Federal Register

Thursday,
August 2, 2001

Part III

Department of Health and Human Services

Center for Medicare & Medicaid Services

42 CFR Parts 405 et al.

Medicare Programs; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2002; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 411, 414, and 415

[CMS–1169–P]

RIN 0938–AK57

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2002

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would refine the resource-based practice expense relative value units and make several changes to Medicare Part B payment. The policy changes concern services and supplies incident to a physician's professional service; anesthesia base unit variations; recognition of CPT tracking codes; and nurse practitioners, physician assistants, and clinical nurse specialists performing screening sigmoidoscopies. We are proposing these refinements and changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We are soliciting comments on the proposed policy changes as well as comments on the payment policy for CPT modifier 62 that is used to report the work of co-surgeons.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 modernizes the mammography screening benefit and authorizes payment under the physician fee schedule effective January 1, 2002; provides for biennial screening pelvic examinations for certain beneficiaries effective July 1, 2001; provides for annual glaucoma screenings for high-risk beneficiaries effective January 1, 2002; expands coverage for screening colonoscopies to all beneficiaries effective July 1, 2001; establishes coverage for medical nutrition therapy services for certain beneficiaries effective January 1, 2002; expands payment for telehealth services effective October 1, 2001; requires certain Indian Health Service providers to be paid for some services under the physician fee schedule effective July 1, 2001; and revises the payment for certain physician pathology services effective January 1, 2001. This proposed rule would conform our regulations to reflect the statutory provisions.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on October 1, 2001.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1169–P, P.O. Box 8013, Baltimore, MD 21244–8013.

To insure that mailed comments are received in time for us to consider them, please allow for possible delays in delivering them. If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses: Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–8013.

Comments mailed to the above addresses may be delayed and received too late for us to consider them.

Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code CMS–1169–P.

For information on viewing public comments, please see the beginning of the Supplementary Information section.

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

Carlos Cano, (410) 786–0245 (for issues related to screenings for sigmoidoscopies).

Paul W. Kim, (410) 786–7410 (for issues related to incident to services).

Rick Ensor, (410) 786–5617 (for issues related to mammography screenings).

Bill Larson, (410) 786–4639 (for issues related to screening pelvic examinations, screenings for glaucoma, and coverage for screening colonoscopies).

Bob Ulikowski, (410) 786–5721 (for issues related to the payment for screening colonoscopies).

Mary Stojak, (410) 786–6939 (for issues related to medical nutrition therapy).

Joan Mitchell, (410) 786–4508 (for issues related to the payment for medical nutrition therapy).

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

Terri Harris, (410) 786–6830 (for issues related to Indian Health Service providers).

Jim Menas, (410) 786–4507 (for issues related to anesthesia and pathology services).

Diane Milstead, (410) 786–3355 (for all other issues).

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at 7500 Security Blvd, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 5 p.m. Please call (410) 786–7197 to make an appointment to view the public comments.

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $9. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

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

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

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

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

To assist readers in referencing sections contained in this preamble, we are providing the following table of contents. Some of the issues discussed in this preamble affect the payment policies but do not require changes to the regulations in the Code of Federal Regulations. Information on the regulation's impact appears throughout the preamble and is not exclusively in section VI.

Table of Contents

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

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

I. Background

A. Legislative History

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

B. Published Changes to the Fee Schedule

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

In the November 2000 final rule with comment period (65 FR 65376), we revised the policy for resource-based practice expense relative value units (RVUs); the geographic practice cost indices; resource-based malpractice RVUs; critical care RVUs; care plan oversight, physician certification and recertification for home health services; observation care codes; ocular photodynamic therapy and other ophthalmologic treatments; electrical bioimpedance; antigen supply, and the implantation of ventricular assist devices. This rule also addressed the comments received on the May 3, 2000 interim final rule (65 FR 25664) on the supplemental survey criteria and made modifications to the criteria for data submitted in 2001. Based on public comments, we withdrew our proposals related to the global period for insertion, removal, and replacement of pacemakers and cardioverter defibrillators, and to the removal of RVUs for low intensity ultrasound. The November 2000 final rule also discussed or clarified the payment policy for incomplete medical direction, pulse oximetry services, outpatient therapy supervision, outpatient therapy caps, HCPCS ''G'' Codes, and the second 5-year refinement of work RVUs for services furnished beginning January 1, 2002. In addition, we finalized the calendar year (CY) 2000 interim physician work RVUs and issued interim RVUs for new and revised codes for CY 2001. We made these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. This final rule also announced the CY 2001 Medicare physician fee schedule conversion factor under the Medicare Supplementary Medical Insurance (Part B) program as required by section 1848(d) of the Act. The 2001 Medicare physician fee schedule conversion factor was $38.2581.

II. Specific Proposals for Calendar Year 2002

This proposed rule would affect the regulations set forth at Part 405, Federal health insurance for the aged and disabled, Part 410, Supplementary medical insurance (SMI) benefits; Part 411, Exclusions from Medicare and limitations on Medicare payment; Part 414, Payment for Part B medical and other health services; and Part 415, Services furnished by physicians in providers, supervising physicians in teaching settings, and residents in certain settings.

A. Resource-Based Practice Expense Relative Value Units

1. Resource-Based Practice Expense Legislation

Section 121 of the Social Security Act Amendments of 1994 (Public Law 103–432), enacted on October 31, 1994, required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician's service beginning in

1998. In developing the methodology, we were to consider the staff, equipment, and supplies used in providing medical and surgical services in various settings. The legislation specifically required that, in implementing the new system of practice expense RVUs, we apply the same budget-neutrality provisions that we apply to other adjustments under the physician fee schedule.

Section 4505(a) of the BBA amended section 1848(c)(2)(ii) of the Act and delayed the effective date of the resource-based practice expense RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based practice expense RVUs to resource-based RVUs. The practice expense RVUs for CY 1999 were the product of 75 percent of charge-based RVUs and 25 percent of the resource-based RVUs. For CY 2000, the RVUs were 50 percent charge-based RVUs and 50 percent resource-based RVUs. For CY 2001, the RVUs are 25 percent charge-based and 75 percent resource-based. After CY 2001, the RVUs will be totally resource-based.

Section 4505(e) of the BBA amended section 1848(c)(2) of the Act by providing that 1998 practice expense RVUs be adjusted for certain services in anticipation of implementation of resource-based practice expenses beginning in 1999. As a result, the statute required us to increase practice expense RVUs for office visits. For other services in which practice expense RVUs exceeded 110 percent of the work RVUs and were furnished less than 75 percent of the time in an office setting, the statute required us to reduce the 1998 practice expense RVUs to a number equal to 110 percent of the work RVUs. This reduction did not apply to services that had proposed resource-based practice expense RVUs that increased from their 1997 practice expense RVUs as reflected in the June 18, 1997 proposed rule (62 FR 33196). The services affected and the final RVUs for 1998 were published in the October 1997 final rule (62 FR 59103).

Further legislation affecting resource-based practice expense RVUs was included in the Balanced Budget Refinement Act of 1999 (BBRA) (Public Law 106–113). Section 212 of the BBRA amended section 1848(c)(2)(ii) of the Act by directing us to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations. These data would supplement the data we normally collect in determining the practice expense component of the physician fee schedule for payments in CY 2001 and CY 2002.

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

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

a. Practice Expense Cost Pools. We used actual practice expense data by specialty, derived from the 1995 through 1998 SMS survey data, to create six cost pools—administrative labor, clinical labor, medical supplies, medical equipment, office supplies, and all other expenses. There were three steps in the creation of the cost pools. (Please note that use of the 1998 data was incorporated for CY 2001.)

- Step (1) We used the AMA's SMS survey of actual cost data to determine practice expenses per hour by cost category. The practice expenses per hour for each physician respondent's practice was calculated as the practice expenses for the practice divided by the total number of hours spent in patient care activities. The practice expenses per hour for the specialty were an average of the practice expenses per hour for the respondent physicians in that specialty. For the CY 2000 physician fee schedule, we also used data from a survey submitted by the Society of Thoracic Surgeons (STS) in calculating thoracic and cardiac surgeons' practice expense per hour. (Please see the November 1999 final rule (64 FR 59391) for additional information concerning acceptance of these data.) For CY 2001 we used these STS data, as well as survey data submitted by the American Society of Vascular Surgery and the Society of Vascular Surgery. (Please see the November 2000 final rule (65 FR 65385) for additional information on acceptance of these data.)
- Step (2) We determined the total number of physician hours (by specialty) spent treating Medicare patients. This was calculated from physician time data for each procedure code and from Medicare claims data.
- Step (3) We calculated the practice expense pools by specialty and by cost category by multiplying the specialty practice expenses per hour for each category by the total physician hours.

For services with work RVUs equal to zero (including the technical component (TC) of services with a TC and professional component (PC)), we created a separate practice expense pool using the average clinical staff time from the CPEP data (since these codes by definition do not have physician time) and the ''all physicians'' practice expense per hour.

b. Cost Allocation Methodology. For each specialty, we divided the six practice expense pools into two groups, based on whether direct or indirect costs were involved, and used a different allocation basis for each group. The first group included clinical labor, medical supplies, and medical equipment. The second group included administrative labor, office expenses, and all other expenses.

(i) Direct Costs. For direct costs (including clinical labor, medical supplies, and medical equipment), we used the CPEP data as the allocation basis. The CPEP data for clinical labor, medical supplies, and medical equipment were used to allocate the costs for each of the respective cost pools.

For the separate practice expense pool for services with work RVUs equal to zero, we used adjusted 1998 practice expense RVUs as an interim measure to allocate the direct cost pools. (Please see the November 1998 final rule (63 FR 58891) for further information related to this adjustment.) Also, for all radiology services that are assigned work RVUs, we used the adjusted 1998 practice expense RVUs for radiology services as an interim measure to allocate the direct practice expense cost pool for radiology. For all other specialties that perform radiology services, we used the CPEP data for radiology services in the allocation of that specialty's direct practice expense cost pools.

(ii) Indirect Costs. To allocate the cost pools for indirect costs, including administrative labor, office expenses, and all other expenses, we used the total direct costs, as described above, in combination with the physician fee schedule work RVUs. We converted the work RVUs to dollars using the Medicare CF (expressed in 1995 dollars

for consistency with the SMS survey years).

The SMS pool was divided by the CPEP pool for each specialty to produce a scaling factor that was applied to the CPEP direct cost inputs. This was intended to match costs counted as practice expenses in the SMS survey with items counted as practice expenses in the CPEP process. When the specialty-specific scaling factor exceeded the average scaling factor by more than 3 standard deviations, we used the average scaling factor. (Please see the November 1999 final rule (64 FR 59390) for further discussion of this issue.)

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

c. Other Methodological Issues. (i) Global Practice Expense Relative Value Units. For services with the PC and TC paid under the physician fee schedule, the global practice expense RVUs were set equal to the sum of the PC and TC.

(ii) Practice Expenses per Hour Adjustments and Specialty Crosswalks. Since many specialties identified in our claims data did not correspond exactly to the specialties included in the practice expense tables from the SMS survey data, it was necessary to crosswalk these specialties to the most appropriate SMS specialty category. We also made the following adjustments to the practice expense per hour data. (For the rationale for these adjustments to the practice expense per hour, see the November 1998 final rule (63 FR 58841).)

- We set the medical materials and supplies practice expenses per hour for the specialty of ''oncology'' equal to the ''all physician'' medical materials and supplies practice expenses per hour.
- We based the administrative payroll, office, and other practice expenses per hour for the specialties of ''physical therapy'' and ''occupational therapy'' on data used to develop the salary equivalency guidelines for these specialties. We set the remaining practice expense per hour categories equal to the ''all physician'' practice expenses per hour from the SMS survey data. (Note that in the November 2000 final rule (65 FR 65403), we increased the space allotment for therapy services to 750 square feet.)
- Due to uncertainty concerning the appropriate crosswalk and time data for the nonphysician specialty ''audiologist,'' we derived the resource-based practice expense RVUs for codes performed by audiologists from the practice expenses per hour of the other specialties that perform these services.
- For the specialty of ''emergency medicine,'' we used the ''all physician'' practice expense per hour to create practice expense cost pools for the categories ''clerical payroll'' and ''other expenses.''
- For the specialty of ''podiatry,'' we used the ''all physician'' practice expense per hour to create the practice expense pool.
- For the specialty of ''pathology,'' we removed the supervision and autopsy hours reimbursed through Part A of the Medicare program from the practice expense per hour calculation.
- For the specialty ''maxillofacial prosthetics,'' we used the ''all physician'' practice expense per hour to create practice expense cost pools and, as an interim measure, allocated these pools using the adjusted 1998 practice expense RVUs.
- We split the practice expenses per hour for the specialty ''radiology'' into ''radiation oncology'' and ''radiology other than radiation oncology'' and used this split practice expense per hour to create practice expense cost pools for these specialties.

(iii) Time Associated with the Work RVUs. The time data resulting from the refinement of the work RVUs have been, on average, 25 percent greater than the time data obtained by the Harvard study for the same services. We increased the Harvard study's time data to ensure consistency between these data sources.

For services with no assigned physician time, such as dialysis, physical therapy, psychology, and many radiology and other diagnostic services, we calculated estimated total physician time based on work RVUs, maximum clinical staff time for each service as shown in the CPEP data, or the judgment of our clinical staff.

We calculated the time for CPT codes (hereafter referred to as ''codes'') 00100 through 01996 using the base and time units from the anesthesia fee schedule and the Medicare allowed claims data.

3. Refinement

a. Background. Section 4505(d)(1)(C) of the BBA amended section 1848(c)(2)(C)(ii) of the Act by directing us to develop a refinement process to be used during each of the 4 years of the transition period. We did not propose a specific long-term refinement process in the June 1998 proposed rule (63 FR 30835). Rather, we set out the parameters for an acceptable refinement process for practice expense RVUs and solicited comments on our proposal. We received a variety of comments about broad methodology issues, practice expense per-hour data, and detailed code-level data. We made adjustments to our proposal based on comments we received. We also indicated that we would consider other comments for possible refinement and that the RVUs for all codes would be considered interim for 1999 and for future years during the transition period.

We outlined in the November 1998 final rule (63 FR 58832) the steps we were undertaking as part of the initial refinement process. These steps included the following:

- Establishment of a mechanism to receive independent advice for dealing with broad practice expense RVU technical and methodological issues.
- Evaluation of any additional recommendations from the General Accounting Office, the Medicare Payment Advisory Commission (MedPAC), and the Practicing Physicians Advisory Council (PPAC).
- Consultation with physician and other groups about these issues.

We also discussed a proposal submitted by the AMA's Specialty Society Relative Value Update Committee (RUC) for development of a new advisory committee, the Practice Expense Advisory Committee (PEAC), to review comments and recommendations on the code-specific CPEP data during the refinement period. In addition, we solicited comments and suggestions about our practice expense methodology from organizations that have a broad range of interests and expertise in practice expense and survey issues.

b. Current Status of Refinement Activities. In the 1999 and 2000 proposed and final rules, we provided further information on refinement activities underway, including the AMA's formation of the PEAC and the support contract that we awarded to the Lewin Group to focus on methodologic issues. In addition, in these rules we announced actions taken and decisions made in response to the hundreds of comments received on our resource-based physician practice expense initiative. Because the transition will be completed in CY 2002 and the practice expense RVUs will then be totally resource-based, it is appropriate to recap the specific achievements reached and decisions implemented during this refinement effort to date.

(i) Use of the Top-Down Approach. Most of the physician organizations commenting agreed that this methodology was preferred for computing resource-based practice expense RVUs and that it was in accordance with the requirements of the

BBA. KPMG Peat Marwick, under contract to us, reviewed the top-down methodology in which aggregate specialty costs are applied to specific procedures and concluded that it followed reasonable cost accounting principles. A 1999 GAO report concludes, ''HCFA's new approach represents a reasonable starting point for creating resource-based practice expense RVUs. It uses the best available data for this purpose and explicitly recognizes specialty differences in practice expense.'' Based on these comments and assessments, we made the decision to continue to use the top-down methodology to calculate the resource-based practice expense RVUs.

(ii) Use of the SMS Survey. The supplemental non-SMS survey data submitted by several specialties in response to the 1998 proposed rule, with the exception of the survey data from the thoracic surgeons, were not compatible with the format or methodology of the SMS. We awarded a contract to the Lewin Group to recommend criteria for the acceptance of specialty-specific practice expense data so that we could supplement the SMS data as appropriate. These recommended criteria are contained in the final report, ''An Evaluation of the Health Care Financing Administration's Resource-Based Practice Expense Methodology.'' This report is available on our web page under the same title. (Access to our web site is discussed under the **SUPPLEMENTARY INFORMATION** section above.)

The report also contains recommendations for revisions to the SMS or other surveys to efficiently meet the needs of our practice expense methodology. We augmented these recommendations and forwarded our suggestions for revisions to any future surveys to the AMA. For example, we developed supplementary survey questions that would allow us to distinguish both costs and direct patient care hours for all midlevel practitioners. We also suggested revisions that would capture the necessary information on separately billable supplies and services so that we could eliminate these costs from the specialty-specific practice expense per-hour calculations.

To obtain supplementary specialty-specific practice expense data that could be used in computing practice expense RVUs beginning January 1, 2001, we published an interim final rule on May 3, 2000 (65 FR 25664) that set forth the criteria applicable to supplemental survey data submitted to us by August 1, 2000.

We also provided a 60-day period for submission of public comments on our criteria for survey data submitted between August 2, 2000 and August 1, 2001 for use in computing the practice expense RVUs for the CY 2002 physician fee schedule.

In the November 1, 2000 final rule (65 FR 65385), we responded to comments received on the interim final rule and made modifications to the criteria for supplemental survey data that will be considered in computing practice expense RVUs for the CY 2002 physician fee schedule. These data can then be used to supplement the SMS survey data currently used to estimate each specialty's aggregate practice costs or to replace the crosswalks used for specialties not represented in the SMS.

In our November 1999 final rule, we accepted supplementary data submitted by the thoracic surgeons and, in our November 2000 rule, we accepted survey data from the vascular surgeons that replaced the previously crosswalked practice expense per hour data for that specialty. If we receive additional specialty-specific survey data before August 1, 2001 that meets the criteria outlined in the November 1, 2000 final rule, we will use this supplementary data in calculating the CY 2002 practice expense RVUs.

We accepted our contractor's recommendation to incorporate the latest SMS data into our practice-expense-per-hour calculations. For CY 2001, we incorporated the 1998 SMS data into a 4-year average and are proposing to incorporate the 1999 SMS data into a 5-year average to calculate the CY 2002 practice expense RVUs.

We also accepted the contractor's recommendation to standardize the survey practice expense data to a common year. We adjusted the data to reflect a 1995 cost year.

We received comments that urged us to use the median SMS specialty-specific data instead of the mean, as well as comments supporting our use of the mean values. We made a decision to continue to use the mean in calculating the specialty-specific practice expense per hour. We believe that, in a small sample, using the median could eliminate outlying data from the calculation that represent real costs and thus should be considered.

(iii) CPEP Data. The AMA has formed a multispecialty sub-committee of their Relative Value Update Committee (RUC), the Practice Expense Advisory Committee (PEAC), to review the CPEP clinical staff, equipment, and supply data for all physician services. This multispecialty committee, which includes representatives from all major specialty societies, would then make recommendations on suggested refinements to this data. We indicated in our November 1998 final rule (63 FR 58833) that we would work with the PEAC and RUC to refine the practice expense direct cost inputs. This refinement process was supported in comments we received from almost every major physician specialty society.

In our 1999 physician fee schedule final rule, we implemented most CPEP refinements recommended by the RUC. For the 2000 final rule, the RUC forwarded to us significant additional refinement recommendations that reflected multispecialty agreement on the typical resources for many important services, including visit codes, that account for approximately 24 percent of Medicare spending for physician services. Again we received and accepted almost all of these RUC recommendations. In addition, at its October 2000, February 2001, and April 2001 meetings, the PEAC focused on high-volume services and on standardizing inputs across wide ranges of services. We, therefore, anticipate that the pace of refinement of the CPEP inputs will continue to accelerate.

In addition to implementing most of the RUC-recommended refinements, we responded to comments on errors and anomalies in the CPEP data in both the November 1999 and November 2000 final rules. For example, we removed separately billable casting supplies and drugs from all services, we adjusted the prices of certain supplies that were clearly in error, we removed duplicated equipment from the direct inputs of the nuclear medicine codes, we added clearly essential equipment that was missing from the lithotripsy and photochemotherapy codes, we corrected anomalies in inputs within several families of codes, and we changed the crosswalks for the CPEP inputs of several codes not valued by the CPEP panels when a commenter suggested more appropriate crosswalks.

We simplified the refinement of equipment inputs by combining both the procedure-specific and overhead equipment into a single equipment category. We also deleted stand-by equipment and equipment used for multiple services at one time from the direct cost inputs because of the difficulty of allocating these costs at the code-specific level.

We are resolving issues related to averaging input costs for codes that were valued by more than one CPEP panel. While we have received comments agreeing and disagreeing with our use of mean costs, the issue is moot because we are substituting refined data for the data previously produced by multiple CPEPs.

(iv) Physician Time Data. In the November 1999 rule (64 FR 59404), we stated that, in general, requests for revisions for the procedure-specific physician times should be deferred to either the RUC process or the 5-year review process. However, we did adopt the newer data to correct the physician time for the pediatric surgery codes and made the requested revisions to correct anomalies in the times of certain psychotherapy codes.

In response to comments on the times associated with physical and occupational therapy services, we added preservice and postservice times to all of these codes.

(v) Crosswalk Issues. In response to concerns expressed by specialty societies representing emergency medicine that the SMS data did not capture the costs of uncompensated care, we crosswalked emergency medicine's administrative labor and other expenses cost pools to the practice expense per hour for ''all physicians.''

We resolved issues related to the specialty crosswalk for nursing specialties by eliminating the separate practice expense pools for midlevel practitioners.

(vi) Calculation of Practice Expense Pools—Other Issues. We addressed concerns that potential errors in our specialty utilization data will have an effect on the calculation of practice expense RVUs. In the July 2000 proposed rule (65 FR 44178), we discussed our simulations that demonstrated that the small percentage of potential errors in our very large database have no adverse effect on specialty-specific practice expense RVUs.

We have created the zero-work pool for services with no physician work to ensure that these services are not inappropriately disadvantaged by our methodology. We have also agreed with the request of all the specialty societies that commented that their services should be moved out of the zero-work pool and into the specialty-specific pool. The specialties whose services remain in the zero-work pool have indicated that they wish their services to remain there. We plan to eliminate this separate pool for services with no physician work only when we have determined what revisions to our methodology are required so that we can value these services appropriately outside of the zero-work pool.

(vii) Calculation of Indirect Cost. We requested that our contractor evaluate various options for calculating indirect costs. The final report, referenced above, contains an analysis of the impacts of six alternative allocation methodologies. In confirming the suitability of our allocation methodology, the report concludes that ''HCFA's approach is broadly consistent with most of the alternative methods. This consistency suggests that, from a broad perspective, no other allocation methodology offers a compelling reason to abandon the current HCFA approach.''

(viii) Site-of-Service. The practice expense RVUs would be expected to be higher in the non-facility setting, where the practitioner bears the costs of the necessary staff, supplies, and equipment, than in the facility setting. To prevent potential anomalies in our calculations due to the different mix of specialties performing a given service in different settings, we capped the facility practice expense RVUs at the non-facility level for each specific service.

In the November 1999 final rule (64 FR 59407), in response to a comment from the Renal Physicians Association, we agreed that the monthly capitated service codes should always be reported using the non-facility designation. The site of service designations are not meaningful for a monthly service that may be provided in different settings for the same patient during a given month.

Although we need to do additional work to complete the refinement of all practice expense RVUs, we believe that the above description of our actions to date shows that much has been accomplished. We also believe that it demonstrates that we have been responsive to comments from the medical community and have established a process that enables this community to participate fully in the refinement of both the specialty-specific practice expense per hour and the CPEP code-specific inputs.

Practice Expense Proposals for Calendar Year 2002

(1) Use of 1999 SMS Survey Data

We are currently using data from the 1995 through the 1998 SMS surveys (1994 through 1997 practice expense data) in order to calculate the specialty-specific practice expense per hour. The 1999 SMS survey data is now available. Because we want to incorporate the most recent survey data into our methodology during the transition period, we are proposing to add this 1999 data to the 4 years of data we are currently using.

We are proposing to use these 5 years of data in addition to any supplemental specialty-specific data that meet our criteria as the basis of the practice expense per hour calculations until the first 5-year review of practice expense RVUs in 2007. At that time, we anticipate that newer practice expense survey data might be available.

The proposed specialty-specific practice-expense per hour calculations are shown in Table 1. The specialty level impact of using the additional SMS data is shown in Table 5 of the regulatory impact statement. As indicated, Table 5 shows the impact of this change only relative to the current estimated fully-implemented practice expense RVUs.

TABLE 1.—SPECIALTY-SPECIFIC PRACTICE EXPENSE PER HOUR CALCULATIONS

Specialty	Clinical payroll per hour	Clerical payroll per hour	Office expense per hour	Supplies expense per hour	Equipment expense per hour	Other expense per hour	Total expense per hour
ALL PHYSICIANS	12.3	15.4	19.4	7.4	3.2	11.5	69
GENERAL/FAMILY PRACTICE	14.8	14.9	17.7	7.9	3.1	8.8	67.1
GENERAL INTERNAL MEDICINE	9.4	14.4	17.9	6.1	2.1	6.6	56.5
CARDIOVASCULAR DISEASE	15.8	15.2	20.7	6.2	5.9	17.8	81.6
GASTROENTEROLOGY	8.9	17	18	3.6	2.1	12.3	61.8
ALLERGY/IMMUNOLOGY	36.3	25.3	31.4	16	2	15.8	128.8
PULMONARY DISEASE	6.9	12.4	15.7	2.6	1.6	6.9	46.1
ONCOLOGY (with supplies adjustment)	27.4	24.1	26.5	7.4	4.6	9.3	99.3
GENERAL SURGERY	7.2	15.6	16.8	3.4	2	9.9	54.9
OTOLARYNGOLOGY	17.2	25.2	32.9	7.5	5.6	17.2	105.7
ORTHOPEDIC SURGERY	16.6	28.5	29.7	10.3	3.8	19.1	108
OPHTHALMOLOGY	25.1	25.8	34.1	10.8	8.4	21.1	125.3
UROLOGICAL SURGERY	12.4	18.5	23.2	25.5	5.3	11.3	96.2
PLASTIC SURGERY	15	20.3	32.4	18.5	5.7	25.2	117.2
NEUROLOGICAL SURGERY	8.6	25.6	28.6	1.8	1.4	16.1	82.2
CARDIAC/THORACIC SURGERY	18.1	16.8	16.8	1.8	2.2	13.1	68.8

TABLE 1.—SPECIALTY-SPECIFIC PRACTICE EXPENSE PER HOUR CALCULATIONS—Continued

Specialty	Clinical payroll per hour	Clerical payroll per hour	Office expense per hour	Supplies expense per hour	Equipment expense per hour	Other expense per hour	Total expense per hour
PEDIATRICS	12.4	12.9	18.9	10.2	1.7	8.6	64.8
OBSTETRICS/GYNECOLOGY	16.4	18.8	24.7	7.3	3.2	11.2	81.7
RADIATION ONCOLOGY	14	9.2	12.1	5.4	9.7	16.4	66.8
RADIOLOGY	9.3	10.8	14.8	4.8	7.4	20.9	68
PSYCHIATRY	1.7	5.1	10.5	0.4	0.4	7.2	25.3
ANESTHESIOLOGY	11.3	3.7	5.9	0.4	0.4	5.9	27.6
PATHOLOGY (adjusted to remove Part A Hrs)	11.2	14	11.9	6.8	2	21	66.9
DERMATOLOGY	22.5	28.4	33.4	12.6	5.4	17.2	119.4
EMERGENCY MEDICINE (adjusted for admin/other)	3.3	15.4	2	0.7	0.1	11.5	33
NEUROLOGY	8.3	23	19.5	5.2	4.4	9.3	69.7
PHYS MED/RHEUMATOLOGY	14.9	23.7	30.7	6.5	6.2	12.2	94.2
OTHER SPECIALTY	9.3	13	19.3	4.9	1.9	8.8	57.3
VASCULAR SURGERY (supplemental data)	20.2	18.1	17.7	3.2	4.5	11.4	75.1
PHYSICAL AND OCCUPATIONAL THERAPY (see	12.3	5.9	7.5	7.4	3.2	4.4	40.7

*Total expenses exclude professional liability insurance premiums and employee physician payroll.

Notes:

—Only self-employed non-federal non-resident patient care physicians who responded to all relevant expense questions are included. Self-employed physician respondents with no practice expenses for the year are excluded.

