brain aneurysm repr complx	69.63	NA	NA	44.95	41.70	24.93	090
61700		A	Brain aneurysm repr simple	50.62	NA	NA	34.03	32.74	18.02	090
61702		A	Inner skull vessel surgery	60.04	NA	NA	39.59	36.93	21.50	090
61703		A	Clamp neck artery	18.80	NA	NA	15.09	14.39	6.74	090
61705		A	Revise circulation to head	38.10	NA	NA	26.42	24.59	13.65	090
61708		A	Revise circulation to head	37.20	NA	NA	22.58	20.67	3.07	090
61710		A	Revise circulation to head	31.29	NA	NA	16.13	17.18	6.50	090
61711		A	Fusion of skull arteries	38.23	NA	NA	26.42	25.01	13.69	090
61720		A	Incise skull/brain surgery	17.62	NA	NA	14.05	12.58	6.31	090
61735		A	Incise skull/brain surgery	22.35	NA	NA	15.01	14.16	8.00	090
61750		A	Incise skull/brain biopsy	19.83	NA	NA	15.20	14.44	7.05	090
61751		A	Brain biopsy w/ct/mr guide	18.79	NA	NA	15.57	14.84	6.68	090
61760		A	Implant brain electrodes	22.39	NA	NA	16.93	15.59	8.01	090
61770		A	Incise skull for treatment	23.19	NA	NA	17.17	15.66	8.18	090
61781		A	Scan proc cranial intra	3.75	NA	NA	2.14	2.14	1.25	ZZZ
61782		A	Scan proc cranial extra	3.18	NA	NA	1.81	1.81	0.87	ZZZ
61783		A	Scan proc spinal	3.75	NA	NA	2.14	2.14	0.15	ZZZ
61790		A	Treat trigeminal nerve	11.60	NA	NA	10.44	9.66	4.06	090
61791		A	Treat trigeminal tract	15.41	NA	NA	12.67	11.93	5.19	090
61796		A	Srs cranial lesion simple	13.93	NA	NA	11.40	9.94	4.62	090
61797		A	Srs cran les simple addl	3.48	NA	NA	1.94	1.80	1.15	ZZZ
61798		A	Srs cranial lesion complex	19.85	NA	NA	14.69	11.61	6.59	090
61799		A	Srs cran les complex addl	4.81	NA	NA	2.68	2.48	1.59	ZZZ
61800		A	Apply srs headframe add-on	2.25	NA	NA	1.58	1.48	0.73	ZZZ
61850		A	Implant neuroelectrodes	13.34	NA	NA	8.23	9.17	4.79	090
61860		A	Implant neuroelectrodes	22.26	NA	NA	16.65	15.86	7.97	090
61863		A	Implant neuroelectrode	20.71	NA	NA	16.69	15.98	7.39	090
61864		A	Implant neuroelectrde addl	4.49	NA	NA	2.51	2.42	1.60	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
61867		A	Implant neuroelectrode	33.03	NA	NA	23.62	22.54	11.80	090
61868		A	Implant neuroelectrde addl	7.91	NA	NA	4.41	4.26	2.84	ZZZ
61870		A	Implant neuroelectrodes	16.34	NA	NA	13.19	12.66	5.85	090
61875		A	Implant neuroelectrodes	16.46	NA	NA	13.25	12.54	1.17	090
61880		A	Revise/remove neuroelectrode	6.95	NA	NA	7.44	6.95	2.46	090
61885		A	Insrt/redo neurostim 1 array	6.05	NA	NA	7.22	7.82	2.06	090
61886		A	Implant neurostim arrays	9.93	NA	NA	11.59	10.88	3.52	090
61888		A	Revise/remove neuroreceiver	5.23	NA	NA	4.68	4.54	1.71	010
62000		A	Treat skull fracture	13.93	NA	NA	11.84	10.10	5.00	090
62005		A	Treat skull fracture	17.63	NA	NA	14.06	13.14	6.31	090
62010		A	Treatment of head injury	21.43	NA	NA	16.72	15.72	7.67	090
62100		A	Repair brain fluid leakage	23.53	NA	NA	17.22	16.25	7.50	090
62115		A	Reduction of skull defect	22.91	NA	NA	12.99	11.62	1.62	090
62116		A	Reduction of skull defect	25.02	NA	NA	19.12	18.20	8.96	090
62117		A	Reduction of skull defect	28.35	NA	NA	20.36	19.50	3.65	090
62120		A	Repair skull cavity lesion	24.59	NA	NA	23.74	22.83	3.16	090
62121		A	Incise skull repair	23.03	NA	NA	19.61	18.80	8.26	090
62140		A	Repair of skull defect	14.55	NA	NA	11.93	11.28	4.74	090
62141		A	Repair of skull defect	16.07	NA	NA	12.85	12.22	5.30	090
62142		A	Remove skull plate/flap	11.83	NA	NA	10.57	10.03	4.07	090
62143		A	Replace skull plate/flap	14.15	NA	NA	11.84	11.21	5.00	090
62145		A	Repair of skull & brain	20.09	NA	NA	15.01	14.35	7.20	090
62146		A	Repair of skull with graft	17.28	NA	NA	13.86	12.89	6.19	090
62147		A	Repair of skull with graft	20.67	NA	NA	15.76	14.84	7.39	090
62148		A	Retr bone flap to fix skull	2.00	NA	NA	1.12	1.05	0.71	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	NA	1.66	1.61	1.07	ZZZ
62161		A	Dissect brain w/scope	21.23	NA	NA	16.55	15.74	7.60	090
62162		A	Remove colloid cyst w/scope	26.80	NA	NA	20.22	19.34	9.59	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
62163		A	Neuroendoscopy w/fb removal	16.53	NA	NA	14.10	13.49	5.91	090
62164		A	Remove brain tumor w/scope	29.43	NA	NA	22.59	21.01	10.55	090
62165		A	Remove pituit tumor w/scope	23.23	NA	NA	17.35	16.45	6.36	090
62180		A	Establish brain cavity shunt	22.58	NA	NA	17.26	16.43	8.09	090
62190		A	Establish brain cavity shunt	12.17	NA	NA	11.01	10.39	4.36	090
62192		A	Establish brain cavity shunt	13.35	NA	NA	11.18	10.55	4.62	090
62194		A	Replace/irrigate catheter	5.78	NA	NA	6.56	5.28	0.45	010
62200		A	Establish brain cavity shunt	19.29	NA	NA	14.99	14.24	6.91	090
62201		A	Brain cavity shunt w/scope	16.04	NA	NA	14.13	13.35	5.72	090
62220		A	Establish brain cavity shunt	14.10	NA	NA	11.50	10.84	4.82	090
62223		A	Establish brain cavity shunt	14.05	NA	NA	12.49	11.88	4.83	090
62225		A	Replace/irrigate catheter	6.19	NA	NA	7.03	6.58	2.20	090
62230		A	Replace/revise brain shunt	11.43	NA	NA	9.69	9.21	3.97	090
62252		A	Csf shunt reprogram	0.74	1.43	1.72	NA	NA	0.25	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.02	1.33	NA	NA	0.01	XXX
62252	26	A	Csf shunt reprogram	0.74	0.41	0.39	0.41	0.39	0.24	XXX
62256		A	Remove brain cavity shunt	7.38	NA	NA	7.78	7.35	2.62	090
62258		A	Replace brain cavity shunt	15.64	NA	NA	12.43	11.87	5.42	090
62263		A	Epidural lysis mult sessions	6.54	15.67	13.85	5.76	4.72	0.52	010
62264		A	Epidural lysis on single day	4.42	8.07	7.40	2.54	2.07	0.35	010
62267		A	Interdiscal perq aspir dx	3.00	3.81	3.98	1.37	1.39	0.30	000
62268		A	Drain spinal cord cyst	4.73	2.04	5.21	2.53	2.46	0.45	000
62269		A	Needle biopsy spinal cord	5.01	1.92	5.61	2.31	2.27	0.56	000
62270		A	Spinal fluid tap diagnostic	1.37	2.86	2.98	0.71	0.72	0.23	000
62272		A	Drain cerebro spinal fluid	1.35	4.08	4.00	0.84	0.83	0.33	000
62273		A	Inject epidural patch	2.15	2.76	2.59	1.08	0.93	0.20	000
62280		A	Treat spinal cord lesion	2.63	6.74	6.41	1.92	1.64	0.50	010
62281		A	Treat spinal cord lesion	2.66	4.03	4.71	1.73	1.48	0.27	010

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62282		A	Treat spinal canal lesion	2.33	5.90	6.03	1.70	1.50	0.29	010
62284		A	Injection for myelogram	1.54	4.18	4.58	0.81	0.86	0.18	000
62287		A	Percutaneous diskectomy	9.03	NA	NA	6.89	6.35	0.81	090
62290		A	Inject for spine disk x-ray	3.00	6.65	6.49	1.92	1.73	0.30	000
62291		A	Inject for spine disk x-ray	2.91	6.34	6.06	1.88	1.67	0.27	000
62292		A	Injection into disk lesion	9.24	NA	NA	8.48	6.05	0.75	090
62294		A	Injection into spinal artery	12.87	NA	NA	4.63	6.34	1.02	090
62310		A	Inject spine c/t	1.91	5.15	4.73	1.20	0.98	0.16	000
62311		A	Inject spine l/s (cd)	1.54	4.37	4.18	0.99	0.84	0.12	000
62318		A	Inject spine w/cath c/t	2.04	4.98	4.79	0.84	0.72	0.16	000
62319		A	Inject spine w/cath l/s (cd)	1.87	2.98	3.54	0.87	0.74	0.16	000
62350		A	Implant spinal canal cath	6.05	NA	NA	4.95	4.38	1.05	010
62351		A	Implant spinal canal cath	11.66	NA	NA	10.89	10.10	3.38	090
62355		A	Remove spinal canal catheter	4.35	NA	NA	4.02	3.59	0.73	010
62360		A	Insert spine infusion device	4.33	NA	NA	4.18	3.66	0.87	010
62361		A	Implant spine infusion pump	5.65	NA	NA	4.95	4.69	1.10	010
62362		A	Implant spine infusion pump	6.10	NA	NA	5.10	4.67	1.22	010
62365		A	Remove spine infusion device	4.65	NA	NA	4.43	4.03	0.88	010
62367		A	Analyze spine infusion pump	0.48	0.72	0.66	0.23	0.19	0.05	XXX
62368		A	Analyze spine infusion pump	0.75	1.01	0.88	0.37	0.30	0.07	XXX
63001		A	Removal of spinal lamina	17.61	NA	NA	13.71	12.96	5.68	090
63003		A	Removal of spinal lamina	17.74	NA	NA	13.78	13.05	5.62	090
63005		A	Removal of spinal lamina	16.43	NA	NA	13.71	13.08	5.07	090
63011		A	Removal of spinal lamina	15.91	NA	NA	12.76	11.93	4.01	090
63012		A	Removal of spinal lamina	16.85	NA	NA	13.53	12.96	5.09	090
63015		A	Removal of spinal lamina	20.85	NA	NA	16.47	15.69	6.99	090
63016		A	Removal of spinal lamina	22.03	NA	NA	16.65	15.73	6.76	090
63017		A	Removal of spinal lamina	17.33	NA	NA	14.40	13.71	5.55	090

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63020		A	Neck spine disk surgery	16.20	NA	NA	13.61	12.98	5.05	090
63030		A	Low back disk surgery	13.18	NA	NA	11.89	11.30	3.86	090
63035		A	Spinal disk surgery add-on	3.15	NA	NA	1.80	1.74	0.88	ZZZ
63040		A	Laminotomy single cervical	20.31	NA	NA	15.47	14.73	6.26	090
63042		A	Laminotomy single lumbar	18.76	NA	NA	14.97	14.27	5.19	090
63043		C	Laminotomy addl cervical	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63044		C	Laminotomy addl lumbar	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63045		A	Removal of spinal lamina	17.95	NA	NA	14.34	13.65	5.72	090
63046		A	Removal of spinal lamina	17.25	NA	NA	13.83	13.16	5.13	090
63047		A	Removal of spinal lamina	15.37	NA	NA	13.09	12.50	4.40	090
63048		A	Remove spinal lamina add-on	3.47	NA	NA	1.98	1.90	1.00	ZZZ
63050		A	Cervical laminoplasty	22.01	NA	NA	17.41	16.26	7.89	090
63051		A	C-laminoplasty w/graft/plate	25.51	NA	NA	18.77	17.76	7.22	090
63055		A	Decompress spinal cord	23.55	NA	NA	17.54	16.74	7.65	090
63056		A	Decompress spinal cord	21.86	NA	NA	16.34	15.52	6.18	090
63057		A	Decompress spine cord add-on	5.25	NA	NA	3.00	2.88	1.51	ZZZ
63064		A	Decompress spinal cord	26.22	NA	NA	18.93	17.92	7.93	090
63066		A	Decompress spine cord add-on	3.26	NA	NA	1.82	1.77	1.17	ZZZ
63075		A	Neck spine disk surgery	19.60	NA	NA	15.40	14.78	6.10	090
63076		A	Neck spine disk surgery	4.04	NA	NA	2.29	2.21	1.25	ZZZ
63077		A	Spine disk surgery thorax	22.88	NA	NA	16.29	15.50	5.85	090
63078		A	Spine disk surgery thorax	3.28	NA	NA	1.87	1.78	0.75	ZZZ
63081		A	Removal of vertebral body	26.10	NA	NA	19.18	18.25	7.88	090
63082		A	Remove vertebral body add-on	4.36	NA	NA	2.48	2.39	1.30	ZZZ
63085		A	Removal of vertebral body	29.47	NA	NA	19.52	18.64	7.92	090
63086		A	Remove vertebral body add-on	3.19	NA	NA	1.72	1.68	0.87	ZZZ
63087		A	Removal of vertebral body	37.53	NA	NA	24.49	23.44	9.71	090
63088		A	Remove vertebral body add-on	4.32	NA	NA	2.48	2.38	1.06	ZZZ

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63090		A	Removal of vertebral body	30.93	NA	NA	21.10	19.96	7.18	090
63091		A	Remove vertebral body add-on	3.03	NA	NA	1.70	1.63	0.68	ZZZ
63101		A	Removal of vertebral body	34.10	NA	NA	24.98	23.73	10.61	090
63102		A	Removal of vertebral body	34.10	NA	NA	24.62	23.40	8.58	090
63103		A	Remove vertebral body add-on	4.82	NA	NA	2.75	2.67	1.29	ZZZ
63170		A	Incise spinal cord tract(s)	22.21	NA	NA	17.49	16.25	7.96	090
63172		A	Drainage of spinal cyst	19.76	NA	NA	15.32	14.50	7.06	090
63173		A	Drainage of spinal cyst	24.31	NA	NA	18.66	17.73	8.73	090
63180		A	Revise spinal cord ligaments	20.53	NA	NA	16.55	14.99	7.35	090
63182		A	Revise spinal cord ligaments	22.82	NA	NA	17.83	15.15	8.18	090
63185		A	Incise spinal column/nerves	16.49	NA	NA	13.34	12.46	5.91	090
63190		A	Incise spinal column/nerves	18.89	NA	NA	14.90	14.11	4.28	090
63191		A	Incise spinal column/nerves	18.92	NA	NA	15.50	12.23	3.73	090
63194		A	Incise spinal column & cord	22.10	NA	NA	16.17	15.43	2.84	090
63195		A	Incise spinal column & cord	21.64	NA	NA	16.63	15.54	7.75	090
63196		A	Incise spinal column & cord	25.27	NA	NA	13.49	15.30	1.79	090
63197		A	Incise spinal column & cord	24.08	NA	NA	18.53	17.53	8.64	090
63198		A	Incise spinal column & cord	29.90	NA	NA	15.75	14.84	2.12	090
63199		A	Incise spinal column & cord	31.47	NA	NA	16.44	17.96	2.23	090
63200		A	Release of spinal cord	21.44	NA	NA	16.60	15.70	7.56	090
63250		A	Revise spinal cord vessels	43.86	NA	NA	29.65	27.92	15.71	090
63251		A	Revise spinal cord vessels	44.64	NA	NA	30.54	28.98	16.00	090
63252		A	Revise spinal cord vessels	44.63	NA	NA	30.54	28.93	16.00	090
63265		A	Excise intraspinal lesion	23.82	NA	NA	18.05	17.18	8.07	090
63266		A	Excise intraspinal lesion	24.68	NA	NA	18.41	17.48	8.38	090
63267		A	Excise intraspinal lesion	19.45	NA	NA	15.42	14.70	6.25	090
63268		A	Excise intraspinal lesion	20.02	NA	NA	16.31	15.16	7.17	090
63270		A	Excise intraspinal lesion	29.80	NA	NA	21.78	20.55	10.69	090

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63271		A	Excise intraspinal lesion	29.92	NA	NA	21.58	20.53	10.55	090
63272		A	Excise intraspinal lesion	27.50	NA	NA	20.03	19.10	9.45	090
63273		A	Excise intraspinal lesion	26.47	NA	NA	19.92	18.29	9.48	090
63275		A	Biopsy/excise spinal tumor	25.86	NA	NA	19.12	18.15	8.80	090
63276		A	Biopsy/excise spinal tumor	25.69	NA	NA	19.09	18.13	8.69	090
63277		A	Biopsy/excise spinal tumor	22.39	NA	NA	17.12	16.25	6.98	090
63278		A	Biopsy/excise spinal tumor	22.12	NA	NA	17.49	16.31	7.93	090
63280		A	Biopsy/excise spinal tumor	30.29	NA	NA	22.13	21.23	10.81	090
63281		A	Biopsy/excise spinal tumor	29.99	NA	NA	22.09	21.07	10.65	090
63282		A	Biopsy/excise spinal tumor	28.15	NA	NA	20.96	20.05	9.93	090
63283		A	Biopsy/excise spinal tumor	26.76	NA	NA	20.54	19.35	9.57	090
63285		A	Biopsy/excise spinal tumor	38.05	NA	NA	26.58	25.09	13.63	090
63286		A	Biopsy/excise spinal tumor	37.62	NA	NA	26.26	25.05	13.17	090
63287		A	Biopsy/excise spinal tumor	40.08	NA	NA	27.99	26.46	14.37	090
63290		A	Biopsy/excise spinal tumor	40.82	NA	NA	28.00	26.64	14.63	090
63295		A	Repair of laminectomy defect	5.25	NA	NA	2.94	2.74	1.87	ZZZ
63300		A	Removal of vertebral body	26.80	NA	NA	19.47	18.51	8.66	090
63301		A	Removal of vertebral body	31.57	NA	NA	23.23	21.07	11.31	090
63302		A	Removal of vertebral body	31.15	NA	NA	23.00	20.96	11.15	090
63303		A	Removal of vertebral body	33.55	NA	NA	23.88	21.66	12.00	090
63304		A	Removal of vertebral body	33.85	NA	NA	24.51	23.07	12.11	090
63305		A	Removal of vertebral body	36.24	NA	NA	25.75	23.21	12.98	090
63306		A	Removal of vertebral body	35.55	NA	NA	15.91	19.30	12.74	090
63307		A	Removal of vertebral body	34.96	NA	NA	24.75	23.07	12.53	090
63308		A	Remove vertebral body add-on	5.24	NA	NA	2.91	2.82	1.56	ZZZ
63600		A	Remove spinal cord lesion	15.12	NA	NA	10.46	8.20	1.58	090
63610		A	Stimulation of spinal cord	8.72	2.03	15.94	2.41	2.33	0.68	000
63615		A	Remove lesion of spinal cord	17.32	NA	NA	13.50	12.25	6.19	090

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63620		A	Srs spinal lesion	15.60	NA	NA	12.19	10.34	5.17	090
63621		A	Srs spinal lesion addl	4.00	NA	NA	2.24	2.07	1.32	ZZZ
63650		A	Implant neuroelectrodes	7.20	NA	NA	5.26	4.39	0.64	010
63655		A	Implant neuroelectrodes	11.56	NA	NA	10.74	10.04	3.61	090
63661		A	Remove spine eltrd perq aray	5.08	11.83	11.83	3.94	3.94	0.71	010
63662		A	Remove spine eltrd plate	11.00	NA	NA	8.57	8.57	1.55	090
63663		A	Revise spine eltrd perq aray	7.75	16.34	16.34	5.29	5.29	1.09	010
63664		A	Revise spine eltrd plate	11.52	NA	NA	8.83	8.83	1.60	090
63685		A	Insrt/redo spine n generator	6.05	NA	NA	5.10	4.54	1.10	010
63688		A	Revise/remove neuroreceiver	5.30	NA	NA	4.74	4.25	1.00	010
63700		A	Repair of spinal herniation	17.47	NA	NA	15.02	13.85	6.25	090
63702		A	Repair of spinal herniation	19.41	NA	NA	16.10	15.25	6.95	090
63704		A	Repair of spinal herniation	22.43	NA	NA	18.79	16.95	8.03	090
63706		A	Repair of spinal herniation	25.35	NA	NA	20.42	19.10	9.10	090
63707		A	Repair spinal fluid leakage	12.65	NA	NA	11.06	10.42	3.49	090
63709		A	Repair spinal fluid leakage	15.65	NA	NA	12.73	12.10	4.49	090
63710		A	Graft repair of spine defect	15.40	NA	NA	12.78	12.13	4.85	090
63740		A	Install spinal shunt	12.63	NA	NA	11.01	10.64	4.25	090
63741		A	Install spinal shunt	9.12	NA	NA	7.60	6.69	2.19	090
63744		A	Revision of spinal shunt	8.94	NA	NA	8.09	7.40	3.06	090
63746		A	Removal of spinal shunt	7.33	NA	NA	7.84	7.20	2.62	090
64400		A	N block inj trigeminal	1.11	2.18	2.04	0.78	0.67	0.18	000
64402		A	N block inj facial	1.25	1.99	1.89	0.79	0.71	0.18	000
64405		A	N block inj occipital	1.32	1.95	1.73	0.90	0.76	0.26	000
64408		A	N block inj vagus	1.41	2.21	2.05	1.24	1.11	0.16	000
64410		A	N block inj phrenic	1.43	2.75	2.61	0.76	0.70	0.33	000
64412		A	N block inj spinal accessor	1.18	3.26	3.02	0.92	0.81	0.20	000
64413		A	N block inj cervical plexus	1.40	2.01	1.89	0.83	0.73	0.20	000

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64415		A	N block inj brachial plexus	1.48	1.90	2.02	0.36	0.40	0.11	000
64416		A	N block cont infuse b plex	1.81	NA	NA	0.43	0.44	0.14	000
64417		A	N block inj axillary	1.44	2.25	2.24	0.56	0.50	0.11	000
64418		A	N block inj suprascapular	1.32	2.70	2.60	0.83	0.73	0.12	000
64420		A	N block inj intercost sng	1.18	2.01	2.71	0.77	0.66	0.12	000
64421		A	N block inj intercost mlt	1.68	2.64	3.88	0.97	0.82	0.20	000
64425		A	N block inj ilio-ing/hypogi	1.75	2.08	1.90	0.96	0.82	0.20	000
64430		A	N block inj pudendal	1.46	2.26	2.62	0.79	0.85	0.14	000
64435		A	N block inj paracervical	1.45	2.36	2.47	0.79	0.77	0.24	000
64445		A	N block inj sciatic sng	1.48	2.30	2.30	0.54	0.58	0.16	000
64446		A	N blk inj sciatic cont inf	1.81	NA	NA	0.44	0.48	0.14	000
64447		A	N block inj fem single	1.50	1.89	1.89	0.36	0.33	0.11	000
64448		A	N block inj fem cont inf	1.63	NA	NA	0.39	0.41	0.12	000
64449		A	N block inj lumbar plexus	1.81	NA	NA	0.51	0.53	0.14	000
64450		A	N block other peripheral	1.27	1.73	1.63	0.68	0.64	0.11	000
64455		A	N block inj plantar digit	0.75	0.59	0.61	0.24	0.27	0.08	000
64479		A	Inj foramen epidural c/t	2.29	4.76	5.27	1.54	1.30	0.27	000
64480		A	Inj foramen epidural add-on	1.20	2.36	2.35	0.64	0.59	0.18	ZZZ
64483		A	Inj foramen epidural l/s	1.90	4.55	5.23	1.35	1.16	0.16	000
64484		A	Inj foramen epidural add-on	1.00	1.61	2.06	0.52	0.48	0.08	ZZZ
64490		A	Inj paravert f jnt c/t 1 lev	1.82	3.78	3.78	1.26	1.26	0.20	000
64491		A	Inj paravert f jnt c/t 2 lev	1.16	1.59	1.59	0.58	0.58	0.11	ZZZ
64492		A	Inj paravert f jnt c/t 3 lev	1.16	1.63	1.63	0.61	0.61	0.11	ZZZ
64493		A	Inj paravert f jnt l/s 1 lev	1.52	3.50	3.50	1.10	1.10	0.14	000
64494		A	Inj paravert f jnt l/s 2 lev	1.00	1.51	1.51	0.49	0.49	0.08	ZZZ
64495		A	Inj paravert f jnt l/s 3 lev	1.00	1.54	1.54	0.52	0.52	0.08	ZZZ
64505		A	N block spenopalatine gangl	1.36	1.45	1.43	1.02	0.95	0.10	000
64508		A	N block carotid sinus s/p	1.12	0.50	1.72	0.94	0.85	0.24	000

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64510		A	N block stellate ganglion	1.22	2.49	2.65	0.90	0.74	0.10	000
64517		A	N block inj hypogas plxs	2.20	2.99	2.73	1.35	1.15	0.18	000
64520		A	N block lumbar/thoracic	1.35	4.33	4.18	1.01	0.85	0.11	000
64530		A	N block inj celiac pelus	1.58	4.06	3.99	1.06	0.94	0.14	000
64550		A	Apply neurostimulator	0.18	0.29	0.27	0.08	0.07	0.01	000
64553		A	Implant neuroelectrodes	2.36	3.39	3.33	2.01	1.97	0.38	010
64555		A	Implant neuroelectrodes	2.32	3.02	3.35	1.72	1.80	0.26	010
64560		A	Implant neuroelectrodes	2.41	4.85	4.19	2.50	2.20	0.16	010
64561		A	Implant neuroelectrodes	7.15	14.88	20.88	3.88	4.17	0.77	010
64565		A	Implant neuroelectrodes	1.81	3.31	3.15	1.81	1.61	0.24	010
64566		A	Neuroeltrd stim post tibial	0.60	3.17	3.17	0.23	0.23	0.05	000
64568		A	Inc for vagus n elect impl	9.00	NA	NA	8.67	8.67	1.25	090
64569		A	Revise/repl vagus n eltrd	11.00	NA	NA	4.50	4.50	3.15	090
64570		A	Remove vagus n eltrd	9.10	NA	NA	4.06	4.06	3.26	090
64575		A	Implant neuroelectrodes	4.42	NA	NA	4.21	3.58	0.43	090
64577		A	Implant neuroelectrodes	4.69	NA	NA	2.75	3.54	1.67	090
64580		A	Implant neuroelectrodes	4.19	NA	NA	3.92	3.82	0.88	090
64581		A	Implant neuroelectrodes	12.20	NA	NA	6.04	7.05	1.58	090
64585		A	Revise/remove neuroelectrode	2.11	4.75	6.22	1.89	2.10	0.27	010
64590		A	Insrt/redo pn/gastr stimul	2.45	4.76	5.71	1.96	2.22	0.29	010
64595		A	Revise/rmv pn/gastr stimul	1.78	4.97	6.38	1.70	1.92	0.22	010
64600		A	Injection treatment of nerve	3.49	8.24	8.08	2.81	2.46	0.53	010
64605		A	Injection treatment of nerve	5.65	15.95	13.00	4.84	3.93	0.43	010
64610		A	Injection treatment of nerve	7.20	13.02	12.12	5.26	5.00	2.15	010
64611		A	Chemodenerv saliv glands	1.03	1.64	1.64	1.35	1.35	0.29	010
64612		A	Destroy nerve face muscle	2.01	2.52	2.39	2.19	1.93	0.65	010
64613		A	Destroy nerve neck muscle	2.01	2.29	2.24	1.93	1.69	0.58	010
64614		A	Destroy nerve extrem musc	2.20	2.59	2.54	2.09	1.86	0.42	010

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64620		A	Injection treatment of nerve	2.89	3.06	3.87	2.12	1.82	0.29	010
64622		A	Destr paravertebrl nerve l/s	3.05	6.96	6.57	2.51	2.08	0.26	010
64623		A	Destr paravertebral n add-on	0.99	2.76	2.61	0.51	0.40	0.08	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.92	8.15	7.49	3.66	3.04	0.34	010
64627		A	Destr paravertebral n add-on	1.16	3.96	3.78	0.60	0.47	0.10	ZZZ
64630		A	Injection treatment of nerve	3.05	3.16	3.26	2.16	2.15	0.34	010
64632		A	N block inj common digit	1.23	1.17	1.17	0.72	0.75	0.10	010
64640		A	Injection treatment of nerve	2.81	3.27	3.37	1.94	1.90	0.24	010
64650		A	Chemodenerv eccrine glands	0.70	2.60	1.90	0.42	0.38	0.11	000
64653		A	Chemodenerv eccrine glands	0.88	2.94	2.11	0.48	0.44	0.24	000
64680		A	Injection treatment of nerve	2.67	6.47	6.29	2.03	1.84	0.30	010
64681		A	Injection treatment of nerve	3.78	6.51	6.93	1.70	1.79	0.30	010
64702		A	Revise finger/toe nerve	6.26	NA	NA	7.53	6.80	1.06	090
64704		A	Revise hand/foot nerve	4.69	NA	NA	4.33	4.25	0.54	090
64708		A	Revise arm/leg nerve	6.36	NA	NA	7.09	6.63	1.15	090
64712		A	Revision of sciatic nerve	8.07	NA	NA	7.25	6.71	1.33	090
64713		A	Revision of arm nerve(s)	11.40	NA	NA	9.05	8.55	2.34	090
64714		A	Revise low back nerve(s)	10.55	NA	NA	8.66	7.44	1.71	090
64716		A	Revision of cranial nerve	6.99	NA	NA	7.97	7.49	1.13	090
64718		A	Revise ulnar nerve at elbow	7.26	NA	NA	8.90	8.29	1.48	090
64719		A	Revise ulnar nerve at wrist	4.97	NA	NA	5.98	5.64	0.92	090
64721		A	Carpal tunnel surgery	4.97	6.74	6.40	6.66	6.34	0.98	090
64722		A	Relieve pressure on nerve(s)	4.82	NA	NA	4.82	4.41	0.84	090
64726		A	Release foot/toe nerve	4.27	NA	NA	3.57	3.47	0.39	090
64727		A	Internal nerve revision	3.10	NA	NA	1.89	1.77	0.60	ZZZ
64732		A	Incision of brow nerve	4.89	NA	NA	6.32	5.65	1.77	090
64734		A	Incision of cheek nerve	5.55	NA	NA	7.15	6.18	0.71	090
64736		A	Incision of chin nerve	5.23	NA	NA	5.97	5.58	1.87	090

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64738		A	Incision of jaw nerve	6.36	NA	NA	7.60	6.56	2.27	090
64740		A	Incision of tongue nerve	6.22	NA	NA	7.01	6.49	0.80	090
64742		A	Incision of facial nerve	6.85	NA	NA	7.10	6.29	0.87	090
64744		A	Incise nerve back of head	5.72	NA	NA	6.79	5.77	2.04	090
64746		A	Incise diaphragm nerve	6.56	NA	NA	4.78	4.88	1.53	090
64752		A	Incision of vagus nerve	7.69	NA	NA	6.06	5.68	1.81	090
64755		A	Incision of stomach nerves	15.05	NA	NA	9.12	8.28	3.20	090
64760		A	Incision of vagus nerve	7.59	NA	NA	6.01	5.34	1.60	090
64761		A	Incision of pelvis nerve	7.04	NA	NA	5.43	5.11	1.00	090
64763		A	Incise hip/thigh nerve	7.56	NA	NA	5.90	6.31	1.60	090
64766		A	Incise hip/thigh nerve	9.47	NA	NA	7.08	6.96	0.91	090
64771		A	Sever cranial nerve	8.15	NA	NA	7.55	7.36	1.05	090
64772		A	Incision of spinal nerve	7.84	NA	NA	7.68	7.18	1.81	090
64774		A	Remove skin nerve lesion	5.80	NA	NA	5.64	5.27	1.05	090
64776		A	Remove digit nerve lesion	5.60	NA	NA	5.30	4.96	0.84	090
64778		A	Digit nerve surgery add-on	3.11	NA	NA	2.25	1.93	0.61	ZZZ
64782		A	Remove limb nerve lesion	6.86	NA	NA	5.76	5.45	0.91	090
64783		A	Limb nerve surgery add-on	3.71	NA	NA	2.58	2.28	0.45	ZZZ
64784		A	Remove nerve lesion	10.62	NA	NA	9.49	8.76	2.00	090
64786		A	Remove sciatic nerve lesion	16.25	NA	NA	13.07	12.10	3.20	090
64787		A	Implant nerve end	4.29	NA	NA	2.28	2.26	0.68	ZZZ
64788		A	Remove skin nerve lesion	5.24	NA	NA	5.68	5.26	1.07	090
64790		A	Removal of nerve lesion	12.10	NA	NA	10.32	9.55	2.74	090
64792		A	Removal of nerve lesion	15.86	NA	NA	12.21	11.77	5.68	090
64795		A	Biopsy of nerve	3.01	NA	NA	2.15	2.00	0.81	000
64802		A	Remove sympathetic nerves	10.37	NA	NA	8.86	6.90	0.81	090
64804		A	Remove sympathetic nerves	15.91	NA	NA	6.62	6.83	1.26	090
64809		A	Remove sympathetic nerves	14.71	NA	NA	10.82	9.09	1.17	090

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64818		A	Remove sympathetic nerves	11.34	NA	NA	6.76	6.22	2.06	090
64820		A	Remove sympathetic nerves	10.74	NA	NA	10.51	9.66	1.90	090
64821		A	Remove sympathetic nerves	9.33	NA	NA	9.45	8.99	1.83	090
64822		A	Remove sympathetic nerves	9.33	NA	NA	9.45	8.84	1.83	090
64823		A	Remove sympathetic nerves	10.94	NA	NA	10.42	9.62	2.15	090
64831		A	Repair of digit nerve	9.16	NA	NA	9.80	9.13	1.63	090
64832		A	Repair nerve add-on	5.65	NA	NA	3.72	3.44	1.00	ZZZ
64834		A	Repair of hand or foot nerve	10.81	NA	NA	9.80	9.11	1.85	090
64835		A	Repair of hand or foot nerve	11.73	NA	NA	10.36	9.72	2.30	090
64836		A	Repair of hand or foot nerve	11.73	NA	NA	10.36	9.74	2.30	090
64837		A	Repair nerve add-on	6.25	NA	NA	3.74	3.63	0.76	ZZZ
64840		A	Repair of leg nerve	14.02	NA	NA	11.22	10.60	1.07	090
64856		A	Repair/transpose nerve	15.07	NA	NA	12.79	11.91	2.84	090
64857		A	Repair arm/leg nerve	15.82	NA	NA	13.16	12.31	2.91	090
64858		A	Repair sciatic nerve	17.82	NA	NA	15.92	14.50	3.50	090
64859		A	Nerve surgery	4.25	NA	NA	3.07	2.72	0.83	ZZZ
64861		A	Repair of arm nerves	20.89	NA	NA	12.46	12.94	4.11	090
64862		A	Repair of low back nerves	21.09	NA	NA	16.84	14.53	7.55	090
64864		A	Repair of facial nerve	13.41	NA	NA	11.13	10.36	1.70	090
64865		A	Repair of facial nerve	16.09	NA	NA	16.12	15.50	2.04	090
64866		A	Fusion of facial/other nerve	16.83	NA	NA	14.71	14.80	2.16	090
64868		A	Fusion of facial/other nerve	14.90	NA	NA	14.59	13.85	1.90	090
64870		A	Fusion of facial/other nerve	17.08	NA	NA	12.19	10.98	3.99	090
64872		A	Subsequent repair of nerve	1.99	NA	NA	1.19	1.16	0.26	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	NA	2.07	1.84	0.37	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	NA	1.88	1.74	0.65	ZZZ
64885		A	Nerve graft head or neck	17.60	NA	NA	13.91	13.10	2.24	090
64886		A	Nerve graft head or neck	20.82	NA	NA	15.86	15.17	2.66	090

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64890		A	Nerve graft hand or foot	16.24	NA	NA	13.06	12.45	3.19	090
64891		A	Nerve graft hand or foot	17.35	NA	NA	15.58	13.85	3.42	090
64892		A	Nerve graft arm or leg	15.74	NA	NA	12.76	12.08	3.11	090
64893		A	Nerve graft arm or leg	16.87	NA	NA	14.17	12.90	3.34	090
64895		A	Nerve graft hand or foot	20.39	NA	NA	17.77	15.53	4.01	090
64896		A	Nerve graft hand or foot	21.96	NA	NA	15.97	15.49	7.88	090
64897		A	Nerve graft arm or leg	19.38	NA	NA	15.58	14.41	3.82	090
64898		A	Nerve graft arm or leg	20.97	NA	NA	16.34	15.49	4.13	090
64901		A	Nerve graft add-on	10.20	NA	NA	7.38	6.41	2.00	ZZZ
64902		A	Nerve graft add-on	11.81	NA	NA	8.54	7.35	2.31	ZZZ
64905		A	Nerve pedicle transfer	15.11	NA	NA	13.04	12.09	2.97	090
64907		A	Nerve pedicle transfer	20.03	NA	NA	11.02	12.44	1.41	090
64910		A	Nerve repair w/allograft	11.39	NA	NA	11.50	10.70	1.97	090
64911		A	Neurorraphy w/vein autograft	14.39	NA	NA	14.30	12.79	2.84	090
64999		C	Nervous system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
65091		A	Revise eye	7.26	NA	NA	10.44	9.69	1.44	090
65093		A	Revise eye with implant	7.04	NA	NA	10.43	9.79	1.39	090
65101		A	Removal of eye	8.30	NA	NA	12.26	11.37	1.63	090
65103		A	Remove eye/insert implant	8.84	NA	NA	12.64	11.68	1.74	090
65105		A	Remove eye/attach implant	9.93	NA	NA	13.77	12.68	1.94	090
65110		A	Removal of eye	15.70	NA	NA	18.37	16.77	2.00	090
65112		A	Remove eye/revise socket	18.51	NA	NA	21.25	19.40	2.35	090
65114		A	Remove eye/revise socket	19.65	NA	NA	22.05	20.02	2.51	090
65125		A	Revise ocular implant	3.27	9.18	9.02	4.84	4.46	0.64	090
65130		A	Insert ocular implant	8.42	NA	NA	11.99	11.05	1.64	090
65135		A	Insert ocular implant	8.60	NA	NA	12.12	11.19	1.67	090
65140		A	Attach ocular implant	9.46	NA	NA	13.08	12.08	1.22	090
65150		A	Revise ocular implant	6.43	NA	NA	9.65	9.06	0.45	090

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65155		A	Reinsert ocular implant	10.10	NA	NA	13.53	12.49	1.97	090
65175		A	Removal of ocular implant	7.40	NA	NA	10.94	10.14	0.95	090
65205		A	Remove foreign body from eye	0.71	0.82	0.77	0.51	0.45	0.10	000
65210		A	Remove foreign body from eye	0.84	1.09	1.01	0.67	0.58	0.12	000
65220		A	Remove foreign body from eye	0.71	0.87	0.81	0.46	0.41	0.11	000
65222		A	Remove foreign body from eye	0.93	1.18	1.10	0.71	0.62	0.14	000
65235		A	Remove foreign body from eye	9.01	NA	NA	10.96	9.78	1.24	090
65260		A	Remove foreign body from eye	12.54	NA	NA	14.38	12.90	0.88	090
65265		A	Remove foreign body from eye	14.34	NA	NA	15.98	14.29	3.07	090
65270		A	Repair of eye wound	1.95	5.32	5.23	1.99	1.79	0.27	010
65272		A	Repair of eye wound	4.62	9.27	8.79	5.26	4.68	0.33	090
65273		A	Repair of eye wound	5.16	NA	NA	5.57	4.97	0.37	090
65275		A	Repair of eye wound	6.29	9.82	8.87	6.74	5.87	0.86	090
65280		A	Repair of eye wound	9.10	NA	NA	9.66	8.63	1.79	090
65285		A	Repair of eye wound	14.71	NA	NA	14.50	12.79	2.59	090
65286		A	Repair of eye wound	6.63	12.85	12.24	7.32	6.50	0.90	090
65290		A	Repair of eye socket wound	6.53	NA	NA	7.28	6.52	1.28	090
65400		A	Removal of eye lesion	7.50	11.46	10.54	9.42	8.46	1.03	090
65410		A	Biopsy of cornea	1.47	2.49	2.36	1.47	1.30	0.31	000
65420		A	Removal of eye lesion	4.36	9.87	9.50	6.19	5.66	0.56	090
65426		A	Removal of eye lesion	6.05	12.00	11.41	7.39	6.65	0.83	090
65430		A	Corneal smear	1.47	1.73	1.59	1.44	1.29	0.22	000
65435		A	Curette/treat cornea	0.92	1.31	1.22	1.04	0.94	0.16	000
65436		A	Curette/treat cornea	4.82	6.04	5.46	5.62	5.03	0.84	090
65450		A	Treatment of corneal lesion	3.47	5.59	5.16	5.50	5.06	0.48	090
65600		A	Revision of cornea	4.20	6.80	6.28	5.47	4.88	0.60	090
65710		A	Corneal transplant	14.45	NA	NA	16.70	14.98	1.97	090
65730		A	Corneal transplant	16.35	NA	NA	18.22	16.28	2.23	090

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65750		A	Corneal transplant	16.90	NA	NA	17.89	15.96	2.16	090
65755		A	Corneal transplant	16.79	NA	NA	17.81	15.89	2.28	090
65756		A	Corneal trnspl endothelial	16.84	NA	NA	16.58	14.56	1.20	090
65757		C	Prep corneal endo allograft	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
65760		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65765		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65767		N	Corneal tissue transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65770		A	Revise cornea with implant	19.74	NA	NA	19.87	17.68	7.06	090
65771		N	Radial keratotomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65772		A	Correction of astigmatism	5.09	7.51	6.91	6.32	5.68	0.65	090
65775		A	Correction of astigmatism	6.91	NA	NA	8.58	7.77	0.49	090
65778		A	Cover eye w/membrane	1.19	35.71	35.71	0.84	0.84	0.18	010
65779		A	Cover eye w/membrane stent	3.92	29.05	29.05	4.09	4.09	0.56	010
65780		A	Ocular reconst transplant	10.73	NA	NA	14.18	12.94	1.39	090
65781		A	Ocular reconst transplant	18.14	NA	NA	19.44	17.46	1.28	090
65782		A	Ocular reconst transplant	15.43	NA	NA	16.99	15.29	3.06	090
65800		A	Drainage of eye	1.91	2.25	2.07	1.77	1.57	0.27	000
65805		A	Drainage of eye	1.91	2.64	2.47	1.78	1.58	0.34	000
65810		A	Drainage of eye	5.82	NA	NA	7.46	6.70	0.84	090
65815		A	Drainage of eye	6.00	11.65	11.08	7.40	6.65	1.06	090
65820		A	Relieve inner eye pressure	8.91	NA	NA	12.03	11.04	0.62	090
65850		A	Incision of eye	11.39	NA	NA	12.25	10.99	1.98	090
65855		A	Laser surgery of eye	3.99	5.48	5.07	4.38	3.95	0.62	010
65860		A	Incise inner eye adhesions	3.59	5.06	4.70	3.55	3.18	1.32	090
65865		A	Incise inner eye adhesions	5.77	NA	NA	7.47	6.85	0.39	090
65870		A	Incise inner eye adhesions	7.39	NA	NA	9.19	8.32	1.29	090
65875		A	Incise inner eye adhesions	7.81	NA	NA	9.86	8.93	1.07	090
65880		A	Incise inner eye adhesions	8.36	NA	NA	10.25	9.24	0.60	090

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65900		A	Remove eye lesion	12.51	NA	NA	14.58	13.14	0.88	090
65920		A	Remove implant of eye	9.99	NA	NA	12.14	10.93	1.29	090
65930		A	Remove blood clot from eye	8.39	NA	NA	9.52	8.60	1.48	090
66020		A	Injection treatment of eye	1.64	3.51	3.37	2.05	1.86	0.11	010
66030		A	Injection treatment of eye	1.30	3.27	3.16	1.81	1.65	0.18	010
66130		A	Remove eye lesion	7.83	11.58	10.85	8.20	7.34	1.66	090
66150		A	Glaucoma surgery	10.53	NA	NA	14.03	12.69	0.73	090
66155		A	Glaucoma surgery	10.52	NA	NA	14.02	12.67	0.73	090
66160		A	Glaucoma surgery	12.39	NA	NA	15.34	13.81	0.87	090
66165		A	Glaucoma surgery	10.24	NA	NA	13.83	12.50	0.72	090
66170		A	Glaucoma surgery	15.02	NA	NA	18.68	16.78	1.91	090
66172		A	Incision of eye	18.86	NA	NA	23.66	21.22	2.40	090
66174		A	Translum dil eye canal	12.85	NA	NA	13.84	13.84	2.27	090
66175		A	Trnslum dil eye canal w/stnt	13.60	NA	NA	14.37	14.37	4.86	090
66180		A	Implant eye shunt	16.30	NA	NA	16.55	14.67	2.12	090
66185		A	Revise eye shunt	9.58	NA	NA	11.48	10.28	1.67	090
66220		A	Repair eye lesion	9.21	NA	NA	11.66	10.36	1.26	090
66225		A	Repair/graft eye lesion	12.63	NA	NA	13.59	12.09	2.47	090
66250		A	Follow-up surgery of eye	7.10	13.63	12.96	8.55	7.65	1.40	090
66500		A	Incision of iris	3.83	NA	NA	6.03	5.60	0.27	090
66505		A	Incision of iris	4.22	NA	NA	6.58	6.10	0.30	090
66600		A	Remove iris and lesion	10.12	NA	NA	13.19	11.84	0.76	090
66605		A	Removal of iris	14.22	NA	NA	15.54	13.78	1.02	090
66625		A	Removal of iris	5.30	NA	NA	6.74	6.11	0.72	090
66630		A	Removal of iris	7.28	NA	NA	8.72	7.82	1.22	090
66635		A	Removal of iris	7.37	NA	NA	8.78	7.87	0.52	090
66680		A	Repair iris & ciliary body	6.39	NA	NA	8.10	7.29	1.36	090
66682		A	Repair iris & ciliary body	7.33	NA	NA	10.47	9.45	1.45	090

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66700		A	Destruction ciliary body	5.14	7.44	6.82	5.92	5.30	0.49	090
66710		A	Ciliary transsleral therapy	5.14	7.19	6.59	5.91	5.29	1.02	090
66711		A	Ciliary endoscopic ablation	7.93	NA	NA	10.12	9.09	0.56	090
66720		A	Destruction ciliary body	5.00	8.16	7.49	6.80	6.17	0.68	090
66740		A	Destruction ciliary body	5.14	7.09	6.49	5.92	5.32	0.35	090
66761		A	Revision of iris	3.00	5.25	5.85	3.63	4.46	0.45	010
66762		A	Revision of iris	5.38	7.91	7.25	6.59	5.91	0.68	090
66770		A	Removal of inner eye lesion	6.13	8.63	7.89	7.43	6.67	0.42	090
66820		A	Incision secondary cataract	4.01	NA	NA	6.91	6.54	0.67	090
66821		A	After cataract laser surgery	3.42	5.77	5.33	5.26	4.81	0.53	090
66825		A	Reposition intraocular lens	9.01	NA	NA	12.23	11.23	1.17	090
66830		A	Removal of lens lesion	9.47	NA	NA	10.60	9.46	0.67	090
66840		A	Removal of lens material	9.18	NA	NA	10.41	9.28	1.81	090
66850		A	Removal of lens material	10.55	NA	NA	11.75	10.48	1.45	090
66852		A	Removal of lens material	11.41	NA	NA	12.37	11.03	2.00	090
66920		A	Extraction of lens	10.13	NA	NA	11.10	9.90	0.71	090
66930		A	Extraction of lens	11.61	NA	NA	12.52	11.15	0.81	090
66940		A	Extraction of lens	10.37	NA	NA	11.62	10.38	1.74	090
66982		A	Cataract surgery complex	15.02	NA	NA	14.70	13.07	2.32	090
66983		A	Cataract surg w/iol 1 stage	10.43	NA	NA	10.41	9.28	0.83	090
66984		A	Cataract surg w/iol 1 stage	10.52	NA	NA	10.85	9.72	1.64	090
66985		A	Insert lens prosthesis	9.98	NA	NA	11.68	10.43	1.29	090
66986		A	Exchange lens prosthesis	12.26	NA	NA	13.32	11.99	1.56	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	NA	1.06	0.91	0.10	ZZZ
66999		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67005		A	Partial removal of eye fluid	5.89	NA	NA	7.36	6.63	1.25	090
67010		A	Partial removal of eye fluid	7.06	NA	NA	8.18	7.34	0.98	090
67015		A	Release of eye fluid	7.14	NA	NA	9.11	8.28	0.99	090

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67025		A	Replace eye fluid	8.11	12.14	11.23	9.66	8.64	1.44	090
67027		A	Implant eye drug system	11.62	NA	NA	12.31	10.97	2.02	090
67028		A	Injection eye drug	1.44	1.43	2.15	1.38	1.52	0.20	000
67030		A	Incise inner eye strands	6.11	NA	NA	8.77	7.96	0.42	090
67031		A	Laser surgery eye strands	4.47	6.39	5.86	5.55	4.98	0.58	090
67036		A	Removal of inner eye fluid	13.32	NA	NA	13.71	12.20	1.82	090
67039		A	Laser treatment of retina	16.74	NA	NA	17.98	16.08	2.96	090
67040		A	Laser treatment of retina	19.61	NA	NA	20.40	18.17	2.69	090
67041		A	Vit for macular pucker	19.25	NA	NA	18.16	15.87	2.63	090
67042		A	Vit for macular hole	22.38	NA	NA	20.37	17.73	3.08	090
67043		A	Vit for membrane dissect	23.24	NA	NA	21.69	18.94	4.09	090
67101		A	Repair detached retina	8.80	13.11	12.00	10.16	9.07	1.55	090
67105		A	Repair detached retina	8.53	11.66	10.62	9.59	8.55	1.17	090
67107		A	Repair detached retina	16.71	NA	NA	17.54	15.56	2.95	090
67108		A	Repair detached retina	22.89	NA	NA	22.40	19.77	3.14	090
67110		A	Repair detached retina	10.25	14.05	12.87	11.55	10.29	1.30	090
67112		A	Rerepair detached retina	18.75	NA	NA	18.65	16.47	2.57	090
67113		A	Repair retinal detach cplx	25.35	NA	NA	23.92	20.91	3.48	090
67115		A	Release encircling material	6.11	NA	NA	7.89	7.10	0.77	090
67120		A	Remove eye implant material	7.10	11.23	10.42	8.59	7.70	1.40	090
67121		A	Remove eye implant material	12.25	NA	NA	13.34	11.85	2.16	090
67141		A	Treatment of retina	6.15	8.51	7.74	7.54	6.76	1.09	090
67145		A	Treatment of retina	6.32	8.46	7.67	7.66	6.86	0.86	090
67208		A	Treatment of retinal lesion	7.65	9.18	8.26	8.61	7.68	0.53	090
67210		A	Treatment of retinal lesion	9.45	9.96	8.87	9.34	8.24	1.40	090
67218		A	Treatment of retinal lesion	20.36	NA	NA	18.72	16.48	1.45	090
67220		A	Treatment of choroid lesion	14.39	15.45	13.82	14.10	12.44	2.54	090
67221		R	Ocular photodynamic ther	3.45	4.58	4.35	2.62	2.29	0.48	000

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67225		A	Eye photodynamic ther add-on	0.47	0.38	0.33	0.33	0.28	0.03	ZZZ
67227		A	Treatment of retinal lesion	7.53	9.59	8.69	8.53	7.61	0.53	090
67228		A	Treatment of retinal lesion	13.82	18.53	17.49	16.01	14.24	2.09	090
67229		A	Tr retinal les preterm inf	16.30	NA	NA	15.61	13.98	1.17	090
67250		A	Reinforce eye wall	9.61	NA	NA	12.25	11.22	1.62	090
67255		A	Reinforce/graft eye wall	10.17	NA	NA	13.37	12.25	1.98	090
67299		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67311		A	Revise eye muscle	7.77	NA	NA	9.04	8.11	1.30	090
67312		A	Revise two eye muscles	9.66	NA	NA	10.36	9.23	1.90	090
67314		A	Revise eye muscle	8.79	NA	NA	10.12	9.05	1.48	090
67316		A	Revise two eye muscles	10.93	NA	NA	11.59	10.29	2.15	090
67318		A	Revise eye muscle(s)	9.12	NA	NA	10.71	9.57	0.64	090
67320		A	Revise eye muscle(s) add-on	5.40	NA	NA	3.78	3.18	0.38	ZZZ
67331		A	Eye surgery follow-up add-on	5.13	NA	NA	3.56	2.99	0.86	ZZZ
67332		A	Rerevise eye muscles add-on	5.56	NA	NA	3.90	3.28	0.92	ZZZ
67334		A	Revise eye muscle w/suture	5.05	NA	NA	3.56	2.98	0.35	ZZZ
67335		A	Eye suture during surgery	2.49	NA	NA	1.74	1.50	0.41	ZZZ
67340		A	Revise eye muscle add-on	6.00	NA	NA	4.23	3.55	0.42	ZZZ
67343		A	Release eye tissue	8.47	NA	NA	9.88	8.86	1.66	090
67345		A	Destroy nerve of eye muscle	3.01	3.57	3.22	2.93	2.60	0.80	010
67346		A	Biopsy eye muscle	2.87	NA	NA	2.79	2.48	0.61	000
67399		C	Eye muscle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67400		A	Explore/biopsy eye socket	11.20	NA	NA	14.82	13.64	2.06	090
67405		A	Explore/drain eye socket	9.20	NA	NA	12.95	12.00	1.18	090
67412		A	Explore/treat eye socket	10.30	NA	NA	13.50	12.52	1.86	090
67413		A	Explore/treat eye socket	10.24	NA	NA	13.65	12.65	2.00	090
67414		A	Explr/decompress eye socket	17.94	NA	NA	19.33	17.20	2.28	090
67415		A	Aspiration orbital contents	1.76	NA	NA	1.24	1.05	0.24	000

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67420		A	Explore/treat eye socket	21.87	NA	NA	23.61	21.38	4.30	090
67430		A	Explore/treat eye socket	15.29	NA	NA	19.61	17.99	1.09	090
67440		A	Explore/drain eye socket	14.84	NA	NA	18.92	17.33	1.90	090
67445		A	Explr/decompress eye socket	19.12	NA	NA	20.30	18.22	3.76	090
67450		A	Explore/biopsy eye socket	15.41	NA	NA	19.69	18.04	1.97	090
67500		A	Inject/treat eye socket	1.44	0.89	0.83	0.71	0.62	0.11	000
67505		A	Inject/treat eye socket	1.27	1.25	1.09	1.04	0.86	0.26	000
67515		A	Inject/treat eye socket	1.40	1.34	1.14	1.13	0.93	0.26	000
67550		A	Insert eye socket implant	11.77	NA	NA	15.24	14.01	2.30	090
67560		A	Revise eye socket implant	12.18	NA	NA	15.56	14.21	1.56	090
67570		A	Decompress optic nerve	14.40	NA	NA	17.46	16.18	5.15	090
67599		C	Orbit surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67700		A	Drainage of eyelid abscess	1.40	5.86	5.85	1.85	1.68	0.23	010
67710		A	Incision of eyelid	1.07	4.99	5.03	1.65	1.52	0.22	010
67715		A	Incision of eyelid fold	1.27	5.16	5.16	1.78	1.63	0.26	010
67800		A	Remove eyelid lesion	1.41	2.13	1.98	1.50	1.35	0.24	010
67801		A	Remove eyelid lesions	1.91	2.62	2.41	1.86	1.65	0.37	010
67805		A	Remove eyelid lesions	2.27	3.36	3.11	2.38	2.13	0.43	010
67808		A	Remove eyelid lesion(s)	4.60	NA	NA	5.74	5.17	0.90	090
67810		A	Biopsy of eyelid	1.48	4.53	4.58	1.08	0.98	0.22	000
67820		A	Revise eyelashes	0.71	0.70	0.65	0.79	0.72	0.11	000
67825		A	Revise eyelashes	1.43	2.15	2.00	1.97	1.81	0.27	010
67830		A	Revise eyelashes	1.75	5.53	5.46	2.13	1.93	0.34	010
67835		A	Revise eyelashes	5.70	NA	NA	6.63	5.99	1.13	090
67840		A	Remove eyelid lesion	2.09	5.47	5.39	2.37	2.14	0.34	010
67850		A	Treat eyelid lesion	1.74	4.25	4.24	2.11	2.00	0.24	010
67875		A	Closure of eyelid by suture	1.35	3.36	3.30	1.39	1.24	0.24	000
67880		A	Revision of eyelid	4.60	8.12	7.64	5.74	5.17	0.81	090

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67882		A	Revision of eyelid	6.02	9.67	9.02	7.25	6.52	1.18	090
67900		A	Repair brow defect	6.82	11.01	10.37	7.51	6.79	1.22	090
67901		A	Repair eyelid defect	7.59	13.34	11.74	8.60	7.68	1.49	090
67902		A	Repair eyelid defect	9.82	NA	NA	10.59	9.24	1.93	090
67903		A	Repair eyelid defect	6.51	10.03	9.61	7.12	6.50	1.26	090
67904		A	Repair eyelid defect	7.97	12.41	11.55	8.85	7.83	1.52	090
67906		A	Repair eyelid defect	6.93	NA	NA	7.39	6.63	0.49	090
67908		A	Repair eyelid defect	5.30	8.45	7.88	6.62	6.12	1.05	090
67909		A	Revise eyelid defect	5.57	9.29	8.80	6.72	6.13	1.10	090
67911		A	Revise eyelid defect	7.50	NA	NA	8.32	7.34	1.40	090
67912		A	Correction eyelid w/implant	6.36	18.05	18.00	7.48	6.85	0.92	090
67914		A	Repair eyelid defect	3.75	6.98	6.70	4.35	3.94	0.68	090
67915		A	Repair eyelid defect	3.26	6.28	6.08	3.86	3.53	0.45	090
67916		A	Repair eyelid defect	5.48	9.47	8.97	6.65	6.05	0.95	090
67917		A	Repair eyelid defect	6.19	10.10	9.53	7.16	6.49	1.15	090
67921		A	Repair eyelid defect	3.47	6.77	6.50	4.14	3.75	0.68	090
67922		A	Repair eyelid defect	3.14	6.09	5.91	3.71	3.40	0.42	090
67923		A	Repair eyelid defect	6.05	9.74	9.16	7.05	6.38	1.13	090
67924		A	Repair eyelid defect	5.93	10.32	9.80	6.69	6.03	1.13	090
67930		A	Repair eyelid wound	3.65	6.47	6.18	3.16	2.80	0.71	010
67935		A	Repair eyelid wound	6.36	10.18	9.59	6.14	5.50	1.25	090
67938		A	Remove eyelid foreign body	1.38	5.25	5.23	1.87	1.71	0.22	010
67950		A	Revision of eyelid	5.99	9.94	9.43	7.04	6.42	1.10	090
67961		A	Revision of eyelid	5.86	10.12	9.60	6.93	6.31	1.10	090
67966		A	Revision of eyelid	8.97	12.50	11.49	9.56	8.43	1.70	090
67971		A	Reconstruction of eyelid	10.01	NA	NA	10.40	9.33	1.96	090
67973		A	Reconstruction of eyelid	13.13	NA	NA	13.16	11.80	2.58	090
67974		A	Reconstruction of eyelid	13.10	NA	NA	13.13	11.75	2.58	090

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67975		A	Reconstruction of eyelid	9.35	NA	NA	9.96	8.95	1.83	090
67999		C	Revision of eyelid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68020		A	Incise/drain eyelid lining	1.42	1.92	1.77	1.69	1.53	0.20	010
68040		A	Treatment of eyelid lesions	0.85	0.97	0.89	0.65	0.57	0.16	000
68100		A	Biopsy of eyelid lining	1.35	3.30	3.25	1.41	1.27	0.20	000
68110		A	Remove eyelid lining lesion	1.82	4.38	4.25	2.35	2.14	0.35	010
68115		A	Remove eyelid lining lesion	2.41	6.13	5.99	2.76	2.49	0.31	010
68130		A	Remove eyelid lining lesion	5.10	9.81	9.37	6.47	5.88	0.35	090
68135		A	Remove eyelid lining lesion	1.89	2.49	2.28	2.34	2.13	0.26	010
68200		A	Treat eyelid by injection	0.49	0.69	0.64	0.49	0.44	0.08	000
68320		A	Revise/graft eyelid lining	6.64	13.42	12.75	8.50	7.65	1.29	090
68325		A	Revise/graft eyelid lining	8.63	NA	NA	9.91	8.88	1.68	090
68326		A	Revise/graft eyelid lining	8.42	NA	NA	9.75	8.72	1.64	090
68328		A	Revise/graft eyelid lining	9.45	NA	NA	10.57	9.48	1.86	090
68330		A	Revise eyelid lining	5.78	10.95	10.40	7.17	6.45	1.14	090
68335		A	Revise/graft eyelid lining	8.46	NA	NA	9.74	8.72	1.66	090
68340		A	Separate eyelid adhesions	4.97	10.07	9.62	6.23	5.60	0.99	090
68360		A	Revise eyelid lining	5.17	9.49	9.01	6.34	5.72	1.02	090
68362		A	Revise eyelid lining	8.61	NA	NA	9.86	8.81	1.68	090
68371		A	Harvest eye tissue alograft	5.09	NA	NA	6.50	5.93	0.35	010
68399		C	Eyelid lining surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68400		A	Incise/drain tear gland	1.74	5.97	5.90	1.96	1.83	0.34	010
68420		A	Incise/drain tear sac	2.35	6.43	6.30	2.39	2.21	0.30	010
68440		A	Incise tear duct opening	0.99	1.85	1.83	1.77	1.64	0.20	010
68500		A	Removal of tear gland	12.77	NA	NA	14.66	13.13	2.99	090
68505		A	Partial removal tear gland	12.69	NA	NA	14.60	13.23	2.47	090
68510		A	Biopsy of tear gland	4.60	7.76	7.46	3.70	3.19	0.90	000
68520		A	Removal of tear sac	8.78	NA	NA	10.49	9.52	1.14	090

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68525		A	Biopsy of tear sac	4.42	NA	NA	3.11	2.66	0.86	000
68530		A	Clearance of tear duct	3.70	8.05	7.90	3.56	3.21	0.72	010
68540		A	Remove tear gland lesion	12.18	NA	NA	13.95	12.53	1.56	090
68550		A	Remove tear gland lesion	15.16	NA	NA	16.89	15.09	1.93	090
68700		A	Repair tear ducts	7.87	NA	NA	9.12	8.17	1.53	090
68705		A	Revise tear duct opening	2.11	4.40	4.26	2.56	2.31	0.41	010
68720		A	Create tear sac drain	9.96	NA	NA	11.32	10.20	1.66	090
68745		A	Create tear duct drain	9.90	NA	NA	11.47	10.34	1.94	090
68750		A	Create tear duct drain	10.10	NA	NA	12.02	10.85	1.97	090
68760		A	Close tear duct opening	1.78	3.75	3.63	2.31	2.10	0.34	010
68761		A	Close tear duct opening	1.41	2.68	2.55	1.92	1.76	0.22	010
68770		A	Close tear system fistula	8.29	NA	NA	9.41	7.96	1.62	090
68801		A	Dilate tear duct opening	1.00	2.45	2.35	2.00	1.88	0.16	010
68810		A	Probe nasolacrimal duct	2.15	4.54	4.30	3.09	2.90	0.39	010
68811		A	Probe nasolacrimal duct	2.45	NA	NA	3.34	3.06	0.48	010
68815		A	Probe nasolacrimal duct	3.30	9.01	8.76	3.93	3.57	0.58	010
68816		A	Probe nl duct w/balloon	3.06	17.09	16.34	4.00	3.60	0.60	010
68840		A	Explore/irrigate tear ducts	1.30	2.26	2.08	1.96	1.76	0.24	010
68850		A	Injection for tear sac x-ray	0.80	0.84	0.90	0.70	0.75	0.07	000
68899		C	Tear duct system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69000		A	Drain external ear lesion	1.50	3.80	3.67	1.89	1.78	0.22	010
69005		A	Drain external ear lesion	2.16	4.00	3.84	2.35	2.22	0.29	010
69020		A	Drain outer ear canal lesion	1.53	5.25	5.12	2.61	2.51	0.20	010
69090		N	Pierce earlobes	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69100		A	Biopsy of external ear	0.81	2.03	2.12	0.60	0.55	0.11	000
69105		A	Biopsy of external ear canal	0.85	3.26	3.20	1.00	0.95	0.10	000
69110		A	Remove external ear partial	3.53	9.61	9.45	5.80	5.66	0.53	090
69120		A	Removal of external ear	4.14	NA	NA	7.53	7.21	0.60	090

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69140		A	Remove ear canal lesion(s)	8.14	NA	NA	17.35	16.82	1.05	090
69145		A	Remove ear canal lesion(s)	2.70	8.89	8.54	4.57	4.35	0.35	090
69150		A	Extensive ear canal surgery	13.61	NA	NA	16.24	15.60	1.94	090
69155		A	Extensive ear/neck surgery	23.35	NA	NA	24.99	23.64	3.00	090
69200		A	Clear outer ear canal	0.77	2.80	2.75	0.88	0.81	0.10	000
69205		A	Clear outer ear canal	1.21	NA	NA	1.72	1.64	0.16	010
69210		A	Remove impacted ear wax	0.61	0.85	0.79	0.32	0.28	0.07	000
69220		A	Clean out mastoid cavity	0.83	3.21	3.14	0.97	0.92	0.10	000
69222		A	Clean out mastoid cavity	1.45	4.99	4.89	2.54	2.47	0.18	010
69300		R	Revise external ear	6.69	13.43	12.23	7.10	6.60	0.86	YYY
69310		A	Rebuild outer ear canal	10.97	NA	NA	20.58	19.93	1.44	090
69320		A	Rebuild outer ear canal	17.18	NA	NA	27.24	26.32	2.20	090
69399		C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69400		A	Inflate middle ear canal	0.83	3.49	3.36	0.97	0.91	0.10	000
69401		A	Inflate middle ear canal	0.63	1.90	1.80	0.80	0.76	0.07	000
69405		A	Catheterize middle ear canal	2.68	4.93	4.69	2.90	2.74	0.34	010
69420		A	Incision of eardrum	1.38	4.22	4.11	2.13	2.03	0.18	010
69421		A	Incision of eardrum	1.78	NA	NA	2.57	2.48	0.23	010
69424		A	Remove ventilating tube	0.85	2.90	2.85	0.95	0.90	0.10	000
69433		A	Create eardrum opening	1.57	4.26	4.12	2.21	2.10	0.22	010
69436		A	Create eardrum opening	2.01	NA	NA	2.66	2.57	0.26	010
69440		A	Exploration of middle ear	7.71	NA	NA	12.39	11.76	0.99	090
69450		A	Eardrum revision	5.69	NA	NA	10.21	9.72	0.72	090
69501		A	Mastoidectomy	9.21	NA	NA	12.08	11.41	1.18	090
69502		A	Mastoidectomy	12.56	NA	NA	15.60	14.73	1.68	090
69505		A	Remove mastoid structures	13.17	NA	NA	21.83	21.00	1.70	090
69511		A	Extensive mastoid surgery	13.70	NA	NA	22.15	21.34	1.77	090
69530		A	Extensive mastoid surgery	20.38	NA	NA	27.62	26.40	2.61	090

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69535		A	Remove part of temporal bone	37.42	NA	NA	39.58	37.37	5.21	090
69540		A	Remove ear lesion	1.25	4.88	4.78	2.47	2.39	0.16	010
69550		A	Remove ear lesion	11.15	NA	NA	19.14	18.44	1.44	090
69552		A	Remove ear lesion	19.81	NA	NA	25.75	24.56	2.54	090
69554		A	Remove ear lesion	35.97	NA	NA	37.14	34.18	4.60	090
69601		A	Mastoid surgery revision	13.45	NA	NA	16.99	16.04	1.71	090
69602		A	Mastoid surgery revision	13.76	NA	NA	17.91	16.94	1.77	090
69603		A	Mastoid surgery revision	14.20	NA	NA	22.44	21.70	1.82	090
69604		A	Mastoid surgery revision	14.20	NA	NA	18.17	17.31	1.82	090
69605		A	Mastoid surgery revision	18.69	NA	NA	26.62	25.52	2.39	090
69610		A	Repair of eardrum	4.47	6.71	6.49	3.96	3.72	0.58	010
69620		A	Repair of eardrum	6.03	14.14	13.78	8.13	7.76	0.76	090
69631		A	Repair eardrum structures	10.05	NA	NA	15.72	14.94	1.29	090
69632		A	Rebuild eardrum structures	12.96	NA	NA	18.44	17.50	1.66	090
69633		A	Rebuild eardrum structures	12.31	NA	NA	18.00	17.10	1.59	090
69635		A	Repair eardrum structures	13.51	NA	NA	22.05	21.15	1.74	090
69636		A	Rebuild eardrum structures	15.43	NA	NA	24.70	23.75	1.97	090
69637		A	Rebuild eardrum structures	15.32	NA	NA	24.67	23.71	2.00	090
69641		A	Revise middle ear & mastoid	12.89	NA	NA	17.36	16.47	1.67	090
69642		A	Revise middle ear & mastoid	17.06	NA	NA	21.83	20.68	2.19	090
69643		A	Revise middle ear & mastoid	15.59	NA	NA	19.97	18.90	2.00	090
69644		A	Revise middle ear & mastoid	17.23	NA	NA	25.68	24.70	2.21	090
69645		A	Revise middle ear & mastoid	16.71	NA	NA	25.46	24.46	2.17	090
69646		A	Revise middle ear & mastoid	18.37	NA	NA	26.38	25.26	2.35	090
69650		A	Release middle ear bone	9.80	NA	NA	13.61	12.75	1.25	090
69660		A	Revise middle ear bone	12.03	NA	NA	14.92	14.11	1.55	090
69661		A	Revise middle ear bone	15.92	NA	NA	19.19	18.17	2.00	090
69662		A	Revise middle ear bone	15.60	NA	NA	17.96	16.97	2.00	090