—Physicians whose typical number of hours worked in patient care activities per week is missing, less than 20, or equal to 168 are excluded. Physicians whose number of weeks worked the previous year is missing or less than 26 are excluded.

—For each respondent, total practice expense and expense components per hour are calculated as (4)/(5) below.

—Expenses adjusted for practice size = self-employed respondent expenses X # physician owners

—Hours adjusted for practice size =(respondent hours * # physician owners) + (employee physician hours (see (6) below) * # employee physicians)

—The typical number of hours worked in patient care activities for the employee physician(s) of a self-employed physician's practice is not known.

Mean hours worked in patient care activities for employee physicians of each specialty are used as an estimate of employee physician hours.

—As described earlier in this proposed rule, the practice expense per hour shown above reflect:

—the ''All Physician'' supplies expense per hour for Oncology

—use of supplemental SMS practice expense data for Cardiac and Thoracic Surgery in addition to regular SMS data collection.

—removal of hours spent in Part A activities for Pathology.

—Using the ''All Physician'' administration and other practice expense data for Emergency Medicine.

—Vascular Surgery data is based on supplemental survey not the SMS.

—Physical and occupational therapy data is based on ''All Physician'' for clinical, staff, supplies and equipment.

It is based on salary equivalency guidelines assuming 750 square feet of office space for clerical, office and other.

Supplemental Practice Expense Survey Data

To ensure the maximum opportunity for specialties to submit supplementary practice expense data, we are proposing to accept survey data that meets the criteria set forth in the November 2000 final rule for an additional 2 years. The deadlines for submission of such supplemental data to be considered in CY 2003 and CY 2004 are August 1, 2002 and August 1, 2003, respectively.

Repricing of CPEP Inputs

The cost of the original CPEP inputs for staff, supplies, and equipment were assigned by our contractor, Abt Associates, based primarily on 1994 and 1995 pricing data. In addition, for many items on the equipment and supply list, the associated costs were based on the recommendation of a CPEP panel member, rather than on actual catalog prices. Several equipment and supply items and clinical staff types also have been added subsequent to the CPEP panels. In general, the costs of these inputs have been provided by the relevant specialty society, with and without documentation of the costs.

We are proposing to revise the salary and cost estimates by using the most current pricing data available. We contracted with a consultant to help us in this endeavor and the contractor also solicited advice and information from the major medical specialty societies. We appreciate the time and effort given to this project by the staff of many of the specialty societies. We have at this time completed our proposals for the update of clinical staff salary data and discuss these proposals below. However, we have not yet completed the pricing update for all of the hundreds of supplies and pieces of equipment that are in our CPEP database. We have had difficulty in identifying some of these inputs because many of the original descriptions are too general to price (for example, ''laser'' or ''antibody'') or because the item cannot be found in any supplier's catalog. In addition, several of the pieces of equipment are now obsolete and we need input regarding the appropriate equipment to price. Therefore, we need to work closely with the specialty societies in the coming months so that we can propose accurate prices for all the supply and equipment inputs in next year's proposed rule.

Staff Types and Wages

For the original CPEP wage data, Abt Associates used three primary external data sets: The Bureau of Labor Statistics' (BLS) Occupation Compensation Survey, 1993; The University of Texas Medical Branch (UTMB) Survey of Hospital and Medical School Salaries, 1994; and the Current Population Survey, 1993. Abt's report on the CPEP cost estimation stated that, ''* * * the BLS data were considered to be the preferred data set. The BLS' reputation for publishing valid estimates that are nationally representative led to the choice of the BLS data as the main source. If more than one data set provided an exact mapping for a receptionist, then the BLS wage was chosen over any other mapping.''

We agreed with this assessment and directed our current contractor to use the most current BLS survey (1999) as the main source of wage data. The two other data sets used by Abt were not useful in this pricing update. The UTMB survey has apparently not been repeated and the Current Population Survey was used mainly for administrative staff types that are no longer treated as a direct cost.

It should also be noted that the BLS discontinued the Occupational Compensation Survey used in 1995 and now conducts the National Compensation Survey that has a different breakdown of staff types than the earlier survey. This survey also does not cover all the staff types contained in the CPEP data. Therefore, it has been necessary for us to crosswalk or extrapolate the wages for several staff types using supplementary data sources for verification whenever possible.

We used three other data sources to price wages of staff types that were not referenced in the BLS data—the American Society of Clinical

Pathologists' survey of laboratory staff salaries (found at *www.ascp.org*); the survey done by the American Academy of Health Physics and the American Board of Health Physics (found at *www.hps1.org*); and national salary data from the *Salary Expert,* an Internet site that develops national and local salary ranges and averages for thousands of job titles using mainly government sources. (A detailed explanation of the methodology used to determine the specific job salaries can be found at *www.salaryexpert.com.*)

We welcome comments and input on both our proposed wage rates and our proposed crosswalks. We are particularly seeking any additional sources of reliable national pricing for the wages of staff types not included in the BLS. Anecdotal information regarding individual pay scales will not be particularly helpful for setting national rates, though such information could help with verification of other data. For those staff types that are included in the BLS, we would require data that is equally representative and valid in order to consider revising our proposed salaries.

The table below lists the clinical staff types whose input has been priced, the source for the data, the staff type crosswalk used, the proposed annual salary in 2001 dollars (using the Medicare Economic Index to convert 1999 salaries to 2001 dollars), the proposed cost per minute (including benefits) and the current cost per minute (including benefits) for comparison purposes. The proposed cost per minute was derived by dividing the annual salary by 2080 to arrive at the hourly wage rate and then again by 60 to arrive at the per minute cost. To account for the employers' cost of providing fringe benefits, such as sick leave, we used the same benefits multiplier of 1.366 used by Abt. The last column in the table refers to the numbered notes following the table that contain proposals regarding the pricing of the staff types and additional information as needed.

TABLE 2.—PROPOSED WAGE RATES FOR CPEP CLINICAL STAFF TYPES

Description	Source	Crosswalk	Mean yrly 2001	Proposed per minute	Current per minute	Note #
Physical Therapy Aide	BLS	Physical Therapist Aides	21,077.36	0.226	0.232	
Medical Assistant	BLS	Medical Assistants	23,680.67	0.254	0.162	1
Technical Aide	BLS	Medical Assistants	23,680.67	0.254	0.225	1
Medical Technician	BLS	Medical Assistants	23,680.67	0.254	0.225	1
EKG Technician	BLS	Medical Assistants	23,680.67	0.254	0.204	1
Anesthesia Technician	BLS	Medical Assistants	23,680.67	0.254	0.225	1
Technician	BLS	Medical Assistants	23,680.67	0.254	0.225	1
Cast Technician	BLS	Medical Assistants	23,680.67	0.254	0.177	1
LPN	BLS	Licensed Practical Nurses	30,340.53	0.325	0.267	
RN	BLS	Registered Nurses	46,493.56	0.498	0.422	
RN Cardiology	BLS	Registered Nurses	46,493.56	0.498	0.574	2
RN Oncology	BLS	Registered Nurses plus adjustment	54,862.40	0.587	0.497	2
Surgery Assistant	BLS	Surgical Technologists	28,814.09	0.308	0.326	3
Certified Surgical Technician	BLS	Surgical Technologists	28,814.09	0.308	0.262	
Lab Technician	BLS	Medical and Clinical Laboratory Technicians.	29,723.68	0.318	0.288	
Histotechnician	ASCP	Histologic Technologist	33,924.51	0.363	0.306	4
Electron Microscopy Technician	ASCP	Histologic Technologist	33,924.51	0.363	0.312	5
Cytotechnologist	BLS	Medical and Clinical Laboratory Technologists.	41,098.76	0.440	0.415	
EEG Technician	Salary Expert	Electroencephalographic Technician.	29,150.74	0.312	0.283	6
Electrodiagnostic Technologist	BLS	Electroneurodiagnostic Technologists.	33,529.31	0.359	0.302	6
Registered EEG Technologist	Current Rate	Registered EEG Technologist	37,645.00	0.403	0.403	6
Vascular Technician	BLS	Cardiovascular Technologists and Technicians.	34,794.37	0.372	0.351	7
Cardiovascular Technician	BLS	Cardiovascular Technologists and Technicians.	34,794.37	0.372	0.351	
Radiation Technologist	BLS	Radiologic Technologists and Technicians.	37,125.85	0.397	0.319	8
X-Ray Technologist	BLS	Radiologic Technologists and Technicians.	37,125.85	0.397	0.319	8
Angiographic Technician	BLS	Radiologic Technologists and Technicians.	37,125.85	0.397	0.351	9
CAT Scan Technician	BLS	Radiologic Technologists and Technicians.	37,125.85	0.397	0.319	9
MRI Technician	BLS	Radiologic Technologists and Technicians.	37,125.85	0.397	0.319	9
Nuclear Medicine Technician	BLS	Nuclear Medicine Technologists	44,360.73	0.475	0.392	
Nuclear Cardiology Technician	BLS	Nuclear Medicine Technologists	44,360.73	0.475	0.392	10
Ultrasound Technician	BLS	Diagnostic Medical Sonographers	45,751.26	0.490	0.389	11
Sonographer	BLS	Diagnostic Medical Sonographers	45,751.26	0.490	0.389	11
Cardiac Sonographer	BLS	Diagnostic Medical Sonographers	45,751.26	0.490	0.389	11
Radiation Technical Therapist	BLS	Radiation Therapists	45,333.05	0.485	0.404	
Dosimetrist	BLS	Radiation Therapists	45,333.05	0.485	0.500	
Physicist	AAHP	Certified Health Physicists	84,495.54	0.905	0.968	12
COT	X–WALK	Lab Technician	29,723.68	0.318	0.256	13
COMT	X–WALK	Histotechnician	33,924.51	0.363	0.278	13
Optician	BLS	Opticians, Dispensing	26,336.25	0.282	0.278	

TABLE 2.—PROPOSED WAGE RATES FOR CPEP CLINICAL STAFF TYPES—Continued

Description	Source	Crosswalk	Mean yrly 2001	Proposed per minute	Current per minute	Note #
Certified Retinal Angiographer	Salary Expert	Ophthalmic Photographer	35,453.04	0.380	0.351	14
Orthoptist	X–WALK	COMT	33,924.51	0.363	0.315	15
Respiratory Therapist	BLS	Respiratory Therapists	38,537.28	0.413	0.421	
Speech Pathologist	BLS	Speech-Language Pathologists	49,996.00	0.535	0.419	
Audiologist	BLS	Audiologists	47,748.17	0.511	0.411	
Registered Dietician	BLS	Dieticians and Nutritionists	39,049.57	0.418	0.365	
Counselor	BLS	Mental Health Counselors	30,769.18	0.329	0.422	

(1) We are proposing to collapse the medical assistant, technical aide, medical technician, EKG technician, anesthesia technician, technician, and cast technician staff types into a new staff type called, ''medical or technical assistant'' that will be priced at the medical assistant proposed wage rate per minute. This will represent an increased per minute rate for all the bundled staff types.

(2) We are proposing to bundle the staff type ''RN-cardiology'' into the staff type ''RN.'' RN-cardiology is used as the staff type for the pre- and post-service time of only three percutaneous valvuloplasty services, codes 92986, 92987 and 92990. We were unable to find any national salary data for the oncology certified nurse (OCN). In the absence of other information, we are adjusting the proposed wage rate to be 18 percent higher than the RN; this is the same differential that currently exists between these two staff types.

(3) We are proposing to bundle the staff type ''surgery assistant'', which is assigned to only 19 surgical services, into the staff type ''certified surgical technologist (CST)'', which is assigned to 133 services. It also appears that Abt mapped the averaged costs from a first assistant and certified scrub technician to the surgery assistant staff type, which does not appear to be the most appropriate crosswalk for the office setting.

(4) We used the average hourly rate for histologic technologists from the 1998 American Society of Clinical Pathologists' survey to propose a wage for the histotechnician staff type. This survey's average hourly rate of $12.90 for laboratory technician generally corresponds to our proposed rate of $13.67 and its average hourly rate of $19.00 for cytotechnologists almost matches our proposed rate of $18.90. Therefore, we believe that the $15.60 hourly rate we are proposing for the histotechnician maintains the current relativity between these laboratory staff types.

(5) We were unable to find any national salary data for the electron microscopy technician and, in the absence of such data, are crosswalking the salary from the wage rate for the histotechnician. This does represent an increase in the per minute cost for this staff type. However, we would welcome reliable national survey data from the specialty that we could use in pricing this staff type.

(6) We were only able to find direct BLS salary data for the electroneurodiagnostic technologist staff type. This information was contained in the BLS Occupational Outlook Handbook rather than in the listing of Occupational Employment Statistics where we found all other BLS data. We are proposing to crosswalk the corresponding salary from the Handbook to the electrodiagnostic technologist staff type. Data for the EEG technician came from the *Salary Expert.* We were unable to find any national salary data for registered EEG technologist (REEGT) and are proposing to maintain the current rate, since the speciality society recently recommended this rate of pay. However, we would also welcome reliable national survey data from the specialty that we could use in pricing these three levels of neurodiagnostic staff.

(7) We are proposing to bundle the vascular technician in with the cardiovascular technology staff type. Currently both are priced at the same rate.

(8) We are proposing to merge the x-ray technician and radiation technologist staff types, which are currently priced at the same rate, into a staff type called ''Radiologic Technologist.''

(9) Because we were unable to find any national survey data regarding the salaries for CAT scan technician, MRI technician, or angiographic technician, we are proposing to crosswalk these staff types to the BLS radiologic technologist pay scale. If there is a generally applied differential for these specialized radiologic technologists, we would welcome any reliable national survey data that would allow us to separately price these staff types.

(10) We are proposing to merge the nuclear cardiology technician in with the nuclear medicine technician staff type. Currently, both are priced at the same rate.

(11) We are proposing to merge the cardiac sonographer and the ultrasound technician into the sonographer staff type. Currently, all three are priced at the same rate.

(12) We are proposing to use the average salary data for all certified health physicists from the 1999 survey done by the American Academy of Health Physics and the American Board of Health Physics.

(13) We were unable to find representative national salary data for either the certified ophthalmic technician (COT) or the certified ophthalmic medical technologist (COMT). Until we can obtain such data, we are proposing to crosswalk the COT and COMT to the lab technician and histotechnician, respectively, since we believe that the skill and responsibility of these staff types would generally correspond. Again, we would welcome reliable and representative national salary data for these staff types.

(14) Data for our proposed salary for the certified retinal angiographer came from the *Salary Expert.* The position description for the ophthalmic photographer appeared to match the duties of a retinal angiographer: ''Photographs medical phenomena of eye to document diseases, surgeries, treatment and congenital problems * * * Injects contrast medium into vein of patient and photographs fluorescent dye as it flows through retina or iris vessels to obtain angiogram of eye * * *''

(15) In the absence of any national salary data for the orthoptist, we crosswalked the salary from that of the COMT, the highest level of ophthalmic medical personnel.

We are also proposing to delete those clinical staff that can bill separately from the list of CPEP staff types. We believe that these staff types are used as physician extenders and thus their salaries should not be considered as

practice expense. Therefore, we are proposing to substitute physical therapy aide for physical therapist, registered nurse for physician assistant, nurse practitioner and psychologist, and counselor for social worker. We are also proposing to delete as redundant the ophthalmic medical personnel (OMP) staff type and are substituting the COMT/COT/RN/CST blend that was suggested by the American Academy of Ophthalmology and recommended by the AMA's Relative Value Update Committee.

The CPEP clinical staff inputs also include blends of staff types that are used for those services where more than one type of clinical staff may be used in the performance of the service. We are proposing to establish the payment rates for these blends by calculating a simple average of the wage rates of the staff types included. The table below shows the blended staff types, the proposed cost per minute and the current cost per minute.

TABLE 3.—PROPOSED WAGE RATES FOR CPEP BLENDED CLINICAL STAFF TYPES

Current description	Proposed description	Proposed per minute	Current per minute
COMT/COT/RN/CST	Same	0.372	0.307
EKG Tech/MA	Medical or Technical Assistant (MTA)	0.254	0.183
EKG Tech/Med Tech	Medical or Technical Assistant (MTA)	0.254	0.214
Lab Tech/Histotech	Same	0.341	0.297
Lab Tech/Med Tech	Lab Tech/MTA	0.286	0.257
Optician/COMT	Same	0.323	0.278
RN/LPN	Same	0.412	0.389
RN/LPN/MA	RN/LPN/MTA	0.359	0.317
RN/LPN/MA/Tech	RN/LPN/MTA	0.359	0.269
RN/Med Tech/MA	RN/LPN/MTA	0.359	0.269
RN/OCN	Same	0.543	0.497
RN/PA/Cast Tech	RN/LPN/MTA	0.359	0.402
RN/Respiratory Therapist	Same	0.456	0.421
RN/Tech	RN/LPN/MTA	0.359	0.323
RN/Ultrasound Tech	RN/Sonographer	0.494	0.405
RN//MA	RN/LPN/MTA	0.359	0.326

Note: The proposed descriptions are based on our proposals on staff types from the previous table. We have eliminated the staff types we have proposed deleting from the above blends. We are also proposing to add LPN to the blend of an RN and a medical or technical assistant because we believe that if an RN and an assistant can perform a service, it is reasonable to assume that an LPN could as well.

Revision of the Ophthalmology Visit Supply Package

In its May 2000 submission to us, the RUC recommended the use of an ophthalmology visit supply package that would contain the routine supplies typically used in each 90-day global postsurgical visit for ophthalmology services. We accepted this recommendation. However, upon further review, we noted that two of the supplies—rev eyes and post myd spectacles—were not used in many of the postsurgical office visits. Therefore, after consulting with the ophthalmology specialty society, we are proposing to remove these two items from the ophthalmology visit package. Instead, we propose to include these items as appropriate on a code-by-code basis.

Deletion of Contrast Agents From the Practice Expense Inputs

Section 430(b) of BIPA amends section 1861(t)(1) of the Act to include contrast agents in the definition of drugs and biologicals. Previously, contrast agents were defined as supplies and were included in the list of CPEP supplies for the appropriate services. Therefore, we are proposing to delete the costs of the following contrast agents from our CPEP data—hypaque, methylene blue, high density barium, polibar, telopaque tablets, barium paste contrast, effervescent sparkies (fizzies) and renographin-60 iodinated contrast.

Physician Time

RUC Time Database

The primary sources for the physician time data used in creating the specialty-specific practice expense pools are the surveys performed for the initial establishment of the work RVUs and the surveys submitted to the AMA RUC. The AMA informed us that some of the times used for the November 1998 final rule (63 FR 58823) differed from the official RUC database, and we agreed to use the RUC-verified physician time database when we received it from the AMA. Subsequently, the AMA notified us that there were gaps in its own database for certain global surgery codes and that a revised time database would be sent to us once all the times were verified. We have now received this revised database and are proposing to use it in the calculation of the specialty-specific practice expense pools. It should be noted that the RUC database reflects the proposed physician times for those codes that were surveyed as part of the 5-year review of physician work.

c. Site-of-Service: Comments on Site of Service. In the November 2, 1998 final rule (63 FR 58830) and the November 2, 1999 final rule (64 FR 59407), we indicated the circumstances under which either the facility or the non-facility RVUs are used to calculate payment for a service. Specifically, we indicated that the lower facility practice expense RVUs apply when the service is performed in an Ambulatory Service Center (ASC) and the procedure is on the ASC-approved procedures list. The higher non-facility practice expense RVUs apply to procedures performed in an ASC that are not on the ASC-approved list because there will be no separate facility payment for these services. We have recently received a number of inquiries asking about the place-of-service that should be used on the Medicare claim when a service not on the ASC-approved procedures list is provided in an ASC. In these circumstances, physicians should indicate ASC as the place-of-service on the Medicare claim. Other questions have arisen as to whether a beneficiary can be billed the ASC facility fee when Medicare does not pay a facility fee because a procedure not on the ASC list is performed in a certified ASC. In this situation, Medicare pays the higher non-facility practice expense RVUs because the ASC is effectively serving as a physician's office, and Medicare's payment for the physician's service

includes payment for all practice expenses incurred in furnishing the service. The ASC benefit does not apply since the services do not meet the provisions of section 1833(i) of the Act. The services are covered as physicians' services and paid under the physician fee schedule. Therefore, payment to the physician reflects payment for the whole service, and the beneficiary cannot be charged in excess of the limiting charge for the physician fee schedule service.

B. Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists Performing Screening Sigmoidoscopies

On January 1, 1998, we implemented regulations at § 410.37(d) (Conditions for coverage of screening flexible sigmoidoscopies) requiring that screening flexible sigmoidoscopies be performed by a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act). Based on our review of current medical literature, we believe that there are other practitioners whose services are covered under Medicare who have been trained and are qualified to perform these procedures safely and accurately, such as nurse practitioners, clinical nurse specialists, and physician assistants.

A growing body of literature has shown that certain non-physician health care professionals can carry out screening by flexible sigmoidoscopy as accurately and safely as physicians when properly trained. This procedure requires fewer supervised examinations to attain objective measures of technical competency than other endoscopic procedures, does not require sedation, and has a low rate of related complications. In the studies reviewed, physician and non-physician endoscopists achieved similar polyp detection rates and depth of insertion in screenings performed independently. No significant complications from sigmoidoscopy were reported in any of these studies. The level of satisfaction with the procedure was similar for all practitioners.

Therefore, we are proposing to revise § 410.37(d) to provide that, in addition to medical doctors and doctors of osteopathy, physician assistants, nurse practitioners, and clinical nurse specialists also be allowed to perform screening flexible sigmoidoscopies for beneficiaries if they meet the applicable Medicare qualification requirements in §§ 410.74, 410.75, and 410.76, and if they are authorized to perform these services under State law.

C. Services and Supplies Incident to a Physician's Professional Services: Conditions

Section 1861(s)(2)(A) of the Act authorizes coverage of services and supplies (including drugs and biologicals that cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's service, of kinds which are commonly furnished in physicians' offices and are commonly either furnished without charge or included in the physician's bills. This statutory ''incident to'' benefit differs from the ''incident to'' benefit in the hospital setting as set forth in section 1861(s)(2)(B) of the Act, which authorizes coverage of hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to a physician's service furnished to outpatients and partial hospitalization services furnished to outpatients incident to a physician's service. This proposal only addresses the ''incident to'' benefit set forth in section 1861(s)(2)(A) of the Act.

In addition, the statute provides Medicare coverage of services incident to practitioners other than physicians. For example, section 1861(s)(2)(K) of the Act authorizes Medicare to pay for services incident to a service of a nurse practitioner or a physician assistant.

Section 2050 of the Medicare Carriers Manual (the manual) clarifies the coverage of services ''incident to'' physician services as described in section 1861(s)(2)(A) of the Act. Specifically, services incident to a physician service may be furnished by an employee of the physician. Alternatively, both the physician and the individual furnishing the ''incident to'' service must be employed by a common employer. Furthermore, the individual furnishing the ''incident to'' service may be any staff member working with the physician and not just one of the non-physician practitioners listed in section 1842(b)(18)(C) of the Act. We shall refer to these staff members as auxiliary personnel, a term which includes registered nurses and medical assistants.

Currently, our manual requires that the physician be either the employer of the auxiliary personnel or be an employee of the same entity that employs the auxiliary personnel. We note that, under our manual, auxiliary personnel may be either employees, leased employees, or independent contractors. An independent contractor relationship appears to be common current practice because it affords the auxiliary personnel the flexibility to work with various physicians or practitioners on a part-time basis. We do not believe that the nature of the employment relationship is critical for purposes of payment for services incident to the services of physicians and practitioners, so long as the auxiliary personnel reports to a physician or practitioner under the required level of supervision. We see no clinical reason to exclude independent contractor physicians and practitioners from the class of practitioners who can receive Medicare payment for services incident to their own services based solely on their status as independent contractors. Accordingly, we propose to allow auxiliary personnel to provide services incident to the services of physicians or practitioners who supervise them, regardless of the employment relationship. Thus, auxiliary personnel may be employees, leased employees, or independent contractors, and may provide services incident to the services of physicians and practitioners who employ or contract with them or who are employees or independent contractors of the same entity, provided that the other requirements for payment for ''incident to'' services are met. We note, however, that the employment relationship remains relevant under our rules prohibiting reassignment of Medicare benefits. (§§ 424.73 and 424.80) We also propose to codify the following definitions:

- *Auxiliary personnel* means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner).
- *Direct supervision* means the level of supervision by the physician (or other practitioner) of auxiliary personnel as defined in § 410.32(b)(3)(ii).
- *Independent contractor* means an individual who performs part-time or full-time work for which the individual receives an IRS–1099 form.
- *Leased employment* means an employment relationship that is recognized by applicable State law and that is established by two employers by a contract such that one employer hires the services of an employee of the other employer.
- *Noninstitutional setting* means all settings other than a hospital or skilled nursing facility.
- *Practitioner* means a non-physician practitioner who is authorized by the

Act to receive payment for services incident to his or her own services.

• *Services and supplies* means any service or supply (including any drug and biological that cannot be self-administered) that is included in section 1861(s)(2)(A) of the Act and is not specifically listed in the Act as a separate benefit included in the Medicare program.

We also propose to codify the provisions in section 2050 of the manual by revising § 410.26 to clarify the requirements for ''incident to'' services. Section 410.26 would be revised as follows:

• Services and supplies must be furnished in a noninstitutional setting to noninstitutional patients.

• Services and supplies must be an integral, although incidental, part of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness.

• Services and supplies must be commonly furnished without charge or included in the bill of a physician (or other practitioner).

• Services and supplies must be of a type that are commonly furnished in the office or clinic of a physician (or other practitioner).

• Services and supplies must be furnished under the direct supervision of the physician (or other practitioner).

• Services and supplies must be furnished by the physician, practitioner with an incident to benefit, or by auxiliary personnel.

• A physician (or other practitioner) may be an employee or an independent contractor.

• Drugs and biologicals are also subject to the limitations specified in § 410.29.

D. Anesthesia Services

Section 4048(b) of the Omnibus Budget Reconciliation Act of 1987 amended section 1842(b) of the Act and required us to establish a uniform relative value guide for use in all carrier localities in determining payment for anesthesia services furnished by physicians under Medicare Part B. In accordance with the law, the uniform relative value guide was designed so that Medicare payment for anesthesia services would not exceed the amount that would have occurred under the then-existing system of payment.

We implemented the uniform relative value guide in March 1989 and selected the 1988 American Society of Anesthesiologists' (ASA) Relative Value Guide as the basis for the uniform relative value guide. (For a discussion of this issue, please see the August 7, 1990 final rule (55 FR 32078).)

To determine base unit values, we used the 1988 ASA base unit values for each anesthesia code, except for codes 00142 (lens surgery) and 00147 (iridectomy). The base unit values for each of these codes were set at 4 units instead of the ASA values of 6 and 5 units, respectively.

The ASA has requested that we ensure that the anesthesia base units under our uniform relative value guide are the same as those listed in the ASA's most current guide. Standardization of base units between Medicare and the ASA guide will simplify billing by anesthesiologists. The ASA's base unit values for the following 8 codes are different than CMS's values:

Code	CMS	ASA
0081	6	5
00902	4	5
01150	8	10
01214	10	8
01432	5	6
01440	5	8
01770	8	6
01921	7	8

We are proposing to use the ASA base unit values from the 1999 guide beginning in CY 2002 for the above codes. However, the base unit values for codes 00142 and 00147 would remain at 4 units. The values for these codes were established by us under the ''inherent reasonableness'' process in 1987.

We would make an adjustment to the anesthesia conversion factor in 2001 so that payments would not exceed payments that would have been made using the current values. We currently estimate that this adjustment will be less than 0.5 percent.

E. Performance Measurement and Emerging Technology Codes

In modernizing the CPT, the AMA has developed two new categories of codes. In addition to the traditional codes for physicians' and other practitioners' services, referred to as Category I CPT codes, which are coded by five digit numbers, the new codes describe Performance Measures and Emerging Technologies and are coded with four digits followed by a letter.

The Performance Measure codes, referred to as Category II CPT codes, are intended to facilitate data collection. These codes are designed to decrease the need for review of medical records to document when services were performed. They allow practitioners to indicate in their billing records that the visit addressed issues that need to be tracked for quality and outcome measurement. For example, there is likely to be a code to indicate that a diabetic patient received a retinal examination. The visit that contained that specific service might have been reported with an evaluation and management code or with a more general ophthalmological service code and paid for based on the code selected. Thus, the performance measurement code is used only to assist the practitioner to specify that the performance measurement service was furnished. The syntax of this code will be four digits followed by the letter ''F.'' We are proposing that no values are placed on the Performance Measure codes and no additional payment is made for the use of these codes. Practitioners will, however, be able to list them on their Medicare bills, to facilitate the tracking of these services.

The Emerging Technology codes, referred to as Category III CPT codes, are intended to track new and emerging technologies. These codes were developed to facilitate data collection on and assessment of new services and procedures. These data could be used to document the use of services and procedures in the Food and Drug Administration approval process or while the efficacy of a procedure is being demonstrated. The syntax of these codes is four digits followed by the letter ''T.'' In general, these codes represent services that are still experimental or have unverified effectiveness and would not be covered services. Although we were concerned that codes with a ''T'' designation might be needed for use by some Medicaid programs, we now believe that we would be able to process claims with the ''T'' in the fifth digit. However, we propose not to provide payment for all of the Emerging Technology Codes. Rather, we would provide payment on a case-by-case basis only in specific situations when we determine that the codes represent services that are not, in fact, experimental, but have been shown to be safe and effective. If the coverage policy is not consistent with the existing tracking codes, a Medicare-specific code may need to be developed to allow payment for the service. Thus, we propose that only specific emerging technology codes will be recognized for Medicare payment.

F. Payment Policy for CPT Modifier 62 (Co-Surgery)

The CPT modifier code 62 is used to report the work of co-surgeons. Currently, if we pay for co-surgery, we pay a total of 125 percent of the fee schedule amount to the co-surgeons who each receive half of this total payment. This policy was established at the beginning of the fee schedule and

the level of payment reflected the predominant payment rate used by Medicare carriers at that time. Unlike other components of the fee schedule, this payment policy was not based on an analysis of the relative physician work effort for surgical services involving co-surgeons.

In addition, surgical practice has changed significantly over the past 10 years. For example, there is increasing use of noninvasive, minimally invasive, percutaneous, and endoscopic approaches to performing surgical procedures that were formerly performed as open procedures. Therefore, we are reviewing our payment policies for co-surgery to consider possible ways to ensure that they reflect current clinical practices and properly reflect the relative resources and work effort required to perform these services.

Among the issues we are considering are:

(1) Whether it would be possible to establish criteria for distinguishing the roles of a co-surgeon (when both surgeons are paid at 125 percent of the surgery amount) and assistant at surgery (when the total payment is 116 percent of the surgery amount);

(2) Whether any such criteria should vary by type of procedure (that is, open surgical, minimally invasive (including interventional procedures), and endoscopic procedures);

(3) Which procedures require a co-surgeon and under what circumstances should documentation be required for payment; and

(4) How to value the work performed by a co-surgeon.

While we are not making a specific proposal at this time, we will consider any information we receive to assist us in deciding whether to make a future proposal affecting payments for co-surgery.

III. Implementation of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Public Law 106–554), enacted on December 21, 2000, provides for revisions to policies applicable to the physician fee schedule. These revisions are presented below.

A. Screening Mammography

Medicare has paid for screening mammography since January 1, 1991. Section 1834(c) of the Act governing these screenings did not include screening mammography under the physician fee schedule and required payment using a different methodology. As stated in § 405.534, Medicare payment for screening mammography currently equals the lesser of the following: the actual charge for the service; the applicable amount under the physician fee schedule in an area for a bilateral diagnostic mammogram; or $55, a figure specified in section 1834(c)(3) of the Act, updated since 1991 by the Medicare Economic Index (MEI). In 2001, the statutory payment limit for screening mammography is $69.23. In most cases, payment for screening mammography is made at the national limit with no differences among geographical areas.

Section 104 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) amends section 1848(j)(3) of the Act to include screening mammography as a physician service for which payment is made under the physician fee schedule beginning January 1, 2002. We are proposing to amend §§ 405.534 and 405.535 to reflect the inclusion of screening mammography as a physician service which will be payable under the physician fee schedule. In addition, we are amending § 414.2 to include screening mammography under the definition for physicians' services. In accordance with part 414, payments for screening mammography will be resource-based and will have geographic adjustments that reflect cost differences among areas as do all other services under the physician fee schedule, including diagnostic mammography. The following is a discussion of our proposed RVUs for the professional and technical components (PC and TC) of a screening mammography, code 76092, under the physician fee schedule.

Professional Component

We are proposing to establish physician work RVUs=0.70. This value is equal to the proposed work RVUs from the 5-year review of physician work for code 76090, unilateral diagnostic mammogram. Due to the comparable number of views taken in both a unilateral diagnostic mammography and a screening mammography, we believe the physician work associated with the performance of screening mammography is similar to the physician work associated with unilateral diagnostic mammography.

We note that in the June 8, 2001 proposed notice on the 5-year review of work RVUs (66 FR 31028), we proposed to increase the work RVUs for unilateral diagnostic mammography from 0.58 to 0.70 RVUs, an increase of 21 percent. Additionally, we are proposing to increase the work RVUs for bilateral diagnostic mammography from 0.69 to 0.87 RVUs, an increase of 26 percent. Both of these increases would be effective for services performed on or after January 1, 2002. Our proposal to establish physician work RVUs for screening mammography equal to the physician work RVUs for unilateral diagnostic mammography, since both involve a four view film study, incorporates the increases we have proposed in the June 8, 2001 proposed notice.

We also believe that the practice expense and malpractice expense for the professional component of screening mammography is similar to the professional component of unilateral diagnostic mammography. As a result, we are proposing 0.25 practice expense RVUs and 0.03 malpractice RVUs for the PC of screening mammography. These proposed RVUs reflect changes to the practice expense RVUs for code 76090.

Technical Component

We propose valuing the technical component of screening mammography using a methodology that updates the original statutory limit for the technical component of screening mammography of $37.40, by the cumulative increase in physician fee schedule rates between 1992 and 2001. While screening mammography payments increased through application of the MEI between 1992 and 2001, resulting in a cumulative increase of 25.9 percent, physician fee schedule payments increased by 35.6 percent during this period. As a result, increasing payment for screening mammography by the statutory limit led to lower payment than if payment for the procedure had increased at the same rate as physician fee schedule services.

We propose updating the technical component of the initial screening mammography statutory limit of $37.40 by the same update factor that would have applied if screening mammography had received the same increases as physician fee schedule services. Currently, payment for the technical component of a screening mammography is equal to 68 percent of the statutory payment limit. To update the current value, we took 68 percent of the original $55 payment limit and increased it by 35.6 percent ($55 $\times$ 0.68 $\times$ 1.356 = $50.70). We divided this figure by the 2001 physician fee schedule CF of $38.2581 to determine total RVUs of 1.33. Since the TC is comprised only of practice and malpractice RVUs, we then used the

practice expense and malpractice expense percentages for the TC of unilateral diagnostic mammography (95.3 and 4.7 percent, respectively) to determine the practice expense and malpractice RVUs for the technical component of screening mammography. We multiplied the total RVUs of 1.33 by 0.953 to determine the proposed practice expense RVUs of 1.27 and by 0.047 to determine the proposed malpractice expense RVUs of 0.06.

Overall, the proposed total RVUs associated with the combined PC and TC of code 76092 are 2.31 (0.70 work RVUs, 1.52 practice expense RVUs, and 0.09 malpractice expense RVUs). These proposed RVUs would result in a payment for CY 2002 of approximately $88.50, before application of any geographic adjustments.

New Technology Mammography

The BIPA requires us to determine whether the assignment of new HCPCS codes is appropriate for both screening and diagnostic mammography using new technologies. If new codes are appropriate, the provision requires us to provide for their use beginning January 1, 2002. The provision defines new technology mammography to be an advance in technology with respect to the test or equipment that results in: (a) A significant increase or decrease in the resources used in the test or in the manufacture of the equipment; (b) a significant improvement in the performance of the test or equipment; or (c) a significant advance in medical technology that is expected to significantly improve the treatment of Medicare beneficiaries.

Before January 1, 2002, the BIPA provides for temporary payment amounts during the period April 1, 2001 to December 31, 2001 for two types of new technology mammography used in both diagnostic and screening procedures. The BIPA specifies that payment for technologies that directly take digital images would equal 150 percent of the amount that would otherwise be paid for bilateral diagnostic mammography. The BIPA also specifies that for technologies that convert standard film to a digital form which is then analyzed, payment would be equal to the statutory screening mammography limit for CY 2001, plus an additional payment of $15.00. Moreover, the BIPA specifies that the same payment amount be used for a screening or diagnostic procedure for each of the new technologies. We have implemented the temporary payment provisions via a Program Memorandum sent to Medicare carriers on February 1, 2000.

We believe that new HCPCS codes are appropriate for new technology mammography beginning with January 1, 2002 and propose codes to be used with the associated RVUs described below. We propose to establish three separate codes for directly taking a digital image (one for screening and one each for unilateral and bilateral diagnostic). Our approach would establish a single add-on code for computer-aided diagnosis with conversion of standard film images to digital images. At the present time, the FDA has approved computer-aided diagnosis only for use in conjunction with standard film screening mammography. Thus, at the present time, our proposal would only allow Gxxx4 to be billed as an add-on to 76090 if medically necessary. In the section that follows, we discuss the proposed coding and payment methodologies for new technology mammography.

Screening mammography, direct digital image (Gxxx1). We propose to use HCPCS code Gxxx1 to report screening mammography performed using direct digital images as opposed to mammography that is performed using the standard film images associated with code 76092, or conversion of a standard film image to a digital image. (**Note:** Gxxx is used as a placeholder; the actual ''G'' code designation for payment will be included in the final rule.)

We believe that the physician work and malpractice expense associated with both the PC and TC of HCPCS code Gxxx1 are analogous to the professional and technical components of CPT code 76092. (**Note:** Proposed work RVUs for code 76092, discussed above, are being increased to 0.70.) However, because the equipment involved with direct digital images is different from the equipment involved with standard film images, we believe that the practice expense RVUs are different than the practice expense RVUs for code 76092. Thus, we are proposing to value the practice expense for the PC of this service using the methodology for determining resource-based practice expense RVUs. We are proposing to value the practice expense RVUs for the TC of the service using the practice expense methodology for the ''zero work pool.'' (For more information about the practice expense methodology for PC and TC services, see the November 2, 1998 final rule (63 FR 58817).

For the PC of HCPCS code Gxxx1, we propose 0.70 work RVUs, 0.28 practice expense RVUs, and 0.03 malpractice expense RVUs. For the TC of HCPCS code Gxxx1, for which there is no physician work associated, we propose 2.50 practice expense RVUs and 0.06 malpractice RVUs. Please see Table 4 below for a summary of all component RVUs associated with this and other mammography services.

Diagnostic mammography, unilateral, direct digital image (Gxxx2). We propose to use HCPCS code Gxxx2 to report unilateral diagnostic mammography performed using direct digital images as opposed to mammography performed using the standard film images associated with code 76090, or conversion of a standard film image to a digital image.

We believe that the physician work and malpractice expense associated with both the PC and TC of HCPCS code Gxxx2 are analogous to the PC and TC of code 76090. (**Note:** Proposed work RVUs for code 76090, discussed above, are being increased to 0.70). However, because the equipment involved with direct digital images is different from the equipment involved with standard film images, we believe that the practice expense RVUs are different than those for code 76090. Thus, we are proposing to value the practice expense for the PC of this service using the methodology for determining resource-based practice expense RVUs. We are proposing to value the practice expense RVUs for the TC of the service using the practice expense methodology for the ''zero work pool.''

For the professional component of HCPCS code Gxxx2, we propose 0.70 work RVUs, 0.28 practice expense RVUs, and 0.03 malpractice expense RVUs. For the TC of HCPCS code Gxxx2, for which there is no physician work associated, we propose 1.99 practice expense RVUs and 0.05 malpractice expense RVUs. Please see Table 4 below for a summary of all component RVUs associated with this and other mammography services.

Diagnostic mammography, bilateral, direct digital image (Gxxx3). We propose to use HCPCS code Gxxx3 to report bilateral diagnostic mammography that is performed using direct digital images as opposed to mammography performed using the standard film images associated with code 76091, or conversion of a standard film image to a digital image.

We believe that the physician work and malpractice expenses associated with both the PC and TC of HCPCS code Gxxx3 are analogous to the PC and TC of code 76091. (**Note:** Proposed work RVUs for code 76091, discussed above, are being increased to 0.87). However, because the equipment involved with direct digital images is different from the equipment involved with standard

film images, we believe that the practice expense RVUs are different than those for code 76091. Thus, we are proposing to value the practice expense for the PC of this service using the methodology for determining resource-based practice expense RVUs. The practice expense RVUs for the TC of the service are being valued using the practice expense methodology for the ''zero work pool.''

For the PC of HCPCS code Gxxx3, we propose 0.87 work RVUs, 0.34 practice expense RVUs, and 0.03 malpractice expense RVUs. For the TC of HCPCS code Gxxx3, with which there is no physician work associated, we propose 2.47 practice expense RVUs and 0.06 malpractice expense RVUs. Please see Table 4 below for a summary of all component relative values associated with this and other mammography services.

Computer-aided detection, conversion of standard film images to digital images (HCPCS Code Gxxx4). We propose to use HCPCS code Gxxx4 to report conversion of standard film images to digital images when used in conjunction with computer-aided diagnosis software.

We propose establishing HCPCS code Gxxx4 as an add-on code that can be billed only in conjunction with the primary service, code 76092. At this time, we understand that the only FDA-approved use of the computer-aided diagnosis mammography software is with screening film images. If there are other FDA-approved uses of computer-aided diagnosis, we allow for use of Gxxx4 as an add-on to other mammography services. We believe that the physician work associated with CPT code 76375, *Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computerized tomography, magnetic resonance imaging, or other tomographic modality*, is comparable, per unit of time, to the physician work of Gxxx4. We have determined that the physician time associated with HCPCS code Gxxx4 is approximately 1/3 of the physician time associated with CPT code 76375. Using this relationship, we propose 0.06 work relative value units for HCPCS code Gxxx4. Additionally, we believe the malpractice expense RVUs for HCPCS code Gxxx4 are analogous to a level two established office visit, CPT code 99212. However, we believe that the practice expense RVUs for HCPCS code Gxxx4 are markedly different from either of the two aforementioned services; therefore, we are valuing the PC of this service using the methodology for determining resource-based practice expense RVUs. The TC of the service is being valued using the practice expense methodology for the ''zero work pool.''

For the PC of code Gxxx4, we propose 0.06 work RVUs, 0.02 practice expense RVUs, and 0.01 malpractice expense RVUs. For the TC of HCPCS code Gxxx4, with which there is no physician work associated, we propose 0.41 practice expense RVUs and 0.01 malpractice expense RVUs. Table 4 below summarizes all component RVUs associated with this and other mammography services.

TABLE 4.—PROPOSED RVUS FOR MAMMOGRAPHY SERVICES

Code	Modifier	Work	Practice expense	Malpractice	Total
76090	.....	0.70	1.28	0.08	2.06
76090	26	0.70	0.24	0.03	0.97
76090	TC	0.00	1.04	0.05	1.09
76091	.....	0.87	1.59	0.09	2.55
76091	26	0.87	0.30	0.03	1.20
76091	TC	0.00	1.29	0.06	1.35
76092	.....	0.70	1.52	0.09	2.31
76092	26	0.70	0.25	0.03	0.98
76092	TC	0.00	1.27	0.06	1.33
Gxxx1	.....	0.70	2.78	0.09	3.57
Gxxx1	26	0.70	0.28	0.03	1.01
Gxxx1	TC	0.00	2.50	0.06	2.56
Gxxx2	.....	0.70	2.27	0.08	3.05
Gxxx2	26	0.70	0.28	0.03	1.01
Gxxx2	TC	0.00	1.99	0.05	2.04
Gxxx3	.....	0.87	2.81	0.09	3.77
Gxxx3	26	0.87	0.34	0.03	1.24
Gxxx3	TC	0.00	2.47	0.06	2.53
Gxxx4	.....	0.06	0.43	0.02	0.51
Gxxx4	26	0.06	0.02	0.01	0.09
Gxxx4	TC	0.00	0.41	0.01	0.42

B. Screening Pelvic Examinations

Before the enactment of the BIPA, section 1861(nn)(2) of the Act authorized Medicare coverage for a screening pelvic examination (including a clinical breast examination) furnished to a woman for the purpose of early detection of cervical or vaginal cancer once every 3 years, or once every year for a woman who is at high risk for one of these conditions, or who is of childbearing age and meets certain other requirements.

Section 101 of the BIPA amends section 1861(nn)(2) of the Act (effective July 1, 2001) to provide that a woman who does not qualify for annual coverage of a screening pelvic examination under one of the statutory exceptions, qualifies for coverage of a screening pelvic examination (including a clinical breast examination) once every 2 years rather than once every 3 years.

We are conforming § 410.56 (Screening Pelvic Examinations) of the regulations to the new statutory provision that has been implemented through sections 4603, 3628.1 and 4731 of the Medicare Carrier Manual, the Medicare Intermediary Manual, and the Medicare Hospital Manual, respectively.

C. Screening for Glaucoma

Section 102 of BIPA provides for Medicare coverage under Part B for screening for glaucoma for individuals with diabetes, a family history of glaucoma, or others determined to be at ''high risk'' for glaucoma effective for services furnished on or after January 1,

2002. The statute provides for coverage of glaucoma screening, including (1) a dilated eye examination with an intraocular pressure measurement, and (2) a direct ophthalmoscopy or a slit-lamp biomicroscopic examination, subject to certain frequency and other limitations.

Currently, Medicare coverage policy allows for payment for examinations to diagnose glaucoma and related medically necessary services that are furnished to beneficiaries. Under this policy, diagnostic glaucoma tests are covered if they are medically necessary to evaluate a specific complaint or symptom that might indicate glaucoma or to monitor an existing medical condition of an individual who has had a history of elevated intraocular pressure or other signs of possible glaucoma. This coverage is based on sections 1861(s)(1) and (s)(3) of the Act. Section 1861(s)(1) of the Act provides for general Medicare coverage of physicians' services, including a physician's interpretation of the results of tests performed. Section 1861(s)(3) of the Act provides for general Medicare coverage of diagnostic x-ray, clinical laboratory, and other diagnostic tests. Before the enactment of the BIPA, screening for glaucoma was excluded from coverage based on § 411.15 (Particular services excluded from coverage), paragraphs (a) and (k).

To conform our regulations to the statutory requirements of the BIPA, we are specifying an exception to the list of examples of routine physical checkups excluded from coverage in §§ 411.15(a)(1) and 411.15(k)(9) for glaucoma screening examinations that meet the frequency limitation and the conditions for coverage that we are specifying under new § 410.23 (Screening for Glaucoma: Conditions for and Limitations on Coverage). Coverage of glaucoma screening is provided under Medicare Part B only. As provided in the statute, this new coverage allows payment for one glaucoma screening examination every year. We are proposing to add new § 410.23 (Screening for Glaucoma: Conditions for and Limitations on Coverage), to provide for coverage of the various types of glaucoma screening examinations specified in the statute. We are proposing several definitions of terms that would be included to implement the statutory provisions and to help the reader in understanding the provisions of the regulation. These include definitions of the following terms: (1) Screening for glaucoma, (2) eligible beneficiaries, and (3) direct supervision.

Section 102(b) of the BIPA defines the term ''screening for glaucoma'' to mean a dilated eye examination with an intraocular pressure measurement and a direct ophthalmoscopy or a slit-lamp biomicroscopic examination for the early detection of glaucoma. This section also provides that the screening examinations that are to be covered under Medicare are to be furnished by or under the direct supervision of an optometrist or ophthalmologist who is legally authorized to furnish these services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished. These are services that would otherwise be covered if furnished by a physician or as incident to a physician's professional service.

Section 102(a) of BIPA also provides that coverage of screening for glaucoma services will be available only for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma and individuals with diabetes. Based on our review of the medical literature, and consultation with staff of the National Eye Institute and representatives of the American Academy of Ophthalmology and the American Optometric Association, we are proposing to interpret the statutory language, ''individuals determined to be at high risk for glaucoma'' to include Medicare beneficiaries who are African-Americans age 50 and over. While the National Eye Institute and others have provided us with information indicating that age and other factors may place a Medicare beneficiary at increased risk for glaucoma, we believe that the medical evidence available at this time is only sufficient to support inclusion of African-Americans age 50 and over in the statutory ''high risk'' category, in addition to individuals with diabetes and those with a family history of glaucoma who are covered separately under the new screening benefit. Studies have shown that the prevalence of glaucoma increases with age and is four to five times more likely to occur in African-Americans than in Caucasians. (Tielsch et al. JAMA 1991; Quigley. NEJM 1997) For African-Americans, the evidence indicates that the onset of the disease comes at an earlier age, and that the damage is more severe at the time of diagnosis. In view of the possibility that it may be appropriate to include other individuals in the statutory definition of those at ''high risk'' for glaucoma, however, we are requesting public comments on this issue. Specifically, we ask that anyone providing us with specific recommendations on this issue should provide documentation in support of them from the medical literature. In addition, we are proposing to use the term ''eligible beneficiaries'' to indicate who may qualify for the new screening glaucoma benefit, and we are proposing to define that term to include: (1) Individuals with diabetes mellitus, (2) individuals with a family history of glaucoma, and (3) African-Americans age 50 and over.

Section 102(b) of the BIPA also provides that the glaucoma screening examination is to be furnished by or under the direct supervision of an ophthalmologist or optometrist who is legally authorized to furnish such services under State law or regulation in which the services are furnished. We are proposing to define the term ''direct supervision'' as that term is defined in § 410.32(b)(3)(ii) for purposes of the oversight of covered diagnostic laboratory services as they are performed in the office setting. Specifically, we are proposing that the term ''direct supervision'' be defined to mean that the ophthalmologist or optometrist must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. The proposed definition states that the term ''direct supervision'' does not mean the physician must be present in the room when the procedure is performed.

Payment for Glaucoma Screening

We believe that services provided as part of glaucoma screening will often overlap other services a physician provides during a patient encounter as part of basic ophthalmological services and will result in no additional work or practice expense. Therefore, we propose bundling payment for glaucoma screening when it is provided on the same day as an evaluation and management (E/M) service, or when it is provided as part of any ophthalmology service. When glaucoma screening is the only service provided, or when it is provided as part of an otherwise noncovered service (for example, CPT 99397, preventive services visit), we propose to establish the following HCPCS codes and payments:

Gxxx5, Glaucoma Screening Furnished by a Physician for High Risk Patients

For physician work and for malpractice, we propose crosswalking this new HCPCS code to a level II E/M code, CPT 99212, which we believe represents a comparable level of work. The proposed work and malpractice RVUs are 0.45 and 0.02, respectively.

Gxxx6, Glaucoma Screening Furnished Under the Direct Supervision of a Physician for High Risk Patients

For physician work and for malpractice, we propose crosswalking this new HCPCS code to the lowest level E/M code, CPT 99211, which we believe represents a comparable level of work. The proposed work and malpractice RVUs are 0.17 and 0.01, respectively.

For non-facility settings, we propose the following practice expense inputs for both of the above HCPCS Codes:

clinical staff time-certified ophthalmic medical technologist/certified ophthalmic technician/registered nurse: five minutes;
equipment: screening lane; and
supplies: ophthalmology visit supply package.

D. Screening Colonoscopy

Before the enactment of the BIPA, sections 1861(pp)(1)(C) and 1834(d)(3)(E) of the Act authorized Medicare coverage of screening colonoscopies once every 2 years for individuals at high risk for colorectal cancer. Individuals not at high risk for colorectal cancer did not qualify for coverage of screening colonoscopies under the colorectal cancer screening benefit, but they did qualify for coverage of other colorectal cancer screening examinations specified in the statute. These other examinations that were covered for individuals not at high risk for colorectal cancer included screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening barium enema examinations at certain frequency intervals specified in the statute and the regulations at § 410.37 (Colorectal cancer screening tests).

Section 103 of the BIPA amended sections 1861(pp)(1)(C), 1834(d)(2)(E)(ii), and 1834(d)(3)(F) of the Act to add coverage of screening colonoscopies once every 10 years for individuals not at high risk for colorectal cancer. However, in the case of an individual who is not at high risk for colorectal cancer, but who has had a screening flexible sigmoidoscopy within the last 4 years, the statute provides that payment may be made for a screening colonoscopy only after at least 47 months have passed following the month in which the last screening flexible sigmoidoscopy was performed. In addition, the statute provides that in the case of an individual who is not at high risk for colorectal cancer but who does have a screening colonoscopy performed on or after July 1, 2001, payment may be made for a screening flexible sigmoidoscopy only after at least 119 months have passed following the month in which the last screening colonoscopy was performed.

In view of the statutory changes, we are conforming §§ 410.37(e) and 410.37(g) (related to limitations on coverage of screening colonoscopies and screening flexible sigmoidoscopies) to make them consistent with the new provisions of the statute that have been implemented through manual provisions of the Medicare Carriers Manual, the Medicare Intermediary Manual Part III, and the Medicare Hospital Manual in transmittal numbers 6097, 1824, and 7069, respectively, in February 2001.

Payment for Screening Colonoscopy

Payment for screening colonoscopy will be made under HCPCS code G0121: colorectal screening; colonoscopy for an individual not meeting criteria for high risk. As with current code G0105, screening colonoscopy for an individual at high risk, payment will be made at the level for a diagnostic colonoscopy, CPT code 45378, because the work is the same whether a procedure is screening or diagnostic. As the statute requires for both individuals who are or are not at high risk, if, during the course of the screening colonoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as colonoscopy with biopsy or removal should be billed and paid rather than HCPCS code G0105 or G0121.

E. Medical Nutrition Therapy

1. Legislation

Section 105 of the BIPA amended section 1861(s)(2) of the Act to authorize Medicare Part B coverage under Part B of medical nutrition therapy (MNT) for beneficiaries who have diabetes or renal disease, effective for services furnished on or after January 1, 2002. The legislation also:

- Authorizes dietitians and nutritionists who meet certain qualifications to be reimbursed directly by Medicare.
- Excludes from coverage beneficiaries who are receiving maintenance dialysis for which payment is made under section 1881 of the Act.
- Requires coordination of medical nutrition therapy benefits with the existing benefit for diabetes outpatient self-management training services.
- Defines a registered dietitian or other nutrition professional, and grandfathers dietitians or nutrition professionals who were licensed or certified in their States as of December 21, 2000, but would not otherwise meet the new requirements.
- Specifies that Medicare payment for MNT services must equal 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the physician fee schedule for the same services if furnished by a physician.
- Requires that we submit a report to the Congress by July 1, 2003, that contains recommendations with respect to expansion of the MNT benefit for other medical conditions.

This new benefit, while related, differs from the diabetes outpatient self-management training (DSMT) benefit, which was established by the BBA in section 1861(s)(2)(S) of the Act and described at section 1861(qq). The DSMT benefit is a comprehensive diabetes training program, of which nutrition training is only one component. Most of the available research (Diabetes Control and Complication Trial Research Group, 1993; UK Prospective Diabetes Study Group, 1995; and UK Prospective Diabetes Study Group, 1998) supports the use of a multi-disciplinary approach to diabetes, which includes nutrition training. As a result, nutrition training is considered to be an essential element of the DSMT benefit. Section 1861(qq) of the Act mandates the use of quality standards for DSMT and allows certified individuals or entities designated by the Secretary that meet such standards to receive Medicare payment for the service, provided that the physician managing the patient certified that DSMT is needed.

The approach in the BIPA with regard to MNT is different. The statute mandates specific qualifications regarding who may provide MNT services, but does not require that we establish quality standards. We are also instructed by the Congress to establish criteria for recognition of individuals in States that do not have licensure or certification requirements for registered dietitians or nutrition professionals.

We set specific duration and frequency limits for DSMT, consistent with the statutory authority granted by the BBA. In accordance with our regulations in § 410.141(c), all beneficiaries receiving the DSMT benefit may have up to 10 hours of initial training within a continuous 12-month period. For most beneficiaries, 9 of these 10 hours of training must be in a group setting. One hour of training may be on an individual basis for purposes of conducting an individual assessment and providing specialized training. Once a beneficiary has completed the 10 hours of initial

training, the benefit provides for up to 2 hours of follow-up training each subsequent year. As with the DSMT benefit the duration and frequency of the MNT benefit was not prescribed by the Congress. However, since the Congress has indicated that beneficiaries who have received DSMT within a designated time period (to be specified by the Secretary) are not eligible for MNT, the two benefits must be coordinated.

2. Proposed Policy

Consistent with section 105(a)(3) of the BIPA, we considered the protocols of the American Dietetic Association and the National Kidney Foundation regarding nutrition training for both diabetes and renal disease. Because the protocols were inconclusive with respect to the duration and frequency issues, we are proposing to determine the duration and frequency of the benefit through the National Coverage Determination (NCD) process rather than through the rulemaking process. We will solicit the opinions of all interested parties as a part of the NCD process.