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69666		A	Repair middle ear structures	9.89	NA	NA	13.65	12.89	1.28	090
69667		A	Repair middle ear structures	9.90	NA	NA	13.63	12.92	1.28	090
69670		A	Remove mastoid air cells	11.73	NA	NA	15.74	14.87	1.51	090
69676		A	Remove middle ear nerve	9.69	NA	NA	14.54	13.86	1.24	090
69700		A	Close mastoid fistula	8.37	NA	NA	11.59	11.11	1.07	090
69710		N	Implant/replace hearing aid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69711		A	Remove/repair hearing aid	10.62	NA	NA	14.49	13.81	1.36	090
69714		A	Implant temple bone w/stimul	14.45	NA	NA	16.78	15.84	1.86	090
69715		A	Temple bne implnt w/stimulat	18.96	NA	NA	19.63	18.44	2.42	090
69717		A	Temple bone implant revision	15.43	NA	NA	17.40	16.58	1.97	090
69718		A	Revise temple bone implant	19.21	NA	NA	19.78	18.59	2.44	090
69720		A	Release facial nerve	14.71	NA	NA	19.47	18.44	1.89	090
69725		A	Release facial nerve	27.64	NA	NA	26.95	25.14	3.54	090
69740		A	Repair facial nerve	16.27	NA	NA	17.65	16.61	2.08	090
69745		A	Repair facial nerve	17.02	NA	NA	19.08	18.06	2.17	090
69799		C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69801		A	Incise inner ear	2.06	3.63	3.63	1.58	6.61	0.27	000
69802		A	Incise inner ear	13.50	NA	NA	16.79	15.85	1.71	090
69805		A	Explore inner ear	14.71	NA	NA	15.93	14.91	1.89	090
69806		A	Explore inner ear	12.63	NA	NA	14.81	13.98	1.63	090
69820		A	Establish inner ear window	10.52	NA	NA	14.43	13.78	1.36	090
69840		A	Revise inner ear window	10.44	NA	NA	12.74	13.68	0.73	090
69905		A	Remove inner ear	11.26	NA	NA	15.46	14.71	1.45	090
69910		A	Remove inner ear & mastoid	13.91	NA	NA	15.65	14.78	1.79	090
69915		A	Incise inner ear nerve	22.77	NA	NA	21.88	20.36	2.96	090
69930		A	Implant cochlear device	17.73	NA	NA	17.74	16.81	2.27	090
69949		C	Inner ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69950		A	Incise inner ear nerve	27.63	NA	NA	28.86	25.12	3.54	090

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69955		A	Release facial nerve	29.42	NA	NA	28.02	26.17	3.78	090
69960		A	Release inner ear canal	29.42	NA	NA	26.42	24.54	3.78	090
69970		A	Remove inner ear lesion	32.41	NA	NA	29.77	27.80	4.16	090
69979		C	Temporal bone surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69990		R	Microsurgery add-on	3.46	NA	NA	1.94	1.87	1.15	ZZZ
70010		A	Contrast x-ray of brain	1.19	0.80	2.39	0.80	2.39	0.16	XXX
70015		A	Contrast x-ray of brain	1.19	3.02	3.10	NA	NA	0.08	XXX
70015	TC	A	Contrast x-ray of brain	0.00	2.57	2.60	NA	NA	0.01	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.45	0.50	0.45	0.50	0.07	XXX
70030		A	X-ray eye for foreign body	0.17	0.63	0.67	NA	NA	0.02	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.57	0.60	NA	NA	0.01	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.06	0.07	0.06	0.07	0.01	XXX
70100		A	X-ray exam of jaw	0.18	0.80	0.78	NA	NA	0.02	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.72	0.70	NA	NA	0.01	XXX
70100	26	A	X-ray exam of jaw	0.18	0.08	0.08	0.08	0.08	0.01	XXX
70110		A	X-ray exam of jaw	0.25	0.86	0.90	NA	NA	0.02	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.76	0.80	NA	NA	0.01	XXX
70110	26	A	X-ray exam of jaw	0.25	0.10	0.10	0.10	0.10	0.01	XXX
70120		A	X-ray exam of mastoids	0.18	0.85	0.85	NA	NA	0.02	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.77	0.77	NA	NA	0.01	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.08	0.08	0.08	0.08	0.01	XXX
70130		A	X-ray exam of mastoids	0.34	1.28	1.31	NA	NA	0.02	XXX
70130	TC	A	X-ray exam of mastoids	0.00	1.14	1.17	NA	NA	0.01	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.14	0.14	0.14	0.14	0.01	XXX
70134		A	X-ray exam of middle ear	0.34	0.95	1.02	NA	NA	0.02	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.82	0.88	NA	NA	0.01	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.13	0.14	0.13	0.14	0.01	XXX
70140		A	X-ray exam of facial bones	0.19	0.66	0.69	NA	NA	0.02	XXX

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70140	TC	A	X-ray exam of facial bones	0.00	0.56	0.60	NA	NA	0.01	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.10	0.09	0.10	0.09	0.01	XXX
70150		A	X-ray exam of facial bones	0.26	0.94	0.99	NA	NA	0.02	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.83	0.88	NA	NA	0.01	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.11	0.11	0.11	0.11	0.01	XXX
70160		A	X-ray exam of nasal bones	0.17	0.77	0.79	NA	NA	0.02	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.70	0.72	NA	NA	0.01	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.07	0.07	0.07	0.07	0.01	XXX
70170		C	X-ray exam of tear duct	0.00	0.00	0.00	NA	NA	0.00	XXX
70170	TC	C	X-ray exam of tear duct	0.00	0.00	0.00	NA	NA	0.00	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.11	0.12	0.11	0.12	0.03	XXX
70190		A	X-ray exam of eye sockets	0.21	0.80	0.84	NA	NA	0.02	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.71	0.75	NA	NA	0.01	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.09	0.09	0.09	0.09	0.01	XXX
70200		A	X-ray exam of eye sockets	0.28	0.94	1.01	NA	NA	0.02	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.83	0.89	NA	NA	0.01	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.11	0.12	0.11	0.12	0.01	XXX
7020F		I	Mammo assess cat in dbase	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70210		A	X-ray exam of sinuses	0.17	0.71	0.73	NA	NA	0.02	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.63	0.65	NA	NA	0.01	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.08	0.08	0.08	0.08	0.01	XXX
70220		A	X-ray exam of sinuses	0.25	0.85	0.89	NA	NA	0.02	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.74	0.79	NA	NA	0.01	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.11	0.10	0.11	0.10	0.01	XXX
70240		A	X-ray exam pituitary saddle	0.19	0.64	0.68	NA	NA	0.02	XXX
70240	TC	A	X-ray exam pituitary saddle	0.00	0.56	0.60	NA	NA	0.01	XXX
70240	26	A	X-ray exam pituitary saddle	0.19	0.08	0.08	0.08	0.08	0.01	XXX
70250		A	X-ray exam of skull	0.24	0.81	0.84	NA	NA	0.02	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70250	TC	A	X-ray exam of skull	0.00	0.70	0.73	NA	NA	0.01	XXX
70250	26	A	X-ray exam of skull	0.24	0.11	0.11	0.11	0.11	0.01	XXX
70260		A	X-ray exam of skull	0.34	0.99	1.05	NA	NA	0.02	XXX
70260	TC	A	X-ray exam of skull	0.00	0.84	0.91	NA	NA	0.01	XXX
70260	26	A	X-ray exam of skull	0.34	0.15	0.14	0.15	0.14	0.01	XXX
70300		A	X-ray exam of teeth	0.10	0.31	0.32	NA	NA	0.02	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.24	0.26	NA	NA	0.01	XXX
70300	26	A	X-ray exam of teeth	0.10	0.07	0.06	0.07	0.06	0.01	XXX
70310		A	X-ray exam of teeth	0.16	0.97	0.93	NA	NA	0.02	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.86	0.84	NA	NA	0.01	XXX
70310	26	A	X-ray exam of teeth	0.16	0.11	0.09	0.11	0.09	0.01	XXX
70320		A	Full mouth x-ray of teeth	0.22	1.26	1.25	NA	NA	0.02	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	1.13	1.14	NA	NA	0.01	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.13	0.11	0.13	0.11	0.01	XXX
70328		A	X-ray exam of jaw joint	0.18	0.70	0.72	NA	NA	0.02	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.62	0.64	NA	NA	0.01	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.08	0.08	0.08	0.08	0.01	XXX
70330		A	X-ray exam of jaw joints	0.24	1.14	1.17	NA	NA	0.02	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	1.02	1.06	NA	NA	0.01	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.12	0.11	0.12	0.11	0.01	XXX
70332		A	X-ray exam of jaw joint	0.54	1.88	1.95	NA	NA	0.04	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	1.57	1.68	NA	NA	0.01	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.31	0.27	0.31	0.27	0.03	XXX
70336		A	Magnetic image jaw joint	1.48	8.94	11.80	NA	NA	0.09	XXX
70336	TC	A	Magnetic image jaw joint	0.00	8.40	11.20	NA	NA	0.01	XXX
70336	26	A	Magnetic image jaw joint	1.48	0.54	0.60	0.54	0.60	0.08	XXX
70350		A	X-ray head for orthodontia	0.17	0.44	0.44	NA	NA	0.02	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.32	0.34	NA	NA	0.01	XXX

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70350	26	A	X-ray head for orthodontia	0.17	0.12	0.10	0.12	0.10	0.01	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.39	0.42	NA	NA	0.02	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.27	0.32	NA	NA	0.01	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.12	0.10	0.12	0.10	0.01	XXX
70360		A	X-ray exam of neck	0.17	0.60	0.63	NA	NA	0.02	XXX
70360	TC	A	X-ray exam of neck	0.00	0.53	0.56	NA	NA	0.01	XXX
70360	26	A	X-ray exam of neck	0.17	0.07	0.07	0.07	0.07	0.01	XXX
70370		A	Throat x-ray & fluoroscopy	0.32	2.14	2.08	NA	NA	0.02	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	2.00	1.94	NA	NA	0.01	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.14	0.14	0.14	0.14	0.01	XXX
70371		A	Speech evaluation complex	0.84	1.77	1.92	NA	NA	0.04	XXX
70371	TC	A	Speech evaluation complex	0.00	1.41	1.58	NA	NA	0.01	XXX
70371	26	A	Speech evaluation complex	0.84	0.36	0.34	0.36	0.34	0.03	XXX
70373		A	Contrast x-ray of larynx	0.44	1.92	1.97	NA	NA	0.02	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.74	1.80	NA	NA	0.01	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.18	0.17	0.18	0.17	0.01	XXX
70380		A	X-ray exam of salivary gland	0.17	1.00	0.98	NA	NA	0.02	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.89	0.89	NA	NA	0.01	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.11	0.09	0.11	0.09	0.01	XXX
70390		A	X-ray exam of salivary duct	0.38	2.48	2.60	NA	NA	0.04	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	2.33	2.44	NA	NA	0.01	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.15	0.16	0.15	0.16	0.03	XXX
70450		A	Ct head/brain w/o dye	0.85	3.85	4.92	NA	NA	0.05	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	3.53	4.57	NA	NA	0.01	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.32	0.35	0.32	0.35	0.04	XXX
70460		A	Ct head/brain w/dye	1.13	5.06	6.41	NA	NA	0.06	XXX
70460	TC	A	Ct head/brain w/dye	0.00	4.63	5.94	NA	NA	0.01	XXX
70460	26	A	Ct head/brain w/dye	1.13	0.43	0.47	0.43	0.47	0.05	XXX

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70470		A	Ct head/brain w/o & w/dye	1.27	6.18	7.84	NA	NA	0.08	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	5.70	7.31	NA	NA	0.01	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.48	0.53	0.48	0.53	0.07	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	6.66	7.98	NA	NA	0.08	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	6.17	7.44	NA	NA	0.01	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.49	0.54	0.49	0.54	0.07	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	7.78	9.36	NA	NA	0.09	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	7.26	8.79	NA	NA	0.01	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.52	0.57	0.52	0.57	0.08	XXX
70482		A	Ct orbit/ear/fossa w/o&w/dye	1.45	8.72	10.70	NA	NA	0.09	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	8.18	10.10	NA	NA	0.01	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.54	0.60	0.54	0.60	0.08	XXX
70486		A	Ct maxillofacial w/o dye	1.14	5.40	6.57	NA	NA	0.06	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	4.95	6.09	NA	NA	0.01	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.45	0.48	0.45	0.48	0.05	XXX
70487		A	Ct maxillofacial w/dye	1.30	6.52	7.99	NA	NA	0.08	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	6.03	7.45	NA	NA	0.01	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.49	0.54	0.49	0.54	0.07	XXX
70488		A	Ct maxillofacial w/o & w/dye	1.42	8.04	9.89	NA	NA	0.09	XXX
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	7.50	9.30	NA	NA	0.01	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.54	0.59	0.54	0.59	0.08	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	5.05	6.27	NA	NA	0.08	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	4.57	5.73	NA	NA	0.01	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.48	0.54	0.48	0.54	0.07	XXX
70491		A	Ct soft tissue neck w/dye	1.38	6.27	7.73	NA	NA	0.08	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	5.74	7.15	NA	NA	0.01	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.53	0.58	0.53	0.58	0.07	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	7.69	9.56	NA	NA	0.09	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	7.15	8.96	NA	NA	0.01	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.54	0.60	0.54	0.60	0.08	XXX
70496		A	Ct angiography head	1.75	12.58	15.76	NA	NA	0.11	XXX
70496	TC	A	Ct angiography head	0.00	11.93	15.03	NA	NA	0.01	XXX
70496	26	A	Ct angiography head	1.75	0.65	0.73	0.65	0.73	0.10	XXX
70498		A	Ct angiography neck	1.75	13.08	16.06	NA	NA	0.11	XXX
70498	TC	A	Ct angiography neck	0.00	12.43	15.32	NA	NA	0.01	XXX
70498	26	A	Ct angiography neck	1.75	0.65	0.74	0.65	0.74	0.10	XXX
70540		A	Mri orbit/face/neck w/o dye	1.35	10.35	13.38	NA	NA	0.09	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	9.85	12.83	NA	NA	0.01	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.50	0.55	0.50	0.55	0.08	XXX
70542		A	Mri orbit/face/neck w/dye	1.62	11.64	14.85	NA	NA	0.11	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	11.03	14.18	NA	NA	0.01	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.61	0.67	0.61	0.67	0.10	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	13.96	19.37	NA	NA	0.13	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	13.16	18.49	NA	NA	0.01	XXX
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.80	0.88	0.80	0.88	0.12	XXX
70544		A	Mr angiography head w/o dye	1.20	11.97	14.93	NA	NA	0.08	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	11.52	14.44	NA	NA	0.01	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.45	0.49	0.45	0.49	0.07	XXX
70545		A	Mr angiography head w/dye	1.20	11.86	14.83	NA	NA	0.08	XXX
70545	TC	A	Mr angiography head w/dye	0.00	11.41	14.34	NA	NA	0.01	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.45	0.49	0.45	0.49	0.07	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	18.13	23.45	NA	NA	0.12	XXX
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	17.45	22.71	NA	NA	0.01	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.68	0.74	0.68	0.74	0.11	XXX
70547		A	Mr angiography neck w/o dye	1.20	11.96	14.91	NA	NA	0.08	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	11.51	14.41	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70547	26	A	Mr angiography neck w/o dye	1.20	0.45	0.50	0.45	0.50	0.07	XXX
70548		A	Mr angiography neck w/dye	1.20	12.77	15.71	NA	NA	0.08	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	12.32	15.21	NA	NA	0.01	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.45	0.50	0.45	0.50	0.07	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	18.14	23.47	NA	NA	0.11	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	17.47	22.73	NA	NA	0.01	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.67	0.74	0.67	0.74	0.10	XXX
70551		A	Mri brain w/o dye	1.48	10.84	13.76	NA	NA	0.09	XXX
70551	TC	A	Mri brain w/o dye	0.00	10.28	13.15	NA	NA	0.01	XXX
70551	26	A	Mri brain w/o dye	1.48	0.56	0.61	0.56	0.61	0.08	XXX
70552		A	Mri brain w/dye	1.78	11.97	15.21	NA	NA	0.12	XXX
70552	TC	A	Mri brain w/dye	0.00	11.30	14.47	NA	NA	0.01	XXX
70552	26	A	Mri brain w/dye	1.78	0.67	0.74	0.67	0.74	0.11	XXX
70553		A	Mri brain w/o & w/dye	2.36	13.74	19.00	NA	NA	0.15	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	12.86	18.02	NA	NA	0.01	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.88	0.98	0.88	0.98	0.14	XXX
70554		A	Fmri brain by tech	2.11	12.07	14.68	NA	NA	0.13	XXX
70554	TC	A	Fmri brain by tech	0.00	11.25	13.78	NA	NA	0.01	XXX
70554	26	A	Fmri brain by tech	2.11	0.82	0.90	0.82	0.90	0.12	XXX
70555		C	Fmri brain by phys/psych	0.00	0.00	0.00	NA	NA	0.00	XXX
70555	TC	C	Fmri brain by phys/psych	0.00	0.00	0.00	NA	NA	0.00	XXX
70555	26	A	Fmri brain by phys/psych	2.54	0.93	1.06	0.93	1.06	0.24	XXX
70557		C	Mri brain w/o dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70557	TC	C	Mri brain w/o dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70557	26	A	Mri brain w/o dye	2.90	1.62	1.51	1.62	1.51	1.05	XXX
70558		C	Mri brain w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70558	TC	C	Mri brain w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70558	26	A	Mri brain w/dye	3.20	1.21	1.33	1.21	1.33	0.30	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70559		C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70559	TC	C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70559	26	A	Mri brain w/o & w/dye	3.20	1.25	1.39	1.25	1.39	0.30	XXX
71010		A	Chest x-ray	0.18	0.46	0.50	NA	NA	0.02	XXX
71010	TC	A	Chest x-ray	0.00	0.39	0.43	NA	NA	0.01	XXX
71010	26	A	Chest x-ray	0.18	0.07	0.07	0.07	0.07	0.01	XXX
71015		A	Chest x-ray	0.21	0.62	0.67	NA	NA	0.02	XXX
71015	TC	A	Chest x-ray	0.00	0.54	0.58	NA	NA	0.01	XXX
71015	26	A	Chest x-ray	0.21	0.08	0.09	0.08	0.09	0.01	XXX
71020		A	Chest x-ray	0.22	0.62	0.68	NA	NA	0.02	XXX
71020	TC	A	Chest x-ray	0.00	0.53	0.59	NA	NA	0.01	XXX
71020	26	A	Chest x-ray	0.22	0.09	0.09	0.09	0.09	0.01	XXX
71021		A	Chest x-ray	0.27	0.79	0.85	NA	NA	0.02	XXX
71021	TC	A	Chest x-ray	0.00	0.67	0.73	NA	NA	0.01	XXX
71021	26	A	Chest x-ray	0.27	0.12	0.12	0.12	0.12	0.01	XXX
71022		A	Chest x-ray	0.31	1.00	1.05	NA	NA	0.02	XXX
71022	TC	A	Chest x-ray	0.00	0.87	0.92	NA	NA	0.01	XXX
71022	26	A	Chest x-ray	0.31	0.13	0.13	0.13	0.13	0.01	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	1.60	1.66	NA	NA	0.02	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	1.45	1.49	NA	NA	0.01	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.15	0.17	0.15	0.17	0.01	XXX
71030		A	Chest x-ray	0.31	0.96	1.04	NA	NA	0.02	XXX
71030	TC	A	Chest x-ray	0.00	0.84	0.91	NA	NA	0.01	XXX
71030	26	A	Chest x-ray	0.31	0.12	0.13	0.12	0.13	0.01	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	1.91	2.15	NA	NA	0.02	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.73	1.93	NA	NA	0.01	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.18	0.22	0.18	0.22	0.01	XXX
71035		A	Chest x-ray	0.18	0.81	0.86	NA	NA	0.02	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
71035	TC	A	Chest x-ray	0.00	0.74	0.78	NA	NA	0.01	XXX
71035	26	A	Chest x-ray	0.18	0.07	0.08	0.07	0.08	0.01	XXX
71040		A	Contrast x-ray of bronchi	0.58	2.15	2.27	NA	NA	0.02	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.94	2.03	NA	NA	0.01	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.21	0.24	0.21	0.24	0.01	XXX
71060		A	Contrast x-ray of bronchi	0.74	3.23	3.41	NA	NA	0.05	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.95	3.11	NA	NA	0.01	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.28	0.30	0.28	0.30	0.04	XXX
71090		C	X-ray & pacemaker insertion	0.00	0.00	0.00	NA	NA	0.00	XXX
71090	TC	C	X-ray & pacemaker insertion	0.00	0.00	0.00	NA	NA	0.00	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.21	0.26	0.21	0.26	0.04	XXX
71100		A	X-ray exam of ribs	0.22	0.69	0.73	NA	NA	0.02	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.60	0.64	NA	NA	0.01	XXX
71100	26	A	X-ray exam of ribs	0.22	0.09	0.09	0.09	0.09	0.01	XXX
71101		A	X-ray exam of ribs/chest	0.27	0.84	0.89	NA	NA	0.02	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.73	0.78	NA	NA	0.01	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.11	0.11	0.11	0.11	0.01	XXX
71110		A	X-ray exam of ribs	0.27	0.88	0.92	NA	NA	0.02	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.76	0.81	NA	NA	0.01	XXX
71110	26	A	X-ray exam of ribs	0.27	0.12	0.11	0.12	0.11	0.01	XXX
71111		A	X-ray exam of ribs/chest	0.32	1.19	1.23	NA	NA	0.02	XXX
71111	TC	A	X-ray exam of ribs/chest	0.00	1.05	1.09	NA	NA	0.01	XXX
71111	26	A	X-ray exam of ribs/chest	0.32	0.14	0.14	0.14	0.14	0.01	XXX
71120		A	X-ray exam of breastbone	0.20	0.67	0.73	NA	NA	0.02	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.59	0.65	NA	NA	0.01	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.08	0.08	0.08	0.08	0.01	XXX
71130		A	X-ray exam of breastbone	0.22	0.82	0.87	NA	NA	0.02	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.73	0.78	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
71130	26	A	X-ray exam of breastbone	0.22	0.09	0.09	0.09	0.09	0.01	XXX
71250		A	Ct thorax w/o dye	1.00	4.97	6.38	NA	NA	0.07	XXX
71250	TC	A	Ct thorax w/o dye	0.00	4.59	5.93	NA	NA	0.01	XXX
71250	26	A	Ct thorax w/o dye	1.00	0.38	0.45	0.38	0.45	0.06	XXX
71260		A	Ct thorax w/dye	1.24	6.24	7.90	NA	NA	0.08	XXX
71260	TC	A	Ct thorax w/dye	0.00	5.77	7.38	NA	NA	0.01	XXX
71260	26	A	Ct thorax w/dye	1.24	0.47	0.52	0.47	0.52	0.07	XXX
71270		A	Ct thorax w/o & w/dye	1.38	7.73	9.86	NA	NA	0.08	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	7.21	9.29	NA	NA	0.01	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.52	0.57	0.52	0.57	0.07	XXX
71275		A	Ct angiography chest	1.92	9.46	12.05	NA	NA	0.12	XXX
71275	TC	A	Ct angiography chest	0.00	8.74	11.25	NA	NA	0.01	XXX
71275	26	A	Ct angiography chest	1.92	0.72	0.80	0.72	0.80	0.11	XXX
71550		A	Mri chest w/o dye	1.46	12.02	15.21	NA	NA	0.09	XXX
71550	TC	A	Mri chest w/o dye	0.00	11.48	14.61	NA	NA	0.01	XXX
71550	26	A	Mri chest w/o dye	1.46	0.54	0.60	0.54	0.60	0.08	XXX
71551		A	Mri chest w/dye	1.73	13.59	17.05	NA	NA	0.11	XXX
71551	TC	A	Mri chest w/dye	0.00	12.94	16.34	NA	NA	0.01	XXX
71551	26	A	Mri chest w/dye	1.73	0.65	0.71	0.65	0.71	0.10	XXX
71552		A	Mri chest w/o & w/dye	2.26	16.70	22.48	NA	NA	0.13	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	15.86	21.54	NA	NA	0.01	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.84	0.94	0.84	0.94	0.12	XXX
71555		R	Mri angio chest w or w/o dye	1.81	11.59	14.53	NA	NA	0.11	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	10.91	13.77	NA	NA	0.01	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.68	0.76	0.68	0.76	0.10	XXX
72010		A	X-ray exam of spine	0.45	1.76	1.72	NA	NA	0.04	XXX
72010	TC	A	X-ray exam of spine	0.00	1.55	1.53	NA	NA	0.01	XXX
72010	26	A	X-ray exam of spine	0.45	0.21	0.19	0.21	0.19	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72020		A	X-ray exam of spine	0.15	0.50	0.54	NA	NA	0.02	XXX
72020	TC	A	X-ray exam of spine	0.00	0.44	0.47	NA	NA	0.01	XXX
72020	26	A	X-ray exam of spine	0.15	0.06	0.07	0.06	0.07	0.01	XXX
72040		A	X-ray exam of neck spine	0.22	0.89	0.90	NA	NA	0.04	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.79	0.80	NA	NA	0.01	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.10	0.10	0.10	0.10	0.03	XXX
72050		A	X-ray exam of neck spine	0.31	1.16	1.23	NA	NA	0.04	XXX
72050	TC	A	X-ray exam of neck spine	0.00	1.04	1.10	NA	NA	0.01	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.12	0.13	0.12	0.13	0.03	XXX
72052		A	X-ray exam of neck spine	0.36	1.55	1.61	NA	NA	0.04	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.40	1.45	NA	NA	0.01	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.15	0.16	0.15	0.16	0.03	XXX
72069		A	X-ray exam of trunk spine	0.22	0.85	0.86	NA	NA	0.04	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.75	0.76	NA	NA	0.01	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.10	0.10	0.10	0.10	0.03	XXX
72070		A	X-ray exam of thoracic spine	0.22	0.73	0.77	NA	NA	0.02	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.63	0.67	NA	NA	0.01	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.10	0.10	0.10	0.10	0.01	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.81	0.88	NA	NA	0.02	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.73	0.79	NA	NA	0.01	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.08	0.09	0.08	0.09	0.01	XXX
72074		A	X-ray exam of thoracic spine	0.22	1.01	1.09	NA	NA	0.02	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.92	1.00	NA	NA	0.01	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.09	0.09	0.09	0.09	0.01	XXX
72080		A	X-ray exam of trunk spine	0.22	0.81	0.83	NA	NA	0.04	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.71	0.73	NA	NA	0.01	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.10	0.10	0.10	0.10	0.03	XXX
72090		A	X-ray exam of trunk spine	0.28	1.15	1.15	NA	NA	0.05	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72090	TC	A	X-ray exam of trunk spine	0.00	1.02	1.02	NA	NA	0.01	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.13	0.13	0.13	0.13	0.04	XXX
72100		A	X-ray exam of lower spine	0.22	0.94	0.96	NA	NA	0.04	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.84	0.86	NA	NA	0.01	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.10	0.10	0.10	0.10	0.03	XXX
72110		A	X-ray exam of lower spine	0.31	1.26	1.30	NA	NA	0.04	XXX
72110	TC	A	X-ray exam of lower spine	0.00	1.13	1.17	NA	NA	0.01	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.13	0.13	0.13	0.13	0.03	XXX
72114		A	X-ray exam of lower spine	0.36	1.78	1.81	NA	NA	0.05	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.62	1.65	NA	NA	0.01	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.16	0.16	0.16	0.16	0.04	XXX
72120		A	X-ray exam of lower spine	0.22	1.29	1.28	NA	NA	0.04	XXX
72120	TC	A	X-ray exam of lower spine	0.00	1.18	1.18	NA	NA	0.01	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.11	0.10	0.11	0.10	0.03	XXX
72125		A	Ct neck spine w/o dye	1.00	5.01	6.42	NA	NA	0.07	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	4.64	5.97	NA	NA	0.01	XXX
72125	26	A	Ct neck spine w/o dye	1.00	0.37	0.45	0.37	0.45	0.06	XXX
72126		A	Ct neck spine w/dye	1.22	6.26	7.90	NA	NA	0.08	XXX
72126	TC	A	Ct neck spine w/dye	0.00	5.80	7.40	NA	NA	0.01	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.46	0.50	0.46	0.50	0.07	XXX
72127		A	Ct neck spine w/o & w/dye	1.27	7.70	9.80	NA	NA	0.08	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	7.23	9.28	NA	NA	0.01	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.47	0.52	0.47	0.52	0.07	XXX
72128		A	Ct chest spine w/o dye	1.00	5.01	6.40	NA	NA	0.07	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	4.63	5.95	NA	NA	0.01	XXX
72128	26	A	Ct chest spine w/o dye	1.00	0.38	0.45	0.38	0.45	0.06	XXX
72129		A	Ct chest spine w/dye	1.22	6.28	7.92	NA	NA	0.08	XXX
72129	TC	A	Ct chest spine w/dye	0.00	5.82	7.41	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72129	26	A	Ct chest spine w/dye	1.22	0.46	0.51	0.46	0.51	0.07	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	7.69	9.82	NA	NA	0.08	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	7.22	9.29	NA	NA	0.01	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.47	0.53	0.47	0.53	0.07	XXX
72131		A	Ct lumbar spine w/o dye	1.00	4.99	6.38	NA	NA	0.07	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	4.61	5.93	NA	NA	0.01	XXX
72131	26	A	Ct lumbar spine w/o dye	1.00	0.38	0.45	0.38	0.45	0.06	XXX
72132		A	Ct lumbar spine w/dye	1.22	6.25	7.90	NA	NA	0.08	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	5.79	7.39	NA	NA	0.01	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.46	0.51	0.46	0.51	0.07	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.27	7.69	9.81	NA	NA	0.08	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	7.21	9.28	NA	NA	0.01	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.48	0.53	0.48	0.53	0.07	XXX
72141		A	Mri neck spine w/o dye	1.60	9.36	12.13	NA	NA	0.11	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	8.75	11.47	NA	NA	0.01	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.61	0.66	0.61	0.66	0.10	XXX
72142		A	Mri neck spine w/dye	1.92	12.07	15.28	NA	NA	0.12	XXX
72142	TC	A	Mri neck spine w/dye	0.00	11.33	14.48	NA	NA	0.01	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.74	0.80	0.74	0.80	0.11	XXX
72146		A	Mri chest spine w/o dye	1.60	9.38	12.33	NA	NA	0.11	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	8.77	11.67	NA	NA	0.01	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.61	0.66	0.61	0.66	0.10	XXX
72147		A	Mri chest spine w/dye	1.92	10.52	13.58	NA	NA	0.12	XXX
72147	TC	A	Mri chest spine w/dye	0.00	9.79	12.78	NA	NA	0.01	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.73	0.80	0.73	0.80	0.11	XXX
72148		A	Mri lumbar spine w/o dye	1.48	9.31	12.26	NA	NA	0.11	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	8.74	11.65	NA	NA	0.01	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.57	0.61	0.57	0.61	0.10	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72149		A	Mri lumbar spine w/dye	1.78	11.85	15.14	NA	NA	0.12	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	11.17	14.39	NA	NA	0.01	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.68	0.75	0.68	0.75	0.11	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	13.54	18.76	NA	NA	0.17	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	12.57	17.70	NA	NA	0.01	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.97	1.06	0.97	1.06	0.16	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	12.42	17.49	NA	NA	0.17	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	11.46	16.43	NA	NA	0.01	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.96	1.06	0.96	1.06	0.16	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	13.41	18.64	NA	NA	0.17	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	12.52	17.67	NA	NA	0.01	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.89	0.97	0.89	0.97	0.16	XXX
72159		R	Mr angio spine w/o&w/dye	1.80	13.68	16.30	NA	NA	0.08	XXX
72159	TC	R	Mr angio spine w/o&w/dye	0.00	12.89	15.52	NA	NA	0.01	XXX
72159	26	R	Mr angio spine w/o&w/dye	1.80	0.79	0.78	0.79	0.78	0.07	XXX
72170		A	X-ray exam of pelvis	0.17	0.57	0.60	NA	NA	0.04	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.49	0.52	NA	NA	0.01	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.08	0.08	0.08	0.08	0.03	XXX
72190		A	X-ray exam of pelvis	0.21	0.99	1.00	NA	NA	0.04	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.89	0.90	NA	NA	0.01	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.10	0.10	0.10	0.10	0.03	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.81	8.98	11.56	NA	NA	0.13	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	8.31	10.81	NA	NA	0.01	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.67	0.75	0.67	0.75	0.12	XXX
72192		A	Ct pelvis w/o dye	1.09	4.71	6.06	NA	NA	0.06	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	4.30	5.60	NA	NA	0.01	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.41	0.46	0.41	0.46	0.05	XXX
72193		A	Ct pelvis w/dye	1.16	5.89	7.49	NA	NA	0.08	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72193	TC	A	Ct pelvis w/dye	0.00	5.46	7.01	NA	NA	0.01	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.43	0.48	0.43	0.48	0.07	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	7.83	9.88	NA	NA	0.08	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	7.37	9.38	NA	NA	0.01	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.46	0.50	0.46	0.50	0.07	XXX
72195		A	Mri pelvis w/o dye	1.46	10.73	13.68	NA	NA	0.11	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	10.17	13.08	NA	NA	0.01	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.56	0.60	0.56	0.60	0.10	XXX
72196		A	Mri pelvis w/dye	1.73	11.81	15.05	NA	NA	0.11	XXX
72196	TC	A	Mri pelvis w/dye	0.00	11.15	14.33	NA	NA	0.01	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.66	0.72	0.66	0.72	0.10	XXX
72197		A	Mri pelvis w/o & w/dye	2.26	14.23	19.61	NA	NA	0.13	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	13.39	18.68	NA	NA	0.01	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.84	0.93	0.84	0.93	0.12	XXX
72198		A	Mr angio pelvis w/o & w/dye	1.80	11.58	14.47	NA	NA	0.11	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	10.91	13.73	NA	NA	0.01	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.67	0.74	0.67	0.74	0.10	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.66	0.69	NA	NA	0.02	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.59	0.62	NA	NA	0.01	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.07	0.07	0.07	0.07	0.01	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.77	0.83	NA	NA	0.02	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.70	0.75	NA	NA	0.01	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.07	0.08	0.07	0.08	0.01	XXX
72220		A	X-ray exam of tailbone	0.17	0.64	0.68	NA	NA	0.02	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.57	0.61	NA	NA	0.01	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.07	0.07	0.07	0.07	0.01	XXX
72240		A	Contrast x-ray of neck spine	0.91	2.74	3.33	NA	NA	0.06	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	2.39	2.95	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72240	26	A	Contrast x-ray of neck spine	0.91	0.35	0.38	0.35	0.38	0.05	XXX
72255		A	Contrast x-ray thorax spine	0.91	2.66	3.07	NA	NA	0.05	XXX
72255	TC	A	Contrast x-ray thorax spine	0.00	2.29	2.70	NA	NA	0.01	XXX
72255	26	A	Contrast x-ray thorax spine	0.91	0.37	0.37	0.37	0.37	0.04	XXX
72265		A	Contrast x-ray lower spine	0.83	2.76	3.21	NA	NA	0.05	XXX
72265	TC	A	Contrast x-ray lower spine	0.00	2.43	2.86	NA	NA	0.01	XXX
72265	26	A	Contrast x-ray lower spine	0.83	0.33	0.35	0.33	0.35	0.04	XXX
72270		A	Contrast x-ray spine	1.33	4.26	4.97	NA	NA	0.08	XXX
72270	TC	A	Contrast x-ray spine	0.00	3.75	4.41	NA	NA	0.01	XXX
72270	26	A	Contrast x-ray spine	1.33	0.51	0.56	0.51	0.56	0.07	XXX
72275		A	Epidurography	0.76	2.68	2.50	NA	NA	0.05	XXX
72275	TC	A	Epidurography	0.00	2.30	2.18	NA	NA	0.01	XXX
72275	26	A	Epidurography	0.76	0.38	0.32	0.38	0.32	0.04	XXX
72285		A	X-ray c/t spine disk	1.16	2.28	3.15	NA	NA	0.06	XXX
72285	TC	A	X-ray c/t spine disk	0.00	1.67	2.64	NA	NA	0.01	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.61	0.51	0.61	0.51	0.05	XXX
72291		C	Perq verte/sacroplsty fluor	0.00	0.00	0.00	NA	NA	0.00	XXX
72291	TC	C	Perq verte/sacroplsty fluor	0.00	0.00	0.00	NA	NA	0.00	XXX
72291	26	A	Perq verte/sacroplsty fluor	1.31	0.60	0.61	0.60	0.61	0.22	XXX
72292		C	Perq verte/sacroplsty ct	0.00	0.00	0.00	NA	NA	0.00	XXX
72292	TC	C	Perq verte/sacroplsty ct	0.00	0.00	0.00	NA	NA	0.00	XXX
72292	26	A	Perq verte/sacroplsty ct	1.38	0.58	0.62	0.58	0.62	0.20	XXX
72295		A	X-ray of lower spine disk	0.83	2.12	2.97	NA	NA	0.05	XXX
72295	TC	A	X-ray of lower spine disk	0.00	1.70	2.60	NA	NA	0.01	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.42	0.37	0.42	0.37	0.04	XXX
73000		A	X-ray exam of collar bone	0.16	0.66	0.67	NA	NA	0.02	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.58	0.60	NA	NA	0.01	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.08	0.07	0.08	0.07	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73010		A	X-ray exam of shoulder blade	0.17	0.72	0.71	NA	NA	0.04	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.63	0.63	NA	NA	0.01	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.09	0.08	0.09	0.08	0.03	XXX
73020		A	X-ray exam of shoulder	0.15	0.52	0.55	NA	NA	0.02	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.45	0.48	NA	NA	0.01	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.07	0.07	0.07	0.07	0.01	XXX
73030		A	X-ray exam of shoulder	0.18	0.68	0.70	NA	NA	0.04	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.59	0.61	NA	NA	0.01	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.09	0.09	0.09	0.09	0.03	XXX
73040		A	Contrast x-ray of shoulder	0.54	2.48	2.62	NA	NA	0.05	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	2.25	2.38	NA	NA	0.01	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.23	0.24	0.23	0.24	0.04	XXX
73050		A	X-ray exam of shoulders	0.20	0.91	0.91	NA	NA	0.04	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.81	0.81	NA	NA	0.01	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.10	0.10	0.10	0.10	0.03	XXX
73060		A	X-ray exam of humerus	0.17	0.65	0.69	NA	NA	0.02	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.57	0.61	NA	NA	0.01	XXX
73060	26	A	X-ray exam of humerus	0.17	0.08	0.08	0.08	0.08	0.01	XXX
73070		A	X-ray exam of elbow	0.15	0.65	0.67	NA	NA	0.02	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.58	0.60	NA	NA	0.01	XXX
73070	26	A	X-ray exam of elbow	0.15	0.07	0.07	0.07	0.07	0.01	XXX
73080		A	X-ray exam of elbow	0.17	0.77	0.82	NA	NA	0.02	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.70	0.75	NA	NA	0.01	XXX
73080	26	A	X-ray exam of elbow	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73085		A	Contrast x-ray of elbow	0.54	2.22	2.32	NA	NA	0.04	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	1.97	2.08	NA	NA	0.01	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.25	0.24	0.25	0.24	0.03	XXX
73090		A	X-ray exam of forearm	0.16	0.62	0.65	NA	NA	0.02	XXX

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73090	TC	A	X-ray exam of forearm	0.00	0.55	0.58	NA	NA	0.01	XXX
73090	26	A	X-ray exam of forearm	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73092		A	X-ray exam of arm infant	0.16	0.76	0.73	NA	NA	0.02	XXX
73092	TC	A	X-ray exam of arm infant	0.00	0.69	0.66	NA	NA	0.01	XXX
73092	26	A	X-ray exam of arm infant	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73100		A	X-ray exam of wrist	0.16	0.73	0.73	NA	NA	0.04	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.65	0.65	NA	NA	0.01	XXX
73100	26	A	X-ray exam of wrist	0.16	0.08	0.08	0.08	0.08	0.03	XXX
73110		A	X-ray exam of wrist	0.17	0.90	0.89	NA	NA	0.02	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.82	0.81	NA	NA	0.01	XXX
73110	26	A	X-ray exam of wrist	0.17	0.08	0.08	0.08	0.08	0.01	XXX
73115		A	Contrast x-ray of wrist	0.54	2.67	2.65	NA	NA	0.05	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	2.42	2.40	NA	NA	0.01	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.25	0.25	0.25	0.25	0.04	XXX
73120		A	X-ray exam of hand	0.16	0.62	0.65	NA	NA	0.02	XXX
73120	TC	A	X-ray exam of hand	0.00	0.55	0.58	NA	NA	0.01	XXX
73120	26	A	X-ray exam of hand	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73130		A	X-ray exam of hand	0.17	0.75	0.76	NA	NA	0.02	XXX
73130	TC	A	X-ray exam of hand	0.00	0.67	0.69	NA	NA	0.01	XXX
73130	26	A	X-ray exam of hand	0.17	0.08	0.07	0.08	0.07	0.01	XXX
73140		A	X-ray exam of finger(s)	0.13	0.81	0.79	NA	NA	0.02	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.75	0.73	NA	NA	0.01	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.06	0.06	0.06	0.06	0.01	XXX
73200		A	Ct upper extremity w/o dye	1.00	4.95	6.19	NA	NA	0.07	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	4.57	5.76	NA	NA	0.01	XXX
73200	26	A	Ct upper extremity w/o dye	1.00	0.38	0.43	0.38	0.43	0.06	XXX
73201		A	Ct upper extremity w/dye	1.16	6.18	7.64	NA	NA	0.08	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	5.74	7.16	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73201	26	A	Ct upper extremity w/dye	1.16	0.44	0.48	0.44	0.48	0.07	XXX
73202		A	Ct uppr extremity w/o&w/dye	1.22	8.13	10.06	NA	NA	0.08	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	7.67	9.56	NA	NA	0.01	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.22	0.46	0.50	0.46	0.50	0.07	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	8.51	10.99	NA	NA	0.09	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	7.84	10.22	NA	NA	0.01	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.67	0.77	0.67	0.77	0.08	XXX
73218		A	Mri upper extremity w/o dye	1.35	10.97	13.91	NA	NA	0.08	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	10.44	13.35	NA	NA	0.01	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.53	0.56	0.53	0.56	0.07	XXX
73219		A	Mri upper extremity w/dye	1.62	11.48	14.88	NA	NA	0.11	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	10.86	14.21	NA	NA	0.01	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.62	0.67	0.62	0.67	0.10	XXX
73220		A	Mri uppr extremity w/o&w/dye	2.15	14.27	19.66	NA	NA	0.13	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	13.46	18.77	NA	NA	0.01	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.15	0.81	0.89	0.81	0.89	0.12	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	10.17	13.00	NA	NA	0.11	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	9.63	12.43	NA	NA	0.01	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.54	0.57	0.54	0.57	0.10	XXX
73222		A	Mri joint upr extrem w/dye	1.62	10.81	14.03	NA	NA	0.11	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	10.19	13.36	NA	NA	0.01	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.62	0.67	0.62	0.67	0.10	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	13.30	18.55	NA	NA	0.13	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	12.48	17.66	NA	NA	0.01	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.82	0.89	0.82	0.89	0.12	XXX
73225		R	Mr angio upr extr w/o&w/dye	1.73	13.65	16.08	NA	NA	0.08	XXX
73225	TC	R	Mr angio upr extr w/o&w/dye	0.00	12.89	15.33	NA	NA	0.01	XXX
73225	26	R	Mr angio upr extr w/o&w/dye	1.73	0.76	0.75	0.76	0.75	0.07	XXX

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73500		A	X-ray exam of hip	0.17	0.58	0.59	NA	NA	0.04	XXX
73500	TC	A	X-ray exam of hip	0.00	0.50	0.51	NA	NA	0.01	XXX
73500	26	A	X-ray exam of hip	0.17	0.08	0.08	0.08	0.08	0.03	XXX
73510		A	X-ray exam of hip	0.21	0.89	0.90	NA	NA	0.04	XXX
73510	TC	A	X-ray exam of hip	0.00	0.79	0.80	NA	NA	0.01	XXX
73510	26	A	X-ray exam of hip	0.21	0.10	0.10	0.10	0.10	0.03	XXX
73520		A	X-ray exam of hips	0.26	0.90	0.92	NA	NA	0.04	XXX
73520	TC	A	X-ray exam of hips	0.00	0.78	0.81	NA	NA	0.01	XXX
73520	26	A	X-ray exam of hips	0.26	0.12	0.11	0.12	0.11	0.03	XXX
73525		A	Contrast x-ray of hip	0.54	2.38	2.40	NA	NA	0.05	XXX
73525	TC	A	Contrast x-ray of hip	0.00	2.11	2.14	NA	NA	0.01	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.27	0.26	0.27	0.26	0.04	XXX
73530		C	X-ray exam of hip	0.00	0.00	0.00	NA	NA	0.00	XXX
73530	TC	C	X-ray exam of hip	0.00	0.00	0.00	NA	NA	0.00	XXX
73530	26	A	X-ray exam of hip	0.29	0.11	0.12	0.11	0.12	0.03	XXX
73540		A	X-ray exam of pelvis & hips	0.20	1.04	0.98	NA	NA	0.04	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.94	0.89	NA	NA	0.01	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.10	0.09	0.10	0.09	0.03	XXX
73542		A	X-ray exam sacroiliac joint	0.59	1.85	1.82	NA	NA	0.04	XXX
73542	TC	A	X-ray exam sacroiliac joint	0.00	1.56	1.57	NA	NA	0.01	XXX
73542	26	A	X-ray exam sacroiliac joint	0.59	0.29	0.25	0.29	0.25	0.03	XXX
73550		A	X-ray exam of thigh	0.17	0.62	0.66	NA	NA	0.04	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.54	0.58	NA	NA	0.01	XXX
73550	26	A	X-ray exam of thigh	0.17	0.08	0.08	0.08	0.08	0.03	XXX
73560		A	X-ray exam of knee 1 or 2	0.17	0.69	0.70	NA	NA	0.04	XXX
73560	TC	A	X-ray exam of knee 1 or 2	0.00	0.61	0.62	NA	NA	0.01	XXX
73560	26	A	X-ray exam of knee 1 or 2	0.17	0.08	0.08	0.08	0.08	0.03	XXX
73562		A	X-ray exam of knee 3	0.18	0.87	0.87	NA	NA	0.04	XXX

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73562	TC	A	X-ray exam of knee 3	0.00	0.78	0.78	NA	NA	0.01	XXX
73562	26	A	X-ray exam of knee 3	0.18	0.09	0.09	0.09	0.09	0.03	XXX
73564		A	X-ray exam knee 4 or more	0.22	1.00	1.00	NA	NA	0.04	XXX
73564	TC	A	X-ray exam knee 4 or more	0.00	0.90	0.90	NA	NA	0.01	XXX
73564	26	A	X-ray exam knee 4 or more	0.22	0.10	0.10	0.10	0.10	0.03	XXX
73565		A	X-ray exam of knees	0.17	0.83	0.80	NA	NA	0.04	XXX
73565	TC	A	X-ray exam of knees	0.00	0.74	0.71	NA	NA	0.01	XXX
73565	26	A	X-ray exam of knees	0.17	0.09	0.09	0.09	0.09	0.03	XXX
73580		A	Contrast x-ray of knee joint	0.54	3.44	3.31	NA	NA	0.06	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	3.14	3.04	NA	NA	0.01	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.30	0.27	0.30	0.27	0.05	XXX
73590		A	X-ray exam of lower leg	0.17	0.60	0.63	NA	NA	0.02	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.53	0.56	NA	NA	0.01	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73592		A	X-ray exam of leg infant	0.16	0.79	0.75	NA	NA	0.02	XXX
73592	TC	A	X-ray exam of leg infant	0.00	0.71	0.68	NA	NA	0.01	XXX
73592	26	A	X-ray exam of leg infant	0.16	0.08	0.07	0.08	0.07	0.01	XXX
73600		A	X-ray exam of ankle	0.16	0.66	0.66	NA	NA	0.02	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.59	0.59	NA	NA	0.01	XXX
73600	26	A	X-ray exam of ankle	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73610		A	X-ray exam of ankle	0.17	0.78	0.78	NA	NA	0.02	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.70	0.71	NA	NA	0.01	XXX
73610	26	A	X-ray exam of ankle	0.17	0.08	0.07	0.08	0.07	0.01	XXX
73615		A	Contrast x-ray of ankle	0.54	2.52	2.50	NA	NA	0.05	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	2.25	2.25	NA	NA	0.01	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.27	0.25	0.27	0.25	0.04	XXX
73620		A	X-ray exam of foot	0.16	0.64	0.64	NA	NA	0.02	XXX
73620	TC	A	X-ray exam of foot	0.00	0.58	0.58	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73620	26	A	X-ray exam of foot	0.16	0.06	0.06	0.06	0.06	0.01	XXX
73630		A	X-ray exam of foot	0.17	0.73	0.75	NA	NA	0.02	XXX
73630	TC	A	X-ray exam of foot	0.00	0.66	0.68	NA	NA	0.01	XXX
73630	26	A	X-ray exam of foot	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73650		A	X-ray exam of heel	0.16	0.65	0.66	NA	NA	0.02	XXX
73650	TC	A	X-ray exam of heel	0.00	0.58	0.59	NA	NA	0.01	XXX
73650	26	A	X-ray exam of heel	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73660		A	X-ray exam of toe(s)	0.13	0.74	0.72	NA	NA	0.02	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.68	0.67	NA	NA	0.01	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.06	0.05	0.06	0.05	0.01	XXX
73700		A	Ct lower extremity w/o dye	1.00	4.96	6.21	NA	NA	0.07	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	4.59	5.78	NA	NA	0.01	XXX
73700	26	A	Ct lower extremity w/o dye	1.00	0.37	0.43	0.37	0.43	0.06	XXX
73701		A	Ct lower extremity w/dye	1.16	6.25	7.73	NA	NA	0.08	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	5.82	7.24	NA	NA	0.01	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.43	0.49	0.43	0.49	0.07	XXX
73702		A	Ct lwr extremity w/o&w/dye	1.22	8.19	10.12	NA	NA	0.08	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	7.73	9.61	NA	NA	0.01	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.46	0.51	0.46	0.51	0.07	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	9.57	12.15	NA	NA	0.12	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	8.86	11.34	NA	NA	0.01	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.71	0.81	0.71	0.81	0.11	XXX
73718		A	Mri lower extremity w/o dye	1.35	10.68	13.60	NA	NA	0.09	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	10.17	13.04	NA	NA	0.01	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.51	0.56	0.51	0.56	0.08	XXX
73719		A	Mri lower extremity w/dye	1.62	11.61	14.83	NA	NA	0.11	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	11.00	14.17	NA	NA	0.01	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.61	0.66	0.61	0.66	0.10	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73720		A	Mri lwr extremity w/o&w/dye	2.15	14.32	19.69	NA	NA	0.13	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	13.52	18.80	NA	NA	0.01	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.80	0.89	0.80	0.89	0.12	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	10.42	13.29	NA	NA	0.11	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	9.89	12.72	NA	NA	0.01	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.53	0.57	0.53	0.57	0.10	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	11.14	14.28	NA	NA	0.12	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	10.51	13.60	NA	NA	0.01	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.63	0.68	0.63	0.68	0.11	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	13.29	18.52	NA	NA	0.13	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	12.48	17.63	NA	NA	0.01	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.81	0.89	0.81	0.89	0.12	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	11.61	14.49	NA	NA	0.11	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	10.94	13.74	NA	NA	0.01	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.67	0.75	0.67	0.75	0.10	XXX
74000		A	X-ray exam of abdomen	0.18	0.49	0.54	NA	NA	0.02	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.42	0.47	NA	NA	0.01	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.07	0.07	0.07	0.07	0.01	XXX
74010		A	X-ray exam of abdomen	0.23	0.85	0.89	NA	NA	0.02	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.76	0.79	NA	NA	0.01	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.09	0.10	0.09	0.10	0.01	XXX
74020		A	X-ray exam of abdomen	0.27	0.85	0.90	NA	NA	0.02	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.75	0.79	NA	NA	0.01	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.10	0.11	0.10	0.11	0.01	XXX
74022		A	X-ray exam series abdomen	0.32	1.03	1.09	NA	NA	0.02	XXX
74022	TC	A	X-ray exam series abdomen	0.00	0.91	0.96	NA	NA	0.01	XXX
74022	26	A	X-ray exam series abdomen	0.32	0.12	0.13	0.12	0.13	0.01	XXX
74150		A	Ct abdomen w/o dye	1.19	4.73	6.05	NA	NA	0.08	XXX

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74150	TC	A	Ct abdomen w/o dye	0.00	4.29	5.56	NA	NA	0.01	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.44	0.49	0.44	0.49	0.07	XXX
74160		A	Ct abdomen w/dye	1.27	6.86	8.55	NA	NA	0.08	XXX
74160	TC	A	Ct abdomen w/dye	0.00	6.38	8.02	NA	NA	0.01	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.48	0.53	0.48	0.53	0.07	XXX
74170		A	Ct abdomen w/o & w/dye	1.40	9.39	11.60	NA	NA	0.09	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	8.86	11.02	NA	NA	0.01	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.53	0.58	0.53	0.58	0.08	XXX
74175		A	Ct angio abdom w/o & w/dye	1.90	9.61	12.31	NA	NA	0.13	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	8.90	11.52	NA	NA	0.01	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.71	0.79	0.71	0.79	0.12	XXX
74176		A	Ct abd & pelvis w/o contrast	1.74	4.54	4.54	NA	NA	0.11	XXX
74176	TC	A	Ct abd & pelvis w/o contrast	0.00	3.89	3.89	NA	NA	0.01	XXX
74176	26	A	Ct abd & pelvis w/o contrast	1.74	0.65	0.65	0.65	0.65	0.10	XXX
74177		A	Ct abdomen&pelvis w/contrast	1.82	8.11	8.11	NA	NA	0.11	XXX
74177	TC	A	Ct abdomen&pelvis w/contrast	0.00	7.42	7.42	NA	NA	0.01	XXX
74177	26	A	Ct abdomen&pelvis w/contrast	1.82	0.69	0.69	0.69	0.69	0.10	XXX
74178		A	Ct abd&pelv 1+ section/regns	2.01	10.57	10.57	NA	NA	0.14	XXX
74178	TC	A	Ct abd&pelv 1+ section/regns	0.00	9.81	9.81	NA	NA	0.02	XXX
74178	26	A	Ct abd&pelv 1+ section/regns	2.01	0.76	0.76	0.76	0.76	0.12	XXX
74181		A	Mri abdomen w/o dye	1.46	9.33	12.10	NA	NA	0.09	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	8.79	11.50	NA	NA	0.01	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.54	0.60	0.54	0.60	0.08	XXX
74182		A	Mri abdomen w/dye	1.73	13.17	16.62	NA	NA	0.11	XXX
74182	TC	A	Mri abdomen w/dye	0.00	12.53	15.91	NA	NA	0.01	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.64	0.71	0.64	0.71	0.10	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	14.29	19.66	NA	NA	0.13	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	13.45	18.73	NA	NA	0.01	XXX

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74183	26	A	Mri abdomen w/o & w/dye	2.26	0.84	0.93	0.84	0.93	0.12	XXX
74185		R	Mri angio abdom w orw/o dye	1.80	11.57	14.44	NA	NA	0.11	XXX
74185	TC	R	Mri angio abdom w orw/o dye	0.00	10.90	13.70	NA	NA	0.01	XXX
74185	26	R	Mri angio abdom w orw/o dye	1.80	0.67	0.74	0.67	0.74	0.10	XXX
74190		C	X-ray exam of peritoneum	0.00	0.00	0.00	NA	NA	0.00	XXX
74190	TC	C	X-ray exam of peritoneum	0.00	0.00	0.00	NA	NA	0.00	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.18	0.20	0.18	0.20	0.04	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.86	1.94	NA	NA	0.02	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.72	1.79	NA	NA	0.01	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.14	0.15	0.14	0.15	0.01	XXX
74220		A	Contrast x-ray esophagus	0.46	2.10	2.18	NA	NA	0.04	XXX
74220	TC	A	Contrast x-ray esophagus	0.00	1.93	1.99	NA	NA	0.01	XXX
74220	26	A	Contrast x-ray esophagus	0.46	0.17	0.19	0.17	0.19	0.03	XXX
74230		A	Cine/vid x-ray throat/esoph	0.53	2.05	2.15	NA	NA	0.04	XXX
74230	TC	A	Cine/vid x-ray throat/esoph	0.00	1.85	1.93	NA	NA	0.01	XXX
74230	26	A	Cine/vid x-ray throat/esoph	0.53	0.20	0.22	0.20	0.22	0.03	XXX
74235		C	Remove esophagus obstruction	0.00	0.00	0.00	NA	NA	0.00	XXX
74235	TC	C	Remove esophagus obstruction	0.00	0.00	0.00	NA	NA	0.00	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.67	0.63	0.67	0.63	0.10	XXX
74240		A	X-ray exam upper gi tract	0.69	2.53	2.58	NA	NA	0.05	XXX
74240	TC	A	X-ray exam upper gi tract	0.00	2.26	2.29	NA	NA	0.01	XXX
74240	26	A	X-ray exam upper gi tract	0.69	0.27	0.29	0.27	0.29	0.04	XXX
74241		A	X-ray exam upper gi tract	0.69	2.71	2.79	NA	NA	0.04	XXX
74241	TC	A	X-ray exam upper gi tract	0.00	2.45	2.51	NA	NA	0.01	XXX
74241	26	A	X-ray exam upper gi tract	0.69	0.26	0.28	0.26	0.28	0.03	XXX
74245		A	X-ray exam upper gi tract	0.91	4.12	4.29	NA	NA	0.06	XXX
74245	TC	A	X-ray exam upper gi tract	0.00	3.78	3.91	NA	NA	0.01	XXX
74245	26	A	X-ray exam upper gi tract	0.91	0.34	0.38	0.34	0.38	0.05	XXX

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74246		A	Contrst x-ray uppr gi tract	0.69	2.92	3.03	NA	NA	0.05	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	2.66	2.74	NA	NA	0.01	XXX
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.26	0.29	0.26	0.29	0.04	XXX
74247		A	Contrst x-ray uppr gi tract	0.69	3.36	3.45	NA	NA	0.05	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	3.10	3.16	NA	NA	0.01	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.26	0.29	0.26	0.29	0.04	XXX
74249		A	Contrst x-ray uppr gi tract	0.91	4.54	4.70	NA	NA	0.06	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	4.20	4.32	NA	NA	0.01	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.34	0.38	0.34	0.38	0.05	XXX
74250		A	X-ray exam of small bowel	0.47	2.60	2.65	NA	NA	0.04	XXX
74250	TC	A	X-ray exam of small bowel	0.00	2.42	2.46	NA	NA	0.01	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.18	0.19	0.18	0.19	0.03	XXX
74251		A	X-ray exam of small bowel	0.69	10.60	10.12	NA	NA	0.05	XXX
74251	TC	A	X-ray exam of small bowel	0.00	10.34	9.83	NA	NA	0.01	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.26	0.29	0.26	0.29	0.04	XXX
74260		A	X-ray exam of small bowel	0.50	8.75	8.42	NA	NA	0.04	XXX
74260	TC	A	X-ray exam of small bowel	0.00	8.56	8.22	NA	NA	0.01	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.19	0.20	0.19	0.20	0.03	XXX
74261		A	Ct colonography dx	2.40	12.76	12.76	NA	NA	0.14	XXX
74261	TC	A	Ct colonography dx	0.00	11.85	11.85	NA	NA	0.01	XXX
74261	26	A	Ct colonography dx	2.40	0.91	0.91	0.91	0.91	0.13	XXX
74262		A	Ct colonography dx w/dye	2.50	14.33	14.33	NA	NA	0.15	XXX
74262	TC	A	Ct colonography dx w/dye	0.00	13.39	13.39	NA	NA	0.01	XXX
74262	26	A	Ct colonography dx w/dye	2.50	0.94	0.94	0.94	0.94	0.14	XXX
74263		N	Ct colonography screening	2.28	20.17	20.17	NA	NA	0.13	XXX
74263	TC	N	Ct colonography screening	0.00	19.17	19.17	NA	NA	0.01	XXX
74263	26	N	Ct colonography screening	2.28	1.00	1.00	1.00	1.00	0.12	XXX
74270		A	Contrast x-ray exam of colon	0.69	3.74	3.81	NA	NA	0.05	XXX

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74270	TC	A	Contrast x-ray exam of colon	0.00	3.48	3.52	NA	NA	0.01	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.26	0.29	0.26	0.29	0.04	XXX
74280		A	Contrast x-ray exam of colon	0.99	5.18	5.25	NA	NA	0.06	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	4.81	4.84	NA	NA	0.01	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.37	0.41	0.37	0.41	0.05	XXX
74283		A	Contrast x-ray exam of colon	2.02	3.77	4.00	NA	NA	0.06	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.99	3.16	NA	NA	0.01	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.78	0.84	0.78	0.84	0.05	XXX
74290		A	Contrast x-ray gallbladder	0.32	1.66	1.68	NA	NA	0.02	XXX
74290	TC	A	Contrast x-ray gallbladder	0.00	1.54	1.55	NA	NA	0.01	XXX
74290	26	A	Contrast x-ray gallbladder	0.32	0.12	0.13	0.12	0.13	0.01	XXX
74291		A	Contrast x-rays gallbladder	0.20	1.77	1.68	NA	NA	0.02	XXX
74291	TC	A	Contrast x-rays gallbladder	0.00	1.69	1.60	NA	NA	0.01	XXX
74291	26	A	Contrast x-rays gallbladder	0.20	0.08	0.08	0.08	0.08	0.01	XXX
74300		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74300	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.14	0.15	0.14	0.15	0.03	XXX
74301		C	X-rays at surgery add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
74301	TC	C	X-rays at surgery add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
74301	26	A	X-rays at surgery add-on	0.21	0.08	0.09	0.08	0.09	0.03	ZZZ
74305		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74305	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74305	26	A	X-ray bile ducts/pancreas	0.42	0.15	0.17	0.15	0.17	0.04	XXX
74320		A	Contrast x-ray of bile ducts	0.54	2.26	2.63	NA	NA	0.04	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	2.06	2.40	NA	NA	0.01	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.20	0.23	0.20	0.23	0.03	XXX
74327		A	X-ray bile stone removal	0.70	3.18	3.26	NA	NA	0.13	XXX
74327	TC	A	X-ray bile stone removal	0.00	2.92	2.97	NA	NA	0.01	XXX

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74327	26	A	X-ray bile stone removal	0.70	0.26	0.29	0.26	0.29	0.12	XXX
74328		C	X-ray bile duct endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74328	TC	C	X-ray bile duct endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.29	0.31	0.29	0.31	0.05	XXX
74329		C	X-ray for pancreas endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74329	TC	C	X-ray for pancreas endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.29	0.31	0.29	0.31	0.05	XXX
74330		C	X-ray bile/panc endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74330	TC	C	X-ray bile/panc endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74330	26	A	X-ray bile/panc endoscopy	0.90	0.36	0.39	0.36	0.39	0.07	XXX
74340		C	X-ray guide for gi tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74340	TC	C	X-ray guide for gi tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74340	26	A	X-ray guide for gi tube	0.54	0.21	0.23	0.21	0.23	0.04	XXX
74355		C	X-ray guide intestinal tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74355	TC	C	X-ray guide intestinal tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74355	26	A	X-ray guide intestinal tube	0.76	0.31	0.33	0.31	0.33	0.07	XXX
74360		C	X-ray guide gi dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74360	TC	C	X-ray guide gi dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74360	26	A	X-ray guide gi dilation	0.54	0.28	0.28	0.28	0.28	0.04	XXX
74363		C	X-ray bile duct dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74363	TC	C	X-ray bile duct dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74363	26	A	X-ray bile duct dilation	0.88	0.32	0.37	0.32	0.37	0.08	XXX
74400		A	Contrst x-ray urinary tract	0.49	2.65	2.79	NA	NA	0.04	XXX
74400	TC	A	Contrst x-ray urinary tract	0.00	2.47	2.59	NA	NA	0.01	XXX
74400	26	A	Contrst x-ray urinary tract	0.49	0.18	0.20	0.18	0.20	0.03	XXX
74410		A	Contrst x-ray urinary tract	0.49	2.66	2.89	NA	NA	0.04	XXX
74410	TC	A	Contrst x-ray urinary tract	0.00	2.47	2.68	NA	NA	0.01	XXX
74410	26	A	Contrst x-ray urinary tract	0.49	0.19	0.21	0.19	0.21	0.03	XXX

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74415		A	Contrst x-ray urinary tract	0.49	3.36	3.52	NA	NA	0.04	XXX
74415	TC	A	Contrst x-ray urinary tract	0.00	3.18	3.32	NA	NA	0.01	XXX
74415	26	A	Contrst x-ray urinary tract	0.49	0.18	0.20	0.18	0.20	0.03	XXX
74420		C	Contrst x-ray urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	TC	C	Contrst x-ray urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	26	A	Contrst x-ray urinary tract	0.36	0.14	0.15	0.14	0.15	0.03	XXX
74425		C	Contrst x-ray urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74425	TC	C	Contrst x-ray urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74425	26	A	Contrst x-ray urinary tract	0.36	0.13	0.15	0.13	0.15	0.03	XXX
74430		A	Contrast x-ray bladder	0.32	0.82	1.47	NA	NA	0.02	XXX
74430	TC	A	Contrast x-ray bladder	0.00	0.70	1.34	NA	NA	0.01	XXX
74430	26	A	Contrast x-ray bladder	0.32	0.12	0.13	0.12	0.13	0.01	XXX
74440		A	X-ray male genital tract	0.38	2.03	2.15	NA	NA	0.04	XXX
74440	TC	A	X-ray male genital tract	0.00	1.88	1.99	NA	NA	0.01	XXX
74440	26	A	X-ray male genital tract	0.38	0.15	0.16	0.15	0.16	0.03	XXX
74445		C	X-ray exam of penis	0.00	0.00	0.00	NA	NA	0.00	XXX
74445	TC	C	X-ray exam of penis	0.00	0.00	0.00	NA	NA	0.00	XXX
74445	26	A	X-ray exam of penis	1.14	0.45	0.50	0.45	0.50	0.10	XXX
74450		C	X-ray urethra/bladder	0.00	0.00	0.00	NA	NA	0.00	XXX
74450	TC	C	X-ray urethra/bladder	0.00	0.00	0.00	NA	NA	0.00	XXX
74450	26	A	X-ray urethra/bladder	0.33	0.12	0.14	0.12	0.14	0.03	XXX
74455		A	X-ray urethra/bladder	0.33	2.11	2.31	NA	NA	0.02	XXX
74455	TC	A	X-ray urethra/bladder	0.00	1.98	2.17	NA	NA	0.01	XXX
74455	26	A	X-ray urethra/bladder	0.33	0.13	0.14	0.13	0.14	0.01	XXX
74470		C	X-ray exam of kidney lesion	0.00	0.00	0.00	NA	NA	0.00	XXX
74470	TC	C	X-ray exam of kidney lesion	0.00	0.00	0.00	NA	NA	0.00	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.20	0.23	0.20	0.23	0.04	XXX
74475		A	X-ray control cath insert	0.54	2.23	2.74	NA	NA	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
74475	TC	A	X-ray control cath insert	0.00	2.03	2.51	NA	NA	0.01	XXX
74475	26	A	X-ray control cath insert	0.54	0.20	0.23	0.20	0.23	0.03	XXX
74480		A	X-ray control cath insert	0.54	2.24	2.75	NA	NA	0.04	XXX
74480	TC	A	X-ray control cath insert	0.00	2.04	2.52	NA	NA	0.01	XXX
74480	26	A	X-ray control cath insert	0.54	0.20	0.23	0.20	0.23	0.03	XXX
74485		A	X-ray guide gu dilation	0.54	2.28	2.70	NA	NA	0.04	XXX
74485	TC	A	X-ray guide gu dilation	0.00	2.08	2.47	NA	NA	0.01	XXX
74485	26	A	X-ray guide gu dilation	0.54	0.20	0.23	0.20	0.23	0.03	XXX
74710		A	X-ray measurement of pelvis	0.34	0.68	0.82	NA	NA	0.02	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	0.55	0.68	NA	NA	0.01	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.13	0.14	0.13	0.14	0.01	XXX
74740		A	X-ray female genital tract	0.38	1.85	1.95	NA	NA	0.02	XXX
74740	TC	A	X-ray female genital tract	0.00	1.70	1.79	NA	NA	0.01	XXX
74740	26	A	X-ray female genital tract	0.38	0.15	0.16	0.15	0.16	0.01	XXX
74742		C	X-ray fallopian tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74742	TC	C	X-ray fallopian tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74742	26	A	X-ray fallopian tube	0.61	0.24	0.25	0.24	0.25	0.05	XXX
74775		C	X-ray exam of perineum	0.00	0.00	0.00	NA	NA	0.00	XXX
74775	TC	C	X-ray exam of perineum	0.00	0.00	0.00	NA	NA	0.00	XXX
74775	26	A	X-ray exam of perineum	0.62	0.23	0.26	0.23	0.26	0.05	XXX
75557		A	Cardiac mri for morph	2.35	8.14	10.81	NA	NA	0.11	XXX
75557	TC	A	Cardiac mri for morph	0.00	7.25	9.75	NA	NA	0.01	XXX
75557	26	A	Cardiac mri for morph	2.35	0.89	1.06	0.89	1.06	0.10	XXX
75559		A	Cardiac mri w/stress img	2.95	11.69	16.11	NA	NA	0.13	XXX
75559	TC	A	Cardiac mri w/stress img	0.00	10.56	14.72	NA	NA	0.01	XXX
75559	26	A	Cardiac mri w/stress img	2.95	1.13	1.39	1.13	1.39	0.12	XXX
75561		A	Cardiac mri for morph w/dye	2.60	11.40	15.24	NA	NA	0.12	XXX
75561	TC	A	Cardiac mri for morph w/dye	0.00	10.41	14.07	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75561	26	A	Cardiac mri for morph w/dye	2.60	0.99	1.17	0.99	1.17	0.11	XXX
75563		A	Card mri w/stress img & dye	3.00	13.60	18.75	NA	NA	0.12	XXX
75563	TC	A	Card mri w/stress img & dye	0.00	12.43	17.28	NA	NA	0.01	XXX
75563	26	A	Card mri w/stress img & dye	3.00	1.17	1.47	1.17	1.47	0.11	XXX
75565		A	Card mri veloc flow mapping	0.25	1.93	1.93	NA	NA	0.02	ZZZ
75565	TC	A	Card mri veloc flow mapping	0.00	1.82	1.82	NA	NA	0.01	ZZZ
75565	26	A	Card mri veloc flow mapping	0.25	0.11	0.11	0.11	0.11	0.01	ZZZ
75571		A	Ct hrt w/o dye w/ca test	0.58	2.56	2.56	NA	NA	0.02	XXX
75571	TC	A	Ct hrt w/o dye w/ca test	0.00	2.34	2.34	NA	NA	0.01	XXX
75571	26	A	Ct hrt w/o dye w/ca test	0.58	0.22	0.22	0.22	0.22	0.01	XXX
75572		A	Ct hrt w/3d image	1.75	6.84	6.84	NA	NA	0.06	XXX
75572	TC	A	Ct hrt w/3d image	0.00	6.17	6.17	NA	NA	0.01	XXX
75572	26	A	Ct hrt w/3d image	1.75	0.67	0.67	0.67	0.67	0.05	XXX
75573		A	Ct hrt w/3d image congen	2.55	9.14	9.14	NA	NA	0.09	XXX
75573	TC	A	Ct hrt w/3d image congen	0.00	8.14	8.14	NA	NA	0.01	XXX
75573	26	A	Ct hrt w/3d image congen	2.55	1.00	1.00	1.00	1.00	0.08	XXX
75574		A	Ct angio hrt w/3d image	2.40	10.67	10.67	NA	NA	0.09	XXX
75574	TC	A	Ct angio hrt w/3d image	0.00	9.75	9.75	NA	NA	0.01	XXX
75574	26	A	Ct angio hrt w/3d image	2.40	0.92	0.92	0.92	0.92	0.08	XXX
75600		A	Contrast x-ray exam of aorta	0.49	5.46	7.48	NA	NA	0.04	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	5.27	7.25	NA	NA	0.01	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.19	0.23	0.19	0.23	0.03	XXX
75605		A	Contrast x-ray exam of aorta	1.14	3.19	5.16	NA	NA	0.08	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	2.77	4.65	NA	NA	0.01	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.42	0.51	0.42	0.51	0.07	XXX
75625		A	Contrast x-ray exam of aorta	1.14	3.28	5.13	NA	NA	0.11	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	2.87	4.66	NA	NA	0.01	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.41	0.47	0.41	0.47	0.10	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75630		A	X-ray aorta leg arteries	1.79	3.52	5.53	NA	NA	0.11	XXX
75630	TC	A	X-ray aorta leg arteries	0.00	2.86	4.77	NA	NA	0.01	XXX
75630	26	A	X-ray aorta leg arteries	1.79	0.66	0.76	0.66	0.76	0.10	XXX
75635		A	Ct angio abdominal arteries	2.40	10.20	13.51	NA	NA	0.15	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	9.30	12.48	NA	NA	0.03	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.90	1.03	0.90	1.03	0.12	XXX
75650		A	Artery x-rays head & neck	1.49	3.45	5.32	NA	NA	0.11	XXX
75650	TC	A	Artery x-rays head & neck	0.00	2.90	4.69	NA	NA	0.01	XXX
75650	26	A	Artery x-rays head & neck	1.49	0.55	0.63	0.55	0.63	0.10	XXX
75658		A	Artery x-rays arm	1.31	4.07	5.69	NA	NA	0.09	XXX
75658	TC	A	Artery x-rays arm	0.00	3.60	5.18	NA	NA	0.01	XXX
75658	26	A	Artery x-rays arm	1.31	0.47	0.51	0.47	0.51	0.08	XXX
75660		A	Artery x-rays head & neck	1.31	4.18	5.84	NA	NA	0.05	XXX
75660	TC	A	Artery x-rays head & neck	0.00	3.65	5.26	NA	NA	0.01	XXX
75660	26	A	Artery x-rays head & neck	1.31	0.53	0.58	0.53	0.58	0.04	XXX
75662		A	Artery x-rays head & neck	1.66	5.07	6.80	NA	NA	0.10	XXX
75662	TC	A	Artery x-rays head & neck	0.00	4.40	6.04	NA	NA	0.03	XXX
75662	26	A	Artery x-rays head & neck	1.66	0.67	0.76	0.67	0.76	0.07	XXX
75665		A	Artery x-rays head & neck	1.31	4.42	6.08	NA	NA	0.12	XXX
75665	TC	A	Artery x-rays head & neck	0.00	3.89	5.51	NA	NA	0.01	XXX
75665	26	A	Artery x-rays head & neck	1.31	0.53	0.57	0.53	0.57	0.11	XXX
75671		A	Artery x-rays head & neck	1.66	5.26	6.95	NA	NA	0.13	XXX
75671	TC	A	Artery x-rays head & neck	0.00	4.61	6.23	NA	NA	0.03	XXX
75671	26	A	Artery x-rays head & neck	1.66	0.65	0.72	0.65	0.72	0.10	XXX
75676		A	Artery x-rays neck	1.31	4.04	5.77	NA	NA	0.12	XXX
75676	TC	A	Artery x-rays neck	0.00	3.53	5.21	NA	NA	0.01	XXX
75676	26	A	Artery x-rays neck	1.31	0.51	0.56	0.51	0.56	0.11	XXX
75680		A	Artery x-rays neck	1.66	4.58	6.39	NA	NA	0.11	XXX

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75680	TC	A	Artery x-rays neck	0.00	3.94	5.66	NA	NA	0.01	XXX
75680	26	A	Artery x-rays neck	1.66	0.64	0.73	0.64	0.73	0.10	XXX
75685		A	Artery x-rays spine	1.31	4.14	5.83	NA	NA	0.09	XXX
75685	TC	A	Artery x-rays spine	0.00	3.62	5.26	NA	NA	0.01	XXX
75685	26	A	Artery x-rays spine	1.31	0.52	0.57	0.52	0.57	0.08	XXX
75705		A	Artery x-rays spine	2.18	4.46	6.17	NA	NA	0.08	XXX
75705	TC	A	Artery x-rays spine	0.00	3.60	5.23	NA	NA	0.01	XXX
75705	26	A	Artery x-rays spine	2.18	0.86	0.94	0.86	0.94	0.07	XXX
75710		A	Artery x-rays arm/leg	1.14	3.93	5.71	NA	NA	0.06	XXX
75710	TC	A	Artery x-rays arm/leg	0.00	3.51	5.24	NA	NA	0.01	XXX
75710	26	A	Artery x-rays arm/leg	1.14	0.42	0.47	0.42	0.47	0.05	XXX
75716		A	Artery x-rays arms/legs	1.31	4.72	6.55	NA	NA	0.13	XXX
75716	TC	A	Artery x-rays arms/legs	0.00	4.24	6.01	NA	NA	0.03	XXX
75716	26	A	Artery x-rays arms/legs	1.31	0.48	0.54	0.48	0.54	0.10	XXX
75722		A	Artery x-rays kidney	1.14	3.55	5.48	NA	NA	0.08	XXX
75722	TC	A	Artery x-rays kidney	0.00	3.13	4.98	NA	NA	0.01	XXX
75722	26	A	Artery x-rays kidney	1.14	0.42	0.50	0.42	0.50	0.07	XXX
75724		A	Artery x-rays kidneys	1.49	4.22	6.37	NA	NA	0.08	XXX
75724	TC	A	Artery x-rays kidneys	0.00	3.65	5.65	NA	NA	0.03	XXX
75724	26	A	Artery x-rays kidneys	1.49	0.57	0.72	0.57	0.72	0.05	XXX
75726		A	Artery x-rays abdomen	1.14	3.85	5.63	NA	NA	0.09	XXX
75726	TC	A	Artery x-rays abdomen	0.00	3.44	5.16	NA	NA	0.01	XXX
75726	26	A	Artery x-rays abdomen	1.14	0.41	0.47	0.41	0.47	0.08	XXX
75731		A	Artery x-rays adrenal gland	1.14	3.82	5.77	NA	NA	0.05	XXX
75731	TC	A	Artery x-rays adrenal gland	0.00	3.39	5.24	NA	NA	0.01	XXX
75731	26	A	Artery x-rays adrenal gland	1.14	0.43	0.53	0.43	0.53	0.04	XXX
75733		A	Artery x-rays adrenals	1.31	4.46	6.64	NA	NA	0.07	XXX
75733	TC	A	Artery x-rays adrenals	0.00	3.95	6.00	NA	NA	0.03	XXX

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75733	26	A	Artery x-rays adrenals	1.31	0.51	0.64	0.51	0.64	0.04	XXX
75736		A	Artery x-rays pelvis	1.14	3.78	5.63	NA	NA	0.06	XXX
75736	TC	A	Artery x-rays pelvis	0.00	3.36	5.15	NA	NA	0.01	XXX
75736	26	A	Artery x-rays pelvis	1.14	0.42	0.48	0.42	0.48	0.05	XXX
75741		A	Artery x-rays lung	1.31	3.27	5.09	NA	NA	0.09	XXX
75741	TC	A	Artery x-rays lung	0.00	2.80	4.54	NA	NA	0.01	XXX
75741	26	A	Artery x-rays lung	1.31	0.47	0.55	0.47	0.55	0.08	XXX
75743		A	Artery x-rays lungs	1.66	3.66	5.49	NA	NA	0.11	XXX
75743	TC	A	Artery x-rays lungs	0.00	3.06	4.79	NA	NA	0.01	XXX
75743	26	A	Artery x-rays lungs	1.66	0.60	0.70	0.60	0.70	0.10	XXX
75746		A	Artery x-rays lung	1.14	3.63	5.42	NA	NA	0.08	XXX
75746	TC	A	Artery x-rays lung	0.00	3.20	4.94	NA	NA	0.01	XXX
75746	26	A	Artery x-rays lung	1.14	0.43	0.48	0.43	0.48	0.07	XXX
75756		A	Artery x-rays chest	1.14	3.83	5.79	NA	NA	0.23	XXX
75756	TC	A	Artery x-rays chest	0.00	3.41	5.25	NA	NA	0.01	XXX
75756	26	A	Artery x-rays chest	1.14	0.42	0.54	0.42	0.54	0.22	XXX
75774		A	Artery x-ray each vessel	0.36	2.51	4.31	NA	NA	0.04	ZZZ
75774	TC	A	Artery x-ray each vessel	0.00	2.38	4.16	NA	NA	0.01	ZZZ
75774	26	A	Artery x-ray each vessel	0.36	0.13	0.15	0.13	0.15	0.03	ZZZ
75791		A	Av dialysis shunt imaging	1.71	7.88	7.88	NA	NA	0.11	XXX
75791	TC	A	Av dialysis shunt imaging	0.00	7.25	7.25	NA	NA	0.01	XXX
75791	26	A	Av dialysis shunt imaging	1.71	0.63	0.63	0.63	0.63	0.10	XXX
75801		C	Lymph vessel x-ray arm/leg	0.00	0.00	0.00	NA	NA	0.00	XXX
75801	TC	C	Lymph vessel x-ray arm/leg	0.00	0.00	0.00	NA	NA	0.00	XXX
75801	26	A	Lymph vessel x-ray arm/leg	0.81	0.35	0.33	0.35	0.33	0.18	XXX
75803		C	Lymph vessel x-ray arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	TC	C	Lymph vessel x-ray arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	26	A	Lymph vessel x-ray arms/legs	1.17	0.44	0.50	0.44	0.50	0.10	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75805		C	Lymph vessel x-ray trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75805	TC	C	Lymph vessel x-ray trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75805	26	A	Lymph vessel x-ray trunk	0.81	0.31	0.34	0.31	0.34	0.07	XXX
75807		C	Lymph vessel x-ray trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75807	TC	C	Lymph vessel x-ray trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75807	26	A	Lymph vessel x-ray trunk	1.17	0.45	0.50	0.45	0.50	0.10	XXX
75809		A	Nonvascular shunt x-ray	0.47	2.50	2.39	NA	NA	0.04	XXX
75809	TC	A	Nonvascular shunt x-ray	0.00	2.31	2.19	NA	NA	0.01	XXX
75809	26	A	Nonvascular shunt x-ray	0.47	0.19	0.20	0.19	0.20	0.03	XXX
75810		C	Vein x-ray spleen/liver	0.00	0.00	0.00	NA	NA	0.00	XXX
75810	TC	C	Vein x-ray spleen/liver	0.00	0.00	0.00	NA	NA	0.00	XXX
75810	26	A	Vein x-ray spleen/liver	1.14	0.43	0.49	0.43	0.49	0.10	XXX
75820		A	Vein x-ray arm/leg	0.70	2.90	2.98	NA	NA	0.05	XXX
75820	TC	A	Vein x-ray arm/leg	0.00	2.64	2.68	NA	NA	0.01	XXX
75820	26	A	Vein x-ray arm/leg	0.70	0.26	0.30	0.26	0.30	0.04	XXX
75822		A	Vein x-ray arms/legs	1.06	3.37	3.42	NA	NA	0.08	XXX
75822	TC	A	Vein x-ray arms/legs	0.00	2.98	2.99	NA	NA	0.01	XXX
75822	26	A	Vein x-ray arms/legs	1.06	0.39	0.43	0.39	0.43	0.07	XXX
75825		A	Vein x-ray trunk	1.14	3.11	4.89	NA	NA	0.09	XXX
75825	TC	A	Vein x-ray trunk	0.00	2.70	4.43	NA	NA	0.01	XXX
75825	26	A	Vein x-ray trunk	1.14	0.41	0.46	0.41	0.46	0.08	XXX
75827		A	Vein x-ray chest	1.14	3.28	4.96	NA	NA	0.08	XXX
75827	TC	A	Vein x-ray chest	0.00	2.87	4.52	NA	NA	0.01	XXX
75827	26	A	Vein x-ray chest	1.14	0.41	0.44	0.41	0.44	0.07	XXX
75831		A	Vein x-ray kidney	1.14	3.22	4.99	NA	NA	0.25	XXX
75831	TC	A	Vein x-ray kidney	0.00	2.81	4.53	NA	NA	0.01	XXX
75831	26	A	Vein x-ray kidney	1.14	0.41	0.46	0.41	0.46	0.24	XXX
75833		A	Vein x-ray kidneys	1.49	3.86	5.59	NA	NA	0.09	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75833	TC	A	Vein x-ray kidneys	0.00	3.34	5.01	NA	NA	0.01	XXX
75833	26	A	Vein x-ray kidneys	1.49	0.52	0.58	0.52	0.58	0.08	XXX
75840		A	Vein x-ray adrenal gland	1.14	3.07	4.87	NA	NA	0.25	XXX
75840	TC	A	Vein x-ray adrenal gland	0.00	2.69	4.44	NA	NA	0.01	XXX
75840	26	A	Vein x-ray adrenal gland	1.14	0.38	0.43	0.38	0.43	0.24	XXX
75842		A	Vein x-ray adrenal glands	1.49	3.81	5.60	NA	NA	0.09	XXX
75842	TC	A	Vein x-ray adrenal glands	0.00	3.25	4.98	NA	NA	0.01	XXX
75842	26	A	Vein x-ray adrenal glands	1.49	0.56	0.62	0.56	0.62	0.08	XXX
75860		A	Vein x-ray neck	1.14	3.21	5.08	NA	NA	0.09	XXX
75860	TC	A	Vein x-ray neck	0.00	2.78	4.58	NA	NA	0.01	XXX
75860	26	A	Vein x-ray neck	1.14	0.43	0.50	0.43	0.50	0.08	XXX
75870		A	Vein x-ray skull	1.14	3.16	5.01	NA	NA	0.08	XXX
75870	TC	A	Vein x-ray skull	0.00	2.73	4.54	NA	NA	0.01	XXX
75870	26	A	Vein x-ray skull	1.14	0.43	0.47	0.43	0.47	0.07	XXX
75872		A	Vein x-ray skull	1.14	6.73	7.19	NA	NA	0.08	XXX
75872	TC	A	Vein x-ray skull	0.00	6.10	6.60	NA	NA	0.01	XXX
75872	26	A	Vein x-ray skull	1.14	0.63	0.59	0.63	0.59	0.07	XXX
75880		A	Vein x-ray eye socket	0.70	5.54	4.34	NA	NA	0.05	XXX
75880	TC	A	Vein x-ray eye socket	0.00	5.20	4.02	NA	NA	0.01	XXX
75880	26	A	Vein x-ray eye socket	0.70	0.34	0.32	0.34	0.32	0.04	XXX
75885		A	Vein x-ray liver	1.44	3.30	5.12	NA	NA	0.09	XXX
75885	TC	A	Vein x-ray liver	0.00	2.78	4.52	NA	NA	0.01	XXX
75885	26	A	Vein x-ray liver	1.44	0.52	0.60	0.52	0.60	0.08	XXX
75887		A	Vein x-ray liver	1.44	3.39	5.21	NA	NA	0.06	XXX
75887	TC	A	Vein x-ray liver	0.00	2.86	4.60	NA	NA	0.01	XXX
75887	26	A	Vein x-ray liver	1.44	0.53	0.61	0.53	0.61	0.05	XXX
75889		A	Vein x-ray liver	1.14	3.22	5.00	NA	NA	0.08	XXX
75889	TC	A	Vein x-ray liver	0.00	2.81	4.53	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75889	26	A	Vein x-ray liver	1.14	0.41	0.47	0.41	0.47	0.07	XXX
75891		A	Vein x-ray liver	1.14	3.22	5.00	NA	NA	0.08	XXX
75891	TC	A	Vein x-ray liver	0.00	2.81	4.53	NA	NA	0.01	XXX
75891	26	A	Vein x-ray liver	1.14	0.41	0.47	0.41	0.47	0.07	XXX
75893		A	Venous sampling by catheter	0.54	2.95	4.72	NA	NA	0.02	XXX
75893	TC	A	Venous sampling by catheter	0.00	2.75	4.50	NA	NA	0.01	XXX
75893	26	A	Venous sampling by catheter	0.54	0.20	0.22	0.20	0.22	0.01	XXX
75894		C	X-rays transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75894	TC	C	X-rays transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75894	26	A	X-rays transcath therapy	1.31	0.48	0.54	0.48	0.54	0.16	XXX
75896		C	X-rays transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75896	TC	C	X-rays transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75896	26	A	X-rays transcath therapy	1.31	0.48	0.56	0.48	0.56	0.16	XXX
75898		C	Follow-up angiography	0.00	0.00	0.00	NA	NA	0.00	XXX
75898	TC	C	Follow-up angiography	0.00	0.00	0.00	NA	NA	0.00	XXX
75898	26	A	Follow-up angiography	1.65	0.62	0.71	0.62	0.71	0.20	XXX
75900		C	Intravascular cath exchange	0.00	0.00	0.00	NA	NA	0.00	XXX
75900	TC	C	Intravascular cath exchange	0.00	0.00	0.00	NA	NA	0.00	XXX
75900	26	A	Intravascular cath exchange	0.49	0.17	0.20	0.17	0.20	0.05	XXX
75901		A	Remove cva device obstruct	0.49	4.58	4.43	NA	NA	0.04	XXX
75901	TC	A	Remove cva device obstruct	0.00	4.40	4.23	NA	NA	0.01	XXX
75901	26	A	Remove cva device obstruct	0.49	0.18	0.20	0.18	0.20	0.03	XXX
75902		A	Remove cva lumen obstruct	0.39	1.77	1.86	NA	NA	0.05	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.63	1.70	NA	NA	0.01	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.14	0.16	0.14	0.16	0.04	XXX
75940		C	X-ray placement vein filter	0.00	0.00	0.00	NA	NA	0.00	XXX
75940	TC	C	X-ray placement vein filter	0.00	0.00	0.00	NA	NA	0.00	XXX
75940	26	A	X-ray placement vein filter	0.54	0.20	0.21	0.20	0.21	0.07	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75945		C	Intravascular us	0.00	0.00	0.00	NA	NA	0.00	XXX
75945	TC	C	Intravascular us	0.00	0.00	0.00	NA	NA	0.00	XXX
75945	26	A	Intravascular us	0.40	0.14	0.16	0.14	0.16	0.05	XXX
75946		C	Intravascular us add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75946	TC	C	Intravascular us add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75946	26	A	Intravascular us add-on	0.40	0.13	0.15	0.13	0.15	0.07	ZZZ
75952		C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	26	A	Endovasc repair abdom aorta	4.49	1.55	1.64	1.55	1.64	0.86	XXX
75953		C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75953	TC	C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.36	0.47	0.50	0.47	0.50	0.27	XXX
75954		C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75954	TC	C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	2.25	0.79	0.83	0.79	0.83	0.41	XXX
75956		C	Xray endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75956	TC	C	Xray endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75956	26	A	Xray endovasc thor ao repr	7.00	2.35	2.55	2.35	2.55	1.44	XXX
75957		C	Xray endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	TC	C	Xray endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	26	A	Xray endovasc thor ao repr	6.00	2.02	2.19	2.02	2.19	1.21	XXX
75958		C	Xray place prox ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75958	TC	C	Xray place prox ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75958	26	A	Xray place prox ext thor ao	4.00	1.34	1.42	1.34	1.42	0.81	XXX
75959		C	Xray place dist ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75959	TC	C	Xray place dist ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75959	26	A	Xray place dist ext thor ao	3.50	1.05	1.20	1.05	1.20	0.83	XXX
75960		A	Transcath iv stent rs&i	0.82	2.70	4.86	NA	NA	0.06	XXX

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75960	TC	A	Transcath iv stent rs&i	0.00	2.40	4.52	NA	NA	0.01	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.30	0.34	0.30	0.34	0.05	XXX
75961		A	Retrieval broken catheter	4.24	4.79	6.40	NA	NA	0.28	XXX
75961	TC	A	Retrieval broken catheter	0.00	3.27	4.67	NA	NA	0.01	XXX
75961	26	A	Retrieval broken catheter	4.24	1.52	1.73	1.52	1.73	0.27	XXX
75962		A	Repair arterial blockage	0.54	3.47	5.71	NA	NA	0.04	XXX
75962	TC	A	Repair arterial blockage	0.00	3.27	5.49	NA	NA	0.01	XXX
75962	26	A	Repair arterial blockage	0.54	0.20	0.22	0.20	0.22	0.03	XXX
75964		A	Repair artery blockage each	0.36	2.35	3.52	NA	NA	0.05	ZZZ
75964	TC	A	Repair artery blockage each	0.00	2.22	3.38	NA	NA	0.01	ZZZ
75964	26	A	Repair artery blockage each	0.36	0.13	0.14	0.13	0.14	0.04	ZZZ
75966		A	Repair arterial blockage	1.31	3.72	6.17	NA	NA	0.08	XXX
75966	TC	A	Repair arterial blockage	0.00	3.23	5.59	NA	NA	0.01	XXX
75966	26	A	Repair arterial blockage	1.31	0.49	0.58	0.49	0.58	0.07	XXX
75968		A	Repair artery blockage each	0.36	2.21	3.46	NA	NA	0.02	ZZZ
75968	TC	A	Repair artery blockage each	0.00	2.08	3.30	NA	NA	0.01	ZZZ
75968	26	A	Repair artery blockage each	0.36	0.13	0.16	0.13	0.16	0.01	ZZZ
75970		C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
75970	TC	C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
75970	26	A	Vascular biopsy	0.83	0.30	0.35	0.30	0.35	0.07	XXX
75978		A	Repair venous blockage	0.54	3.64	5.73	NA	NA	0.04	XXX
75978	TC	A	Repair venous blockage	0.00	3.44	5.51	NA	NA	0.01	XXX
75978	26	A	Repair venous blockage	0.54	0.20	0.22	0.20	0.22	0.03	XXX
75980		C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75980	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.53	0.60	0.53	0.60	0.12	XXX
75982		C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75982	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75982	26	A	Contrast xray exam bile duct	1.44	0.52	0.60	0.52	0.60	0.12	XXX
75984		A	Xray control catheter change	0.72	2.46	2.64	NA	NA	0.05	XXX
75984	TC	A	Xray control catheter change	0.00	2.20	2.34	NA	NA	0.01	XXX
75984	26	A	Xray control catheter change	0.72	0.26	0.30	0.26	0.30	0.04	XXX
75989		A	Abscess drainage under x-ray	1.19	2.38	2.78	NA	NA	0.06	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	1.94	2.28	NA	NA	0.01	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.44	0.50	0.44	0.50	0.05	XXX
76000		A	Fluoroscope examination	0.17	1.30	2.10	NA	NA	0.02	XXX
76000	TC	A	Fluoroscope examination	0.00	1.23	2.03	NA	NA	0.01	XXX
76000	26	A	Fluoroscope examination	0.17	0.07	0.07	0.07	0.07	0.01	XXX
76001		C	Fluoroscope exam extensive	0.00	0.00	0.00	NA	NA	0.00	XXX
76001	TC	C	Fluoroscope exam extensive	0.00	0.00	0.00	NA	NA	0.00	XXX
76001	26	A	Fluoroscope exam extensive	0.67	0.30	0.30	0.30	0.30	0.08	XXX
76010		A	X-ray nose to rectum	0.18	0.56	0.63	NA	NA	0.02	XXX
76010	TC	A	X-ray nose to rectum	0.00	0.49	0.55	NA	NA	0.01	XXX
76010	26	A	X-ray nose to rectum	0.18	0.07	0.08	0.07	0.08	0.01	XXX
76080		A	X-ray exam of fistula	0.54	1.15	1.27	NA	NA	0.04	XXX
76080	TC	A	X-ray exam of fistula	0.00	0.95	1.04	NA	NA	0.01	XXX
76080	26	A	X-ray exam of fistula	0.54	0.20	0.23	0.20	0.23	0.03	XXX
76098		A	X-ray exam breast specimen	0.16	0.33	0.39	NA	NA	0.02	XXX
76098	TC	A	X-ray exam breast specimen	0.00	0.27	0.32	NA	NA	0.01	XXX
76098	26	A	X-ray exam breast specimen	0.16	0.06	0.07	0.06	0.07	0.01	XXX
76100		A	X-ray exam of body section	0.58	2.34	3.00	NA	NA	0.06	XXX
76100	TC	A	X-ray exam of body section	0.00	2.03	2.72	NA	NA	0.01	XXX
76100	26	A	X-ray exam of body section	0.58	0.31	0.28	0.31	0.28	0.05	XXX
76101		A	Complex body section x-ray	0.58	3.73	4.56	NA	NA	0.09	XXX
76101	TC	A	Complex body section x-ray	0.00	3.32	4.23	NA	NA	0.01	XXX
76101	26	A	Complex body section x-ray	0.58	0.41	0.33	0.41	0.33	0.08	XXX

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76102		A	Complex body section x-rays	0.58	5.21	6.35	NA	NA	0.11	XXX
76102	TC	A	Complex body section x-rays	0.00	4.79	6.02	NA	NA	0.01	XXX
76102	26	A	Complex body section x-rays	0.58	0.42	0.33	0.42	0.33	0.10	XXX
76120		A	Cine/video x-rays	0.38	1.74	1.86	NA	NA	0.04	XXX
76120	TC	A	Cine/video x-rays	0.00	1.59	1.71	NA	NA	0.01	XXX
76120	26	A	Cine/video x-rays	0.38	0.15	0.15	0.15	0.15	0.03	XXX
76125		C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	TC	C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.11	0.13	0.11	0.13	0.03	ZZZ
76140		I	X-ray consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76376		A	3d render w/o postprocess	0.20	1.46	1.90	NA	NA	0.02	XXX
76376	TC	A	3d render w/o postprocess	0.00	1.38	1.81	NA	NA	0.01	XXX
76376	26	A	3d render w/o postprocess	0.20	0.08	0.09	0.08	0.09	0.01	XXX
76377		A	3d rendering w/postprocess	0.79	1.43	1.93	NA	NA	0.05	XXX
76377	TC	A	3d rendering w/postprocess	0.00	1.13	1.60	NA	NA	0.01	XXX
76377	26	A	3d rendering w/postprocess	0.79	0.30	0.33	0.30	0.33	0.04	XXX
76380		A	Cat scan follow-up study	0.98	3.71	4.59	NA	NA	0.05	XXX
76380	TC	A	Cat scan follow-up study	0.00	3.33	4.18	NA	NA	0.01	XXX
76380	26	A	Cat scan follow-up study	0.98	0.38	0.41	0.38	0.41	0.04	XXX
76390		N	Mr spectroscopy	1.40	11.95	12.57	NA	NA	0.06	XXX
76390	TC	N	Mr spectroscopy	0.00	11.33	11.97	NA	NA	0.01	XXX
76390	26	N	Mr spectroscopy	1.40	0.62	0.60	0.62	0.60	0.05	XXX
76496		C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76496	TC	C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76496	26	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497		C	Ct procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76497	TC	C	Ct procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76497	26	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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76498		C	Mri procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76498	TC	C	Mri procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76498	26	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499		C	Radiographic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76499	TC	C	Radiographic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76506		A	Echo exam of head	0.63	2.83	2.91	NA	NA	0.05	XXX
76506	TC	A	Echo exam of head	0.00	2.59	2.65	NA	NA	0.01	XXX
76506	26	A	Echo exam of head	0.63	0.24	0.26	0.24	0.26	0.04	XXX
76510		A	Ophth us b & quant a	1.55	3.25	3.12	NA	NA	0.27	XXX
76510	TC	A	Ophth us b & quant a	0.00	2.17	2.19	NA	NA	0.01	XXX
76510	26	A	Ophth us b & quant a	1.55	1.08	0.93	1.08	0.93	0.26	XXX
76511		A	Ophth us quant a only	0.94	1.95	1.98	NA	NA	0.02	XXX
76511	TC	A	Ophth us quant a only	0.00	1.31	1.43	NA	NA	0.01	XXX
76511	26	A	Ophth us quant a only	0.94	0.64	0.55	0.64	0.55	0.01	XXX
76512		A	Ophth us b w/non-quant a	0.94	1.69	1.73	NA	NA	0.05	XXX
76512	TC	A	Ophth us b w/non-quant a	0.00	1.06	1.18	NA	NA	0.01	XXX
76512	26	A	Ophth us b w/non-quant a	0.94	0.63	0.55	0.63	0.55	0.04	XXX
76513		A	Echo exam of eye water bath	0.66	1.95	1.92	NA	NA	0.02	XXX
76513	TC	A	Echo exam of eye water bath	0.00	1.58	1.59	NA	NA	0.01	XXX
76513	26	A	Echo exam of eye water bath	0.66	0.37	0.33	0.37	0.33	0.01	XXX
76514		A	Echo exam of eye thickness	0.17	0.25	0.22	NA	NA	0.02	XXX
76514	TC	A	Echo exam of eye thickness	0.00	0.14	0.12	NA	NA	0.01	XXX
76514	26	A	Echo exam of eye thickness	0.17	0.11	0.10	0.11	0.10	0.01	XXX
76516		A	Echo exam of eye	0.54	1.62	1.57	NA	NA	0.02	XXX
76516	TC	A	Echo exam of eye	0.00	1.26	1.26	NA	NA	0.01	XXX
76516	26	A	Echo exam of eye	0.54	0.36	0.31	0.36	0.31	0.01	XXX
76519		A	Echo exam of eye	0.54	1.78	1.72	NA	NA	0.04	XXX

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76519	TC	A	Echo exam of eye	0.00	1.40	1.40	NA	NA	0.01	XXX
76519	26	A	Echo exam of eye	0.54	0.38	0.32	0.38	0.32	0.03	XXX
76529		A	Echo exam of eye	0.57	1.64	1.57	NA	NA	0.04	XXX
76529	TC	A	Echo exam of eye	0.00	1.24	1.23	NA	NA	0.01	XXX
76529	26	A	Echo exam of eye	0.57	0.40	0.34	0.40	0.34	0.03	XXX
76536		A	Us exam of head and neck	0.56	2.89	2.91	NA	NA	0.04	XXX
76536	TC	A	Us exam of head and neck	0.00	2.67	2.68	NA	NA	0.01	XXX
76536	26	A	Us exam of head and neck	0.56	0.22	0.23	0.22	0.23	0.03	XXX
76604		A	Us exam chest	0.55	1.91	2.02	NA	NA	0.04	XXX
76604	TC	A	Us exam chest	0.00	1.71	1.80	NA	NA	0.01	XXX
76604	26	A	Us exam chest	0.55	0.20	0.22	0.20	0.22	0.03	XXX
76645		A	Us exam breast(s)	0.54	2.21	2.26	NA	NA	0.05	XXX
76645	TC	A	Us exam breast(s)	0.00	2.01	2.04	NA	NA	0.01	XXX
76645	26	A	Us exam breast(s)	0.54	0.20	0.22	0.20	0.22	0.04	XXX
76700		A	Us exam abdom complete	0.81	3.17	3.31	NA	NA	0.05	XXX
76700	TC	A	Us exam abdom complete	0.00	2.86	2.98	NA	NA	0.01	XXX
76700	26	A	Us exam abdom complete	0.81	0.31	0.33	0.31	0.33	0.04	XXX
76705		A	Echo exam of abdomen	0.59	2.44	2.55	NA	NA	0.04	XXX
76705	TC	A	Echo exam of abdomen	0.00	2.22	2.30	NA	NA	0.01	XXX
76705	26	A	Echo exam of abdomen	0.59	0.22	0.25	0.22	0.25	0.03	XXX
76770		A	Us exam abdo back wall comp	0.74	3.00	3.18	NA	NA	0.05	XXX
76770	TC	A	Us exam abdo back wall comp	0.00	2.72	2.87	NA	NA	0.01	XXX
76770	26	A	Us exam abdo back wall comp	0.74	0.28	0.31	0.28	0.31	0.04	XXX
76775		A	Us exam abdo back wall lim	0.58	2.46	2.69	NA	NA	0.04	XXX
76775	TC	A	Us exam abdo back wall lim	0.00	2.24	2.44	NA	NA	0.01	XXX
76775	26	A	Us exam abdo back wall lim	0.58	0.22	0.25	0.22	0.25	0.03	XXX
76776		A	Us exam k transpl w/doppler	0.76	3.55	3.68	NA	NA	0.05	XXX
76776	TC	A	Us exam k transpl w/doppler	0.00	3.27	3.37	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76776	26	A	Us exam k transpl w/doppler	0.76	0.28	0.31	0.28	0.31	0.04	XXX
76800		A	Us exam spinal canal	1.13	2.92	2.77	NA	NA	0.05	XXX
76800	TC	A	Us exam spinal canal	0.00	2.42	2.32	NA	NA	0.01	XXX
76800	26	A	Us exam spinal canal	1.13	0.50	0.45	0.50	0.45	0.04	XXX
76801		A	Ob us < 14 wks single fetus	0.99	2.63	2.83	NA	NA	0.04	XXX
76801	TC	A	Ob us < 14 wks single fetus	0.00	2.22	2.41	NA	NA	0.01	XXX
76801	26	A	Ob us < 14 wks single fetus	0.99	0.41	0.42	0.41	0.42	0.03	XXX
76802		A	Ob us < 14 wks addl fetus	0.83	1.09	1.20	NA	NA	0.04	ZZZ
76802	TC	A	Ob us < 14 wks addl fetus	0.00	0.74	0.85	NA	NA	0.01	ZZZ
76802	26	A	Ob us < 14 wks addl fetus	0.83	0.35	0.35	0.35	0.35	0.03	ZZZ
76805		A	Ob us >/= 14 wks sngl fetus	0.99	3.24	3.39	NA	NA	0.04	XXX
76805	TC	A	Ob us >/= 14 wks sngl fetus	0.00	2.82	2.97	NA	NA	0.01	XXX
76805	26	A	Ob us >/= 14 wks sngl fetus	0.99	0.42	0.42	0.42	0.42	0.03	XXX
76810		A	Ob us >/= 14 wks addl fetus	0.98	1.81	1.88	NA	NA	0.04	ZZZ
76810	TC	A	Ob us >/= 14 wks addl fetus	0.00	1.39	1.46	NA	NA	0.01	ZZZ
76810	26	A	Ob us >/= 14 wks addl fetus	0.98	0.42	0.42	0.42	0.42	0.03	ZZZ
76811		A	Ob us detailed sngl fetus	1.90	3.45	3.76	NA	NA	0.06	XXX
76811	TC	A	Ob us detailed sngl fetus	0.00	2.58	2.95	NA	NA	0.01	XXX
76811	26	A	Ob us detailed sngl fetus	1.90	0.87	0.81	0.87	0.81	0.05	XXX
76812		A	Ob us detailed addl fetus	1.78	4.34	4.24	NA	NA	0.06	ZZZ
76812	TC	A	Ob us detailed addl fetus	0.00	3.53	3.48	NA	NA	0.01	ZZZ
76812	26	A	Ob us detailed addl fetus	1.78	0.81	0.76	0.81	0.76	0.05	ZZZ
76813		A	Ob us nuchal meas 1 gest	1.18	2.41	2.53	NA	NA	0.05	XXX
76813	TC	A	Ob us nuchal meas 1 gest	0.00	1.87	2.04	NA	NA	0.01	XXX
76813	26	A	Ob us nuchal meas 1 gest	1.18	0.54	0.49	0.54	0.49	0.04	XXX
76814		A	Ob us nuchal meas add-on	0.99	1.35	1.38	NA	NA	0.04	XXX
76814	TC	A	Ob us nuchal meas add-on	0.00	0.89	0.96	NA	NA	0.01	XXX
76814	26	A	Ob us nuchal meas add-on	0.99	0.46	0.42	0.46	0.42	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76815		A	Ob us limited fetus(s)	0.65	1.93	2.04	NA	NA	0.02	XXX
76815	TC	A	Ob us limited fetus(s)	0.00	1.66	1.77	NA	NA	0.01	XXX
76815	26	A	Ob us limited fetus(s)	0.65	0.27	0.27	0.27	0.27	0.01	XXX
76816		A	Ob us follow-up per fetus	0.85	2.56	2.58	NA	NA	0.04	XXX
76816	TC	A	Ob us follow-up per fetus	0.00	2.18	2.22	NA	NA	0.01	XXX
76816	26	A	Ob us follow-up per fetus	0.85	0.38	0.36	0.38	0.36	0.03	XXX
76817		A	Transvaginal us obstetric	0.75	2.16	2.27	NA	NA	0.04	XXX
76817	TC	A	Transvaginal us obstetric	0.00	1.84	1.96	NA	NA	0.01	XXX
76817	26	A	Transvaginal us obstetric	0.75	0.32	0.31	0.32	0.31	0.03	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.46	2.54	NA	NA	0.04	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.98	2.09	NA	NA	0.01	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.48	0.45	0.48	0.45	0.03	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.77	1.92	NA	NA	0.04	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.43	1.59	NA	NA	0.01	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.34	0.33	0.34	0.33	0.03	XXX
76820		A	Umbilical artery echo	0.50	0.67	0.86	NA	NA	0.02	XXX
76820	TC	A	Umbilical artery echo	0.00	0.44	0.65	NA	NA	0.01	XXX
76820	26	A	Umbilical artery echo	0.50	0.23	0.21	0.23	0.21	0.01	XXX
76821		A	Middle cerebral artery echo	0.70	2.03	2.15	NA	NA	0.04	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.71	1.85	NA	NA	0.01	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.32	0.30	0.32	0.30	0.03	XXX
76825		A	Echo exam of fetal heart	1.67	4.66	4.71	NA	NA	0.05	XXX
76825	TC	A	Echo exam of fetal heart	0.00	3.93	4.01	NA	NA	0.01	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.73	0.70	0.73	0.70	0.04	XXX
76826		A	Echo exam of fetal heart	0.83	2.92	2.84	NA	NA	0.04	XXX
76826	TC	A	Echo exam of fetal heart	0.00	2.56	2.50	NA	NA	0.01	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.36	0.34	0.36	0.34	0.03	XXX
76827		A	Echo exam of fetal heart	0.58	1.17	1.37	NA	NA	0.02	XXX

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76827	TC	A	Echo exam of fetal heart	0.00	0.92	1.13	NA	NA	0.01	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.25	0.24	0.25	0.24	0.01	XXX
76828		A	Echo exam of fetal heart	0.56	0.73	0.87	NA	NA	0.02	XXX
76828	TC	A	Echo exam of fetal heart	0.00	0.48	0.63	NA	NA	0.01	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.25	0.24	0.25	0.24	0.01	XXX
76830		A	Transvaginal us non-ob	0.69	2.90	2.98	NA	NA	0.04	XXX
76830	TC	A	Transvaginal us non-ob	0.00	2.62	2.69	NA	NA	0.01	XXX
76830	26	A	Transvaginal us non-ob	0.69	0.28	0.29	0.28	0.29	0.03	XXX
76831		A	Echo exam uterus	0.72	2.91	2.96	NA	NA	0.04	XXX
76831	TC	A	Echo exam uterus	0.00	2.58	2.66	NA	NA	0.01	XXX
76831	26	A	Echo exam uterus	0.72	0.33	0.30	0.33	0.30	0.03	XXX
76856		A	Us exam pelvic complete	0.69	2.86	2.97	NA	NA	0.04	XXX
76856	TC	A	Us exam pelvic complete	0.00	2.59	2.68	NA	NA	0.01	XXX
76856	26	A	Us exam pelvic complete	0.69	0.27	0.29	0.27	0.29	0.03	XXX
76857		A	Us exam pelvic limited	0.38	2.34	2.59	NA	NA	0.04	XXX
76857	TC	A	Us exam pelvic limited	0.00	2.19	2.42	NA	NA	0.01	XXX
76857	26	A	Us exam pelvic limited	0.38	0.15	0.17	0.15	0.17	0.03	XXX
76870		A	Us exam scrotum	0.64	2.86	2.99	NA	NA	0.05	XXX
76870	TC	A	Us exam scrotum	0.00	2.62	2.72	NA	NA	0.01	XXX
76870	26	A	Us exam scrotum	0.64	0.24	0.27	0.24	0.27	0.04	XXX
76872		A	Us transrectal	0.69	3.06	3.43	NA	NA	0.05	XXX
76872	TC	A	Us transrectal	0.00	2.79	3.12	NA	NA	0.01	XXX
76872	26	A	Us transrectal	0.69	0.27	0.31	0.27	0.31	0.04	XXX
76873		A	Echograp trans r pros study	1.55	3.42	3.65	NA	NA	0.09	XXX
76873	TC	A	Echograp trans r pros study	0.00	2.76	2.98	NA	NA	0.01	XXX
76873	26	A	Echograp trans r pros study	1.55	0.66	0.67	0.66	0.67	0.08	XXX
76881		A	Us xtr non-vasc complete	0.59	2.76	2.76	NA	NA	0.05	XXX
76881	TC	A	Us xtr non-vasc complete	0.00	2.54	2.54	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76881	26	A	Us xtr non-vasc complete	0.59	0.22	0.22	0.22	0.22	0.04	XXX
76882		A	Us xtr non-vasc lmtd	0.41	0.44	0.44	NA	NA	0.04	XXX
76882	TC	A	Us xtr non-vasc lmtd	0.00	0.29	0.29	NA	NA	0.01	XXX
76882	26	A	Us xtr non-vasc lmtd	0.41	0.15	0.15	0.15	0.15	0.03	XXX
76885		A	Us exam infant hips dynamic	0.74	3.50	3.52	NA	NA	0.05	XXX
76885	TC	A	Us exam infant hips dynamic	0.00	3.21	3.21	NA	NA	0.01	XXX
76885	26	A	Us exam infant hips dynamic	0.74	0.29	0.31	0.29	0.31	0.04	XXX
76886		A	Us exam infant hips static	0.62	3.04	2.78	NA	NA	0.02	XXX
76886	TC	A	Us exam infant hips static	0.00	2.74	2.50	NA	NA	0.01	XXX
76886	26	A	Us exam infant hips static	0.62	0.30	0.28	0.30	0.28	0.01	XXX
76930		A	Echo guide cardiocentesis	0.67	1.64	1.99	NA	NA	0.02	XXX
76930	TC	A	Echo guide cardiocentesis	0.00	1.38	1.67	NA	NA	0.01	XXX
76930	26	A	Echo guide cardiocentesis	0.67	0.26	0.32	0.26	0.32	0.01	XXX
76932		C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	TC	C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.26	0.33	0.26	0.33	0.04	XXX
76936		A	Echo guide for artery repair	1.99	6.29	6.98	NA	NA	0.24	XXX
76936	TC	A	Echo guide for artery repair	0.00	5.58	6.18	NA	NA	0.01	XXX
76936	26	A	Echo guide for artery repair	1.99	0.71	0.80	0.71	0.80	0.23	XXX
76937		A	Us guide vascular access	0.30	0.67	0.70	NA	NA	0.04	ZZZ
76937	TC	A	Us guide vascular access	0.00	0.56	0.58	NA	NA	0.01	ZZZ
76937	26	A	Us guide vascular access	0.30	0.11	0.12	0.11	0.12	0.03	ZZZ
76940		C	Us guide tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
76940	TC	C	Us guide tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
76940	26	A	Us guide tissue ablation	2.00	0.80	0.82	0.80	0.82	0.29	XXX
76941		C	Echo guide for transfusion	0.00	0.00	0.00	NA	NA	0.00	XXX
76941	TC	C	Echo guide for transfusion	0.00	0.00	0.00	NA	NA	0.00	XXX
76941	26	A	Echo guide for transfusion	1.34	0.62	0.58	0.62	0.58	0.11	XXX

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76942		A	Echo guide for biopsy	0.67	4.98	5.13	NA	NA	0.05	XXX
76942	TC	A	Echo guide for biopsy	0.00	4.72	4.85	NA	NA	0.01	XXX
76942	26	A	Echo guide for biopsy	0.67	0.26	0.28	0.26	0.28	0.04	XXX
76945		C	Echo guide villus sampling	0.00	0.00	0.00	NA	NA	0.00	XXX
76945	TC	C	Echo guide villus sampling	0.00	0.00	0.00	NA	NA	0.00	XXX
76945	26	A	Echo guide villus sampling	0.67	0.31	0.29	0.31	0.29	0.04	XXX
76946		A	Echo guide for amniocentesis	0.38	0.52	0.72	NA	NA	0.02	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	0.35	0.56	NA	NA	0.01	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.17	0.16	0.17	0.16	0.01	XXX
76948		A	Echo guide ova aspiration	0.38	0.54	0.72	NA	NA	0.04	XXX
76948	TC	A	Echo guide ova aspiration	0.00	0.36	0.56	NA	NA	0.01	XXX
76948	26	A	Echo guide ova aspiration	0.38	0.18	0.16	0.18	0.16	0.03	XXX
76950		A	Echo guidance radiotherapy	0.58	1.29	1.43	NA	NA	0.04	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	1.03	1.18	NA	NA	0.01	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.26	0.25	0.26	0.25	0.03	XXX
76965		A	Echo guidance radiotherapy	1.34	1.20	2.07	NA	NA	0.09	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	0.64	1.48	NA	NA	0.01	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.56	0.59	0.56	0.59	0.08	XXX
76970		A	Ultrasound exam follow-up	0.40	2.57	2.40	NA	NA	0.05	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	2.40	2.24	NA	NA	0.01	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.17	0.16	0.17	0.16	0.04	XXX
76975		C	Gi endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX
76975	TC	C	Gi endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX
76975	26	A	Gi endoscopic ultrasound	0.81	0.40	0.39	0.40	0.39	0.08	XXX
76977		A	Us bone density measure	0.05	0.14	0.24	NA	NA	0.02	XXX
76977	TC	A	Us bone density measure	0.00	0.12	0.22	NA	NA	0.01	XXX
76977	26	A	Us bone density measure	0.05	0.02	0.02	0.02	0.02	0.01	XXX
76998		C	Us guide intraop	0.00	0.00	0.00	NA	NA	0.00	XXX

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76998	TC	C	Us guide intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
76998	26	A	Us guide intraop	1.20	0.47	0.47	0.47	0.47	0.26	XXX
76999		C	Echo examination procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76999	TC	C	Echo examination procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77001		A	Fluoroguide for vein device	0.38	3.00	2.97	NA	NA	0.04	ZZZ
77001	TC	A	Fluoroguide for vein device	0.00	2.86	2.81	NA	NA	0.01	ZZZ
77001	26	A	Fluoroguide for vein device	0.38	0.14	0.16	0.14	0.16	0.03	ZZZ
77002		A	Needle localization by xray	0.54	1.66	1.65	NA	NA	0.04	XXX
77002	TC	A	Needle localization by xray	0.00	1.41	1.41	NA	NA	0.01	XXX
77002	26	A	Needle localization by xray	0.54	0.25	0.24	0.25	0.24	0.03	XXX
77003		A	Fluoroguide for spine inject	0.60	1.25	1.20	NA	NA	0.04	XXX
77003	TC	A	Fluoroguide for spine inject	0.00	0.96	0.96	NA	NA	0.01	XXX
77003	26	A	Fluoroguide for spine inject	0.60	0.29	0.24	0.29	0.24	0.03	XXX
77011		A	Ct scan for localization	1.21	5.40	13.03	NA	NA	0.05	XXX
77011	TC	A	Ct scan for localization	0.00	4.85	12.49	NA	NA	0.01	XXX
77011	26	A	Ct scan for localization	1.21	0.55	0.54	0.55	0.54	0.04	XXX
77012		A	Ct scan for needle biopsy	1.16	2.47	3.63	NA	NA	0.05	XXX
77012	TC	A	Ct scan for needle biopsy	0.00	2.04	3.14	NA	NA	0.01	XXX
77012	26	A	Ct scan for needle biopsy	1.16	0.43	0.49	0.43	0.49	0.04	XXX
77013		C	Ct guide for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77013	TC	C	Ct guide for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77013	26	A	Ct guide for tissue ablation	3.99	1.46	1.66	1.46	1.66	0.37	XXX
77014		A	Ct scan for therapy guide	0.85	4.55	4.78	NA	NA	0.05	XXX
77014	TC	A	Ct scan for therapy guide	0.00	4.17	4.41	NA	NA	0.01	XXX
77014	26	A	Ct scan for therapy guide	0.85	0.38	0.37	0.38	0.37	0.04	XXX
77021		A	Mr guidance for needle place	1.50	9.82	11.20	NA	NA	0.13	XXX
77021	TC	A	Mr guidance for needle place	0.00	9.26	10.58	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77021	26	A	Mr guidance for needle place	1.50	0.56	0.62	0.56	0.62	0.12	XXX
77022		C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	TC	C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	26	A	Mri for tissue ablation	4.24	1.65	1.74	1.65	1.74	0.38	XXX
77031		A	Stereotact guide for brst bx	1.59	2.02	3.05	NA	NA	0.13	XXX
77031	TC	A	Stereotact guide for brst bx	0.00	1.41	2.40	NA	NA	0.01	XXX
77031	26	A	Stereotact guide for brst bx	1.59	0.61	0.65	0.61	0.65	0.12	XXX
77032		A	Guidance for needle breast	0.56	0.87	1.05	NA	NA	0.04	XXX
77032	TC	A	Guidance for needle breast	0.00	0.66	0.82	NA	NA	0.01	XXX
77032	26	A	Guidance for needle breast	0.56	0.21	0.23	0.21	0.23	0.03	XXX
77051		A	Computer dx mammogram add-on	0.06	0.20	0.26	NA	NA	0.02	ZZZ
77051	TC	A	Computer dx mammogram add-on	0.00	0.18	0.24	NA	NA	0.01	ZZZ
77051	26	A	Computer dx mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ
77052		A	Comp screen mammogram add-on	0.06	0.20	0.26	NA	NA	0.02	ZZZ
77052	TC	A	Comp screen mammogram add-on	0.00	0.18	0.24	NA	NA	0.01	ZZZ
77052	26	A	Comp screen mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ
77053		A	X-ray of mammary duct	0.36	1.27	1.62	NA	NA	0.02	XXX
77053	TC	A	X-ray of mammary duct	0.00	1.14	1.47	NA	NA	0.01	XXX
77053	26	A	X-ray of mammary duct	0.36	0.13	0.15	0.13	0.15	0.01	XXX
77054		A	X-ray of mammary ducts	0.45	1.75	2.23	NA	NA	0.04	XXX
77054	TC	A	X-ray of mammary ducts	0.00	1.58	2.04	NA	NA	0.01	XXX
77054	26	A	X-ray of mammary ducts	0.45	0.17	0.19	0.17	0.19	0.03	XXX
77055		A	Mammogram one breast	0.70	1.70	1.81	NA	NA	0.05	XXX
77055	TC	A	Mammogram one breast	0.00	1.44	1.52	NA	NA	0.01	XXX
77055	26	A	Mammogram one breast	0.70	0.26	0.29	0.26	0.29	0.04	XXX
77056		A	Mammogram both breasts	0.87	2.23	2.34	NA	NA	0.06	XXX
77056	TC	A	Mammogram both breasts	0.00	1.90	1.98	NA	NA	0.01	XXX
77056	26	A	Mammogram both breasts	0.87	0.33	0.36	0.33	0.36	0.05	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77057		A	Mammogram screening	0.70	1.51	1.65	NA	NA	0.05	XXX
77057	TC	A	Mammogram screening	0.00	1.24	1.36	NA	NA	0.01	XXX
77057	26	A	Mammogram screening	0.70	0.27	0.29	0.27	0.29	0.04	XXX
77058		A	Mri one breast	1.63	16.10	20.67	NA	NA	0.11	XXX
77058	TC	A	Mri one breast	0.00	15.49	20.00	NA	NA	0.01	XXX
77058	26	A	Mri one breast	1.63	0.61	0.67	0.61	0.67	0.10	XXX
77059		A	Mri both breasts	1.63	15.99	21.52	NA	NA	0.11	XXX
77059	TC	A	Mri both breasts	0.00	15.39	20.85	NA	NA	0.01	XXX
77059	26	A	Mri both breasts	1.63	0.60	0.67	0.60	0.67	0.10	XXX
77071		A	X-ray stress view	0.41	1.03	0.90	1.03	0.90	0.07	XXX
77072		A	X-rays for bone age	0.19	0.47	0.49	NA	NA	0.02	XXX
77072	TC	A	X-rays for bone age	0.00	0.39	0.41	NA	NA	0.01	XXX
77072	26	A	X-rays for bone age	0.19	0.08	0.08	0.08	0.08	0.01	XXX
77073		A	X-rays bone length studies	0.27	0.82	0.84	NA	NA	0.05	XXX
77073	TC	A	X-rays bone length studies	0.00	0.68	0.71	NA	NA	0.01	XXX
77073	26	A	X-rays bone length studies	0.27	0.14	0.13	0.14	0.13	0.04	XXX
77074		A	X-rays bone survey limited	0.45	1.49	1.59	NA	NA	0.04	XXX
77074	TC	A	X-rays bone survey limited	0.00	1.32	1.40	NA	NA	0.01	XXX
77074	26	A	X-rays bone survey limited	0.45	0.17	0.19	0.17	0.19	0.03	XXX
77075		A	X-rays bone survey complete	0.54	2.37	2.48	NA	NA	0.04	XXX
77075	TC	A	X-rays bone survey complete	0.00	2.16	2.25	NA	NA	0.01	XXX
77075	26	A	X-rays bone survey complete	0.54	0.21	0.23	0.21	0.23	0.03	XXX
77076		A	X-rays bone survey infant	0.70	2.26	2.22	NA	NA	0.05	XXX
77076	TC	A	X-rays bone survey infant	0.00	1.99	1.95	NA	NA	0.01	XXX
77076	26	A	X-rays bone survey infant	0.70	0.27	0.27	0.27	0.27	0.04	XXX
77077		A	Joint survey single view	0.31	0.82	0.89	NA	NA	0.05	XXX
77077	TC	A	Joint survey single view	0.00	0.67	0.75	NA	NA	0.01	XXX
77077	26	A	Joint survey single view	0.31	0.15	0.14	0.15	0.14	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77078		A	Ct bone density axial	0.25	3.55	4.40	NA	NA	0.02	XXX
77078	TC	A	Ct bone density axial	0.00	3.45	4.30	NA	NA	0.01	XXX
77078	26	A	Ct bone density axial	0.25	0.10	0.10	0.10	0.10	0.01	XXX
77079		A	Ct bone density peripheral	0.22	0.92	1.26	NA	NA	0.02	XXX
77079	TC	A	Ct bone density peripheral	0.00	0.82	1.17	NA	NA	0.01	XXX
77079	26	A	Ct bone density peripheral	0.22	0.10	0.09	0.10	0.09	0.01	XXX
77080		A	Dxa bone density axial	0.31	3.32	3.32	NA	NA	0.19	XXX
77080	TC	A	Dxa bone density axial	0.00	3.22	3.22	NA	NA	0.18	XXX
77080	26	A	Dxa bone density axial	0.31	0.10	0.10	0.10	0.10	0.01	XXX
77081		A	Dxa bone density/peripheral	0.22	0.61	0.61	NA	NA	0.02	XXX
77081	TC	A	Dxa bone density/peripheral	0.00	0.55	0.55	NA	NA	0.01	XXX
77081	26	A	Dxa bone density/peripheral	0.22	0.06	0.06	0.06	0.06	0.01	XXX
77082		A	Dxa bone density vert fx	0.18	0.84	0.84	NA	NA	0.06	XXX
77082	TC	A	Dxa bone density vert fx	0.00	0.78	0.78	NA	NA	0.05	XXX
77082	26	A	Dxa bone density vert fx	0.18	0.06	0.06	0.06	0.06	0.01	XXX
77083		A	Radiographic absorptiometry	0.20	0.47	0.53	NA	NA	0.02	XXX
77083	TC	A	Radiographic absorptiometry	0.00	0.38	0.45	NA	NA	0.01	XXX
77083	26	A	Radiographic absorptiometry	0.20	0.09	0.08	0.09	0.08	0.01	XXX
77084		A	Magnetic image bone marrow	1.60	11.03	13.94	NA	NA	0.11	XXX
77084	TC	A	Magnetic image bone marrow	0.00	10.42	13.27	NA	NA	0.01	XXX
77084	26	A	Magnetic image bone marrow	1.60	0.61	0.67	0.61	0.67	0.10	XXX
77261		A	Radiation therapy planning	1.39	0.67	0.65	0.67	0.65	0.10	XXX
77262		A	Radiation therapy planning	2.11	0.95	0.93	0.95	0.93	0.18	XXX
77263		A	Radiation therapy planning	3.14	1.40	1.37	1.40	1.37	0.26	XXX
77280		A	Set radiation therapy field	0.70	4.57	4.85	NA	NA	0.04	XXX
77280	TC	A	Set radiation therapy field	0.00	4.26	4.55	NA	NA	0.01	XXX
77280	26	A	Set radiation therapy field	0.70	0.31	0.30	0.31	0.30	0.03	XXX
77285		A	Set radiation therapy field	1.05	8.31	8.69	NA	NA	0.06	XXX

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77285	TC	A	Set radiation therapy field	0.00	7.84	8.24	NA	NA	0.01	XXX
77285	26	A	Set radiation therapy field	1.05	0.47	0.45	0.47	0.45	0.05	XXX
77290		A	Set radiation therapy field	1.56	13.80	14.04	NA	NA	0.08	XXX
77290	TC	A	Set radiation therapy field	0.00	13.10	13.37	NA	NA	0.01	XXX
77290	26	A	Set radiation therapy field	1.56	0.70	0.67	0.70	0.67	0.07	XXX
77295		A	Set radiation therapy field	4.56	8.01	11.86	NA	NA	0.28	XXX
77295	TC	A	Set radiation therapy field	0.00	5.97	9.89	NA	NA	0.04	XXX
77295	26	A	Set radiation therapy field	4.56	2.04	1.97	2.04	1.97	0.24	XXX
77299		C	Radiation therapy planning	0.00	0.00	0.00	NA	NA	0.00	XXX
77299	TC	C	Radiation therapy planning	0.00	0.00	0.00	NA	NA	0.00	XXX
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77300		A	Radiation therapy dose plan	0.62	1.27	1.41	NA	NA	0.04	XXX
77300	TC	A	Radiation therapy dose plan	0.00	0.99	1.14	NA	NA	0.01	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.28	0.27	0.28	0.27	0.03	XXX
77301		A	Radiotherapy dose plan imrt	7.99	45.27	53.19	NA	NA	0.63	XXX
77301	TC	A	Radiotherapy dose plan imrt	0.00	41.70	49.73	NA	NA	0.22	XXX
77301	26	A	Radiotherapy dose plan imrt	7.99	3.57	3.46	3.57	3.46	0.41	XXX
77305		A	Teletx isodose plan simple	0.70	0.98	1.22	NA	NA	0.04	XXX
77305	TC	A	Teletx isodose plan simple	0.00	0.67	0.92	NA	NA	0.01	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.31	0.30	0.31	0.30	0.03	XXX
77310		A	Teletx isodose plan intermed	1.05	1.38	1.68	NA	NA	0.06	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	0.91	1.22	NA	NA	0.01	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.47	0.46	0.47	0.46	0.05	XXX
77315		A	Teletx isodose plan complex	1.56	2.29	2.59	NA	NA	0.08	XXX
77315	TC	A	Teletx isodose plan complex	0.00	1.59	1.91	NA	NA	0.01	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.70	0.68	0.70	0.68	0.07	XXX
77321		A	Special teletx port plan	0.95	1.63	2.17	NA	NA	0.05	XXX
77321	TC	A	Special teletx port plan	0.00	1.21	1.76	NA	NA	0.01	XXX

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77321	26	A	Special teletx port plan	0.95	0.42	0.41	0.42	0.41	0.04	XXX
77326		A	Brachytx isodose calc simp	0.93	3.11	3.30	NA	NA	0.07	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.69	2.90	NA	NA	0.03	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.42	0.40	0.42	0.40	0.04	XXX
77327		A	Brachytx isodose calc interm	1.39	4.28	4.59	NA	NA	0.10	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.66	3.99	NA	NA	0.03	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.62	0.60	0.62	0.60	0.07	XXX
77328		A	Brachytx isodose plan compl	2.09	5.49	5.98	NA	NA	0.14	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.56	5.08	NA	NA	0.04	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.93	0.90	0.93	0.90	0.10	XXX
77331		A	Special radiation dosimetry	0.87	0.91	0.95	NA	NA	0.05	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.52	0.57	NA	NA	0.01	XXX
77331	26	A	Special radiation dosimetry	0.87	0.39	0.38	0.39	0.38	0.04	XXX
77332		A	Radiation treatment aid(s)	0.54	1.63	1.75	NA	NA	0.04	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.39	1.52	NA	NA	0.01	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.24	0.23	0.24	0.23	0.03	XXX
77333		A	Radiation treatment aid(s)	0.84	0.62	0.89	NA	NA	0.05	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	0.24	0.52	NA	NA	0.01	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.38	0.37	0.38	0.37	0.04	XXX
77334		A	Radiation treatment aid(s)	1.24	2.89	3.25	NA	NA	0.06	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	2.34	2.71	NA	NA	0.01	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.55	0.54	0.55	0.54	0.05	XXX
77336		A	Radiation physics consult	0.00	1.14	1.53	NA	NA	0.01	XXX
77338		A	Design mlc device for imrt	4.29	9.65	9.65	NA	NA	0.27	XXX
77338	TC	A	Design mlc device for imrt	0.00	7.73	7.73	NA	NA	0.04	XXX
77338	26	A	Design mlc device for imrt	4.29	1.92	1.92	1.92	1.92	0.23	XXX
77370		A	Radiation physics consult	0.00	3.04	3.41	NA	NA	0.04	XXX
77371		C	Srs multisource	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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77372		A	Srs linear based	0.00	23.02	25.18	NA	NA	0.05	XXX
77373		A	Sbrt delivery	0.00	43.31	47.02	NA	NA	0.07	XXX
77399		C	External radiation dosimetry	0.00	0.00	0.00	NA	NA	0.00	XXX
77399	TC	C	External radiation dosimetry	0.00	0.00	0.00	NA	NA	0.00	XXX
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77401		A	Radiation treatment delivery	0.00	0.53	0.75	NA	NA	0.01	XXX
77402		A	Radiation treatment delivery	0.00	5.89	5.20	NA	NA	0.01	XXX
77403		A	Radiation treatment delivery	0.00	3.82	3.87	NA	NA	0.01	XXX
77404		A	Radiation treatment delivery	0.00	4.27	4.31	NA	NA	0.01	XXX
77406		A	Radiation treatment delivery	0.00	4.32	4.35	NA	NA	0.01	XXX
77407		A	Radiation treatment delivery	0.00	8.00	7.55	NA	NA	0.01	XXX
77408		A	Radiation treatment delivery	0.00	5.26	5.28	NA	NA	0.01	XXX
77409		A	Radiation treatment delivery	0.00	5.89	5.87	NA	NA	0.01	XXX
77411		A	Radiation treatment delivery	0.00	5.86	5.84	NA	NA	0.01	XXX
77412		A	Radiation treatment delivery	0.00	6.92	6.89	NA	NA	0.01	XXX
77413		A	Radiation treatment delivery	0.00	6.96	6.93	NA	NA	0.01	XXX
77414		A	Radiation treatment delivery	0.00	7.84	7.76	NA	NA	0.01	XXX
77416		A	Radiation treatment delivery	0.00	7.89	7.80	NA	NA	0.01	XXX
77417		A	Radiology port film(s)	0.00	0.37	0.43	NA	NA	0.01	XXX
77418		A	Radiation tx delivery imrt	0.00	13.38	15.38	NA	NA	0.01	XXX
77421		A	Stereoscopic x-ray guidance	0.39	2.46	2.84	NA	NA	0.02	XXX
77421	TC	A	Stereoscopic x-ray guidance	0.00	2.29	2.67	NA	NA	0.01	XXX
77421	26	A	Stereoscopic x-ray guidance	0.39	0.17	0.17	0.17	0.17	0.01	XXX
77422		A	Neutron beam tx simple	0.00	5.35	5.89	NA	NA	0.01	XXX
77423		A	Neutron beam tx complex	0.00	7.56	7.49	NA	NA	0.01	XXX
77427		A	Radiation tx management x5	2.92	1.52	1.59	1.52	1.59	0.23	XXX
77431		A	Radiation therapy management	1.81	0.99	0.97	0.99	0.97	0.14	XXX
77432		A	Stereotactic radiation trmt	7.92	3.57	3.49	3.57	3.49	0.65	XXX

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77435		A	Sbrt management	13.00	5.96	5.91	5.96	5.96	1.07	XXX
77470		A	Special radiation treatment	2.09	2.17	3.77	NA	NA	0.11	XXX
77470	TC	A	Special radiation treatment	0.00	1.24	2.87	NA	NA	0.01	XXX
77470	26	A	Special radiation treatment	2.09	0.93	0.90	0.93	0.90	0.10	XXX
77499		C	Radiation therapy management	0.00	0.00	0.00	NA	NA	0.00	XXX
77499	TC	C	Radiation therapy management	0.00	0.00	0.00	NA	NA	0.00	XXX
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77520		C	Proton trmt simple w/o comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77522		C	Proton trmt simple w/comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77523		C	Proton trmt intermediate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77525		C	Proton treatment complex	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77600		R	Hyperthermia treatment	1.56	10.46	10.41	NA	NA	0.10	XXX
77600	TC	R	Hyperthermia treatment	0.00	9.76	9.73	NA	NA	0.03	XXX
77600	26	R	Hyperthermia treatment	1.56	0.70	0.68	0.70	0.68	0.07	XXX
77605		R	Hyperthermia treatment	2.09	30.44	25.03	NA	NA	0.41	XXX
77605	TC	R	Hyperthermia treatment	0.00	29.53	24.20	NA	NA	0.03	XXX
77605	26	R	Hyperthermia treatment	2.09	0.91	0.83	0.91	0.83	0.38	XXX
77610		R	Hyperthermia treatment	1.56	27.92	23.41	NA	NA	0.10	XXX
77610	TC	R	Hyperthermia treatment	0.00	27.24	22.78	NA	NA	0.03	XXX
77610	26	R	Hyperthermia treatment	1.56	0.68	0.63	0.68	0.63	0.07	XXX
77615		R	Hyperthermia treatment	2.09	26.45	26.55	NA	NA	0.17	XXX
77615	TC	R	Hyperthermia treatment	0.00	25.51	25.65	NA	NA	0.07	XXX
77615	26	R	Hyperthermia treatment	2.09	0.94	0.90	0.94	0.90	0.10	XXX
77620		R	Hyperthermia treatment	1.56	14.24	12.57	NA	NA	0.08	XXX
77620	TC	R	Hyperthermia treatment	0.00	13.56	11.95	NA	NA	0.04	XXX
77620	26	R	Hyperthermia treatment	1.56	0.68	0.62	0.68	0.62	0.04	XXX
77750		A	Infuse radioactive materials	5.00	5.17	5.13	NA	NA	0.29	090
77750	TC	A	Infuse radioactive materials	0.00	2.94	2.98	NA	NA	0.03	090

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77750	26	A	Infuse radioactive materials	5.00	2.23	2.15	2.23	2.15	0.26	090
77761		A	Apply intrcav radiat simple	3.85	6.72	6.80	NA	NA	0.24	090
77761	TC	A	Apply intrcav radiat simple	0.00	5.02	5.17	NA	NA	0.04	090
77761	26	A	Apply intrcav radiat simple	3.85	1.70	1.63	1.70	1.63	0.20	090
77762		A	Apply intrcav radiat interm	5.76	8.35	8.52	NA	NA	0.35	090
77762	TC	A	Apply intrcav radiat interm	0.00	5.80	6.05	NA	NA	0.05	090
77762	26	A	Apply intrcav radiat interm	5.76	2.55	2.47	2.55	2.47	0.30	090
77763		A	Apply intrcav radiat compl	8.66	11.35	11.54	NA	NA	0.50	090
77763	TC	A	Apply intrcav radiat compl	0.00	7.52	7.82	NA	NA	0.07	090
77763	26	A	Apply intrcav radiat compl	8.66	3.83	3.72	3.83	3.72	0.43	090
77776		A	Apply interstit radiat simpl	4.70	7.17	7.42	NA	NA	0.36	090
77776	TC	A	Apply interstit radiat simpl	0.00	5.05	5.40	NA	NA	0.05	090
77776	26	A	Apply interstit radiat simpl	4.70	2.12	2.02	2.12	2.02	0.31	090
77777		A	Apply interstit radiat inter	7.52	8.83	9.22	NA	NA	0.54	090
77777	TC	A	Apply interstit radiat inter	0.00	5.48	5.90	NA	NA	0.05	090
77777	26	A	Apply interstit radiat inter	7.52	3.35	3.32	3.35	3.32	0.49	090
77778		A	Apply interstit radiat compl	11.32	12.62	12.88	NA	NA	0.68	090
77778	TC	A	Apply interstit radiat compl	0.00	7.63	8.02	NA	NA	0.08	090
77778	26	A	Apply interstit radiat compl	11.32	4.99	4.86	4.99	4.86	0.60	090
77785		A	Hdr brachytx 1 channel	1.42	5.60	4.99	NA	NA	0.10	XXX
77785	TC	A	Hdr brachytx 1 channel	0.00	4.97	4.37	NA	NA	0.03	XXX
77785	26	A	Hdr brachytx 1 channel	1.42	0.63	0.62	0.63	0.62	0.07	XXX
77786		A	Hdr brachytx 2-12 channel	3.25	12.46	13.44	NA	NA	0.21	XXX
77786	TC	A	Hdr brachytx 2-12 channel	0.00	11.00	12.07	NA	NA	0.05	XXX
77786	26	A	Hdr brachytx 2-12 channel	3.25	1.46	1.37	1.46	1.37	0.16	XXX
77787		A	Hdr brachytx over 12 chan	4.89	22.05	21.73	NA	NA	0.34	XXX
77787	TC	A	Hdr brachytx over 12 chan	0.00	19.85	19.58	NA	NA	0.08	XXX
77787	26	A	Hdr brachytx over 12 chan	4.89	2.20	2.15	2.20	2.15	0.26	XXX

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77789		A	Apply surface radiation	1.14	2.12	2.09	NA	NA	0.06	000
77789	TC	A	Apply surface radiation	0.00	1.59	1.58	NA	NA	0.01	000
77789	26	A	Apply surface radiation	1.14	0.53	0.51	0.53	0.51	0.05	000
77790		A	Radiation handling	1.05	1.60	1.59	NA	NA	0.05	XXX
77790	TC	A	Radiation handling	0.00	1.13	1.14	NA	NA	0.01	XXX
77790	26	A	Radiation handling	1.05	0.47	0.45	0.47	0.45	0.04	XXX
77799		C	Radium/radioisotope therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78000		A	Thyroid single uptake	0.19	1.81	1.91	NA	NA	0.02	XXX
78000	TC	A	Thyroid single uptake	0.00	1.74	1.83	NA	NA	0.01	XXX
78000	26	A	Thyroid single uptake	0.19	0.07	0.08	0.07	0.08	0.01	XXX
78001		A	Thyroid multiple uptakes	0.26	2.32	2.43	NA	NA	0.04	XXX
78001	TC	A	Thyroid multiple uptakes	0.00	2.23	2.32	NA	NA	0.03	XXX
78001	26	A	Thyroid multiple uptakes	0.26	0.09	0.11	0.09	0.11	0.01	XXX
78003		A	Thyroid suppress/stimul	0.33	1.94	2.02	NA	NA	0.02	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	1.82	1.88	NA	NA	0.01	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.12	0.14	0.12	0.14	0.01	XXX
78006		A	Thyroid imaging with uptake	0.49	6.33	6.41	NA	NA	0.06	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	6.16	6.21	NA	NA	0.03	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.17	0.20	0.17	0.20	0.03	XXX
78007		A	Thyroid image mult uptakes	0.50	6.72	5.22	NA	NA	0.06	XXX
78007	TC	A	Thyroid image mult uptakes	0.00	6.54	5.01	NA	NA	0.03	XXX
78007	26	A	Thyroid image mult uptakes	0.50	0.18	0.21	0.18	0.21	0.03	XXX
78010		A	Thyroid imaging	0.39	4.34	4.39	NA	NA	0.04	XXX
78010	TC	A	Thyroid imaging	0.00	4.20	4.23	NA	NA	0.03	XXX
78010	26	A	Thyroid imaging	0.39	0.14	0.16	0.14	0.16	0.01	XXX
78011		A	Thyroid imaging with flow	0.45	4.56	4.80	NA	NA	0.06	XXX