We propose to set forth the provisions regarding medical nutrition therapy at Part 410, subpart G and at § 414.64. The MNT provisions of the proposed rule are as follows:

Definitions (§ 410.130). We propose to define ''renal disease'' for the purpose of this benefit as only chronic renal insufficiency and post-transplant care provided after discharge from the hospital. The exclusion of patients receiving maintenance dialysis under section 1881 of the Act is consistent with section 1861(s)(2) of the Act, as amended by section 105(a)(3) of the BIPA. We propose to limit post-transplant care to care furnished within 6 months after discharge from the hospital, if the transplant is viable and effective, because under such conditions we believe the beneficiary would no longer have renal disease and would not be eligible to receive the benefit under the statutory provision. We propose a 6-month time period based on expert opinions. We specifically request comments on this proposed time period and request that commenters submit articles from clinical journals to support their comments. We do not make separate payments for MNT while the beneficiary is an inpatient in the hospital because the statute only authorizes payment for this service under Part B. We are proposing definitions of ''diabetes'' and ''chronic renal insufficiency'' for the purpose of this benefit using definitions from the Institute of Medicine report, ''The Role of Nutrition in Maintaining Health in the Nation's Elderly,'' published in 2000.

We propose to define ''episode of care'' as a time period that may not exceed 12 months, starting with the assessment (based on a referral from a physician), and including all covered interventions. The number of episodes of care covered during the lifetime of an individual beneficiary is unlimited. We chose a 12-month period to allow for the coordination of the MNT and DSMT benefits, as authorized by section 105(a)(3) of the BIPA.

Finally, in accordance with the statute, we define MNT services as nutritional diagnostic, therapy, and counseling services provided by a registered dietitian or nutrition professional for the purpose of managing disease. This definition tracks the language of the statute.

Medical Nutrition Therapy (§ 410.132).

At proposed § 410.132(a), we set forth conditions for coverage of MNT services. Specifically, we provide that Medicare Part B pays for MNT services furnished by a registered dietitian or nutrition professional as defined in § 410.134 when the beneficiary is referred for the service by the beneficiary's treating physician. We limit the definition of physician to ''treating physician'' to ensure that the physician establishing the need for MNT is actually treating the beneficiary for the chronic disease and the therapy is coordinated with the care being provided by the treating physician. Referrals by a non-treating physician might also be interpreted as an indication that a fraudulent situation exists.

We are proposing that the services covered will consist of nutritional assessment, interventions, reassessment, and follow-up interventions. We chose not to define the specific components of the benefit in more detail because we anticipate that registered dietitians and nutritionists will use nationally recognized protocols, such as those developed by the American Dietetic Association (ADA) as they normally would in their business practice. We also chose not to specify the number of hours of MNT that will be covered. Rather, we will develop these frequency limits using the NCD process. After we complete a literature review, we will solicit input from interested parties as part of the NCD process.

At § 410.132(b), we set forth proposed coverage limitations for MNT services. In accordance with section 1861(s)(2)(V)(ii) of the Act, we would provide that MNT services are not covered for beneficiaries on dialysis for end-stage renal disease. We do not exclude all beneficiaries who are diagnosed with end-stage renal disease because a few individuals with end-stage renal disease do not receive maintenance dialysis and the statute specifically excludes beneficiaries receiving maintenance dialysis under section 1881 of the Act. The other provisions of this section would coordinate the referrals for MNT for diabetes and renal disease, and coordinate MNT services with DSMT services as follows:

- If a beneficiary has both diabetes and a renal disease as defined in this subpart, the beneficiary may receive both MNT and DSMT, but coverage in any 12-month period would be limited to the number of hours the beneficiary would receive under either the MNT benefit or the DSMT benefit for that period, whichever is greater.
- MNT would only be covered if the beneficiary had not started initial training under the diabetes self-management training benefit (as described in § 410.141) within the past 12 months, unless: (1) the need for a reassessment had been documented by the referring physician; or (2) the beneficiary had been diagnosed with both diabetes and renal disease.
- If a beneficiary diagnosed with diabetes was referred for both follow-up DSMT services and MNT, the beneficiary would only receive the total amount of hours covered under either follow-up DSMT services or MNT, whichever was greater.

If DSMT and MNT benefits overlapped, we would not allow the number of hours covered under the MNT benefit to exceed the hours Medicare would cover if the beneficiary was only receiving DSMT, except if a beneficiary receiving initial DSMT subsequently was diagnosed with renal disease or if there was a change in diagnosis or medical condition that occurred during an episode of care. We would allow additional hours of coverage for patients with renal disease and diabetes because MNT for renal disease is more complex than MNT for diabetes alone.

Eligibility for MNT services would be dependent upon diagnoses and referrals made by the treating physician. At proposed § 410.132(c), we provide that referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease, with documentation maintained by the referring physician in the beneficiary's medical record. Referrals must be made for each episode of care. We note that the statute

specifies that a physician, as defined in section 1861(r)(1) of the Act, must refer the beneficiary in order for the therapy to be covered. We are proposing to limit referrals to those made by the treating physician as noted earlier.

At proposed § 410.132(d), we set forth requirements regarding reassessment and follow-up interventions. Specifically, we provide that reassessments and follow-up interventions would only be covered when the referring physician determines that there was a change of diagnosis or medical condition within an episode of care that made a change in diet necessary.

Provider Qualifications (§ 410.134). BIPA specifies how we must define ''registered dietitian or nutrition professional'' for the purposes of this benefit and allows for the grandfathering of nutrition professionals licensed or certified by States at the time of BIPA's enactment. Pursuant to BIPA, a registered dietitian or nutrition professional means an individual who meets the following criteria:

- Holds a bachelor's or higher degree granted by a regionally accredited ollege or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization we have recognized for this purpose.
- Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
- Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed, or, if a State does not provide for licensure or certification, meets other criteria established by the Secretary.

We propose to exercise our statutory discretion, with respect to such alternative criteria, by providing that in States that do not provide licensure or certification requirements, we would use the designation of ''registered dietitian'' as certified by the Commission on Dietetic Registration, the credentialing agency for the American Dietetic Association; or require compliance with the statutory educational and experience requirements alone. The Commission on Dietetic Registration is currently considered to be the recognized standard in certification programs for registered dietitians. If an individual can supply documentation to us that he/she is a ''registered dietitian,'' we would not require that individual to also supply documentation that he/she meets the minimum statutory educational and experience requirements, because these latter requirements are also requirements an individual must currently meet to become a ''registered dietitian.'' Likewise, if an individual supplies documentation to us that he/she meets the minimum statutory educational and experience requirements, that individual would not need to supply documentation to us that he/she is a ''registered dietitian.''

The statute also requires that an individual who, as of December 21, 2000 (BIPA's date of enactment), is licensed or certified under the law of the State in which the services are performed as a dietitian or nutrition professional, qualifies as a ''registered dietitian or nutrition professional'' even if he or she does not meet the other education and experience requirements. There is no provision in the law to allow grandfathering of dietitian or nutrition professionals in States with no licensure or certification requirements, or of individuals who did not choose to be licensed or credentialed as of the date of enactment of section 1861(vv)(3) of the Act. Therefore, we only provide for ''grandfathering'' of individuals who do meet the specific criteria of section 1861(vv)(3) of the Act.

Payment for Medical Nutrition Therapy (§ 414.64). Section 105(c) of the BIPA requires that we pay for medical nutrition therapy services at 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the physician fee schedule for the same services if such services had been furnished by a physician. Section 1848 of the Act requires that payments under the physician fee schedule be established on national uniform RVUs based on the resources used in furnishing a service. We have consulted with the ADA to assess the types of resource inputs that are used to furnish a 15-minute medical nutrition therapy session by a Registered Dietitian or Professional Nutritionist.

As stated above, these services would be paid under the physician fee schedule. Malpractice RVUs for medical nutrition therapy services have been extrapolated based on analogous service procedures. The statute specifically provides that medical nutrition therapy services may only be provided by registered dietitians or nutrition professionals. We do not believe that physicians will be able to satisfy the qualification requirements and therefore will not be able to provide this service themselves. Therefore, we are not establishing physician work RVUs for this service. We interpret section 105(c)(2) of BIPA to mean that if a physician were to furnish this service, that the service was performed ''incident to'' the physicians treatment plan and provided by a registered dietitian or nutrition professional. Since we are not proposing work RVUs for medical nutrition therapy, we propose to determine practice expense RVUs using the practice expense methodology for the ''zero work pool.'' (For more information about the practice expense methodology for services that have no physician work, see the November 2, 1998 final rule (63 FR 58814)). The proposed RVUs for individuals and individuals in a group are found in Table 5 as follows:

TABLE 5.—RVUS FOR INDIVIDUALS AND INDIVIDUALS IN A GROUP

Code	Description	Work RVUs	Practice expense RVUs	Malpractice RVUs	Total
97802	Medical nutrition, individual, initial	0.00	0.47	0.01	0.48
97803	Medical nutrition, individual, subseq	0.00	0.34	0.01	0.35
97804	Medical nutrition, group	0.00	0.14	0.01	0.15

Much like diabetes education, the number of MNT beneficiaries attending a group session would vary. As defined in the CPT's Physical Medicine Rehabilitation codes, a group is considered to be two or more individuals.

We would refine the medical nutritional therapy services payment amounts in the future by including the services into the refinement process

used for other Medicare services payable under the physician fee schedule.

Medicare co-payments and deductibles would apply for medical nutritional therapy services. We are proposing to pay for this service under the physician fee schedule using the following codes:

CPT 97802—Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.

CPT 97803—reassessments and intervention, individual, face-to-face with the patient, each 15 minutes.

CPT 97804—Group, 2 or more individuals, each 30 minutes.

Since payment for MNT will be included in our payment for facility services, separate payment will not be made for hospital inpatients or skilled nursing facility patients. Section 105(c) of BIPA amends section 1833(a)(1) to add subparagraph (T), requiring Medicare payment to equal 80 percent of the of the lesser of the actual charge for the service or 85 percent of the amount determined under the physician fee schedule. Thus, we will make payment in the hospital outpatient department, Federally Qualified Health Centers and Rural Health Clinics at the lesser of 80 percent of the actual charge or 85 percent of the physician fee schedule amount. The RVUs shown above do not reflect this 85 percent adjustment. To determine payment, the RVUs shown above will need to be multiplied by the physician fee schedule conversion factor and 0.85. We expect to provide the Medicare carriers with a payment file that includes this 85 percent adjustment. That is, we expect to determine the payment amount using the RVUs shown and apply the 85 percent adjustment to the product of the geographically adjusted RVUs and conversion factor. The Medicare carriers will not need to make any additional adjustment to the payments we provide.

F. Telehealth Services

1. Background

a. History. Before January 1, 1999, payment for services delivered via a telecommunications system was limited to services that do not require a face-to-face, ''hands-on'' encounter under the traditional delivery of medical care. Examples of these services include interpretation of an x-ray, electrocardiogram and electroencephalogram tracings, and cardiac pacemaker analysis.

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 (HPSA) as defined by section 332(a)(1)(A) of the Public Health Services Act. Additionally, a Medicare practitioner was required to be with the patient at the time of a teleconsultation.

The BBA specified that payment for a teleconsultation had to be shared between the consulting physician or practitioner and the referring physician or 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 line charges or facility fees associated with the teleconsultation and clarified that the beneficiary may not be billed for these charges or fees.

These provisions became effective January 1, 1999. The November 2, 1998 final rule on ''Revisions to Payment Policies Under the Physicians Fee Schedule for Calendar Year 1999'' (63 FR 58879) implemented these provisions.

b. Legislative Summary. In section 223 of the BIPA, the Congress provided for a ''Revision of Medicare Reimbursement for Telehealth Services'' and specified a ''sunset'' date for the current statutory teleconsultation provisions. The current teleconsultation provisions contained in section 4206(a) and (b) of the BBA and implemented in §§ 410.78 and 414.65 apply only to teleconsultations provided on or after January 1, 1999 and before October 1, 2001.

Beginning October 1, 2001, the BIPA amends section 1834 of the Act to provide for a new subsection (m) ''Payment for Telehealth Services.'' This amendment provides for an expansion of Medicare payment for telehealth services. A summary of the expansion appears below.

The BIPA specifies that we pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1861(r) of the Act) or a practitioner (described in section 1842(b)(18)(C) of the Act). Telehealth services may be provided only to an eligible telehealth individual enrolled under Medicare, notwithstanding the fact that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary.

The BIPA defines Medicare telehealth services as professional consultations, office or other outpatient visits, and office psychiatry services identified as of July 1, 2000, by CPT codes 99241 through 99275; 99201 through 99215, 90804 through 90809 and 90862 (and as we may subsequently modify) and any additional service we specify.

The statute requires us to establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes) as appropriate, to the services specified above, for authorized payment under Medicare.

Section 1834(m)(4)(B) of the Act, as added by the BIPA, specifies that an eligible telehealth individual means an individual enrolled under Part B who receives a telehealth service furnished at an originating site. Originating sites are defined only as specified medical facilities located in specific geographic areas. Section 1834(m)(4)(C) of the Act, as added by the BIPA, limits originating sites to the following types of facilities:

- The office of a physician or practitioner.
- A critical access hospital (as defined in section 1861(mm)(1) of the Act).
- A rural health clinic (as defined in section 1861(aa)(s) of the Act).
- A Federally qualified health center (as defined in section 1861(aa)(4) of the Act).
- A hospital (as defined in section 1861(e) of the Act).

The BIPA specifies that the originating site must be located in one of the following geographic areas:

- In an area that is designated as a rural health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act.
- In a county that is not included in a Metropolitan Statistical Area.
- From an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

The BIPA relaxes some of the conditions for payment imposed by the BBA. Section 1834(m)(2)(C) of the Act, as added by the BIPA, specifies that a telepresenter is not required and specifically states that nothing in section 1834(m)(2)(C) of the Act shall be construed as requiring an eligible telehealth beneficiary to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system, unless it is medically necessary (as determined by the physician or practitioner at the distant site).

Additionally, section 1834(m)(1) of the Act, as added by the BIPA, specifies that, for purposes of defining a telecommunications system, in the case of any Federal telemedicine demonstration program conducted in Alaska or Hawaii, the term ''telecommunications system'' includes store and forward technologies that

provide for the asynchronous transmission of health care information in single or multimedia formats.

Section 1834(m)(2) of the Act, as added by the BIPA, states that we pay a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth beneficiary an amount equal to the amount that the physician or practitioner would have been paid under Medicare had the service been furnished without the use of a telecommunications system.

This section also provides for a facility fee payment to the originating site. It specifies that for the period beginning October 1, 2001 through December 31, 2002, the originating site facility fee is equal to $20. For each subsequent year, the facility fee for the preceding year is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act.

The BIPA amended section 1833(a)(1) of the Act by adding subparagraph (U), specifying that with respect to the originating site facility fees, the amount paid is 80 percent of the lesser of the actual charge or the amounts specified in new section 1834(m)(2) of the Act.

Section 1834(m)(3) of the Act requires that the provisions of sections 1848(g) and 1842(b)(18)(A) and (B) of the Act apply to physicians and practitioners. The provisions of section 1842(b)(18) of the Act apply to originating sites receiving a facility payment as the provisions apply to practitioners under section 1834(m) of the Act.

Section 1848(g) of the Act provides a limitation of charges to beneficiaries and provides sanctions if a physician, supplier, or other person knowingly and willfully bills or collects for services in violation of the limitation. It also provides for sanctions if a physician, supplier, or other person fails—(1) to timely correct excess charges by reducing the actual charge billed for the service to an amount that does not exceed the limiting charge for the service, or (2) to timely refund excess collections. In addition, it requires that physicians and suppliers submit claims for services they furnished to a beneficiary to a carrier on behalf of the beneficiary using a standard Medicare claim form. The statute imposes a penalty for failure to submit the claim. In addition, section 1848(g) of the Act prohibits imposing any charge relating to completing and submitting the claim. Section 1842(b)(18) of the Act provides that services furnished by a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, anesthesiologist's assistant, certified nurse-midwife, clinical social worker, or clinical psychologist for which payment may be made on a reasonable charge or fee schedule basis may be made only on an assignment-related basis. It also limits the beneficiary's liability to any applicable deductible and coinsurance amounts. It further provides for sanctions against a practitioner who knowingly and willfully bills (or collects an amount) in violation of the limitation.

c. Implementation. Section 223 of the BIPA limits the application of the existing telehealth provision to services furnished before October 1, 2001 and mandates that the expanded benefit be effective for services furnished on or after October 1, 2001. Therefore, this benefit expansion is being implemented via program memorandum. The program memorandum is effective October 1, 2001 when the telehealth benefit supercedes the teleconsultation benefit authorized by section 4206 of the BBA and existing regulations at § 410.78 and § 414.65. Any regulatory changes resulting from this rulemaking process will be effective January 1, 2002.

d. Proposed Policies. This rule proposes to establish policies for implementing the provisions of section 1834(m) of the Act, as added by the BIPA, that change Medicare payment for telehealth services.

(i) Scope of telehealth benefit. Section 1834(m)(4)(B) of the Act, as added by the BIPA, defines an eligible telehealth individual as a Medicare beneficiary who receives a telehealth service furnished at an originating site. As discussed earlier, originating sites are limited to certain facilities within specifically identified geographic areas.

We would revise § 410.78 to specify that Medicare beneficiaries are eligible for telehealth services only if they receive services from an originating site located in either a rural HPSA as defined by section 332(a)(1)(A) of the Public Health Services Act or in a county outside of a MSA as defined by section 1886(d)(2)(D) of the Act. Additionally, we would provide for an exception if an entity participates in a Federal telemedicine demonstration project that has been approved by, or receives funding from, us as of December 31, 2000. That entity would not be required to be in a rural HPSA or non-MSA as described above.

We would also specify that, providing the geographic criteria are met, the following sites qualify as originating sites under this provision:

- The office of a physician or practitioner.
- A hospital as defined in section 1861(e) of the Act.
- A critical access hospital as defined in section 1861(mm)(1).
- A rural health clinic as defined in section 1861(aa)(2) of the Act.
- A Federally qualified health center as defined in section 1861(aa)(4) of the Act.

Covered Services. Section 1834(m)(4)(F) of the Act, as added by the BIPA, defines telehealth services as professional consultations, office and other outpatient visits, individual psychotherapy, pharmacologic management and any additional service we specify. Additionally, this provision identifies covered services by HCPCS codes identified as of July 1, 2000. We propose to revise § 410.78 to implement this coverage expansion. The services and corresponding CPT codes are listed below:

- Consultations (codes 99241 through 99275).
- Office and other outpatient visits (codes 99201 through 99215).
- Individual Psychotherapy (codes 90804 through 90809).
- Pharmacologic management (code 90862).

The BIPA provision is effective for services beginning on October 1, 2001. Payment for the statutorily specified codes, as listed above, will be implemented beginning with that date. We propose to make any additions or deletions to the services defined as telehealth effective on a January 1st basis. We plan to use the annual physician fee schedule proposed rule published in the summer and the final rule (published by November 1) each year as the vehicle to make these changes. Since the statutory provision will be implemented on October 1, 2001, and there is limited published data on telehealth in clinical settings, we will not make any recommendations on additional services until we have had time to ensure we have a process for redefining covered services in place.

We are soliciting suggestions and comments from the public regarding the guidelines that we should use to make additions or deletions of services. We also solicit suggestions and comments about specific services that may be appropriate to be covered under the Medicare telehealth benefit. Once we complete our review of these suggestions and comments, we will propose a more detailed approach as to how we would make modifications to the existing telehealth benefit.

(ii) Conditions of Payment: *Technology.* The Congress defines the term ''telecommunications system'' with respect to demonstration projects conducted in Alaska or Hawaii; however, the BIPA does not define a

telecommunications system in any other case. In a non-telehealth setting, Medicare pays for these codes only if there is a face-to-face encounter between the patient and attending physician or practitioner. We believe that the patient's presence and use of an interactive audio and video telecommunications system permitting the distant site practitioner to interact with the patient provides a reasonable substitute for a face-to-face encounter.

Limited exception to the interactive telecommunications requirement. For purposes of defining a telecommunications system, section 1834(m)(1) of the Act includes the use of store and forward technology in very limited circumstances. This provision specifies that, in the case of a Federal telemedicine demonstration program conducted in Alaska or Hawaii, Medicare payment is permitted when asynchronous, store and forward technologies, in single or multimedia formats is used to deliver the service.

Store and forward technology substitutes for an interactive, patient-present encounter in these limited circumstances. The patient is not present or available to interact with the distant site physician or practitioner in real-time.

We believe that when store and forward technologies are used to substitute for an interactive patient encounter, the technology must permit the distant site practitioner adequate medical information for recommending or confirming a diagnosis or treatment plan. A patient's medical information may typically include various combinations of the following items—video clips, still images, x-rays, magnetic resonance images, electrocardiogram and electroencephalogram tracings, tissue samples, laboratory results, and audio clips of heart or lungs.

We propose to specify at § 410.78 that, except for the statutory provision noted above, an interactive telecommunications system must be used and that the medical examination of the patient is at the control of the physician or practitioner at the distant site. We would define interactive telecommunications system as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and physician or practitioner at the distant site. We would also specify that telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

Additionally, we would provide an exception to the interactive requirements where the patient must be present for a Federal telemedicine demonstration program conducted in Alaska or Hawaii. We would specify that for Federal telemedicine demonstration programs conducted in Alaska or Hawaii, Medicare payment is permitted for telehealth when asynchronous store and forward technologies, in single or multimedia formats, are used as a substitute for an interactive telecommunications system. Additionally, we would specify that the physician or practitioner at the distant site must be affiliated with the demonstration program.

This exception would be permitted for Federal telemedicine demonstration projects conducted in Alaska or Hawaii only. Interactive telecommunications system with the real-time presence of the patient is required as a condition of payment in all other circumstances.

We would define asynchronous, store and forward technologies, as the transmission of the patient's medical information from an originating site to the physician or practitioner at the distant site. The physician or practitioner at the distant site can review the medical case without the patient being present. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patient's medical condition and adequate for rendering or confirming a diagnosis or treatment plan. Dermatological photographs, for example, a photograph of a skin lesion may be considered to meet the requirement of a single media format under this provision.

Additionally, we would define the originating site as the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous, store and forward telecommunications technologies, an originating site is a Federal telemedicine demonstration program conducted in Alaska or Hawaii.

Telepresenter. As mentioned earlier, the BIPA changed the telepresenter requirements. In accordance with section 1834(m)(2)(C) of the Act, a telepresenter is not required to be present. Therefore, we would not require a telepresenter as a condition of Medicare payment.

Practitioners eligible to receive payment for Medicare Telehealth Services. Section 1834(m)(1) of the Act requires that Medicare make payments for telehealth services furnished via a telecommunications system by a physician or a practitioner (described in section 1842(b)(18)(C) of the Act). Non-physician practitioners described in this section of the Act include nurse practitioners, physician assistants, clinical nurse specialists, certified nurse midwives, clinical psychologists, clinical social workers, and certified registered nurse anesthetists or anesthesiologists' assistants. Section 1834(m)(2) of the Act specifies that the payment amount to the physician or practitioner at the distant site who furnishes a telehealth service be equal to the amount that the physician or practitioner would have been paid under Medicare had the service been furnished without the use of a telecommunications system.

As discussed earlier in this document, covered telehealth services include office visits (codes 99201 through 99215), consultation (codes 99241 through 99275), individual psychotherapy (codes 90804 through 90809), and pharmacologic management (code 90862). If a physician, clinical nurse specialist, nurse practitioner, physician assistant, nurse midwife, clinical psychologist, or clinical social worker is licensed under State law to provide a service listed above, then these practitioners may bill for and receive payment for this service when delivered via a telecommunications system.

Clinical psychologists and clinical social workers cannot bill or receive payment for psychotherapy involving evaluation and management services under Medicare when the service is delivered face-to-face (that is, without the use of a telecommunications system). Therefore, clinical psychologists and clinical social workers cannot receive payment for these services under the telehealth benefit.

Certified registered nurse anesthetists and anesthesiologists' assistants are not eligible. Certified registered nurse anesthetists and anesthesiologists' assistants would not be permitted to bill for and receive payment for a telehealth service under this provision. Section 1861(bb) of the Act defines services provided by these practitioners as anesthesia services and related care only. Under the Medicare program, these practitioners do not receive payment for office visits, consultation, individual psychotherapy, or pharmacologic management when these services are furnished without the use of a telecommunications system. Section 1834(m)(2) of the Act specifies that the

payment amount made to the distant site physician or practitioner must be equal to what would have been paid for the service without the use of a telecommunications system. Therefore, certified registered nurse anesthetists and anesthesiologists' assistants would not receive payment for telehealth services.

Proposed regulatory provisions. Based on the law, we would state at § 410.78 that, as a condition of Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under State law. When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (that is, professional consultations, office and other outpatient visits, individual psychotherapy, and pharmacologic management), then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

We would specify that the physician or practitioner at the distant site may be any of the following (provided that the physician or practitioner is licensed to bill for the service being furnished via a telecommunications system):

- A physician as described in § 410.20.
- A physician assistant as defined in § 410.74.
- A nurse practitioner as defined in § 410.75.
- A clinical nurse specialist as described in § 410.76.
- A nurse midwife as defined in § 410.77.
- A clinical psychologist as described in § 410.71.
- A clinical social worker as defined in § 410.73.

However, we would further specify that a clinical psychologist and clinical social worker may bill for individual psychotherapy furnished via a telecommunications system, but may not seek payment for medical evaluation and management services.

Documentation. Documentation requirements as specified in our most recent documentation guidelines are applicable to services delivered via a telecommunications system. At this time, we will not require additional documentation under this provision beyond what is already required for medical services delivered without the use of a telecommunications system. Medicare documentation guidelines are available from our web site. You may access our documentation guidelines by using the following directions:

1. Go to the CMS Homepage (*http://www.cms.gov*).
2. Click on ''Medicare'' (Top left hand column).
3. Click on ''Professional/Technical Information''
4. Click on ''Documentation Guidelines for Evaluation and Management Services:''
5. You may choose the 1995 version or the 1997 version whichever best fits your needs.

(iii) Payment provisions. *Professional Services: General*—Section 1834(m)(2)(A) of the Act, specifies that the payment amount for the professional service is equal to the amount that would have been paid without the use of a telecommunications system. Medicare payment for physicians' services is generally based, under section 1848 of the Act, on the resource-based physician fee schedule. Payment to other health care practitioners listed earlier, authorized under section 1833 of the Act, is based on a percentage of the physician fee schedule payment amount. Therefore, we would pay for office or other outpatient visits, consultation, individual psychotherapy, and pharmacologic management services furnished by physicians at 80 percent of the lower of the actual charge or the fee schedule amount for physicians' services. We would also pay for services furnished by other practitioners at 80 percent of the lower of the actual charge or that practitioner's respective percentage of the physician fee schedule (for example, the fee schedule amount for clinical psychologists would be 100 percent of the physician fee schedule; for clinical social workers, the payment would be made at 75 percent of the clinical psychologist fee schedule; for certified nurse midwives, the payment would be made at 65 percent of the physicians fee schedule; and for all other eligible health care practitioners, payment would be made at 85 percent of the physician fee schedule). Assuming the beneficiary has met his or her Part B deductible, the beneficiary would be responsible for 20 percent of the appropriate payment amount.

Payment for Telepresenter. Section 1834(m)(2) of the Act, provides for a professional fee for the physician or practitioner at the distant site (equal to the applicable Part B fee schedule amount) and a $20 facility fee for the originating site. Telepresenters are not required, unless one is deemed medically necessary by the physician or practitioner at the distant site. BIPA does not address the issue of payment for the telepresenter. The Office of the Inspector General has advised us that permitting the physician or practitioner at the distant site to pay the telepresenter creates a significant risk under the anti-kickback statute and may also violate many State fee-splitting laws. Therefore, we would propose in § 414.65 that payments made to the distant site physician or practitioner for professional fees, including deductible and coinsurance (for the professional service), are not to be shared with the referring practitioner or telepresenter.

However, the telepresenter could bill and receive payment for services that are not telehealth services that a telepresenter would otherwise be allowed to provide under the Medicare statute, including services furnished on the same day as the telehealth service.

Facility Fee for the Originating Site. The BBA prohibited any payment for line charges or facility fees associated with a professional consultation via a telecommunications system. Section 1834(m)(2)(B) of the Act, as added by the BIPA, provides for a facility fee payment to the originating site, specifying that the amount of payment is 80 percent of the lesser of the actual charge or a facility fee of $20.00. The BIPA further specifies that, beginning January 1, 2003, the originating facility fee be increased annually by the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. Additionally, we clarify that the Geographic Practice Cost Index (GPCI) would not apply to the facility fee for the originating site. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the physician's fee schedule. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance. We would revise § 414.65 to provide for payment of a facility fee to the originating site.