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78011	TC	A	Thyroid imaging with flow	0.00	4.39	4.61	NA	NA	0.03	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.17	0.19	0.17	0.19	0.03	XXX
78015		A	Thyroid met imaging	0.67	5.44	5.62	NA	NA	0.07	XXX
78015	TC	A	Thyroid met imaging	0.00	5.22	5.36	NA	NA	0.03	XXX
78015	26	A	Thyroid met imaging	0.67	0.22	0.26	0.22	0.26	0.04	XXX
78016		A	Thyroid met imaging/studies	0.82	7.14	8.12	NA	NA	0.06	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	7.00	7.86	NA	NA	0.03	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.14	0.26	0.14	0.26	0.03	XXX
78018		A	Thyroid met imaging body	0.86	7.92	8.48	NA	NA	0.07	XXX
78018	TC	A	Thyroid met imaging body	0.00	7.64	8.15	NA	NA	0.03	XXX
78018	26	A	Thyroid met imaging body	0.86	0.28	0.33	0.28	0.33	0.04	XXX
78020		A	Thyroid met uptake	0.60	1.67	1.92	NA	NA	0.04	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.50	1.69	NA	NA	0.01	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.17	0.23	0.17	0.23	0.03	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	3.41	4.00	NA	NA	0.07	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	3.13	3.67	NA	NA	0.03	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.28	0.33	0.28	0.33	0.04	XXX
78075		A	Adrenal nuclear imaging	0.74	11.21	11.78	NA	NA	0.08	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	10.98	11.49	NA	NA	0.04	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.23	0.29	0.23	0.29	0.04	XXX
78099		C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78102		A	Bone marrow imaging ltd	0.55	4.08	4.31	NA	NA	0.06	XXX
78102	TC	A	Bone marrow imaging ltd	0.00	3.91	4.10	NA	NA	0.03	XXX
78102	26	A	Bone marrow imaging ltd	0.55	0.17	0.21	0.17	0.21	0.03	XXX
78103		A	Bone marrow imaging mult	0.75	5.27	5.67	NA	NA	0.07	XXX
78103	TC	A	Bone marrow imaging mult	0.00	5.05	5.39	NA	NA	0.03	XXX

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78103	26	A	Bone marrow imaging mult	0.75	0.22	0.28	0.22	0.28	0.04	XXX
78104		A	Bone marrow imaging body	0.80	5.98	6.50	NA	NA	0.07	XXX
78104	TC	A	Bone marrow imaging body	0.00	5.73	6.18	NA	NA	0.03	XXX
78104	26	A	Bone marrow imaging body	0.80	0.25	0.32	0.25	0.32	0.04	XXX
78110		A	Plasma volume single	0.19	2.18	2.22	NA	NA	0.04	XXX
78110	TC	A	Plasma volume single	0.00	2.11	2.14	NA	NA	0.03	XXX
78110	26	A	Plasma volume single	0.19	0.07	0.08	0.07	0.08	0.01	XXX
78111		A	Plasma volume multiple	0.22	1.81	2.33	NA	NA	0.04	XXX
78111	TC	A	Plasma volume multiple	0.00	1.76	2.25	NA	NA	0.03	XXX
78111	26	A	Plasma volume multiple	0.22	0.05	0.08	0.05	0.08	0.01	XXX
78120		A	Red cell mass single	0.23	2.14	2.33	NA	NA	0.04	XXX
78120	TC	A	Red cell mass single	0.00	2.05	2.23	NA	NA	0.03	XXX
78120	26	A	Red cell mass single	0.23	0.09	0.10	0.09	0.10	0.01	XXX
78121		A	Red cell mass multiple	0.32	2.25	2.62	NA	NA	0.04	XXX
78121	TC	A	Red cell mass multiple	0.00	2.13	2.49	NA	NA	0.03	XXX
78121	26	A	Red cell mass multiple	0.32	0.12	0.13	0.12	0.13	0.01	XXX
78122		A	Blood volume	0.45	2.09	2.83	NA	NA	0.04	XXX
78122	TC	A	Blood volume	0.00	1.96	2.66	NA	NA	0.03	XXX
78122	26	A	Blood volume	0.45	0.13	0.17	0.13	0.17	0.01	XXX
78130		A	Red cell survival study	0.61	3.58	3.89	NA	NA	0.08	XXX
78130	TC	A	Red cell survival study	0.00	3.35	3.63	NA	NA	0.04	XXX
78130	26	A	Red cell survival study	0.61	0.23	0.26	0.23	0.26	0.04	XXX
78135		A	Red cell survival kinetics	0.64	9.28	9.44	NA	NA	0.07	XXX
78135	TC	A	Red cell survival kinetics	0.00	9.03	9.17	NA	NA	0.03	XXX
78135	26	A	Red cell survival kinetics	0.64	0.25	0.27	0.25	0.27	0.04	XXX
78140		A	Red cell sequestration	0.61	2.90	3.43	NA	NA	0.07	XXX
78140	TC	A	Red cell sequestration	0.00	2.68	3.18	NA	NA	0.03	XXX
78140	26	A	Red cell sequestration	0.61	0.22	0.25	0.22	0.25	0.04	XXX

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78185		A	Spleen imaging	0.40	5.42	5.50	NA	NA	0.04	XXX
78185	TC	A	Spleen imaging	0.00	5.27	5.33	NA	NA	0.03	XXX
78185	26	A	Spleen imaging	0.40	0.15	0.17	0.15	0.17	0.01	XXX
78190		A	Platelet survival kinetics	1.09	9.56	10.02	NA	NA	0.07	XXX
78190	TC	A	Platelet survival kinetics	0.00	9.13	9.58	NA	NA	0.03	XXX
78190	26	A	Platelet survival kinetics	1.09	0.43	0.44	0.43	0.44	0.04	XXX
78191		A	Platelet survival	0.61	3.60	4.55	NA	NA	0.08	XXX
78191	TC	A	Platelet survival	0.00	3.37	4.30	NA	NA	0.04	XXX
78191	26	A	Platelet survival	0.61	0.23	0.25	0.23	0.25	0.04	XXX
78195		A	Lymph system imaging	1.20	8.87	9.11	NA	NA	0.10	XXX
78195	TC	A	Lymph system imaging	0.00	8.46	8.63	NA	NA	0.03	XXX
78195	26	A	Lymph system imaging	1.20	0.41	0.48	0.41	0.48	0.07	XXX
78199		C	Blood/lymph nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78201		A	Liver imaging	0.44	4.92	4.99	NA	NA	0.07	XXX
78201	TC	A	Liver imaging	0.00	4.77	4.82	NA	NA	0.03	XXX
78201	26	A	Liver imaging	0.44	0.15	0.17	0.15	0.17	0.04	XXX
78202		A	Liver imaging with flow	0.51	5.04	5.43	NA	NA	0.04	XXX
78202	TC	A	Liver imaging with flow	0.00	4.90	5.25	NA	NA	0.03	XXX
78202	26	A	Liver imaging with flow	0.51	0.14	0.18	0.14	0.18	0.01	XXX
78205		A	Liver imaging (3d)	0.71	5.18	5.94	NA	NA	0.07	XXX
78205	TC	A	Liver imaging (3d)	0.00	4.95	5.66	NA	NA	0.03	XXX
78205	26	A	Liver imaging (3d)	0.71	0.23	0.28	0.23	0.28	0.04	XXX
78206		A	Liver image (3d) with flow	0.96	8.72	9.25	NA	NA	0.07	XXX
78206	TC	A	Liver image (3d) with flow	0.00	8.40	8.87	NA	NA	0.03	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.32	0.38	0.32	0.38	0.04	XXX
78215		A	Liver and spleen imaging	0.49	4.89	5.13	NA	NA	0.06	XXX

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78215	TC	A	Liver and spleen imaging	0.00	4.71	4.93	NA	NA	0.03	XXX
78215	26	A	Liver and spleen imaging	0.49	0.18	0.20	0.18	0.20	0.03	XXX
78216		A	Liver & spleen image/flow	0.57	2.73	3.23	NA	NA	0.06	XXX
78216	TC	A	Liver & spleen image/flow	0.00	2.54	3.01	NA	NA	0.03	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.19	0.22	0.19	0.22	0.03	XXX
78220		A	Liver function study	0.49	3.01	3.51	NA	NA	0.04	XXX
78220	TC	A	Liver function study	0.00	2.84	3.32	NA	NA	0.03	XXX
78220	26	A	Liver function study	0.49	0.17	0.19	0.17	0.19	0.01	XXX
78223		A	Hepatobiliary imaging	0.84	8.74	8.86	NA	NA	0.07	XXX
78223	TC	A	Hepatobiliary imaging	0.00	8.44	8.52	NA	NA	0.03	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.30	0.34	0.30	0.34	0.04	XXX
78230		A	Salivary gland imaging	0.45	4.29	4.40	NA	NA	0.06	XXX
78230	TC	A	Salivary gland imaging	0.00	4.12	4.22	NA	NA	0.03	XXX
78230	26	A	Salivary gland imaging	0.45	0.17	0.18	0.17	0.18	0.03	XXX
78231		A	Serial salivary imaging	0.52	2.87	3.24	NA	NA	0.04	XXX
78231	TC	A	Serial salivary imaging	0.00	2.67	3.03	NA	NA	0.03	XXX
78231	26	A	Serial salivary imaging	0.52	0.20	0.21	0.20	0.21	0.01	XXX
78232		A	Salivary gland function exam	0.47	2.13	2.94	NA	NA	0.06	XXX
78232	TC	A	Salivary gland function exam	0.00	2.05	2.79	NA	NA	0.03	XXX
78232	26	A	Salivary gland function exam	0.47	0.08	0.15	0.08	0.15	0.03	XXX
78258		A	Esophageal motility study	0.74	5.70	5.94	NA	NA	0.06	XXX
78258	TC	A	Esophageal motility study	0.00	5.43	5.63	NA	NA	0.03	XXX
78258	26	A	Esophageal motility study	0.74	0.27	0.31	0.27	0.31	0.03	XXX
78261		A	Gastric mucosa imaging	0.69	6.31	6.62	NA	NA	0.07	XXX
78261	TC	A	Gastric mucosa imaging	0.00	6.05	6.33	NA	NA	0.03	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.26	0.29	0.26	0.29	0.04	XXX
78262		A	Gastroesophageal reflux exam	0.68	6.19	6.52	NA	NA	0.04	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	5.95	6.25	NA	NA	0.03	XXX

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78262	26	A	Gastroesophageal reflux exam	0.68	0.24	0.27	0.24	0.27	0.01	XXX
78264		A	Gastric emptying study	0.78	7.29	7.60	NA	NA	0.07	XXX
78264	TC	A	Gastric emptying study	0.00	7.01	7.28	NA	NA	0.03	XXX
78264	26	A	Gastric emptying study	0.78	0.28	0.32	0.28	0.32	0.04	XXX
78267		X	Breath tst attain/anal c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78268		X	Breath test analysis c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78270		A	Vit b-12 absorption exam	0.20	2.08	2.18	NA	NA	0.02	XXX
78270	TC	A	Vit b-12 absorption exam	0.00	2.00	2.10	NA	NA	0.01	XXX
78270	26	A	Vit b-12 absorption exam	0.20	0.08	0.08	0.08	0.08	0.01	XXX
78271		A	Vit b-12 absrp exam int fac	0.20	2.30	2.31	NA	NA	0.02	XXX
78271	TC	A	Vit b-12 absrp exam int fac	0.00	2.21	2.23	NA	NA	0.01	XXX
78271	26	A	Vit b-12 absrp exam int fac	0.20	0.09	0.08	0.09	0.08	0.01	XXX
78272		A	Vit b-12 absorp combined	0.27	2.21	2.38	NA	NA	0.04	XXX
78272	TC	A	Vit b-12 absorp combined	0.00	2.10	2.28	NA	NA	0.03	XXX
78272	26	A	Vit b-12 absorp combined	0.27	0.11	0.10	0.11	0.10	0.01	XXX
78278		A	Acute gi blood loss imaging	0.99	8.79	9.13	NA	NA	0.08	XXX
78278	TC	A	Acute gi blood loss imaging	0.00	8.44	8.73	NA	NA	0.03	XXX
78278	26	A	Acute gi blood loss imaging	0.99	0.35	0.40	0.35	0.40	0.05	XXX
78282		C	Gi protein loss exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78282	TC	C	Gi protein loss exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78282	26	A	Gi protein loss exam	0.38	0.14	0.16	0.14	0.16	0.03	XXX
78290		A	Meckels divert exam	0.68	8.69	8.75	NA	NA	0.07	XXX
78290	TC	A	Meckels divert exam	0.00	8.45	8.47	NA	NA	0.03	XXX
78290	26	A	Meckels divert exam	0.68	0.24	0.28	0.24	0.28	0.04	XXX
78291		A	Leveen/shunt patency exam	0.88	6.29	6.50	NA	NA	0.08	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	5.99	6.15	NA	NA	0.03	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.30	0.35	0.30	0.35	0.05	XXX
78299		C	Gi nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX

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78299	TC	C	Gi nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78299	26	C	Gi nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78300		A	Bone imaging limited area	0.62	4.37	4.53	NA	NA	0.06	XXX
78300	TC	A	Bone imaging limited area	0.00	4.14	4.27	NA	NA	0.03	XXX
78300	26	A	Bone imaging limited area	0.62	0.23	0.26	0.23	0.26	0.03	XXX
78305		A	Bone imaging multiple areas	0.83	5.73	5.97	NA	NA	0.07	XXX
78305	TC	A	Bone imaging multiple areas	0.00	5.43	5.64	NA	NA	0.03	XXX
78305	26	A	Bone imaging multiple areas	0.83	0.30	0.33	0.30	0.33	0.04	XXX
78306		A	Bone imaging whole body	0.86	6.15	6.56	NA	NA	0.07	XXX
78306	TC	A	Bone imaging whole body	0.00	5.85	6.21	NA	NA	0.03	XXX
78306	26	A	Bone imaging whole body	0.86	0.30	0.35	0.30	0.35	0.04	XXX
78315		A	Bone imaging 3 phase	1.02	8.75	9.10	NA	NA	0.08	XXX
78315	TC	A	Bone imaging 3 phase	0.00	8.39	8.69	NA	NA	0.03	XXX
78315	26	A	Bone imaging 3 phase	1.02	0.36	0.41	0.36	0.41	0.05	XXX
78320		A	Bone imaging (3d)	1.04	5.33	6.09	NA	NA	0.08	XXX
78320	TC	A	Bone imaging (3d)	0.00	4.99	5.68	NA	NA	0.03	XXX
78320	26	A	Bone imaging (3d)	1.04	0.34	0.41	0.34	0.41	0.05	XXX
78350		N	Bone mineral single photon	0.22	0.68	0.74	NA	NA	0.02	XXX
78350	TC	N	Bone mineral single photon	0.00	0.58	0.65	NA	NA	0.01	XXX
78350	26	N	Bone mineral single photon	0.22	0.10	0.09	0.10	0.09	0.01	XXX
78351		N	Bone mineral dual photon	0.30	0.13	0.13	0.13	0.13	0.01	XXX
78399		C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78414		C	Non-imaging heart function	0.00	0.00	0.00	NA	NA	0.00	XXX
78414	TC	C	Non-imaging heart function	0.00	0.00	0.00	NA	NA	0.00	XXX
78414	26	A	Non-imaging heart function	0.45	0.20	0.18	0.20	0.18	0.03	XXX
78428		A	Cardiac shunt imaging	0.78	4.38	4.89	NA	NA	0.06	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78428	TC	A	Cardiac shunt imaging	0.00	4.10	4.54	NA	NA	0.03	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.28	0.35	0.28	0.35	0.03	XXX
78445		A	Vascular flow imaging	0.49	4.32	4.53	NA	NA	0.04	XXX
78445	TC	A	Vascular flow imaging	0.00	4.16	4.34	NA	NA	0.03	XXX
78445	26	A	Vascular flow imaging	0.49	0.16	0.19	0.16	0.19	0.01	XXX
78451		A	Ht muscle image spect sing	1.38	8.62	8.62	NA	NA	0.08	XXX
78451	TC	A	Ht muscle image spect sing	0.00	8.10	8.10	NA	NA	0.03	XXX
78451	26	A	Ht muscle image spect sing	1.38	0.52	0.52	0.52	0.52	0.05	XXX
78452		A	Ht muscle image spect mult	1.62	12.40	12.40	NA	NA	0.09	XXX
78452	TC	A	Ht muscle image spect mult	0.00	11.78	11.78	NA	NA	0.04	XXX
78452	26	A	Ht muscle image spect mult	1.62	0.62	0.62	0.62	0.62	0.05	XXX
78453		A	Ht muscle image planar sing	1.00	7.58	7.58	NA	NA	0.08	XXX
78453	TC	A	Ht muscle image planar sing	0.00	7.21	7.21	NA	NA	0.03	XXX
78453	26	A	Ht muscle image planar sing	1.00	0.37	0.37	0.37	0.37	0.05	XXX
78454		A	Ht musc image planar mult	1.34	11.08	11.08	NA	NA	0.09	XXX
78454	TC	A	Ht musc image planar mult	0.00	10.58	10.58	NA	NA	0.04	XXX
78454	26	A	Ht musc image planar mult	1.34	0.50	0.50	0.50	0.50	0.05	XXX
78456		A	Acute venous thrombus image	1.00	8.79	9.40	NA	NA	0.06	XXX
78456	TC	A	Acute venous thrombus image	0.00	8.42	8.93	NA	NA	0.03	XXX
78456	26	A	Acute venous thrombus image	1.00	0.37	0.47	0.37	0.47	0.03	XXX
78457		A	Venous thrombosis imaging	0.77	4.70	4.93	NA	NA	0.07	XXX
78457	TC	A	Venous thrombosis imaging	0.00	4.42	4.62	NA	NA	0.03	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.28	0.31	0.28	0.31	0.04	XXX
78458		A	Ven thrombosis images bilat	0.90	4.08	4.82	NA	NA	0.08	XXX
78458	TC	A	Ven thrombosis images bilat	0.00	3.87	4.51	NA	NA	0.03	XXX
78458	26	A	Ven thrombosis images bilat	0.90	0.21	0.31	0.21	0.31	0.05	XXX
78459		C	Heart muscle imaging (pet)	0.00	0.00	0.00	NA	NA	0.00	XXX
78459	TC	C	Heart muscle imaging (pet)	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78459	26	A	Heart muscle imaging (pet)	1.50	0.45	0.62	0.45	0.62	0.10	XXX
78466		A	Heart infarct image	0.69	4.18	4.58	NA	NA	0.06	XXX
78466	TC	A	Heart infarct image	0.00	3.92	4.27	NA	NA	0.03	XXX
78466	26	A	Heart infarct image	0.69	0.26	0.31	0.26	0.31	0.03	XXX
78468		A	Heart infarct image (ef)	0.80	4.87	5.61	NA	NA	0.06	XXX
78468	TC	A	Heart infarct image (ef)	0.00	4.56	5.23	NA	NA	0.03	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.31	0.38	0.31	0.38	0.03	XXX
78469		A	Heart infarct image (3d)	0.92	6.09	6.64	NA	NA	0.06	XXX
78469	TC	A	Heart infarct image (3d)	0.00	5.69	6.19	NA	NA	0.03	XXX
78469	26	A	Heart infarct image (3d)	0.92	0.40	0.45	0.40	0.45	0.03	XXX
78472		A	Gated heart planar single	0.98	5.56	6.39	NA	NA	0.07	XXX
78472	TC	A	Gated heart planar single	0.00	5.21	5.96	NA	NA	0.03	XXX
78472	26	A	Gated heart planar single	0.98	0.35	0.43	0.35	0.43	0.04	XXX
78473		A	Gated heart multiple	1.47	6.89	8.28	NA	NA	0.08	XXX
78473	TC	A	Gated heart multiple	0.00	6.34	7.61	NA	NA	0.03	XXX
78473	26	A	Gated heart multiple	1.47	0.55	0.67	0.55	0.67	0.05	XXX
78481		A	Heart first pass single	0.98	4.21	5.19	NA	NA	0.04	XXX
78481	TC	A	Heart first pass single	0.00	3.83	4.71	NA	NA	0.01	XXX
78481	26	A	Heart first pass single	0.98	0.38	0.48	0.38	0.48	0.03	XXX
78483		A	Heart first pass multiple	1.47	5.55	7.06	NA	NA	0.08	XXX
78483	TC	A	Heart first pass multiple	0.00	4.98	6.33	NA	NA	0.03	XXX
78483	26	A	Heart first pass multiple	1.47	0.57	0.73	0.57	0.73	0.05	XXX
78491		C	Heart image (pet) single	0.00	0.00	0.00	NA	NA	0.00	XXX
78491	TC	C	Heart image (pet) single	0.00	0.00	0.00	NA	NA	0.00	XXX
78491	26	A	Heart image (pet) single	1.50	0.49	0.65	0.49	0.65	0.10	XXX
78492		C	Heart image (pet) multiple	0.00	0.00	0.00	NA	NA	0.00	XXX
78492	TC	C	Heart image (pet) multiple	0.00	0.00	0.00	NA	NA	0.00	XXX
78492	26	A	Heart image (pet) multiple	1.87	0.66	0.86	0.66	0.86	0.12	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78494		A	Heart image spect	1.19	5.59	6.66	NA	NA	0.07	XXX
78494	TC	A	Heart image spect	0.00	5.12	6.11	NA	NA	0.03	XXX
78494	26	A	Heart image spect	1.19	0.47	0.55	0.47	0.55	0.04	XXX
78496		A	Heart first pass add-on	0.50	0.74	1.88	NA	NA	0.02	ZZZ
78496	TC	A	Heart first pass add-on	0.00	0.55	1.64	NA	NA	0.01	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.19	0.24	0.19	0.24	0.01	ZZZ
78499		C	Cardiovascular nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78580		A	Lung perfusion imaging	0.74	5.15	5.48	NA	NA	0.06	XXX
78580	TC	A	Lung perfusion imaging	0.00	4.90	5.18	NA	NA	0.03	XXX
78580	26	A	Lung perfusion imaging	0.74	0.25	0.30	0.25	0.30	0.03	XXX
78584		A	Lung v/q image single breath	0.99	3.03	3.44	NA	NA	0.08	XXX
78584	TC	A	Lung v/q image single breath	0.00	2.66	3.03	NA	NA	0.03	XXX
78584	26	A	Lung v/q image single breath	0.99	0.37	0.41	0.37	0.41	0.05	XXX
78585		A	Lung v/q imaging	1.09	8.79	9.27	NA	NA	0.08	XXX
78585	TC	A	Lung v/q imaging	0.00	8.41	8.83	NA	NA	0.03	XXX
78585	26	A	Lung v/q imaging	1.09	0.38	0.44	0.38	0.44	0.05	XXX
78586		A	Aerosol lung image single	0.40	4.33	4.49	NA	NA	0.04	XXX
78586	TC	A	Aerosol lung image single	0.00	4.18	4.32	NA	NA	0.03	XXX
78586	26	A	Aerosol lung image single	0.40	0.15	0.17	0.15	0.17	0.01	XXX
78587		A	Aerosol lung image multiple	0.49	5.35	5.62	NA	NA	0.06	XXX
78587	TC	A	Aerosol lung image multiple	0.00	5.19	5.43	NA	NA	0.03	XXX
78587	26	A	Aerosol lung image multiple	0.49	0.16	0.19	0.16	0.19	0.03	XXX
78588		A	Perfusion lung image	1.09	8.87	8.95	NA	NA	0.08	XXX
78588	TC	A	Perfusion lung image	0.00	8.48	8.51	NA	NA	0.03	XXX
78588	26	A	Perfusion lung image	1.09	0.39	0.44	0.39	0.44	0.05	XXX
78591		A	Vent image 1 breath 1 proj	0.40	4.36	4.54	NA	NA	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78591	TC	A	Vent image 1 breath 1 proj	0.00	4.21	4.37	NA	NA	0.03	XXX
78591	26	A	Vent image 1 breath 1 proj	0.40	0.15	0.17	0.15	0.17	0.01	XXX
78593		A	Vent image 1 proj gas	0.49	4.96	5.24	NA	NA	0.06	XXX
78593	TC	A	Vent image 1 proj gas	0.00	4.79	5.04	NA	NA	0.03	XXX
78593	26	A	Vent image 1 proj gas	0.49	0.17	0.20	0.17	0.20	0.03	XXX
78594		A	Vent image mult proj gas	0.53	5.16	5.81	NA	NA	0.06	XXX
78594	TC	A	Vent image mult proj gas	0.00	5.00	5.61	NA	NA	0.03	XXX
78594	26	A	Vent image mult proj gas	0.53	0.16	0.20	0.16	0.20	0.03	XXX
78596		A	Lung differential function	1.27	9.03	9.68	NA	NA	0.07	XXX
78596	TC	A	Lung differential function	0.00	8.60	9.19	NA	NA	0.03	XXX
78596	26	A	Lung differential function	1.27	0.43	0.49	0.43	0.49	0.04	XXX
78599		C	Respiratory nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78599	TC	C	Respiratory nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78600		A	Brain image < 4 views	0.44	4.58	4.83	NA	NA	0.04	XXX
78600	TC	A	Brain image < 4 views	0.00	4.42	4.64	NA	NA	0.03	XXX
78600	26	A	Brain image < 4 views	0.44	0.16	0.19	0.16	0.19	0.01	XXX
78601		A	Brain image w/flow < 4 views	0.51	5.44	5.73	NA	NA	0.06	XXX
78601	TC	A	Brain image w/flow < 4 views	0.00	5.26	5.53	NA	NA	0.03	XXX
78601	26	A	Brain image w/flow < 4 views	0.51	0.18	0.20	0.18	0.20	0.03	XXX
78605		A	Brain image 4+ views	0.53	4.91	5.24	NA	NA	0.06	XXX
78605	TC	A	Brain image 4+ views	0.00	4.71	5.01	NA	NA	0.03	XXX
78605	26	A	Brain image 4+ views	0.53	0.20	0.23	0.20	0.23	0.03	XXX
78606		A	Brain image w/flow 4 + views	0.64	8.75	8.88	NA	NA	0.04	XXX
78606	TC	A	Brain image w/flow 4 + views	0.00	8.52	8.62	NA	NA	0.03	XXX
78606	26	A	Brain image w/flow 4 + views	0.64	0.23	0.26	0.23	0.26	0.01	XXX
78607		A	Brain imaging (3d)	1.23	8.70	9.42	NA	NA	0.08	XXX
78607	TC	A	Brain imaging (3d)	0.00	8.31	8.94	NA	NA	0.03	XXX

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78607	26	A	Brain imaging (3d)	1.23	0.39	0.48	0.39	0.48	0.05	XXX
78608		C	Brain imaging (pet)	0.00	0.00	0.00	NA	NA	0.00	XXX
78608	TC	C	Brain imaging (pet)	0.00	0.00	0.00	NA	NA	0.00	XXX
78608	26	A	Brain imaging (pet)	1.50	0.48	0.58	0.48	0.58	0.11	XXX
78609		N	Brain imaging (pet)	1.50	0.66	0.63	NA	NA	0.10	XXX
78609	TC	N	Brain imaging (pet)	0.00	0.00	0.00	NA	NA	0.00	XXX
78609	26	N	Brain imaging (pet)	1.50	0.66	0.63	0.66	0.63	0.10	XXX
78610		A	Brain flow imaging only	0.30	4.49	4.90	NA	NA	0.04	XXX
78610	TC	A	Brain flow imaging only	0.00	4.38	4.77	NA	NA	0.03	XXX
78610	26	A	Brain flow imaging only	0.30	0.11	0.13	0.11	0.13	0.01	XXX
78630		A	Cerebrospinal fluid scan	0.68	8.87	9.20	NA	NA	0.06	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	8.63	8.92	NA	NA	0.03	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.24	0.28	0.24	0.28	0.03	XXX
78635		A	Csf ventriculography	0.61	8.87	8.83	NA	NA	0.04	XXX
78635	TC	A	Csf ventriculography	0.00	8.64	8.57	NA	NA	0.03	XXX
78635	26	A	Csf ventriculography	0.61	0.23	0.26	0.23	0.26	0.01	XXX
78645		A	Csf shunt evaluation	0.57	8.52	8.72	NA	NA	0.06	XXX
78645	TC	A	Csf shunt evaluation	0.00	8.33	8.49	NA	NA	0.03	XXX
78645	26	A	Csf shunt evaluation	0.57	0.19	0.23	0.19	0.23	0.03	XXX
78647		A	Cerebrospinal fluid scan	0.90	8.80	9.30	NA	NA	0.08	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	8.51	8.95	NA	NA	0.03	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.29	0.35	0.29	0.35	0.05	XXX
78650		A	Csf leakage imaging	0.61	8.73	9.05	NA	NA	0.07	XXX
78650	TC	A	Csf leakage imaging	0.00	8.53	8.81	NA	NA	0.03	XXX
78650	26	A	Csf leakage imaging	0.61	0.20	0.24	0.20	0.24	0.04	XXX
78660		A	Nuclear exam of tear flow	0.53	4.65	4.64	NA	NA	0.06	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	4.43	4.41	NA	NA	0.03	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.22	0.23	0.22	0.23	0.03	XXX

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78699		C	Nervous system nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78699	TC	C	Nervous system nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78700		A	Kidney imaging morphol	0.45	4.41	4.70	NA	NA	0.06	XXX
78700	TC	A	Kidney imaging morphol	0.00	4.25	4.51	NA	NA	0.03	XXX
78700	26	A	Kidney imaging morphol	0.45	0.16	0.19	0.16	0.19	0.03	XXX
78701		A	Kidney imaging with flow	0.49	5.44	5.74	NA	NA	0.06	XXX
78701	TC	A	Kidney imaging with flow	0.00	5.27	5.54	NA	NA	0.03	XXX
78701	26	A	Kidney imaging with flow	0.49	0.17	0.20	0.17	0.20	0.03	XXX
78707		A	K flow/funct image w/o drug	0.96	5.47	5.99	NA	NA	0.07	XXX
78707	TC	A	K flow/funct image w/o drug	0.00	5.15	5.61	NA	NA	0.03	XXX
78707	26	A	K flow/funct image w/o drug	0.96	0.32	0.38	0.32	0.38	0.04	XXX
78708		A	K flow/funct image w/drug	1.21	3.37	4.04	NA	NA	0.08	XXX
78708	TC	A	K flow/funct image w/drug	0.00	2.96	3.55	NA	NA	0.03	XXX
78708	26	A	K flow/funct image w/drug	1.21	0.41	0.49	0.41	0.49	0.05	XXX
78709		A	K flow/funct image multiple	1.41	8.95	9.33	NA	NA	0.10	XXX
78709	TC	A	K flow/funct image multiple	0.00	8.47	8.76	NA	NA	0.03	XXX
78709	26	A	K flow/funct image multiple	1.41	0.48	0.57	0.48	0.57	0.07	XXX
78710		A	Kidney imaging (3d)	0.66	5.05	5.88	NA	NA	0.04	XXX
78710	TC	A	Kidney imaging (3d)	0.00	4.85	5.63	NA	NA	0.03	XXX
78710	26	A	Kidney imaging (3d)	0.66	0.20	0.25	0.20	0.25	0.01	XXX
78725		A	Kidney function study	0.38	2.49	2.61	NA	NA	0.04	XXX
78725	TC	A	Kidney function study	0.00	2.35	2.46	NA	NA	0.03	XXX
78725	26	A	Kidney function study	0.38	0.14	0.15	0.14	0.15	0.01	XXX
78730		A	Urinary bladder retention	0.15	1.80	2.04	NA	NA	0.02	ZZZ
78730	TC	A	Urinary bladder retention	0.00	1.74	1.96	NA	NA	0.01	ZZZ
78730	26	A	Urinary bladder retention	0.15	0.06	0.08	0.06	0.08	0.01	ZZZ
78740		A	Ureteral reflux study	0.57	5.88	5.91	NA	NA	0.06	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78740	TC	A	Ureteral reflux study	0.00	5.65	5.66	NA	NA	0.03	XXX
78740	26	A	Ureteral reflux study	0.57	0.23	0.25	0.23	0.25	0.03	XXX
78761		A	Testicular imaging w/flow	0.71	5.26	5.50	NA	NA	0.07	XXX
78761	TC	A	Testicular imaging w/flow	0.00	4.99	5.20	NA	NA	0.03	XXX
78761	26	A	Testicular imaging w/flow	0.71	0.27	0.30	0.27	0.30	0.04	XXX
78799		C	Genitourinary nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78800		A	Tumor imaging limited area	0.66	4.54	4.80	NA	NA	0.07	XXX
78800	TC	A	Tumor imaging limited area	0.00	4.29	4.54	NA	NA	0.03	XXX
78800	26	A	Tumor imaging limited area	0.66	0.25	0.26	0.25	0.26	0.04	XXX
78801		A	Tumor imaging mult areas	0.79	6.29	6.60	NA	NA	0.07	XXX
78801	TC	A	Tumor imaging mult areas	0.00	6.00	6.28	NA	NA	0.03	XXX
78801	26	A	Tumor imaging mult areas	0.79	0.29	0.32	0.29	0.32	0.04	XXX
78802		A	Tumor imaging whole body	0.86	8.15	8.72	NA	NA	0.07	XXX
78802	TC	A	Tumor imaging whole body	0.00	7.87	8.38	NA	NA	0.03	XXX
78802	26	A	Tumor imaging whole body	0.86	0.28	0.34	0.28	0.34	0.04	XXX
78803		A	Tumor imaging (3d)	1.09	8.38	9.21	NA	NA	0.08	XXX
78803	TC	A	Tumor imaging (3d)	0.00	8.05	8.79	NA	NA	0.03	XXX
78803	26	A	Tumor imaging (3d)	1.09	0.33	0.42	0.33	0.42	0.05	XXX
78804		A	Tumor imaging whole body	1.07	14.85	15.99	NA	NA	0.10	XXX
78804	TC	A	Tumor imaging whole body	0.00	14.50	15.57	NA	NA	0.05	XXX
78804	26	A	Tumor imaging whole body	1.07	0.35	0.42	0.35	0.42	0.05	XXX
78805		A	Abscess imaging ltd area	0.73	4.30	4.65	NA	NA	0.07	XXX
78805	TC	A	Abscess imaging ltd area	0.00	4.05	4.36	NA	NA	0.03	XXX
78805	26	A	Abscess imaging ltd area	0.73	0.25	0.29	0.25	0.29	0.04	XXX
78806		A	Abscess imaging whole body	0.86	8.40	9.07	NA	NA	0.07	XXX
78806	TC	A	Abscess imaging whole body	0.00	8.11	8.73	NA	NA	0.03	XXX

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78806	26	A	Abscess imaging whole body	0.86	0.29	0.34	0.29	0.34	0.04	XXX
78807		A	Nuclear localization/abscess	1.09	8.36	9.21	NA	NA	0.07	XXX
78807	TC	A	Nuclear localization/abscess	0.00	8.04	8.79	NA	NA	0.03	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.32	0.42	0.32	0.42	0.04	XXX
78808		A	Iv inj ra drug dx study	0.18	0.89	1.06	NA	NA	0.03	XXX
78811		C	Pet image ltd area	0.00	0.00	0.00	NA	NA	0.00	XXX
78811	TC	C	Pet image ltd area	0.00	0.00	0.00	NA	NA	0.00	XXX
78811	26	A	Pet image ltd area	1.54	0.55	0.63	0.55	0.63	0.18	XXX
78812		C	Pet image skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78812	TC	C	Pet image skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78812	26	A	Pet image skull-thigh	1.93	0.66	0.78	0.66	0.78	0.16	XXX
78813		C	Pet image full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78813	TC	C	Pet image full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78813	26	A	Pet image full body	2.00	0.72	0.83	0.72	0.83	0.18	XXX
78814		C	Pet image w/ct lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	TC	C	Pet image w/ct lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	26	A	Pet image w/ct lmtd	2.20	0.73	0.87	0.73	0.87	0.20	XXX
78815		C	Pet image w/ct skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78815	TC	C	Pet image w/ct skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78815	26	A	Pet image w/ct skull-thigh	2.44	0.84	0.98	0.84	0.98	0.22	XXX
78816		C	Pet image w/ct full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78816	TC	C	Pet image w/ct full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78816	26	A	Pet image w/ct full body	2.50	0.80	0.98	0.80	0.98	0.22	XXX
78999		C	Nuclear diagnostic exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79005		A	Nuclear rx oral admin	1.80	1.93	2.33	NA	NA	0.08	XXX
79005	TC	A	Nuclear rx oral admin	0.00	1.27	1.61	NA	NA	0.01	XXX

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79005	26	A	Nuclear rx oral admin	1.80	0.66	0.72	0.66	0.72	0.07	XXX
79101		A	Nuclear rx iv admin	1.96	2.25	2.72	NA	NA	0.08	XXX
79101	TC	A	Nuclear rx iv admin	0.00	1.35	1.74	NA	NA	0.01	XXX
79101	26	A	Nuclear rx iv admin	1.96	0.90	0.98	0.90	0.98	0.07	XXX
79200		A	Nuclear rx intracav admin	1.99	2.43	2.83	NA	NA	0.12	XXX
79200	TC	A	Nuclear rx intracav admin	0.00	1.67	1.99	NA	NA	0.01	XXX
79200	26	A	Nuclear rx intracav admin	1.99	0.76	0.84	0.76	0.84	0.11	XXX
79300		C	Nuclr rx interstit colloid	0.00	0.00	0.00	NA	NA	0.00	XXX
79300	TC	C	Nuclr rx interstit colloid	0.00	0.00	0.00	NA	NA	0.00	XXX
79300	26	A	Nuclr rx interstit colloid	1.60	0.61	0.66	0.61	0.66	0.14	XXX
79403		A	Hematopoietic nuclear tx	2.25	2.89	3.64	NA	NA	0.14	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	2.08	2.70	NA	NA	0.03	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.81	0.94	0.81	0.94	0.11	XXX
79440		A	Nuclear rx intra-articular	1.99	2.38	2.59	NA	NA	0.06	XXX
79440	TC	A	Nuclear rx intra-articular	0.00	1.46	1.67	NA	NA	0.01	XXX
79440	26	A	Nuclear rx intra-articular	1.99	0.92	0.92	0.92	0.92	0.05	XXX
79445		C	Nuclear rx intra-arterial	0.00	0.00	0.00	NA	NA	0.00	XXX
79445	TC	C	Nuclear rx intra-arterial	0.00	0.00	0.00	NA	NA	0.00	XXX
79445	26	A	Nuclear rx intra-arterial	2.40	0.77	0.94	0.77	0.94	0.20	XXX
79999		C	Nuclear medicine therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
79999	TC	C	Nuclear medicine therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
80500		A	Lab pathology consultation	0.37	0.19	0.21	0.12	0.14	0.03	XXX
80502		A	Lab pathology consultation	1.33	0.47	0.49	0.41	0.43	0.07	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.18	0.17	0.18	0.17	0.03	XXX
83912	26	A	Genetic examination	0.37	0.16	0.15	0.16	0.15	0.03	XXX
84165	26	A	Protein e-phoresis serum	0.37	0.18	0.16	0.18	0.16	0.03	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.18	0.16	0.18	0.16	0.03	XXX

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84181	26	A	Western blot test	0.37	0.18	0.17	0.18	0.17	0.03	XXX
84182	26	A	Protein western blot test	0.37	0.17	0.16	0.17	0.16	0.03	XXX
85060		A	Blood smear interpretation	0.45	0.22	0.20	0.22	0.20	0.03	XXX
85097		A	Bone marrow interpretation	0.94	1.37	1.54	0.40	0.39	0.05	XXX
85390	26	A	Fibrinolysins screen	0.37	0.19	0.18	0.19	0.18	0.03	XXX
85396		A	Clotting assay whole blood	0.37	NA	NA	0.17	0.16	0.03	XXX
85576	26	A	Blood platelet aggregation	0.37	0.18	0.17	0.18	0.17	0.03	XXX
86077		A	Physician blood bank service	0.94	0.55	0.51	0.46	0.43	0.05	XXX
86078		A	Physician blood bank service	0.94	0.56	0.52	0.46	0.43	0.05	XXX
86079		A	Physician blood bank service	0.94	0.55	0.53	0.45	0.43	0.05	XXX
86255	26	A	Fluorescent antibody screen	0.37	0.18	0.17	0.18	0.17	0.03	XXX
86256	26	A	Fluorescent antibody titer	0.37	0.18	0.17	0.18	0.17	0.01	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.18	0.17	0.18	0.17	0.01	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.18	0.16	0.18	0.16	0.01	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.21	0.20	0.21	0.20	0.03	XXX
86334	26	A	Immunofix e-phoresis serum	0.37	0.18	0.17	0.18	0.17	0.03	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.18	0.17	0.18	0.17	0.03	XXX
86485		C	Skin test candida	0.00	0.00	0.00	0.00	0.00	0.00	XXX
86486		A	Skin test nos antigen	0.00	0.13	0.14	NA	NA	0.01	XXX
86490		A	Coccidioidomycosis skin test	0.00	0.17	0.19	NA	NA	0.01	XXX
86510		A	Histoplasmosis skin test	0.00	0.16	0.19	NA	NA	0.01	XXX
86580		A	Tb intradermal test	0.00	0.20	0.21	NA	NA	0.01	XXX
87164	26	A	Dark field examination	0.37	0.18	0.17	0.18	0.17	0.03	XXX
87207	26	A	Smear special stain	0.37	0.19	0.17	0.19	0.17	0.03	XXX
88104		A	Cytopath fl nongyn smears	0.56	1.36	1.35	NA	NA	0.02	XXX
88104	TC	A	Cytopath fl nongyn smears	0.00	1.11	1.11	NA	NA	0.01	XXX
88104	26	A	Cytopath fl nongyn smears	0.56	0.25	0.24	0.25	0.24	0.01	XXX
88106		A	Cytopath fl nongyn filter	0.56	1.74	1.78	NA	NA	0.02	XXX

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88106	TC	A	Cytopath fl nongyn filter	0.00	1.49	1.55	NA	NA	0.01	XXX
88106	26	A	Cytopath fl nongyn filter	0.56	0.25	0.23	0.25	0.23	0.01	XXX
88107		A	Cytopath fl nongyn sm/fltr	0.76	2.07	2.15	NA	NA	0.04	XXX
88107	TC	A	Cytopath fl nongyn sm/fltr	0.00	1.73	1.82	NA	NA	0.01	XXX
88107	26	A	Cytopath fl nongyn sm/fltr	0.76	0.34	0.33	0.34	0.33	0.03	XXX
88108		A	Cytopath concentrate tech	0.56	1.59	1.64	NA	NA	0.02	XXX
88108	TC	A	Cytopath concentrate tech	0.00	1.35	1.41	NA	NA	0.01	XXX
88108	26	A	Cytopath concentrate tech	0.56	0.24	0.23	0.24	0.23	0.01	XXX
88112		A	Cytopath cell enhance tech	1.18	1.67	1.80	NA	NA	0.05	XXX
88112	TC	A	Cytopath cell enhance tech	0.00	1.21	1.35	NA	NA	0.01	XXX
88112	26	A	Cytopath cell enhance tech	1.18	0.46	0.45	0.46	0.45	0.04	XXX
88120		A	Cytp urne 3-5 probes ea spec	1.20	12.22	12.22	NA	NA	0.05	XXX
88120	TC	A	Cytp urne 3-5 probes ea spec	0.00	11.91	11.91	NA	NA	0.02	XXX
88120	26	A	Cytp urne 3-5 probes ea spec	1.20	0.31	0.31	0.31	0.31	0.03	XXX
88121		A	Cytp urine 3-5 probes cmptr	1.00	10.34	10.34	NA	NA	0.03	XXX
88121	TC	A	Cytp urine 3-5 probes cmptr	0.00	10.00	10.00	NA	NA	0.01	XXX
88121	26	A	Cytp urine 3-5 probes cmptr	1.00	0.34	0.34	0.34	0.34	0.02	XXX
88125		A	Forensic cytopathology	0.26	0.36	0.37	NA	NA	0.02	XXX
88125	TC	A	Forensic cytopathology	0.00	0.24	0.25	NA	NA	0.01	XXX
88125	26	A	Forensic cytopathology	0.26	0.12	0.12	0.12	0.12	0.01	XXX
88141		A	Cytopath c/v interpret	0.42	0.42	0.40	0.42	0.40	0.03	XXX
88160		A	Cytopath smear other source	0.50	1.08	1.08	NA	NA	0.02	XXX
88160	TC	A	Cytopath smear other source	0.00	0.86	0.87	NA	NA	0.01	XXX
88160	26	A	Cytopath smear other source	0.50	0.22	0.21	0.22	0.21	0.01	XXX
88161		A	Cytopath smear other source	0.50	1.01	1.08	NA	NA	0.02	XXX
88161	TC	A	Cytopath smear other source	0.00	0.82	0.89	NA	NA	0.01	XXX
88161	26	A	Cytopath smear other source	0.50	0.19	0.19	0.19	0.19	0.01	XXX
88162		A	Cytopath smear other source	0.76	1.39	1.51	NA	NA	0.04	XXX

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88162	TC	A	Cytopath smear other source	0.00	1.10	1.21	NA	NA	0.01	XXX
88162	26	A	Cytopath smear other source	0.76	0.29	0.30	0.29	0.30	0.03	XXX
88172		A	Cytp dx eval fna 1st ea site	0.60	0.76	0.87	NA	NA	0.02	XXX
88172	TC	A	Cytp dx eval fna 1st ea site	0.00	0.47	0.60	NA	NA	0.01	XXX
88172	26	A	Cytp dx eval fna 1st ea site	0.60	0.29	0.27	0.29	0.27	0.01	XXX
88173		A	Cytopath eval fna report	1.39	2.56	2.62	NA	NA	0.05	XXX
88173	TC	A	Cytopath eval fna report	0.00	1.95	2.04	NA	NA	0.01	XXX
88173	26	A	Cytopath eval fna report	1.39	0.61	0.58	0.61	0.58	0.04	XXX
88177		A	Cytp c/v auto thin lyr addl	0.42	0.38	0.38	NA	NA	0.02	ZZZ
88177	TC	A	Cytp c/v auto thin lyr addl	0.00	0.18	0.18	NA	NA	0.01	ZZZ
88177	26	A	Cytp c/v auto thin lyr addl	0.42	0.20	0.20	0.20	0.20	0.01	ZZZ
88182		A	Cell marker study	0.77	2.08	2.24	NA	NA	0.06	XXX
88182	TC	A	Cell marker study	0.00	1.86	2.02	NA	NA	0.03	XXX
88182	26	A	Cell marker study	0.77	0.22	0.22	0.22	0.22	0.03	XXX
88184		A	Flowcytometry/ tc 1 marker	0.00	2.30	2.47	NA	NA	0.01	XXX
88185		A	Flowcytometry/tc add-on	0.00	1.40	1.48	NA	NA	0.01	ZZZ
88187		A	Flowcytometry/read 2-8	1.36	0.59	0.55	0.59	0.55	0.08	XXX
88188		A	Flowcytometry/read 9-15	1.69	0.76	0.68	0.76	0.68	0.10	XXX
88189		A	Flowcytometry/read 16 & >	2.23	0.71	0.69	0.71	0.69	0.12	XXX
88199		C	Cytopathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88199	TC	C	Cytopathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88291		A	Cyto/molecular report	0.52	0.31	0.31	0.31	0.31	0.03	XXX
88299		C	Cytogenetic study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88300		A	Surgical path gross	0.08	0.71	0.69	NA	NA	0.02	XXX
88300	TC	A	Surgical path gross	0.00	0.67	0.65	NA	NA	0.01	XXX
88300	26	A	Surgical path gross	0.08	0.04	0.04	0.04	0.04	0.01	XXX
88302		A	Tissue exam by pathologist	0.13	1.41	1.43	NA	NA	0.02	XXX

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88302	TC	A	Tissue exam by pathologist	0.00	1.35	1.38	NA	NA	0.01	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.06	0.05	0.06	0.05	0.01	XXX
88304		A	Tissue exam by pathologist	0.22	1.44	1.61	NA	NA	0.02	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.34	1.52	NA	NA	0.01	XXX
88304	26	A	Tissue exam by pathologist	0.22	0.10	0.09	0.10	0.09	0.01	XXX
88305		A	Tissue exam by pathologist	0.75	2.19	2.35	NA	NA	0.02	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.87	2.04	NA	NA	0.01	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.32	0.31	0.32	0.31	0.01	XXX
88307		A	Tissue exam by pathologist	1.59	5.09	5.04	NA	NA	0.05	XXX
88307	TC	A	Tissue exam by pathologist	0.00	4.34	4.33	NA	NA	0.01	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.75	0.71	0.75	0.71	0.04	XXX
88309		A	Tissue exam by pathologist	2.80	7.38	7.21	NA	NA	0.11	XXX
88309	TC	A	Tissue exam by pathologist	0.00	6.05	5.99	NA	NA	0.03	XXX
88309	26	A	Tissue exam by pathologist	2.80	1.33	1.22	1.33	1.22	0.08	XXX
88311		A	Decalcify tissue	0.24	0.30	0.29	NA	NA	0.02	XXX
88311	TC	A	Decalcify tissue	0.00	0.19	0.19	NA	NA	0.01	XXX
88311	26	A	Decalcify tissue	0.24	0.11	0.10	0.11	0.10	0.01	XXX
88312		A	Special stains group 1	0.54	2.53	2.59	NA	NA	0.02	XXX
88312	TC	A	Special stains group 1	0.00	2.31	2.37	NA	NA	0.01	XXX
88312	26	A	Special stains group 1	0.54	0.22	0.22	0.22	0.22	0.01	XXX
88313		A	Special stains group 2	0.24	1.97	2.04	NA	NA	0.02	XXX
88313	TC	A	Special stains group 2	0.00	1.87	1.95	NA	NA	0.01	XXX
88313	26	A	Special stains group 2	0.24	0.10	0.09	0.10	0.09	0.01	XXX
88314		A	Histochemical stains add-on	0.45	2.00	2.18	NA	NA	0.02	XXX
88314	TC	A	Histochemical stains add-on	0.00	1.79	1.98	NA	NA	0.01	XXX
88314	26	A	Histochemical stains add-on	0.45	0.21	0.20	0.21	0.20	0.01	XXX
88318		A	Chemical histochemistry	0.42	3.20	3.00	NA	NA	0.02	XXX
88318	TC	A	Chemical histochemistry	0.00	3.01	2.82	NA	NA	0.01	XXX

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88318	26	A	Chemical histochemistry	0.42	0.19	0.18	0.19	0.18	0.01	XXX
88319		A	Enzyme histochemistry	0.53	3.58	3.75	NA	NA	0.04	XXX
88319	TC	A	Enzyme histochemistry	0.00	3.34	3.53	NA	NA	0.01	XXX
88319	26	A	Enzyme histochemistry	0.53	0.24	0.22	0.24	0.22	0.03	XXX
88321		A	Microslide consultation	1.63	0.97	0.94	0.72	0.67	0.10	XXX
88323		A	Microslide consultation	1.83	2.17	2.33	NA	NA	0.05	XXX
88323	TC	A	Microslide consultation	0.00	1.57	1.73	NA	NA	0.01	XXX
88323	26	A	Microslide consultation	1.83	0.60	0.60	0.60	0.60	0.04	XXX
88325		A	Comprehensive review of data	2.50	3.29	3.27	1.28	1.14	0.12	XXX
88329		A	Path consult introp	0.67	0.84	0.83	0.32	0.30	0.04	XXX
88331		A	Path consult intraop 1 bloc	1.19	1.52	1.49	NA	NA	0.02	XXX
88331	TC	A	Path consult intraop 1 bloc	0.00	0.93	0.94	NA	NA	0.01	XXX
88331	26	A	Path consult intraop 1 bloc	1.19	0.59	0.55	0.59	0.55	0.01	XXX
88332		A	Path consult intraop addl	0.59	0.59	0.58	NA	NA	0.02	XXX
88332	TC	A	Path consult intraop addl	0.00	0.31	0.32	NA	NA	0.01	XXX
88332	26	A	Path consult intraop addl	0.59	0.28	0.26	0.28	0.26	0.01	XXX
88333		A	Intraop cyto path consult 1	1.20	1.61	1.57	NA	NA	0.05	XXX
88333	TC	A	Intraop cyto path consult 1	0.00	1.04	1.03	NA	NA	0.01	XXX
88333	26	A	Intraop cyto path consult 1	1.20	0.57	0.54	0.57	0.54	0.04	XXX
88334		A	Intraop cyto path consult 2	0.73	1.00	0.97	NA	NA	0.04	XXX
88334	TC	A	Intraop cyto path consult 2	0.00	0.65	0.64	NA	NA	0.01	XXX
88334	26	A	Intraop cyto path consult 2	0.73	0.35	0.33	0.35	0.33	0.03	XXX
88342		A	Immunohistochemistry	0.85	2.12	2.18	NA	NA	0.04	XXX
88342	TC	A	Immunohistochemistry	0.00	1.78	1.85	NA	NA	0.01	XXX
88342	26	A	Immunohistochemistry	0.85	0.34	0.33	0.34	0.33	0.03	XXX
88346		A	Immunofluorescent study	0.86	2.04	2.13	NA	NA	0.02	XXX
88346	TC	A	Immunofluorescent study	0.00	1.68	1.79	NA	NA	0.01	XXX
88346	26	A	Immunofluorescent study	0.86	0.36	0.34	0.36	0.34	0.01	XXX

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88347		A	Immunofluorescent study	0.86	1.27	1.41	NA	NA	0.02	XXX
88347	TC	A	Immunofluorescent study	0.00	1.03	1.15	NA	NA	0.01	XXX
88347	26	A	Immunofluorescent study	0.86	0.24	0.26	0.24	0.26	0.01	XXX
88348		A	Electron microscopy	1.51	17.96	18.48	NA	NA	0.12	XXX
88348	TC	A	Electron microscopy	0.00	17.34	17.88	NA	NA	0.08	XXX
88348	26	A	Electron microscopy	1.51	0.62	0.60	0.62	0.60	0.04	XXX
88349		A	Scanning electron microscopy	0.76	10.57	9.78	NA	NA	0.07	XXX
88349	TC	A	Scanning electron microscopy	0.00	10.19	9.43	NA	NA	0.04	XXX
88349	26	A	Scanning electron microscopy	0.76	0.38	0.35	0.38	0.35	0.03	XXX
88355		A	Analysis skeletal muscle	1.85	3.23	4.41	NA	NA	0.06	XXX
88355	TC	A	Analysis skeletal muscle	0.00	2.69	3.84	NA	NA	0.01	XXX
88355	26	A	Analysis skeletal muscle	1.85	0.54	0.57	0.54	0.57	0.05	XXX
88356		A	Analysis nerve	3.02	4.51	5.15	NA	NA	0.18	XXX
88356	TC	A	Analysis nerve	0.00	3.94	4.44	NA	NA	0.04	XXX
88356	26	A	Analysis nerve	3.02	0.57	0.71	0.57	0.71	0.14	XXX
88358		A	Analysis tumor	0.95	1.16	1.21	NA	NA	0.04	XXX
88358	TC	A	Analysis tumor	0.00	0.91	0.95	NA	NA	0.01	XXX
88358	26	A	Analysis tumor	0.95	0.25	0.26	0.25	0.26	0.03	XXX
88360		A	Tumor immunohistochem/manual	1.10	2.41	2.50	NA	NA	0.04	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	1.99	2.09	NA	NA	0.01	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.42	0.41	0.42	0.41	0.03	XXX
88361		A	Tumor immunohistochem/comput	1.18	3.02	3.24	NA	NA	0.05	XXX
88361	TC	A	Tumor immunohistochem/comput	0.00	2.58	2.82	NA	NA	0.01	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.44	0.42	0.44	0.42	0.04	XXX
88362		A	Nerve teasing preparations	2.17	6.06	6.03	NA	NA	0.14	XXX
88362	TC	A	Nerve teasing preparations	0.00	5.12	5.14	NA	NA	0.04	XXX
88362	26	A	Nerve teasing preparations	2.17	0.94	0.89	0.94	0.89	0.10	XXX
88363		A	Xm archive tissue molec anal	0.37	0.72	0.72	0.10	0.10	0.03	XXX

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88365		A	Insitu hybridization (fish)	1.20	3.57	3.65	NA	NA	0.04	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	3.10	3.19	NA	NA	0.01	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.47	0.46	0.47	0.46	0.03	XXX
88367		A	Insitu hybridization auto	1.30	6.08	6.21	NA	NA	0.06	XXX
88367	TC	A	Insitu hybridization auto	0.00	5.63	5.77	NA	NA	0.01	XXX
88367	26	A	Insitu hybridization auto	1.30	0.45	0.44	0.45	0.44	0.05	XXX
88368		A	Insitu hybridization manual	1.40	4.83	5.04	NA	NA	0.05	XXX
88368	TC	A	Insitu hybridization manual	0.00	4.47	4.65	NA	NA	0.01	XXX
88368	26	A	Insitu hybridization manual	1.40	0.36	0.39	0.36	0.39	0.04	XXX
88371	26	A	Protein western blot tissue	0.37	0.18	0.16	0.18	0.16	0.03	XXX
88372	26	A	Protein analysis w/probe	0.37	0.18	0.17	0.18	0.17	0.03	XXX
88380		A	Microdissection laser	1.56	2.61	3.56	NA	NA	0.05	XXX
88380	TC	A	Microdissection laser	0.00	2.16	3.03	NA	NA	0.01	XXX
88380	26	A	Microdissection laser	1.56	0.45	0.53	0.45	0.53	0.04	XXX
88381		A	Microdissection manual	1.18	2.81	4.22	NA	NA	0.04	XXX
88381	TC	A	Microdissection manual	0.00	2.56	3.86	NA	NA	0.01	XXX
88381	26	A	Microdissection manual	1.18	0.25	0.36	0.25	0.36	0.03	XXX
88384		C	Eval molecular probes 11-50	0.00	0.00	0.00	NA	NA	0.00	XXX
88384	TC	C	Eval molecular probes 11-50	0.00	0.00	0.00	NA	NA	0.00	XXX
88384	26	C	Eval molecular probes 11-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88385		A	Eval molecul probes 51-250	1.50	15.14	15.40	NA	NA	0.07	XXX
88385	TC	A	Eval molecul probes 51-250	0.00	14.77	15.00	NA	NA	0.03	XXX
88385	26	A	Eval molecul probes 51-250	1.50	0.37	0.40	0.37	0.40	0.04	XXX
88386		A	Eval molecul probes 251-500	1.88	13.92	16.95	NA	NA	0.08	XXX
88386	TC	A	Eval molecul probes 251-500	0.00	13.57	16.34	NA	NA	0.03	XXX
88386	26	A	Eval molecul probes 251-500	1.88	0.35	0.61	0.35	0.61	0.05	XXX
88387		A	Tiss exam molecular study	0.62	0.55	0.55	NA	NA	0.02	XXX
88387	TC	A	Tiss exam molecular study	0.00	0.25	0.25	NA	NA	0.01	XXX

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88387	26	A	Tiss exam molecular study	0.62	0.30	0.30	0.30	0.30	0.01	XXX
88388		A	Tiss ex molecul study add-on	0.45	0.22	0.22	NA	NA	0.02	XXX
88388	TC	A	Tiss ex molecul study add-on	0.00	0.12	0.12	NA	NA	0.01	XXX
88388	26	A	Tiss ex molecul study add-on	0.45	0.10	0.10	0.10	0.10	0.01	XXX
88399		C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	TC	C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
89049		A	Chct for mal hyperthermia	1.40	5.82	6.02	0.40	0.46	0.10	XXX
89060	26	A	Exam synovial fluid crystals	0.37	0.18	0.17	0.18	0.17	0.03	XXX
89220		A	Sputum specimen collection	0.00	0.44	0.46	NA	NA	0.01	XXX
89230		A	Collect sweat for test	0.00	0.06	0.08	NA	NA	0.01	XXX
89240		C	Pathology lab procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90281		I	Human ig im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90283		I	Human ig iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90284		X	Human ig sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90287		I	Botulinum antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90288		I	Botulism ig iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90291		I	Cmv ig iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90296		E	Diphtheria antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90371		E	Hep b ig im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90375		E	Rabies ig im/sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90376		E	Rabies ig heat treated	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90378		X	Rsv mab im 50mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90384		I	Rh ig full-dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90385		E	Rh ig minidose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90386		I	Rh ig iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90389		I	Tetanus ig im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90393		E	Vaccina ig im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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90396		E	Varicella-zoster ig im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90399		I	Immune globulin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90460		A	Imadm any route 1st vac/tox	0.17	0.50	0.50	NA	NA	0.01	XXX
90461		A	Inadm any route addl vac/tox	0.15	0.20	0.18	NA	NA	0.01	ZZZ
90470		I	Immune admin h1n1 im/nasal	0.20	0.40	0.40	NA	NA	0.01	XXX
90471		A	Immunization admin	0.17	0.50	0.50	NA	NA	0.01	XXX
90472		A	Immunization admin each add	0.15	0.20	0.18	NA	NA	0.01	ZZZ
90473		R	Immune admin oral/nasal	0.17	0.50	0.50	NA	NA	0.01	XXX
90474		R	Immune admin oral/nasal addl	0.15	0.20	0.18	NA	NA	0.01	ZZZ
90476		E	Adenovirus vaccine type 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90477		E	Adenovirus vaccine type 7	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90581		E	Anthrax vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90585		E	Bcg vaccine percut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90586		E	Bcg vaccine intravesical	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90632		E	Hep a vaccine adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90633		E	Hep a vacc ped/adol 2 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90634		E	Hep a vacc ped/adol 3 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90636		E	Hep a/hep b vacc adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90644		X	Meningoccl hib vac 4 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90645		E	Hib vaccine hboc im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90646		E	Hib vaccine prp-d im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90647		E	Hib vaccine prp-omp im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90648		E	Hib vaccine prp-t im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90649		E	Hpv vaccine 4 valent im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90650		E	Hpv vaccine 2 valent im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90654		X	Flu vaccine no preserv, id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90655		X	Flu vaccine no preserv 6-35m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90656		X	Flu vaccine no preserv 3 & >	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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90657		X	Flu vaccine 3 yrs im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90658		I	Flu vaccine 3 yrs & > im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90660		X	Flu vaccine nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90661		X	Flu vacc cell cult prsv free	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90662		X	Flu vacc prsv free inc antig	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90663		X	Flu vacc pandemic h1n1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90664		X	Flu vacc pandemic intranasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90665		E	Lyme disease vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90666		X	Flu vac pandem prsrv free im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90667		X	Flu vac pandemic adjuvant im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90668		X	Flu vac pandemic splt im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90669		X	Pneumococcal vacc 7 val im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90670		X	Pneumococcal vacc 13 val im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90675		E	Rabies vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90676		E	Rabies vaccine id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90680		E	Rotovirus vacc 3 dose oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90681		E	Rotavirus vacc 2 dose oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90690		E	Typhoid vaccine oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90691		E	Typhoid vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90692		E	Typhoid vaccine h-p sc/id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90693		E	Typhoid vaccine akd sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90696		E	Dtap-ipv vacc 4-6 yr im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90698		E	Dtap-hib-ip vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90700		E	Dtap vaccine < 7 yrs im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90701		E	Dtp vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90702		E	Dt vaccine < 7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90703		E	Tetanus vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90704		E	Mumps vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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90705		E	Measles vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90706		E	Rubella vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90707		E	Mmr vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90708		E	Measles-rubella vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90710		E	Mmrv vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90712		E	Oral poliovirus vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90713		E	Poliovirus ipv sc/im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90714		E	Td vaccine no prsrv >/= 7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90715		E	Tdap vaccine >7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90716		E	Chicken pox vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90717		E	Yellow fever vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90718		E	Td vaccine > 7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90719		E	Diphtheria vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90720		E	Dtp/hib vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90721		E	Dtap/hib vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90723		I	Dtap-hep b-ipv vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90725		E	Cholera vaccine injectable	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90727		E	Plague vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90732		X	Pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90733		E	Meningococcal vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90734		E	Meningococcal vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90735		E	Encephalitis vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90736		E	Zoster vacc sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90738		I	Inactivated je vacc im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90740		X	Hepb vacc ill pat 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90743		X	Hep b vacc adol 2 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90744		X	Hepb vacc ped/adol 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90746		X	Hep b vaccine adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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90747		X	Hepb vacc ill pat 4 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90748		I	Hep b/hib vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90749		E	Vaccine toxoid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.80	1.55	1.62	0.60	0.72	0.11	XXX
90802		A	Intac psy dx interview	3.01	1.83	1.80	0.78	0.84	0.12	XXX
90804		A	Psytx office 20-30 min	1.21	0.57	0.61	0.18	0.25	0.04	XXX
90805		A	Psytx off 20-30 min w/e&m	1.37	0.70	0.70	0.28	0.32	0.05	XXX
90806		A	Psytx off 45-50 min	1.86	0.46	0.58	0.25	0.37	0.07	XXX
90807		A	Psytx off 45-50 min w/e&m	2.02	0.83	0.85	0.42	0.47	0.08	XXX
90808		A	Psytx office 75-80 min	2.79	0.63	0.79	0.43	0.59	0.10	XXX
90809		A	Psytx off 75-80 w/e&m	2.95	1.03	1.07	0.64	0.71	0.12	XXX
90810		A	Intac psytx off 20-30 min	1.32	0.48	0.56	0.21	0.27	0.05	XXX
90811		A	Intac psytx 20-30 w/e&m	1.48	0.87	0.84	0.32	0.36	0.07	XXX
90812		A	Intac psytx off 45-50 min	1.97	0.57	0.70	0.26	0.39	0.07	XXX
90813		A	Intac psytx 45-50 min w/e&m	2.13	0.97	0.98	0.43	0.50	0.08	XXX
90814		A	Intac psytx off 75-80 min	2.90	0.74	0.94	0.38	0.62	0.11	XXX
90815		A	Intac psytx 75-80 w/e&m	3.06	1.35	1.30	0.82	0.82	0.14	XXX
90816		A	Psytx hosp 20-30 min	1.25	0.26	0.26	0.26	0.35	0.04	XXX
90817		A	Psytx hosp 20-30 min w/e&m	1.41	0.41	0.41	0.41	0.44	0.05	XXX
90818		A	Psytx hosp 45-50 min	1.89	0.34	0.34	0.34	0.48	0.07	XXX
90819		A	Psytx hosp 45-50 min w/e&m	2.05	0.55	0.55	0.55	0.60	0.08	XXX
90821		A	Psytx hosp 75-80 min	2.83	0.48	0.48	0.48	0.67	0.10	XXX
90822		A	Psytx hosp 75-80 min w/e&m	2.99	0.74	0.74	0.74	0.81	0.12	XXX
90823		A	Intac psytx hosp 20-30 min	1.36	0.29	0.29	0.29	0.38	0.04	XXX
90824		A	Intac psytx hsp 20-30 w/e&m	1.52	0.43	0.43	0.43	0.47	0.07	XXX
90826		A	Intac psytx hosp 45-50 min	2.01	0.38	0.38	0.38	0.51	0.07	XXX
90827		A	Intac psytx hsp 45-50 w/e&m	2.16	0.56	0.56	0.56	0.61	0.08	XXX
90828		A	Intac psytx hosp 75-80 min	2.94	0.51	0.51	0.51	0.71	0.10	XXX

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90829		A	Intac psytx hsp 75-80 w/e&m	3.10	0.75	0.75	0.75	0.83	0.12	XXX
90845		A	Psychoanalysis	1.79	0.43	0.48	0.36	0.42	0.07	XXX
90846		R	Family psytx w/o patient	1.83	0.49	0.58	0.40	0.50	0.07	XXX
90847		R	Family psytx w/patient	2.21	0.70	0.81	0.44	0.57	0.08	XXX
90849		R	Multiple family group psytx	0.59	0.39	0.38	0.22	0.25	0.03	XXX
90853		A	Group psychotherapy	0.59	0.33	0.32	0.25	0.25	0.03	XXX
90857		A	Intac group psytx	0.63	0.44	0.43	0.30	0.29	0.03	XXX
90862		A	Medication management	0.95	0.73	0.71	0.32	0.33	0.04	XXX
90865		A	Narcosynthesis	2.84	1.77	1.70	0.70	0.80	0.11	XXX
90867		C	Tcranial magn stim tx plan	0.00	0.00	0.00	0.00	0.00	0.00	YYY
90868		C	Tcranial magn stim tx deli	0.00	0.00	0.00	0.00	0.00	0.00	YYY
90870		A	Electroconvulsive therapy	2.50	2.33	2.31	0.58	0.56	0.11	000
90875		N	Psychophysiological therapy	1.20	0.84	0.87	0.53	0.52	0.08	XXX
90876		N	Psychophysiological therapy	1.90	1.13	1.15	0.84	0.82	0.12	XXX
90880		A	Hypnotherapy	2.19	0.53	0.69	0.36	0.47	0.08	XXX
90882		N	Environmental manipulation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90885		B	Psy evaluation of records	0.97	0.43	0.42	0.43	0.42	0.07	XXX
90887		B	Consultation with family	1.48	0.99	0.99	0.65	0.64	0.10	XXX
90889		B	Preparation of report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90901		A	Biofeedback train any meth	0.41	0.70	0.66	0.19	0.17	0.01	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.47	1.61	0.37	0.38	0.07	000
90935		A	Hemodialysis one evaluation	1.48	NA	NA	0.57	0.64	0.08	000
90937		A	Hemodialysis repeated eval	2.11	NA	NA	0.82	0.93	0.11	000
90940		X	Hemodialysis access study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90945		A	Dialysis one evaluation	1.56	0.60	0.66	NA	NA	0.08	000
90947		A	Dialysis repeated eval	2.52	NA	NA	0.97	1.01	0.15	000
90951		A	Esrd serv 4 visits p mo <2	18.46	8.04	8.68	8.04	8.68	1.02	XXX