Coding. For office and other outpatient visits, consultation, individual psychotherapy, and pharmacologic management delivered via a telecommunications system, we would use modifiers in conjunction with existing CPT codes to indicate the use of a telecommunications system in delivering the service.

A new HCPCS code for the facility fee for the originating site will be used to identify this fee. Since this is a new occasion of payment under Medicare, a separate and distinct code for the facility fee is necessary for contractors to make the appropriate payment.

G. Indian Health Service

The Indian health care system provides primary health care to many American Indian and Alaska Native Medicare beneficiaries. This system consists of programs operated by a

Federal agency, the Indian Health Service (IHS), and Federally funded programs operated by Indian tribes, tribal organizations, and urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act). These programs deliver a range of clinical and preventive health services to their beneficiaries through a network of facilities including hospitals and outpatient clinics. Programs operated in IHS-owned or leased facilities, by IHS or by tribes or tribal organizations, are considered ''Federal providers'' by Medicare. Sections 1814(c) and 1835(d) of the Act generally prohibit payment to Federal providers, subject to exceptions contained in section 1880 of the Act for these IHS facilities. Prior to enactment of the BIPA, the exception in section 1880 of the Act was applicable only to IHS hospitals including provider-based clinics (IHS hospital outpatient clinics) and skilled nursing facilities. The exception did not permit Medicare to pay for services furnished by IHS free-standing outpatient clinics or to pay any IHS facilities for services by physicians and other practitioners paid under a fee schedule.

Effective July 1, 2001, section 432 of the BIPA extends the exception in section 1880 of the Act to permit Medicare payments to hospitals and outpatient clinics (provider-based or free-standing), operated by the IHS or by a tribe or tribal organization, for services furnished by physicians and specified non-physician practitioners in or at the direction of an IHS hospital or outpatient clinic. Payments for these services are made to the IHS or tribal hospital or outpatient clinic, not to the physician or other practitioner. These payments are subject to the same situations, terms, and conditions as would apply if the services were furnished in or at the direction of a hospital or outpatient clinic that is not operated by the IHS or by a tribe or tribal organization. The payments include incentive payments for physicians furnishing covered physicians' services in rural or urban HPSAs if the usual HPSA criteria are met. (For further information see section 1833 of the Act and § 414.42 of our regulations.) Payments will not be made under these provisions to the extent that Medicare is otherwise paying for the same services under other provisions (for example, as part of a bundled payment, or if a tribal hospital outpatient clinic continues to bill as a Federally qualified health center (FQHC)).

We are adding a new § 410.46 to our regulations to reflect this new statutory provision. Due to the statutory effective date of July 1, 2001, we will implement this BIPA provision through program memorandum instructions.

H. Pathology Services

Background

The November 2, 1999 final rule (64 FR 59380) provided that, for services furnished on or after January, 1, 2001, carriers would no longer pay claims to independent laboratories under the physician fee schedule for the technical component (TC) of physician pathology services for hospital inpatients. Before this rule, independent laboratories could bill the carrier under the physician fee schedule for the TC of a physician pathology service furnished to a hospital inpatient. Under the rule, independent labs would still have been able to bill and receive payment for TC physician pathology services furnished to patients who are not hospital inpatients. (The TC of physicians' pathology services includes the TC of cytopathology and surgical pathology physicians' services as described in the Medicare Carrier Manual, section 15020 B and C.) This change was to take effect for services furnished on or after January 1, 2001. The delay between publication and effective date was intended to allow independent laboratories and hospitals sufficient time to negotiate new arrangements, if necessary.

BIPA Provision

Section 542 of the BIPA requires the Medicare carrier to continue to pay for the TC of physician pathology services when an independent laboratory furnishes these services to an inpatient or outpatient of a covered hospital. The BIPA provisions apply to TC services furnished during the 2-year period beginning January 1, 2001 and continuing through December 31, 2002. We informed the carriers and the intermediaries of this provision through program memorandum AB–01–47 which was issued in March 2001. This program memorandum requested the carriers to notify independent laboratories of this provision in their next regularly scheduled bulletin and to place this bulletin on their Internet web site.

In the absence of further legislation, the policy of the November 1999 final rule will take effect for the TC of physician pathology services furnished to hospital patients after December 31, 2002.

Definitions

For this provision, ''covered hospital'' means a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients and submitted claims for payment for the TC to a carrier. The TC could have been submitted separately or combined with the professional component and reported as a combined service.

The term ''fee-for-service Medicare beneficiary'' means an individual who—(1) Is entitled to benefits under Part A or enrolled under Part B of Title XVIII or both, and; (2) Is not enrolled in any of the following:

- A Medicare+Choice plan under Part C of that title.
- A plan offered by an eligible organization under section 1876 of the Act.
- A program of all-inclusive care for the elderly (PACE) under section 1894 of the Act.
- A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987.

V. Collection of Information Requirements

Under the Paperwork Reduction Act (PRA) of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

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

§ 410.132—Medical Nutrition Therapy

Paragraph (c) of this section requires a referring physician or practitioner to

maintain referral documentation in the beneficiary's medical record for each referral. Paragraph (b)(3)(i) requires that the referring physician or qualified non-physician practitioner document a reassessment in the beneficiary's medical record. Paragraph (e) of this section requires the medical nutrition therapy care plan to be sent to the referring physician initially and each time the medical nutrition therapy care plan is updated. If the physician makes recommendations regarding the medical nutrition therapy care plan, the registered dietitian or nutrition professional must integrate the requirements into the medical nutrition therapy care plan.

We believe the burden associated with these provisions is exempt in accordance with 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with these requirements would be incurred by certified providers in the normal course of business activities.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Attn.: John Burke, CMS–1169–P, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Eydt, CMS Desk Officer.

VI. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the ''DATES'' section of this preamble, and, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

VII. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for proposed rules with economically significant effects (that is, a proposed rule that would have an annual effect on the economy of $100 million or more or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities). We estimate the changes to the practice expense RVUs (not including earlier proposed changes to the work RVUs) may result in a redistribution of payments among physician specialties of approximately $100 million. We estimate the benefit changes in this proposed rule resulting from the BIPA will likely result in additional Medicare expenditures of $210 to $360 million or more for any single FY through FY 2006. Therefore, this proposed rule is considered economically significant, and, thus, we have prepared a regulatory impact analysis.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals, and most other providers, physicians, and health care suppliers are small entities, either by nonprofit status or by having revenues of $7.5 million or less annually for physicians and $5 million or less for other practitioners. For purposes of the RFA and based on small business administration data for 1997, we estimate that there are 162,000 physician organizations that meet the definition of a small entity. There are about 700,000 physicians and other practitioners who receive Medicare payment under the physician fee schedule. Individuals and States are not included in the definition of a small entity.

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. We have determined that this proposed rule will have no consequential effect on State, local, or tribal governments. We believe the private sector cost of this rule falls below the above-stated threshold as well.

Thus, we have prepared the following analysis, which together with the rest of this preamble, meets all assessment requirements. It explains the rationale for, and purposes of, the rule, details the costs and benefits of the rule, analyzes alternatives, and presents the measures we propose to use to minimize the burden on small entities.

A. Resource-Based Practice Expense Relative Value Units and 5-Year Review Changes

Under section 1848(c)(2) of the Act, adjustments to relative value units may not cause the amount of expenditures to differ by more than $20 million from the amount expenditures would have been without such adjustments. We are proposing several changes that would result in a change of expenditures exceeding $20 million without offsetting adjustments to either the conversion factor or relative value units. In the June 8, 2001 Five-Year Review of Relative Value Units Under the Physician Fee Schedule, (66 FR 31028), we described the specialty level impact on payments of proposed changes in work RVUs. We estimated that the increase in physician work RVUs would increase expenditures by more than $20 million without an offsetting adjustment to either the relative value units or conversion factor. We proposed to meet the budget neutrality requirements in the statute by reducing the physician fee schedule conversion factor by an estimated 0.3 percent. Since the changes to the physician work RVUs included in our earlier proposed notice will affect payments in 2002, we are repeating those impacts in Table 6. In addition, we are also showing the impact of proposed changes that will affect the practice expense relative value units.

With respect to practice expense, our policy has been to meet the budget neutrality requirements in the statute by incorporating a rescaling adjustment in the practice expense methodology. That is, we determined the aggregate number of practice expense relative values that will be paid under current and proposed policy in 2002. We apply a uniform adjustment factor to all proposed practice expense relative value units to make them equal to the aggregate

number of practice expense relative values that we estimate will be paid under current policy. Table 6 shows the specialty level impact on payment of changes being proposed for 2002.

The three columns under the label ''5-Year Review of Work'' show the estimated change in payments that will result from our earlier notice on the 5-Year Review of Work Relative Value Units. The column labeled ''Work'' shows the impact on total payments that will result from increases in physician work relative value units. Since the practice expense relative value units are based, in part, on the physician work, the 5-year review will also result in a change to the practice expense relative value units. The column labeled ''Practice Expense'' shows this impact and includes the effect of the rescaling adjustment discussed above to make the practice expense relative value units budget neutral. The column labeled ''Total'' reflects the total impact on payments resulting from proposed changes in work and practice expense from the 5-year review of physician work. This column includes the effect of a 0.3 percent reduction to the physician fee schedule conversion factor to meet the budget neutrality requirements in the statute.

The column labeled ''New Time'' reflects the estimated specialty level impact on payments that will result from using new physician times in the practice expense methodology. As described earlier in section II.A., physician time is used in conjunction with information on practice expense per hour and Medicare utilization to create specialty practice expense pools that are used to allocate practice expenses to different services. The RUC earlier indicated to us that some of the times we were using in the practice expense methodology differed from the times included in the RUC database. We understand that the RUC has made substantial efforts to validate the time in its database with physician specialty societies and to supply us with times that were missing for some services. The RUC recently forwarded the results of this effort to us and is recommending that we use the new times in the practice expense methodology. In addition, several physician specialty societies obtained new and more recent survey times as a result of the five-year review of physician work. The RUC has reviewed and forwarded these times to us as well and is also recommending that we use them in the practice expense methodology. We believe the times supplied to us by the RUC are more likely to be reflective of the actual time it takes to perform a procedure. For this reason, we are proposing to use these new times in the practice expense methodology. As indicated in our June 8, 2001 proposed notice, our expectation was that the substitution of new times would reduce payments to cardiac and thoracic surgeons because the new times for many heart and chest procedures are shorter than those we have been using in the practice expense methodology. We estimate that substitution of new physician times will reduce payments to cardiac and thoracic surgeons by an estimated 5 and 4 percent, respectively. Combining this reduction with the change in work relative value units will result in a total estimated increase in payments from between 0 and 1 percent for cardiac and thoracic surgeons. We estimate change in payments to other specialties from using new time data will be one percent or less.

The column labeled ''New SMS'' refers to our proposal to recalculate the practice expense per hour data based on the 1995 through 1999 SMS. (We refer to the SMS based on its publication year. The practice expense data is actually from surveys performed the year prior to publication. For example, the 1998 SMS includes 1997 cost data.) The proposed changes in practice expense per hour from incorporating the latest SMS data are modest. Payments to pathologists are estimated to increase by 2 percent. Specialty 69—Independent Laboratory, the largest specialty included in the supplier category, bills for many of the same services as pathologists, producing our estimated 2 percent increase in Medicare payments to suppliers.

The column labeled ''Clinical Labor Repricing'' reflects our proposal to use 1999 information from the Bureau of Labor Statistics to update the wage rate information that is used to price clinical labor inputs in the practice expense methodology. We estimate that this proposal will result in less than a 1 percent change in payments to any physician specialty.

The column labeled ''Other'' refers to our proposal to make minor modifications to the specialty utilization. As discussed earlier, we are proposing to recode the specialty for several very low volume physician specialties that likely have practice expenses that are similar to other larger physician specialties. In addition, this policy reflects our proposal to drop the utilization for a number of specialties from the practice expense methodology because a very small percentage (one percent or less) of their allowed charges are from physician fee schedule services. The modifications to the utilization data that we are proposing have virtually no specialty level impact on any specialty.

TABLE 6.—IMPACT OF PROPOSED WORK AND PRACTICE EXPENSE CHANGES TOTAL ALLOWED CHARGES BY SPECIALTY

Specialty	Allowed charges $ Billions	5 year review of work practice			New time	New SMS	Clinical labor re-pricing	Other	Total
		Work	Expense	Total					
ANESTHESIOLOGY	1.5	1%	0%	1%	0%	0%	0%	0%	1%
CARDIAC SURGERY	0.3	5%	1%	6%	5%	0%	0%	0%	0%
CARDIOLOGY	4.2	0%	0%	0%	0%	0%	0%	0%	0%
CHIROPRACTOR	0.4	0%	0%	0%	0%	0%	0%	0%	0%
CLINICS	1.6	0%	0%	0%	0%	0%	0%	0%	0%
DERMATOLOGY	1.4	0%	0%	0%	0%	1%	0%	0%	1%
EMERGENCY MEDICINE	1.0	0%	0%	0%	0%	0%	0%	0%	0%
FAMILY PRACTICE	3.3	0%	0%	0%	0%	0%	0%	0%	0%
GASTROENTEROLOGY	1.2	0%	0%	0%	1%	0%	0%	0%	1%
GENERAL PRACTICE	1.0	0%	0%	0%	0%	0%	0%	0%	0%
GENERAL SURGERY	2.0	3%	1%	4%	0%	0%	0%	0%	4%
HEMATOLOGY ONCOLOGY	0.6	0%	−1%	−1%	0%	0%	0%	0%	0%
INTERNAL MEDICINE	7.1	0%	0%	0%	0%	0%	0%	0%	0%
NEPHROLOGY	1.0	0%	0%	0%	0%	0%	0%	0%	0%
NEUROLOGY	0.9	0%	0%	0%	0%	0%	0%	0%	0%
NEUROSURGERY	0.4	0%	0%	0%	0%	0%	0%	0%	0%
NONPHYSICIAN PRACTITIONER	1.2	0%	0%	0%	0%	0%	0%	0%	0%
OBSTETRICS/GYNECOLOGY	0.4	0%	0%	1%	0%	1%	0%	0%	1%
OPHTHALMOLOGY	3.9	0%	0%	0%	0%	−1%	0%	0%	−1%
OPTOMETRIST	0.5	0%	0%	0%	0%	−1%	1%	0%	0%

TABLE 6.—IMPACT OF PROPOSED WORK AND PRACTICE EXPENSE CHANGES TOTAL ALLOWED CHARGES BY SPECIALTY—Continued

Specialty	Allowed charges $ Billions	5 year review of work practice			New time	New SMS	Clinical labor re-pricing	Other	Total
		Work	Expense	Total					
ORTHOPEDIC SURGERY	2.3	0%	0%	0%	0%	0%	0%	0%	0%
OTHER PHYSICIAN	1.6	0%	0%	0%	0%	0%	0%	0%	1%
OTOLARYNGOLOGY	0.6	0%	0%	0%	1%	0%	0%	0%	0%
PATHOLOGY	0.6	0%	0%	0%	0%	2%	0%	0%	3%
PLASTIC SURGERY	0.2	0%	0%	0%	0%	0%	0%	0%	0%
PODIATRY	1.1	0%	0%	0%	1%	0%	0%	0%	1%
PSYCHIATRY	1.1	0%	0%	0%	0%	0%	0%	0%	0%
PULMONARY	1.1	0%	0%	0%	0%	0%	0%	0%	0%
RADIATION ONCOLOGY	0.7	0%	−1%	−1%	0%	0%	0%	0%	0%
RADIOLOGY	3.3	0%	−1%	0%	0%	0%	0%	0%	0%
RHEUMATOLOGY	0.3	0%	0%	0%	0%	0%	0%	0%	0%
SUPPLIERS	0.5	0%	−1%	−1%	−1%	2%	0%	1%	2%
THORACIC SURGERY	0.5	4%	1%	5%	−4%	0%	0%	0%	1%
UROLOGY	1.3	0%	0%	0%	0%	0%	0%	0%	1%
VASCULAR SURGERY	0.3	2%	0%	2%	−1%	0%	0%	0%	2%

Table 7 shows the impact on payments for selected high volume procedures of all of the changes previously discussed. This table shows the combined impact of the change in physician work and the fully implemented practice expense relative value units on total payment for the procedure. There are separate columns that show the change in the old and new facility rates and the old and new nonfacility rates. The table does not show the actual change in payments from 2001 to 2002 for the procedures because the ''old'' payments do not take into account that the practice expense relative value units in 2001 are a blend of the old charge-based relative value units and the new resource-based practice expense relative value determined under current policy. We show the amounts in this way to isolate the impact of new proposals on the change in payment without including the effect of continuing to transition resource-based practice expense relative value units that will occur regardless of whether we publish this proposed rule. For an explanation of facility and non-facility practice expense refer to § 414.22(b)(5)(i).

TABLE 7.—IMPACT OF 5 YEAR REVIEW AND PROPOSED RULE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES

HCPCS	MOD	Desc	Old non-facility	New non-facility	Percent change	Old facility	New facility	Percent change
11721		Debride nail, 6 or more	$42.47	$42.47	0%	$30.61	$30.61	0%
17000		Destroy benign/premal lesion	$63.89	$65.80	3%	$34.43	$34.43	0%
27130		Total hip replacement	NA	NA	NA	$1,499.72	$1,502.40	0%
27236		Treat thigh fracture	NA	NA	NA	$1,150.80	$1,152.72	0%
27244		Treat thigh fracture	NA	NA	NA	$1,174.91	$1,177.20	0%
27447		Total knee replacement	NA	NA	NA	$1,567.43	$1,570.50	0%
33533		CABG, arterial, single	NA	NA	NA	$1,855.90	$1,900.28	2%
35301		Rechanneling of artery	NA	NA	NA	$1,170.32	$1,141.24	−2%
43239		Upper GI endoscopy, biopsy	$298.03	$318.31	7%	$157.24	$158.39	1%
45385		Lesion removal colonoscopy	$501.95	$534.47	6%	$299.56	$303.00	1%
66821		After cataract laser surgery	$229.93	$228.02	−1%	$215.01	$212.72	−1%
66984		Cataract surg w/iol, i stage	NA	NA	NA	$697.83	$691.71	−1%
67210		Treatment of retinal lesion	$627.82	$620.55	−1%	$575.40	$569.66	−1%
71010	26	Chest x-ray	$9.56	$9.56	0%	$9.56	$9.56	0%
71020	26	Chest x-ray	$11.86	$11.86	0%	$11.86	$11.86	0%
77427		Radiation tx management, x5	$176.75	$177.52	0%	$176.75	$177.52	0%
78465	26	Heart image (3d), multiple	$79.58	$78.81	−1%	$79.58	$78.81	−1%
88305	26	Tissue exam by pathologist	$42.08	$42.85	2%	$42.08	$42.85	2%
90801		Psy dx interview	$153.80	$152.65	−1%	$145.00	$144.62	0%
90806		Psytx, off, 45–50 min	$102.15	$101.38	−1%	$96.41	$96.41	0%
90807		Psytx, off, 45–50 min w/e&m	$109.80	$109.42	0%	$104.44	$104.44	0%
90862		Medication management	$53.94	$53.94	0%	$48.97	$48.97	0%
90921		ESRD related services, month	$278.90	$279.28	0%	$278.90	$279.28	0%
90935		Hemodialysis, one evaluation	NA	NA	NA	$77.66	$78.05	1%
92004		Eye exam, new patient	$131.23	$130.84	0%	$92.58	$92.20	0%
92012		Eye exam established pat	$66.19	$65.80	−1%	$37.88	$37.49	−1%
92014		Eye exam & treatment	$94.88	$94.50	0%	$62.36	$61.60	−1%
92980		Insert intracoronary stent	NA	NA	NA	$845.12	$832.88	1%
92982		Coronary artery dilation	NA	NA	NA	$625.90	$616.34	−2%
93000		Electrocardiogram, complete	$27.55	$27.16	−1%	NA	NA	NA
93010		Electrocardiogram report	$9.56	$9.18	−4%	$9.56	$9.18	−4%
93015		Cardiovascular stress test	$108.65	$107.51	−1%	NA	NA	NA
93307	26	Echo exam of heart	$51.27	$50.50	−2%	$51.27	$50.50	−2%
93510	26	Left heart catheterization	$246.00	$242.17	−2%	$246.00	$242.17	−2%
98941		Chiropractic manipulation	$37.49	$37.49	0%	$32.52	$32.52	0%
99202		Office/outpatient visit, new	$63.89	$63.89	0%	$48.21	$48.21	0%
99203		Office/outpatient visit, new	$95.65	$95.26	0%	$73.46	$73.46	0%
99204		Office/outpatient visit, new	$137.73	$136.96	−1%	$108.65	$108.65	0%
99205		Office/outpatient visit, new	$174.46	$174.46	0%	$143.85	$143.47	0%
99211		Office/outpatient visit, est	$21.04	$21.04	0%	$9.18	$9.18	0%
99212		Office/outpatient visit, est	$37.49	$37.49	0%	$24.49	$24.49	0%

TABLE 7.—IMPACT OF 5 YEAR REVIEW AND PROPOSED RULE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES—Continued

HCPCS	MOD	Desc	Old non-facility	New non-facility	Percent change	Old facility	New facility	Percent change
99213		Office/outpatient visit, est	$52.41	$52.41	0%	$35.96	$35.96	0%
99214		Office/outpatient visit, est	$82.64	$82.64	0%	$58.92	$58.92	0%
99215		Office/outpatient visit, est	$120.90	$121.28	0%	$95.26	$95.26	0%
99221		Initial hospital care	NA	NA	NA	$68.86	$68.86	0%
99222		Initial hospital care	NA	NA	NA	$114.01	$114.01	0%
99223		Initial hospital care	NA	NA	NA	$159.15	$159.15	0%
99231		Subsequent hospital care	NA	NA	NA	$34.43	$34.43	0%
99232		Subsequent hospital care	NA	NA	NA	$56.24	$56.24	0%
99233		Subsequent hospital care	NA	NA	NA	$80.34	$80.34	0%
99236		Observ/hosp same date	NA	NA	NA	$225.72	$225.34	0%
99238		Hospital discharge day	NA	NA	NA	$67.72	$67.72	0%
99239		Hospital discharge day	NA	NA	NA	$92.58	$92.58	0%
99241		Office consultation	$48.97	$48.97	0%	$34.81	$34.81	0%
99242		Office consultation	$91.05	$90.67	0%	$71.54	$71.54	0%
99243		Office consultation	$120.90	$120.51	0%	$95.26	$94.88	0%
99244		Office consultation	$171.78	$171.78	0%	$140.79	$140.79	0%
99245		Office consultation	$223.04	$223.43	0%	$186.70	$186.32	0%
99251		Initial inpatient consult	NA	NA	NA	$38.26	$38.26	0%
99252		Initial inpatient consult	NA	NA	NA	$75.37	$75.37	0%
99253		Initial inpatient consult	NA	NA	NA	$102.15	$102.15	0%
99254		Initial inpatient consult	NA	NA	NA	$146.15	$146.15	0%
99255		Initial inpatient consult	NA	NA	NA	$200.47	$200.47	0%
99261		Follow-up inpatient consult	NA	NA	NA	$24.87	$24.87	0%
99262		Follow-up inpatient consult	NA	NA	NA	$47.82	$47.82	0%
99263		Follow-up inpatient consult	NA	NA	NA	$70.01	$70.01	0%
99282		Emergency dept visit	NA	NA	NA	$27.93	$27.93	0%
99283		Emergency dept visit	NA	NA	NA	$62.74	$62.74	0%
99284		Emergency dept visit	NA	NA	NA	$97.94	$98.32	0%
99285		Emergency dept visit	NA	NA	NA	$152.65	$153.03	0%
99291		Critical care, first hour	$218.45	$219.22	0%	$208.89	$209.27	0%
99292		Critical care, addl 30 min	$111.71	$112.10	0%	$104.06	$104.44	0%
99301		Nursing facility care	NA	NA	NA	$63.51	$63.51	0%
99302		Nursing facility care	NA	NA	NA	$84.93	$84.93	0%
99303		Nursing facility care	NA	NA	NA	$105.59	$105.59	0%
99311		Nursing fac care, subseq	NA	NA	NA	$31.75	$31.75	0%
99312		Nursing fac care, subseq	NA	NA	NA	$52.41	$52.41	0%
99313		Nursing fac care, subseq	NA	NA	NA	$74.60	$74.60	0%
99348		Home visit, est patient	$77.28	$76.90	0%	$70.01	$70.01	0%
99350		Home visit, est patient	$176.37	$175.60	0%	$164.13	$164.13	0%

B. Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists Performing Screening Sigmoidoscopies

As discussed in section II.B. of the preamble, this proposed regulation would expand the scope of who is allowed to perform screening flexible sigmoidoscopies for Medicare coverage and payment purposes to include nurse practitioners, physician assistants, and clinical nurse specialists, as long as those practitioners meet applicable Medicare qualification requirements, and they are authorized to perform those screening services under State law. At present, the Medicare condition of coverage for screening flexible sigmoidoscopies limits coverage of those services to those that are performed by either a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act) who is authorized under State law to perform the examination.

We estimate that this expansion in the scope of who is allowed to perform screening flexible sigmoidoscopies will increase beneficiary access to these screening services and will result in an increase in the number of covered exams that are performed. At the same time, we estimate that this proposed rule will result in a decrease in payments that are made for certain screening flexible sigmoidoscopies because they will be performed by nurse practitioners, physician assistants, and clinical nurse specialists who are paid at 85 percent of the amount of payment that is made to physicians for the same screening service. Taking these factors into account, we estimate that this proposal will result in negligible additional Medicare program costs. For a more detailed discussion of this provision see section II.B. of this preamble.

C. Services and Supplies Incident to a Physician's Professional Services—Conditions

We are proposing to allow auxiliary personnel to provide services incident to the services of physicians or practitioners who supervise them, regardless of the employment relationship. There are no costs or savings to the Medicare program associated with this proposal because the same physicians and practitioners would have performed these services before publication of this proposed rule. For a more detailed discussion of this provision see section II.C. of this preamble.

D. Anesthesia Services—Anesthesia Base Units

As previously discussed in section II.D. of the preamble, with the exception of codes 00142 and 00147, we propose to use the same anesthesia base unit per anesthesia code as the ASA provides in its uniform relative value guide. There are eight codes for which the base unit values would be different under our proposed rule.

Under this proposal, the estimated total number of base units would decrease. This is due primarily to the fact that code 001214 is the dominant code in terms of allowed services and the base unit for this code would decrease from 10 to 8 units.

To maintain neutrality in the anesthesia conversion factor, we would provide for a slight increase in the

anesthesia conversion factor, less than 0.5 percent. For a more detailed discussion of this provision see section II.D. of this preamble.

E. Performance Measurement and Emerging Technology Codes

As previously discussed in section II.E. of the preamble, the AMA has developed two new categories of codes: performance codes and emerging technology. Allowing the performance measurement code to be referenced on Medicare billing forms will have no budgetary impact since we are not proposing payment for these codes. We are proposing to allow for carrier pricing of the emerging technology codes.

We expect that the emerging technology codes will be used infrequently and may be used in place of ''unlisted'' procedure codes that are also carrier priced. There would be few, if any, no Medicare program costs associated with this proposal. For a more detailed discussion of this provision see section II.E. of this preamble.

F. BIPA Provisions Included in This Proposed Rule

The following provisions of the BIPA are discussed in detail in section III of this preamble. This proposed rule would conform the regulations text to the BIPA provisions. Table 8 provides the estimated costs (in millions of dollars) for the Medicare program for these provisions for the fiscal years shown:

TABLE 8.—MEDICARE COST ESTIMATES FOR BIPA 2000 PROVISIONS

[In millions]

BIPA provisions	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Sec. 101 Biennial Pelvic Examinations	10	20	20	20	20
Sec. 102 Screening Glaucoma	30	50	50	60	60
Sec. 103 Screening Colonoscopy	40	40	30	10	10
Sec. 104 Screening Mammography	30	40	40	40	50
Sec. 105 Medical Nutrition	20	50	60	70	70
Sec. 223 Telehealth Services	20	30	40	50	60
Sec. 432 Indian Health	60	70	80	80	90

1. Screening Mammography

As discussed in section III.A. of the preamble, the BIPA eliminates the statutorily prescribed payment rate for screening mammography and specifies that it will be paid under the physician fee schedule beginning January 1, 2002. To pay for the professional component of the screening mammography, we propose to use the work and malpractice RVUs that have been established for unilateral diagnostic mammography. We are establishing the practice expense RVUs for the professional component under the resource-based methodology. To establish practice expense RVUs for the technical component, we propose using the statutory payment limit and the applicable physician fee schedule update factor used each year. Currently, we pay for screening mammography under section 1834(c) of the Act. Payment for screening mammography is not subject to the budget neutrality requirements that apply to physician fee schedule services under section 1848(c)(2)(B)(ii)(II) of the Act. Effective January 1, 2002, screening mammography will be subject to the budget neutrality requirements that apply to physician fee schedule services. We will include the current payment amounts for screening mammography in aggregate physician fee schedule payments subject to the budget neutrality requirements. As a result, the BIPA requirement to pay for screening mammography under the physician fee schedule will not result in an increase in Medicare program expenditures. However, the increase in payment for screening mammography under the physician fee schedule will be included in the budget neutrality adjustments that apply to physician fee schedule services. The BIPA also establishes a methodology for determining payment for certain types of new technology that are used in providing both diagnostic and screening mammography services. The statutory provisions are in effect from April 1, 2001 to December 31, 2001. The statute gives us the authority to determine whether separate codes and payment amounts are appropriate for screening and diagnostic mammography services that involve use of a new technology on or after January 1, 2002. We are proposing several new codes and fee schedule amounts for screening and diagnostic mammography services that involve use of a new technology. The BIPA provisions related to new technology mammography will result in the Medicare program costs shown in Table 8. The BIPA makes no changes to provisions for Medicare coverage of screening mammography.

2. Screening Pelvic Examinations

As discussed in section III.B. of the preamble, section 101 of the BIPA provides for expanded coverage for screening pelvic examinations (including a clinical breast examination) furnished on or after July 1, 2001. Specifically, the revised benefit will allow for biennial coverage of screening pelvic examination for all women who do not qualify under the law for annual coverage of such tests. We estimate that this change in the frequency of coverage for certain beneficiaries will result in an increase in Medicare payments. These payments will be made to a large number of physicians and other practitioners who provide these tests, any medically necessary follow-up tests, or treatment that may be required as a result of the increased frequency of coverage of these tests. Medicare program expenditures associated with screening pelvic examinations have been included in the budget. The impact of this provision is shown in Table 8.

3. Screening for Glaucoma

As discussed in section III.C. of the preamble, section 102 of the BIPA authorizes coverage of glaucoma screening examinations effective January 1, 2002, subject to certain frequency and other limitations. We believe services provided as part of glaucoma screening will often overlap with other services a physician provides during a patient encounter that is associated with a higher payment amount. We believe that physicians will more commonly provide glaucoma tests in conjunction with other services and will rarely provide only glaucoma screening to Medicare patients. Based on the projected utilization of these screening services and related medically necessary follow-up tests and treatment that may be required for the beneficiaries screened, we estimate that this new benefit will result in an

increase in Medicare payments. These payments will be made to ophthalmologists or optometrists who will provide these screening tests and related follow-up tests and treatment that may be required. Medicare program expenditures associated with the BIPA provision that establishes coverage for screening glaucoma are shown in Table 8.

4. Screening Colonoscopy

As discussed in section III.D. of the preamble, section 103 of the BIPA amended the Act to add coverage of screening colonoscopies once every 10 years for individuals not at high risk for colorectal cancer. We estimate that this new benefit will result in an increase in Medicare payments. These payments will be made to practitioners who will provide these screening tests and related follow-up tests and treatment that may be required. The impact of this provision is shown in Table 8.

5. Medical Nutrition Therapy

As discussed in section III.E. of the preamble, section 105 of the BIPA amended the Act to authorize Medicare coverage under Part B of medical nutrition therapy (MNT) for beneficiaries who have diabetes or renal disease, effective for services furnished on or after January 1, 2002. We propose to implement this provision at part 410, subpart G. Specifically, the proposed rule discusses the education, experience, and licensing requirements for dietitians or nutritionists furnishing the service. In addition, the proposed rule discusses the payment provisions, a referral requirement, and the manner by which the medical nutrition therapy and diabetes outpatient self-management training benefits will be coordinated to avoid duplicate payment. We also propose to establish payment amounts for these services under the physician fee schedule.

We estimate that this new benefit will result in an increase in Medicare payments. These payments will be made to dietitians and nutrition professionals who will provide these diagnostic therapy and counseling services. Costs to the Medicare program associated with this provision are shown in Table 8.

6. Telehealth

We estimate that the cost of providing office or other outpatient visits, consultation services, individual psychotherapy, and pharmacologic management in accordance with section 223 of the BIPA will be approximately $20 million in FY 2002 and approximately $60 million by FY 2006, as indicated above in Table 8.

This rule does not mandate that entities provide consultation, office or other outpatient visits, individual psychotherapy or pharmacological management services via a telecommunications system. Thus, this rule would not require entities to purchase telehealth equipment or to acquire the telecommunications infrastructure necessary to deliver these services via a telecommunications system. Therefore, this rule does not impose costs associated with starting and operating a telehealth network.

7. Indian Health Services

As discussed in section III.G. of the preamble, in addition to payment for Medicare services in hospitals and skilled nursing facilities, section 432 of the BIPA authorizes payment under the physician fee schedule to physicians and certain practitioners for services furnished in a hospital and an ambulatory care clinic, whether provider-based or free-standing, of the Indian Health Service effective for services furnished on or after July 1, 2001. We propose to add a new § 410.46 to conform our regulations to the statute. Costs to the Medicare program for this BIPA provision are shown in Table 8.

8. Pathology Services

As discussed in section III.H. of the preamble, in the November 2, 1999 physician fee schedule final rule (64 FR 59381), we stated that we would implement a policy to pay only hospitals for the TC of physician pathology services furnished to hospital inpatients. Before the effective date of this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology to a hospital inpatient. The regulation provided that for services furnished on or after January 1, 2001, the carriers would no longer pay claims to an independent laboratory under the physician fee schedule for the TC of physician pathology services furnished for hospital inpatients. Similar treatment was provided under the hospital outpatient prospective payment system for the TC of physician pathology services to hospital outpatients. We delayed implementation of this provision for one year; it was to take effect for services furnished on or after January 1, 2001. The delay was intended to allow independent laboratories and hospitals sufficient time to negotiate arrangements.

Section 542 of the BIPA requires Medicare to continue to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital. This provision applies to TC services furnished during the 2-year period beginning on January 1, 2001.

In the November 2, 1999 final rule, we estimated that payment under the physician fee schedule for TC billings by independent laboratories would decrease by $6 million per year if the original proposal had been implemented on January 1, 2001. As a result of the BIPA, these savings are not realized for two years.

G. Budget Neutrality

Each year since the fee schedule has been implemented, our actuaries have determined any adjustments needed to meet the budget neutrality requirement of the statute. A component of the actuarial determination of budget-neutrality involves estimating the impact of changes in the volume and intensity of physicians' services provided to Medicare beneficiaries as a result of the proposed changes. Since the November 1998 final rule (63 FR 58891), we have used a model that assumes 30 percent of anticipated payment reductions will be offset through an increase in the volume and intensity of services. We will continue to use the same assumption in this year's final rule.

H. Impact on Beneficiaries

Although changes in physicians' payments were large when the physician fee schedule was implemented in 1992, we detected no problems with beneficiary access to care. Furthermore, since beginning our transition to a resource-based practice expense system in 1999, we have not found that there are problems with beneficiary access to care. In addition, the implementation of the BIPA proposals that are contained in this rule will improve beneficiary access to health care under the Medicare program since certain preventative services, such as screening glaucoma, will now be covered for the first time and coverage of several existing services is being expanded.

I. Federalism

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

In accordance with the provisions of Executive Order 12866, this regulation

was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 405

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

42 CFR Part 410

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

42 CFR Part 411

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 requirements, Rural areas, X-rays.

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Health Care Financing Administration proposes to amend 42 CFR chapter IV as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. The authority citation for part 405 continues to read as follows:

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

2. In § 405.534, an introductory paragraph is added to read as follows:

§ 405.534 Limitation on payment for screening mammography services.

The provisions in paragraphs (a), (b), and (c) of this section apply for services provided from January 1, 1991 until December 31, 2001. Screening mammography services provided after December 31, 2001 are paid under the physician fee schedule in accordance with § 414.2 of this chapter.

* * * * *

3. In § 405.535, the section heading is revised and the introductory text is amended by adding two sentences to the beginning to read as follows:

§ 405.535 Special rule for nonparticipating physicians and suppliers furnishing screening mammography services before January 1, 2002.

The provisions in this section apply for screening mammography services provided from January 1, 1991 until December 31, 2001. Screening mammography services provided after December 31, 2001 are paid under the physician fee schedule in accordance with § 414.2 of this chapter. * * *

* * * * *

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

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

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

2. Section 410.3 is amended by revising paragraph (a)(1) to read as follows:

§ 410.3 Scope of benefits.

(a) * * *

(1) Medical and other health services such as physicians' services, outpatient services furnished by a hospital or a CAH, diagnostic tests, outpatient physical therapy and speech pathology services, rural health clinic services, Federally qualified health center services, IHS, Indian tribe, or tribal organization facility services, and outpatient renal dialysis services.

* * * * *

3. Section 410.10 is amended by adding paragraph (x) to read as follows:

§ 410.10 Medical and other health services: Included services.

* * * * *

(x) IHS, Indian tribe, or tribal organization facility services.

4. Section 410.22 is redesignated as § 410.21, § 410.23 is redesignated as § 410.22, and a new § 410.23 is added to read as follows:

§ 410.23 Screening for glaucoma: Conditions for and limitations on coverage.

(a) *Definitions:* As used in this section, the following definitions apply:

(1) *Direct supervision in the office setting* means the optometrist or the ophthalmologist must be present in the office suite and be immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean the physician must be present in the room when the procedure is performed.

(2) *Eligible beneficiary* means:

(i) Individual with diabetes mellitus;

(ii) Individual with a family history of glaucoma; or

(iii) African-Americans age 50 and over.

(3) *Screening for glaucoma* means the following procedures furnished to an individual for the early detection of glaucoma:

(i) A dilated eye examination with an intraocular pressure measurement.

(ii) A direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination.

(b) *Condition for coverage of screening for glaucoma.*

Medicare Part B pays for glaucoma screening examinations provided to eligible beneficiaries as described in paragraph (a)(2) of this section if they are furnished by or under the direct supervision in the office setting of an optometrist or ophthalmologist who is legally authorized to perform these services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or incident to a physician's professional service.

(c) *Limitations on coverage of glaucoma screening examinations.*

(1) Payment may not be made for a glaucoma screening examination that is performed for an individual who is not an eligible beneficiary as described in paragraph (a)(2) of this section.

(2) Payment may be made for a glaucoma screening examination that is performed on an individual who is an eligible beneficiary as described in paragraph (a)(2) of this section, after at least 11 months have passed following the month in which the last glaucoma screening examination was performed.

5. In § 410.26, paragraph (b) is redesignated as paragraph (c), paragraph (a) is redesignated as paragraph (b) and revised, a new paragraph (a) is added, and newly designated paragraph (c) is amended by adding a paragraph heading:

§ 410.26 Services and supplies incident to a physician's professional service: Conditions.

(a) *Definitions.* For purposes of this section, the following definitions apply:

(1) *Auxiliary personnel* means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner).

(2) *Direct supervision* means the level of supervision by the physician (or other practitioner) of auxiliary personnel as defined in § 410.32(b)(3)(ii).

(3) *Independent contractor* means an individual who performs part-time or full-time work for which the individual receives an IRS–1099 form.

(4) *Leased employment* means an employment relationship that is

recognized by applicable State law and that is established by two employers by a contract such that one employer hires the services of an employee of the other employer.

(5) *Noninstitutional setting* means all settings other than a hospital or skilled nursing facility.

(6) *Practitioner* means a non-physician practitioner who is authorized by the Act to receive payment for services incident to his or her own services.

(7) *Services and supplies* means any service or supply (including any drug or biological that cannot be self-administered) that is included in section 1861(s)(2)(A) of the Act and is not specifically listed in the Act as a separate benefit included in the Medicare program.

(b) Medicare Part B pays for services and supplies incident to the service of a physician (or other practitioner).

(1) Services and supplies must be furnished in a noninstitutional setting to noninstitutional patients.

(2) Services and supplies must be an integral, though incidental, part of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness.

(3) Services and supplies must be commonly furnished without charge or included in the bill of a physician (or other practitioner).

(4) Services and supplies must be of a type that are commonly furnished in the office or clinic of a physician (or other practitioner).

(5) Services and supplies must be furnished under the supervision of the physician (or other practitioner).

(6) Services and supplies must be furnished by the physician, practitioner with an incident to benefit, or auxiliary personnel.

(7) A physician (or other practitioner) may be an employee or an independent contractor.

(c) *Limitation.* * * *

6. In § 410.37, paragraphs (d), (e)(2), and (g) are revised and paragraph (e)(3) is added to read as follows:

§ 410.37 Colorectal cancer screening tests: Conditions for and limitations on coverage.

* * * * *

(d) *Condition for coverage of flexible sigmoidoscopy screening.* Medicare Part B pays for a flexible sigmoidoscopy screening service if it is performed by a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act), or by a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act and §§ 410.74, 410.75, and 410.76) who is authorized under State law to perform the examination.

(e) *Limitations on coverage of screening flexible sigmoidoscopies.* * * *

(2) For an individual 50 years of age or over, except as described in paragraph (e)(3) of this section, payment may be made for screening flexible sigmoidoscopy after at least 47 months have passed following the month in which the last screening flexible sigmoidoscopy or, as provided in paragraphs (h) and (i) of this section, the last screening barium enema was performed.

(3) In the case of an individual who is not at high risk for colorectal cancer as described in paragraph (a)(3) of this section but who has had a screening colonoscopy performed, payment may be made for a screening flexible sigmoidosocopy only after at least 119 months have passed following the month in which the last screening colonoscopy was performed.

* * * * *

(g) *Limitations on coverage of screening colonoscopies.* (1) Effective for services furnished on or after January 1, 1998 through June 30, 2001, payment may not be made for a screening colonoscopy for an individual who is not at high risk for colorectal cancer as described in paragraph (a)(3) of this section.

(2) Effective for services furnished on or after July 1, 2001, except as described in paragraph (g)(4) of this section, payment may be made for a screening colonoscopy performed for an individual who is not at high risk for colorectal cancer as described in paragraph (a)(3) of this section, after at least 119 months have passed following the month in which the last screening colonoscopy was performed.

(3) Payment may be made for a screening colonoscopy performed for an individual who is at high risk for colorectal cancer as described in paragraph (a)(3) of this section, after at least 23 months have passed following the month in which the last screening colonoscopy was performed, or, as provided in paragraphs (h) and (i) of this section, the last screening barium enema was performed.

(4) In the case of an individual who is not at high risk for colorectal cancer as described in paragraph (a)(3) of this section but who has had a screening flexible sigmoidoscopy performed, payment may be made for a screening colonoscopy only after at least 47 months have passed following the month in which the last screening flexible sigmoidoscopy was performed.

* * * * *

7. Section 410.46 is added to read as follows:

§ 410.46 Physician and other practitioner services furnished in or at the direction of an IHS or Indian tribal hospital or clinic: Scope and conditions.

(a) Medicare Part B pays, in accordance with the physician fee schedule, for services furnished in or at the direction of a hospital or outpatient clinic (provider-based or free-standing) that is operated by the Indian Health Service (IHS) or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act). These services are subject to the same situations, terms, and conditions that would apply if the services were furnished in or at the direction of a hospital or clinic that is not operated by IHS or by an Indian tribe or tribal organization. Payments include health professional shortage areas incentive payments when the requirements for these incentive payments in § 414.42 of this chapter are met.

(b) Payment is not made under this section to the extent that Medicare otherwise pays for the same services under other provisions.

(c) Payment is made under these provisions for the following services:

(1) Services for which payment is made under the physician fee schedule in accordance with part 414 of this chapter.

(2) Services furnished by non-physician practitioners for which payment under Part B is made under the physician fee schedule.

(3) Services furnished by a physical therapist or occupational therapist, for which payment under Part B is made under the physician fee schedule.

(d) Payments under these provisions will be paid to the IHS or tribal hospital or clinic.

8. In § 410.56, paragraphs (b)(1), the introductory text of (b)(2), and (b)(3) are revised to read as follows:

§ 410.56 Screening pelvic examinations.

* * * * *

(b) * * *

(1) *General rule.* Except as specified in paragraphs (b)(2) and (b)(3) of this section, payment may be made for a pelvic examination performed on an asymptomatic woman only if the individual has not had a pelvic examination paid for by Medicare during the preceding 23 months following the month in which her last Medicare-covered screening pelvic examination was performed.

(2) *More frequent screening based on high-risk factors.* Subject to the limitation as specified in paragraph (b)(4) of this section, payment may be made for a screening pelvic examination performed more frequently than once every 24 months if the test is performed by a physician or other practitioner specified in paragraph (a) of this section, and there is evidence that the woman is at high risk (on the basis of her medical history or other findings) of developing cervical cancer or vaginal cancer, as determined in accordance with the following risk factors:

* * * * *

(3) *More frequent screening for women of childbearing age.* Subject to the limitation as specified in paragraph (b)(4) of this section, payment may be made for a screening pelvic examination performed more frequently than once every 24 months if the test is performed by a physician or other practitioner as specified in paragraph (a) of this section for a woman of childbearing age who has had an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding 3 years. The term ''woman of childbearing age'' means a woman who is premenopausal, and has been determined by a physician, or a qualified practitioner, as specified in paragraph (a) of this section, to be of childbearing age, based on her medical history or other findings.

* * * * *

9. Section 410.78 is revised to read as follows:

§ 410.78 Office and other outpatient visits, consultation, individual psychotherapy and pharmacologic management via an interactive telecommunications system.

(a) *Definitions.* For the purposes of this section the following definitions apply:

(1) *Asynchronous store and forward technologies* means the transmission of a patient's medical information from an originating site to the physician or practitioner at the distant site. The physician or practitioner at the distant site can review the medical case without the patient being present. An asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs visualized by a telecommunications system must be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis and or treatment plan. Dermatological photographs, for example, a photograph of a skin lesion, may be considered to meet the requirement of a single media format under this provision.

(2) *Distant site* means the site at which the physician or practitioner delivering the service is located at the time the service is provided via a telecommunications system.

(3) *Interactive telecommunications system* means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

(4) *Originating site* means, for purposes of a consultation, office or other outpatient visit, individual psychotherapy, or pharmacologic management via an interactive telecommunications system, the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous store and forward telecommunications technologies, the only originating sites are Federal telemedicine demonstration programs conducted in Alaska or Hawaii.

(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, individual psychotherapy, and pharmacologic management furnished by means of an interactive telecommunications system if the following conditions are met:

(1) The physician or practitioner at the distant site must be licensed to provide the service under State law. When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (that is, professional consultations, office and other outpatient visits, individual psychotherapy, and pharmacologic management), he or she may bill for, and receive payment for, this service when delivered via a telecommunications system.

(2) The practitioner at the distant site is one of the following:

(i) A physician as described in § 410.20.

(ii) A physician assistant as described § 410.74.

(iii) A nurse practitioner as described in § 410.75.

(iv) A clinical nurse specialist as described in § 410.76.

(v) A nurse-midwife as described in § 410.77.

(vi) A clinical psychologist as described in § 410.71.

(vii) A clinical social worker as described in § 410.73.

(3) The services are furnished to a beneficiary at an originating site, which is one of the following:

(i) The office of a physician or practitioner.

(ii) A critical access hospital (as described in section 1861(mm)(1) of the Act).

(iii) A rural health clinic (as described in section 1861(aa)(2) of the Act).

(iv) A Federally qualified health center (as defined in section 1861(aa)(4) of the Act).

(v) A hospital (as defined in section 1861(e) of the Act).

(4) Originating sites must be located in either a rural health professional shortage area as defined under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) or in a county that is not included in a Metropolitan Statistical Area as defined in section 1886(d)(2)(D) of the Act. Entities participating in a Federal telemedicine demonstration project that have been approved by, or receive funding from, the Secretary as of December 31, 2000 qualify as an eligible originating site regardless of geographic location.

(5) The medical examination of the patient is under the control of the physician or practitioner at the distant site.

(c) *Telepresenter not required.* A telepresenter is not required as a condition of payment unless a telepresenter is medically necessary as determined by the physician or practitioner at the distant site.

(d) *Exception to the interactive telecommunications system requirement.* For Federal telemedicine demonstration programs conducted in Alaska or Hawaii only, Medicare payment is permitted for telehealth when asynchronous store and forward technologies, in single or multimedia formats, are used as a substitute for an interactive telecommunications system.

(e) *Limitation.* A clinical psychologist and a clinical social worker may bill and receive payment for individual psychotherapy via a telecommunications system, but may not seek payment for medical evaluation and management services.

10. A new subpart G is added to read as follows:

Subpart G—Medical Nutrition Therapy

Sec.

Subpart G—Medical Nutrition Therapy

§ 410.130 Definitions.

For the purposes of this subpart, the following definitions apply:

Chronic renal insufficiency is defined as the stage of renal disease associated with a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate [GFR] 13–50 ml/min/1.73m^2).

Diabetes is diabetes mellitus consisting of two types. Type 1 is an autoimmune disease that destroys the beta cells of the pancreas, leading to insulin deficiency. Type 2 is familial hyperglycemia that occurs primarily in adults but can also occur in children and adolescents. The diagnostic criterion for a diagnosis of diabetes for a fasting glucose tolerance test is greater than or equal to 126 mg/dL.

Episode of care means a time period not exceeding 12 months, starting with the assessment and including all covered interventions based on a referral from a physician as specified in § 410.132(c).

Medical nutrition therapy services means nutritional diagnostic, therapy, and counseling services provided by a registered dietitian or nutrition professional for the purpose of managing diabetes or renal disease.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section of 1101(a)(7) of the Act).

Renal disease means chronic renal insufficiency and the medical condition of a beneficiary who has been discharged from the hospital within the last six months after a successful renal transplant.

§ 410.132 Medical nutrition therapy.

(a) *Conditions for coverage of medical nutrition therapy services.* Medicare Part B pays for medical nutrition therapy services provided by a registered dietitian or nutrition professional as defined in § 410.134 when the beneficiary is referred for the service by the treating physician. Services covered consist of nutritional assessment, interventions, and reassessment and follow-up interventions in accordance with nationally accepted dietary or nutritional protocols.

(b) *Limitations on coverage of medical nutrition therapy services.*

(1) Medical nutrition therapy services are not covered for beneficiaries receiving maintenance dialysis for which payment is made under section 1881 of the Act.

(2) If a beneficiary has both diabetes and renal disease, the beneficiary may receive both MNT and DSMT, but coverage is limited to the number of hours the beneficiary would receive under either the MNT benefit or the DSMT benefit for the episode of care, whichever is greater.

(3) Medical nutrition therapy is only covered if the beneficiary has not started initial training under the diabetes self-management training benefit as described in § 410.141 within the 12 months previous to initial referral for MNT, unless—

(i) The need for a reassessment and additional therapy has been documented by the referring physician as a result of a change in diagnosis or medical condition; or

(ii) The beneficiary is diagnosed with both diabetes and renal disease.

(4) If a beneficiary diagnosed with diabetes has been referred for both follow-up diabetes self-management training services and medical nutrition therapy, the number of hours the beneficiary may receive is limited to the number of hours under either follow-up diabetes self-management training services or medical nutrition therapy for any 12 month period.

(c) *Referrals.* Referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease as defined in this subpart with documentation maintained by the referring physician in the beneficiary's medical record. Referrals must be made for each episode of care and any reassessments or follow-up interventions during an episode of care.

(d) *Reassessments and follow-up interventions.* Reassessments and follow-up interventions are only covered within an episode of care when the referring physician determines there is a change of diagnosis or medical condition within such episode of care that makes a change in diet necessary.

§ 410.134 Provider qualifications.

For Medicare Part B coverage of medical nutrition therapy, only a registered dietitian or nutrition professional may provide the services. ''Registered dietitian or nutrition professional'' means an individual who on or after December 22, 2000—

(a) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose;

(b) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

(c) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a ''registered dietitian'' by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a) and (b) of this section; or a dietitian or nutritionist licensed or certified in a State as of December 21, 2000.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

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

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

2. In § 411.15, paragraph (a)(1) is revised, and a new paragraph (k)(10) is added to 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 examinations, prostate cancer screening tests, or glaucoma screening exams that meet the criteria specified in paragraphs (k)(6) through (k)(10) of this section.

* * * * *

(k) * * *

(10) In the case of screening exams for glaucoma, for the purpose of early detection of glaucoma, subject to the conditions and limitations specified in § 410.23 of this chapter.

* * * * *

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

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

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

2. In 414.2, the definition of ''Physician services'' is amended by

adding a new paragraph (8) to read as follows:

§ 414.2 Definitions.

* * * * *

Physician Services * * *

(8) Screening mammography services.

* * * * *

3. A new § 414.64 is added to read as follows:

§ 414.64 Payment for medical nutrition therapy.

(a) *Payment under the physician fee schedule.* Medicare payment for medical nutrition therapy is made under the physician fee schedule in accordance with subpart B of this part.

(b) *To whom payment may be made.* Payment may be made to a supplier (registered dietitian or nutrition professional) approved by CMS to furnish medical nutrition therapy in accordance with part 410, subpart G of this chapter.

(c) *Effective date of payment.* Medicare pays suppliers of medical nutrition therapy on or after the effective date of enrollment of the supplier at the carrier.

(d) *Limitation on payment.* Payment is made only for nutritional therapy sessions actually attended by the beneficiary and documented for payment purposes.

(e) *Other conditions for fee-for-service payment.* Payment is made only if the beneficiary:

(1) Is not an inpatient of a hospital, SNF, nursing home, or hospice.

(2) Is not receiving services in an RHC, FQHC or ESRD dialysis facility.

4. Section 414.65 is revised to read as follows:

§ 414.65 Payment for office or other outpatient visits, consultation, individual psychotherapy, and pharmacologic management via interactive telecommunications systems.

(a) *Professional service.* Medicare payment for the professional service via an interactive telecommunications system is made according to the following limitations:

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, and pharmacologic management via an interactive telecommunications system is equal to the current fee schedule amount applicable to services of the physician or practitioner.

(2) Only the physician or practitioner at the distant site may bill and receive payment for the professional service via an interactive telecommunications system.

(3) Payments made to the physician or practitioner at the distant site, including deductible and coinsurance, for the professional service may not be shared with the referring practitioner or telepresenter.

(b) *Originating site facility fee.* For office or other outpatient visits, consultation, individual psychotherapy, or pharmacologic management services delivered via an interactive telecommunications system furnished on or after October 1, 2001.

(1) *Payment amount.* For services furnished on or after October 1, 2001 through December 31, 2002, the payment amount to the originating site is the lesser of the actual charge or the originating site facility fee of $20. For services furnished on or after January 1 of each subsequent year, the facility fee for the originating site will be updated by the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act.

(2) *Who may bill for the originating site facility fee.* Only the originating site may bill for the originating site facility fee and only on an assignment-related basis. The distant site physician or practitioner may not bill for or receive payment for facility fees associated with the professional service furnished via an interactive telecommunications system.

(c) *Deductible and coinsurance apply.* The payment for the professional service and originating site facility fee is subject to the coinsurance and deductible requirements of sections 1833(a)(1) and (b) of the Act.

(d) *Sanctions.* A distant site practitioner or originating site facility may be subject to the applicable sanctions provided for in chapter IV, part 402 and chapter V, parts 1001, 1002, and 1003 of this title if he or she does any of the following:

(1) Knowingly and willfully bills or collects for services in violation of the limitation of this section.

(2) Fails to timely correct excess charges by reducing the actual charge billed for the service in an amount that does not exceed the limiting charge for the service or fails to timely refund excess collections.

(3) Fails to submit a claim on a standard form for services provided for which payment is made on a fee schedule basis; or

(4) Imposes a charge for completing and submitting the standard claims form.

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

1. 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).

2. Section 415.130 is amended by:

A. Redesignating paragraphs (a), (b), and (c) as paragraphs (b), (c), and (d).

B. Adding a new paragraph (a).

C. Amending newly designated paragraph (b)(3) by removing the reference ''paragraph (b)'' and adding ''paragraph (c)'' in its place.

D. Amending newly designated paragraph (b)(4) by removing the reference ''paragraphs (b)(1), (b)(3), and (b)(4)'' and adding ''paragraphs (c)(1), (c)(3), and (c)(4)'' in their place.

E. Revising newly designated paragraph (d).

§ 415.130 Conditions for payment: Physician pathology services.

(a) *Definitions.* The following definitions are used in this section.

(1) *Covered hospital* means, with respect to an inpatient or an outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients, and submitted claims for payment for this technical component to a Medicare carrier and not to the hospital.