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90952		C	Esrd serv 2-3 vsts p mo <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90953		C	Esrd serv 1 visit p mo <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90954		A	Esrd serv 4 vsts p mo 2-11	15.98	6.95	6.74	6.95	6.74	0.90	XXX
90955		A	Esrd srv 2-3 vsts p mo 2-11	8.79	4.09	4.07	4.09	4.07	0.49	XXX
90956		A	Esrd srv 1 visit p mo 2-11	5.95	2.99	2.87	2.99	2.87	0.34	XXX
90957		A	Esrd srv 4 vsts p mo 12-19	12.52	5.62	5.65	5.62	5.65	0.72	XXX
90958		A	Esrd srv 2-3 vsts p mo 12-19	8.34	3.99	3.98	3.99	3.98	0.48	XXX
90959		A	Esrd serv 1 vst p mo 12-19	5.50	2.84	2.71	2.84	2.71	0.31	XXX
90960		A	Esrd srv 4 visits p mo 20+	5.18	2.80	2.91	2.80	2.91	0.31	XXX
90961		A	Esrd srv 2-3 vsts p mo 20+	4.26	2.45	2.39	2.45	2.39	0.26	XXX
90962		A	Esrd serv 1 visit p mo 20+	3.15	2.02	1.81	2.02	1.81	0.20	XXX
90963		A	Esrd home pt serv p mo <2	10.56	4.78	4.93	4.78	4.93	0.60	XXX
90964		A	Esrd home pt serv p mo 2-11	9.14	4.23	4.01	4.23	4.01	0.52	XXX
90965		A	Esrd home pt serv p mo 12-19	8.69	4.06	3.85	4.06	3.85	0.49	XXX
90966		A	Esrd home pt serv p mo 20+	4.26	2.44	2.35	2.44	2.35	0.26	XXX
90967		A	Esrd home pt serv p day <2	0.35	0.16	0.19	0.16	0.19	0.01	XXX
90968		A	Esrd home pt srv p day 2-11	0.30	0.14	0.14	0.14	0.14	0.01	XXX
90969		A	Esrd home pt srv p day 12-19	0.29	0.14	0.14	0.14	0.14	0.01	XXX
90970		A	Esrd home pt serv p day 20+	0.14	0.08	0.08	0.08	0.08	0.01	XXX
90989		X	Dialysis training complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90993		X	Dialysis training incompl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90997		A	Hemoperfusion	1.84	NA	NA	0.69	0.69	0.10	000
90999		C	Dialysis procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91010		A	Esophagus motility study	1.28	3.73	4.17	NA	NA	0.08	000
91010	TC	A	Esophagus motility study	0.00	3.04	3.49	NA	NA	0.01	000
91010	26	A	Esophagus motility study	1.28	0.69	0.68	0.69	0.68	0.07	000
91013		A	Esophgl motil w/stim/perfus	0.18	0.48	0.48	NA	NA	0.02	ZZZ
91013	TC	A	Esophgl motil w/stim/perfus	0.00	0.38	0.38	NA	NA	0.01	ZZZ

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91013	26	A	Esophgl motil w/stim/perfus	0.18	0.10	0.10	0.10	0.10	0.01	ZZZ
91020		A	Gastric motility studies	1.44	5.24	5.49	NA	NA	0.08	000
91020	TC	A	Gastric motility studies	0.00	4.46	4.72	NA	NA	0.01	000
91020	26	A	Gastric motility studies	1.44	0.78	0.77	0.78	0.77	0.07	000
91022		A	Duodenal motility study	1.44	3.47	3.92	NA	NA	0.06	000
91022	TC	A	Duodenal motility study	0.00	2.66	3.10	NA	NA	0.01	000
91022	26	A	Duodenal motility study	1.44	0.81	0.82	0.81	0.82	0.05	000
91030		A	Acid perfusion of esophagus	0.91	3.02	3.20	NA	NA	0.05	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.51	2.69	NA	NA	0.01	000
91030	26	A	Acid perfusion of esophagus	0.91	0.51	0.51	0.51	0.51	0.04	000
91034		A	Gastroesophageal reflux test	0.97	4.40	4.82	NA	NA	0.05	000
91034	TC	A	Gastroesophageal reflux test	0.00	3.87	4.31	NA	NA	0.01	000
91034	26	A	Gastroesophageal reflux test	0.97	0.53	0.51	0.53	0.51	0.04	000
91035		A	G-esoph reflx tst w/electrod	1.59	12.02	12.70	NA	NA	0.08	000
91035	TC	A	G-esoph reflx tst w/electrod	0.00	11.16	11.85	NA	NA	0.01	000
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.86	0.85	0.86	0.85	0.07	000
91037		A	Esoph imped function test	0.97	3.60	3.78	NA	NA	0.08	000
91037	TC	A	Esoph imped function test	0.00	3.07	3.25	NA	NA	0.01	000
91037	26	A	Esoph imped function test	0.97	0.53	0.53	0.53	0.53	0.07	000
91038		A	Esoph imped funct test > 1h	1.10	12.00	7.67	NA	NA	0.06	000
91038	TC	A	Esoph imped funct test > 1h	0.00	11.40	7.07	NA	NA	0.01	000
91038	26	A	Esoph imped funct test > 1h	1.10	0.60	0.60	0.60	0.60	0.05	000
91040		A	Esoph balloon distension tst	0.97	7.09	9.13	NA	NA	0.04	000
91040	TC	A	Esoph balloon distension tst	0.00	6.71	8.65	NA	NA	0.01	000
91040	26	A	Esoph balloon distension tst	0.97	0.38	0.48	0.38	0.48	0.03	000
91065		A	Breath hydrogen test	0.20	2.36	2.13	NA	NA	0.02	000
91065	TC	A	Breath hydrogen test	0.00	2.25	2.03	NA	NA	0.01	000
91065	26	A	Breath hydrogen test	0.20	0.11	0.10	0.11	0.10	0.01	000

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91110		A	Gi tract capsule endoscopy	3.64	21.61	23.37	NA	NA	0.17	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	19.59	21.36	NA	NA	0.01	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	2.02	2.01	2.02	2.01	0.16	XXX
91111		A	Esophageal capsule endoscopy	1.00	19.45	20.72	NA	NA	0.05	XXX
91111	TC	A	Esophageal capsule endoscopy	0.00	18.90	20.15	NA	NA	0.01	XXX
91111	26	A	Esophageal capsule endoscopy	1.00	0.55	0.57	0.55	0.57	0.04	XXX
91117		A	Colon motility 6 hr study	2.45	1.36	1.36	1.64	1.64	0.38	000
91120		A	Rectal sensation test	0.97	9.11	10.31	NA	NA	0.09	XXX
91120	TC	A	Rectal sensation test	0.00	8.66	9.89	NA	NA	0.01	XXX
91120	26	A	Rectal sensation test	0.97	0.45	0.42	0.45	0.42	0.08	XXX
91122		A	Anal pressure record	1.77	4.46	4.86	NA	NA	0.11	000
91122	TC	A	Anal pressure record	0.00	3.67	4.09	NA	NA	0.01	000
91122	26	A	Anal pressure record	1.77	0.79	0.77	0.79	0.77	0.10	000
91132		A	Electrogastrography	0.52	3.61	3.62	NA	NA	0.04	XXX
91132	TC	A	Electrogastrography	0.00	3.34	3.34	NA	NA	0.01	XXX
91132	26	A	Electrogastrography	0.52	0.27	0.28	0.27	0.28	0.03	XXX
91133		A	Electrogastrography w/test	0.66	4.39	4.40	NA	NA	0.05	XXX
91133	TC	A	Electrogastrography w/test	0.00	4.02	4.02	NA	NA	0.01	XXX
91133	26	A	Electrogastrography w/test	0.66	0.37	0.38	0.37	0.38	0.04	XXX
91299		C	Gastroenterology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
91299	TC	C	Gastroenterology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92002		A	Eye exam new patient	0.88	1.37	1.28	0.49	0.43	0.07	XXX
92004		A	Eye exam new patient	1.82	2.37	2.19	1.05	0.92	0.12	XXX
92012		A	Eye exam established pat	0.92	1.48	1.37	0.60	0.51	0.07	XXX
92014		A	Eye exam & treatment	1.42	2.06	1.90	0.89	0.76	0.10	XXX
92015		N	Refraction	0.38	0.18	0.38	0.17	0.16	0.03	XXX
92018		A	New eye exam & treatment	2.50	NA	NA	1.66	1.43	0.16	XXX

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92019		A	Eye exam & treatment	1.31	NA	NA	0.67	0.60	0.07	XXX
92020		A	Special eye evaluation	0.37	0.40	0.37	0.24	0.21	0.03	XXX
92025		A	Corneal topography	0.35	0.71	0.66	NA	NA	0.02	XXX
92025	TC	A	Corneal topography	0.00	0.48	0.46	NA	NA	0.01	XXX
92025	26	A	Corneal topography	0.35	0.23	0.20	0.23	0.20	0.01	XXX
92060		A	Special eye evaluation	0.69	1.14	1.05	NA	NA	0.04	XXX
92060	TC	A	Special eye evaluation	0.00	0.71	0.67	NA	NA	0.01	XXX
92060	26	A	Special eye evaluation	0.69	0.43	0.38	0.43	0.38	0.03	XXX
92065		A	Orthoptic/pleoptic training	0.37	1.13	1.04	NA	NA	0.02	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.98	0.90	NA	NA	0.01	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.15	0.14	0.15	0.14	0.01	XXX
92070		A	Fitting of contact lens	0.70	1.30	1.24	0.43	0.37	0.04	XXX
92081		A	Visual field examination(s)	0.30	1.03	1.10	NA	NA	0.03	XXX
92081	TC	A	Visual field examination(s)	0.00	0.86	0.93	NA	NA	0.01	XXX
92081	26	A	Visual field examination(s)	0.30	0.17	0.17	0.17	0.17	0.02	XXX
92082		A	Visual field examination(s)	0.40	1.51	1.55	NA	NA	0.05	XXX
92082	TC	A	Visual field examination(s)	0.00	1.28	1.34	NA	NA	0.01	XXX
92082	26	A	Visual field examination(s)	0.40	0.23	0.21	0.23	0.21	0.04	XXX
92083		A	Visual field examination(s)	0.50	2.06	1.95	NA	NA	0.04	XXX
92083	TC	A	Visual field examination(s)	0.00	1.74	1.67	NA	NA	0.01	XXX
92083	26	A	Visual field examination(s)	0.50	0.32	0.28	0.32	0.28	0.03	XXX
92100		A	Serial tonometry exam(s)	0.92	1.82	1.70	0.55	0.47	0.05	XXX
92120		A	Tonography & eye evaluation	0.81	1.40	1.32	0.47	0.41	0.05	XXX
92130		A	Water provocation tonography	0.81	1.67	1.57	0.51	0.45	0.04	XXX
92132		A	Cmptr ophth dx img ant segmt	0.35	0.68	0.68	NA	NA	0.04	XXX
92132	TC	A	Cmptr ophth dx img ant segmt	0.00	0.44	0.44	NA	NA	0.01	XXX
92132	26	A	Cmptr ophth dx img ant segmt	0.35	0.24	0.24	0.24	0.24	0.03	XXX
92133		A	Cmptr ophth img optic nerve	0.50	0.77	0.77	NA	NA	0.04	XXX

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92133	TC	A	Cmptr ophth img optic nerve	0.00	0.44	0.44	NA	NA	0.01	XXX
92133	26	A	Cmptr ophth img optic nerve	0.50	0.33	0.33	0.33	0.33	0.03	XXX
92134		A	Cptr ophth dx img post segmt	0.50	0.77	0.77	NA	NA	0.04	XXX
92134	TC	A	Cptr ophth dx img post segmt	0.00	0.44	0.44	NA	NA	0.01	XXX
92134	26	A	Cptr ophth dx img post segmt	0.50	0.33	0.33	0.33	0.33	0.03	XXX
92136		A	Ophthalmic biometry	0.54	1.95	1.88	NA	NA	0.02	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.57	1.56	NA	NA	0.01	XXX
92136	26	A	Ophthalmic biometry	0.54	0.38	0.32	0.38	0.32	0.01	XXX
92140		A	Glaucoma provocative tests	0.50	1.26	1.20	0.28	0.24	0.03	XXX
92225		A	Special eye exam initial	0.38	0.39	0.34	0.24	0.21	0.03	XXX
92226		A	Special eye exam subsequent	0.33	0.38	0.33	0.23	0.19	0.01	XXX
92227		A	Remote dx retinal imaging	0.00	0.33	0.33	NA	NA	0.01	XXX
92228		A	Remote retinal imaging mgmt	0.30	0.56	0.56	NA	NA	0.02	XXX
92228	TC	A	Remote retinal imaging mgmt	0.00	0.36	0.36	NA	NA	0.01	XXX
92228	26	A	Remote retinal imaging mgmt	0.30	0.20	0.20	0.20	0.20	0.01	XXX
92230		A	Eye exam with photos	0.60	1.01	1.06	0.36	0.31	0.04	XXX
92235		A	Eye exam with photos	0.81	3.10	3.00	NA	NA	0.04	XXX
92235	TC	A	Eye exam with photos	0.00	2.53	2.51	NA	NA	0.01	XXX
92235	26	A	Eye exam with photos	0.81	0.57	0.49	0.57	0.49	0.03	XXX
92240		A	Icg angiography	1.10	5.87	5.90	NA	NA	0.04	XXX
92240	TC	A	Icg angiography	0.00	5.10	5.23	NA	NA	0.01	XXX
92240	26	A	Icg angiography	1.10	0.77	0.67	0.77	0.67	0.03	XXX
92250		A	Eye exam with photos	0.44	1.74	1.70	NA	NA	0.02	XXX
92250	TC	A	Eye exam with photos	0.00	1.48	1.47	NA	NA	0.01	XXX
92250	26	A	Eye exam with photos	0.44	0.26	0.23	0.26	0.23	0.01	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.33	0.32	0.13	0.11	0.01	XXX
92265		A	Eye muscle evaluation	0.81	1.60	1.48	NA	NA	0.02	XXX
92265	TC	A	Eye muscle evaluation	0.00	1.03	1.04	NA	NA	0.01	XXX

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92265	26	A	Eye muscle evaluation	0.81	0.57	0.44	0.57	0.44	0.01	XXX
92270		A	Electro-oculography	0.81	1.73	1.73	NA	NA	0.04	XXX
92270	TC	A	Electro-oculography	0.00	1.34	1.37	NA	NA	0.01	XXX
92270	26	A	Electro-oculography	0.81	0.39	0.36	0.39	0.36	0.03	XXX
92275		A	Electroretinography	1.01	3.40	3.13	NA	NA	0.05	XXX
92275	TC	A	Electroretinography	0.00	2.70	2.53	NA	NA	0.01	XXX
92275	26	A	Electroretinography	1.01	0.70	0.60	0.70	0.60	0.04	XXX
92283		A	Color vision examination	0.17	1.32	1.25	NA	NA	0.02	XXX
92283	TC	A	Color vision examination	0.00	1.23	1.17	NA	NA	0.01	XXX
92283	26	A	Color vision examination	0.17	0.09	0.08	0.09	0.08	0.01	XXX
92284		A	Dark adaptation eye exam	0.24	1.40	1.49	NA	NA	0.02	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.29	1.39	NA	NA	0.01	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.11	0.10	0.11	0.10	0.01	XXX
92285		A	Eye photography	0.05	0.49	0.75	NA	NA	0.02	XXX
92285	TC	A	Eye photography	0.00	0.46	0.69	NA	NA	0.01	XXX
92285	26	A	Eye photography	0.05	0.03	0.06	0.03	0.06	0.01	XXX
92286		A	Internal eye photography	0.66	2.81	2.82	NA	NA	0.02	XXX
92286	TC	A	Internal eye photography	0.00	2.39	2.46	NA	NA	0.01	XXX
92286	26	A	Internal eye photography	0.66	0.42	0.36	0.42	0.36	0.01	XXX
92287		A	Internal eye photography	0.81	2.67	2.58	0.57	0.47	0.04	XXX
92310		N	Contact lens fitting	1.17	1.50	1.51	0.51	0.51	0.08	XXX
92311		A	Contact lens fitting	1.08	1.82	1.68	0.56	0.49	0.08	XXX
92312		A	Contact lens fitting	1.26	2.11	1.91	0.64	0.57	0.05	XXX
92313		A	Contact lens fitting	0.92	2.00	1.82	0.58	0.49	0.05	XXX
92314		N	Prescription of contact lens	0.69	1.52	1.50	0.30	0.30	0.04	XXX
92315		A	Prescription of contact lens	0.45	1.70	1.58	0.22	0.20	0.04	XXX
92316		A	Prescription of contact lens	0.68	2.32	2.05	0.48	0.39	0.04	XXX
92317		A	Prescription of contact lens	0.45	1.68	1.60	0.18	0.17	0.01	XXX

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92325		A	Modification of contact lens	0.00	1.07	0.98	NA	NA	0.01	XXX
92326		A	Replacement of contact lens	0.00	0.93	1.04	NA	NA	0.01	XXX
92340		N	Fitting of spectacles	0.37	0.61	0.65	0.16	0.16	0.03	XXX
92341		N	Fitting of spectacles	0.47	0.65	0.69	0.21	0.20	0.03	XXX
92342		N	Fitting of spectacles	0.53	0.68	0.72	0.23	0.23	0.04	XXX
92352		B	Special spectacles fitting	0.37	0.76	0.78	0.16	0.16	0.03	XXX
92353		B	Special spectacles fitting	0.50	0.81	0.84	0.22	0.21	0.03	XXX
92354		B	Special spectacles fitting	0.00	0.36	1.67	NA	NA	0.01	XXX
92355		B	Special spectacles fitting	0.00	0.56	1.16	NA	NA	0.01	XXX
92358		B	Eye prosthesis service	0.00	0.30	0.42	NA	NA	0.01	XXX
92370		N	Repair & adjust spectacles	0.32	0.54	0.56	0.14	0.14	0.03	XXX
92371		B	Repair & adjust spectacles	0.00	0.30	0.37	NA	NA	0.01	XXX
92499		C	Eye service or procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
92499	TC	C	Eye service or procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92502		A	Ear and throat examination	1.51	NA	NA	1.36	1.28	0.07	000
92504		A	Ear microscopy examination	0.18	0.70	0.70	0.11	0.10	0.01	XXX
92506		A	Speech/hearing evaluation	0.86	0.66	2.26	NA	NA	0.05	XXX
92507		A	Speech/hearing therapy	1.30	0.69	1.05	NA	NA	0.07	XXX
92508		A	Speech/hearing therapy	0.33	0.24	0.45	NA	NA	0.01	XXX
92511		A	Nasopharyngoscopy	0.84	3.84	3.85	0.95	0.90	0.04	XXX
92512		A	Nasal function studies	0.55	1.22	1.24	0.31	0.27	0.03	XXX
92516		A	Facial nerve function test	0.43	1.61	1.54	0.25	0.23	0.03	XXX
92520		A	Laryngeal function studies	0.75	1.38	1.21	0.49	0.42	0.04	XXX
92526		A	Oral function therapy	1.34	0.78	1.36	NA	NA	0.07	XXX
92531		B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92532		B	Positional nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92533		B	Caloric vestibular test	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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92534		B	Optokinetic nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92540		A	Basic vestibular evaluation	1.50	1.31	1.31	NA	NA	0.05	XXX
92540	TC	A	Basic vestibular evaluation	0.00	0.54	0.54	NA	NA	0.01	XXX
92540	26	A	Basic vestibular evaluation	1.50	0.77	0.77	0.77	0.77	0.04	XXX
92541		A	Spontaneous nystagmus test	0.40	0.46	0.92	NA	NA	0.02	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	0.25	0.73	NA	NA	0.01	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.21	0.19	0.21	0.19	0.01	XXX
92542		A	Positional nystagmus test	0.33	0.42	0.99	NA	NA	0.02	XXX
92542	TC	A	Positional nystagmus test	0.00	0.25	0.83	NA	NA	0.01	XXX
92542	26	A	Positional nystagmus test	0.33	0.17	0.16	0.17	0.16	0.01	XXX
92543		A	Caloric vestibular test	0.10	0.30	0.54	NA	NA	0.02	XXX
92543	TC	A	Caloric vestibular test	0.00	0.25	0.49	NA	NA	0.01	XXX
92543	26	A	Caloric vestibular test	0.10	0.05	0.05	0.05	0.05	0.01	XXX
92544		A	Optokinetic nystagmus test	0.26	0.37	0.81	NA	NA	0.02	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.24	0.69	NA	NA	0.01	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.13	0.12	0.13	0.12	0.01	XXX
92545		A	Oscillating tracking test	0.23	0.36	0.77	NA	NA	0.02	XXX
92545	TC	A	Oscillating tracking test	0.00	0.24	0.66	NA	NA	0.01	XXX
92545	26	A	Oscillating tracking test	0.23	0.12	0.11	0.12	0.11	0.01	XXX
92546		A	Sinusoidal rotational test	0.29	2.60	2.47	NA	NA	0.02	XXX
92546	TC	A	Sinusoidal rotational test	0.00	2.46	2.34	NA	NA	0.01	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.14	0.13	0.14	0.13	0.01	XXX
92547		A	Supplemental electrical test	0.00	0.15	0.14	0.15	0.14	0.01	ZZZ
92548		A	Posturography	0.50	2.66	2.50	NA	NA	0.02	XXX
92548	TC	A	Posturography	0.00	2.40	2.26	NA	NA	0.01	XXX
92548	26	A	Posturography	0.50	0.26	0.24	0.26	0.24	0.01	XXX
92550		A	Tympanometry & reflex thresh	0.35	0.25	0.25	NA	NA	0.01	XXX
92551		N	Pure tone hearing test air	0.00	0.31	0.33	NA	NA	0.01	XXX

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92552		A	Pure tone audiometry air	0.00	0.82	0.75	NA	NA	0.01	XXX
92553		A	Audiometry air & bone	0.00	0.99	0.94	NA	NA	0.01	XXX
92555		A	Speech threshold audiometry	0.00	0.59	0.54	NA	NA	0.01	XXX
92556		A	Speech audiometry complete	0.00	0.93	0.85	NA	NA	0.01	XXX
92557		A	Comprehensive hearing test	0.60	0.47	0.56	0.33	0.45	0.03	XXX
92559		N	Group audiometric testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92560		N	Bekesy audiometry screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92561		A	Bekesy audiometry diagnosis	0.00	1.04	0.96	NA	NA	0.01	XXX
92562		A	Loudness balance test	0.00	1.13	0.93	NA	NA	0.01	XXX
92563		A	Tone decay hearing test	0.00	0.81	0.72	NA	NA	0.01	XXX
92564		A	Sisi hearing test	0.00	0.70	0.65	NA	NA	0.01	XXX
92565		A	Stenger test pure tone	0.00	0.37	0.38	NA	NA	0.01	XXX
92567		A	Tympanometry	0.20	0.20	0.24	0.11	0.16	0.01	XXX
92568		A	Acoustic refl threshold tst	0.29	0.16	0.19	0.16	0.18	0.01	XXX
92570		A	Acoustic immitance testing	0.55	0.36	0.36	0.30	0.30	0.03	XXX
92571		A	Filtered speech hearing test	0.00	0.65	0.58	NA	NA	0.01	XXX
92572		A	Staggered spondaic word test	0.00	1.28	0.93	NA	NA	0.01	XXX
92575		A	Sensorineural acuity test	0.00	1.74	1.45	NA	NA	0.01	XXX
92576		A	Synthetic sentence test	0.00	0.90	0.78	NA	NA	0.01	XXX
92577		A	Stenger test speech	0.00	0.44	0.47	NA	NA	0.01	XXX
92579		A	Visual audiometry (vra)	0.70	0.56	0.56	0.41	0.43	0.03	XXX
92582		A	Conditioning play audiometry	0.00	1.70	1.50	NA	NA	0.01	XXX
92583		A	Select picture audiometry	0.00	1.06	1.04	NA	NA	0.01	XXX
92584		A	Electrocochleography	0.00	1.89	1.96	NA	NA	0.01	XXX
92585		A	Auditor evoke potent compre	0.50	3.07	2.82	NA	NA	0.02	XXX
92585	TC	A	Auditor evoke potent compre	0.00	2.80	2.58	NA	NA	0.01	XXX
92585	26	A	Auditor evoke potent compre	0.50	0.27	0.24	0.27	0.24	0.01	XXX
92586		A	Auditor evoke potent limit	0.00	2.21	2.07	NA	NA	0.01	XXX

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92587		A	Evoked auditory test	0.13	0.87	0.94	NA	NA	0.02	XXX
92587	TC	A	Evoked auditory test	0.00	0.80	0.87	NA	NA	0.01	XXX
92587	26	A	Evoked auditory test	0.13	0.07	0.07	0.07	0.07	0.01	XXX
92588		A	Evoked auditory test	0.36	1.62	1.57	NA	NA	0.02	XXX
92588	TC	A	Evoked auditory test	0.00	1.42	1.39	NA	NA	0.01	XXX
92588	26	A	Evoked auditory test	0.36	0.20	0.18	0.20	0.18	0.01	XXX
92590		N	Hearing aid exam one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92591		N	Hearing aid exam both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92592		N	Hearing aid check one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92593		N	Hearing aid check both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92594		N	Electro hearng aid test one	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92595		N	Electro hearng aid tst both	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92596		A	Ear protector evaluation	0.00	1.23	1.16	NA	NA	0.01	XXX
92597		A	Oral speech device eval	1.26	0.81	1.55	NA	NA	0.07	XXX
92601		A	Cochlear implt f/up exam < 7	2.30	1.52	1.89	1.01	1.41	0.11	XXX
92602		A	Reprogram cochlear implt < 7	1.30	1.02	1.29	0.57	0.86	0.07	XXX
92603		A	Cochlear implt f/up exam 7 >	2.25	1.87	1.84	1.22	1.31	0.11	XXX
92604		A	Reprogram cochlear implt 7 >	1.25	1.22	1.19	0.68	0.75	0.05	XXX
92605		B	Eval for nonspeech device rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92606		B	Non-speech device service	1.40	0.93	0.93	0.62	0.62	0.01	XXX
92607		A	Ex for speech device rx 1hr	1.85	1.50	3.25	NA	NA	0.01	XXX
92608		A	Ex for speech device rx addl	0.70	0.67	0.80	NA	NA	0.01	ZZZ
92609		A	Use of speech device service	1.50	1.04	1.84	NA	NA	0.01	XXX
92610		A	Evaluate swallowing function	1.30	0.93	1.73	0.67	0.67	0.07	XXX
92611		A	Motion fluoroscopy/swallow	1.34	1.10	1.93	NA	NA	0.08	XXX
92612		A	Endoscopy swallow tst (fees)	1.27	3.62	3.59	0.72	0.67	0.07	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.40	0.38	0.39	0.38	0.04	XXX
92614		A	Laryngoscopic sensory test	1.27	3.10	3.05	0.74	0.68	0.07	XXX

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92615		A	Eval laryngoscopy sense tst	0.63	0.37	0.35	0.37	0.35	0.03	XXX
92616		A	Fees w/laryngeal sense test	1.88	3.98	3.96	1.05	0.97	0.10	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.44	0.41	0.44	0.41	0.04	XXX
92620		A	Auditory function 60 min	1.50	1.17	0.86	0.88	0.71	0.07	XXX
92621		A	Auditory function + 15 min	0.35	0.28	0.20	0.18	0.15	0.01	ZZZ
92625		A	Tinnitus assessment	1.15	0.84	0.66	0.62	0.55	0.05	XXX
92626		A	Eval aud rehab status	1.40	1.12	1.01	0.74	0.82	0.07	XXX
92627		A	Eval aud status rehab add-on	0.33	0.29	0.26	0.17	0.20	0.01	ZZZ
92630		I	Aud rehab pre-ling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92633		I	Aud rehab postling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92640		A	Aud brainstem implt programg	1.76	1.23	0.78	0.91	0.62	0.37	XXX
92700		C	Ent procedure/service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92950		A	Heart/lung resuscitation cpr	3.79	4.20	4.20	1.07	1.05	0.30	000
92953		A	Temporary external pacing	0.23	NA	NA	0.07	0.09	0.01	000
92960		A	Cardioversion electric ext	2.25	3.64	4.72	1.13	1.41	0.14	000
92961		A	Cardioversion electric int	4.59	NA	NA	2.04	2.48	0.43	000
92970		A	Cardioassist internal	3.51	NA	NA	1.36	1.52	0.24	000
92971		A	Cardioassist external	1.77	NA	NA	0.83	1.05	0.11	000
92973		A	Percut coronary thrombectomy	3.28	NA	NA	1.28	1.65	0.71	ZZZ
92974		A	Cath place cardio brachytx	3.00	NA	NA	1.17	1.51	0.65	ZZZ
92975		A	Dissolve clot heart vessel	7.24	NA	NA	2.89	3.64	1.58	000
92977		A	Dissolve clot heart vessel	0.00	1.44	2.70	NA	NA	0.03	XXX
92978		C	Intravasc us heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92978	TC	C	Intravasc us heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92978	26	A	Intravasc us heart add-on	1.80	0.70	0.90	0.70	0.90	0.12	ZZZ
92979		C	Intravasc us heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92979	TC	C	Intravasc us heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92979	26	A	Intravasc us heart add-on	1.44	0.56	0.73	0.56	0.73	0.10	ZZZ

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92980		A	Insert intracoronary stent	14.82	NA	NA	5.99	7.67	3.23	000
92981		A	Insert intracoronary stent	4.16	NA	NA	1.63	2.09	0.90	ZZZ
92982		A	Coronary artery dilation	10.96	NA	NA	4.47	5.72	2.38	000
92984		A	Coronary artery dilation	2.97	NA	NA	1.16	1.49	0.64	ZZZ
92986		A	Revision of aortic valve	22.85	NA	NA	11.73	14.64	4.97	090
92987		A	Revision of mitral valve	23.63	NA	NA	11.96	15.06	5.13	090
92990		A	Revision of pulmonary valve	18.27	NA	NA	9.76	11.85	3.98	090
92992		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92993		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92995		A	Coronary atherectomy	12.07	NA	NA	4.91	6.30	2.62	000
92996		A	Coronary atherectomy add-on	3.26	NA	NA	1.28	1.64	0.71	ZZZ
92997		A	Pul art balloon repr percut	11.98	NA	NA	4.83	5.63	2.61	000
92998		A	Pul art balloon repr percut	5.99	NA	NA	2.33	2.87	1.30	ZZZ
93000		A	Electrocardiogram complete	0.17	0.32	0.40	NA	NA	0.02	XXX
93005		A	Electrocardiogram tracing	0.00	0.25	0.32	NA	NA	0.01	XXX
93010		A	Electrocardiogram report	0.17	0.07	0.08	0.07	0.08	0.01	XXX
93015		A	Cardiovascular stress test	0.75	1.59	1.95	NA	NA	0.03	XXX
93016		A	Cardiovascular stress test	0.45	0.18	0.22	0.18	0.22	0.01	XXX
93017		A	Cardiovascular stress test	0.00	1.29	1.58	NA	NA	0.01	XXX
93018		A	Cardiovascular stress test	0.30	0.12	0.15	0.12	0.15	0.01	XXX
93024		A	Cardiac drug stress test	1.17	1.90	2.23	NA	NA	0.05	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.44	1.67	NA	NA	0.01	XXX
93024	26	A	Cardiac drug stress test	1.17	0.46	0.56	0.46	0.56	0.04	XXX
93025		A	Microvolt t-wave assess	0.75	3.69	4.91	NA	NA	0.04	XXX
93025	TC	A	Microvolt t-wave assess	0.00	3.39	4.54	NA	NA	0.01	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.30	0.37	0.30	0.37	0.03	XXX
93040		A	Rhythm ecg with report	0.15	0.19	0.22	NA	NA	0.02	XXX
93041		A	Rhythm ecg tracing	0.00	0.14	0.16	NA	NA	0.01	XXX

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93042		A	Rhythm ecg report	0.15	0.05	0.06	0.05	0.06	0.01	XXX
93224		A	Ecg monit/reprt up to 48 hrs	0.52	1.97	2.54	NA	NA	0.03	XXX
93225		A	Ecg monit/reprt up to 48 hrs	0.00	0.90	1.01	NA	NA	0.01	XXX
93226		A	Ecg monit/reprt up to 48 hrs	0.00	0.83	1.26	NA	NA	0.01	XXX
93227		A	Ecg monit/reprt up to 48 hrs	0.52	0.24	0.27	0.24	0.27	0.01	XXX
93228		A	Remote 30 day ecg rev/report	0.52	0.21	0.21	0.21	0.21	0.03	XXX
93229		A	Remote 30 day ecg tech supp	0.00	20.13	20.13	NA	NA	0.01	XXX
93268		A	Ecg record/review	0.52	5.69	6.85	NA	NA	0.03	XXX
93270		A	Remote 30 day ecg rev/report	0.00	0.24	0.44	NA	NA	0.01	XXX
93271		A	Ecg/monitoring and analysis	0.00	5.25	6.18	NA	NA	0.01	XXX
93272		A	Ecg/review interpret only	0.52	0.20	0.23	0.20	0.23	0.01	XXX
93278		A	Ecg/signal-averaged	0.25	0.61	0.77	NA	NA	0.02	XXX
93278	TC	A	Ecg/signal-averaged	0.00	0.50	0.65	NA	NA	0.01	XXX
93278	26	A	Ecg/signal-averaged	0.25	0.11	0.12	0.11	0.12	0.01	XXX
93279		A	Pm device progr eval sngl	0.65	0.71	0.87	NA	NA	0.04	XXX
93279	TC	A	Pm device progr eval sngl	0.00	0.45	0.54	NA	NA	0.01	XXX
93279	26	A	Pm device progr eval sngl	0.65	0.26	0.33	0.26	0.33	0.03	XXX
93280		A	Pm device progr eval dual	0.77	0.81	1.02	NA	NA	0.04	XXX
93280	TC	A	Pm device progr eval dual	0.00	0.51	0.62	NA	NA	0.01	XXX
93280	26	A	Pm device progr eval dual	0.77	0.30	0.40	0.30	0.40	0.03	XXX
93281		A	Pm device progr eval multi	0.90	0.94	1.19	NA	NA	0.04	XXX
93281	TC	A	Pm device progr eval multi	0.00	0.59	0.72	NA	NA	0.01	XXX
93281	26	A	Pm device progr eval multi	0.90	0.35	0.47	0.35	0.47	0.03	XXX
93282		A	Icd device prog eval 1 sngl	0.85	0.85	1.07	NA	NA	0.04	XXX
93282	TC	A	Icd device prog eval 1 sngl	0.00	0.52	0.64	NA	NA	0.01	XXX
93282	26	A	Icd device prog eval 1 sngl	0.85	0.33	0.43	0.33	0.43	0.03	XXX
93283		A	Icd device progr eval dual	1.15	1.05	1.31	NA	NA	0.05	XXX
93283	TC	A	Icd device progr eval dual	0.00	0.60	0.74	NA	NA	0.01	XXX

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93283	26	A	Icd device progr eval dual	1.15	0.45	0.57	0.45	0.57	0.04	XXX
93284		A	Icd device progr eval mult	1.25	1.18	1.50	NA	NA	0.05	XXX
93284	TC	A	Icd device progr eval mult	0.00	0.69	0.85	NA	NA	0.01	XXX
93284	26	A	Icd device progr eval mult	1.25	0.49	0.65	0.49	0.65	0.04	XXX
93285		A	Ilr device eval progr	0.52	0.61	0.76	NA	NA	0.02	XXX
93285	TC	A	Ilr device eval progr	0.00	0.40	0.49	NA	NA	0.01	XXX
93285	26	A	Ilr device eval progr	0.52	0.21	0.27	0.21	0.27	0.01	XXX
93286		A	Pre-op pm device eval	0.30	0.41	0.46	NA	NA	0.02	XXX
93286	TC	A	Pre-op pm device eval	0.00	0.29	0.34	NA	NA	0.01	XXX
93286	26	A	Pre-op pm device eval	0.30	0.12	0.12	0.12	0.12	0.01	XXX
93287		A	Pre-op icd device eval	0.45	0.50	0.56	NA	NA	0.02	XXX
93287	TC	A	Pre-op icd device eval	0.00	0.32	0.38	NA	NA	0.01	XXX
93287	26	A	Pre-op icd device eval	0.45	0.18	0.18	0.18	0.18	0.01	XXX
93288		A	Pm device eval in person	0.43	0.58	0.73	NA	NA	0.02	XXX
93288	TC	A	Pm device eval in person	0.00	0.41	0.50	NA	NA	0.01	XXX
93288	26	A	Pm device eval in person	0.43	0.17	0.23	0.17	0.23	0.01	XXX
93289		A	Icd device interrogate	0.92	0.86	1.05	NA	NA	0.04	XXX
93289	TC	A	Icd device interrogate	0.00	0.50	0.62	NA	NA	0.01	XXX
93289	26	A	Icd device interrogate	0.92	0.36	0.43	0.36	0.43	0.03	XXX
93290		A	Icm device eval	0.43	0.41	0.45	NA	NA	0.02	XXX
93290	TC	A	Icm device eval	0.00	0.24	0.28	NA	NA	0.01	XXX
93290	26	A	Icm device eval	0.43	0.17	0.17	0.17	0.17	0.01	XXX
93291		A	Ilr device interrogate	0.43	0.54	0.69	NA	NA	0.02	XXX
93291	TC	A	Ilr device interrogate	0.00	0.37	0.46	NA	NA	0.01	XXX
93291	26	A	Ilr device interrogate	0.43	0.17	0.23	0.17	0.23	0.01	XXX
93292		A	Wcd device interrogate	0.43	0.45	0.56	NA	NA	0.02	XXX
93292	TC	A	Wcd device interrogate	0.00	0.28	0.34	NA	NA	0.01	XXX
93292	26	A	Wcd device interrogate	0.43	0.17	0.22	0.17	0.22	0.01	XXX

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93293		A	Pm phone r-strip device eval	0.32	1.15	1.32	NA	NA	0.02	XXX
93293	TC	A	Pm phone r-strip device eval	0.00	1.03	1.18	NA	NA	0.01	XXX
93293	26	A	Pm phone r-strip device eval	0.32	0.12	0.14	0.12	0.14	0.01	XXX
93294		A	Pm device interrogate remote	0.65	0.26	0.34	0.26	0.34	0.04	XXX
93295		A	Icd device interrogat remote	1.29	0.51	0.64	0.51	0.64	0.08	XXX
93296		A	Pm/icd remote tech serv	0.00	0.70	0.96	NA	NA	0.01	XXX
93297		A	Icm device interrogat remote	0.52	0.20	0.21	0.20	0.21	0.03	XXX
93298		A	Ilr device interrogat remote	0.52	0.20	0.27	0.20	0.27	0.03	XXX
93299		C	Icm/ilr remote tech serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93303		A	Echo transthoracic	1.30	4.25	4.86	NA	NA	0.05	XXX
93303	TC	A	Echo transthoracic	0.00	3.72	4.25	NA	NA	0.01	XXX
93303	26	A	Echo transthoracic	1.30	0.53	0.61	0.53	0.61	0.04	XXX
93304		A	Echo transthoracic	0.75	2.87	3.17	NA	NA	0.04	XXX
93304	TC	A	Echo transthoracic	0.00	2.57	2.83	NA	NA	0.01	XXX
93304	26	A	Echo transthoracic	0.75	0.30	0.34	0.30	0.34	0.03	XXX
93306		A	Tte w/doppler complete	1.30	4.03	5.53	NA	NA	0.05	XXX
93306	TC	A	Tte w/doppler complete	0.00	3.51	4.87	NA	NA	0.01	XXX
93306	26	A	Tte w/doppler complete	1.30	0.52	0.66	0.52	0.66	0.04	XXX
93307		A	Tte w/o doppler complete	0.92	2.28	3.41	NA	NA	0.04	XXX
93307	TC	A	Tte w/o doppler complete	0.00	1.90	2.96	NA	NA	0.01	XXX
93307	26	A	Tte w/o doppler complete	0.92	0.38	0.45	0.38	0.45	0.03	XXX
93308		A	Tte f-up or lmtd	0.53	2.17	2.56	NA	NA	0.02	XXX
93308	TC	A	Tte f-up or lmtd	0.00	1.96	2.30	NA	NA	0.01	XXX
93308	26	A	Tte f-up or lmtd	0.53	0.21	0.26	0.21	0.26	0.01	XXX
93312		A	Echo transesophageal	2.20	6.60	7.26	NA	NA	0.10	XXX
93312	TC	A	Echo transesophageal	0.00	5.81	6.29	NA	NA	0.03	XXX
93312	26	A	Echo transesophageal	2.20	0.79	0.97	0.79	0.97	0.07	XXX
93313		A	Echo transesophageal	0.95	NA	NA	0.23	0.20	0.07	XXX

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93314		A	Echo transesophageal	1.25	6.61	7.10	NA	NA	0.07	XXX
93314	TC	A	Echo transesophageal	0.00	6.14	6.54	NA	NA	0.03	XXX
93314	26	A	Echo transesophageal	1.25	0.47	0.56	0.47	0.56	0.04	XXX
93315		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	26	A	Echo transesophageal	2.78	1.05	1.29	1.05	1.29	0.23	XXX
93316		A	Echo transesophageal	0.95	NA	NA	0.28	0.30	0.07	XXX
93317		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	26	A	Echo transesophageal	1.83	0.67	0.73	0.67	0.73	0.23	XXX
93318		C	Echo transesophageal intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
93318	TC	C	Echo transesophageal intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
93318	26	A	Echo transesophageal intraop	2.20	0.77	0.87	0.77	0.87	0.31	XXX
93320		A	Doppler echo exam heart	0.38	0.88	1.45	NA	NA	0.02	ZZZ
93320	TC	A	Doppler echo exam heart	0.00	0.73	1.27	NA	NA	0.01	ZZZ
93320	26	A	Doppler echo exam heart	0.38	0.15	0.18	0.15	0.18	0.01	ZZZ
93321		A	Doppler echo exam heart	0.15	0.51	0.70	NA	NA	0.02	ZZZ
93321	TC	A	Doppler echo exam heart	0.00	0.45	0.63	NA	NA	0.01	ZZZ
93321	26	A	Doppler echo exam heart	0.15	0.06	0.07	0.06	0.07	0.01	ZZZ
93325		A	Doppler color flow add-on	0.07	0.47	0.97	NA	NA	0.02	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	0.44	0.94	NA	NA	0.01	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.03	0.03	0.03	0.03	0.01	ZZZ
93350		A	Stress tte only	1.46	4.20	4.69	NA	NA	0.06	XXX
93350	TC	A	Stress tte only	0.00	3.62	3.96	NA	NA	0.01	XXX
93350	26	A	Stress tte only	1.46	0.58	0.73	0.58	0.73	0.05	XXX
93351		A	Stress tte complete	1.75	4.76	5.49	NA	NA	0.08	XXX
93351	TC	A	Stress tte complete	0.00	4.07	4.58	NA	NA	0.03	XXX
93351	26	A	Stress tte complete	1.75	0.69	0.91	0.69	0.91	0.05	XXX

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93352		A	Admin ecg contrast agent	0.19	0.72	0.87	NA	NA	0.01	ZZZ
93451		A	Right heart cath	2.72	19.21	19.21	NA	NA	0.61	000
93451	TC	A	Right heart cath	0.00	18.14	18.14	NA	NA	0.03	000
93451	26	A	Right heart cath	2.72	1.07	1.07	1.07	1.07	0.58	000
93452		A	Left hrt cath w/ventrclgrphy	4.75	19.19	19.19	NA	NA	1.09	000
93452	TC	A	Left hrt cath w/ventrclgrphy	0.00	17.33	17.33	NA	NA	0.04	000
93452	26	A	Left hrt cath w/ventrclgrphy	4.75	1.86	1.86	1.86	1.86	1.05	000
93453		A	R&l hrt cath w/ventriclgrphy	6.24	25.10	25.10	NA	NA	1.42	000
93453	TC	A	R&l hrt cath w/ventriclgrphy	0.00	22.66	22.66	NA	NA	0.05	000
93453	26	A	R&l hrt cath w/ventriclgrphy	6.24	2.44	2.44	2.44	2.44	1.37	000
93454		A	Coronary artery angio s&i	4.79	19.94	19.94	NA	NA	1.10	000
93454	TC	A	Coronary artery angio s&i	0.00	18.06	18.06	NA	NA	0.04	000
93454	26	A	Coronary artery angio s&i	4.79	1.88	1.88	1.88	1.88	1.06	000
93455		A	Coronary art/grft angio s&i	5.54	23.33	23.33	NA	NA	1.25	000
93455	TC	A	Coronary art/grft angio s&i	0.00	21.16	21.16	NA	NA	0.05	000
93455	26	A	Coronary art/grft angio s&i	5.54	2.17	2.17	2.17	2.17	1.20	000
93456		A	R hrt coronary artery angio	6.15	24.78	24.78	NA	NA	1.39	000
93456	TC	A	R hrt coronary artery angio	0.00	22.37	22.37	NA	NA	0.05	000
93456	26	A	R hrt coronary artery angio	6.15	2.41	2.41	2.41	2.41	1.34	000
93457		A	R hrt art/grft angio	6.89	28.18	28.18	NA	NA	1.54	000
93457	TC	A	R hrt art/grft angio	0.00	25.48	25.48	NA	NA	0.05	000
93457	26	A	R hrt art/grft angio	6.89	2.70	2.70	2.70	2.70	1.49	000
93458		A	L hrt artery/ventricle angio	5.85	23.97	23.97	NA	NA	1.33	000
93458	TC	A	L hrt artery/ventricle angio	0.00	21.68	21.68	NA	NA	0.05	000
93458	26	A	L hrt artery/ventricle angio	5.85	2.29	2.29	2.29	2.29	1.28	000
93459		A	L hrt art/grft angio	6.60	26.33	26.33	NA	NA	1.48	000
93459	TC	A	L hrt art/grft angio	0.00	23.75	23.75	NA	NA	0.05	000
93459	26	A	L hrt art/grft angio	6.60	2.58	2.58	2.58	2.58	1.43	000

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93460		A	R&l hrt art/ventricle angio	7.35	27.83	27.83	NA	NA	1.64	000
93460	TC	A	R&l hrt art/ventricle angio	0.00	24.95	24.95	NA	NA	0.05	000
93460	26	A	R&l hrt art/ventricle angio	7.35	2.88	2.88	2.88	2.88	1.59	000
93461		A	R&l hrt art/ventricle angio	8.10	32.26	32.26	NA	NA	1.83	000
93461	TC	A	R&l hrt art/ventricle angio	0.00	29.09	29.09	NA	NA	0.06	000
93461	26	A	R&l hrt art/ventricle angio	8.10	3.17	3.17	3.17	3.17	1.77	000
93462		A	L hrt cath trnsptl puncture	3.73	1.48	1.48	1.48	1.48	0.80	ZZZ
93463		A	Drug admin & hemodynmic meas	2.00	0.79	0.79	0.79	0.79	0.39	ZZZ
93464		A	Exercise w/hemodynamic meas	1.80	5.28	5.28	NA	NA	0.36	ZZZ
93464	TC	A	Exercise w/hemodynamic meas	0.00	4.63	4.63	NA	NA	0.01	ZZZ
93464	26	A	Exercise w/hemodynamic meas	1.80	0.65	0.65	0.65	0.65	0.35	ZZZ
93503		A	Insert/place heart catheter	2.91	NA	NA	0.77	0.77	0.27	000
93505		A	Biopsy of heart lining	4.37	17.43	18.46	NA	NA	0.86	000
93505	TC	A	Biopsy of heart lining	0.00	15.71	16.29	NA	NA	0.03	000
93505	26	A	Biopsy of heart lining	4.37	1.72	2.17	1.72	2.17	0.83	000
93530		C	Rt heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93530	TC	C	Rt heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93530	26	A	Rt heart cath congenital	4.22	1.68	2.06	1.68	2.06	0.91	000
93531		C	R & l heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93531	TC	C	R & l heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93531	26	A	R & l heart cath congenital	8.34	3.30	3.98	3.30	3.98	1.82	000
93532		C	R & l heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93532	TC	C	R & l heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93532	26	A	R & l heart cath congenital	9.99	3.89	4.64	3.89	4.64	2.17	000
93533		C	R & l heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93533	TC	C	R & l heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93533	26	A	R & l heart cath congenital	6.69	2.60	3.13	2.60	3.13	1.47	000
93561		C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000

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93561	TC	C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93561	26	A	Cardiac output measurement	0.50	0.20	0.19	0.20	0.19	0.04	000
93562		C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93562	TC	C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93562	26	A	Cardiac output measurement	0.16	0.06	0.05	0.06	0.05	0.01	000
93563		A	Inject congenital card cath	1.11	0.44	0.44	0.44	0.44	0.10	ZZZ
93564		A	Inject hrt congntl art/grft	1.13	0.45	0.45	0.45	0.45	0.10	ZZZ
93565		A	Inject l ventr/atrial angio	0.86	0.34	0.34	0.34	0.34	0.08	ZZZ
93566		A	Inject r ventr/atrial angio	0.86	4.06	4.06	0.34	0.34	0.07	ZZZ
93567		A	Inject suprvlv aortography	0.97	3.08	3.08	0.38	0.38	0.08	ZZZ
93568		A	Inject pulm art hrt cath	0.88	3.56	3.56	0.35	0.35	0.08	ZZZ
93571		C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93571	TC	C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93571	26	A	Heart flow reserve measure	1.80	0.71	0.90	0.71	0.90	0.11	ZZZ
93572		C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93572	TC	C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93572	26	A	Heart flow reserve measure	1.44	0.56	0.70	0.56	0.70	0.11	ZZZ
93580		A	Transcath closure of asd	17.97	NA	NA	7.41	9.22	3.91	000
93581		A	Transcath closure of vsd	24.39	NA	NA	9.83	11.58	5.31	000
93600		C	Bundle of his recording	0.00	0.00	0.00	NA	NA	0.00	000
93600	TC	C	Bundle of his recording	0.00	0.00	0.00	NA	NA	0.00	000
93600	26	A	Bundle of his recording	2.12	0.84	1.05	0.84	1.05	0.45	000
93602		C	Intra-atrial recording	0.00	0.00	0.00	NA	NA	0.00	000
93602	TC	C	Intra-atrial recording	0.00	0.00	0.00	NA	NA	0.00	000
93602	26	A	Intra-atrial recording	2.12	0.83	1.03	0.83	1.03	0.45	000
93603		C	Right ventricular recording	0.00	0.00	0.00	NA	NA	0.00	000
93603	TC	C	Right ventricular recording	0.00	0.00	0.00	NA	NA	0.00	000
93603	26	A	Right ventricular recording	2.12	0.82	1.03	0.82	1.03	0.45	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93609		C	Map tachycardia add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93609	TC	C	Map tachycardia add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93609	26	A	Map tachycardia add-on	4.99	1.96	2.48	1.96	2.48	1.09	ZZZ
93610		C	Intra-atrial pacing	0.00	0.00	0.00	NA	NA	0.00	000
93610	TC	C	Intra-atrial pacing	0.00	0.00	0.00	NA	NA	0.00	000
93610	26	A	Intra-atrial pacing	3.02	1.17	1.46	1.17	1.46	0.65	000
93612		C	Intraventricular pacing	0.00	0.00	0.00	NA	NA	0.00	000
93612	TC	C	Intraventricular pacing	0.00	0.00	0.00	NA	NA	0.00	000
93612	26	A	Intraventricular pacing	3.02	1.16	1.44	1.16	1.44	0.65	000
93613		A	Electrophys map 3d add-on	6.99	NA	NA	2.74	3.50	1.52	ZZZ
93615		C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93615	TC	C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93615	26	A	Esophageal recording	0.99	0.39	0.48	0.39	0.48	0.05	000
93616		C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93616	TC	C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93616	26	A	Esophageal recording	1.49	0.35	0.39	0.35	0.39	0.11	000
93618		C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	TC	C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	26	A	Heart rhythm pacing	4.25	1.66	2.14	1.66	2.14	0.91	000
93619		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	26	A	Electrophysiology evaluation	7.31	2.86	3.72	2.86	3.72	1.59	000
93620		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	26	A	Electrophysiology evaluation	11.57	4.54	5.82	4.54	5.82	2.51	000
93621		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93621	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93621	26	A	Electrophysiology evaluation	2.10	0.82	1.05	0.82	1.05	0.45	ZZZ

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93622		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93622	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93622	26	A	Electrophysiology evaluation	3.10	1.22	1.52	1.22	1.52	0.67	ZZZ
93623		C	Stimulation pacing heart	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93623	TC	C	Stimulation pacing heart	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93623	26	A	Stimulation pacing heart	2.85	1.12	1.42	1.12	1.42	0.62	ZZZ
93624		C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	TC	C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	26	A	Electrophysiologic study	4.80	1.87	2.44	NA	NA	1.05	000
93631		C	Heart pacing mapping	0.00	0.00	0.00	NA	NA	0.00	000
93631	TC	C	Heart pacing mapping	0.00	0.00	0.00	NA	NA	0.00	000
93631	26	A	Heart pacing mapping	7.59	2.77	3.08	2.77	3.08	1.81	000
93640		C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	TC	C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	26	A	Evaluation heart device	3.51	1.39	1.74	1.39	1.74	0.76	000
93641		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93641	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93641	26	A	Electrophysiology evaluation	5.92	2.32	2.95	2.32	2.95	1.29	000
93642		A	Electrophysiology evaluation	4.88	5.71	7.53	NA	NA	0.21	000
93642	TC	A	Electrophysiology evaluation	0.00	3.79	5.04	NA	NA	0.03	000
93642	26	A	Electrophysiology evaluation	4.88	1.92	2.49	1.92	2.49	0.18	000
93650		A	Ablate heart dysrhythm focus	10.49	NA	NA	4.39	5.54	2.27	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	NA	6.36	8.09	3.53	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	NA	6.95	8.82	3.84	000
93660		A	Tilt table evaluation	1.89	2.37	2.88	NA	NA	0.08	000
93660	TC	A	Tilt table evaluation	0.00	1.62	1.94	NA	NA	0.01	000
93660	26	A	Tilt table evaluation	1.89	0.75	0.94	0.75	0.94	0.07	000
93662		C	Intracardiac ecg (ice)	0.00	0.00	0.00	NA	NA	0.00	ZZZ

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93662	TC	C	Intracardiac ecg (ice)	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93662	26	A	Intracardiac ecg (ice)	2.80	1.09	1.39	1.09	1.39	0.20	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.51	0.54	NA	NA	0.01	XXX
93701		A	Bioimpedance cv analysis	0.00	0.65	0.78	NA	NA	0.01	XXX
93720		A	Total body plethysmography	0.17	1.23	1.25	NA	NA	0.02	XXX
93721		A	Plethysmography tracing	0.00	1.17	1.19	NA	NA	0.01	XXX
93722		A	Plethysmography report	0.17	0.06	0.06	0.06	0.06	0.01	XXX
93724		A	Analyze pacemaker system	4.88	2.67	3.78	NA	NA	0.19	000
93724	TC	A	Analyze pacemaker system	0.00	0.72	1.35	NA	NA	0.01	000
93724	26	A	Analyze pacemaker system	4.88	1.95	2.43	1.95	2.43	0.18	000
93740		B	Temperature gradient studies	0.16	0.07	0.07	NA	NA	0.02	XXX
93740	TC	B	Temperature gradient studies	0.00	0.00	0.04	NA	NA	0.01	XXX
93740	26	B	Temperature gradient studies	0.16	0.07	0.07	0.07	0.07	0.01	XXX
93745		C	Set-up cardiovert-defibrill	0.00	0.00	0.00	NA	NA	0.00	XXX
93745	TC	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	NA	NA	0.00	XXX
93745	26	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93750		A	Interrogation vad in person	0.92	0.54	0.54	0.34	0.34	0.05	XXX
93770		B	Measure venous pressure	0.16	0.07	0.07	NA	NA	0.02	XXX
93770	TC	B	Measure venous pressure	0.00	0.00	0.01	NA	NA	0.01	XXX
93770	26	B	Measure venous pressure	0.16	0.07	0.07	0.07	0.07	0.01	XXX
93784		A	Ambulatory bp monitoring	0.38	1.13	1.42	NA	NA	0.03	XXX
93786		A	Ambulatory bp recording	0.00	0.83	0.91	NA	NA	0.01	XXX
93788		A	Ambulatory bp analysis	0.00	0.14	0.34	NA	NA	0.01	XXX
93790		A	Review/report bp recording	0.38	0.16	0.17	0.16	0.17	0.01	XXX
93797		A	Cardiac rehab	0.18	0.30	0.34	0.08	0.09	0.01	000
93798		A	Cardiac rehab/monitor	0.28	0.41	0.47	0.12	0.14	0.01	000
93799		C	Cardiovascular procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
93799	TC	C	Cardiovascular procedure	0.00	0.00	0.00	NA	NA	0.00	XXX

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93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93875		A	Extracranial study	0.22	2.75	2.88	NA	NA	0.02	XXX
93875	TC	A	Extracranial study	0.00	2.66	2.79	NA	NA	0.01	XXX
93875	26	A	Extracranial study	0.22	0.09	0.09	0.09	0.09	0.01	XXX
93880		A	Extracranial study	0.60	6.26	6.75	NA	NA	0.05	XXX
93880	TC	A	Extracranial study	0.00	6.03	6.50	NA	NA	0.01	XXX
93880	26	A	Extracranial study	0.60	0.23	0.25	0.23	0.25	0.04	XXX
93882		A	Extracranial study	0.40	4.58	4.67	NA	NA	0.06	XXX
93882	TC	A	Extracranial study	0.00	4.43	4.52	NA	NA	0.01	XXX
93882	26	A	Extracranial study	0.40	0.15	0.15	0.15	0.15	0.05	XXX
93886		A	Intracranial study	0.94	9.14	8.80	NA	NA	0.05	XXX
93886	TC	A	Intracranial study	0.00	8.72	8.40	NA	NA	0.01	XXX
93886	26	A	Intracranial study	0.94	0.42	0.40	0.42	0.40	0.04	XXX
93888		A	Intracranial study	0.62	5.38	5.56	NA	NA	0.05	XXX
93888	TC	A	Intracranial study	0.00	5.12	5.30	NA	NA	0.01	XXX
93888	26	A	Intracranial study	0.62	0.26	0.26	0.26	0.26	0.04	XXX
93890		A	Tcd vasoreactivity study	1.00	6.76	6.95	NA	NA	0.05	XXX
93890	TC	A	Tcd vasoreactivity study	0.00	6.34	6.54	NA	NA	0.01	XXX
93890	26	A	Tcd vasoreactivity study	1.00	0.42	0.41	0.42	0.41	0.04	XXX
93892		A	Tcd emboli detect w/o inj	1.15	8.65	8.24	NA	NA	0.06	XXX
93892	TC	A	Tcd emboli detect w/o inj	0.00	8.13	7.75	NA	NA	0.01	XXX
93892	26	A	Tcd emboli detect w/o inj	1.15	0.52	0.49	0.52	0.49	0.05	XXX
93893		A	Tcd emboli detect w/inj	1.15	9.49	8.65	NA	NA	0.06	XXX
93893	TC	A	Tcd emboli detect w/inj	0.00	8.97	8.15	NA	NA	0.01	XXX
93893	26	A	Tcd emboli detect w/inj	1.15	0.52	0.50	0.52	0.50	0.05	XXX
93922		A	Upr/l xtremity art 2 levels	0.25	2.39	2.99	NA	NA	0.02	XXX
93922	TC	A	Upr/l xtremity art 2 levels	0.00	2.29	2.89	NA	NA	0.01	XXX
93922	26	A	Upr/l xtremity art 2 levels	0.25	0.10	0.10	0.10	0.10	0.01	XXX

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93923		A	Upr/lxtr art stdy 3+ lvls	0.45	3.65	4.54	NA	NA	0.05	XXX
93923	TC	A	Upr/lxtr art stdy 3+ lvls	0.00	3.48	4.36	NA	NA	0.01	XXX
93923	26	A	Upr/lxtr art stdy 3+ lvls	0.45	0.17	0.18	0.17	0.18	0.04	XXX
93924		A	Lwr xtr vasc stdy bilat	0.50	4.72	5.76	NA	NA	0.05	XXX
93924	TC	A	Lwr xtr vasc stdy bilat	0.00	4.53	5.55	NA	NA	0.01	XXX
93924	26	A	Lwr xtr vasc stdy bilat	0.50	0.19	0.21	0.19	0.21	0.04	XXX
93925		A	Lower extremity study	0.58	8.12	8.70	NA	NA	0.07	XXX
93925	TC	A	Lower extremity study	0.00	7.90	8.47	NA	NA	0.03	XXX
93925	26	A	Lower extremity study	0.58	0.22	0.23	0.22	0.23	0.04	XXX
93926		A	Lower extremity study	0.39	5.37	5.63	NA	NA	0.06	XXX
93926	TC	A	Lower extremity study	0.00	5.23	5.48	NA	NA	0.01	XXX
93926	26	A	Lower extremity study	0.39	0.14	0.15	0.14	0.15	0.05	XXX
93930		A	Upper extremity study	0.46	6.49	6.87	NA	NA	0.05	XXX
93930	TC	A	Upper extremity study	0.00	6.32	6.68	NA	NA	0.01	XXX
93930	26	A	Upper extremity study	0.46	0.17	0.19	0.17	0.19	0.04	XXX
93931		A	Upper extremity study	0.31	4.31	4.58	NA	NA	0.04	XXX
93931	TC	A	Upper extremity study	0.00	4.20	4.46	NA	NA	0.01	XXX
93931	26	A	Upper extremity study	0.31	0.11	0.12	0.11	0.12	0.03	XXX
93965		A	Extremity study	0.35	3.12	3.35	NA	NA	0.04	XXX
93965	TC	A	Extremity study	0.00	2.99	3.21	NA	NA	0.01	XXX
93965	26	A	Extremity study	0.35	0.13	0.14	0.13	0.14	0.03	XXX
93970		A	Extremity study	0.68	6.49	6.87	NA	NA	0.08	XXX
93970	TC	A	Extremity study	0.00	6.24	6.60	NA	NA	0.01	XXX
93970	26	A	Extremity study	0.68	0.25	0.27	0.25	0.27	0.07	XXX
93971		A	Extremity study	0.45	4.23	4.51	NA	NA	0.05	XXX
93971	TC	A	Extremity study	0.00	4.06	4.33	NA	NA	0.01	XXX
93971	26	A	Extremity study	0.45	0.17	0.18	0.17	0.18	0.04	XXX
93975		A	Vascular study	1.80	8.57	9.27	NA	NA	0.17	XXX

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93975	TC	A	Vascular study	0.00	7.89	8.53	NA	NA	0.03	XXX
93975	26	A	Vascular study	1.80	0.68	0.74	0.68	0.74	0.14	XXX
93976		A	Vascular study	1.21	4.74	5.12	NA	NA	0.09	XXX
93976	TC	A	Vascular study	0.00	4.28	4.62	NA	NA	0.01	XXX
93976	26	A	Vascular study	1.21	0.46	0.50	0.46	0.50	0.08	XXX
93978		A	Vascular study	0.65	6.08	6.44	NA	NA	0.08	XXX
93978	TC	A	Vascular study	0.00	5.84	6.18	NA	NA	0.01	XXX
93978	26	A	Vascular study	0.65	0.24	0.26	0.24	0.26	0.07	XXX
93979		A	Vascular study	0.44	4.22	4.48	NA	NA	0.05	XXX
93979	TC	A	Vascular study	0.00	4.06	4.31	NA	NA	0.01	XXX
93979	26	A	Vascular study	0.44	0.16	0.17	0.16	0.17	0.04	XXX
93980		A	Penile vascular study	1.25	3.52	3.89	NA	NA	0.08	XXX
93980	TC	A	Penile vascular study	0.00	3.03	3.34	NA	NA	0.01	XXX
93980	26	A	Penile vascular study	1.25	0.49	0.55	0.49	0.55	0.07	XXX
93981		A	Penile vascular study	0.44	2.70	3.09	NA	NA	0.04	XXX
93981	TC	A	Penile vascular study	0.00	2.53	2.91	NA	NA	0.01	XXX
93981	26	A	Penile vascular study	0.44	0.17	0.18	0.17	0.18	0.03	XXX
93982		R	Aneurysm pressure sens study	0.30	0.87	0.92	NA	NA	0.05	XXX
93990		A	Doppler flow testing	0.25	5.89	5.92	NA	NA	0.05	XXX
93990	TC	A	Doppler flow testing	0.00	5.80	5.83	NA	NA	0.01	XXX
93990	26	A	Doppler flow testing	0.25	0.09	0.09	0.09	0.09	0.04	XXX
94002		A	Vent mgmt inpat init day	1.99	NA	NA	0.60	0.52	0.16	XXX
94003		A	Vent mgmt inpat subq day	1.37	NA	NA	0.50	0.45	0.10	XXX
94004		A	Vent mgmt nf per day	1.00	NA	NA	0.36	0.33	0.07	XXX
94005		B	Home vent mgmt supervision	1.50	1.10	1.10	NA	NA	0.10	XXX
94010		A	Breathing capacity test	0.17	0.83	0.85	NA	NA	0.02	XXX
94010	TC	A	Breathing capacity test	0.00	0.76	0.78	NA	NA	0.01	XXX
94010	26	A	Breathing capacity test	0.17	0.07	0.07	0.07	0.07	0.01	XXX