(2) *Fee-for-service Medicare beneficiaries* means those beneficiaries who are entitled to benefits under Part A or are enrolled under Part B of Title XVIII of the Act or both and are not enrolled in any of the following:

(i) A Medicare+Choice plan under Part C of Title XVIII of the Act.

(ii) A plan offered by an eligible organization under section 1876 of the Act;

(iii) A program of all-inclusive care for the elderly (PACE) under 1894 of the Act; or

(iv) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987.

* * * * *

(d) *Physician pathology services furnished by an independent laboratory.* The technical component of physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient before January 1, 2001 may be paid on a fee schedule basis. After December 31, 2001 but before January 1, 2003, if an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service Medicare beneficiary who is an

inpatient or outpatient of a covered hospital, the carrier will treat the technical component as a service for which payment will be made to the laboratory under the physician fee schedule. The service will not be treated as an inpatient hospital service for which payment is made to the hospital under section 1886(d) of the Act or as an outpatient hospital service for which payment is made to the hospital under section 1833(t) of the Act. After December 31, 2002, the technical component for physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient is paid only to the hospital.

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

Dated: June 19, 2001.

Thomas A. Scully,

Administrator, Health Care Financing Administration.

Approved: July 12, 2001.

Tommy G. Thompson,

Secretary.

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

Addendum A—Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2002. Addendum B contains the RVUs for work, non-facility practice expense, facility practice expense, and malpractice expense, and other information for all services included in the physician fee schedule.

Addendum B—2002 Relative Value Units and Related Information Used in Determining Medicare Payments for 2002

This addendum contains the following information for each CPT code and alphanumeric HCPCS code, except for alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics), and codes for anesthesiology.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier -26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code: One for the global values (both professional and technical); one for modifier -26 (PC); and one for modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier -53 is shown for a discontinued procedure. There will be RVUs for the code (CPT code 45378) with this modifier.

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

A = Active code. These codes are separately payable under the fee schedule if covered. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national decision regarding the coverage of the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)

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

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

E = Excluded from physician fee schedule by regulation. These codes are for items or services that we chose to exclude from the physician fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the physician fee schedule for these codes. Payment for them, if they are covered, continues under reasonable charge or other payment procedures.

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

N = Noncovered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

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

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

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

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

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

X = Exclusion by law. These codes represent an item or service that is not within the definition of ''physicians'' services'' for physician fee schedule payment purposes. No RVUs are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 2000. Codes that are not used for Medicare payment are identified with a ''+.''

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

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

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2000.

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

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

11. *Global period.* This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = The code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = The code is part of another service and falls within the global period for the other service.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
10040	.....	A	Acne surgery of skin abscess	1.18	0.52	1.63	0.05	1.75	2.86	010
10060	.....	A	Drainage of skin abscess	1.17	0.66	1.35	0.08	1.91	2.60	010
10061	.....	A	Drainage of skin abscess	2.40	1.15	2.07	0.17	3.72	4.64	010
10080	.....	A	Drainage of pilonidal cyst	1.17	0.71	2.11	0.09	1.97	3.37	010
10081	.....	A	Drainage of pilonidal cyst	2.45	1.55	2.89	0.19	4.19	5.53	010
10120	.....	A	Remove foreign body	1.22	0.73	1.83	0.10	2.05	3.15	010
10121	.....	A	Remove foreign body	2.69	1.77	2.83	0.25	4.71	5.77	010
10140	.....	A	Drainage of hematoma/fluid	1.53	0.87	1.42	0.15	2.55	3.10	010
10160	.....	A	Puncture drainage of lesion	1.20	0.77	1.56	0.11	2.08	2.87	010
10180	.....	A	Complex drainage, wound	2.25	1.25	1.51	0.25	3.75	4.01	010
11000	.....	A	Debride infected skin	0.60	0.24	0.58	0.05	0.89	1.23	000
11001	.....	A	Debride infected skin add-on	0.30	0.11	0.34	0.02	0.43	0.66	ZZZ
11010	.....	A	Debride skin, fx	4.20	2.00	2.51	0.45	6.65	7.16	010
11011	.....	A	Debride skin/muscle, fx	4.95	2.59	3.87	0.53	8.07	9.35	000
11012	.....	A	Debride skin/muscle/bone, fx	6.88	4.21	5.67	0.89	11.98	13.44	000
11040	.....	A	Debride skin, partial	0.50	0.21	0.50	0.05	0.76	1.05	000
11041	.....	A	Debride skin, full	0.82	0.34	0.67	0.08	1.24	1.57	000
11042	.....	A	Debride skin/tissue	1.12	0.46	0.95	0.11	1.69	2.18	000
11043	.....	A	Debride tissue/muscle	2.38	1.38	2.60	0.24	4.00	5.22	010
11044	.....	A	Debride tissue/muscle/bone	3.06	1.80	3.11	0.34	5.20	6.51	010
11055	.....	R	Trim skin lesion	0.27	0.12	0.38	0.02	0.41	0.67	000
11056	.....	R	Trim skin lesion, 2 to 4	0.39	0.17	0.42	0.03	0.59	0.84	000
11057	.....	R	Trim skin lesions, over 4	0.50	0.22	0.46	0.04	0.76	1.00	000
11100	.....	A	Biopsy of skin lesion	0.81	0.38	1.49	0.04	1.23	2.34	000
11101	.....	A	Biopsy, skin add-on	0.41	0.20	0.70	0.02	0.63	1.13	ZZZ
11200	.....	A	Removal of skin tags	0.77	0.31	1.17	0.04	1.12	1.98	010
11201	.....	A	Remove skin tags add-on	0.29	0.12	0.52	0.02	0.43	0.83	ZZZ
11300	.....	A	Shave skin lesion	0.51	0.22	1.02	0.03	0.76	1.56	000
11301	.....	A	Shave skin lesion	0.85	0.38	1.11	0.04	1.27	2.00	000
11302	.....	A	Shave skin lesion	1.05	0.48	1.21	0.05	1.58	2.31	000
11303	.....	A	Shave skin lesion	1.24	0.54	1.34	0.06	1.84	2.64	000
11305	.....	A	Shave skin lesion	0.67	0.29	0.81	0.04	1.00	1.52	000
11306	.....	A	Shave skin lesion	0.99	0.43	1.06	0.05	1.47	2.10	000
11307	.....	A	Shave skin lesion	1.14	0.51	1.18	0.05	1.70	2.37	000
11308	.....	A	Shave skin lesion	1.41	0.63	1.27	0.07	2.11	2.75	000
11310	.....	A	Shave skin lesion	0.73	0.33	1.12	0.04	1.10	1.89	000
11311	.....	A	Shave skin lesion	1.05	0.50	1.23	0.05	1.60	2.33	000
11312	.....	A	Shave skin lesion	1.20	0.57	1.30	0.06	1.83	2.56	000
11313	.....	A	Shave skin lesion	1.62	0.75	1.58	0.09	2.46	3.29	000
11400	.....	A	Removal of skin lesion	0.91	0.73	2.42	0.06	1.70	3.39	010
11401	.....	A	Removal of skin lesion	1.32	0.88	2.43	0.09	2.29	3.84	010
11402	.....	A	Removal of skin lesion	1.61	0.96	2.52	0.12	2.69	4.25	010
11403	.....	A	Removal of skin lesion	1.92	1.07	2.76	0.16	3.15	4.84	010
11404	.....	A	Removal of skin lesion	2.20	1.17	2.92	0.18	3.55	5.30	010
11406	.....	A	Removal of skin lesion	2.76	1.38	3.20	0.25	4.39	6.21	010
11420	.....	A	Removal of skin lesion	1.06	0.77	2.03	0.08	1.91	3.17	010
11421	.....	A	Removal of skin lesion	1.53	0.99	2.36	0.11	2.63	4.00	010
11422	.....	A	Removal of skin lesion	1.76	1.06	2.51	0.14	2.96	4.41	010
11423	.....	A	Removal of skin lesion	2.17	1.22	2.94	0.17	3.56	5.28	010
11424	.....	A	Removal of skin lesion	2.62	1.41	3.09	0.21	4.24	5.92	010
11426	.....	A	Removal of skin lesion	3.78	1.85	3.74	0.34	5.97	7.86	010
11440	.....	A	Removal of skin lesion	1.15	0.92	2.54	0.08	2.15	3.77	010
11441	.....	A	Removal of skin lesion	1.61	1.16	2.70	0.11	2.88	4.42	010
11442	.....	A	Removal of skin lesion	1.87	1.25	2.77	0.14	3.26	4.78	010
11443	.....	A	Removal of skin lesion	2.49	1.59	3.32	0.18	4.26	5.99	010
11444	.....	A	Removal of skin lesion	3.42	2.00	3.74	0.25	5.67	7.41	010
11446	.....	A	Removal of skin lesion	4.49	2.49	4.18	0.30	7.28	8.97	010
11450	.....	A	Removal, sweat gland lesion	2.73	1.05	4.02	0.26	4.04	7.01	090
11451	.....	A	Removal, sweat gland lesion	3.95	1.59	4.83	0.39	5.93	9.17	090
11462	.....	A	Removal, sweat gland lesion	2.51	0.98	4.14	0.23	3.72	6.88	090
11463	.....	A	Removal, sweat gland lesion	3.95	1.62	5.63	0.40	5.97	9.98	090
11470	.....	A	Removal, sweat gland lesion	3.25	1.28	4.41	0.30	4.83	7.96	090
11471	.....	A	Removal, sweat gland lesion	4.41	1.77	5.42	0.40	6.58	10.23	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
11600	.....	A	Removal of skin lesion	1.41	0.94	2.57	0.09	2.44	4.07	010
11601	.....	A	Removal of skin lesion	1.93	1.08	2.63	0.12	3.13	4.68	010
11602	.....	A	Removal of skin lesion	2.09	1.32	2.69	0.13	3.54	4.91	010
11603	.....	A	Removal of skin lesion	2.35	1.39	2.88	0.16	3.90	5.39	010
11604	.....	A	Removal of skin lesion	2.58	1.46	3.07	0.18	4.22	5.83	010
11606	.....	A	Removal of skin lesion	3.43	1.75	3.63	0.28	5.46	7.34	010
11620	.....	A	Removal of skin lesion	1.34	0.89	2.53	0.09	2.32	3.96	010
11621	.....	A	Removal of skin lesion	1.97	1.35	2.67	0.12	3.44	4.76	010
11622	.....	A	Removal of skin lesion	2.34	1.50	2.84	0.15	3.99	5.33	010
11623	.....	A	Removal of skin lesion	2.93	1.71	2.79	0.20	4.84	5.92	010
11624	.....	A	Removal of skin lesion	3.43	1.93	3.16	0.25	5.61	6.84	010
11626	.....	A	Removal of skin lesion	4.30	2.34	4.18	0.35	6.99	8.83	010
11640	.....	A	Removal of skin lesion	1.53	1.11	2.62	0.10	2.74	4.25	010
11641	.....	A	Removal of skin lesion	2.44	1.66	2.96	0.15	4.25	5.55	010
11642	.....	A	Removal of skin lesion	2.93	1.88	2.89	0.18	4.99	6.00	010
11643	.....	A	Removal of skin lesion	3.50	2.17	3.25	0.24	5.91	6.99	010
11644	.....	A	Removal of skin lesion	4.55	2.68	3.91	0.33	7.56	8.79	010
11646	.....	A	Removal of skin lesion	5.95	3.38	5.19	0.46	9.79	11.60	010
11719	.....	R	Trim nail(s)	0.11	0.07	0.54	0.01	0.19	0.66	000
11720	.....	A	Debride nail, 1–5	0.32	0.13	0.42	0.02	0.47	0.76	000
11721	.....	A	Debride nail, 6 or more	0.54	0.22	0.53	0.04	0.80	1.11	000
11730	.....	A	Removal of nail plate	1.13	0.46	0.74	0.09	1.68	1.96	000
11732	.....	A	Remove nail plate, add-on	0.57	0.24	0.29	0.05	0.86	0.91	ZZZ
11740	.....	A	Drain blood from under nail	0.37	0.14	0.68	0.03	0.54	1.08	000
11750	.....	A	Removal of nail bed	1.86	0.79	1.55	0.16	2.81	3.57	010
11752	.....	A	Remove nail bed/finger tip	2.67	1.75	1.99	0.33	4.75	4.99	010
11755	.....	A	Biopsy, nail unit	1.31	0.59	1.03	0.06	1.96	2.40	000
11760	.....	A	Repair of nail bed	1.58	1.19	1.70	0.17	2.94	3.45	010
11762	.....	A	Reconstruction of nail bed	2.89	1.87	2.15	0.32	5.08	5.36	010
11765	.....	A	Excision of nail fold, toe	0.69	0.45	0.97	0.05	1.19	1.71	010
11770	.....	A	Removal of pilonidal lesion	2.61	1.26	2.97	0.24	4.11	5.82	010
11771	.....	A	Removal of pilonidal lesion	5.74	3.92	5.34	0.56	10.22	11.64	090
11772	.....	A	Removal of pilonidal lesion	6.98	4.36	6.12	0.68	12.02	13.78	090
11900	.....	A	Injection into skin lesions	0.52	0.23	0.76	0.02	0.77	1.30	000
11901	.....	A	Added skin lesions injection	0.80	0.37	0.89	0.03	1.20	1.72	000
11920	.....	R	Correct skin color defects	1.61	0.83	2.24	0.17	2.61	4.02	000
11921	.....	R	Correct skin color defects	1.93	1.04	2.63	0.21	3.18	4.77	000
11922	.....	R	Correct skin color defects	0.49	0.26	0.39	0.05	0.80	0.93	ZZZ
11950	.....	R	Therapy for contour defects	0.84	0.47	1.28	0.06	1.37	2.18	000
11951	.....	R	Therapy for contour defects	1.19	0.54	1.71	0.10	1.83	3.00	000
11952	.....	R	Therapy for contour defects	1.69	0.89	2.15	0.17	2.75	4.01	000
11954	.....	R	Therapy for contour defects	1.85	0.94	2.85	0.19	2.98	4.89	000
11960	.....	A	Insert tissue expander(s)	9.08	10.76	NA	0.88	20.72	NA	090
11970	.....	A	Replace tissue expander	7.06	5.06	NA	0.77	12.89	NA	090
11971	.....	A	Remove tissue expander(s)	2.13	3.86	6.15	0.21	6.20	8.49	090
11975	.....	N	Insert contraceptive cap	+1.48	0.59	1.54	0.14	2.21	3.16	XXX
11976	.....	R	Removal of contraceptive cap	1.78	0.77	1.58	0.17	2.72	3.53	XXX
11977	.....	N	Removal/reinsert contra cap	+3.30	1.30	2.25	0.31	4.91	5.86	XXX
11980	.....	A	Implant hormone pellet(s)	1.48	0.63	1.13	0.10	2.21	2.71	000
12001	.....	A	Repair superficial wound(s)	1.70	0.83	2.31	0.13	2.66	4.14	010
12002	.....	A	Repair superficial wound(s)	1.86	0.86	2.41	0.15	2.87	4.42	010
12004	.....	A	Repair superficial wound(s)	2.24	0.98	2.59	0.17	3.39	5.00	010
12005	.....	A	Repair superficial wound(s)	2.86	1.23	3.05	0.23	4.32	6.14	010
12006	.....	A	Repair superficial wound(s)	3.67	1.92	4.15	0.31	5.90	8.13	010
12007	.....	A	Repair superficial wound(s)	4.12	2.24	4.63	0.37	6.73	9.12	010
12011	.....	A	Repair superficial wound(s)	1.76	0.83	2.37	0.14	2.73	4.27	010
12013	.....	A	Repair superficial wound(s)	1.99	0.89	2.53	0.16	3.04	4.68	010
12014	.....	A	Repair superficial wound(s)	2.46	1.06	2.83	0.18	3.70	5.47	010
12015	.....	A	Repair superficial wound(s)	3.19	1.26	3.26	0.24	4.69	6.69	010
12016	.....	A	Repair superficial wound(s)	3.93	1.50	3.79	0.32	5.75	8.04	010
12017	.....	A	Repair superficial wound(s)	4.71	2.44	5.41	0.39	7.54	10.51	010
12018	.....	A	Repair superficial wound(s)	5.53	2.69	6.31	0.46	8.68	12.30	010
12020	.....	A	Closure of split wound	2.62	1.45	2.60	0.24	4.31	5.46	010
12021	.....	A	Closure of split wound	1.84	1.12	2.11	0.19	3.15	4.14	010
12031	.....	A	Layer closure of wound(s)	2.15	1.19	2.74	0.15	3.49	5.04	010
12032	.....	A	Layer closure of wound(s)	2.47	1.27	2.80	0.15	3.89	5.42	010
12034	.....	A	Layer closure of wound(s)	2.92	1.44	3.06	0.21	4.57	6.19	010
12035	.....	A	Layer closure of wound(s)	3.43	1.65	3.03	0.30	5.38	6.76	010
12036	.....	A	Layer closure of wound(s)	4.05	2.47	5.20	0.41	6.93	9.66	010
12037	.....	A	Layer closure of wound(s)	4.67	2.82	5.61	0.49	7.98	10.77	010
12041	.....	A	Layer closure of wound(s)	2.37	1.26	3.03	0.17	3.80	5.57	010
12042	.....	A	Layer closure of wound(s)	2.74	1.41	3.01	0.17	4.32	5.92	010
12044	.....	A	Layer closure of wound(s)	3.14	1.61	3.17	0.24	4.99	6.55	010
12045	.....	A	Layer closure of wound(s)	3.64	1.84	3.58	0.34	5.82	7.56	010

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
12046	.....	A	Layer closure of wound(s)	4.25	2.53	5.31	0.40	7.18	9.96	010
12047	.....	A	Layer closure of wound(s)	4.65	2.90	5.94	0.41	7.96	11.00	010
12051	.....	A	Layer closure of wound(s)	2.47	1.41	3.00	0.16	4.04	5.63	010
12052	.....	A	Layer closure of wound(s)	2.77	1.37	2.97	0.17	4.31	5.91	010
12053	.....	A	Layer closure of wound(s)	3.12	1.51	3.11	0.20	4.83	6.43	010
12054	.....	A	Layer closure of wound(s)	3.46	1.63	3.43	0.25	5.34	7.14	010
12055	.....	A	Layer closure of wound(s)	4.43	2.14	4.67	0.35	6.92	9.45	010
12056	.....	A	Layer closure of wound(s)	5.24	2.86	6.76	0.43	8.53	12.43	010
12057	.....	A	Layer closure of wound(s)	5.96	3.88	6.67	0.50	10.34	13.13	010
13100	.....	A	Repair of wound or lesion	3.12	1.85	3.38	0.21	5.18	6.71	010
13101	.....	A	Repair of wound or lesion	3.92	2.31	3.61	0.22	6.45	7.75	010
13102	.....	A	Repair wound/lesion add-on	1.24	0.58	0.74	0.10	1.92	2.08	ZZZ
13120	.....	A	Repair of wound or lesion	3.30	1.92	3.49	0.23	5.45	7.02	010
13121	.....	A	Repair of wound or lesion	4.33	2.40	3.82	0.25	6.98	8.40	010
13122	.....	A	Repair wound/lesion add-on	1.44	0.67	0.86	0.12	2.23	2.42	ZZZ
13131	.....	A	Repair of wound or lesion	3.79	2.22	3.73	0.25	6.26	7.77	010
13132	.....	A	Repair of wound or lesion	5.95	3.28	4.56	0.32	9.55	10.83	010
13133	.....	A	Repair wound/lesion add-on	2.19	1.02	1.21	0.17	3.38	3.57	ZZZ
13150	.....	A	Repair of wound or lesion	3.81	2.68	5.27	0.29	6.78	9.37	010
13151	.....	A	Repair of wound or lesion	4.45	3.13	5.18	0.28	7.86	9.91	010
13152	.....	A	Repair of wound or lesion	6.33	4.03	5.89	0.38	10.74	12.60	010
13153	.....	A	Repair wound/lesion add-on	2.38	1.11	1.34	0.18	3.67	3.90	ZZZ
13160	.....	A	Late closure of wound	10.48	6.24	NA	1.19	17.91	NA	090
14000	.....	A	Skin tissue rearrangement	5.89	4.63	7.50	0.46	10.98	13.85	090
14001	.....	A	Skin tissue rearrangement	8.47	5.99	8.93	0.65	15.11	18.05	090
14020	.....	A	Skin tissue rearrangement	6.59	5.36	8.11	0.50	12.45	15.20	090
14021	.....	A	Skin tissue rearrangement	10.06	7.16	9.38	0.69	17.91	20.13	090
14040	.....	A	Skin tissue rearrangement	7.87	6.12	8.33	0.53	14.52	16.73	090
14041	.....	A	Skin tissue rearrangement	11.49	7.98	10.13	0.68	20.15	22.30	090
14060	.....	A	Skin tissue rearrangement	8.50	6.97	8.82	0.59	16.06	17.91	090
14061	.....	A	Skin tissue rearrangement	12.29	8.92	10.97	0.75	21.96	24.01	090
14300	.....	A	Skin tissue rearrangement	11.76	8.50	10.37	0.88	21.14	23.01	090
14350	.....	A	Skin tissue rearrangement	9.61	6.41	NA	1.09	17.11	NA	090
15000	.....	A	Skin graft	4.00	1.92	2.52	0.37	6.29	6.89	000
15001	.....	A	Skin graft add-on	1.00	0.43	0.56	0.11	1.54	1.67	ZZZ
15050	.....	A	Skin pinch graft	4.30	3.94	4.91	0.46	8.70	9.67	090
15100	.....	A	Skin split graft	9.05	6.17	6.26	0.94	16.16	16.25	090
15101	.....	A	Skin split graft add-on	1.72	0.75	1.21	0.18	2.65	3.11	ZZZ
15120	.....	A	Skin split graft	9.83	6.67	8.99	0.87	17.37	19.69	090
15121	.....	A	Skin split graft add-on	2.67	1.25	1.57	0.27	4.19	4.51	ZZZ
15200	.....	A	Skin full graft	8.03	5.64	9.59	0.73	14.40	18.35	090
15201	.....	A	Skin full graft add-on	1.32	0.65	1.00	0.14	2.11	2.46	ZZZ
15220	.....	A	Skin full graft	7.87	6.23	9.66	0.68	14.78	18.21	090
15221	.....	A	Skin full graft add-on	1.19	0.58	1.00	0.12	1.89	2.31	ZZZ
15240	.....	A	Skin full graft	9.04	7.12	9.28	0.77	16.93	19.09	090
15241	.....	A	Skin full graft add-on	1.86	0.96	1.53	0.17	2.99	3.56	ZZZ
15260	.....	A	Skin full graft	10.06	7.53	9.16	0.63	18.22	19.85	090
15261	.....	A	Skin full graft add-on	2.23	1.16	1.63	0.17	3.56	4.03	ZZZ
15342	.....	A	Cultured skin graft, 25 cm	1.00	0.79	2.18	0.39	2.18	3.57	010
15343	.....	A	Culture skn graft addl 25 cm	0.25	0.10	0.27	0.09	0.44	0.61	ZZZ
15350	.....	A	Skin homograft	4.00	4.37	7.37	0.42	8.79	11.79	090
15351	.....	A	Skin homograft add-on	1.00	0.42	0.94	0.11	1.53	2.05	ZZZ
15400	.....	A	Skin heterograft	4.00	4.96	4.96	0.40	9.36	9.36	090
15401	.....	A	Skin heterograft add-on	1.00	0.46	1.14	0.11	1.57	2.25	ZZZ
15570	.....	A	Form skin pedicle flap	9.21	6.27	8.42	0.96	16.44	18.59	090
15572	.....	A	Form skin pedicle flap	9.27	6.18	7.54	0.93	16.38	17.74	090
15574	.....	A	Form skin pedicle flap	9.88	6.94	8.53	0.92	17.74	19.33	090
15576	.....	A	Form skin pedicle flap	8.69	6.35	8.97	0.72	15.76	18.38	090
15600	.....	A	Skin graft	1.91	2.34	6.62	0.19	4.44	8.72	090
15610	.....	A	Skin graft	2.42	2.70	4.56	0.25	5.37	7.23	090
15620	.....	A	Skin graft	2.94	3.29	6.92	0.28	6.51	10.14	090
15630	.....	A	Skin graft	3.27	3.73	6.19	0.28	7.28	9.74	090
15650	.....	A	Transfer skin pedicle flap	3.97	3.84	6.26	0.36	8.17	10.59	090
15732	.....	A	Muscle-skin graft, head/neck	17.84	11.39	NA	1.50	30.73	NA	090
15734	.....	A	Muscle-skin graft, trunk	17.79	11.31	NA	1.91	31.01	NA	090
15736	.....	A	Muscle-skin graft, arm	16.27	10.77	NA	1.78	28.82	NA	090
15738	.....	A	Muscle-skin graft, leg	17.92	11.27	NA	1.95	31.14	NA	090
15740	.....	A	Island pedicle flap graft	10.25	7.12	8.87	0.62	17.99	19.74	090
15750	.....	A	Neurovascular pedicle graft	11.41	8.05	NA	1.12	20.58	NA	090
15756	.....	A	Free muscle flap, microvasc	35.23	18.80	NA	3.11	57.14	NA	090
15757	.....	A	Free skin flap, microvasc	35.23	22.15	NA	3.37	60.75	NA	090
15758	.....	A	Free fascial flap, microvasc	35.10	22.48	NA	3.52	61.10	NA	090
15760	.....	A	Composite skin graft	8.74	6.79	9.31	0.72	16.25	18.77	090
15770	.....	A	Derma-fat-fascia graft	7.52	6.02	NA	0.78	14.32	NA	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
15775	.....	R	Hair transplant punch grafts	3.96	1.58	3.04	0.43	5.97	7.43	000
15776	.....	R	Hair transplant punch grafts	5.54	2.94	3.88	0.60	9.08	10.02	000
15780	.....	A	Abrasion treatment of skin	7.29	6.30	6.30	0.41	14.00	14.00	090
15781	.....	A	Abrasion treatment of skin	4.85	4.76	4.76	0.27	9.88	9.88	090
15782	.....	A	Abrasion treatment of skin	4.32	4.10	4.10	0.21	8.63	8.63	090
15783	.....	A	Abrasion treatment of skin	4.29	3.46	4.45	0.26	8.01	9.00	090
15786	.....	A	Abrasion, lesion, single	2.03	1.27	1.69	0.11	3.41	3.83	010
15787	.....	A	Abrasion, lesions, add-on	0.33	0.17	0.37	0.02	0.52	0.72	ZZZ
15788	.....	R	Chemical peel, face, epiderm	2.09	1.05	3.00	0.11	3.25	5.20	090
15789	.....	R	Chemical peel, face, dermal	4.92	3.67	5.59	0.27	8.86	10.78	090
15792	.....	R	Chemical peel, nonfacial	1.86	1.81	2.77	0.10	3.77	4.73	090
15793	.....	A	Chemical peel, nonfacial	3.74	3.34	NA	0.17	7.25	NA	090
15810	.....	A	Salabrasion	4.74	3.85	3.85	0.42	9.01	9.01	090
15811	.....	A	Salabrasion	5.39	4.03	4.03	0.52	9.94	9.94	090
15819	.....	A	Plastic surgery, neck	9.38	6.82	NA	0.77	16.97	NA	090
15820	.....	A	Revision of lower eyelid	5.15	6.55	10.91	0.30	12.00	16.36	090
15821	.....	A	Revision of lower eyelid	5.72	6.67	11.61	0.31	12.70	17.64	090
15822	.....	A	Revision of upper eyelid	4.45	5.86	8.92	0.22	10.53	13.59	090
15823	.....	A	Revision of upper eyelid	7.05	6.95	10.06	0.32	14.32	17.43	090
15824	.....	R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	XXX
15825	.....	R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	XXX
15826	.....	R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	XXX
15828	.....	R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	XXX
15829	.....	R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	XXX
15831	.....	A	Excise excessive skin tissue	12.40	8.14	NA	1.30	21.84	NA	090
15832	.....	A	Excise excessive skin tissue	11.59	7.81	NA	1.21	20.61	NA	090
15833	.....	A	Excise excessive skin tissue	10.64	7.55	NA	1.17	19.36	NA	090
15834	.....	A	Excise excessive skin tissue	10.85	6.03	NA	1.18	18.06	NA	090
15835	.....	A	Excise excessive skin tissue	11.67	5.70	NA	1.13	18.50	NA	090
15836	.....	A	Excise excessive skin tissue	9.34	6.16	NA	0.95	16.45	NA	090
15837	.....	A	Excise excessive skin tissue	8.43	6.10	7.85	0.78	15.31	17.06	090
15838	.....	A	Excise excessive skin tissue	7.13	5.70	NA	0.58	13.41	NA	090
15839	.....	A	Excise excessive skin tissue	9.38	5.95	7.60	0.88	16.21	17.86	090
15840	.....	A	Graft for face nerve palsy	13.26	9.84	NA	1.15	24.25	NA	090
15841	.....	A	Graft for face nerve palsy	23.26	15.24	NA	2.65	41.15	NA	090
15842	.....	A	Flap for face nerve palsy	37.96	21.68	NA	3.99	63.63	NA	090
15845	.....	A	Skin and muscle repair, face	12.57	8.65	NA	0.80	22.02	NA	090
15850	.....	B	Removal of sutures	+0.78	0.31	1.37	0.04	1.13	2.19	XXX
15851	.....	A	Removal of sutures	0.86	0.35	1.56	0.05	1.26	2.47	000
15852	.....	A	Dressing change,not for burn	0.86	0.36	1.76	0.07	1.29	2.69	000
15860	.....	A	Test for blood flow in graft	1.95	0.80	1.31	0.13	2.88	3.39	000
15876	.....	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
15877	.....	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
15878	.....	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
15879	.....	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
15920	.....	A	Removal of tail bone ulcer	7.95	5.38	NA	0.83	14.16	NA	090
15922	.....	A	Removal of tail bone ulcer	9.90	7.27	NA	1.06	18.23	NA	090
15931	.....	A	Remove sacrum pressure sore	9.24	5.59	NA	0.95	15.78	NA	090
15933	.....	A	Remove sacrum pressure sore	10.85	7.74	NA	1.14	19.73	NA	090
15934	.....	A	Remove sacrum pressure sore	12.69	8.36	NA	1.35	22.40	NA	090
15935	.....	A	Remove sacrum pressure sore	14.57	10.35	NA	1.56	26.48	NA	090
15936	.....	A	Remove sacrum pressure sore	12.38	8.98	NA	1.32	22.68	NA	090
15937	.....	A	Remove sacrum pressure sore	14.21	10.45	NA	1.51	26.17	NA	090
15940	.....	A	Remove hip pressure sore	9.34	5.94	NA	0.98	16.26	NA	090
15941	.....	A	Remove hip pressure sore	11.43	9.77	NA	1.23	22.43	NA	090
15944	.....	A	Remove hip pressure sore	11.46	8.68	NA	1.21	21.35	NA	090
15945	.....	A	Remove hip pressure sore	12.69	9.83	NA	1.38	23.90	NA	090
15946	.....	A	Remove hip pressure sore	21.57	14.57	NA	2.32	38.46	NA	090
15950	.....	A	Remove thigh pressure sore	7.54	5.17	NA	0.80	13.51	NA	090
15951	.....	A	Remove thigh pressure sore	10.72	7.67	NA	1.14	19.53	NA	090
15952	.....	A	Remove thigh pressure sore	11.39	7.38	NA	1.19	19.96	NA	090
15953	.....	A	Remove thigh pressure sore	12.63	8.89	NA	1.38	22.90	NA	090
15956	.....	A	Remove thigh pressure sore	15.52	10.60	NA	1.64	27.76	NA	090
15958	.....	A	Remove thigh pressure sore	15.48	10.97	NA	1.66	28.11	NA	090
15999	.....	C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	YYY
16000	.....	A	Initial treatment of burn(s)	0.89	0.27	1.06	0.06	1.22	2.01	000
16010	.....	A	Treatment of burn(s)	0.87	0.38	1.17	0.07	1.32	2.11	000
16015	.....	A	Treatment of burn(s)	2.35	0.97	1.93	0.22	3.54	4.50	000
16020	.....	A	Treatment of burn(s)	0.80	0.26	1.17	0.06	1.12	2.03	000
16025	.....	A	Treatment of burn(s)	1.85	0.68	1.87	0.16	2.69	3.88	000
16030	.....	A	Treatment of burn(s)	2.08	0.93	3.03	0.18	3.19	5.29	000
16035	.....	A	Incision of burn scab, initi	3.75	1.53	NA	0.36	5.64	NA	090
16036	.....	A	Incise burn scab, addl incis	1.50	0.61	NA	0.18	2.29	NA	ZZZ
17000	.....	A	Destroy benign/premal lesion	0.60	0.27	1.09	0.03	0.90	1.72	010