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94011		A	Spirometry up to 2 yrs old	2.00	NA	NA	0.77	0.77	0.14	XXX
94012		A	Spirmtry w/brnchdil inf-2 yr	3.10	NA	NA	1.16	1.16	0.23	XXX
94013		A	Meas lung vol thru 2 yrs	0.66	NA	NA	0.22	0.22	0.04	XXX
94014		A	Patient recorded spirometry	0.52	0.84	0.91	NA	NA	0.02	XXX
94015		A	Patient recorded spirometry	0.00	0.65	0.72	NA	NA	0.01	XXX
94016		A	Review patient spirometry	0.52	0.19	0.19	0.19	0.19	0.01	XXX
94060		A	Evaluation of wheezing	0.31	1.44	1.47	NA	NA	0.02	XXX
94060	TC	A	Evaluation of wheezing	0.00	1.32	1.36	NA	NA	0.01	XXX
94060	26	A	Evaluation of wheezing	0.31	0.12	0.11	0.12	0.11	0.01	XXX
94070		A	Evaluation of wheezing	0.60	1.11	1.13	NA	NA	0.04	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.88	0.92	NA	NA	0.01	XXX
94070	26	A	Evaluation of wheezing	0.60	0.23	0.21	0.23	0.21	0.03	XXX
94150		B	Vital capacity test	0.07	0.61	0.63	NA	NA	0.02	XXX
94150	TC	B	Vital capacity test	0.00	0.58	0.60	NA	NA	0.01	XXX
94150	26	B	Vital capacity test	0.07	0.03	0.03	0.03	0.03	0.01	XXX
94200		A	Lung function test (mbc/mvv)	0.11	0.57	0.58	NA	NA	0.02	XXX
94200	TC	A	Lung function test (mbc/mvv)	0.00	0.53	0.54	NA	NA	0.01	XXX
94200	26	A	Lung function test (mbc/mvv)	0.11	0.04	0.04	0.04	0.04	0.01	XXX
94240		A	Residual lung capacity	0.26	0.86	0.90	NA	NA	0.02	XXX
94240	TC	A	Residual lung capacity	0.00	0.77	0.81	NA	NA	0.01	XXX
94240	26	A	Residual lung capacity	0.26	0.09	0.09	0.09	0.09	0.01	XXX
94250		A	Expired gas collection	0.11	0.57	0.62	NA	NA	0.02	XXX
94250	TC	A	Expired gas collection	0.00	0.53	0.58	NA	NA	0.01	XXX
94250	26	A	Expired gas collection	0.11	0.04	0.04	0.04	0.04	0.01	XXX
94260		A	Thoracic gas volume	0.13	0.78	0.81	NA	NA	0.02	XXX
94260	TC	A	Thoracic gas volume	0.00	0.73	0.77	NA	NA	0.01	XXX
94260	26	A	Thoracic gas volume	0.13	0.05	0.04	0.05	0.04	0.01	XXX
94350		A	Lung nitrogen washout curve	0.26	0.69	0.74	NA	NA	0.02	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
94350	TC	A	Lung nitrogen washout curve	0.00	0.59	0.65	NA	NA	0.01	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.10	0.09	0.10	0.09	0.01	XXX
94360		A	Measure airflow resistance	0.26	1.00	1.03	NA	NA	0.02	XXX
94360	TC	A	Measure airflow resistance	0.00	0.91	0.94	NA	NA	0.01	XXX
94360	26	A	Measure airflow resistance	0.26	0.09	0.09	0.09	0.09	0.01	XXX
94370		A	Breath airway closing volume	0.26	0.69	0.73	NA	NA	0.02	XXX
94370	TC	A	Breath airway closing volume	0.00	0.59	0.64	NA	NA	0.01	XXX
94370	26	A	Breath airway closing volume	0.26	0.10	0.09	0.10	0.09	0.01	XXX
94375		A	Respiratory flow volume loop	0.31	0.78	0.81	NA	NA	0.02	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.66	0.70	NA	NA	0.01	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.12	0.11	0.12	0.11	0.01	XXX
94400		A	Co2 breathing response curve	0.40	1.14	1.17	NA	NA	0.02	XXX
94400	TC	A	Co2 breathing response curve	0.00	1.00	1.03	NA	NA	0.01	XXX
94400	26	A	Co2 breathing response curve	0.40	0.14	0.14	0.14	0.14	0.01	XXX
94450		A	Hypoxia response curve	0.40	1.48	1.33	NA	NA	0.02	XXX
94450	TC	A	Hypoxia response curve	0.00	1.31	1.18	NA	NA	0.01	XXX
94450	26	A	Hypoxia response curve	0.40	0.17	0.15	0.17	0.15	0.01	XXX
94452		A	Hast w/report	0.31	1.29	1.37	NA	NA	0.02	XXX
94452	TC	A	Hast w/report	0.00	1.18	1.27	NA	NA	0.01	XXX
94452	26	A	Hast w/report	0.31	0.11	0.10	0.11	0.10	0.01	XXX
94453		A	Hast w/oxygen titrate	0.40	1.78	1.87	NA	NA	0.02	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.64	1.73	NA	NA	0.01	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.14	0.14	0.14	0.14	0.01	XXX
94610		A	Surfactant admin thru tube	1.16	0.57	0.51	0.57	0.51	0.07	XXX
94620		A	Pulmonary stress test/simple	0.64	0.89	1.19	NA	NA	0.04	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	0.66	0.96	NA	NA	0.01	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.23	0.23	0.23	0.23	0.03	XXX
94621		A	Pulm stress test/complex	1.42	3.12	3.33	NA	NA	0.06	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
94621	TC	A	Pulm stress test/complex	0.00	2.59	2.77	NA	NA	0.01	XXX
94621	26	A	Pulm stress test/complex	1.42	0.53	0.56	0.53	0.56	0.05	XXX
94640		A	Airway inhalation treatment	0.00	0.49	0.46	NA	NA	0.01	XXX
94642		C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94644		A	Cbt 1st hour	0.00	1.22	1.17	NA	NA	0.01	XXX
94645		A	Cbt each addl hour	0.00	0.40	0.42	NA	NA	0.01	XXX
94660		A	Pos airway pressure cpap	0.76	0.96	0.94	0.30	0.27	0.05	XXX
94662		A	Neg press ventilation cnp	0.76	NA	NA	0.26	0.26	0.05	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.47	0.46	NA	NA	0.01	XXX
94667		A	Chest wall manipulation	0.00	0.67	0.66	NA	NA	0.01	XXX
94668		A	Chest wall manipulation	0.00	0.64	0.63	NA	NA	0.01	XXX
94680		A	Exhaled air analysis o2	0.26	1.36	1.45	NA	NA	0.02	XXX
94680	TC	A	Exhaled air analysis o2	0.00	1.25	1.35	NA	NA	0.01	XXX
94680	26	A	Exhaled air analysis o2	0.26	0.11	0.10	0.11	0.10	0.01	XXX
94681		A	Exhaled air analysis o2/co2	0.20	1.20	1.46	NA	NA	0.02	XXX
94681	TC	A	Exhaled air analysis o2/co2	0.00	1.12	1.39	NA	NA	0.01	XXX
94681	26	A	Exhaled air analysis o2/co2	0.20	0.08	0.07	0.08	0.07	0.01	XXX
94690		A	Exhaled air analysis	0.07	1.32	1.44	NA	NA	0.02	XXX
94690	TC	A	Exhaled air analysis	0.00	1.29	1.41	NA	NA	0.01	XXX
94690	26	A	Exhaled air analysis	0.07	0.03	0.03	0.03	0.03	0.01	XXX
94720		A	Monoxide diffusing capacity	0.26	1.19	1.27	NA	NA	0.02	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	1.10	1.18	NA	NA	0.01	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.09	0.09	0.09	0.09	0.01	XXX
94725		A	Membrane diffusion capacity	0.26	1.17	1.48	NA	NA	0.02	XXX
94725	TC	A	Membrane diffusion capacity	0.00	1.07	1.38	NA	NA	0.01	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.10	0.10	0.10	0.10	0.01	XXX
94750		A	Pulmonary compliance study	0.23	2.04	2.05	NA	NA	0.02	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.95	1.97	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
94750	26	A	Pulmonary compliance study	0.23	0.09	0.08	0.09	0.08	0.01	XXX
94760		T	Measure blood oxygen level	0.00	0.08	0.07	NA	NA	0.01	XXX
94761		T	Measure blood oxygen level	0.00	0.12	0.12	NA	NA	0.01	XXX
94762		A	Measure blood oxygen level	0.00	0.29	0.58	NA	NA	0.01	XXX
94770		A	Exhaled carbon dioxide test	0.15	0.07	0.50	0.07	0.50	0.02	XXX
94772		C	Breath recording infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	TC	C	Breath recording infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	26	C	Breath recording infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94774		C	Ped home apnea rec compl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94775		C	Ped home apnea rec hk-up	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94776		C	Ped home apnea rec downld	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94777		C	Ped home apnea rec report	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94799		C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.01	0.17	0.17	NA	NA	0.01	XXX
95010		A	Percut allergy titrate test	0.15	0.38	0.38	NA	NA	0.01	XXX
95012		A	Exhaled nitric oxide meas	0.00	0.55	0.60	NA	NA	0.01	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.29	0.26	0.07	0.07	0.01	XXX
95024		A	Id allergy test drug/bug	0.01	0.19	0.20	NA	NA	0.01	XXX
95027		A	Id allergy titrate-airborne	0.01	0.11	0.12	NA	NA	0.01	XXX
95028		A	Id allergy test-delayed type	0.00	0.38	0.37	NA	NA	0.01	XXX
95044		A	Allergy patch tests	0.00	0.15	0.17	NA	NA	0.01	XXX
95052		A	Photo patch test	0.00	0.17	0.20	NA	NA	0.01	XXX
95056		A	Photosensitivity tests	0.00	1.24	1.20	NA	NA	0.01	XXX
95060		A	Eye allergy tests	0.00	0.91	0.84	0.91	0.84	0.01	XXX
95065		A	Nose allergy test	0.00	0.72	0.71	0.72	0.71	0.01	XXX
95070		A	Bronchial allergy tests	0.00	0.81	1.11	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95071		A	Bronchial allergy tests	0.00	1.24	1.50	NA	NA	0.01	XXX
95075		A	Ingestion challenge test	0.95	0.91	0.91	0.44	0.42	0.04	XXX
95115		A	Immunotherapy one injection	0.00	0.26	0.29	NA	NA	0.01	XXX
95117		A	Immunotherapy injections	0.00	0.31	0.36	NA	NA	0.01	XXX
95120		I	Immunotherapy one injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95125		I	Immunotherapy many antigens	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95130		I	Immunotherapy insect venom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95131		I	Immunotherapy insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95132		I	Immunotherapy insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95133		I	Immunotherapy insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95134		I	Immunotherapy insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95144		A	Antigen therapy services	0.06	0.30	0.30	0.03	0.03	0.01	XXX
95145		A	Antigen therapy services	0.06	0.56	0.49	0.03	0.03	0.01	XXX
95146		A	Antigen therapy services	0.06	1.06	0.91	0.03	0.03	0.01	XXX
95147		A	Antigen therapy services	0.06	0.96	0.85	0.03	0.03	0.01	XXX
95148		A	Antigen therapy services	0.06	1.46	1.27	0.03	0.03	0.01	XXX
95149		A	Antigen therapy services	0.06	1.98	1.71	0.03	0.03	0.01	XXX
95165		A	Antigen therapy services	0.06	0.30	0.30	0.03	0.03	0.01	XXX
95170		A	Antigen therapy services	0.06	0.21	0.22	0.03	0.03	0.01	XXX
95180		A	Rapid desensitization	2.01	1.95	2.08	1.00	1.03	0.07	XXX
95199		C	Allergy immunology services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95250		A	Glucose monitoring cont	0.00	4.37	4.36	NA	NA	0.01	XXX
95251		A	Gluc monitor cont phys i&r	0.85	0.39	0.34	0.39	0.34	0.04	XXX
95800		A	Slp stdy unattended	1.05	37.51	37.51	NA	NA	0.05	XXX
95800	TC	A	Slp stdy unattended	0.00	36.89	36.89	NA	NA	0.01	XXX
95800	26	A	Slp stdy unattended	1.05	0.62	0.62	0.62	0.62	0.04	XXX
95801		A	Slp stdy unatnd w/anal	1.00	64.32	64.32	NA	NA	0.05	XXX
95801	TC	A	Slp stdy unatnd w/anal	0.00	63.85	63.85	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95801	26	A	Slp stdy unatnd w/anal	1.00	0.47	0.47	0.47	0.47	0.04	XXX
95803		A	Actigraphy testing	0.90	3.84	3.84	NA	NA	0.04	XXX
95803	TC	A	Actigraphy testing	0.00	3.40	3.40	NA	NA	0.01	XXX
95803	26	A	Actigraphy testing	0.90	0.44	0.44	0.44	0.44	0.03	XXX
95805		A	Multiple sleep latency test	1.20	10.18	10.84	NA	NA	0.08	XXX
95805	TC	A	Multiple sleep latency test	0.00	9.70	10.26	NA	NA	0.04	XXX
95805	26	A	Multiple sleep latency test	1.20	0.48	0.58	0.48	0.58	0.04	XXX
95806		A	Sleep study unatt&resp efft	1.25	3.50	4.05	NA	NA	0.08	XXX
95806	TC	A	Sleep study unatt&resp efft	0.00	3.01	3.50	NA	NA	0.03	XXX
95806	26	A	Sleep study unatt&resp efft	1.25	0.49	0.55	0.49	0.55	0.05	XXX
95807		A	Sleep study attended	1.28	10.80	12.45	NA	NA	0.15	XXX
95807	TC	A	Sleep study attended	0.00	10.33	11.92	NA	NA	0.10	XXX
95807	26	A	Sleep study attended	1.28	0.47	0.53	0.47	0.53	0.05	XXX
95808		A	Polysomnography 1-3	1.74	16.53	17.28	NA	NA	0.17	XXX
95808	TC	A	Polysomnography 1-3	0.00	15.80	16.44	NA	NA	0.10	XXX
95808	26	A	Polysomnography 1-3	1.74	0.73	0.84	0.73	0.84	0.07	XXX
95810		A	Polysomnography 4 or more	2.50	14.60	17.80	NA	NA	0.21	XXX
95810	TC	A	Polysomnography 4 or more	0.00	13.63	16.70	NA	NA	0.11	XXX
95810	26	A	Polysomnography 4 or more	2.50	0.97	1.10	0.97	1.10	0.10	XXX
95811		A	Polysomnography w/cpap	2.60	15.34	19.30	NA	NA	0.23	XXX
95811	TC	A	Polysomnography w/cpap	0.00	14.34	18.15	NA	NA	0.12	XXX
95811	26	A	Polysomnography w/cpap	2.60	1.00	1.15	1.00	1.15	0.11	XXX
95812		A	Eeg 41-60 minutes	1.08	9.79	8.16	NA	NA	0.07	XXX
95812	TC	A	Eeg 41-60 minutes	0.00	9.27	7.68	NA	NA	0.03	XXX
95812	26	A	Eeg 41-60 minutes	1.08	0.52	0.48	0.52	0.48	0.04	XXX
95813		A	Eeg over 1 hour	1.73	9.79	8.64	NA	NA	0.11	XXX
95813	TC	A	Eeg over 1 hour	0.00	8.99	7.90	NA	NA	0.04	XXX
95813	26	A	Eeg over 1 hour	1.73	0.80	0.74	0.80	0.74	0.07	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95816		A	Eeg awake and drowsy	1.08	9.02	7.46	NA	NA	0.08	XXX
95816	TC	A	Eeg awake and drowsy	0.00	8.50	6.98	NA	NA	0.03	XXX
95816	26	A	Eeg awake and drowsy	1.08	0.52	0.48	0.52	0.48	0.05	XXX
95819		A	Eeg awake and asleep	1.08	10.49	8.47	NA	NA	0.07	XXX
95819	TC	A	Eeg awake and asleep	0.00	9.97	7.99	NA	NA	0.03	XXX
95819	26	A	Eeg awake and asleep	1.08	0.52	0.48	0.52	0.48	0.04	XXX
95822		A	Eeg coma or sleep only	1.08	9.31	7.84	NA	NA	0.07	XXX
95822	TC	A	Eeg coma or sleep only	0.00	8.79	7.36	NA	NA	0.03	XXX
95822	26	A	Eeg coma or sleep only	1.08	0.52	0.48	0.52	0.48	0.04	XXX
95824		C	Eeg cerebral death only	0.00	0.00	0.00	NA	NA	0.00	XXX
95824	TC	C	Eeg cerebral death only	0.00	0.00	0.00	NA	NA	0.00	XXX
95824	26	A	Eeg cerebral death only	0.74	0.35	0.33	0.35	0.33	0.05	XXX
95827		A	Eeg all night recording	1.08	19.36	15.31	NA	NA	0.13	XXX
95827	TC	A	Eeg all night recording	0.00	18.83	14.84	NA	NA	0.08	XXX
95827	26	A	Eeg all night recording	1.08	0.53	0.47	0.53	0.47	0.05	XXX
95829		A	Surgery electrocorticogram	6.20	42.66	37.71	NA	NA	0.21	XXX
95829	TC	A	Surgery electrocorticogram	0.00	39.65	34.96	NA	NA	0.05	XXX
95829	26	A	Surgery electrocorticogram	6.20	3.01	2.75	3.01	2.75	0.16	XXX
95830		A	Insert electrodes for eeg	1.70	3.87	3.79	0.75	0.71	0.14	XXX
95831		A	Limb muscle testing manual	0.28	0.57	0.54	0.14	0.13	0.03	XXX
95832		A	Hand muscle testing manual	0.29	0.57	0.50	0.17	0.14	0.03	XXX
95833		A	Body muscle testing manual	0.47	0.61	0.60	0.16	0.18	0.01	XXX
95834		A	Body muscle testing manual	0.60	0.82	0.73	0.26	0.25	0.03	XXX
95851		A	Range of motion measurements	0.16	0.35	0.34	0.06	0.06	0.01	XXX
95852		A	Range of motion measurements	0.11	0.35	0.32	0.05	0.05	0.01	XXX
95857		A	Cholinesterase challenge	0.53	0.92	0.82	0.30	0.27	0.04	XXX
95860		A	Muscle test one limb	0.96	1.84	1.67	NA	NA	0.04	XXX
95860	TC	A	Muscle test one limb	0.00	1.34	1.20	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95860	26	A	Muscle test one limb	0.96	0.50	0.47	0.50	0.47	0.03	XXX
95861		A	Muscle test 2 limbs	1.54	2.60	2.26	NA	NA	0.06	XXX
95861	TC	A	Muscle test 2 limbs	0.00	1.80	1.52	NA	NA	0.01	XXX
95861	26	A	Muscle test 2 limbs	1.54	0.80	0.74	0.80	0.74	0.05	XXX
95863		A	Muscle test 3 limbs	1.87	3.17	2.73	NA	NA	0.08	XXX
95863	TC	A	Muscle test 3 limbs	0.00	2.23	1.86	NA	NA	0.01	XXX
95863	26	A	Muscle test 3 limbs	1.87	0.94	0.87	0.94	0.87	0.07	XXX
95864		A	Muscle test 4 limbs	1.99	3.35	3.06	NA	NA	0.08	XXX
95864	TC	A	Muscle test 4 limbs	0.00	2.35	2.13	NA	NA	0.01	XXX
95864	26	A	Muscle test 4 limbs	1.99	1.00	0.93	1.00	0.93	0.07	XXX
95865		A	Muscle test larynx	1.57	2.06	1.90	NA	NA	0.05	XXX
95865	TC	A	Muscle test larynx	0.00	1.22	1.12	NA	NA	0.01	XXX
95865	26	A	Muscle test larynx	1.57	0.84	0.78	0.84	0.78	0.04	XXX
95866		A	Muscle test hemidiaphragm	1.25	2.03	1.75	NA	NA	0.06	XXX
95866	TC	A	Muscle test hemidiaphragm	0.00	1.42	1.16	NA	NA	0.01	XXX
95866	26	A	Muscle test hemidiaphragm	1.25	0.61	0.59	0.61	0.59	0.05	XXX
95867		A	Muscle test cran nerv unilat	0.79	1.74	1.54	NA	NA	0.04	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	1.33	1.16	NA	NA	0.01	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.41	0.38	0.41	0.38	0.03	XXX
95868		A	Muscle test cran nerve bilat	1.18	2.26	1.98	NA	NA	0.05	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	1.66	1.43	NA	NA	0.01	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.60	0.55	0.60	0.55	0.04	XXX
95869		A	Muscle test thor paraspinal	0.37	1.63	1.34	NA	NA	0.02	XXX
95869	TC	A	Muscle test thor paraspinal	0.00	1.44	1.16	NA	NA	0.01	XXX
95869	26	A	Muscle test thor paraspinal	0.37	0.19	0.18	0.19	0.18	0.01	XXX
95870		A	Muscle test nonparaspinal	0.37	1.60	1.29	NA	NA	0.02	XXX
95870	TC	A	Muscle test nonparaspinal	0.00	1.41	1.12	NA	NA	0.01	XXX
95870	26	A	Muscle test nonparaspinal	0.37	0.19	0.17	0.19	0.17	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95872		A	Muscle test one fiber	2.88	2.58	2.25	NA	NA	0.12	XXX
95872	TC	A	Muscle test one fiber	0.00	1.20	1.03	NA	NA	0.01	XXX
95872	26	A	Muscle test one fiber	2.88	1.38	1.22	1.38	1.22	0.11	XXX
95873		A	Guide nerv destr elec stim	0.37	1.61	1.34	NA	NA	0.02	ZZZ
95873	TC	A	Guide nerv destr elec stim	0.00	1.40	1.13	NA	NA	0.01	ZZZ
95873	26	A	Guide nerv destr elec stim	0.37	0.21	0.21	0.21	0.21	0.01	ZZZ
95874		A	Guide nerv destr needle emg	0.37	1.54	1.25	NA	NA	0.02	ZZZ
95874	TC	A	Guide nerv destr needle emg	0.00	1.34	1.07	NA	NA	0.01	ZZZ
95874	26	A	Guide nerv destr needle emg	0.37	0.20	0.18	0.20	0.18	0.01	ZZZ
95875		A	Limb exercise test	1.10	2.22	1.94	NA	NA	0.06	XXX
95875	TC	A	Limb exercise test	0.00	1.69	1.44	NA	NA	0.01	XXX
95875	26	A	Limb exercise test	1.10	0.53	0.50	0.53	0.50	0.05	XXX
95900		A	Motor nerve conduction test	0.42	1.45	1.33	NA	NA	0.02	XXX
95900	TC	A	Motor nerve conduction test	0.00	1.23	1.13	NA	NA	0.01	XXX
95900	26	A	Motor nerve conduction test	0.42	0.22	0.20	0.22	0.20	0.01	XXX
95903		A	Motor nerve conduction test	0.60	1.54	1.42	NA	NA	0.04	XXX
95903	TC	A	Motor nerve conduction test	0.00	1.25	1.15	NA	NA	0.01	XXX
95903	26	A	Motor nerve conduction test	0.60	0.29	0.27	0.29	0.27	0.03	XXX
95904		A	Sense nerve conduction test	0.34	1.29	1.20	NA	NA	0.02	XXX
95904	TC	A	Sense nerve conduction test	0.00	1.12	1.04	NA	NA	0.01	XXX
95904	26	A	Sense nerve conduction test	0.34	0.17	0.16	0.17	0.16	0.01	XXX
95905		A	Motor/sens nrve conduct test	0.05	2.42	2.42	NA	NA	0.02	XXX
95905	TC	A	Motor/sens nrve conduct test	0.00	2.39	2.39	NA	NA	0.01	XXX
95905	26	A	Motor/sens nrve conduct test	0.05	0.03	0.03	0.03	0.03	0.01	XXX
95920		A	Intraop nerve test add-on	2.11	2.70	2.47	NA	NA	0.09	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.67	1.52	NA	NA	0.01	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	1.03	0.95	1.03	0.95	0.08	ZZZ
95921		A	Autonomic nerv function test	0.90	1.53	1.41	NA	NA	0.04	XXX

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95921	TC	A	Autonomic nerv function test	0.00	1.12	1.03	NA	NA	0.01	XXX
95921	26	A	Autonomic nerv function test	0.90	0.41	0.38	0.41	0.38	0.03	XXX
95922		A	Autonomic nerv function test	0.96	2.10	1.90	NA	NA	0.04	XXX
95922	TC	A	Autonomic nerv function test	0.00	1.66	1.49	NA	NA	0.01	XXX
95922	26	A	Autonomic nerv function test	0.96	0.44	0.41	0.44	0.41	0.03	XXX
95923		A	Autonomic nerv function test	0.90	3.93	3.33	NA	NA	0.05	XXX
95923	TC	A	Autonomic nerv function test	0.00	3.49	2.92	NA	NA	0.01	XXX
95923	26	A	Autonomic nerv function test	0.90	0.44	0.41	0.44	0.41	0.04	XXX
95925		A	Somatosensory testing	0.54	4.94	4.07	NA	NA	0.02	XXX
95925	TC	A	Somatosensory testing	0.00	4.68	3.83	NA	NA	0.01	XXX
95925	26	A	Somatosensory testing	0.54	0.26	0.24	0.26	0.24	0.01	XXX
95926		A	Somatosensory testing	0.54	4.66	3.90	NA	NA	0.04	XXX
95926	TC	A	Somatosensory testing	0.00	4.41	3.66	NA	NA	0.01	XXX
95926	26	A	Somatosensory testing	0.54	0.25	0.24	0.25	0.24	0.03	XXX
95927		A	Somatosensory testing	0.54	4.06	3.64	NA	NA	0.02	XXX
95927	TC	A	Somatosensory testing	0.00	3.80	3.39	NA	NA	0.01	XXX
95927	26	A	Somatosensory testing	0.54	0.26	0.25	0.26	0.25	0.01	XXX
95928		A	C motor evoked uppr limbs	1.50	6.24	5.31	NA	NA	0.10	XXX
95928	TC	A	C motor evoked uppr limbs	0.00	5.51	4.64	NA	NA	0.03	XXX
95928	26	A	C motor evoked uppr limbs	1.50	0.73	0.67	0.73	0.67	0.07	XXX
95929		A	C motor evoked lwr limbs	1.50	6.70	5.71	NA	NA	0.10	XXX
95929	TC	A	C motor evoked lwr limbs	0.00	5.97	5.04	NA	NA	0.03	XXX
95929	26	A	C motor evoked lwr limbs	1.50	0.73	0.67	0.73	0.67	0.07	XXX
95930		A	Visual evoked potential test	0.35	4.10	3.56	NA	NA	0.02	XXX
95930	TC	A	Visual evoked potential test	0.00	3.92	3.40	NA	NA	0.01	XXX
95930	26	A	Visual evoked potential test	0.35	0.18	0.16	0.18	0.16	0.01	XXX
95933		A	Blink reflex test	0.59	1.79	1.56	NA	NA	0.04	XXX
95933	TC	A	Blink reflex test	0.00	1.49	1.29	NA	NA	0.01	XXX

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95933	26	A	Blink reflex test	0.59	0.30	0.27	0.30	0.27	0.03	XXX
95934		A	H-reflex test	0.51	1.31	1.13	NA	NA	0.02	XXX
95934	TC	A	H-reflex test	0.00	1.06	0.89	NA	NA	0.01	XXX
95934	26	A	H-reflex test	0.51	0.25	0.24	0.25	0.24	0.01	XXX
95936		A	H-reflex test	0.55	0.90	0.80	NA	NA	0.02	XXX
95936	TC	A	H-reflex test	0.00	0.63	0.55	NA	NA	0.01	XXX
95936	26	A	H-reflex test	0.55	0.27	0.25	0.27	0.25	0.01	XXX
95937		A	Neuromuscular junction test	0.65	1.40	1.20	NA	NA	0.05	XXX
95937	TC	A	Neuromuscular junction test	0.00	1.08	0.91	NA	NA	0.01	XXX
95937	26	A	Neuromuscular junction test	0.65	0.32	0.29	0.32	0.29	0.04	XXX
95950		A	Ambulatory eeg monitoring	1.51	7.13	6.38	NA	NA	0.10	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	6.40	5.71	NA	NA	0.03	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.73	0.67	0.73	0.67	0.07	XXX
95951		C	Eeg monitoring/videorecord	0.00	0.00	0.00	NA	NA	0.00	XXX
95951	TC	C	Eeg monitoring/videorecord	0.00	0.00	0.00	NA	NA	0.00	XXX
95951	26	A	Eeg monitoring/videorecord	5.99	2.91	2.67	2.91	2.67	0.48	XXX
95953		A	Eeg monitoring/computer	3.08	9.05	8.93	NA	NA	0.18	XXX
95953	TC	A	Eeg monitoring/computer	0.00	7.55	7.53	NA	NA	0.03	XXX
95953	26	A	Eeg monitoring/computer	3.08	1.50	1.40	1.50	1.40	0.15	XXX
95954		A	Eeg monitoring/giving drugs	2.45	8.00	6.55	NA	NA	0.15	XXX
95954	TC	A	Eeg monitoring/giving drugs	0.00	7.11	5.76	NA	NA	0.04	XXX
95954	26	A	Eeg monitoring/giving drugs	2.45	0.89	0.79	0.89	0.79	0.11	XXX
95955		A	Eeg during surgery	1.01	4.63	3.90	NA	NA	0.05	XXX
95955	TC	A	Eeg during surgery	0.00	4.15	3.47	NA	NA	0.01	XXX
95955	26	A	Eeg during surgery	1.01	0.48	0.43	0.48	0.43	0.04	XXX
95956		A	Eeg monitor technol attended	3.61	32.20	25.89	NA	NA	0.32	XXX
95956	TC	A	Eeg monitor technol attended	0.00	30.54	24.44	NA	NA	0.16	XXX
95956	26	A	Eeg monitor technol attended	3.61	1.66	1.45	1.66	1.45	0.16	XXX

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95957		A	Eeg digital analysis	1.98	9.75	7.92	NA	NA	0.11	XXX
95957	TC	A	Eeg digital analysis	0.00	8.80	7.04	NA	NA	0.01	XXX
95957	26	A	Eeg digital analysis	1.98	0.95	0.88	0.95	0.88	0.10	XXX
95958		A	Eeg monitoring/function test	4.24	10.48	8.89	NA	NA	0.26	XXX
95958	TC	A	Eeg monitoring/function test	0.00	8.51	7.04	NA	NA	0.04	XXX
95958	26	A	Eeg monitoring/function test	4.24	1.97	1.85	1.97	1.85	0.22	XXX
95961		A	Electrode stimulation brain	2.97	5.00	4.29	NA	NA	0.15	XXX
95961	TC	A	Electrode stimulation brain	0.00	3.52	2.92	NA	NA	0.01	XXX
95961	26	A	Electrode stimulation brain	2.97	1.48	1.37	1.48	1.37	0.14	XXX
95962		A	Electrode stim brain add-on	3.21	3.78	3.31	NA	NA	0.15	ZZZ
95962	TC	A	Electrode stim brain add-on	0.00	2.20	1.87	NA	NA	0.01	ZZZ
95962	26	A	Electrode stim brain add-on	3.21	1.58	1.44	1.58	1.44	0.14	ZZZ
95965		C	Meg spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	TC	C	Meg spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	26	A	Meg spontaneous	7.99	3.90	3.71	3.90	3.71	0.64	XXX
95966		C	Meg evoked single	0.00	0.00	0.00	NA	NA	0.00	XXX
95966	TC	C	Meg evoked single	0.00	0.00	0.00	NA	NA	0.00	XXX
95966	26	A	Meg evoked single	3.99	1.95	1.86	1.95	1.86	0.31	XXX
95967		C	Meg evoked each addl	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	TC	C	Meg evoked each addl	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	26	A	Meg evoked each addl	3.49	1.70	1.56	1.70	1.56	0.29	ZZZ
95970		A	Analyze neurostim no prog	0.45	1.41	1.25	0.21	0.19	0.04	XXX
95971		A	Analyze neurostim simple	0.78	0.82	0.85	0.34	0.33	0.07	XXX
95972		A	Analyze neurostim complex	1.50	1.56	1.49	0.70	0.64	0.14	XXX
95973		A	Analyze neurostim complex	0.92	0.86	0.76	0.46	0.39	0.08	ZZZ
95974		A	Cranial neurostim complex	3.00	2.50	2.19	1.41	1.29	0.26	XXX
95975		A	Cranial neurostim complex	1.70	1.28	1.12	0.83	0.75	0.12	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	3.11	2.72	1.73	1.56	0.38	XXX

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95979		A	Analyz neurostim brain addon	1.64	1.25	1.10	0.81	0.74	0.14	ZZZ
95980		A	Io anal gast n-stim init	0.80	NA	NA	0.44	0.37	0.16	XXX
95981		A	Io anal gast n-stim subsq	0.30	0.60	0.57	0.20	0.18	0.03	XXX
95982		A	Io ga n-stim subsq w/reprog	0.65	0.81	0.71	0.36	0.31	0.05	XXX
95990		A	Spin/brain pump refil & main	0.00	2.48	2.20	NA	NA	0.03	XXX
95991		A	Spin/brain pump refil & main	0.77	2.64	2.29	0.36	0.29	0.05	XXX
95992		A	Canalith repositioning proc	0.75	0.46	0.45	0.33	0.32	0.05	XXX
95999		C	Neurological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96000		A	Motion analysis video/3d	1.80	NA	NA	0.93	0.77	0.11	XXX
96001		A	Motion test w/ft press meas	2.15	NA	NA	0.65	0.68	0.12	XXX
96002		A	Dynamic surface emg	0.41	NA	NA	0.21	0.18	0.03	XXX
96003		A	Dynamic fine wire emg	0.37	NA	NA	0.18	0.15	0.03	XXX
96004		A	Phys review of motion tests	2.14	1.03	1.00	1.03	1.00	0.14	XXX
96020		C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	TC	C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	26	A	Functional brain mapping	3.43	1.28	1.46	1.28	1.46	0.31	XXX
96040		B	Genetic counseling 30 min	0.00	1.23	1.29	NA	NA	0.03	XXX
96101		A	Psycho testing by psych/phys	1.86	0.49	0.51	0.29	0.40	0.07	XXX
96102		A	Psycho testing by technician	0.50	1.74	1.43	0.17	0.16	0.03	XXX
96103		A	Psycho testing admin by comp	0.51	1.30	1.12	0.19	0.18	0.03	XXX
96105		A	Assessment of aphasia	1.75	0.17	1.21	NA	NA	0.04	XXX
96110		A	Developmental test lim	0.00	0.24	0.23	NA	NA	0.01	XXX
96111		A	Developmental test extend	2.60	0.84	0.93	0.67	0.79	0.16	XXX
96116		A	Neurobehavioral status exam	1.86	0.70	0.73	0.55	0.56	0.10	XXX
96118		A	Neuropsych tst by psych/phys	1.86	0.69	0.93	0.26	0.38	0.07	XXX
96119		A	Neuropsych testing by tec	0.55	1.39	1.51	0.09	0.13	0.01	XXX
96120		A	Neuropsych tst admin w/comp	0.51	2.08	1.88	0.18	0.17	0.03	XXX
96125		A	Cognitive test by hc pro	1.70	1.04	1.00	NA	NA	0.07	XXX

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96150		A	Assess hlth/behave init	0.50	0.07	0.11	0.07	0.10	0.01	XXX
96151		A	Assess hlth/behave subseq	0.48	0.08	0.11	0.07	0.10	0.01	XXX
96152		A	Intervene hlth/behave indiv	0.46	0.07	0.10	0.06	0.09	0.01	XXX
96153		A	Intervene hlth/behave group	0.10	0.02	0.03	0.02	0.02	0.01	XXX
96154		A	Interv hlth/behav fam w/pt	0.45	0.07	0.10	0.06	0.09	0.01	XXX
96155		N	Interv hlth/behav fam no pt	0.44	0.20	0.20	0.19	0.19	0.03	XXX
96360		A	Hydration iv infusion init	0.17	1.34	1.48	NA	NA	0.03	XXX
96361		A	Hydrate iv infusion add-on	0.09	0.31	0.36	NA	NA	0.01	ZZZ
96365		A	Ther/proph/diag iv inf init	0.21	1.71	1.86	NA	NA	0.03	XXX
96366		A	Ther/proph/diag iv inf addon	0.18	0.42	0.45	NA	NA	0.01	ZZZ
96367		A	Tx/proph/dg addl seq iv inf	0.19	0.66	0.77	NA	NA	0.01	ZZZ
96368		A	Ther/diag concurrent inf	0.17	0.35	0.40	NA	NA	0.01	ZZZ
96369		A	Sc ther infusion up to 1 hr	0.21	4.84	4.81	NA	NA	0.03	XXX
96370		A	Sc ther infusion addl hr	0.18	0.26	0.26	NA	NA	0.01	ZZZ
96371		A	Sc ther infusion reset pump	0.00	2.25	2.35	NA	NA	0.01	ZZZ
96372		A	Ther/proph/diag inj sc/im	0.17	0.50	0.50	NA	NA	0.01	XXX
96373		A	Ther/proph/diag inj ia	0.17	0.38	0.38	NA	NA	0.01	XXX
96374		A	Ther/proph/diag inj iv push	0.18	1.29	1.44	NA	NA	0.03	XXX
96375		A	Tx/pro/dx inj new drug addon	0.10	0.49	0.56	NA	NA	0.01	ZZZ
96376		X	Tx/pro/dx inj same drug adon	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
96379		C	Ther/prop/diag inj/inf proc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96401		A	Chemo anti-neopl sq/im	0.21	1.77	1.90	NA	NA	0.04	XXX
96402		A	Chemo hormon antineopl sq/im	0.19	0.67	0.84	NA	NA	0.01	XXX
96405		A	Chemo intralesional up to 7	0.52	1.79	1.99	0.37	0.34	0.03	000
96406		A	Chemo intralesional over 7	0.80	2.36	2.65	0.51	0.46	0.04	000
96409		A	Chemo iv push sngl drug	0.24	2.65	3.04	NA	NA	0.05	XXX
96411		A	Chemo iv push addl drug	0.20	1.42	1.64	NA	NA	0.03	ZZZ
96413		A	Chemo iv infusion 1 hr	0.28	3.44	4.00	NA	NA	0.05	XXX

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96415		A	Chemo iv infusion addl hr	0.19	0.62	0.72	NA	NA	0.01	ZZZ
96416		A	Chemo prolong infuse w/pump	0.21	3.87	4.49	NA	NA	0.07	XXX
96417		A	Chemo iv infus each addl seq	0.21	1.64	1.90	NA	NA	0.03	ZZZ
96420		A	Chemo ia push tecnique	0.17	2.58	2.97	NA	NA	0.08	XXX
96422		A	Chemo ia infusion up to 1 hr	0.17	4.27	4.93	NA	NA	0.08	XXX
96423		A	Chemo ia infuse each addl hr	0.17	1.89	2.15	NA	NA	0.04	ZZZ
96425		A	Chemotherapy infusion method	0.17	4.57	5.04	NA	NA	0.10	XXX
96440		A	Chemotherapy intracavitary	2.37	19.93	18.62	1.51	1.45	0.54	000
96446		A	Chemotx admn prtl cavity	0.37	4.79	4.79	0.19	0.19	0.07	XXX
96450		A	Chemotherapy into cns	1.53	3.38	4.23	0.76	0.88	0.11	000
96521		A	Refill/maint portable pump	0.21	3.36	3.67	NA	NA	0.05	XXX
96522		A	Refill/maint pump/resvr syst	0.21	2.71	3.02	NA	NA	0.05	XXX
96523		T	Irrig drug delivery device	0.04	0.61	0.70	NA	NA	0.01	XXX
96542		A	Chemotherapy injection	0.75	2.38	2.96	0.46	0.50	0.04	XXX
96549		C	Chemotherapy unspecified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96567		A	Photodynamic tx skin	0.00	3.78	3.86	NA	NA	0.01	XXX
96570		A	Photodynmc tx 30 min add-on	1.10	0.44	0.47	0.44	0.47	0.18	ZZZ
96571		A	Photodynamic tx addl 15 min	0.55	0.19	0.21	0.19	0.21	0.04	ZZZ
96900		A	Ultraviolet light therapy	0.00	0.57	0.60	NA	NA	0.01	XXX
96902		B	Trichogram	0.41	0.20	0.20	0.18	0.18	0.03	XXX
96904		R	Whole body photography	0.00	1.82	2.00	NA	NA	0.01	XXX
96910		A	Photochemotherapy with uv-b	0.00	1.99	2.04	NA	NA	0.01	XXX
96912		A	Photochemotherapy with uv-a	0.00	2.56	2.62	NA	NA	0.01	XXX
96913		A	Photochemotherapy uv-a or b	0.00	3.61	3.65	NA	NA	0.01	XXX
96920		A	Laser tx skin < 250 sq cm	1.15	3.83	3.92	0.85	0.79	0.04	000
96921		A	Laser tx skin 250-500 sq cm	1.17	3.95	3.91	0.85	0.77	0.04	000
96922		A	Laser tx skin > 500 sq cm	2.10	5.09	5.19	1.56	1.39	0.08	000
96999		C	Dermatological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
97001		A	Pt evaluation	1.20	0.92	0.89	NA	NA	0.05	XXX
97002		A	Pt re-evaluation	0.60	0.58	0.55	NA	NA	0.03	XXX
97003		A	Ot evaluation	1.20	1.23	1.11	NA	NA	0.05	XXX
97004		A	Ot re-evaluation	0.60	0.90	0.80	NA	NA	0.03	XXX
97005		I	Athletic train eval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97006		I	Athletic train reeval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97010		B	Hot or cold packs therapy	0.06	0.10	0.09	NA	NA	0.01	XXX
97012		A	Mechanical traction therapy	0.25	0.20	0.19	NA	NA	0.01	XXX
97014		I	Electric stimulation therapy	0.18	0.27	0.24	NA	NA	0.01	XXX
97016		A	Vasopneumatic device therapy	0.18	0.35	0.32	NA	NA	0.01	XXX
97018		A	Paraffin bath therapy	0.06	0.23	0.21	NA	NA	0.01	XXX
97022		A	Whirlpool therapy	0.17	0.47	0.42	NA	NA	0.01	XXX
97024		A	Diathermy eg microwave	0.06	0.12	0.11	NA	NA	0.01	XXX
97026		R	Infrared therapy	0.06	0.10	0.09	NA	NA	0.01	XXX
97028		A	Ultraviolet therapy	0.08	0.12	0.11	NA	NA	0.01	XXX
97032		A	Electrical stimulation	0.25	0.28	0.26	NA	NA	0.01	XXX
97033		A	Electric current therapy	0.26	0.64	0.56	NA	NA	0.01	XXX
97034		A	Contrast bath therapy	0.21	0.29	0.26	NA	NA	0.01	XXX
97035		A	Ultrasound therapy	0.21	0.14	0.13	NA	NA	0.01	XXX
97036		A	Hydrotherapy	0.28	0.63	0.57	NA	NA	0.01	XXX
97039		C	Physical therapy treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97110		A	Therapeutic exercises	0.45	0.45	0.42	NA	NA	0.01	XXX
97112		A	Neuromuscular reeducation	0.45	0.49	0.45	NA	NA	0.01	XXX
97113		A	Aquatic therapy/exercises	0.44	0.76	0.69	NA	NA	0.01	XXX
97116		A	Gait training therapy	0.40	0.39	0.36	NA	NA	0.01	XXX
97124		A	Massage therapy	0.35	0.38	0.35	NA	NA	0.01	XXX
97139		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97140		A	Manual therapy	0.43	0.41	0.38	NA	NA	0.01	XXX

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97150		A	Group therapeutic procedures	0.27	0.31	0.28	NA	NA	0.01	XXX
97530		A	Therapeutic activities	0.44	0.54	0.50	NA	NA	0.01	XXX
97532		A	Cognitive skills development	0.44	0.31	0.29	NA	NA	0.01	XXX
97533		A	Sensory integration	0.44	0.38	0.36	NA	NA	0.01	XXX
97535		A	Self care mngment training	0.45	0.53	0.49	NA	NA	0.01	XXX
97537		A	Community/work reintegration	0.45	0.40	0.37	NA	NA	0.01	XXX
97542		A	Wheelchair mngment training	0.45	0.41	0.38	NA	NA	0.01	XXX
97545		R	Work hardening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97546		R	Work hardening add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
97597		A	Rmvl devital tis 20 cm/<	0.51	1.56	1.56	0.15	0.15	0.05	000
97598		A	Rmvl devital tis addl 20 cm<	0.24	0.44	0.44	0.07	0.07	0.03	ZZZ
97602		B	Wound(s) care non-selective	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97605		A	Neg press wound tx < 50 cm	0.55	0.58	0.53	0.16	0.17	0.08	XXX
97606		A	Neg press wound tx > 50 cm	0.60	0.59	0.54	0.17	0.18	0.10	XXX
97750		A	Physical performance test	0.45	0.47	0.44	NA	NA	0.03	XXX
97755		A	Assistive technology assess	0.62	0.39	0.37	NA	NA	0.03	XXX
97760		A	Orthotic mgmt and training	0.45	0.61	0.56	NA	NA	0.03	XXX
97761		A	Prosthetic training	0.45	0.47	0.43	NA	NA	0.03	XXX
97762		A	C/o for orthotic/prosth use	0.25	1.06	0.93	NA	NA	0.01	XXX
97799		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97802		A	Medical nutrition indiv in	0.53	0.42	0.38	0.36	0.32	0.03	XXX
97803		A	Med nutrition indiv subseq	0.45	0.37	0.34	0.31	0.28	0.03	XXX
97804		A	Medical nutrition group	0.25	0.18	0.15	0.17	0.15	0.01	XXX
97810		N	Acupunct w/o stimul 15 min	0.60	0.41	0.42	0.26	0.26	0.04	XXX
97811		N	Acupunct w/o stimul addl 15m	0.50	0.27	0.27	0.22	0.21	0.03	ZZZ
97813		N	Acupunct w/stimul 15 min	0.65	0.44	0.44	0.29	0.28	0.04	XXX
97814		N	Acupunct w/stimul addl 15m	0.55	0.32	0.32	0.24	0.24	0.04	ZZZ
98925		A	Osteopathic manipulation	0.45	0.44	0.41	0.21	0.18	0.03	000

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98926		A	Osteopathic manipulation	0.65	0.56	0.52	0.28	0.26	0.03	000
98927		A	Osteopathic manipulation	0.87	0.71	0.64	0.35	0.33	0.04	000
98928		A	Osteopathic manipulation	1.03	0.79	0.73	0.41	0.39	0.05	000
98929		A	Osteopathic manipulation	1.19	0.92	0.84	0.48	0.45	0.07	000
98940		A	Chiropractic manipulation	0.45	0.30	0.29	0.16	0.15	0.01	000
98941		A	Chiropractic manipulation	0.65	0.39	0.37	0.23	0.23	0.03	000
98942		A	Chiropractic manipulation	0.87	0.47	0.44	0.31	0.30	0.03	000
98943		N	Chiropractic manipulation	0.40	0.28	0.28	0.18	0.17	0.03	XXX
98960		B	Self-mgmt educ & train 1 pt	0.00	0.73	0.76	NA	NA	0.01	XXX
98961		B	Self-mgmt educ/train 2-4 pt	0.00	0.35	0.37	NA	NA	0.01	XXX
98962		B	Self-mgmt educ/train 5-8 pt	0.00	0.25	0.27	NA	NA	0.01	XXX
98966		N	Hc pro phone call 5-10 min	0.25	0.15	0.15	0.11	0.10	0.01	XXX
98967		N	Hc pro phone call 11-20 min	0.50	0.26	0.25	0.22	0.21	0.03	XXX
98968		N	Hc pro phone call 21-30 min	0.75	0.37	0.36	0.33	0.32	0.05	XXX
98969		N	Online service by hc pro	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99000		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99001		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99002		B	Device handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99024		B	Postop follow-up visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99026		N	In-hospital on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99027		N	Out-of-hosp on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99050		B	Medical services after hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99051		B	Med serv eve/wkend/holiday	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99053		B	Med serv 10pm-8am 24 hr fac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99056		B	Med service out of office	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99058		B	Office emergency care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99060		B	Out of office emerg med serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99070		B	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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99071		B	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075		N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	1.10	0.48	0.47	NA	NA	0.07	XXX
99100		B	Special anesthesia service	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99116		B	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99135		B	Special anesthesia procedure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99140		B	Emergency anesthesia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99143		C	Mod cs by same phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99144		C	Mod cs by same phys 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99145		C	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99148		C	Mod cs diff phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99149		C	Mod cs diff phys 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99150		C	Mod cs diff phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99170		A	Anogenital exam child	1.75	2.19	2.39	0.86	0.91	0.12	000
99172		N	Ocular function screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99173		N	Visual acuity screen	0.00	0.07	0.07	NA	NA	0.01	XXX
99174		N	Ocular photoscreening	0.00	0.78	0.81	NA	NA	0.01	XXX
99175		A	Induction of vomiting	0.00	0.66	0.71	NA	NA	0.01	XXX
99183		A	Hyperbaric oxygen therapy	2.34	3.69	3.54	0.99	0.89	0.26	XXX
99190		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99191		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99192		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99195		A	Phlebotomy	0.00	2.62	2.50	NA	NA	0.05	XXX
99199		C	Special service/proc/report	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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99201		A	Office/outpatient visit new	0.48	0.73	0.70	0.26	0.24	0.04	XXX
99202		A	Office/outpatient visit new	0.93	1.16	1.09	0.49	0.44	0.07	XXX
99203		A	Office/outpatient visit new	1.42	1.57	1.48	0.72	0.64	0.14	XXX
99204		A	Office/outpatient visit new	2.43	2.15	2.01	1.21	1.06	0.23	XXX
99205		A	Office/outpatient visit new	3.17	2.52	2.37	1.50	1.34	0.27	XXX
99211		A	Office/outpatient visit est	0.18	0.37	0.39	0.08	0.08	0.01	XXX
99212		A	Office/outpatient visit est	0.48	0.73	0.70	0.24	0.22	0.04	XXX
99213		A	Office/outpatient visit est	0.97	1.06	0.99	0.47	0.42	0.07	XXX
99214		A	Office/outpatient visit est	1.50	1.49	1.42	0.71	0.63	0.10	XXX
99215		A	Office/outpatient visit est	2.11	1.91	1.81	1.00	0.90	0.14	XXX
99217		A	Observation care discharge	1.28	NA	NA	0.73	0.68	0.08	XXX
99218		A	Initial observation caree	1.28	NA	NA	0.58	0.54	0.08	XXX
99219		A	Initial observation care	2.14	NA	NA	0.98	0.89	0.14	XXX
99220		A	Initial observation care	2.99	NA	NA	1.35	1.24	0.20	XXX
99221		A	Initial hospital care	1.92	NA	NA	0.86	0.76	0.18	XXX
99222		A	Initial hospital care	2.61	NA	NA	1.21	1.06	0.22	XXX
99223		A	Initial hospital care	3.86	NA	NA	1.78	1.56	0.29	XXX
99224		A	Subsequent observation care	0.54	NA	NA	0.24	0.24	0.04	XXX
99225		A	Subsequent observation care	0.96	NA	NA	0.44	0.44	0.05	XXX
99226		A	Subsequent observation care	1.44	NA	NA	0.65	0.65	0.08	XXX
99231		A	Subsequent hospital care	0.76	NA	NA	0.34	0.32	0.05	XXX
99232		A	Subsequent hospital care	1.39	NA	NA	0.64	0.58	0.08	XXX
99233		A	Subsequent hospital care	2.00	NA	NA	0.90	0.82	0.12	XXX
99234		A	Observ/hosp same date	2.56	NA	NA	1.16	1.10	0.22	XXX
99235		A	Observ/hosp same date	3.41	NA	NA	1.56	1.43	0.23	XXX
99236		A	Observ/hosp same date	4.26	NA	NA	1.90	1.75	0.29	XXX
99238		A	Hospital discharge day	1.28	NA	NA	0.74	0.69	0.07	XXX
99239		A	Hospital discharge day	1.90	NA	NA	1.09	0.98	0.11	XXX

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99241		I	Office consultation	0.64	0.66	0.66	0.24	0.24	0.07	XXX
99242		I	Office consultation	1.34	1.10	1.10	0.51	0.51	0.14	XXX
99243		I	Office consultation	1.88	1.46	1.46	0.71	0.71	0.18	XXX
99244		I	Office consultation	3.02	1.96	1.96	1.14	1.14	0.22	XXX
99245		I	Office consultation	3.77	2.30	2.30	1.38	1.38	0.29	XXX
99251		I	Inpatient consultation	1.00	NA	NA	0.32	0.32	0.07	XXX
99252		I	Inpatient consultation	1.50	NA	NA	0.52	0.52	0.12	XXX
99253		I	Inpatient consultation	2.27	NA	NA	0.84	0.84	0.15	XXX
99254		I	Inpatient consultation	3.29	NA	NA	1.23	1.23	0.18	XXX
99255		I	Inpatient consultation	4.00	NA	NA	1.44	1.44	0.24	XXX
99281		A	Emergency dept visit	0.45	NA	NA	0.15	0.13	0.03	XXX
99282		A	Emergency dept visit	0.88	NA	NA	0.27	0.24	0.07	XXX
99283		A	Emergency dept visit	1.34	NA	NA	0.39	0.36	0.10	XXX
99284		A	Emergency dept visit	2.56	NA	NA	0.67	0.62	0.22	XXX
99285		A	Emergency dept visit	3.80	NA	NA	0.91	0.88	0.30	XXX
99288		B	Direct advanced life support	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99291		A	Critical care first hour	4.50	3.04	2.95	1.68	1.56	0.34	XXX
99292		A	Critical care addl 30 min	2.25	1.13	1.07	0.84	0.78	0.18	ZZZ
99304		A	Nursing facility care init	1.64	0.94	0.82	0.94	0.82	0.14	XXX
99305		A	Nursing facility care init	2.35	1.28	1.09	1.28	1.09	0.20	XXX
99306		A	Nursing facility care init	3.06	1.59	1.34	1.59	1.34	0.23	XXX
99307		A	Nursing fac care subseq	0.76	0.49	0.44	0.49	0.44	0.04	XXX
99308		A	Nursing fac care subseq	1.16	0.77	0.68	0.77	0.68	0.07	XXX
99309		A	Nursing fac care subseq	1.55	1.00	0.88	1.00	0.88	0.08	XXX
99310		A	Nursing fac care subseq	2.35	1.41	1.24	1.41	1.24	0.14	XXX
99315		A	Nursing fac discharge day	1.13	0.70	0.61	0.70	0.61	0.07	XXX
99316		A	Nursing fac discharge day	1.50	0.87	0.77	0.87	0.77	0.08	XXX
99318		A	Annual nursing fac assessmnt	1.71	0.99	0.84	0.99	0.84	0.10	XXX

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99324		A	Domicil/r-home visit new pat	1.01	0.55	0.54	NA	NA	0.07	XXX
99325		A	Domicil/r-home visit new pat	1.52	0.73	0.73	NA	NA	0.10	XXX
99326		A	Domicil/r-home visit new pat	2.63	1.31	1.19	NA	NA	0.16	XXX
99327		A	Domicil/r-home visit new pat	3.46	1.74	1.55	NA	NA	0.22	XXX
99328		A	Domicil/r-home visit new pat	4.09	2.00	1.78	NA	NA	0.24	XXX
99334		A	Domicil/r-home visit est pat	1.07	0.62	0.58	NA	NA	0.07	XXX
99335		A	Domicil/r-home visit est pat	1.72	0.94	0.84	NA	NA	0.10	XXX
99336		A	Domicil/r-home visit est pat	2.46	1.32	1.15	NA	NA	0.14	XXX
99337		A	Domicil/r-home visit est pat	3.58	1.83	1.60	NA	NA	0.23	XXX
99339		B	Domicil/r-home care supervis	1.25	0.92	0.91	NA	NA	0.08	XXX
99340		B	Domicil/r-home care supervis	1.80	1.23	1.22	NA	NA	0.12	XXX
99341		A	Home visit new patient	1.01	0.52	0.53	NA	NA	0.07	XXX
99342		A	Home visit new patient	1.52	0.70	0.71	NA	NA	0.11	XXX
99343		A	Home visit new patient	2.53	1.15	1.11	NA	NA	0.18	XXX
99344		A	Home visit new patient	3.38	1.75	1.54	NA	NA	0.22	XXX
99345		A	Home visit new patient	4.09	2.06	1.81	NA	NA	0.26	XXX
99347		A	Home visit est patient	1.00	0.55	0.53	NA	NA	0.07	XXX
99348		A	Home visit est patient	1.56	0.80	0.76	NA	NA	0.10	XXX
99349		A	Home visit est patient	2.33	1.27	1.11	NA	NA	0.14	XXX
99350		A	Home visit est patient	3.28	1.70	1.50	NA	NA	0.22	XXX
99354		A	Prolonged service office	1.77	1.01	0.93	0.82	0.75	0.11	ZZZ
99355		A	Prolonged service office	1.77	0.96	0.90	0.78	0.72	0.11	ZZZ
99356		A	Prolonged service inpatient	1.71	NA	NA	0.85	0.76	0.11	ZZZ
99357		A	Prolonged service inpatient	1.71	NA	NA	0.85	0.76	0.11	ZZZ
99358		B	Prolong service w/o contact	2.10	0.96	0.94	0.96	0.94	0.14	XXX
99359		B	Prolong serv w/o contact add	1.00	0.48	0.47	0.48	0.47	0.07	ZZZ
99360		X	Physician standby services	1.20	NA	NA	0.53	0.51	0.08	XXX
99363		B	Anticoag mgmt init	1.65	1.87	1.89	0.73	0.70	0.11	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99364		B	Anticoag mgmt subseq	0.63	0.57	0.57	0.28	0.27	0.04	XXX
99366		B	Team conf w/pat by hc pro	0.82	0.38	0.37	0.36	0.35	0.05	XXX
99367		B	Team conf w/o pat by phys	1.10	NA	NA	0.48	0.47	0.07	XXX
99368		B	Team conf w/o pat by hc pro	0.72	NA	NA	0.32	0.31	0.04	XXX
99374		B	Home health care supervision	1.10	0.85	0.85	0.48	0.48	0.07	XXX
99375		I	Home health care supervision	1.73	1.20	1.28	0.76	0.88	0.11	XXX
99377		B	Hospice care supervision	1.10	0.85	0.85	0.48	0.48	0.07	XXX
99378		I	Hospice care supervision	1.73	1.20	1.34	0.76	0.94	0.11	XXX
99379		B	Nursing fac care supervision	1.10	0.85	0.85	0.48	0.48	0.07	XXX
99380		B	Nursing fac care supervision	1.73	1.20	1.20	0.76	0.75	0.11	XXX
99381		N	Init pm e/m new pat inf	1.19	1.43	1.49	0.52	0.51	0.08	XXX
99382		N	Init pm e/m new pat 1-4 yrs	1.36	1.50	1.56	0.60	0.59	0.08	XXX
99383		N	Prev visit new age 5-11	1.36	1.49	1.54	0.60	0.59	0.08	XXX
99384		N	Prev visit new age 12-17	1.53	1.56	1.62	0.67	0.66	0.10	XXX
99385		N	Prev visit new age 18-39	1.53	1.56	1.62	0.67	0.66	0.10	XXX
99386		N	Prev visit new age 40-64	1.88	1.72	1.78	0.83	0.81	0.12	XXX
99387		N	Init pm e/m new pat 65+ yrs	2.06	1.91	1.97	0.91	0.90	0.14	XXX
99391		N	Per pm reeval est pat inf	1.02	1.23	1.25	0.45	0.44	0.07	XXX
99392		N	Prev visit est age 1-4	1.19	1.30	1.32	0.52	0.51	0.08	XXX
99393		N	Prev visit est age 5-11	1.19	1.30	1.31	0.52	0.51	0.08	XXX
99394		N	Prev visit est age 12-17	1.36	1.37	1.39	0.60	0.59	0.08	XXX
99395		N	Prev visit est age 18-39	1.36	1.38	1.39	0.60	0.59	0.08	XXX
99396		N	Prev visit est age 40-64	1.53	1.45	1.47	0.67	0.66	0.10	XXX
99397		N	Per pm reeval est pat 65+ yr	1.71	1.65	1.67	0.75	0.75	0.11	XXX
99401		N	Preventive counseling indiv	0.48	0.52	0.56	0.21	0.21	0.03	XXX
99402		N	Preventive counseling indiv	0.98	0.74	0.78	0.43	0.42	0.07	XXX
99403		N	Preventive counseling indiv	1.46	0.95	1.00	0.64	0.63	0.10	XXX
99404		N	Preventive counseling indiv	1.95	1.17	1.22	0.86	0.85	0.12	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99406		A	Behav chng smoking 3-10 min	0.24	0.16	0.15	0.10	0.10	0.01	XXX
99407		A	Behav chng smoking > 10 min	0.50	0.27	0.25	0.22	0.20	0.03	XXX
99408		N	Audit/dast 15-30 min	0.65	0.34	0.33	0.29	0.28	0.04	XXX
99409		N	Audit/dast over 30 min	1.30	0.62	0.61	0.57	0.56	0.08	XXX
99411		N	Preventive counseling group	0.15	0.30	0.30	0.07	0.06	0.01	XXX
99412		N	Preventive counseling group	0.25	0.34	0.34	0.11	0.11	0.01	XXX
99420		N	Health risk assessment test	0.00	0.28	0.29	NA	NA	0.01	XXX
99429		N	Unlisted preventive service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99441		N	Phone e/m by phys 5-10 min	0.25	0.15	0.15	0.11	0.10	0.01	XXX
99442		N	Phone e/m by phys 11-20 min	0.50	0.26	0.25	0.22	0.21	0.03	XXX
99443		N	Phone e/m by phys 21-30 min	0.75	0.37	0.36	0.33	0.32	0.05	XXX
99444		N	Online e/m by phys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99450		N	Basic life disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99455		R	Work related disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99456		R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99460		A	Init nb em per day hosp	1.17	NA	NA	0.55	0.48	0.05	XXX
99461		A	Init nb em per day non-fac	1.26	1.45	1.35	0.55	0.54	0.08	XXX
99462		A	Sbsq nb em per day hosp	0.62	NA	NA	0.29	0.26	0.04	XXX
99463		A	Same day nb discharge	1.50	NA	NA	0.86	0.76	0.08	XXX
99464		A	Attendance at delivery	1.50	NA	NA	0.60	0.54	0.07	XXX
99465		A	Nb resuscitation	2.93	NA	NA	0.68	0.93	0.22	XXX
99466		A	Ped crit care transport	4.79	NA	NA	2.24	1.99	1.02	XXX
99467		A	Ped crit care transport addl	2.40	NA	NA	1.06	0.95	0.14	ZZZ
99468		A	Neonate crit care initial	18.46	NA	NA	7.42	6.50	1.52	XXX
99469		A	Neonate crit care subsq	7.99	NA	NA	3.52	3.12	0.42	XXX
99471		A	Ped critical care initial	15.98	NA	NA	6.42	5.97	0.87	XXX
99472		A	Ped critical care subsq	7.99	NA	NA	3.29	3.01	0.48	XXX
99475		A	Ped crit care age 2-5 init	11.25	4.53	4.01	4.53	4.01	0.86	XXX

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99476		A	Ped crit care age 2-5 subsq	6.75	2.90	2.50	2.90	2.50	0.52	XXX
99477		A	Init day hosp neonate care	7.00	NA	NA	3.08	2.81	0.38	XXX
99478		A	Ic lbw inf < 1500 gm subsq	2.75	NA	NA	1.11	1.11	0.18	XXX
99479		A	Ic lbw inf 1500-2500 g subsq	2.50	NA	NA	1.22	1.05	0.16	XXX
99480		A	Ic inf pbw 2501-5000 g subsq	2.40	NA	NA	0.96	0.91	0.16	XXX
99499		C	Unlisted e&m service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99500		I	Home visit prenatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99501		I	Home visit postnatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99502		I	Home visit nb care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99503		I	Home visit resp therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99504		I	Home visit mech ventilator	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99505		I	Home visit stoma care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99506		I	Home visit im injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99507		I	Home visit cath maintain	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99509		I	Home visit day life activity	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99510		I	Home visit sing/m/fam couns	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99511		I	Home visit fecal/enema mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99512		I	Home visit for hemodialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99600		I	Home visit nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99601		I	Home infusion/visit 2 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99602		I	Home infusion each addtl hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99605		X	Mtms by pharm np 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99606		X	Mtms by pharm est 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99607		X	Mtms by pharm addl 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4641		C	Radiopharm dx agent noc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4642		C	In111 satumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4890		R	Repair/maint cont hemo equip	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9500		C	Tc99m sestamibi	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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A9501		C	Technetium tc-99m teboroxime	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9502		C	Tc99m tetrofosmin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9503		C	Tc99m medronate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9504		C	Tc99m apcitide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9505		C	Tl201 thallium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9507		C	In111 capromab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9508		C	I131 iodobenguate, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9509		C	Iodine i-123 sod iodide mil	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9510		C	Tc99m disofenin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9512		C	Tc99m pertechnetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9516		C	Iodine i-123 sod iodide mic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9517		C	I131 iodide cap, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9521		C	Tc99m exametazime	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9524		C	I131 serum albumin, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9526		C	Nitrogen n-13 ammonia	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9527		C	Iodine i-125 sodium iodide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9528		C	Iodine i-131 iodide cap, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9529		C	I131 iodide sol, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9530		C	I131 iodide sol, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9531		C	I131 max 100uci	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9532		C	I125 serum albumin, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9536		C	Tc99m depreotide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9537		C	Tc99m mebrofenin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9538		C	Tc99m pyrophosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9539		C	Tc99m pentetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9540		C	Tc99m maa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9541		C	Tc99m sulfur colloid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9542		C	In111 ibritumomab, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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A9543		C	Y90 ibritumomab, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9544		C	I131 tositumomab, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9545		C	I131 tositumomab, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9546		C	Co57/58	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9547		C	In111 oxyquinoline	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9548		C	In111 pentetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9550		C	Tc99m gluceptate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9551		C	Tc99m succimer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9552		C	F18 fdg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9553		C	Cr51 chromate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9554		C	I125 iothalamate, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9555		C	Rb82 rubidium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9556		C	Ga67 gallium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9557		C	Tc99m bicisate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9558		C	Xe133 xenon 10mci	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9559		C	Co57 cyano	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9560		C	Tc99m labeled rbc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9561		C	Tc99m oxidronate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9562		C	Tc99m mertiatide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9563		C	P32 na phosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9564		C	P32 chromic phosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9566		C	Tc99m fanolesomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9567		C	Technetium tc-99m aerosol	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9568		C	Technetium tc99m arcitumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9569		C	Technetium tc-99m auto wbc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9570		C	Indium in-111 auto wbc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9571		C	Indium in-111 auto platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9572		C	Indium in-111 pentetreotide	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
A9580		C	Sodium fluoride f-18	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9600		C	Sr89 strontium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9699		C	Radiopharm rx agent noc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0008		X	Admin influenza virus vac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0009		X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0010		X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0027		X	Semen analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0101		A	Ca screen;pelvic/breast exam	0.45	0.61	0.61	0.32	0.32	0.03	XXX
G0102		A	Prostate ca screening; dre	0.17	0.37	0.39	0.08	0.08	0.01	XXX
G0103		X	Psa screening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0104		A	Ca screen;flexi sigmoidscope	0.96	2.93	2.96	0.80	0.77	0.14	000
G0105		A	Colorectal scrn; hi risk ind	3.69	7.15	7.41	2.27	2.23	0.58	000
G0105	53	A	Colorectal scrn; hi risk ind	0.96	2.93	2.96	0.80	0.77	0.14	000
G0106		A	Colon ca screen;barium enema	0.99	5.18	5.25	NA	NA	0.04	XXX
G0106	TC	A	Colon ca screen;barium enema	0.00	4.81	4.84	NA	NA	0.01	XXX
G0106	26	A	Colon ca screen;barium enema	0.99	0.37	0.41	0.37	0.41	0.03	XXX
G0108		A	Diab manage trn per indiv	0.90	0.55	0.66	NA	NA	0.05	XXX
G0109		A	Diab manage trn ind/group	0.25	0.15	0.29	NA	NA	0.01	XXX
G0117		T	Glaucoma scrn hgh risk direc	0.45	1.03	0.98	NA	NA	0.03	XXX
G0118		T	Glaucoma scrn hgh risk direc	0.17	0.87	0.83	NA	NA	0.01	XXX
G0120		A	Colon ca scrn; barium enema	0.99	5.18	5.25	NA	NA	0.04	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	4.81	4.84	NA	NA	0.01	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.37	0.41	0.37	0.41	0.03	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	7.15	7.41	2.27	2.23	0.58	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.93	2.96	0.80	0.77	0.14	000
G0122		N	Colon ca scrn; barium enema	0.99	7.18	6.90	NA	NA	0.05	XXX
G0122	TC	N	Colon ca scrn; barium enema	0.00	6.74	6.47	NA	NA	0.01	XXX
G0122	26	N	Colon ca scrn; barium enema	0.99	0.44	0.43	0.44	0.43	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G0123		X	Screen cerv/vag thin layer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0124		A	Screen c/v thin layer by md	0.42	0.42	0.40	0.42	0.40	0.03	XXX
G0127		R	Trim nail(s)	0.17	0.48	0.45	0.05	0.06	0.01	000
G0128		R	Corf skilled nursing service	0.08	0.20	0.19	NA	NA	0.01	XXX
G0130		A	Single energy x-ray study	0.22	0.72	0.74	NA	NA	0.02	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.62	0.65	NA	NA	0.01	XXX
G0130	26	A	Single energy x-ray study	0.22	0.10	0.09	0.10	0.09	0.01	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.42	0.40	0.42	0.40	0.03	XXX
G0143		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0144		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0145		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0147		X	Scr c/v cyto, automated sys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0148		X	Scr c/v cyto, autosys, rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0157		E	Hhc pt assistant ea 15	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0158		E	Hhc ot assistant ea 15	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0159		E	Hhc pt maint ea 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0160		E	Hhc occup therapy ea 15	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0161		E	Hhc slp ea 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0162		E	Hhc rn e&m plan svs, 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0163		E	Hhc lpn/rn obs/asses ea 15	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0164		E	Hhc lis nurse train ea 15	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0166		A	Extrnl counterpulse, per tx	0.07	3.86	4.43	NA	NA	0.03	XXX
G0168		A	Wound closure by adhesive	0.45	2.14	2.07	0.30	0.28	0.03	000
G0173		X	Linear acc stereo radsur com	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0175		X	Opps service,sched team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0176		X	Opps/php;activity therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0177		X	Opps/php; train & educ serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0179		A	Md recertification hha pt	0.45	0.68	0.72	NA	NA	0.03	XXX

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G0180		A	Md certification hha patient	0.67	0.80	0.85	NA	NA	0.04	XXX
G0181		A	Home health care supervision	1.73	1.28	1.24	NA	NA	0.10	XXX
G0182		A	Hospice care supervision	1.73	1.29	1.28	NA	NA	0.10	XXX
G0186		C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0202		A	Screeningmammographydigital	0.70	3.34	3.39	NA	NA	0.05	XXX
G0202	TC	A	Screeningmammographydigital	0.00	3.06	3.10	NA	NA	0.01	XXX
G0202	26	A	Screeningmammographydigital	0.70	0.28	0.29	0.28	0.29	0.04	XXX
G0204		A	Diagnosticmammographydigital	0.87	4.06	4.03	NA	NA	0.06	XXX
G0204	TC	A	Diagnosticmammographydigital	0.00	3.70	3.67	NA	NA	0.01	XXX
G0204	26	A	Diagnosticmammographydigital	0.87	0.36	0.36	0.36	0.36	0.05	XXX
G0206		A	Diagnosticmammographydigital	0.70	3.18	3.17	NA	NA	0.05	XXX
G0206	TC	A	Diagnosticmammographydigital	0.00	2.90	2.88	NA	NA	0.01	XXX
G0206	26	A	Diagnosticmammographydigital	0.70	0.28	0.29	0.28	0.29	0.04	XXX
G0219		N	Pet img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	TC	N	Pet img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	26	N	Pet img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0235		N	Pet not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	TC	N	Pet not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	26	N	Pet not otherwise specified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0237		A	Therapeutic procd strg endur	0.00	0.25	0.29	NA	NA	0.01	XXX
G0238		A	Oth resp proc, indiv	0.00	0.26	0.31	NA	NA	0.01	XXX
G0239		A	Oth resp proc, group	0.00	0.31	0.34	NA	NA	0.01	XXX
G0245		R	Initial foot exam pt lops	0.88	1.16	1.09	0.49	0.44	0.05	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.73	0.70	0.24	0.22	0.03	XXX
G0247		R	Routine footcare pt w lops	0.50	1.56	1.17	0.15	0.18	0.04	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	3.23	4.13	NA	NA	0.01	XXX
G0249		R	Provide inr test mater/equip	0.00	3.02	3.65	NA	NA	0.01	XXX
G0250		R	Md inr test revie inter mgmt	0.18	0.07	0.08	NA	NA	0.01	XXX

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G0251		E	Linear acc based stero radio	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0252		N	Pet imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	TC	N	Pet imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	26	N	Pet imaging initial dx	1.50	0.66	0.70	0.66	0.70	0.10	XXX
G0255		N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX
G0255	TC	N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX
G0255	26	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0257		E	Unsched dialysis esrd pt hos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0259		E	Inject for sacroiliac joint	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0260		E	Inj for sacroiliac jt anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0268		A	Removal of impacted wax md	0.61	0.91	0.86	0.36	0.31	0.03	000
G0269		B	Occlusive device in vein art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0270		A	Mnt subs tx for change dx	0.45	0.37	0.34	0.31	0.28	0.03	XXX
G0271		A	Group mnt 2 or more 30 mins	0.25	0.18	0.15	0.17	0.15	0.01	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	NA	0.10	0.13	0.01	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	NA	0.10	0.13	0.01	ZZZ
G0281		A	Elec stim unattend for press	0.18	0.20	0.18	NA	NA	0.01	XXX
G0282		N	Elect stim wound care not pd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0283		A	Elec stim other than wound	0.18	0.20	0.18	NA	NA	0.01	XXX
G0288		A	Recon, cta for surg plan	0.00	1.00	2.56	NA	NA	0.01	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	NA	0.88	0.85	0.29	ZZZ
G0290		E	Drug-eluting stents, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0291		E	Drug-eluting stents,each add	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0293		E	Non-cov surg proc,clin trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0294		E	Non-cov proc, clinical trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0295		N	Electromagnetic therapy onc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0302		X	Pre-op service lvrs complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0303		X	Pre-op service lvrs 10-15dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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G0304		X	Pre-op service lvrs 1-9 dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0305		X	Post op service lvrs min 6	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0306		X	Cbc/diffwbc w/o platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0307		X	Cbc without platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0328		X	Fecal blood scrn immunoassay	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0329		A	Electromagntic tx for ulcers	0.06	0.22	0.20	NA	NA	0.01	XXX
G0333		X	Dispense fee initial 30 day	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0337		X	Hospice evaluation preelecti	1.42	0.63	0.63	0.63	0.63	0.10	XXX
G0339		C	Robot lin-radsurg com, first	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0340		C	Robt lin-radsurg fractx 2-5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0341		A	Percutaneous islet celltrans	6.98	53.67	29.60	3.01	3.85	0.49	000
G0342		A	Laparoscopy islet cell trans	11.92	NA	NA	7.86	7.17	0.84	090
G0343		A	Laparotomy islet cell transp	19.85	NA	NA	13.34	12.14	1.40	090
G0364		A	Bone marrow aspirate &biopsy	0.16	0.19	0.19	0.09	0.09	0.01	ZZZ
G0365		A	Vessel mapping hemo access	0.25	5.89	5.92	NA	NA	0.04	XXX
G0365	TC	A	Vessel mapping hemo access	0.00	5.80	5.83	NA	NA	0.01	XXX
G0365	26	A	Vessel mapping hemo access	0.25	0.09	0.09	0.09	0.09	0.03	XXX
G0372		A	Md service required for pmd	0.17	0.08	0.12	0.08	0.07	0.01	XXX
G0378		X	Hospital observation per hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0379		X	Direct refer hospital observ	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0389		A	Ultrasound exam aaa screen	0.58	2.46	2.69	NA	NA	0.04	XXX
G0389	TC	A	Ultrasound exam aaa screen	0.00	2.24	2.44	NA	NA	0.01	XXX
G0389	26	A	Ultrasound exam aaa screen	0.58	0.22	0.25	0.22	0.25	0.03	XXX
G0396		A	Alcohol/subs interv 15-30mn	0.65	0.32	0.29	0.27	0.23	0.04	XXX
G0397		A	Alcohol/subs interv >30 min	1.30	0.79	0.62	0.74	0.56	0.08	XXX
G0398		C	Home sleep test/type 2 porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0398	TC	C	Home sleep test/type 2 porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0398	26	C	Home sleep test/type 2 porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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G0399		C	Home sleep test/type 3 porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0399	TC	C	Home sleep test/type 3 porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0399	26	C	Home sleep test/type 3 porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0400		C	Home sleep test/type 4 porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0400	TC	C	Home sleep test/type 4 porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0400	26	C	Home sleep test/type 4 porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0402		A	Initial preventive exam	2.43	2.20	1.80	1.15	1.15	0.12	XXX
G0403		A	Ekg for initial prevent exam	0.17	0.32	0.40	NA	NA	0.02	XXX
G0404		A	Ekg tracing for initial prev	0.00	0.25	0.32	NA	NA	0.01	XXX
G0405		A	Ekg interpret & report preve	0.17	0.07	0.08	0.07	0.07	0.01	XXX
G0406		A	Telhealth inpt consult 15min	0.76	NA	NA	0.34	0.32	0.05	XXX
G0407		A	Telheath inpt consult 25min	1.39	NA	NA	0.64	0.58	0.08	XXX
G0408		A	Telhealth inpt consult 35min	2.00	NA	NA	0.90	0.82	0.12	XXX
G0409		A	Corf related serv 15 mins ea	0.00	0.29	0.29	NA	NA	0.01	XXX
G0410		X	Grp psych partial hosp 45-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0411		X	Inter active grp psych parti	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0412		A	Open tx iliac spine uni/bil	10.45	NA	NA	9.26	8.76	2.04	090
G0413		A	Pelvic ring fracture uni/bil	15.73	NA	NA	12.80	12.27	3.06	090
G0414		A	Pelvic ring fx treat int fix	14.65	NA	NA	12.64	12.05	2.85	090
G0415		A	Open tx post pelvic fxcture	20.93	NA	NA	16.42	15.41	4.20	090
G0416		A	Sat biopsy prostate 1-20 spc	3.09	13.96	13.96	NA	NA	0.12	XXX
G0416	TC	A	Sat biopsy prostate 1-20 spc	0.00	12.14	12.14	NA	NA	0.01	XXX
G0416	26	A	Sat biopsy prostate 1-20 spc	3.09	1.82	1.82	1.82	1.82	0.11	XXX
G0417		A	Sat biopsy prostate 21-40	5.86	27.26	27.26	NA	NA	0.25	XXX
G0417	TC	A	Sat biopsy prostate 21-40	0.00	23.71	23.71	NA	NA	0.01	XXX
G0417	26	A	Sat biopsy prostate 21-40	5.86	3.55	3.55	3.55	3.55	0.24	XXX
G0418		A	Sat biopsy prostate 41-60	10.30	46.56	46.56	NA	NA	0.42	XXX
G0418	TC	A	Sat biopsy prostate 41-60	0.00	40.50	40.50	NA	NA	0.01	XXX

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G0418	26	A	Sat biopsy prostate 41-60	10.30	6.06	6.06	6.06	6.06	0.41	XXX
G0419		A	Sat biopsy prostate: >60	11.61	55.86	55.86	NA	NA	0.46	XXX
G0419	TC	A	Sat biopsy prostate: >60	0.00	48.60	48.60	NA	NA	0.01	XXX
G0419	26	A	Sat biopsy prostate: >60	11.61	7.26	7.26	7.26	7.26	0.45	XXX
G0420		A	Ed svc ckd ind per session	2.12	1.03	1.03	NA	NA	0.11	XXX
G0421		A	Ed svc ckd grp per session	0.50	0.24	0.24	NA	NA	0.03	XXX
G0422		A	Intens cardiac rehab w/exerc	1.41	1.21	1.21	1.21	1.21	0.08	XXX
G0423		A	Intens cardiac rehab no exer	1.41	1.21	1.21	1.21	1.21	0.08	XXX
G0424		A	Pulmonary rehab w exer	0.28	0.59	0.59	0.12	0.12	0.03	XXX
G0425		A	Inpt telehealth consult 30m	1.92	NA	NA	0.86	0.86	0.18	XXX
G0426		A	Inpt telehealth consult 50m	2.61	NA	NA	1.21	1.21	0.22	XXX
G0427		A	Inpt telehealth con 70/>m	3.86	NA	NA	1.78	1.78	0.29	XXX
G0428		N	Collagen meniscus implant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0429		A	Dermal filler injection(s)	1.19	1.19	1.19	0.56	0.56	0.24	000
G0431		X	Drug screen multip class	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0432		X	Eia hiv-1/hiv-2 screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0433		X	Elisa hiv-1/hiv-2 screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0434		X	Drug screen multi drug class	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0435		X	Oral hiv-1/hiv-2 screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0436		A	Tobacco-use counsel 3-10 min	0.24	0.16	0.16	0.10	0.10	0.01	XXX
G0437		A	Tobacco-use counsel>10min	0.50	0.30	0.30	0.24	0.24	0.03	XXX
G0438		A	Ppps, initial visit	2.43	2.19	2.19	NA	NA	0.12	XXX
G0439		A	Ppps, subseq visit	1.50	1.63	1.63	NA	NA	0.03	XXX
G0440		A	Skin/dermal subs init 25or<	2.22	2.72	2.72	1.02	1.02	0.27	000
G0441		A	Skin/dermal subs each additi	0.50	0.82	0.82	0.20	0.20	0.07	000
G3001		X	Admin + supply, tositumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9001		X	Mccd, initial rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9002		X	Mccd,maintenance rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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G9003		X	Mccd, risk adj hi, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9004		X	Mccd, risk adj lo, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9005		X	Mccd, risk adj, maintenance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9006		X	Mccd, home monitoring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9007		X	Mccd, sch team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9008		X	Mccd,phys coor-care ovrsght	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9009		X	Mccd, risk adj, level 3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9010		X	Mccd, risk adj, level 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9011		X	Mccd, risk adj, level 5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9012		X	Other specified case mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9013		N	Esrd demo bundle level i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9014		N	Esrd demo bundle-level ii	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9016		N	Demo-smoking cessation coun	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9017		X	Amantadine hcl 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9018		X	Zanamivir,inhalation pwd 10m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9019		X	Oseltamivir phosphate 75mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9020		X	Rimantadine hcl 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9033		X	Amantadine hcl oral brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9034		X	Zanamivir, inh pwdr, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9035		X	Oseltamivir phosp, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9036		X	Rimantadine hcl, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9041		A	Low vision rehab occupationa	0.69	0.28	0.28	0.28	0.28	0.04	XXX
G9042		A	Low vision rehab orient/mobi	0.25	0.25	0.25	0.25	0.25	0.01	XXX
G9043		A	Low vision lowvision therapi	0.25	0.25	0.25	0.25	0.25	0.01	XXX
G9044		A	Low vision rehabilate teache	0.24	0.19	0.19	0.19	0.19	0.01	XXX
G9140		X	Frontier extended stay demo	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9141		X	Influenza a h1n1,admin w cou	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9142		X	Influenza a h1n1, vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G9143		X	Warfarin respon genetic test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9147		N	Outpt iv insulin tx any mea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
M0064		A	Visit for drug monitoring	0.37	1.08	0.99	0.08	0.09	0.01	XXX
P3001		A	Screening pap smear by phys	0.42	0.42	0.40	0.42	0.40	0.03	XXX
Q0035		A	Cardiokymography	0.17	0.31	0.36	NA	NA	0.02	XXX
Q0035	TC	A	Cardiokymography	0.00	0.25	0.30	NA	NA	0.01	XXX
Q0035	26	A	Cardiokymography	0.17	0.06	0.06	0.06	0.06	0.01	XXX
Q0091		A	Obtaining screen pap smear	0.37	0.88	0.88	0.17	0.15	0.03	XXX
Q0092		A	Set up port xray equipment	0.00	0.65	0.59	0.65	0.59	0.01	XXX
Q3001		C	Brachytherapy radioelements	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Q3014		X	Telehealth facility fee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0070		C	Transport portable x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0075		C	Transport port x-ray multipl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0076		B	Transport portable ekg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
V5299		R	Hearing service	0.00	0.00	0.00	0.00	0.00	0.00	XXX

[1] CPT codes and descriptors only are copyright 2010 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

ADDENDUM C: CODES WITH INTERIM RVUs

CPT[1]/ HCPCS	Mod	Status	Description	RVUs Open for Comment			Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
				Work	Practice Expense	Mal-practice							
11010		A	Debride skin at fx site	W	PE		4.19	9.45	8.94	3.49	3.28	0.76	010
11011		A	Debride skin musc at fx site	W	PE		4.94	9.62	9.33	3.11	2.92	0.98	000
11012		A	Deb skin bone at fx site	W	PE		6.87	12.49	12.28	4.68	4.46	1.30	000
11042		A	Deb subq tissue 20 sq cm/<	W	PE	MP	0.80	2.13	1.66	0.62	0.50	0.10	000
11043		A	Deb musc/fascia 20 sq cm/<	W	PE	MP	2.00	3.30	3.30	1.28	1.28	0.33	000
11044		A	Deb bone 20 sq cm/<	W	PE	MP	3.60	4.34	4.34	2.03	2.03	0.62	000
11045		A	Deb subq tissue add-on	W	PE	MP	0.33	0.51	0.51	0.13	0.13	0.07	ZZZ
11046		A	Deb musc/fascia add-on	W	PE	MP	0.70	0.77	0.77	0.31	0.31	0.12	ZZZ
11047		A	Deb bone add-on	W	PE	MP	1.20	1.19	1.19	0.54	0.54	0.22	ZZZ
11900		A	Injection into skin lesions	W	PE	MP	0.52	1.04	1.04	0.38	0.34	0.07	000
11901		A	Added skin lesions injection	W	PE	MP	0.80	1.18	1.16	0.59	0.54	0.11	000
12001		A	Repair superficial wound(s)	W	PE	MP	0.84	1.52	1.84	0.38	0.64	0.14	000
12002		A	Repair superficial wound(s)	W	PE	MP	1.14	1.72	1.98	0.46	0.75	0.19	000
12004		A	Repair superficial wound(s)	W	PE	MP	1.44	1.92	2.25	0.55	0.85	0.24	000
12005		A	Repair superficial wound(s)	W	PE	MP	1.97	2.39	2.76	0.73	1.03	0.33	000
12006		A	Repair superficial wound(s)	W	PE	MP	2.39	2.87	3.31	0.91	1.27	0.41	000
12007		A	Repair superficial wound(s)	W	PE	MP	2.90	3.20	3.72	1.07	1.50	0.50	000
12011		A	Repair superficial wound(s)	W	PE	MP	1.07	1.87	2.12	0.43	0.68	0.19	000
12013		A	Repair superficial wound(s)	W	PE	MP	1.22	1.88	2.21	0.46	0.77	0.20	000
12014		A	Repair superficial wound(s)	W	PE	MP	1.57	2.08	2.47	0.57	0.89	0.26	000
12015		A	Repair superficial wound(s)	W	PE	MP	1.98	2.46	2.96	0.67	1.03	0.33	000
12016		A	Repair superficial wound(s)	W	PE	MP	2.68	2.92	3.45	0.91	1.29	0.46	000
12017		A	Repair superficial wound(s)	W	PE	MP	3.18	NA	NA	0.76	1.34	0.56	000
12018		A	Repair superficial wound(s)	W	PE	MP	3.61	NA	NA	0.85	1.78	0.64	000
15823		A	Revision of upper eyelid	W	PE	MP	6.81	10.15	9.79	8.49	8.16	1.26	090
19357		A	Breast reconstruction	W	PE	MP	18.50	NA	NA	23.79	21.54	3.61	090
20005		A	I&d abscess subfascial	W	PE		3.58	4.64	4.54	2.66	2.62	0.58	010
20664		A	Application of halo	W	PE		10.06	NA	NA	10.63	10.16	3.60	090
20930		B	Sp bone algrft morsel add-on	W	PE		0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931		A	Sp bone algrft struct add-on	W	PE		1.81	NA	NA	1.03	0.99	0.56	ZZZ
22315		A	Treat spine fracture	W	PE		10.11	13.56	12.81	10.46	9.83	2.54	090
22551		A	Neck spine fuse&remove addl	W	PE	MP	25.00	NA	NA	18.65	18.65	7.55	090
22552		A	Addl neck spine fusion	W	PE	MP	6.50	NA	NA	3.65	3.65	1.78	ZZZ
22554		A	Neck spine fusion	W	PE		17.69	NA	NA	14.70	14.28	5.46	090
22585		A	Additional spinal fusion	W	PE		5.52	NA	NA	3.10	3.00	1.59	ZZZ
22851		A	Apply spine prosth device	W	PE		6.70	NA	NA	3.82	3.68	1.89	ZZZ
23430		A	Repair biceps tendon	W	PE	MP	10.17	NA	NA	10.07	9.51	1.97	090
27065		A	Remove hip bone les super	W	PE		6.55	NA	NA	7.14	6.82	1.28	090
27066		A	Remove hip bone les deep	W	PE		11.20	NA	NA	10.81	10.26	2.20	090
27067		A	Remove/graft hip bone lesion	W	PE		14.72	NA	NA	13.30	12.66	2.91	090

CPT[1]/ HCPCS	Mod	Status	Description	RVUs Open for Comment			Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
				Work	Practice Expense	Mal-practice							
27070		A	Part remove hip bone super	W	PE		11.56	NA	NA	11.52	10.99	2.27	090
27071		A	Part removal hip bone deep	W	PE		12.39	NA	NA	12.28	11.76	2.43	090
29540		A	Strapping of ankle and/or ft	W	PE	MP	0.32	0.63	0.62	0.32	0.35	0.03	000
29550		A	Strapping of toes	W	PE	MP	0.15	0.62	0.62	0.27	0.31	0.01	000
29914		A	Hip arthro w/femoroplasty	W	PE	MP	14.67	NA	NA	12.79	12.79	2.91	090
29915		A	Hip arthro acetabuloplasty	W	PE	MP	15.00	NA	NA	12.99	12.99	2.95	090
29916		A	Hip arthro w/labral repair	W	PE	MP	15.00	NA	NA	12.99	12.99	2.95	090
30901		A	Control of nosebleed	W	PE	MP	1.10	1.55	1.57	0.47	0.43	0.16	000
31256		A	Exploration maxillary sinus	W	PE		3.29	NA	NA	2.42	2.26	0.41	000
31267		A	Endoscopy maxillary sinus	W	PE		5.45	NA	NA	3.70	3.43	0.69	000
31276		A	Sinus endoscopy surgical	W	PE		8.84	NA	NA	5.69	5.27	1.14	000
31287		A	Nasal/sinus endoscopy surg	W	PE		3.91	NA	NA	2.79	2.59	0.50	000
31288		A	Nasal/sinus endoscopy surg	W	PE		4.57	NA	NA	3.18	2.96	0.60	000
31295		A	Sinus endo w/balloon dil	W	PE	MP	2.70	57.07	57.07	2.12	2.12	0.35	000
31296		A	Sinus endo w/balloon dil	W	PE	MP	3.29	108.70	108.70	2.47	2.47	0.42	000
31297		A	Sinus endo w/balloon dil	W	PE	MP	2.64	108.37	108.37	2.08	2.08	0.34	000
31634		A	Bronch w/balloon occlusion	W	PE	MP	4.00	48.98	48.98	1.76	1.76	0.33	000
33411		A	Replacement of aortic valve	W	PE		62.07	NA	NA	26.37	26.58	14.90	090
33620		A	Apply r&l pulm art bands	W	PE	MP	30.00	NA	NA	13.45	13.45	7.48	090
33621		A	Transthor cath for stent	W	PE	MP	16.18	NA	NA	7.42	7.42	3.75	090
33622		A	Redo compl cardiac anomaly	W	PE	MP	64.00	NA	NA	28.32	28.32	14.94	090
33860		A	Ascending aortic graft	W	PE		59.46	NA	NA	25.09	25.17	14.22	090
33863		A	Ascending aortic graft	W	PE		58.79	NA	NA	24.02	24.63	14.04	090
33864		A	Ascending aortic graft	W	PE		60.08	NA	NA	24.42	25.40	14.29	090
34900		A	Endovasc iliac repr w/graft	W	PE		16.85	NA	NA	7.63	7.96	3.57	090
35471		A	Repair arterial blockage	W	PE		10.05	61.23	75.23	3.99	4.80	1.98	000
36410		A	Non-routine bl draw > 3 yrs	W	PE	MP	0.18	0.27	0.33	0.08	0.07	0.03	XXX
37205		A	Transcath iv stent percut	W	PE		8.27	108.43	118.66	3.05	3.64	1.56	000
37206		A	Transcath iv stent/perc addl	W	PE		4.12	65.91	72.34	1.49	1.71	0.81	ZZZ
37207		A	Transcath iv stent open	W	PE		8.27	NA	NA	3.23	3.27	1.86	000
37208		A	Transcath iv stent/open addl	W	PE		4.12	NA	NA	1.42	1.43	0.92	ZZZ
37220		A	Iliac revasc	W	PE	MP	8.15	83.88	83.88	3.03	3.03	1.67	000
37221		A	Iliac revasc w/stent	W	PE	MP	10.00	126.56	126.56	3.75	3.75	1.89	000
37222		A	Iliac revasc add-on	W	PE	MP	3.73	22.52	22.52	1.34	1.34	0.76	ZZZ
37223		A	Iliac revasc w/stent add-on	W	PE	MP	4.25	132.39	132.39	1.53	1.53	0.84	ZZZ
37224		A	Fem/popl revas w/tla	W	PE	MP	9.00	101.76	101.76	3.34	3.34	1.81	000
37225		A	Fem/popl revas w/ather	W	PE	MP	12.00	303.34	303.34	4.55	4.55	2.51	000
37226		A	Fem/popl revasc w/stent	W	PE	MP	10.49	254.28	254.28	3.93	3.93	1.29	000
37227		A	Fem/popl revasc stnt & ather	W	PE	MP	14.50	412.19	412.19	5.48	5.48	3.04	000
37228		A	Tib/per revasc w/tla	W	PE	MP	11.00	146.98	146.98	4.04	4.04	2.25	000
37229		A	Tib/per revasc w/ather	W	PE	MP	14.05	298.12	298.12	5.30	5.30	2.97	000
37230		A	Tib/per revasc w/stent	W	PE	MP	13.80	231.18	231.18	5.13	5.13	2.61	000
37231		A	Tib/per revasc stent & ather	W	PE	MP	15.00	379.46	379.46	5.57	5.57	2.84	000

CPT[1]/ HCPCS	Mod	Status	Description	RVUs Open for Comment			Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
				Work	Practice Expense	Mal-practice							
37232		A	Tib/per revasc add-on	W	PE	MP	4.00	31.17	31.17	1.43	1.43	0.81	ZZZ
37233		A	Tibper revasc w/ather add-on	W	PE	MP	6.50	36.11	36.11	2.41	2.41	1.37	ZZZ
37234		A	Revsc opn/prq tib/pero stent	W	PE	MP	5.50	108.02	108.02	1.98	1.98	1.09	ZZZ
37235		A	Tib/per revasc stnt & ather	W	PE	MP	7.80	113.10	113.10	2.81	2.81	1.55	ZZZ
37765		A	Stab phleb veins xtr 10-20	W	PE		7.71	10.69	10.69	4.68	4.75	1.56	090
37766		A	Phleb veins - extrem 20+	W	PE		9.66	12.11	12.11	5.44	5.51	2.01	090
38900		A	Io map of sent lymph node	W	PE	MP	2.50	1.02	1.02	1.02	1.02	0.53	ZZZ
43283		A	Lap esoph lengthening	W	PE	MP	2.95	NA	NA	1.29	1.29	0.60	ZZZ
43327		A	Esoph fundoplasty lap	W	PE	MP	13.35	NA	NA	8.16	8.16	2.84	090
43328		A	Esoph fundoplasty thor	W	PE	MP	19.91	NA	NA	10.87	10.87	4.97	090
43332		A	Transab esoph hiat hern rpr	W	PE	MP	19.62	NA	NA	11.07	11.07	4.17	090
43333		A	Transab esoph hiat hern rpr	W	PE	MP	21.46	NA	NA	11.85	11.85	4.54	090
43334		A	Transthor diaphrag hern rpr	W	PE	MP	22.12	NA	NA	11.44	11.44	4.70	090
43335		A	Transthor diaphrag hern rpr	W	PE	MP	23.97	NA	NA	12.18	12.18	5.07	090
43336		A	Thorabd diaphr hern repair	W	PE	MP	25.81	NA	NA	13.52	13.52	5.84	090
43337		A	Thorabd diaphr hern repair	W	PE	MP	27.65	NA	NA	15.40	15.40	6.26	090
43338		A	Esoph lengthening	W	PE	MP	2.21	NA	NA	1.30	1.30	0.50	ZZZ
43605		A	Biopsy of stomach	W	PE		13.72	NA	NA	8.67	7.71	2.87	090
43753		A	Tx gastro intub w/asp	W	PE	MP	0.45	NA	NA	0.13	0.13	0.03	000
43754		A	Dx gastr intub w/asp spec	W	PE	MP	0.45	1.84	1.84	0.44	0.44	0.04	000
43755		A	Dx gastr intub w/asp specs	W	PE	MP	0.94	2.53	2.53	0.68	0.68	0.08	000
43756		A	Dx duod intub w/asp spec	W	PE	MP	0.77	5.62	5.62	0.71	0.71	0.05	000
43757		A	Dx duod intub w/asp specs	W	PE	MP	1.26	6.95	6.95	0.87	0.87	0.08	000
47480		A	Incision of gallbladder	W	PE		13.25	NA	NA	9.90	9.03	2.74	090
47490		A	Incision of gallbladder	W	PE	MP	4.76	NA	NA	4.32	5.57	0.43	010
49324		A	Lap insert tunnel ip cath	W	PE		6.32	NA	NA	4.13	3.82	1.33	010
49327		A	Lap ins device for rt	W	PE	MP	2.38	NA	NA	1.04	1.04	0.48	ZZZ
49400		A	Air injection into abdomen		PE		1.88	1.81	2.53	0.70	0.77	0.24	000
49412		A	Ins device for rt guide open	W	PE	MP	1.50	NA	NA	0.63	0.63	0.30	ZZZ
49418		A	Insert tun ip cath perc	W	PE	MP	4.21	40.03	40.03	2.07	2.07	0.62	000
49419		A	Insert tun ip cath w/port	W	PE		7.08	NA	NA	4.81	4.61	1.22	090
49421		A	Ins tun ip cath for dial opn	W	PE	MP	4.21	NA	NA	1.91	2.90	0.83	000
49422		A	Remove tunneled ip cath	W	PE		6.29	NA	NA	3.84	3.63	1.29	010
50250		A	Cryoablate renal mass open	W	PE		22.22	NA	NA	11.40	12.86	2.17	090
50542		A	Laparo ablate renal mass	W	PE		21.36	NA	NA	10.92	12.17	2.09	090
50590		A	Fragmenting of kidney stone		PE		9.77	11.28	15.39	5.83	6.50	0.95	090
50684		A	Injection for ureter x-ray		PE		0.76	2.15	3.63	0.62	0.68	0.07	000
51736		A	Urine flow measurement	W	PE	MP	0.17	0.66	0.85	NA	NA	0.02	XXX
51736	TC	A	Urine flow measurement	W	PE	MP	0.00	0.59	0.67	NA	NA	0.01	XXX
51736	26	A	Urine flow measurement	W	PE	MP	0.17	0.07	0.18	0.07	0.18	0.01	XXX
51741		A	Electro-uroflowmetry first	W	PE	MP	0.17	0.76	1.09	NA	NA	0.02	XXX
51741	TC	A	Electro-uroflowmetry first	W	PE	MP	0.00	0.69	0.78	NA	NA	0.01	XXX
51741	26	A	Electro-uroflowmetry first	W	PE	MP	0.17	0.07	0.31	0.07	0.31	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	RVUs Open for Comment			Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
				Work	Practice Expense	Mal-practice							
52281		A	Cystoscopy and treatment	W	PE	MP	2.60	4.57	5.80	1.40	1.61	0.27	000
52332		A	Cystoscopy and treatment	W	PE	MP	1.47	10.39	11.72	0.95	1.39	0.15	000
53860		A	Transurethral rf treatment	W	PE	MP	3.97	38.52	38.52	2.24	2.24	0.68	090
55866		A	Laparo radical prostatectomy	W	PE	MP	32.06	NA	NA	16.00	17.65	3.18	090
55876		A	Place rt device/marker pros	W	PE		1.73	1.98	2.27	1.05	1.20	0.16	000
57155		A	Insert uteri tandems/ovoids	W	PE	MP	3.37	6.05	6.05	1.69	1.69	0.30	000
57156		A	Ins vag brachytx device	W	PE	MP	1.87	2.41	2.41	1.01	1.01	0.16	000
59400		A	Obstetrical care	W	PE	MP	28.69	NA	NA	20.68	19.40	7.97	MMM
59409		A	Obstetrical care	W	PE	MP	12.82	NA	NA	6.02	5.65	3.54	MMM
59410		A	Obstetrical care	W	PE	MP	16.07	NA	NA	8.03	7.40	4.44	MMM
59412		A	Antepartum manipulation	W	PE	MP	1.53	NA	NA	0.88	0.87	0.43	MMM
59414		A	Deliver placenta	W	PE	MP	1.44	NA	NA	0.67	0.65	0.45	MMM
59425		A	Antepartum care only	W	PE	MP	5.63	5.34	5.31	2.62	2.43	1.55	MMM
59426		A	Antepartum care only	W	PE	MP	9.96	9.73	9.67	4.64	4.30	2.69	MMM
59430		A	Care after delivery	W	PE	MP	2.20	2.27	1.84	1.03	1.00	0.60	MMM
59510		A	Cesarean delivery	W	PE	MP	31.80	NA	NA	22.68	21.59	9.04	MMM
59514		A	Cesarean delivery only	W	PE	MP	14.39	NA	NA	6.77	6.53	4.07	MMM
59515		A	Cesarean delivery	W	PE	MP	19.15	NA	NA	10.07	9.25	5.42	MMM
59610		A	Vbac delivery	W	PE	MP	30.22	NA	NA	21.32	20.17	8.68	MMM
59612		A	Vbac delivery only	W	PE	MP	14.35	NA	NA	6.70	6.35	4.11	MMM
59614		A	Vbac care after delivery	W	PE	MP	17.60	NA	NA	8.66	7.92	5.04	MMM
59618		A	Attempted vbac delivery	W	PE	MP	32.26	NA	NA	22.83	22.08	9.26	MMM
59620		A	Attempted vbac delivery only	W	PE	MP	14.86	NA	NA	6.93	6.92	4.26	MMM
59622		A	Attempted vbac after care	W	PE	MP	19.63	NA	NA	10.32	9.78	5.64	MMM
61781		A	Scan proc cranial intra	W	PE	MP	3.75	NA	NA	2.14	2.14	1.25	ZZZ
61782		A	Scan proc cranial extra	W	PE	MP	3.18	NA	NA	1.81	1.81	0.87	ZZZ
61783		A	Scan proc spinal	W	PE	MP	3.75	NA	NA	2.14	2.14	0.15	ZZZ
61885		A	Insrt/redo neurostim 1 array	W	PE	MP	6.05	NA	NA	7.22	7.82	2.06	090
62268		A	Drain spinal cord cyst		PE		4.73	2.04	5.21	2.53	2.46	0.45	000
62269		A	Needle biopsy spinal cord		PE		5.01	1.92	5.61	2.31	2.27	0.56	000
62281		A	Treat spinal cord lesion		PE		2.66	4.03	4.71	1.73	1.48	0.27	010
62319		A	Inject spine w/cath l/s (cd)		PE		1.87	2.98	3.54	0.87	0.74	0.16	000
63075		A	Neck spine disk surgery	W	PE		19.60	NA	NA	15.40	14.78	6.10	090
63076		A	Neck spine disk surgery	W	PE		4.04	NA	NA	2.29	2.21	1.25	ZZZ
63610		A	Stimulation of spinal cord		PE		8.72	2.03	15.94	2.41	2.33	0.68	000
64415		A	N block inj brachial plexus	W	PE	MP	1.48	1.90	2.02	0.36	0.40	0.11	000
64445		A	N block inj sciatic sng	W	PE	MP	1.48	2.30	2.30	0.54	0.58	0.16	000
64447		A	N block inj fem single	W	PE	MP	1.50	1.89	1.89	0.36	0.33	0.11	000
64479		A	Inj foramen epidural c/t	W	PE	MP	2.29	4.76	5.27	1.54	1.30	0.27	000
64480		A	Inj foramen epidural add-on	W	PE	MP	1.20	2.36	2.35	0.64	0.59	0.18	ZZZ
64483		A	Inj foramen epidural l/s	W	PE	MP	1.90	4.55	5.23	1.35	1.16	0.16	000
64484		A	Inj foramen epidural add-on	W	PE	MP	1.00	1.61	2.06	0.52	0.48	0.08	ZZZ
64508		A	N block carotid sinus s/p		PE		1.12	0.50	1.72	0.94	0.85	0.24	000

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				Work	Practice Expense	Mal-practice							
64561		A	Implant neuroelectrodes		PE		7.15	14.88	20.88	3.88	4.17	0.77	010
64566		A	Neuroeltrd stim post tibial	W	PE	MP	0.60	3.17	3.17	0.23	0.23	0.05	000
64568		A	Inc for vagus n elect impl	W	PE	MP	9.00	NA	NA	8.67	8.67	1.25	090
64569		A	Revise/repl vagus n eltrd	W	PE	MP	11.00	NA	NA	4.50	4.50	3.15	090
64570		A	Remove vagus n eltrd	W	PE	MP	9.10	NA	NA	4.06	4.06	3.26	090
64581		A	Implant neuroelectrodes	W	PE		12.20	NA	NA	6.04	7.05	1.58	090
64611		A	Chemodenerv saliv glands	W	PE	MP	1.03	1.64	1.64	1.35	1.35	0.29	010
64708		A	Revise arm/leg nerve	W	PE		6.36	NA	NA	7.09	6.63	1.15	090
64712		A	Revision of sciatic nerve	W	PE		8.07	NA	NA	7.25	6.71	1.33	090
64713		A	Revision of arm nerve(s)	W	PE		11.40	NA	NA	9.05	8.55	2.34	090
64714		A	Revise low back nerve(s)	W	PE		10.55	NA	NA	8.66	7.44	1.71	090
65778		A	Cover eye w/membrane	W	PE	MP	1.19	35.71	35.71	0.84	0.84	0.18	010
65779		A	Cover eye w/membrane stent	W	PE	MP	3.92	29.05	29.05	4.09	4.09	0.56	010
65780		A	Ocular reconst transplant	W	PE		10.73	NA	NA	14.18	12.94	1.39	090
66174		A	Translum dil eye canal	W	PE	MP	12.85	NA	NA	13.84	13.84	2.27	090
66175		A	Trnslum dil eye canal w/stnt	W	PE	MP	13.60	NA	NA	14.37	14.37	4.86	090
66761		A	Revision of iris	W	PE	MP	3.00	5.25	5.85	3.63	4.46	0.45	010
67028		A	Injection eye drug	W	PE	MP	1.44	1.43	2.15	1.38	1.52	0.20	000
69801		A	Incise inner ear	W	PE	MP	2.06	3.63	3.63	1.58	6.61	0.27	000
69802		A	Incise inner ear	W	PE		13.50	NA	NA	16.79	15.85	1.71	090
70010		A	Contrast x-ray of brain		PE		1.19	0.80	2.39	0.80	2.39	0.16	XXX
71250		A	Ct thorax w/o dye	W	PE	MP	1.00	4.97	6.38	NA	NA	0.07	XXX
71250	TC	A	Ct thorax w/o dye	W	PE	MP	0.00	4.59	5.93	NA	NA	0.01	XXX
71250	26	A	Ct thorax w/o dye	W	PE	MP	1.00	0.38	0.45	0.38	0.45	0.06	XXX
72125		A	Ct neck spine w/o dye	W	PE	MP	1.00	5.01	6.42	NA	NA	0.07	XXX
72125	TC	A	Ct neck spine w/o dye	W	PE	MP	0.00	4.64	5.97	NA	NA	0.01	XXX
72125	26	A	Ct neck spine w/o dye	W	PE	MP	1.00	0.37	0.45	0.37	0.45	0.06	XXX
72128		A	Ct chest spine w/o dye	W	PE	MP	1.00	5.01	6.40	NA	NA	0.07	XXX
72128	TC	A	Ct chest spine w/o dye	W	PE	MP	0.00	4.63	5.95	NA	NA	0.01	XXX
72128	26	A	Ct chest spine w/o dye	W	PE	MP	1.00	0.38	0.45	0.38	0.45	0.06	XXX
72131		A	Ct lumbar spine w/o dye	W	PE	MP	1.00	4.99	6.38	NA	NA	0.07	XXX
72131	TC	A	Ct lumbar spine w/o dye	W	PE	MP	0.00	4.61	5.93	NA	NA	0.01	XXX
72131	26	A	Ct lumbar spine w/o dye	W	PE	MP	1.00	0.38	0.45	0.38	0.45	0.06	XXX
73080		A	X-ray exam of elbow	W	PE	MP	0.17	0.77	0.82	NA	NA	0.02	XXX
73080	TC	A	X-ray exam of elbow	W	PE	MP	0.00	0.70	0.75	NA	NA	0.01	XXX
73080	26	A	X-ray exam of elbow	W	PE	MP	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73200		A	Ct upper extremity w/o dye	W	PE	MP	1.00	4.95	6.19	NA	NA	0.07	XXX
73200	TC	A	Ct upper extremity w/o dye	W	PE	MP	0.00	4.57	5.76	NA	NA	0.01	XXX
73200	26	A	Ct upper extremity w/o dye	W	PE	MP	1.00	0.38	0.43	0.38	0.43	0.06	XXX
73510		A	X-ray exam of hip	W	PE	MP	0.21	0.89	0.90	NA	NA	0.04	XXX
73510	TC	A	X-ray exam of hip	W	PE	MP	0.00	0.79	0.80	NA	NA	0.01	XXX
73510	26	A	X-ray exam of hip	W	PE	MP	0.21	0.10	0.10	0.10	0.10	0.03	XXX
73610		A	X-ray exam of ankle	W	PE	MP	0.17	0.78	0.78	NA	NA	0.02	XXX

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73610	TC	A	X-ray exam of ankle	W	PE	MP	0.00	0.70	0.71	NA	NA	0.01	XXX
73610	26	A	X-ray exam of ankle	W	PE	MP	0.17	0.08	0.07	0.08	0.07	0.01	XXX
73630		A	X-ray exam of foot	W	PE	MP	0.17	0.73	0.75	NA	NA	0.02	XXX
73630	TC	A	X-ray exam of foot	W	PE	MP	0.00	0.66	0.68	NA	NA	0.01	XXX
73630	26	A	X-ray exam of foot	W	PE	MP	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73700		A	Ct lower extremity w/o dye	W	PE	MP	1.00	4.96	6.21	NA	NA	0.07	XXX
73700	TC	A	Ct lower extremity w/o dye	W	PE	MP	0.00	4.59	5.78	NA	NA	0.01	XXX
73700	26	A	Ct lower extremity w/o dye	W	PE	MP	1.00	0.37	0.43	0.37	0.43	0.06	XXX
74176		A	Ct abd & pelvis w/o contrast	W	PE	MP	1.74	4.54	4.54	NA	NA	0.11	XXX
74176	TC	A	Ct abd & pelvis w/o contrast	W	PE	MP	0.00	3.89	3.89	NA	NA	0.01	XXX
74176	26	A	Ct abd & pelvis w/o contrast	W	PE	MP	1.74	0.65	0.65	0.65	0.65	0.10	XXX
74177		A	Ct abdomen&pelvis w/contrast	W	PE	MP	1.82	8.11	8.11	NA	NA	0.11	XXX
74177	TC	A	Ct abdomen&pelvis w/contrast	W	PE	MP	0.00	7.42	7.42	NA	NA	0.01	XXX
74177	26	A	Ct abdomen&pelvis w/contrast	W	PE	MP	1.82	0.69	0.69	0.69	0.69	0.10	XXX
74178		A	Ct abd&pelv 1+ section/regns	W	PE	MP	2.01	10.57	10.57	NA	NA	0.14	XXX
74178	TC	A	Ct abd&pelv 1+ section/regns	W	PE	MP	0.00	9.81	9.81	NA	NA	0.02	XXX
74178	26	A	Ct abd&pelv 1+ section/regns	W	PE	MP	2.01	0.76	0.76	0.76	0.76	0.12	XXX
74430		A	Contrast x-ray bladder		PE		0.32	0.82	1.47	NA	NA	0.02	XXX
74430	TC	A	Contrast x-ray bladder		PE		0.00	0.70	1.34	NA	NA	0.01	XXX
74430	26	A	Contrast x-ray bladder		PE		0.32	0.12	0.13	0.12	0.13	0.01	XXX
75954		C	Iliac aneurysm endovas rpr	W	PE		0.00	0.00	0.00	NA	NA	0.00	XXX
75954	TC	C	Iliac aneurysm endovas rpr	W	PE		0.00	0.00	0.00	NA	NA	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	W	PE		2.25	0.79	0.83	0.79	0.83	0.41	XXX
75960		A	Transcath iv stent rs&i	W	PE		0.82	2.70	4.86	NA	NA	0.06	XXX
75960	TC	A	Transcath iv stent rs&i	W	PE		0.00	2.40	4.52	NA	NA	0.01	XXX
75960	26	A	Transcath iv stent rs&i	W	PE		0.82	0.30	0.34	0.30	0.34	0.05	XXX
75962		A	Repair arterial blockage	W	PE		0.54	3.47	5.71	NA	NA	0.04	XXX
75962	TC	A	Repair arterial blockage	W	PE		0.00	3.27	5.49	NA	NA	0.01	XXX
75962	26	A	Repair arterial blockage	W	PE		0.54	0.20	0.22	0.20	0.22	0.03	XXX
75964		A	Repair artery blockage each	W	PE		0.36	2.35	3.52	NA	NA	0.05	ZZZ
75964	TC	A	Repair artery blockage each	W	PE		0.00	2.22	3.38	NA	NA	0.01	ZZZ
75964	26	A	Repair artery blockage each	W	PE		0.36	0.13	0.14	0.13	0.14	0.04	ZZZ
76000		A	Fluoroscope examination		PE		0.17	1.30	2.10	NA	NA	0.02	XXX
76000	TC	A	Fluoroscope examination		PE		0.00	1.23	2.03	NA	NA	0.01	XXX
76000	26	A	Fluoroscope examination		PE		0.17	0.07	0.07	0.07	0.07	0.01	XXX
76881		A	Us xtr non-vasc complete	W	PE	MP	0.59	2.76	2.76	NA	NA	0.05	XXX
76881	TC	A	Us xtr non-vasc complete	W	PE	MP	0.00	2.54	2.54	NA	NA	0.01	XXX
76881	26	A	Us xtr non-vasc complete	W	PE	MP	0.59	0.22	0.22	0.22	0.22	0.04	XXX
76882		A	Us xtr non-vasc lmtd	W	PE	MP	0.41	0.44	0.44	NA	NA	0.04	XXX
76882	TC	A	Us xtr non-vasc lmtd	W	PE	MP	0.00	0.29	0.29	NA	NA	0.01	XXX
76882	26	A	Us xtr non-vasc lmtd	W	PE	MP	0.41	0.15	0.15	0.15	0.15	0.03	XXX
76942		A	Echo guide for biopsy	W	PE		0.67	4.98	5.13	NA	NA	0.05	XXX
76942	TC	A	Echo guide for biopsy	W	PE		0.00	4.72	4.85	NA	NA	0.01	XXX

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76942	26	A	Echo guide for biopsy	W	PE		0.67	0.26	0.28	0.26	0.28	0.04	XXX
77003		A	Fluoroguide for spine inject	W	PE		0.60	1.25	1.20	NA	NA	0.04	XXX
77003	TC	A	Fluoroguide for spine inject	W	PE		0.00	0.96	0.96	NA	NA	0.01	XXX
77003	26	A	Fluoroguide for spine inject	W	PE		0.60	0.29	0.24	0.29	0.24	0.03	XXX
77011		A	Ct scan for localization		PE		1.21	5.40	13.03	NA	NA	0.05	XXX
77011	TC	A	Ct scan for localization		PE		0.00	4.85	12.49	NA	NA	0.01	XXX
77011	26	A	Ct scan for localization		PE		1.21	0.55	0.54	0.55	0.54	0.04	XXX
77012		A	Ct scan for needle biopsy	W	PE		1.16	2.47	3.63	NA	NA	0.05	XXX
77012	TC	A	Ct scan for needle biopsy	W	PE		0.00	2.04	3.14	NA	NA	0.01	XXX
77012	26	A	Ct scan for needle biopsy	W	PE		1.16	0.43	0.49	0.43	0.49	0.04	XXX
77301		A	Radiotherapy dose plan imrt		PE		7.99	45.27	53.19	NA	NA	0.63	XXX
77301	TC	A	Radiotherapy dose plan imrt		PE		0.00	41.70	49.73	NA	NA	0.22	XXX
77301	26	A	Radiotherapy dose plan imrt		PE		7.99	3.57	3.46	3.57	3.46	0.41	XXX
77427		A	Radiation tx management x5	W	PE	MP	2.92	1.52	1.59	1.52	1.59	0.23	XXX
88120		A	Cytp urne 3-5 probes ea spec	W	PE	MP	1.20	12.22	12.22	NA	NA	0.05	XXX
88120	TC	A	Cytp urne 3-5 probes ea spec	W	PE	MP	0.00	11.91	11.91	NA	NA	0.02	XXX
88120	26	A	Cytp urne 3-5 probes ea spec	W	PE	MP	1.20	0.31	0.31	0.31	0.31	0.03	XXX
88121		A	Cytp urine 3-5 probes cmptr	W	PE	MP	1.00	10.34	10.34	NA	NA	0.03	XXX
88121	TC	A	Cytp urine 3-5 probes cmptr	W	PE	MP	0.00	10.00	10.00	NA	NA	0.01	XXX
88121	26	A	Cytp urine 3-5 probes cmptr	W	PE	MP	1.00	0.34	0.34	0.34	0.34	0.02	XXX
88172		A	Cytp dx eval fna 1st ea site	W	PE	MP	0.60	0.76	0.87	NA	NA	0.02	XXX
88172	TC	A	Cytp dx eval fna 1st ea site	W	PE	MP	0.00	0.47	0.60	NA	NA	0.01	XXX
88172	26	A	Cytp dx eval fna 1st ea site	W	PE	MP	0.60	0.29	0.27	0.29	0.27	0.01	XXX
88173		A	Cytopath eval fna report	W	PE		1.39	2.56	2.62	NA	NA	0.05	XXX
88173	TC	A	Cytopath eval fna report	W	PE		0.00	1.95	2.04	NA	NA	0.01	XXX
88173	26	A	Cytopath eval fna report	W	PE		1.39	0.61	0.58	0.61	0.58	0.04	XXX
88177		A	Cytp c/v auto thin lyr addl	W	PE	MP	0.42	0.38	0.38	NA	NA	0.02	ZZZ
88177	TC	A	Cytp c/v auto thin lyr addl	W	PE	MP	0.00	0.18	0.18	NA	NA	0.01	ZZZ
88177	26	A	Cytp c/v auto thin lyr addl	W	PE	MP	0.42	0.20	0.20	0.20	0.20	0.01	ZZZ
88300		A	Surgical path gross	W	PE	MP	0.08	0.71	0.69	NA	NA	0.02	XXX
88300	TC	A	Surgical path gross	W	PE	MP	0.00	0.67	0.65	NA	NA	0.01	XXX
88300	26	A	Surgical path gross	W	PE	MP	0.08	0.04	0.04	0.04	0.04	0.01	XXX
88302		A	Tissue exam by pathologist	W	PE	MP	0.13	1.41	1.43	NA	NA	0.02	XXX
88302	TC	A	Tissue exam by pathologist	W	PE	MP	0.00	1.35	1.38	NA	NA	0.01	XXX
88302	26	A	Tissue exam by pathologist	W	PE	MP	0.13	0.06	0.05	0.06	0.05	0.01	XXX
88304		A	Tissue exam by pathologist	W	PE	MP	0.22	1.44	1.61	NA	NA	0.02	XXX
88304	TC	A	Tissue exam by pathologist	W	PE	MP	0.00	1.34	1.52	NA	NA	0.01	XXX
88304	26	A	Tissue exam by pathologist	W	PE	MP	0.22	0.10	0.09	0.10	0.09	0.01	XXX
88305		A	Tissue exam by pathologist	W	PE	MP	0.75	2.19	2.35	NA	NA	0.02	XXX
88305	TC	A	Tissue exam by pathologist	W	PE	MP	0.00	1.87	2.04	NA	NA	0.01	XXX
88305	26	A	Tissue exam by pathologist	W	PE	MP	0.75	0.32	0.31	0.32	0.31	0.01	XXX
88307		A	Tissue exam by pathologist	W	PE	MP	1.59	5.09	5.04	NA	NA	0.05	XXX
88307	TC	A	Tissue exam by pathologist	W	PE	MP	0.00	4.34	4.33	NA	NA	0.01	XXX

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88307	26	A	Tissue exam by pathologist	W	PE	MP	1.59	0.75	0.71	0.75	0.71	0.04	XXX
88309		A	Tissue exam by pathologist	W	PE		2.80	7.38	7.21	NA	NA	0.11	XXX
88309	TC	A	Tissue exam by pathologist	W	PE		0.00	6.05	5.99	NA	NA	0.03	XXX
88309	26	A	Tissue exam by pathologist	W	PE		2.80	1.33	1.22	1.33	1.22	0.08	XXX
88363		A	Xm archive tissue molec anal	W	PE	MP	0.37	0.72	0.72	0.10	0.10	0.03	XXX
88367		A	Insitu hybridization auto	W	PE		1.30	6.08	6.21	NA	NA	0.06	XXX
88367	TC	A	Insitu hybridization auto	W	PE		0.00	5.63	5.77	NA	NA	0.01	XXX
88367	26	A	Insitu hybridization auto	W	PE		1.30	0.45	0.44	0.45	0.44	0.05	XXX
88368		A	Insitu hybridization manual	W	PE		1.40	4.83	5.04	NA	NA	0.05	XXX
88368	TC	A	Insitu hybridization manual	W	PE		0.00	4.47	4.65	NA	NA	0.01	XXX
88368	26	A	Insitu hybridization manual	W	PE		1.40	0.36	0.39	0.36	0.39	0.04	XXX
90460		A	Imadm any route 1st vac/tox	W	PE	MP	0.17	0.50	0.50	NA	NA	0.01	XXX
90461		A	Inadm any route addl vac/tox	W	PE	MP	0.15	0.20	0.18	NA	NA	0.01	ZZZ
90870		A	Electroconvulsive therapy	W	PE	MP	2.50	2.33	2.31	0.58	0.56	0.11	000
90935		A	Hemodialysis one evaluation	W	PE	MP	1.48	NA	NA	0.57	0.64	0.08	000
90937		A	Hemodialysis repeated eval	W	PE	MP	2.11	NA	NA	0.82	0.93	0.11	000
90945		A	Dialysis one evaluation	W	PE	MP	1.56	0.60	0.66	NA	NA	0.08	000
90947		A	Dialysis repeated eval	W	PE	MP	2.52	NA	NA	0.97	1.01	0.15	000
91010		A	Esophagus motility study	W	PE	MP	1.28	3.73	4.17	NA	NA	0.08	000
91010	TC	A	Esophagus motility study	W	PE	MP	0.00	3.04	3.49	NA	NA	0.01	000
91010	26	A	Esophagus motility study	W	PE	MP	1.28	0.69	0.68	0.69	0.68	0.07	000
91013		A	Esophgl motil w/stim/perfus	W	PE	MP	0.18	0.48	0.48	NA	NA	0.02	ZZZ
91013	TC	A	Esophgl motil w/stim/perfus	W	PE	MP	0.00	0.38	0.38	NA	NA	0.01	ZZZ
91013	26	A	Esophgl motil w/stim/perfus	W	PE	MP	0.18	0.10	0.10	0.10	0.10	0.01	ZZZ
91038		A	Esoph imped funct test > 1h	W			1.10	12.00	7.67	NA	NA	0.06	000
91038	TC	A	Esoph imped funct test > 1h	W			0.00	11.40	7.07	NA	NA	0.01	000
91038	26	A	Esoph imped funct test > 1h	W			1.10	0.60	0.60	0.60	0.60	0.05	000
91117		A	Colon motility 6 hr study	W	PE	MP	2.45	1.36	1.36	1.64	1.64	0.38	000
91132		A	Electrogastrography	W			0.52	3.61	3.62	NA	NA	0.04	XXX
91132	TC	A	Electrogastrography	W			0.00	3.34	3.34	NA	NA	0.01	XXX
91132	26	A	Electrogastrography	W			0.52	0.27	0.28	0.27	0.28	0.03	XXX
91133		A	Electrogastrography w/test	W			0.66	4.39	4.40	NA	NA	0.05	XXX
91133	TC	A	Electrogastrography w/test	W			0.00	4.02	4.02	NA	NA	0.01	XXX
91133	26	A	Electrogastrography w/test	W			0.66	0.37	0.38	0.37	0.38	0.04	XXX
92081		A	Visual field examination(s)	W	PE	MP	0.30	1.03	1.10	NA	NA	0.03	XXX
92081	TC	A	Visual field examination(s)	W	PE	MP	0.00	0.86	0.93	NA	NA	0.01	XXX
92081	26	A	Visual field examination(s)	W	PE	MP	0.30	0.17	0.17	0.17	0.17	0.02	XXX
92082		A	Visual field examination(s)	W	PE	MP	0.40	1.51	1.55	NA	NA	0.05	XXX
92082	TC	A	Visual field examination(s)	W	PE	MP	0.00	1.28	1.34	NA	NA	0.01	XXX
92082	26	A	Visual field examination(s)	W	PE	MP	0.40	0.23	0.21	0.23	0.21	0.04	XXX
92132		A	Cmptr ophth dx img ant segmt	W	PE	MP	0.35	0.68	0.68	NA	NA	0.04	XXX
92132	TC	A	Cmptr ophth dx img ant segmt	W	PE	MP	0.00	0.44	0.44	NA	NA	0.01	XXX
92132	26	A	Cmptr ophth dx img ant segmt	W	PE	MP	0.35	0.24	0.24	0.24	0.24	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	RVUs Open for Comment			Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
				Work	Practice Expense	Mal-practice							
92133		A	Cmptr ophth img optic nerve	W	PE	MP	0.50	0.77	0.77	NA	NA	0.04	XXX
92133	TC	A	Cmptr ophth img optic nerve	W	PE	MP	0.00	0.44	0.44	NA	NA	0.01	XXX
92133	26	A	Cmptr ophth img optic nerve	W	PE	MP	0.50	0.33	0.33	0.33	0.33	0.03	XXX
92134		A	Cptr ophth dx img post segmt	W	PE	MP	0.50	0.77	0.77	NA	NA	0.04	XXX
92134	TC	A	Cptr ophth dx img post segmt	W	PE	MP	0.00	0.44	0.44	NA	NA	0.01	XXX
92134	26	A	Cptr ophth dx img post segmt	W	PE	MP	0.50	0.33	0.33	0.33	0.33	0.03	XXX
92227		A	Remote dx retinal imaging	W	PE		0.00	0.33	0.33	NA	NA	0.01	XXX
92228		A	Remote retinal imaging mgmt	W	PE	MP	0.30	0.56	0.56	NA	NA	0.02	XXX
92228	TC	A	Remote retinal imaging mgmt	W	PE	MP	0.00	0.36	0.36	NA	NA	0.01	XXX
92228	26	A	Remote retinal imaging mgmt	W	PE	MP	0.30	0.20	0.20	0.20	0.20	0.01	XXX
92285		A	Eye photography	W	PE	MP	0.05	0.49	0.75	NA	NA	0.02	XXX
92285	TC	A	Eye photography	W	PE	MP	0.00	0.46	0.69	NA	NA	0.01	XXX
92285	26	A	Eye photography	W	PE	MP	0.05	0.03	0.06	0.03	0.06	0.01	XXX
92504		A	Ear microscopy examination	W	PE	MP	0.18	0.70	0.70	0.11	0.10	0.01	XXX
92507		A	Speech/hearing therapy	W	PE	MP	1.30	0.69	1.05	NA	NA	0.07	XXX
92508		A	Speech/hearing therapy	W	PE	MP	0.33	0.24	0.45	NA	NA	0.01	XXX
92606		B	Non-speech device service	W	PE	MP	1.40	0.93	0.93	0.62	0.62	0.01	XXX
92607		A	Ex for speech device rx 1hr	W	PE	MP	1.85	1.50	3.25	NA	NA	0.01	XXX
92608		A	Ex for speech device rx addl	W	PE	MP	0.70	0.67	0.80	NA	NA	0.01	ZZZ
92609		A	Use of speech device service	W	PE	MP	1.50	1.04	1.84	NA	NA	0.01	XXX
93040		A	Rhythm ecg with report	W	PE	MP	0.15	0.19	0.22	NA	NA	0.02	XXX
93041		A	Rhythm ecg tracing		PE		0.00	0.14	0.16	NA	NA	0.01	XXX
93042		A	Rhythm ecg report	W	PE	MP	0.15	0.05	0.06	0.05	0.06	0.01	XXX
93224		A	Ecg monit/reprt up to 48 hrs	W	PE	MP	0.52	1.97	2.54	NA	NA	0.03	XXX
93225		A	Ecg monit/reprt up to 48 hrs		PE		0.00	0.90	1.01	NA	NA	0.01	XXX
93226		A	Ecg monit/reprt up to 48 hrs		PE		0.00	0.83	1.26	NA	NA	0.01	XXX
93227		A	Ecg monit/reprt up to 48 hrs	W	PE	MP	0.52	0.24	0.27	0.24	0.27	0.01	XXX
93228		A	Remote 30 day ecg rev/report	W	PE		0.52	0.21	0.21	0.21	0.21	0.03	XXX
93229		A	Remote 30 day ecg tech supp		PE		0.00	20.13	20.13	NA	NA	0.01	XXX
93268		A	Ecg record/review	W	PE	MP	0.52	5.69	6.85	NA	NA	0.03	XXX
93270		A	Remote 30 day ecg rev/report		PE		0.00	0.24	0.44	NA	NA	0.01	XXX
93271		A	Ecg/monitoring and analysis		PE		0.00	5.25	6.18	NA	NA	0.01	XXX
93272		A	Ecg/review interpret only	W	PE	MP	0.52	0.20	0.23	0.20	0.23	0.01	XXX
93451		A	Right heart cath	W	PE	MP	2.72	19.21	19.21	NA	NA	0.61	000
93451	TC	A	Right heart cath	W	PE	MP	0.00	18.14	18.14	NA	NA	0.03	000
93451	26	A	Right heart cath	W	PE	MP	2.72	1.07	1.07	1.07	1.07	0.58	000
93452		A	Left hrt cath w/ventrclgrphy	W	PE	MP	4.75	19.19	19.19	NA	NA	1.09	000
93452	TC	A	Left hrt cath w/ventrclgrphy	W	PE	MP	0.00	17.33	17.33	NA	NA	0.04	000
93452	26	A	Left hrt cath w/ventrclgrphy	W	PE	MP	4.75	1.86	1.86	1.86	1.86	1.05	000
93453		A	R&l hrt cath w/ventriclgrphy	W	PE	MP	6.24	25.10	25.10	NA	NA	1.42	000
93453	TC	A	R&l hrt cath w/ventriclgrphy	W	PE	MP	0.00	22.66	22.66	NA	NA	0.05	000
93453	26	A	R&l hrt cath w/ventriclgrphy	W	PE	MP	6.24	2.44	2.44	2.44	2.44	1.37	000
93454		A	Coronary artery angio s&i	W	PE	MP	4.79	19.94	19.94	NA	NA	1.10	000

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				Work	Practice Expense	Mal-practice							
93454	TC	A	Coronary artery angio s&i	W	PE	MP	0.00	18.06	18.06	NA	NA	0.04	000
93454	26	A	Coronary artery angio s&i	W	PE	MP	4.79	1.88	1.88	1.88	1.88	1.06	000
93455		A	Coronary art/grft angio s&i	W	PE	MP	5.54	23.33	23.33	NA	NA	1.25	000
93455	TC	A	Coronary art/grft angio s&i	W	PE	MP	0.00	21.16	21.16	NA	NA	0.05	000
93455	26	A	Coronary art/grft angio s&i	W	PE	MP	5.54	2.17	2.17	2.17	2.17	1.20	000
93456		A	R hrt coronary artery angio	W	PE	MP	6.15	24.78	24.78	NA	NA	1.39	000
93456	TC	A	R hrt coronary artery angio	W	PE	MP	0.00	22.37	22.37	NA	NA	0.05	000
93456	26	A	R hrt coronary artery angio	W	PE	MP	6.15	2.41	2.41	2.41	2.41	1.34	000
93457		A	R hrt art/grft angio	W	PE	MP	6.89	28.18	28.18	NA	NA	1.54	000
93457	TC	A	R hrt art/grft angio	W	PE	MP	0.00	25.48	25.48	NA	NA	0.05	000
93457	26	A	R hrt art/grft angio	W	PE	MP	6.89	2.70	2.70	2.70	2.70	1.49	000
93458		A	L hrt artery/ventricle angio	W	PE	MP	5.85	23.97	23.97	NA	NA	1.33	000
93458	TC	A	L hrt artery/ventricle angio	W	PE	MP	0.00	21.68	21.68	NA	NA	0.05	000
93458	26	A	L hrt artery/ventricle angio	W	PE	MP	5.85	2.29	2.29	2.29	2.29	1.28	000
93459		A	L hrt art/grft angio	W	PE	MP	6.60	26.33	26.33	NA	NA	1.48	000
93459	TC	A	L hrt art/grft angio	W	PE	MP	0.00	23.75	23.75	NA	NA	0.05	000
93459	26	A	L hrt art/grft angio	W	PE	MP	6.60	2.58	2.58	2.58	2.58	1.43	000
93460		A	R&l hrt art/ventricle angio	W	PE	MP	7.35	27.83	27.83	NA	NA	1.64	000
93460	TC	A	R&l hrt art/ventricle angio	W	PE	MP	0.00	24.95	24.95	NA	NA	0.05	000
93460	26	A	R&l hrt art/ventricle angio	W	PE	MP	7.35	2.88	2.88	2.88	2.88	1.59	000
93461		A	R&l hrt art/ventricle angio	W	PE	MP	8.10	32.26	32.26	NA	NA	1.83	000
93461	TC	A	R&l hrt art/ventricle angio	W	PE	MP	0.00	29.09	29.09	NA	NA	0.06	000
93461	26	A	R&l hrt art/ventricle angio	W	PE	MP	8.10	3.17	3.17	3.17	3.17	1.77	000
93462		A	L hrt cath trnsptl puncture	W	PE	MP	3.73	1.48	1.48	1.48	1.48	0.80	ZZZ
93463		A	Drug admin & hemodynmic meas	W	PE	MP	2.00	0.79	0.79	0.79	0.79	0.39	ZZZ
93464		A	Exercise w/hemodynamic meas	W	PE	MP	1.80	5.28	5.28	NA	NA	0.36	ZZZ
93464	TC	A	Exercise w/hemodynamic meas	W	PE	MP	0.00	4.63	4.63	NA	NA	0.01	ZZZ
93464	26	A	Exercise w/hemodynamic meas	W	PE	MP	1.80	0.65	0.65	0.65	0.65	0.35	ZZZ
93563		A	Inject congenital card cath	W	PE	MP	1.11	0.44	0.44	0.44	0.44	0.10	ZZZ
93564		A	Inject hrt congntl art/grft	W	PE	MP	1.13	0.45	0.45	0.45	0.45	0.10	ZZZ
93565		A	Inject l ventr/atrial angio	W	PE	MP	0.86	0.34	0.34	0.34	0.34	0.08	ZZZ
93566		A	Inject r ventr/atrial angio	W	PE	MP	0.86	4.06	4.06	0.34	0.34	0.07	ZZZ
93567		A	Inject suprvlv aortography	W	PE	MP	0.97	3.08	3.08	0.38	0.38	0.08	ZZZ
93568		A	Inject pulm art hrt cath	W	PE	MP	0.88	3.56	3.56	0.35	0.35	0.08	ZZZ
93652		A	Ablate heart dysrhythm focus	W	PE	MP	17.65	NA	NA	6.95	8.82	3.84	000
93922		A	Upr/l xtremity art 2 levels	W	PE	MP	0.25	2.39	2.99	NA	NA	0.02	XXX
93922	TC	A	Upr/l xtremity art 2 levels	W	PE	MP	0.00	2.29	2.89	NA	NA	0.01	XXX
93922	26	A	Upr/l xtremity art 2 levels	W	PE	MP	0.25	0.10	0.10	0.10	0.10	0.01	XXX
93923		A	Upr/lxtr art stdy 3+ lvls	W	PE	MP	0.45	3.65	4.54	NA	NA	0.05	XXX
93923	TC	A	Upr/lxtr art stdy 3+ lvls	W	PE	MP	0.00	3.48	4.36	NA	NA	0.01	XXX
93923	26	A	Upr/lxtr art stdy 3+ lvls	W	PE	MP	0.45	0.17	0.18	0.17	0.18	0.04	XXX
93924		A	Lwr xtr vasc stdy bilat	W	PE	MP	0.50	4.72	5.76	NA	NA	0.05	XXX
93924	TC	A	Lwr xtr vasc stdy bilat	W	PE	MP	0.00	4.53	5.55	NA	NA	0.01	XXX

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				Work	Practice Expense	Mal-practice							
93924	26	A	Lwr xtr vasc stdy bilat	W	PE	MP	0.50	0.19	0.21	0.19	0.21	0.04	XXX
95800		A	Slp stdy unattended	W	PE	MP	1.05	37.51	37.51	NA	NA	0.05	XXX
95800	TC	A	Slp stdy unattended	W	PE	MP	0.00	36.89	36.89	NA	NA	0.01	XXX
95800	26	A	Slp stdy unattended	W	PE	MP	1.05	0.62	0.62	0.62	0.62	0.04	XXX
95801		A	Slp stdy unatnd w/anal	W	PE	MP	1.00	64.32	64.32	NA	NA	0.05	XXX
95801	TC	A	Slp stdy unatnd w/anal	W	PE	MP	0.00	63.85	63.85	NA	NA	0.01	XXX
95801	26	A	Slp stdy unatnd w/anal	W	PE	MP	1.00	0.47	0.47	0.47	0.47	0.04	XXX
95803		A	Actigraphy testing	W	PE	MP	0.90	3.84	3.84	NA	NA	0.04	XXX
95803	TC	A	Actigraphy testing	W	PE	MP	0.00	3.40	3.40	NA	NA	0.01	XXX
95803	26	A	Actigraphy testing	W	PE	MP	0.90	0.44	0.44	0.44	0.44	0.03	XXX
95805		A	Multiple sleep latency test	W	PE	MP	1.20	10.18	10.84	NA	NA	0.08	XXX
95805	TC	A	Multiple sleep latency test	W	PE	MP	0.00	9.70	10.26	NA	NA	0.04	XXX
95805	26	A	Multiple sleep latency test	W	PE	MP	1.20	0.48	0.58	0.48	0.58	0.04	XXX
95806		A	Sleep study unatt&resp efft	W	PE	MP	1.25	3.50	4.05	NA	NA	0.08	XXX
95806	TC	A	Sleep study unatt&resp efft	W	PE	MP	0.00	3.01	3.50	NA	NA	0.03	XXX
95806	26	A	Sleep study unatt&resp efft	W	PE	MP	1.25	0.49	0.55	0.49	0.55	0.05	XXX
95807		A	Sleep study attended	W	PE	MP	1.28	10.80	12.45	NA	NA	0.15	XXX
95807	TC	A	Sleep study attended	W	PE	MP	0.00	10.33	11.92	NA	NA	0.10	XXX
95807	26	A	Sleep study attended	W	PE	MP	1.28	0.47	0.53	0.47	0.53	0.05	XXX
95808		A	Polysomnography 1-3	W	PE	MP	1.74	16.53	17.28	NA	NA	0.17	XXX
95808	TC	A	Polysomnography 1-3	W	PE	MP	0.00	15.80	16.44	NA	NA	0.10	XXX
95808	26	A	Polysomnography 1-3	W	PE	MP	1.74	0.73	0.84	0.73	0.84	0.07	XXX
95810		A	Polysomnography 4 or more	W	PE	MP	2.50	14.60	17.80	NA	NA	0.21	XXX
95810	TC	A	Polysomnography 4 or more	W	PE	MP	0.00	13.63	16.70	NA	NA	0.11	XXX
95810	26	A	Polysomnography 4 or more	W	PE	MP	2.50	0.97	1.10	0.97	1.10	0.10	XXX
95811		A	Polysomnography w/cpap	W	PE	MP	2.60	15.34	19.30	NA	NA	0.23	XXX
95811	TC	A	Polysomnography w/cpap	W	PE	MP	0.00	14.34	18.15	NA	NA	0.12	XXX
95811	26	A	Polysomnography w/cpap	W	PE	MP	2.60	1.00	1.15	1.00	1.15	0.11	XXX
95857		A	Cholinesterase challenge	W	PE		0.53	0.92	0.82	0.30	0.27	0.04	XXX
95950		A	Ambulatory eeg monitoring	W	PE	MP	1.51	7.13	6.38	NA	NA	0.10	XXX
95950	TC	A	Ambulatory eeg monitoring	W	PE	MP	0.00	6.40	5.71	NA	NA	0.03	XXX
95950	26	A	Ambulatory eeg monitoring	W	PE	MP	1.51	0.73	0.67	0.73	0.67	0.07	XXX
95953		A	Eeg monitoring/computer	W	PE	MP	3.08	9.05	8.93	NA	NA	0.18	XXX
95953	TC	A	Eeg monitoring/computer	W	PE	MP	0.00	7.55	7.53	NA	NA	0.03	XXX
95953	26	A	Eeg monitoring/computer	W	PE	MP	3.08	1.50	1.40	1.50	1.40	0.15	XXX
95956		A	Eeg monitor technol attended	W	PE	MP	3.61	32.20	25.89	NA	NA	0.32	XXX
95956	TC	A	Eeg monitor technol attended	W	PE	MP	0.00	30.54	24.44	NA	NA	0.16	XXX
95956	26	A	Eeg monitor technol attended	W	PE	MP	3.61	1.66	1.45	1.66	1.45	0.16	XXX
96105		A	Assessment of aphasia	W	PE	MP	1.75	0.17	1.21	NA	NA	0.04	XXX
96446		A	Chemotx admn prtl cavity	W	PE	MP	0.37	4.79	4.79	0.19	0.19	0.07	XXX
97597		A	Rmvl devital tis 20 cm/<	W	PE	MP	0.51	1.56	1.56	0.15	0.15	0.05	000
97598		A	Rmvl devital tis addl 20 cm<	W	PE	MP	0.24	0.44	0.44	0.07	0.07	0.03	ZZZ
99224		A	Subsequent observation care	W	PE	MP	0.54	NA	NA	0.24	0.24	0.04	XXX

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				Work	Practice Expense	Mal-practice							
99225		A	Subsequent observation care	W	PE	MP	0.96	NA	NA	0.44	0.44	0.05	XXX
99226		A	Subsequent observation care	W	PE	MP	1.44	NA	NA	0.65	0.65	0.08	XXX

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[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

ADDENDUM D: FINAL CY 2011 GEOGRAPHIC ADJUSTMENT FACTORS (GAFs)

Contractor	Locality	Locality Name	2010 GAF[1]	2011 GAF[2]	Percentage Change (2010 to 2011)
10102	00	Alabama	0.949	0.938	-1.16%
00831	01	Alaska**	1.288	1.289	0.08%
03102	00	Arizona	0.984	0.980	-0.41%
00520	13	Arkansas	0.945	0.926	-2.01%
01192	26	Anaheim/Santa Ana, CA	1.128	1.129	0.09%
01192	18	Los Angeles, CA	1.112	1.106	-0.54%
01102	03	Marin/Napa/Solano, CA	1.112	1.119	0.63%
01102	07	Oakland/Berkeley, CA	1.130	1.133	0.27%
01102	05	San Francisco, CA	1.201	1.198	-0.25%
01102	06	San Mateo, CA	1.203	1.199	-0.33%
01102	09	Santa Clara, CA	1.148	1.156	0.70%
01192	17	Ventura, CA	1.121	1.113	-0.71%
01102	99	Rest of California*	1.012	1.025	1.28%
01192	99	Rest of California*	1.012	1.025	1.28%
04102	01	Colorado	0.984	0.984	0.00%
13102	00	Connecticut	1.100	1.094	-0.55%
12202	01	DC + MD/VA Suburbs	1.121	1.124	0.27%
12102	01	Delaware	1.013	1.012	-0.10%
09102	03	Fort Lauderdale, FL	1.056	1.057	0.09%
09102	04	Miami, FL	1.114	1.107	-0.63%
09102	99	Rest of Florida	1.015	1.003	-1.18%
10202	01	Atlanta, GA	1.004	1.002	-0.20%
10202	99	Rest of Georgia	0.968	0.959	-0.93%
01202	01	Hawaii/Guam	1.057	1.074	1.61%
05130	00	Idaho	0.957	0.945	-1.25%
00952	16	Chicago, IL	1.084	1.081	-0.28%
00952	12	East St. Louis, IL	1.013	1.010	-0.30%
00952	15	Suburban Chicago, IL	1.063	1.061	-0.19%
00952	99	Rest of Illinois	0.982	0.972	-1.02%
00630	00	Indiana	0.967	0.954	-1.34%
05102	00	Iowa	0.950	0.930	-2.11%
05202	00	Kansas	0.957	0.946	-1.15%
00660	00	Kentucky	0.956	0.944	-1.26%
00528	01	New Orleans, LA	1.018	0.997	-2.06%
00528	99	Rest of Louisiana	0.969	0.949	-2.06%
14102	03	Southern Maine	0.991	0.987	-0.40%

Contractor	Locality	Locality Name	2010 GAF[1]	2011 GAF[2]	Percentage Change (2010 to 2011)
14102	99	Rest of Maine	0.957	0.942	-1.57%
12302	01	Baltimore/Surr. Cntys, MD	1.035	1.052	1.64%
12302	99	Rest of Maryland	0.991	1.004	1.31%
14202	01	Metropolitan Boston	1.133	1.106	-2.38%
14202	99	Rest of Massachusetts	1.041	1.040	-0.10%
00953	01	Detroit, MI	1.071	1.060	-1.03%
00953	99	Rest of Michigan	0.987	0.983	-0.41%
00954	00	Minnesota	0.967	0.966	-0.10%
00512	00	Mississippi	0.961	0.940	-2.19%
05302	02	Metropolitan Kansas City, MO	0.995	0.989	-0.60%
05302	01	Metropolitan St Louis, MO	0.988	0.984	-0.40%
05302	99	Rest of Missouri	0.961	0.938	-2.39%
03202	01	Montana ***	0.954	0.968	1.47%
05402	00	Nebraska	0.947	0.928	-2.01%
01302	00	Nevada***	1.016	1.024	0.79%
14302	40	New Hampshire	0.996	1.000	0.40%
12402	01	Northern NJ	1.134	1.120	-1.23%
12402	99	Rest of New Jersey	1.082	1.074	-0.74%
04202	05	New Mexico	0.980	0.969	-1.12%
13202	01	Manhattan, NY	1.164	1.153	-0.95%
13202	02	NYC Suburbs/Long I., NY	1.162	1.161	-0.09%
13202	03	Poughkpsie/N NYC Suburbs, NY	1.034	1.037	0.29%
13292	04	Queens, NY	1.130	1.140	0.88%
13282	99	Rest of New York	0.961	0.961	0.00%
05535	00	North Carolina	0.970	0.955	-1.55%
03302	01	North Dakota***	0.942	0.956	1.49%
00883	00	Ohio	0.993	0.990	-0.30%
04302	00	Oklahoma	0.953	0.934	-1.99%
00835	01	Portland, OR	0.987	0.991	0.41%
00835	99	Rest of Oregon	0.964	0.955	-0.93%
12502	01	Metropolitan Philadelphia, PA	1.075	1.068	-0.65%
12502	99	Rest of Pennsylvania	0.987	0.980	-0.71%
09202	20	Puerto Rico	0.904	0.854	-5.53%
14402	01	Rhode Island	1.045	1.042	-0.29%
00880	01	South Carolina	0.959	0.946	-1.36%
03402	02	South Dakota***	0.948	0.949	0.11%
10302	35	Tennessee	0.961	0.947	-1.46%
04402	31	Austin, TX	0.995	0.986	-0.90%
04402	20	Beaumont, TX	0.986	0.966	-2.03%

Contractor	Locality	Locality Name	2010 GAF[1]	2011 GAF[2]	Percentage Change (2010 to 2011)
04402	09	Brazoria, TX	1.002	0.996	-0.60%
04402	11	Dallas, TX	1.009	1.004	-0.50%
04402	28	Fort Worth, TX	0.994	0.990	-0.40%
04402	15	Galveston, TX	1.000	0.997	-0.30%
04402	18	Houston, TX	1.019	1.008	-1.08%
04402	99	Rest of Texas	0.976	0.959	-1.74%
03502	09	Utah	0.981	0.969	-1.22%
14502	50	Vermont	0.977	0.968	-0.92%
00904	00	Virginia	0.975	0.972	-0.31%
09202	50	Virgin Islands	0.996	0.997	0.10%
00836	02	Seattle (King Cnty), WA	1.033	1.045	1.16%
00836	99	Rest of Washington	0.983	0.982	-0.10%
00884	16	West Virginia	0.976	0.956	-2.05%
00951	00	Wisconsin	0.960	0.959	-0.10%
03602	21	Wyoming***	0.961	0.983	2.29%

* Indicates multiple contractors.

** GAF reflects a 1.5 work GPCI floor in Alaska established by the MIPPA.

*** 2011 GAF reflects a 1.0 PE GPCI floor for frontier states as required by the ACA.

[1] 2010 GAF equation: (0.52466*work GPCI)+(0.43669*PE GPCI)+(0.03865*MP GPCI).

2010 GAF contains a 1.0 work GPCI floor and reflects a limited recognition of cost differences for the rent and employee compensation components of the PE GPCI and hold harmless provision as required by the ACA.

[2] 2011 GAF equation: (0.52466*work GPCI)+(0.43669*PE GPCI)+(0.03865*MP GPCI).

2011 GAF does not contain a 1.0 work GPCI floor which expires December 31, 2010 as required by the ACA.

2011 GAF reflects a limited recognition of cost differences for the rent and employee compensation components of the PE GPCI, hold harmless provision and 1.0 PE GPCI floor for frontier States as required by the ACA.

ADDENDUM E: FINAL CY 2011**** GEOGRAPHIC PRACTICE COST INDICES (GPCIs) BY STATE AND MEDICARE LOCALITY

Contractor	Locality	Locality Name	2010 Work GPCI[1]	2010 PE GPCI[2]	2010 MP GPCI	2011 Work GPCI[3]	2011 PE GPCI[2]	2011 MP GPCI	2012 Work GPCI[3]	2012 PE GPCI[4]	2012 MP GPCI
10102	00	Alabama	1.000	0.927	0.496	0.979	0.928	0.484	0.976	0.859	0.471
00831	01	Alaska**	1.500	1.090	0.646	1.500	1.092	0.648	1.500	1.093	0.649
03102	00	Arizona	1.000	0.979	0.822	0.983	0.983	0.913	0.977	0.974	1.003
00520	13	Arkansas	1.000	0.923	0.446	0.964	0.923	0.444	0.967	0.844	0.441
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811	1.039	1.271	0.742	1.043	1.273	0.673
01192	18	Los Angeles, CA	1.041	1.225	0.804	1.039	1.220	0.722	1.036	1.215	0.639
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432	1.042	1.272	0.443	1.050	1.278	0.454
01102	07	Oakland/Berkeley, CA	1.053	1.286	0.425	1.055	1.286	0.469	1.057	1.286	0.513
01102	05	San Francisco, CA	1.059	1.441	0.414	1.065	1.422	0.464	1.071	1.403	0.513
01102	06	San Mateo, CA	1.072	1.433	0.394	1.072	1.418	0.454	1.071	1.403	0.513
01102	09	Santa Clara, CA	1.083	1.294	0.377	1.080	1.310	0.445	1.077	1.326	0.513
01192	17	Ventura, CA	1.027	1.265	0.766	1.030	1.251	0.684	1.033	1.237	0.601
01102	99	Rest of California*	1.007	1.058	0.549	1.016	1.078	0.546	1.024	1.098	0.543
01192	99	Rest of California*	1.007	1.058	0.549	1.016	1.078	0.546	1.024	1.098	0.543
04102	01	Colorado	1.000	0.996	0.641	0.991	0.997	0.754	0.996	0.993	0.866
13102	00	Connecticut	1.038	1.185	0.980	1.031	1.168	1.102	1.023	1.150	1.224
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032	1.048	1.218	1.081	1.048	1.217	1.130
12102	01	Delaware	1.011	1.046	0.678	1.012	1.041	0.678	1.012	1.036	0.678
09102	03	Fort Lauderdale, FL	1.000	1.018	2.250	0.992	1.041	2.112	0.994	1.063	1.973
09102	04	Miami, FL	1.000	1.069	3.167	0.998	1.072	2.984	0.996	1.075	2.800
09102	99	Rest of Florida	1.000	0.970	1.724	0.978	0.976	1.635	0.983	0.964	1.545
10202	01	Atlanta, GA	1.009	1.014	0.836	1.006	1.006	0.890	1.002	0.995	0.944
10202	99	Rest of Georgia	1.000	0.942	0.829	0.978	0.943	0.876	0.977	0.887	0.922
01202	01	Hawaii/Guam	1.000	1.161	0.665	0.999	1.198	0.685	1.000	1.234	0.705

Contractor	Locality	Locality Name	2010 Work GPCI[1]	2010 PE GPCI[2]	2010 MP GPCI	2011 Work GPCI[3]	2011 PE GPCI[2]	2011 MP GPCI	2012 Work GPCI[3]	2012 PE GPCI[4]	2012 MP GPCI
05130	00	Idaho	1.000	0.942	0.546	0.974	0.943	0.572	0.981	0.889	0.597
00952	16	Chicago, IL	1.025	1.080	1.940	1.028	1.062	2.005	1.030	1.044	2.069
00952	12	East St. Louis, IL	1.000	0.960	1.793	0.988	0.962	1.851	0.987	0.928	1.908
00952	15	Suburban Chicago, IL	1.017	1.068	1.629	1.021	1.056	1.665	1.024	1.044	1.700
00952	99	Rest of Illinois	1.000	0.940	1.219	0.976	0.941	1.274	0.976	0.885	1.329
00630	00	Indiana	1.000	0.960	0.599	0.978	0.957	0.603	0.969	0.907	0.607
05102	00	Iowa	1.000	0.935	0.434	0.962	0.934	0.443	0.958	0.865	0.451
05202	00	Kansas	1.000	0.941	0.557	0.966	0.939	0.746	0.962	0.875	0.935
00660	00	Kentucky	1.000	0.930	0.652	0.971	0.932	0.701	0.972	0.866	0.749
00528	01	New Orleans, LA	1.000	1.044	0.956	0.985	1.018	0.933	0.983	0.982	0.910
00528	99	Rest of Louisiana	1.000	0.939	0.892	0.969	0.936	0.816	0.967	0.865	0.740
14102	03	Southern Maine	1.000	1.025	0.492	0.982	1.029	0.584	0.984	1.032	0.675
14102	99	Rest of Maine	1.000	0.947	0.492	0.964	0.947	0.584	0.965	0.892	0.675
12302	01	Baltimore/Surr. Cntys, MD	1.012	1.057	1.086	1.019	1.084	1.147	1.026	1.111	1.207
12302	99	Rest of Maryland	1.000	0.991	0.874	1.002	1.013	0.930	1.010	1.044	0.985
14202	01	Metropolitan Boston	1.029	1.291	0.764	1.021	1.238	0.776	1.013	1.185	0.787
14202	99	Rest of Massachusetts	1.007	1.106	0.764	1.010	1.100	0.776	1.013	1.093	0.787
00953	01	Detroit, MI	1.036	1.040	1.906	1.029	1.026	1.855	1.021	1.012	1.803
00953	99	Rest of Michigan	1.000	0.962	1.083	0.995	0.960	1.075	0.991	0.917	1.067
00954	00	Minnesota	1.000	0.992	0.245	0.995	0.994	0.262	0.997	0.993	0.279
00512	00	Mississippi	1.000	0.927	0.808	0.961	0.929	0.782	0.962	0.861	0.756
05302	02	Metropolitan Kansas City, MO	1.000	0.973	1.188	0.986	0.973	1.204	0.982	0.946	1.220
05302	01	Metropolitan St Louis, MO	1.000	0.966	1.075	0.992	0.968	1.064	0.990	0.940	1.052
05302	99	Rest of Missouri	1.000	0.911	0.997	0.953	0.913	1.004	0.956	0.830	1.011
03202	01	Montana ***	1.000	0.924	0.673	0.948	1.000	0.887	0.946	1.000	1.100
05402	00	Nebraska	1.000	0.946	0.245	0.964	0.943	0.280	0.968	0.881	0.314
01302	00	Nevada ***	1.002	1.026	1.083	0.999	1.042	1.149	0.996	1.057	1.215

Contractor	Locality	Locality Name	2010 Work GPCI[1]	2010 PE GPCI[2]	2010 MP GPCI	2011 Work GPCI[3]	2011 PE GPCI[2]	2011 MP GPCI	2012 Work GPCI[3]	2012 PE GPCI[4]	2012 MP GPCI
14302	40	New Hampshire	1.000	1.039	0.462	0.987	1.046	0.658	0.991	1.052	0.853
12402	01	Northern NJ	1.057	1.228	1.116	1.051	1.206	1.077	1.044	1.184	1.037
12402	99	Rest of New Jersey	1.042	1.126	1.116	1.031	1.125	1.077	1.020	1.123	1.037
04202	05	New Mexico	1.000	0.946	1.096	0.981	0.947	1.054	0.989	0.895	1.011
13202	01	Manhattan, NY	1.064	1.298	1.010	1.063	1.263	1.137	1.062	1.227	1.263
13202	02	NYC Suburbs/Long I., NY	1.051	1.289	1.235	1.050	1.278	1.335	1.048	1.267	1.434
13202	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822	1.013	1.074	0.945	1.011	1.070	1.067
13292	04	Queens, NY	1.032	1.239	1.220	1.047	1.233	1.351	1.062	1.227	1.482
13282	99	Rest of New York	1.000	0.961	0.425	0.993	0.964	0.492	0.988	0.934	0.559
05535	00	North Carolina	1.000	0.963	0.634	0.972	0.960	0.664	0.971	0.912	0.693
03302	01	North Dakota ***	1.000	0.922	0.387	0.957	1.000	0.453	0.966	1.000	0.519
00883	00	Ohio	1.000	0.964	1.232	0.996	0.961	1.230	0.998	0.914	1.227
04302	00	Oklahoma	1.000	0.925	0.627	0.960	0.927	0.671	0.955	0.859	0.715
00835	01	Portland, OR	1.002	1.015	0.472	1.003	1.016	0.542	1.004	1.017	0.612
00835	99	Rest of Oregon	1.000	0.964	0.472	0.974	0.968	0.542	0.980	0.943	0.612
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617	1.015	1.084	1.619	1.014	1.071	1.621
12502	99	Rest of Pennsylvania	1.000	0.963	1.081	0.990	0.958	1.101	0.987	0.906	1.120
09202	20	Puerto Rico	1.000	0.847	0.250	0.907	0.845	0.249	0.909	0.686	0.248
14402	01	Rhode Island	1.013	1.088	0.996	1.015	1.071	1.089	1.016	1.053	1.182
00880	01	South Carolina	1.000	0.954	0.446	0.976	0.952	0.482	0.976	0.900	0.518
03402	02	South Dakota***	1.000	0.932	0.420	0.946	1.000	0.424	0.950	1.000	0.428
10302	35	Tennessee	1.000	0.945	0.608	0.976	0.945	0.566	0.973	0.888	0.523
04402	31	Austin, TX	1.000	0.992	0.969	0.988	0.995	0.859	0.984	0.994	0.748
04402	20	Beaumont, TX	1.000	0.938	1.346	0.978	0.937	1.131	0.971	0.870	0.916
04402	09	Brazoria, TX	1.019	0.961	1.223	1.014	0.967	1.070	1.008	0.945	0.916
04402	11	Dallas, TX	1.009	1.001	1.110	1.009	1.001	0.969	1.008	0.999	0.828
04402	28	Fort Worth, TX	1.000	0.977	1.110	0.999	0.982	0.966	0.999	0.974	0.821

Contractor	Locality	Locality Name	2010 Work GPCI[1]	2010 PE GPCI[2]	2010 MP GPCI	2011 Work GPCI[3]	2011 PE GPCI[2]	2011 MP GPCI	2012 Work GPCI[3]	2012 PE GPCI[4]	2012 MP GPCI
04402	15	Galveston, TX	1.000	0.980	1.223	1.000	0.985	1.100	1.008	0.980	0.977
04402	18	Houston, TX	1.016	0.994	1.345	1.012	0.992	1.131	1.008	0.980	0.916
04402	99	Rest of Texas	1.000	0.940	1.065	0.974	0.943	0.936	0.979	0.892	0.806
03502	09	Utah	1.000	0.954	1.026	0.975	0.953	1.059	0.972	0.901	1.091
14502	50	Vermont	1.000	0.992	0.489	0.973	1.002	0.523	0.977	1.020	0.557
00904	00	Virginia	1.000	0.972	0.657	0.988	0.978	0.692	0.993	0.967	0.727
09202	50	Virgin Islands	1.000	0.990	1.009	0.998	0.994	1.007	0.998	0.995	1.004
00836	02	Seattle (King Cnty), WA	1.014	1.085	0.706	1.020	1.098	0.785	1.025	1.111	0.864
00836	99	Rest of Washington	1.000	0.988	0.693	0.991	0.991	0.770	0.994	0.986	0.846
00884	16	West Virginia	1.000	0.914	1.353	0.968	0.912	1.279	0.963	0.821	1.205
00951	00	Wisconsin	1.000	0.961	0.409	0.988	0.966	0.476	0.987	0.940	0.543
03602	21	Wyoming ***	1.000	0.921	0.889	0.964	1.000	1.052	0.972	1.000	1.215

[1] 2010 work GPCI reflects a 1.0 floor required by the ACA.

[2] 2010 and 2011 PE GPCI reflects a limited recognition of cost differences for the rent and employee compensation components and application of the hold harmless provision as required by ACA.

[3] 2011 and 2012 work GPCI does not reflect a 1.0 floor which expires December 31, 2010 as required by the ACA.

[4] 2012 PE GPCI does not reflect a limited recognition of cost differences for the rent and employee compensation components which expires December 31, 2011 as required by the ACA.

* Indicates multiple contractors.

** Work GPCI reflects a 1.5 floor in Alaska established by the MIPPA.

*** 2011 and 2012 PE GPCIs reflect a 1.0 floor for frontier states as required by the ACA.

**** 2011 GPCIs are the first year of the update transition, 2012 GPCIs are the fully implemented updated GPCIs.

2011 work GPCI transition: ½ the difference between 2010 (without 1.0 work GPCI floor) and 2012 work GPCI.

2011 PE GPCI transition (and hold harmless as required by the ACA): Greater of ½ the difference between 2010 PE GPCI and 2012 PE GPCI with limited recognition of cost differences for the rent and employee compensation components (as required by ACA) or ½ the difference between 2010 PE GPCI and 2012 PE GPCI without the limited recognition of cost differences for the rent and employee compensation components.

2011 MP GPCI transition: ½ the difference between 2010 MP GPCI and 2012 MP GPCI.

ADDENDUM F: CY 2011 DIAGNOSTIC IMAGING SERVICES SUBJECT TO THE MULTIPLE PROCEDURE PAYMENT REDUCTION

CPT/HCPCS Code	Short Descriptor
70336	Magnetic image, jaw joint
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o & w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o & w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o & w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70554	Fmri brain by tech
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye

CPT/HCPCS Code	Short Descriptor
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72191	Ct angiograph pelv w/o & w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o & w/dye
73206	Ct angio upr extrm w/o & w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o & w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o & w/dye
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o & w/dye
73706	Ct angio lwr extr w/o & w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye

CPT/HCPCS Code	Short Descriptor
73720	Mri lwr extremity w/o & w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o & w/dye
73725	Mr ang lwr ext w or w/o dye
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w or w/o dye
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75574	Ct angio hrt w/3d image
75635	Ct angio abdominal arteries
76604	Us exam, chest
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
77058	Mri, one breast
77059	Mri, both breasts

ADDENDUM G: CPT/HCPCS IMAGING CODES DEFINED BY SECTION 5102(b) OF THE DRA

CPT/HCPCS Code	Short Descriptor
70015	Contrast x-ray of brain
70030	X-ray eye for foreign body
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70170	X-ray exam of tear duct
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70332	X-ray exam of jaw joint
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70373	Contrast x-ray of larynx
70380	X-ray exam of salivary gland
70390	X-ray exam of salivary duct
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye

CPT/HCPCS Code	Short Descriptor
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70557	Mri brain w/o dye
70558	Mri brain w/dye
70559	Mri brain w/o & w/dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71040	Contrast x-ray of bronchi
71060	Contrast x-ray of bronchi
71090	X-ray & pacemaker insertion

CPT/HCPCS Code	Short Descriptor
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye

CPT/HCPCS Code	Short Descriptor
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spine w/o&w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
72240	Contrast x-ray of neck spine
72255	Contrast x-ray, thorax spine
72265	Contrast x-ray, lower spine
72270	Contrast x-ray, spine
72275	Epidurography
72285	X-ray c/t spine disk
72291	Percut vertebroplasty fluor
72295	X-ray of lower spine disk
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73040	Contrast x-ray of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus

CPT/HCPCS Code	Short Descriptor
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73085	Contrast x-ray of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73115	Contrast x-ray of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73225	Mr angio upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73525	Contrast x-ray of hip
73530	X-ray exam of hip
73540	X-ray exam of pelvis & hips
73542	X-ray exam, sacroiliac joint
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73580	Contrast x-ray of knee joint
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle

CPT/HCPCS Code	Short Descriptor
73610	X-ray exam of ankle
73615	Contrast x-ray of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74176	Ct abd & pelvis w/o contrast
74177	Ct abdomen & pelvis w/ contrast
74178	Ct abd & pelv 1+ section/regns
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74190	X-ray exam of peritoneum
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74235	Remove esophagus obstruction
74240	X-ray exam, upper gi tract

CPT/HCPCS Code	Short Descriptor
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74251	X-ray exam of small bowel
74260	X-ray exam of small bowel
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
74270	Contrast x-ray exam of colon
74280	Contrast x-ray exam of colon
74283	Contrast x-ray exam of colon
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74300	X-ray bile ducts/pancreas
74301	X-rays at surgery add-on
74305	X-ray bile ducts/pancreas
74320	Contrast x-ray of bile ducts
74327	X-ray bile stone removal
74328	X-ray bile duct endoscopy
74329	X-ray for pancreas endoscopy
74330	X-ray bile/panc endoscopy
74340	X-ray guide for GI tube
74355	X-ray guide, intestinal tube
74360	X-ray guide, GI dilation
74363	X-ray, bile duct dilation
74400	Contrst x-ray, urinary tract
74410	Contrst x-ray, urinary tract
74415	Contrst x-ray, urinary tract
74420	Contrst x-ray, urinary tract
74425	Contrst x-ray, urinary tract
74430	Contrast x-ray, bladder
74440	X-ray, male genital tract
74445	X-ray exam of penis
74450	X-ray, urethra/bladder
74455	X-ray, urethra/bladder
74470	X-ray exam of kidney lesion

CPT/HCPCS Code	Short Descriptor
74475	X-ray control, cath insert
74480	X-ray control, cath insert
74485	X-ray guide, GU dilation
74710	X-ray measurement of pelvis
74740	X-ray, female genital tract
74742	X-ray, fallopian tube
74775	X-ray exam of perineum
75557	Cardiac MRI w/o contrast
75559	Cardiac MRI w/ stress imaging
75561	Cardiac MRI w/ & w/o contrast
75563	Cardiac MRI w/ stress imaging
75565	Card mri vel flw map add-on
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75600	Contrast x-ray exam of aorta
75605	Contrast x-ray exam of aorta
75625	Contrast x-ray exam of aorta
75630	X-ray aorta, leg arteries
75635	Ct angio abdominal arteries
75650	Artery x-rays, head & neck
75658	Artery x-rays, arm
75660	Artery x-rays, head & neck
75662	Artery x-rays, head & neck
75665	Artery x-rays, head & neck
75671	Artery x-rays, head & neck
75676	Artery x-rays, neck
75680	Artery x-rays, neck
75685	Artery x-rays, spine
75705	Artery x-rays, spine
75710	Artery x-rays, arm/leg
75716	Artery x-rays, arms/legs
75722	Artery x-rays, kidney
75724	Artery x-rays, kidneys
75726	Artery x-rays, abdomen
75731	Artery x-rays, adrenal gland
75733	Artery x-rays, adrenals

CPT/HCPCS Code	Short Descriptor
75736	Artery x-rays, pelvis
75741	Artery x-rays, lung
75743	Artery x-rays, lungs
75746	Artery x-rays, lung
75756	Artery x-rays, chest
75774	Artery x-ray, each vessel
75791	Av dialysis shunt imaging
75801	Lymph vessel x-ray, arm/leg
75803	Lymph vessel x-ray, arms/legs
75805	Lymph vessel x-ray, trunk
75807	Lymph vessel x-ray, trunk
75809	Nonvascular shunt, x-ray
75810	Vein x-ray, spleen/liver
75820	Vein x-ray, arm/leg
75822	Vein x-ray, arms/legs
75825	Vein x-ray, trunk
75827	Vein x-ray, chest
75831	Vein x-ray, kidney
75833	Vein x-ray, kidneys
75840	Vein x-ray, adrenal gland
75842	Vein x-ray, adrenal glands
75860	Vein x-ray, neck
75870	Vein x-ray, skull
75872	Vein x-ray, skull
75880	Vein x-ray, eye socket
75885	Vein x-ray, liver
75887	Vein x-ray, liver
75889	Vein x-ray, liver
75891	Vein x-ray, liver
75893	Venous sampling by catheter
75894	X-rays, transcath therapy
75896	X-rays, transcath therapy
75898	Follow-up angiography
75900	Intravascular cath exchange
75901	Remove cva device obstruct
75902	Remove cva lumen obstruct
75940	X-ray placement, vein filter
75945	Intravascular us

CPT/HCPCS Code	Short Descriptor
75946	Intravascular us add-on
75953	Abdom aneurysm endovas rpr
75956	Xray, endovasc thor ao repr
75957	Xray, endovasc thor ao repr
75958	Xray, place prox ext thor ao
75959	Xray, place dist ext thor ao
75960	Transcath iv stent rs&i
75961	Retrieval, broken catheter
75962	Repair arterial blockage
75964	Repair artery blockage, each
75966	Repair arterial blockage
75968	Repair artery blockage, each
75970	Vascular biopsy
75978	Repair venous blockage
75980	Contrast xray exam bile duct
75982	Contrast xray exam bile duct
75984	Xray control catheter change
75989	Abscess drainage under x-ray
76000	Fluoroscope examination
76001	Fluoroscope exam, extensive
76010	X-ray, nose to rectum
76080	X-ray exam of fistula
76098	X-ray exam, breast specimen
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76496	Fluoroscopic procedure
76497	Ct procedure
76498	Mri procedure
76499	Radiographic procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only

CPT/HCPCS Code	Short Descriptor
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76529	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest, b-scan
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus
76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76817	Transvaginal us, obstetric
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76830	Transvaginal us, non-ob
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76872	Us, transrectal
76873	Echograp trans r, pros study

CPT/HCPCS Code	Short Descriptor
76881	Us xtr non-vasc complete
76882	Us xtr non-vasc lmtd
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76930	Echo guide, cardiocentesis
76932	Echo guide for heart biopsy
76936	Echo guide for artery repair
76937	Us guide, vascular access
76940	Us guide, tissue ablation
76941	Echo guide for transfusion
76942	Echo guide for biopsy
76945	Echo guide, villus sampling
76946	Echo guide for amniocentesis
76948	Echo guide, ova aspiration
76950	Echo guidance radiotherapy
76965	Echo guidance radiotherapy
76970	Ultrasound exam follow-up
76975	GI endoscopic ultrasound
76977	Us bone density measure
76998	Ultrasound guide intraoper
77001	Fluoroguide for vein device
77002	Needle localization by x-ray
77003	Fluoroguide for spine inject
77011	Ct scan for localization
77012	Ct scan for needle biopsy
77013	Ct guide for tissue ablation
77014	Ct scan for therapy guide
77021	Mr guidance for needle place
77022	Mri for tissue ablation
77031	Stereotactic breast biopsy
77032	X-ray of needle wire, breast
77053	X-ray of mammary duct
77054	X-ray of mammary ducts
77058	Magnetic image, breast
77059	Magnetic image, both breasts
77072	X-rays for bone age
77073	X-rays, bone evaluation
77074	X-rays, bone survey

CPT/HCPCS Code	Short Descriptor
77075	X-rays, bone survey
77076	X-rays, bone evaluation
77077	Joint survey, single view
77078	Ct bone density, axial
77079	Ct bone density, peripheral
77081	Dxa bone density/peripheral
77083	Radiographic absorptiometry
77084	Magnetic image, bone marrow
77417	Radiology port film(s)
77421	Stereoscopic x-ray guidance
78006	Thyroid imaging with uptake
78007	Thyroid image, mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging
78016	Thyroid met imaging/studies
78018	Thyroid met imaging, body
78020	Thyroid met uptake
78070	Parathyroid nuclear imaging
78075	Adrenal nuclear imaging
78102	Bone marrow imaging, ltd
78103	Bone marrow imaging, mult
78104	Bone marrow imaging, body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging
78190	Platelet survival, kinetics
78195	Lymph system imaging
78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging

CPT/HCPCS Code	Short Descriptor
78232	Salivary gland function exam
78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckel's divert exam
78291	Leveen/shunt patency exam
78300	Bone imaging, limited area
78305	Bone imaging, multiple areas
78306	Bone imaging, whole body
78315	Bone imaging, 3 phase
78320	Bone imaging (3D)
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78451	Ht muscle image spect, sing
78452	Ht muscle image spect, mult
78453	Ht muscle image,planar,sing
78454	Ht musc image, planar, mult
78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Ven thrombosis images, bilat
78459	Heart muscle imaging (PET)
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)
78472	Gated heart, planar, single
78473	Gated heart, multiple
78481	Heart first pass, single
78483	Heart first pass, multiple
78491	Heart image (pet), single
78492	Heart image (pet), multiple
78494	Heart image, spect
78496	Heart first pass add-on
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging

CPT/HCPCS Code	Short Descriptor
78586	Aerosol lung image, single
78587	Aerosol lung image, multiple
78588	Perfusion lung image
78591	Vent image, 1 breath, 1 proj
78593	Vent image, 1 proj, gas
78594	Vent image, mult proj, gas
78596	Lung differential function
78600	Brain imaging, ltd static
78601	Brain imaging, ltd w/flow
78605	Brain imaging, complete
78606	Brain imaging, compl w/flow
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78610	Brain flow imaging only
78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78700	Kidney imaging, static
78701	Kidney imaging with flow
78707	Kidney flow/function image
78708	Kidney flow/function image
78709	Kidney flow/function image
78710	Kidney imaging (3D)
78730	Urinary bladder retention
78740	Ureteral reflux study
78761	Testicular imaging/flow
78800	Tumor imaging, limited area
78801	Tumor imaging, mult areas
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78804	Tumor imaging, whole body
78805	Abscess imaging, ltd area
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess
78811	Tumor imaging (pet), limited

CPT/HCPCS Code	Short Descriptor
78812	Tumor image (pet)/skul-thigh
78813	Tumor image (pet) full body
78814	Tumor image pet/ct, limited
78815	Tumorimage pet/ct skul-thigh
78816	Tumor image pet/ct full body
92132	Cmptr ophth dx img ant segmt
92133	Cmptr ophth dx img optic nerve
92134	Cptr ophth dx img post segmt
92227	remote dx retinal imaging
92228	remote dx retinal imaging mgmt
92235	Fluorscein angioscopy
92240	IDC green angiography
92250	Fundus photography
92285	External ocular photography
92286	Anterior segment photography
93303	Echo transthoracic
93304	Echo transthoracic
93306	Tte w/doppler, complete
93307	Echo exam of heart
93308	Echo exam of heart
93312	Echo transesophageal
93314	Echo transesophageal
93315	Echo transesophageal
93317	Echo transesophageal
93318	Echo transesophageal intraop
93320	Doppler echo exam, heart
93321	Doppler echo exam, heart
93325	Doppler color flow add-on
93350	Echo transthoracic
93351	Stress tte complete
93571	Heart flow reserve measure
93572	Heart flow reserve measure
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj

CPT/HCPCS Code	Short Descriptor
93893	Tcd, emboli detect w/inj
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
0042T	Ct perfusion w/contrast, cbf
0080T	Endovasc aort repr rad s&i
0081T	Endovasc visc extnsn s&i
0174T	Cad cxr with interp
0175T	Cad cxr remote
G0120	Colon ca scrn; barium enema
G0130	Single energy x-ray study
G0288	Recon, CTA for surg plan
G0365	Vessel mapping hemo access

ADDENDUM H--CY 2011 "ALWAYS THERAPY" SERVICES SUBJECT TO THE MULTIPLE PROCEDURE PAYMENT REDUCTION*

CPT/HCPCS Code	Short Descriptor
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx, 1hr
92609	Use of speech device service
96125	Cognitive test by hc pro
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97750	Physical performance test
97755	Assistive technology assess

CPT/HCPCS Code	Short Descriptor
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/o for orthotic/prosth use
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers

*Excludes contractor-priced and bundled codes.

ADDENDUM I: [Reserved]

ADDENDUM J: LIST OF CPT[1]/HCPCS CODES USED TO DEFINE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES[2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT EFFECTIVE JANUARY 1, 2011

CLINICAL LABORATORY SERVICES	
INCLUDE CPT codes for all clinical laboratory services in the 80000 series, except EXCLUDE CPT codes for the following blood component collection services:	
86890	Autologous blood process
86891	Autologous blood op salvage
86927	Plasma fresh frozen
86930	Frozen blood prep
86931	Frozen blood thaw
86932	Frozen blood freeze/thaw
86945	Blood product/irradiation
86950	Leukacyte transfusion
86960	Vol reduction of blood/prod
86965	Pooling blood platelets
86985	Split blood or products
INCLUDE the following CPT and HCPCS level 2 codes for other clinical laboratory services:	
0030T	Antiprothrombin antibody
0058T	Cryopreservation ovary tiss
0059T	Cryopreservation oocyte
0103T	Holotranscobalamin
0111T	RBC membranes fatty acids
36415	Routine venipuncture
78110	Plasma volume single
78111	Plasma volume multiple
78120	Red cell mass single
78121	Red cell mass multiple
78122	Blood volume
78130	Red cell survival study
78191	Platelet survival
78267	Breath tst attain/anal c-14
78268	Breath test analysis c-14
78270	Vit B-12 absorption exam
78271	Vit B-12 absrp exam int fac
78272	Vit B-12 absorp combined
78725	Kidney function study
G0027	Semen analysis
G0103	Psa screening
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr

G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
G0328	Fecal blood scrn immunoassay
G0416	Sat biopsy prostate 1-20 spc
G0417	Sat biopsy prostate 21-40
G0418	Sat biopsy prostate 41-60
G0419	Sat biopsy prostate: >60
G0431	Drug screen single class
G0432	EIA HIV-1/HIV-2 screen
G0433	ELISA HIV-1/HIV-2 screen
G0434	Drug screen multi drug class
G0435	Oral HIV-1/HIV-2 screen
G9143	Warfarin respon genetic test
P2028	Cephalin floculation test
P2029	Congo red blood test
P2033	Blood thymol turbidity
P2038	Blood mucoprotein
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
P9612	Catheterize for urine spec
P9615	Urine specimen collect mult
Q0111	Wet mounts/ w preparations
Q0112	Potassium hydroxide preps
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital mucous exam
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
INCLUDE the following CPT and HCPCS codes for physical therapy/occupational therapy/outpatient speech-language pathology services:	
0019T	Extracorp shock wv tx ms nos
0183T	Wound ultrasound
64550	Apply neurostimulator
90901	Biofeedback train any meth
90911	Biofeedback peri/uro/rectal
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92520	Laryngeal function studies
92526	Oral function therapy
92597	Oral speech device eval

92607	Ex for speech device rx 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
93797	Cardiac rehab
93798	Cardiac rehab/monitor
95831	Limb muscle testing manual
95832	Hand muscle testing manual
95833	Body muscle testing manual
95834	Body muscle testing manual
95851	Range of motion measurements
95852	Range of motion measurements
95992	Canalith repositioning proc
96000	Motion analysis video/3d
96001	Motion test w/ft press meas
96002	Dynamic surface emg
96003	Dynamic fine wire emg
96105	Assessment of aphasia
96110	Developmental test lim
96111	Developmental test extend
96125	Cognitive test by HC pro
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation

97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97545	Work hardening
97546	Work hardening add-on
97597	RMVL devital tis 20cm/<
97598	RMVL devital tis addl 20 cm<
97602	Wound(s) care non-selective
97605	Neg press wound tx < 50 cm
97606	Neg press wound tx > 50 cm
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/O for orthotic/prosth use
97799	Physical medicine procedure
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
INCLUDE the following CPT and HCPCS codes:	
0042T	Ct perfusion w/contrast cbf
0159T	Cad breast mri
0174T	Cad cxr with interp
0175T	Cad cxr remote
51798	Us urine capacity measure
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets

70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70336	Magnetic image jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation complex
70380	X-ray exam of salivary gland
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography head
70498	Ct angiography neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o & w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o & w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70554	Fmri brain by tech
70555	Fmri brain by phys/psych

71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye

72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spine w/o & w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o & w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o & w/dye
73206	Ct angio upr extrm w/o & w/dye
73218	Mri upper extremity w/o dye

73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o & w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o & w/dye
73225	Mr angio upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73540	X-ray exam of pelvis & hips
73550	X-ray exam of thigh
73560	X-ray exam of knee 1 or 2
73562	X-ray exam of knee 3
73564	X-ray exam knee 4 or more
73565	X-ray exam of knees
73590	X-ray exam of lower leg
73592	X-ray exam of leg infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o & w/dye
73706	Ct angio lwr extr w/o &w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o &w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o & w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74176	Ct angio abd & pelvis
74177	Ct angio abd&pelv w/contrast
74178	Ct angio abd & pelv 1+ regns

74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio abdom w or w/o dye
74210	Contrst x-ray exam of throat
74220	Contrast x-ray esophagus
74230	Cine/vid x-ray throat/esoph
74240	X-ray exam upper gi tract
74241	X-ray exam upper gi tract
74245	X-ray exam upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74261	Ct colonography dx
74262	Ct colonography dx w/dye
74290	Contrast x-ray gallbladder
74291	Contrast x-rays gallbladder
74710	X-ray measurement of pelvis
75557	Cardiac MRI for morph
75559	Cardiac MRI w/stress img
75561	Cardiac MRI for morph w/dye
75563	Card MRI w/stress img & dye
75565	Card MRI veloc flow mapping
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image congen
75574	Ct angio hrt w/3d image
75635	Ct angio abdominal arteries
76000	Fluoroscope examination
76010	X-ray nose to rectum
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76499	Radiographic procedure
76506	Echo exam of head
76510	Ophth us b & quant a
76511	Ophth us quant a only
76512	Ophth us b w/non-quant a
76513	Echo exam of eye water bath

76514	Echo exam of eye thickness
76516	Echo exam of eye
76519	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam chest
76645	Us exam breast(s)
76700	Us exam abdom complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall comp
76775	Us exam abdo back wall lim
76776	Us exam k transpl w/Doppler
76800	Us exam spinal canal
76801	Ob us < 14 wks single fetus
76802	Ob us < 14 wks addl fetus
76805	Ob us >/= 14 wks sngl fetus
76810	Ob us >/= 14 wks addl fetus
76811	Ob us detailed sngl fetus
76812	Ob us detailed addl fetus
76815	Ob us limited fetus(s)
76816	Ob us follow-up per fetus
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76856	Us exam pelvic complete
76857	Us exam pelvic limited
76870	Us exam scrotum
76881	Us xtr non-vasc complete
76882	Us xtr non-vasc lmtd
76885	Us exam infant hips dynamic
76886	Us exam infant hips static
76970	Ultrasound exam follow-up
76977	Us bone density measure
76999	Echo examination procedure
77051	Computer dx mammogram add-on
77052	Comp screen mammogram add-on
77055	Mammogram one breast
77056	Mammogram both breasts
77057	Mammogram screening
77058	Mri one breast
77059	Mri both breasts

77071	X-ray stress view
77072	X-rays for bone age
77073	X-rays bone length studies
77074	X-rays bone survey limited
77075	X-rays bone survey complete
77076	X-rays bone survey infant
77077	Joint survey single view
77078	Ct bone density axial
77079	Ct bone density peripheral
77080	Dxa bone density axial
77081	Dxa bone density/peripheral
77082	Dxa bone density vert fx
77083	Radiographic absorptiometry
77084	Magnetic image bone marrow
78006	Thyroid imaging with uptake
78007	Thyroid image mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging
78016	Thyroid met imaging/studies
78018	Thyroid met imaging body
78020	Thyroid met uptake
78070	Parathyroid nuclear imaging
78075	Adrenal nuclear imaging
78099	Endocrine nuclear procedure
78102	Bone marrow imaging ltd
78103	Bone marrow imaging mult
78104	Bone marrow imaging body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging
78190	Platelet survival kinetics
78195	Lymph system imaging
78199	Blood/lymph nuclear exam
78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging
78232	Salivary gland function exam

78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckels divert exam
78291	Leveen/shunt patency exam
78299	GI nuclear procedure
78300	Bone imaging limited area
78305	Bone imaging multiple areas
78306	Bone imaging whole body
78315	Bone imaging 3 phase
78320	Bone imaging (3D)
78399	Musculoskeletal nuclear exam
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78451	Ht muscle image spect sing
78452	Ht muscle image spect mult
78453	Ht muscle image planar sing
78454	Ht musc image planar mult
78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Ven thrombosis images bilat
78459	Heart muscle imaging (PET)
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)
78472	Gated heart planar single
78473	Gated heart multiple
78481	Heart first pass single
78483	Heart first pass multiple
78491	Heart image (pet) single
78492	Heart image (pet) multiple
78494	Heart image spect
78496	Heart first pass add-on
78499	Cardiovascular nuclear exam
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging
78586	Aerosol lung image single
78587	Aerosol lung image multiple
78588	Perfusion lung image
78591	Vent image 1 breath 1 proj
78593	Vent image 1 proj gas

78594	Vent image mult proj gas
78596	Lung differential function
78599	Respiratory nuclear exam
78600	Brain image < 4 views
78601	Brain image w/flow < 4 views
78605	Brain image 4+ views
78606	Brain image w/flow 4 + views
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78610	Brain flow imaging only
78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78699	Nervous system nuclear exam
78700	Kidney imaging morphol
78701	Kidney imaging with flow
78707	K flow/funct image w/o drug
78708	K flow/funct image w/drug
78709	K flow/funct image multiple
78710	Kidney imaging (3D)
78730	Urinary bladder retention
78740	Ureteral reflux study
78761	Testicular imaging w/flow
78799	Genitourinary nuclear exam
78800	Tumor imaging limited area
78801	Tumor imaging mult areas
78802	Tumor imaging whole body
78803	Tumor imaging (3D)
78804	Tumor imaging whole body
78805	Abscess imaging ltd area
78806	Abscess imaging whole body
78807	Nuclear localization/abscess
78811	PET image ltd area
78812	PET image skull-thigh
78813	PET image full body
78814	PET image w/ct lmtd
78815	PET image w/ct skull-thigh
78816	PET image w/ct full body
78999	Nuclear diagnostic exam
91110	Gi tract capsule endoscopy
91111	Esophageal capsule endoscopy
92132	Cpmtr ophth dx img ant segmt

92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92227	Remote dx retinal imaging
92228	Remote retinal imaging mgmt
93303	Echo transthoracic
93304	Echo transthoracic
93306	TTE w/Doppler complete
93307	TTE w/o Doppler complete
93308	TTE f-up or lmtd
93320	Doppler echo exam heart [if used in conjunction with 93303-93304]
93321	Doppler echo exam heart [if used in conjunction with 93303, 93304, 93308]
93325	Doppler color flow add-on [if used in conjunction with 76825, 76826, 76827,76828, 93303, 93304, 93308]
93875	Extracranial study
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd vasoreactivity study
93892	Tcd emboli detect w/o inj
93922	Upr/l xtremity art 2 levels
93923	Upr/lxtr art stdy 3+ lvls
93924	Lwr xtr vasc stdy bilat
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
A4641	Radiopharm dx agent noc
A4642	In111 satumomab
A9500	Tc99m sestamibi
A9501	Technetium TC-99m teboroxime
A9502	Tc99m tetrofosmin
A9503	Tc99m medronate

A9504	Tc99m apcitide
A9505	TL201 thallium
A9507	In111 capromab
A9508	I131 iodobenguate, dx
A9509	Iodine I-123 sod iodide mil
A9510	Tc99m disofenin
A9512	Tc99m pertechnetate
A9516	Iodine I-123 sod iodide mic
A9521	Tc99m exametazime
A9524	I131 serum albumin, dx
A9526	Nitrogen N-13 ammonia
A9528	Iodine I-131 iodide cap, dx
A9529	I131 iodide sol, dx
A9531	I131 max 100uCi
A9532	I125 serum albumin, dx
A9536	TC99m depreotide
A9537	Tc99m mebrofenin
A9538	Tc99m pyrophosphate
A9539	Tc99m pentetate
A9540	Tc99m MAA
A9541	Tc99m sulfur colloid
A9542	In111 ibritumomab, dx
A9544	I131 tositumomab, dx
A9546	CO57/58
A9547	In111 oxyquinoline
A9548	In111 pentetate
A9550	Tc99m gluceptate
A9551	Tc99m succimer
A9552	F18 fdg
A9553	Cr51 chromate
A9554	I125 iothalamate, dx
A9555	Rb82 rubidium
A9556	Ga67 gallium
A9557	Tc99m bicisate
A9558	Xe133 xenon 10mci
A9559	Co57 cyano
A9560	Tc99m labeled rbc
A9561	Tc99m oxidronate
A9562	Tc99m mertiatide
A9566	Tc99m fanolesomab
A9567	Technetium TC-99m aerosol
A9568	Technetium tc99m arcitumomab
A9569	Technetium TC-99m auto WBC
A9570	Indium In-111 auto WBC
A9571	Indium In-111 auto platelet

A9572	Indium In-111 pentetreotide
A9576	Inj prohance multipack
A9577	Inj multihance
A9578	Inj multihance multipack
A9579	Gad-base MR contrast NOS,1ml
A9580	Sodium fluoride F-18
A9700	Echocardiography contrast
G0130	Single energy x-ray study
G0202	Screeningmammographydigital
G0204	Diagnosticmammographydigital
G0206	Diagnosticmammographydigital
G0288	Recon, CTA for surg plan
G0389	Ultrasound exam AAA screen
Q0092	Set up port xray equipment
Q9951	LOCM>=400 mg/ml iodine,1ml
Q9953	Inj Fe-based MR contrast,1ml
Q9954	Oral MR contrast, 100ml
Q9955	Inj perflexane lip micros,ml
Q9956	Inj octafluoropropane mic,ml
Q9957	Inj perflutren lip micros,ml
Q9958	HOCM <=149 mg/ml iodine, 1ml
Q9959	HOCM 150-199mg/ml iodine,1ml
Q9960	HOCM 200-249mg/ml iodine,1ml
Q9961	HOCM 250-299mg/ml iodine,1ml
Q9962	HOCM 300-349mg/ml iodine,1ml
Q9963	HOCM 350-399mg/ml iodine,1ml
Q9964	HOCM>= 400mg/ml iodine, 1ml
Q9965	LOCM 100-199mg/ml iodine,1ml
Q9966	LOCM 200-299mg/ml iodine,1ml
Q9967	LOCM 300-399mg/ml iodine,1ml
R0070	Transport portable x-ray
R0075	Transport port x-ray multipl
RADIATION THERAPY SERVICES AND SUPPLIES	
INCLUDE the following CPT and HCPCS codes:	
0073T	Delivery comp imrt
0182T	HDR elect brachytherapy
0190T	Place intraoc radiation src
0197T	Intrafraction track motion
19296	Place po breast cath for rad
19297	Place breast cath for rad
19298	Place breast rad tube/caths
20555	Place ndl musc/tis for rt
31643	Diag bronchoscope/catheter
32553	Ins mark thor for rt perq
41019	Place needles h & n for rt

49327	Lap ins device for rt
49411	Ins mark abd/pel for rt perq
49412	Ins device for rt guide open
55875	Transperi needle place pros
55876	Place rt device/marker pros
55920	Place needles pelvic for rt
57155	Insert uteri tandems/ovoids
57156	Ins vag brachytx device
58346	Insert heyman uteri capsule
61770	Incise skull for treatment
61796	SRS cranial lesion simple
61797	SRS cran les simple addl
61798	SRS cranial lesion complex
61799	SRS cran les complex addl
61800	Apply SRS headframe add-on
63620	SRS spinal lesion
63621	SRS spinal lesion addl
77261	Radiation therapy planning
77262	Radiation therapy planning
77263	Radiation therapy planning
77280	Set radiation therapy field
77285	Set radiation therapy field
77290	Set radiation therapy field
77295	Set radiation therapy field
77299	Radiation therapy planning
77300	Radiation therapy dose plan
77301	Radiotherapy dose plan imrt
77305	Teletx isodose plan simple
77310	Teletx isodose plan intermed
77315	Teletx isodose plan complex
77321	Special teletx port plan
77326	Brachytx isodose calc simp
77327	Brachytx isodose calc interm
77328	Brachytx isodose plan compl
77331	Special radiation dosimetry
77332	Radiation treatment aid(s)
77333	Radiation treatment aid(s)
77334	Radiation treatment aid(s)
77336	Radiation physics consult
77338	Design mlc device for imrt
77370	Radiation physics consult
77371	Srs multisource
77372	Srs linear based
77373	Sbrt delivery
77399	External radiation dosimetry

77401	Radiation treatment delivery
77402	Radiation treatment delivery
77403	Radiation treatment delivery
77404	Radiation treatment delivery
77406	Radiation treatment delivery
77407	Radiation treatment delivery
77408	Radiation treatment delivery
77409	Radiation treatment delivery
77411	Radiation treatment delivery
77412	Radiation treatment delivery
77413	Radiation treatment delivery
77414	Radiation treatment delivery
77416	Radiation treatment delivery
77417	Radiology port film(s)
77418	Radiation tx delivery imrt
77421	Stereoscopic x-ray guidance
77422	Neutron beam tx simple
77423	Neutron beam tx complex
77427	Radiation tx management x5
77431	Radiation therapy management
77432	Stereotactic radiation trmt
77435	Sbrt management
77470	Special radiation treatment
77499	Radiation therapy management
77520	Proton trmt simple w/o comp
77522	Proton trmt simple w/comp
77523	Proton trmt intermediate
77525	Proton treatment complex
77600	Hyperthermia treatment
77605	Hyperthermia treatment
77610	Hyperthermia treatment
77615	Hyperthermia treatment
77620	Hyperthermia treatment
77750	Infuse radioactive materials
77761	Apply intrcav radiat simple
77762	Apply intrcav radiat interm
77763	Apply intrcav radiat compl
77776	Apply interstit radiat simpl
77777	Apply interstit radiat inter
77778	Apply interstit radiat compl
77785	HDR brachytx 1 channel
77786	HDR brachytx 2-12 channel
77787	HDR brachytx over 12 chan
77789	Apply surface radiation
77790	Radiation handling

77799	Radium/radioisotope therapy
79005	Nuclear rx oral admin
79101	Nuclear rx iv admin
79200	Nuclear rx intracav admin
79300	Nuclr rx interstit colloid
79403	Hematopoietic nuclear tx
79440	Nuclear rx intra-articular
79445	Nuclear rx intra-arterial
79999	Nuclear medicine therapy
92974	Cath place cardio brachytx
A4650	Implant radiation dosimeter
A9517	I131 iodide cap, rx
A9527	Iodine I-125 sodium iodide
A9530	I131 iodide sol, rx
A9543	Y90 ibritumomab, rx
A9545	I131 tositumomab, rx
A9563	P32 Na phosphate
A9564	P32 chromic phosphate
A9600	Sr89 strontium
A9604	Sm 153 lexidronam
A9699	Radiopharm rx agent noc
C1716	Brachytx, non-str, Gold-198
C1717	Brachytx, non-str,HDR Ir-192
C1719	Brachytx, NS, Non-HDRIr-192
C2616	Brachytx, non-str,Yttrium-90
C2634	Brachytx, non-str, HA, I-125
C2635	Brachytx, non-str, HA, P-103
C2636	Brachy linear, non-str,P-103
C2638	Brachytx, stranded, I-125
C2639	Brachytx,non-stranded,I-125
C2640	Brachytx, stranded, P-103
C2641	Brachytx, non-stranded,P-103
C2642	Brachytx, stranded, C-131
C2643	Brachytx, non-stranded,C-131
C2698	Brachytx, stranded, NOS
C2699	Brachytx, non-stranded, NOS
G0173	Linear acc stereo radsur com
G0251	Linear acc based stero radio
G0339	Robot lin-radsurg com, first
G0340	Robt lin-radsurg fractx 2-5
Q3001	Brachytherapy Radioelements
EPO AND OTHER DIALYSIS-RELATED DRUGS	
The physician self-referral prohibition does not apply to the following codes for dialysis-related drugs furnished in or by an ESRD facility if the conditions in §411.355(g) are satisfied:	
No codes reported at this time.	

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
The physician self-referral prohibition does not apply to the following tests if they are performed for screening purposes and satisfy the conditions in §411.355(h):	
77052	Comp screen mammogram add-on
77057	Mammogram screening
80061	Lipid panel [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V81.2]
82270	Occult blood feces
82465	Assay bld/serum cholesterol [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V81.2]
82947	Assay glucose blood quant [only when billed with ICD-9-CM code V77.1]
82950	Glucose test [only when billed with ICD-9-CM code V77.1]
82951	Glucose tolerance test (GTT) [only when billed with ICD-9-CM code V77.1]
83718	Assay of lipoprotein [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V81.2]
84478	Assay of triglycerides [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V81.2]
G0103	PSA screening
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0202	Screeningmammographydigital
G0328	Fecal blood scrn immunoassay
G0389	Ultrasound exam AAA screen
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
The physician self-referral prohibition does not apply to the following immunization and vaccine codes if they satisfy the conditions in §411.355(h):	
90655	Flu vaccine no preserv 6-35m
90656	Flu vaccine no preserv 3 & >
90657	Flu vaccine 3 yrs im
90660	Flu vaccine nasal
90662	Flu vacc prsv free inc antig
90669	Pneumococcal vacc 7 val im
90670	Pneumococcal vacc 13 val im
90732	Pneumococcal vaccine
90740	Hepb vacc ill pat 3 dose im

90743	Hep b vacc adol 2 dose im
90744	Hepb vacc ped/adol 3 dose im
90746	Hep b vaccine adult im
90747	Hepb vacc ill pat 4 dose im
G0432	EIA HIV-1/HIV-2 screen
G0433	ELISA HIV-1/HIV-2 screen
G0435	Oral HIV-1/HIV-2 screen
Q2035	Afluria vacc, 3 yrs & >, im
Q2036	Flulaval vacc, 3 yrs & >, im
Q2037	Fluvirin vacc, 3 yrs & >, im
Q2038	Fluzone vacc, 3 yrs & >, im
Q2039	NOS flu vacc, 3 yrs & >, im

[1] CPT codes and descriptions only are copyright 2010 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

[2] This list does not include codes for the following designated health service (DHS) categories: durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. For the definitions of these DHS categories, refer to §411.351. For more information, refer to the CMS Web site at http://www.cms.gov/PhysicianSelfReferral/.

ADDENDUM K--CY 2011 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8459	0.8003
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.6342	0.6000
10420	Akron, OH Portage County, OH Summit County, OH	0.9346	0.8843
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9550	0.9036
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.9146	0.8653
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9994	0.9456
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8450	0.7995
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9717	0.9194
11020	Altoona, PA Blair County, PA	0.9111	0.8620

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.9136	0.8644
11180	Ames, IA Story County, IA	1.0538	0.9970
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2645	1.1964
11300	Anderson, IN Madison County, IN	0.9715	0.9192
11340	Anderson, SC Anderson County, SC	0.9186	0.8691
11460	Ann Arbor, MI Washtenaw County, MI	1.0700	1.0124
11500	Anniston-Oxford, AL Calhoun County, AL	0.8369	0.7918
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9491	0.9361
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9513	0.9001
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	1.0209	0.9659

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	1.00093	0.9549
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1763	1.1129
12220	Auburn-Opelika, AL Lee County, AL	0.7599	0.7190
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	1.0081	0.9538
12420	Austin-Round Rock-San Marcos, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	1.0056	0.9514

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
12540	Bakersfield-Delano, CA Kern County, CA	1.2373	1.1707
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0839	1.0255
12620	Bangor, ME Penobscot County, ME	1.0334	0.9777
12700	Barnstable Town, MA Barnstable County, MA	1.3553	1.2823
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.9072	0.8583
12980	Battle Creek, MI Calhoun County, MI	1.0206	0.9656
13020	Bay City, MI Bay County, MI	0.9746	0.9221
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8971	0.8488
13380	Bellingham, WA Whatcom County, WA	1.2038	1.1390
13460	Bend, OR Deschutes County, OR	1.2019	1.1372
13644	Bethesda-Rockville-Frederick, MD Frederick County, MD Montgomery County, MD	1.1124	1.0525
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.9168	0.8674
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.9215	0.8719

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.9101	0.8611
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7766	0.7348
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8787	0.8314
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9501	0.8989
14060	Bloomington-Normal, IL McLean County, IL	0.9976	0.9439
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9801	0.9273
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2871	1.2178
14500	Boulder, CO Boulder County, CO	1.0638	1.0065
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.9159	0.8666
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.1274	1.0667
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.3261	1.2547
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9695	0.9173
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9733	0.9209

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	1.0073	0.9530
15500	Burlington, NC Alamance County, NC	0.9368	0.8863
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0513	0.9947
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1890	1.1250
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0977	1.0386
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.9247	0.8749
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9718	0.9195
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.9494	0.8983
16180	Carson City, NV Carson City, NV	1.1061	1.0465
16220	Casper, WY Natrona County, WY	1.0205	0.9655
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.9347	0.8844
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0818	1.0235
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8344	0.7895
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9887	0.9354

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
16740	Charlotte-Gastonia-Rock Hill, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9956	0.9420
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9874	0.9342
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9332	0.8829
16940	Cheyenne, WY Laramie County, WY	0.9927	0.9392
16974	Chicago-Joliet-Naperville, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.1196	1.0593
17020	Chico, CA Butte County, CA	1.2190	1.1533

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	1.0251	0.9699
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8337	0.7888
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8171	0.7731
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9565	0.9050
17660	Coeur d'Alene, ID Kootenai County, ID	0.9897	0.9364
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	1.0134	0.9588
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	1.0021	0.9481
17860	Columbia, MO Boone County, MO Howard County, MO	0.8753	0.8282

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.9230	0.8733
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.9541	0.9027
18020	Columbus, IN Bartholomew County, IN	0.9971	0.9434
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	1.0718	1.0141
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.9074	0.8585
18700	Corvallis, OR Benton County, OR	1.1050	1.0455
18880	Crestview-Fort Walton Beach-Destin, FL Okaloosa, FL	0.9345	0.8842
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8582	0.8186
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	1.0421	0.9860
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.9113	0.8622

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
19180	Danville, IL Vermilion County, IL	1.0245	0.9693
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8633	0.8168
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8878	0.8400
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9660	0.9140
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8055	0.7621
19500	Decatur, IL Macon County, IL	0.8367	0.7916
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.9233	0.8736
19740	Denver-Aurora-Broomfield, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.1328	1.0718
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	1.0169	0.9621
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0251	0.9699
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7858	0.7435
20100	Dover, DE Kent County, DE	1.0486	0.9921

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
20220	Dubuque, IA Dubuque County, IA	0.9273	0.8774
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.1166	1.0565
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0214	0.9664
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	1.0188	0.9639
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1633	1.1006
20940	El Centro, CA Imperial County, CA	0.9785	0.9258
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8930	0.8449
21140	Elkhart-Goshen, IN Elkhart County, IN	1.0004	0.9465
21300	Elmira, NY Chemung County, NY	0.8926	0.8445
21340	El Paso, TX El Paso County, TX	0.8957	0.8475
21500	Erie, PA Erie County, PA	0.8836	0.8360
21660	Eugene-Springfield, OR Lane County, OR	1.2032	1.1384
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8913	0.8433
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1711	1.1080
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.6342	0.6000

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8523	0.8064
22140	Farmington, NM San Juan County, NM	0.9871	0.9339
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9854	0.9323
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9107	0.8616
22380	Flagstaff, AZ Coconino County, AZ	1.3151	1.2443
22420	Flint, MI Genesee County, MI	1.2150	1.1496
22500	Florence, SC Darlington County, SC Florence County, SC	0.8722	0.8252
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8608	0.8144
22540	Fond du Lac, WI Fond du Lac County, WI	0.9748	0.9223
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0455	0.9892
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0738	1.0160
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8032	0.7599
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9895	0.9362
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	1.0013	0.9474
23420	Fresno, CA Fresno County, CA	1.2072	1.1422

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23460	Gadsden, AL Etowah County, AL	0.7589	0.7180
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9681	0.9160
23580	Gainesville, GA Hall County, GA	0.9748	0.9223
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9601	0.9084
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8991	0.8507
24140	Goldsboro, NC Wayne County, NC	0.9583	0.9067
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.8156	0.7717
24300	Grand Junction, CO Mesa County, CO	1.0411	0.9850
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9691	0.9169
24500	Great Falls, MT Cascade County, MT	0.8761	0.8289
24540	Greeley, CO Weld County, CO	1.0037	0.9496
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	1.0132	0.9586
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9388	0.8882
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9903	0.9370
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	1.0193	0.9644

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25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.6342	0.6000
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9382	0.8877
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9781	0.9254
25260	Hanford-Corcoran, CA Kings County, CA	1.1843	1.1205
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9825	0.9296
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9679	0.9158
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1549	1.0927
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.8153	0.7714
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9188	0.8693
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.9468	0.8958
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9123	0.8632
26180	Honolulu, HI Honolulu County, HI	1.2479	1.1807
26300	Hot Springs, AR Garland County, AR	0.9672	0.9151
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.8299	0.7852

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726420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	1.0383	0.9824
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9463	0.8953
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9714	0.9191
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	1.0213	0.9663
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	1.0223	0.9672
26980	Iowa City, IA Johnson County, IA Washington County, IA	1.0207	0.9657
27060	Ithaca, NY Tompkins County, NY	1.0402	0.9842
27100	Jackson, MI Jackson County, MI	0.9676	0.9155
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8500	0.8042

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27180	Jackson, TN Chester County, TN Madison County, TN	0.8882	0.8404
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9390	0.8884
27340	Jacksonville, NC Onslow County, NC	0.8251	0.7807
27500	Janesville, WI Rock County, WI	0.9951	0.9415
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8914	0.8434
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7566	0.8150
27780	Johnstown, PA Cambria County, PA	0.8551	0.8090
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.8199	0.7757
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8682	0.8214
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0878	1.0292
28100	Kankakee-Bradley, IL Kankakee County, IL	1.1224	1.0619

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28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	1.0201	0.9652
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	1.0544	0.9976
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9299	0.8798
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.8020	0.7588
28740	Kingston, NY Ulster County, NY	0.9592	0.9075
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8288	0.7842
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9650	0.9130
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	1.0361	0.9803
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9818	0.9289

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29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8972	0.8489
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8663	0.8196
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.1395	1.0781
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0818	1.0235
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8928	0.8447
29540	Lancaster, PA Lancaster County, PA	0.9876	0.9344
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0884	1.0298
29700	Laredo, TX Webb County, TX	0.8365	0.7914
29740	Las Cruces, NM Dona Ana County, NM	0.9825	0.9296
29820	Las Vegas-Paradise, NV Clark County, NV	1.2788	1.2099
29940	Lawrence, KS Douglas County, KS	0.9019	0.8533
30020	Lawton, OK Comanche County, OK	0.8757	0.8285
30140	Lebanon, PA Lebanon County, PA	0.8251	0.7807
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9891	0.9358
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9410	0.8903
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9319	0.8817
30620	Lima, OH Allen County, OH	0.9799	0.9271

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30700	Lincoln, NE Lancaster County, NE Seward County, NE	1.0164	0.9617
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.9033	0.8546
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9295	0.8794
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.9050	0.8563
31020	Longview, WA Cowlitz County, WA	1.0882	1.0296
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2821	1.2130
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9402	0.8896
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.9351	0.8847
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.9189	0.8694

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31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9726	0.9202
31460	Madera-Chowchilla, CA Madera County, CA	0.8441	0.7986
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1937	1.1294
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0431	0.9869
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.8294	0.7847
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9600	0.9083
31900	Mansfield, OH Richland County, OH	0.9426	0.8918
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.6342	0.6000
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9340	0.8837
32780	Medford, OR Jackson County, OR	1.0634	1.0061
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9796	0.9268
32900	Merced, CA Merced County, CA	1.3063	1.2359
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0705	1.0128
33140	Michigan City-La Porte, IN LaPorte County, IN	1.0009	0.9470
33260	Midland, TX Midland County, TX	1.0264	0.9711

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33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0763	1.0183
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1777	1.1143
33540	Missoula, MT Missoula County, MT	0.9429	0.8921
33660	Mobile, AL Mobile County, AL	0.8413	0.7960
33700	Modesto, CA Stanislaus County, CA	1.2793	1.2104
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.8448	0.7993
33780	Monroe, MI Monroe County, MI	0.9178	0.8684
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8923	0.8442
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8600	0.8137
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7442	0.7041
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0953	1.0363
34620	Muncie, IN Delaware County, IN	0.8673	0.8206

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34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0367	0.9809
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.9235	0.8738
34900	Napa, CA Napa County, CA	1.5435	1.4604
34940	Naples-Marco Island, FL Collier County, FL	1.0250	0.9698
34980	Nashville-Davidson-—Murfreesboro--Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	0.9995	0.9457
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.3016	1.2315
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.2112	1.1460
35300	New Haven-Milford, CT New Haven County, CT	1.2171	1.1515
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9568	0.9070

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35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.3693	1.2955
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9377	0.8872
35840	North Port-Bradenton-Sarasota, FL New London County, CT	1.0021	0.9481
35980	Norwich-New London, CT New London County, CT	1.1853	1.1215
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.7285	1.6354
36100	Ocala, FL Marion County, FL	0.8950	0.8468
36140	Ocean City, NJ Cape May County, NJ	1.1498	1.0879
36220	Odessa, TX Ector County, TX	0.9973	0.9436
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9795	0.9267
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.9382	0.8877
36500	Olympia, WA Thurston County, WA	1.1911	1.1269

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36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	1.0129	0.9583
36740	Orlando-Kissimmee-Sanford, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9685	0.9163
36780	Oshkosh-Neenah, WI Winnebago County, WI	1.0111	0.9566
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8846	0.8370
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.3082	1.2377
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9735	0.9211
37380	Palm Coast, FL Flagler County, FL	0.8883	0.8405
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL	0.8407	0.7954
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7879	0.7455
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8771	0.8299
37764	Peabody, MA Essex County, MA	1.1604	1.0979
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8724	0.8254
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9670	0.9149

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37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.1418	1.0803
38060	Phoenix-Mesa-Glendale, AZ Maricopa County, AZ Pinal County, AZ	1.1248	1.0642
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.8468	0.8012
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.9095	0.8605
38340	Pittsfield, MA Berkshire County, MA	1.0961	1.0371
38540	Pocatello, ID Bannock County, ID Power County, ID	1.0048	0.9507
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.6342	0.6000
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0463	0.9899
38900	Portland-Vancouver-Hillsboro, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.2129	1.1476
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.1333	1.0723

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39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.2000	1.1354
39140	Prescott, AZ Yavapai County, AZ	1.2930	1.2234
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.1324	1.0714
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9852	0.9321
39380	Pueblo, CO Pueblo County, CO	0.9217	0.8721
39460	Punta Gorda, FL Charlotte County, FL	0.9258	0.8759
39540	Racine, WI Racine County, WI	1.1182	1.0580
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	1.0370	0.9811
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.1036	1.0442
39740	Reading, PA Berks County, PA	0.9411	0.8904
39820	Redding, CA Shasta County, CA	1.4939	1.4134
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.1012	1.0419

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40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	1.0211	0.9661
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.2229	1.1570
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.9330	0.8827
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1565	1.0942
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.9084	0.8595
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0604	1.0033
40484	Rockingham, NH Rockingham County, NH Strafford County, NH	1.0597	1.0026

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40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9548	0.9034
40660	Rome, GA Floyd County, GA	0.9127	0.8635
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4853	1.4053
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9225	0.8708
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1671	1.1042
41100	St. George, UT Washington County, UT	0.9653	0.9133
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0888	1.0302
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9607	0.9090
41420	Salem, OR Marion County, OR Polk County, OR	1.1767	1.1133
41500	Salinas, CA Monterey County, CA	1.6579	1.5686

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9518	0.9005
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9794	0.9266
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8776	0.8303
41700	San Antonio- New Braunfels, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.9510	0.8998
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.2661	1.1979
41780	Sandusky, OH Erie County, OH	0.9180	0.8686
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.6629	1.5733
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.6342	0.6000
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.7654	1.6703

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	0.6342	0.6000
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3650	1.2915
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2854	1.2162

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2587	1.1909
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.7693	1.6740
42140	Santa Fe, NM Santa Fe County, NM	1.1465	1.0847
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.7062	1.6143
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9414	0.8907
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8707	0.8238
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.2214	1.1556
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9615	0.9097
43100	Sheboygan, WI Sheboygan County, WI	0.9759	0.9233
43300	Sherman-Denison, TX Grayson County, TX	0.8750	0.8279
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.9022	0.8536
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9609	0.9091
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9828	0.9299
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	1.0514	0.99648
43900	Spartanburg, SC Spartanburg County, SC	0.9917	0.9383
44060	Spokane, WA Spokane County, WA	1.1173	1.0571

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9650	0.9130
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0835	1.0251
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8848	0.8371
44220	Springfield, OH Clark County, OH	0.9760	0.9234
44300	State College, PA Centre County, PA	0.9279	0.8779
44600	Steubenville-Weirton, OH-WV Centre County, PA	0.7731	0.7315
44700	Stockton, CA San Joaquin County, CA	1.3364	1.2644
44940	Sumter, SC Sumter County, SC	0.8307	0.7860
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	1.0469	0.9905
45104	Tacoma, WA Pierce County, WA	1.1989	1.1343
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.9307	0.8806
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9569	0.9054
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9729	0.9205
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8189	0.7748

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9969	0.9432
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.9462	0.8952
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0728	1.0150
46060	Tucson, AZ Pima County, AZ	1.0020	0.9480
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.9294	0.8793
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.9346	0.8843
46340	Tyler, TX Smith County, TX	0.8524	0.8065
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8953	0.8471
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8393	0.7941
46700	Vallejo-Fairfield, CA Solano County, CA	1.5781	1.4931
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8687	0.8219
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.1134	1.0534

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.9471	0.8961
47300	Visalia-Porterville, CA Tulare County, CA	1.1349	1.0738
47380	Waco, TX McLennan County, TX	0.8881	0.8403
47580	Warner Robins, GA Houston County, GA	0.8485	0.8028
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	1.0197	0.9648

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.1333	1.0723
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8944	0.8462
48140	Wausau, WI Marathon County, WI	1.0107	0.9563
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA	1.0162	0.9615
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	1.0500	0.9934
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.7055	0.6675
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9405	0.8898
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	1.0111	0.9566
48700	Williamsport, PA Lycoming County, PA	0.7669	0.7256

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.1182	1.0580
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9726	0.9202
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0571	1.0002
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9448	0.8939
49340	Worcester, MA Worcester County, MA	1.1639	1.1012
49420	Yakima, WA Yakima County, WA	1.0640	1.0067
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.6342	0.6000
49620	York-Hanover, PA York County, PA	1.0551	0.9983
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9116	0.8625
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1672	1.1043
49740	Yuma, AZ Yuma County, AZ	0.9811	0.9283

ADDENDUM L--CY 2011 ESRD WAGE INDEX FOR RURAL AREAS BASED ON CBSA LABOR MARKET AREAS

State Code	Nonurban Area	Composite Rate Wage Index	ESRD PPS Wage Index
1	Alabama	0.7800	0.7380
2	Alaska	1.3458	1.2626
3	Arizona	0.9613	0.9095

State Code	Nonurban Area	Composite Rate Wage Index	ESRD PPS Wage Index
4	Arkansas	0.7633	0.7222
5	California	1.2742	1.2056
6	Colorado	1.0498	0.9933
7	Connecticut	1.1762	1.1128
8	Delaware	1.0312	0.9757
10	Florida	0.8888	0.8409
11	Georgia	0.7997	0.7566
12	Hawaii	1.1826	1.1189
13	Idaho	0.7986	0.7556
14	Illinois	0.8818	0.8343
15	Indiana	0.8869	0.8391
16	Iowa	0.9031	0.8545
17	Kansas	0.8435	0.7981
18	Kentucky	0.8276	0.7830
19	Louisiana	0.8151	0.7712
20	Maine	0.9077	0.8588
21	Maryland	0.9697	0.9175
22	Massachusetts[1]	1.2439	1.1769
23	Michigan	0.9042	0.8555
24	Minnesota	0.9553	0.9038
25	Mississippi	0.8054	0.7620
26	Missouri	0.8091	0.7655
27	Montana	0.9002	0.8517
28	Nebraska	0.9418	0.8911
29	Nevada	0.9882	0.9350
30	New Hampshire	1.0788	1.0207
31	New Jersey[1]	-----	------
32	New Mexico	0.9418	0.8911
33	New York	0.8651	0.8185
34	North Carolina	0.8835	0.8359
35	North Dakota	0.7220	0.6831
36	Ohio	0.9048	0.8561
37	Oklahoma	0.8307	0.7860
38	Oregon	1.0600	1.0029
39	Pennsylvania	0.8963	0.8480
40	Puerto Rico	0.6342	0.6000
41	Rhode Island[1]	-----	-----
42	South Carolina	0.8892	0.8413
43	South Dakota	0.9022	0.8536
44	Tennessee	0.8335	0.7886
45	Texas	0.8250	0.7806

State Code	Nonurban Area	Composite Rate Wage Index	ESRD PPS Wage Index
46	Utah	0.9141	0.8649
47	Vermont	1.0137	0.9591
48	Virgin Islands	0.8448	0.7993
49	Virginia	0.8287	0.7841
50	Washington	1.0764	1.0184
51	West Virginia	0.7899	0.7474
52	Wisconsin	0.9709	0.9186
53	Wyoming	1.0070	0.9528

[1] All counties within the State are classified as urban.

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