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
17003	.....	A	Destroy lesions, 2–14	0.15	0.07	0.24	0.01	0.23	0.40	ZZZ
17004	.....	A	Destroy lesions, 15 or more	2.79	1.29	2.56	0.12	4.20	5.47	010
17106	.....	A	Destruction of skin lesions	4.59	2.68	4.68	0.28	7.55	9.55	090
17107	.....	A	Destruction of skin lesions	9.16	4.75	6.80	0.53	14.44	16.49	090
17108	.....	A	Destruction of skin lesions	13.20	7.27	8.63	0.89	21.36	22.72	090
17110	.....	A	Destruct lesion, 1–14	0.65	0.26	1.07	0.04	0.95	1.76	010
17111	.....	A	Destruct lesion, 15 or more	0.92	0.40	1.13	0.04	1.36	2.09	010
17250	.....	A	Chemical cautery, tissue	0.50	0.21	0.71	0.04	0.75	1.25	000
17260	.....	A	Destruction of skin lesions	0.91	0.42	1.37	0.04	1.37	2.32	010
17261	.....	A	Destruction of skin lesions	1.17	0.55	1.48	0.05	1.77	2.70	010
17262	.....	A	Destruction of skin lesions	1.58	0.75	1.68	0.07	2.40	3.33	010
17263	.....	A	Destruction of skin lesions	1.79	0.82	1.79	0.08	2.69	3.66	010
17264	.....	A	Destruction of skin lesions	1.94	0.84	1.87	0.08	2.86	3.89	010
17266	.....	A	Destruction of skin lesions	2.34	0.94	2.08	0.11	3.39	4.53	010
17270	.....	A	Destruction of skin lesions	1.32	0.62	1.57	0.06	2.00	2.95	010
17271	.....	A	Destruction of skin lesions	1.49	0.72	1.64	0.06	2.27	3.19	010
17272	.....	A	Destruction of skin lesions	1.77	0.85	1.78	0.07	2.69	3.62	010
17273	.....	A	Destruction of skin lesions	2.05	0.98	1.93	0.09	3.12	4.07	010
17274	.....	A	Destruction of skin lesions	2.59	1.19	2.19	0.11	3.89	4.89	010
17276	.....	A	Destruction of skin lesions	3.20	1.71	2.50	0.15	5.06	5.85	010
17280	.....	A	Destruction of skin lesions	1.17	0.54	1.40	0.05	1.76	2.62	010
17281	.....	A	Destruction of skin lesions	1.72	0.83	1.76	0.07	2.62	3.55	010
17282	.....	A	Destruction of skin lesions	2.04	0.99	1.92	0.09	3.12	4.05	010
17283	.....	A	Destruction of skin lesions	2.64	1.24	2.23	0.11	3.99	4.98	010
17284	.....	A	Destruction of skin lesions	3.21	1.50	2.52	0.14	4.85	5.87	010
17286	.....	A	Destruction of skin lesions	4.44	2.48	3.15	0.22	7.14	7.81	010
17304	.....	A	Chemosurgery of skin lesion	7.60	3.67	7.75	0.31	11.58	15.66	000
17305	.....	A	2nd stage chemosurgery	2.85	1.38	3.60	0.12	4.35	6.57	000
17306	.....	A	3rd stage chemosurgery	2.85	1.39	3.64	0.12	4.36	6.61	000
17307	.....	A	Followup skin lesion therapy	2.85	1.41	3.16	0.12	4.38	6.13	000
17310	.....	A	Extensive skin chemosurgery	0.95	0.48	1.49	0.05	1.48	2.49	000
17340	.....	A	Cryotherapy of skin	0.76	0.27	1.36	0.04	1.07	2.16	010
17360	.....	A	Skin peel therapy	1.43	0.70	1.48	0.06	2.19	2.97	010
17380	.....	R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
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	0.29	1.23	0.07	1.20	2.14	000
19001	.....	A	Drain breast lesion add-on	0.42	0.15	0.83	0.03	0.60	1.28	ZZZ
19020	.....	A	Incision of breast lesion	3.57	3.41	6.96	0.35	7.33	10.88	090
19030	.....	A	Injection for breast x-ray	1.53	0.53	11.25	0.07	2.13	12.85	000
19100	.....	A	Biopsy of breast	1.27	0.45	3.56	0.10	1.82	4.93	000
19101	.....	A	Biopsy of breast, open	3.18	3.09	10.62	0.20	6.47	14.00	010
19102	.....	A	Bx breast percut w/image	2.00	0.71	4.88	0.08	2.79	6.96	000
19103	.....	A	Bx breast percut w/device	2.37	0.84	11.46	0.08	3.29	13.91	000
19110	.....	A	Nipple exploration	4.30	4.40	8.43	0.44	9.14	13.17	090
19112	.....	A	Excise breast duct fistula	3.67	3.09	7.24	0.38	7.14	11.29	090
19120	.....	A	Removal of breast lesion	5.56	3.55	4.41	0.56	9.67	10.53	090
19125	.....	A	Excision, breast lesion	6.06	3.70	5.02	0.61	10.37	11.69	090
19126	.....	A	Excision, addl breast lesion	2.93	1.05	NA	0.30	4.28	NA	ZZZ
19140	.....	A	Removal of breast tissue	5.14	3.72	9.03	0.52	9.38	14.69	090
19160	.....	A	Removal of breast tissue	5.99	4.52	NA	0.61	11.12	NA	090
19162	.....	A	Remove breast tissue, nodes	13.53	7.94	NA	1.38	22.85	NA	090
19180	.....	A	Removal of breast	8.80	5.97	NA	0.88	15.65	NA	090
19182	.....	A	Removal of breast	7.73	5.01	NA	0.79	13.53	NA	090
19200	.....	A	Removal of breast	15.49	9.24	NA	1.51	26.24	NA	090
19220	.....	A	Removal of breast	15.72	9.22	NA	1.56	26.50	NA	090
19240	.....	A	Removal of breast	16.00	8.82	NA	1.62	26.44	NA	090
19260	.....	A	Removal of chest wall lesion	15.44	9.35	NA	1.64	26.43	NA	090
19271	.....	A	Revision of chest wall	18.90	11.61	NA	2.27	32.78	NA	090
19272	.....	A	Extensive chest wall surgery	21.55	12.54	NA	2.54	36.63	NA	090
19290	.....	A	Place needle wire, breast	1.27	0.44	5.08	0.06	1.77	6.41	000
19291	.....	A	Place needle wire, breast	0.63	0.22	1.72	0.03	0.88	2.38	ZZZ
19295	.....	A	Place breast clip, percut	0.00	NA	2.65	0.01	NA	2.66	ZZZ
19316	.....	A	Suspension of breast	10.69	7.65	NA	1.15	19.49	NA	090
19318	.....	A	Reduction of large breast	15.62	10.47	NA	1.69	27.78	NA	090
19324	.....	A	Enlarge breast	5.85	4.64	NA	0.63	11.12	NA	090
19325	.....	A	Enlarge breast with implant	8.45	6.82	NA	0.90	16.17	NA	090
19328	.....	A	Removal of breast implant	5.68	4.63	NA	0.61	10.92	NA	090
19330	.....	A	Removal of implant material	7.59	5.35	NA	0.81	13.75	NA	090
19340	.....	A	Immediate breast prosthesis	6.33	3.25	NA	0.68	10.26	NA	ZZZ
19342	.....	A	Delayed breast prosthesis	11.20	8.01	NA	1.21	20.42	NA	090
19350	.....	A	Breast reconstruction	8.92	6.92	14.29	0.95	16.79	24.16	090
19355	.....	A	Correct inverted nipple(s)	7.57	6.10	12.05	0.80	14.47	20.42	090
19357	.....	A	Breast reconstruction	18.16	14.04	NA	1.96	34.16	NA	090
19361	.....	A	Breast reconstruction	19.26	12.20	NA	2.08	33.54	NA	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
19364	.....	A	Breast reconstruction	41.00	22.78	NA	3.91	67.69	NA	090
19366	.....	A	Breast reconstruction	21.28	12.20	NA	2.27	35.75	NA	090
19367	.....	A	Breast reconstruction	25.73	15.53	NA	2.78	44.04	NA	090
19368	.....	A	Breast reconstruction	32.42	19.28	NA	3.51	55.21	NA	090
19369	.....	A	Breast reconstruction	29.82	18.49	NA	3.24	51.55	NA	090
19370	.....	A	Surgery of breast capsule	8.05	6.21	NA	0.86	15.12	NA	090
19371	.....	A	Removal of breast capsule	9.35	7.32	NA	1.01	17.68	NA	090
19380	.....	A	Revise breast reconstruction	9.14	7.21	NA	0.98	17.33	NA	090
19396	.....	A	Design custom breast implant	2.17	0.80	5.35	0.23	3.20	7.75	000
19499	.....	C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
20000	.....	A	Incision of abscess	2.12	1.19	2.01	0.17	3.48	4.30	010
20005	.....	A	Incision of deep abscess	3.42	2.20	2.92	0.34	5.96	6.68	010
20100	.....	A	Explore wound, neck	10.08	4.47	5.92	0.99	15.54	16.99	010
20101	.....	A	Explore wound, chest	3.22	1.30	3.00	0.24	4.76	6.46	010
20102	.....	A	Explore wound, abdomen	3.94	1.67	3.34	0.35	5.96	7.63	010
20103	.....	A	Explore wound, extremity	5.30	2.98	4.10	0.57	8.85	9.97	010
20150	.....	A	Excise epiphyseal bar	13.69	7.83	NA	0.96	22.48	NA	090
20200	.....	A	Muscle biopsy	1.46	0.62	1.72	0.17	2.25	3.35	000
20205	.....	A	Deep muscle biopsy	2.35	0.98	3.72	0.23	3.56	6.30	000
20206	.....	A	Needle biopsy, muscle	0.99	0.36	3.15	0.06	1.41	4.20	000
20220	.....	A	Bone biopsy, trocar/needle	1.27	3.02	4.98	0.06	4.35	6.31	000
20225	.....	A	Bone biopsy, trocar/needle	1.87	3.03	4.52	0.11	5.01	6.50	000
20240	.....	A	Bone biopsy, excisional	3.23	4.07	NA	0.33	7.63	NA	010
20245	.....	A	Bone biopsy, excisional	7.78	6.69	NA	0.44	14.91	NA	010
20250	.....	A	Open bone biopsy	5.03	4.30	NA	0.50	9.83	NA	010
20251	.....	A	Open bone biopsy	5.56	4.74	NA	0.79	11.09	NA	010
20500	.....	A	Injection of sinus tract	1.23	4.03	5.37	0.10	5.36	6.70	010
20501	.....	A	Inject sinus tract for x-ray	0.76	0.26	13.46	0.03	1.05	14.25	000
20520	.....	A	Removal of foreign body	1.85	3.37	5.40	0.17	5.39	7.42	010
20525	.....	A	Removal of foreign body	3.50	4.15	6.66	0.40	8.05	10.56	010
20550	.....	A	Inject tendon/ligament/cyst	0.86	0.22	2.05	0.06	1.14	2.97	000
20600	.....	A	Drain/inject, joint/bursa	0.66	0.27	1.38	0.06	0.99	2.10	000
20605	.....	A	Drain/inject, joint/bursa	0.68	0.27	1.71	0.06	1.01	2.45	000
20610	.....	A	Drain/inject, joint/bursa	0.79	0.56	2.11	0.08	1.43	2.98	000
20615	.....	A	Treatment of bone cyst	2.28	2.51	4.52	0.19	4.98	6.99	010
20650	.....	A	Insert and remove bone pin	2.23	2.90	4.38	0.28	5.41	6.89	010
20660	.....	A	Apply,remove fixation device	2.51	1.49	NA	0.48	4.48	NA	000
20661	.....	A	Application of head brace	4.89	6.47	NA	0.92	12.28	NA	090
20662	.....	A	Application of pelvis brace	6.07	5.15	NA	0.81	12.03	NA	090
20663	.....	A	Application of thigh brace	5.43	4.78	NA	0.77	10.98	NA	090
20664	.....	A	Halo brace application	8.06	8.21	NA	1.49	17.76	NA	090
20665	.....	A	Removal of fixation device	1.31	1.23	2.34	0.17	2.71	3.82	010
20670	.....	A	Removal of support implant	1.74	3.37	5.51	0.23	5.34	7.48	010
20680	.....	A	Removal of support implant	3.35	4.98	4.98	0.46	8.79	8.79	090
20690	.....	A	Apply bone fixation device	3.52	1.89	NA	0.47	5.88	NA	090
20692	.....	A	Apply bone fixation device	6.41	2.50	NA	0.60	9.51	NA	090
20693	.....	A	Adjust bone fixation device	5.86	11.53	NA	0.85	18.24	NA	090
20694	.....	A	Remove bone fixation device	4.16	5.77	8.18	0.57	10.50	12.91	090
20802	.....	A	Replantation, arm, complete	41.15	31.17	NA	5.81	78.13	NA	090
20805	.....	A	Replant, forearm, complete	50.00	49.91	NA	3.95	103.86	NA	090
20808	.....	A	Replantation hand, complete	61.65	43.88	NA	6.49	112.02	NA	090
20816	.....	A	Replantation digit, complete	30.94	43.13	NA	3.01	77.08	NA	090
20822	.....	A	Replantation digit, complete	25.59	39.51	NA	3.07	68.17	NA	090
20824	.....	A	Replantation thumb, complete	30.94	36.86	NA	3.48	71.28	NA	090
20827	.....	A	Replantation thumb, complete	26.41	45.96	NA	3.21	75.58	NA	090
20838	.....	A	Replantation foot, complete	41.41	28.52	NA	5.85	75.78	NA	090
20900	.....	A	Removal of bone for graft	5.58	5.83	6.77	0.77	12.18	13.12	090
20902	.....	A	Removal of bone for graft	7.55	8.29	NA	1.06	16.90	NA	090
20910	.....	A	Remove cartilage for graft	5.34	6.69	8.21	0.50	12.53	14.05	090
20912	.....	A	Remove cartilage for graft	6.35	7.51	NA	0.55	14.41	NA	090
20920	.....	A	Removal of fascia for graft	5.31	5.57	NA	0.54	11.42	NA	090
20922	.....	A	Removal of fascia for graft	6.61	6.25	8.76	0.88	13.74	16.25	090
20924	.....	A	Removal of tendon for graft	6.48	6.73	NA	0.82	14.03	NA	090
20926	.....	A	Removal of tissue for graft	5.53	6.23	NA	0.73	12.49	NA	090
20930	.....	B	Spinal bone allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931	.....	A	Spinal bone allograft	1.81	0.97	NA	0.34	3.12	NA	ZZZ
20936	.....	B	Spinal bone autograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20937	.....	A	Spinal bone autograft	2.79	1.53	NA	0.43	4.75	NA	ZZZ
20938	.....	A	Spinal bone autograft	3.02	1.63	NA	0.52	5.17	NA	ZZZ
20950	.....	A	Fluid pressure, muscle	1.26	2.10	NA	0.16	3.52	NA	000
20955	.....	A	Fibula bone graft, microvasc	39.21	30.01	NA	4.35	73.57	NA	090
20956	.....	A	Iliac bone graft, microvasc	39.27	28.48	NA	5.77	73.52	NA	090
20957	.....	A	Mt bone graft, microvasc	40.65	24.37	NA	5.74	70.76	NA	090
20962	.....	A	Other bone graft, microvasc	39.27	28.18	NA	5.19	72.64	NA	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
20969	.....	A	Bone/skin graft, microvasc	43.92	32.94	NA	4.34	81.20	NA	090
20970	.....	A	Bone/skin graft, iliac crest	43.06	30.40	NA	4.64	78.10	NA	090
20972	.....	A	Bone/skin graft, metatarsal	42.99	18.86	NA	6.07	67.92	NA	090
20973	.....	A	Bone/skin graft, great toe	45.76	22.15	NA	4.65	72.56	NA	090
20974	.....	A	Electrical bone stimulation	0.62	0.34	0.39	0.09	1.05	1.10	000
20975	.....	A	Electrical bone stimulation	2.60	1.42	NA	0.42	4.44	NA	000
20979	.....	A	Us bone stimulation	0.62	0.25	0.56	0.04	0.91	1.22	000
20999	.....	C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21010	.....	A	Incision of jaw joint	10.14	7.05	NA	0.54	17.73	NA	090
21015	.....	A	Resection of facial tumor	5.29	7.20	NA	0.52	13.01	NA	090
21025	.....	A	Excision of bone, lower jaw	10.06	6.86	7.38	0.79	17.71	18.23	090
21026	.....	A	Excision of facial bone(s)	4.85	4.83	5.49	0.40	10.08	10.74	090
21029	.....	A	Contour of face bone lesion	7.71	6.11	6.87	0.74	14.56	15.32	090
21030	.....	A	Removal of face bone lesion	6.46	4.88	5.39	0.60	11.94	12.45	090
21031	.....	A	Remove exostosis, mandible	3.24	2.11	3.34	0.28	5.63	6.86	090
21032	.....	A	Remove exostosis, maxilla	3.24	2.15	3.30	0.27	5.66	6.81	090
21034	.....	A	Removal of face bone lesion	16.17	10.67	12.00	1.37	28.21	29.54	090
21040	.....	A	Removal of jaw bone lesion	2.11	1.85	2.98	0.19	4.15	5.28	090
21041	.....	A	Removal of jaw bone lesion	6.71	4.34	5.61	0.56	11.61	12.88	090
21044	.....	A	Removal of jaw bone lesion	11.86	7.92	NA	0.87	20.65	NA	090
21045	.....	A	Extensive jaw surgery	16.17	10.27	NA	1.20	27.64	NA	090
21050	.....	A	Removal of jaw joint	10.77	11.32	NA	0.84	22.93	NA	090
21060	.....	A	Remove jaw joint cartilage	10.23	10.11	NA	1.16	21.50	NA	090
21070	.....	A	Remove coronoid process	8.20	6.09	NA	0.67	14.96	NA	090
21076	.....	A	Prepare face/oral prosthesis	13.42	7.29	9.70	1.36	22.07	24.48	010
21077	.....	A	Prepare face/oral prosthesis	33.75	18.34	24.39	3.43	55.52	61.57	090
21079	.....	A	Prepare face/oral prosthesis	22.34	12.68	17.23	1.59	36.61	41.16	090
21080	.....	A	Prepare face/oral prosthesis	25.10	14.25	19.36	2.55	41.90	47.01	090
21081	.....	A	Prepare face/oral prosthesis	22.88	12.99	17.65	1.87	37.74	42.40	090
21082	.....	A	Prepare face/oral prosthesis	20.87	11.34	15.08	1.46	33.67	37.41	090
21083	.....	A	Prepare face/oral prosthesis	19.30	10.96	14.89	1.96	32.22	36.15	090
21084	.....	A	Prepare face/oral prosthesis	22.51	12.78	17.36	1.57	36.86	41.44	090
21085	.....	A	Prepare face/oral prosthesis	9.00	4.89	6.50	0.65	14.54	16.15	010
21086	.....	A	Prepare face/oral prosthesis	24.92	14.15	19.22	1.86	40.93	46.00	090
21087	.....	A	Prepare face/oral prosthesis	24.92	13.54	18.00	2.22	40.68	45.14	090
21088	.....	C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21089	.....	C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21100	.....	A	Maxillofacial fixation	4.22	4.06	5.89	0.18	8.46	10.29	090
21110	.....	A	Interdental fixation	5.21	4.57	5.23	0.28	10.06	10.72	090
21116	.....	A	Injection, jaw joint x-ray	0.81	0.30	8.08	0.05	1.16	8.94	000
21120	.....	A	Reconstruction of chin	4.93	6.32	10.45	0.29	11.54	15.67	090
21121	.....	A	Reconstruction of chin	7.64	5.82	8.09	0.56	14.02	16.29	090
21122	.....	A	Reconstruction of chin	8.52	7.36	NA	0.59	16.47	NA	090
21123	.....	A	Reconstruction of chin	11.16	8.54	NA	1.16	20.86	NA	090
21125	.....	A	Augmentation, lower jaw bone	10.62	8.72	9.17	0.72	20.06	20.51	090
21127	.....	A	Augmentation, lower jaw bone	11.12	6.69	9.64	0.76	18.57	21.52	090
21137	.....	A	Reduction of forehead	9.82	6.95	NA	0.53	17.30	NA	090
21138	.....	A	Reduction of forehead	12.19	9.93	NA	1.47	23.59	NA	090
21139	.....	A	Reduction of forehead	14.61	9.39	NA	1.02	25.02	NA	090
21141	.....	A	Reconstruct midface, lefort	18.10	11.14	NA	1.63	30.87	NA	090
21142	.....	A	Reconstruct midface, lefort	18.81	11.26	NA	1.16	31.23	NA	090
21143	.....	A	Reconstruct midface, lefort	19.58	11.74	NA	0.90	32.22	NA	090
21145	.....	A	Reconstruct midface, lefort	19.94	11.43	NA	2.09	33.46	NA	090
21146	.....	A	Reconstruct midface, lefort	20.71	12.11	NA	2.13	34.95	NA	090
21147	.....	A	Reconstruct midface, lefort	21.77	13.27	NA	1.52	36.56	NA	090
21150	.....	A	Reconstruct midface, lefort	25.24	14.91	NA	1.09	41.24	NA	090
21151	.....	A	Reconstruct midface, lefort	28.30	18.38	NA	1.98	48.66	NA	090
21154	.....	A	Reconstruct midface, lefort	30.52	18.49	NA	4.86	53.87	NA	090
21155	.....	A	Reconstruct midface, lefort	34.45	18.24	NA	5.48	58.17	NA	090
21159	.....	A	Reconstruct midface, lefort	42.38	21.37	NA	6.74	70.49	NA	090
21160	.....	A	Reconstruct midface, lefort	46.44	24.49	NA	4.39	75.32	NA	090
21172	.....	A	Reconstruct orbit/forehead	27.80	18.30	NA	1.91	48.01	NA	090
21175	.....	A	Reconstruct orbit/forehead	33.17	18.70	NA	5.16	57.03	NA	090
21179	.....	A	Reconstruct entire forehead	22.25	18.90	NA	2.48	43.63	NA	090
21180	.....	A	Reconstruct entire forehead	25.19	19.28	NA	2.15	46.62	NA	090
21181	.....	A	Contour cranial bone lesion	9.90	8.90	NA	0.97	19.77	NA	090
21182	.....	A	Reconstruct cranial bone	32.19	22.36	NA	2.53	57.08	NA	090
21183	.....	A	Reconstruct cranial bone	35.31	23.10	NA	2.75	61.16	NA	090
21184	.....	A	Reconstruct cranial bone	38.24	21.38	NA	4.12	63.74	NA	090
21188	.....	A	Reconstruction of midface	22.46	15.78	NA	1.85	40.09	NA	090
21193	.....	A	Reconst lwr jaw w/o graft	17.15	11.03	NA	1.53	29.71	NA	090
21194	.....	A	Reconst lwr jaw w/graft	19.84	12.07	NA	1.39	33.30	NA	090
21195	.....	A	Reconst lwr jaw w/o fixation	17.24	12.94	NA	1.20	31.38	NA	090
21196	.....	A	Reconst lwr jaw w/fixation	18.91	12.88	NA	1.62	33.41	NA	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
21198	.....	A	Reconstr lwr jaw segment	14.16	11.84	NA	1.05	27.05	NA	090
21199	.....	A	Reconstr lwr jaw w/advance	16.00	10.56	NA	1.00	27.56	NA	090
21206	.....	A	Reconstruct upper jaw bone	14.10	10.13	NA	1.01	25.24	NA	090
21208	.....	A	Augmentation of facial bones	10.23	8.46	10.12	0.92	19.61	21.27	090
21209	.....	A	Reduction of facial bones	6.72	5.69	8.96	0.60	13.01	16.28	090
21210	.....	A	Face bone graft	10.23	8.02	8.95	0.88	19.13	20.06	090
21215	.....	A	Lower jaw bone graft	10.77	6.88	8.75	1.04	18.69	20.56	090
21230	.....	A	Rib cartilage graft	10.77	10.27	NA	0.96	22.00	NA	090
21235	.....	A	Ear cartilage graft	6.72	8.03	11.81	0.52	15.27	19.05	090
21240	.....	A	Reconstruction of jaw joint	14.05	11.49	NA	1.15	26.69	NA	090
21242	.....	A	Reconstruction of jaw joint	12.95	11.53	NA	1.40	25.88	NA	090
21243	.....	A	Reconstruction of jaw joint	20.79	14.75	NA	1.85	37.39	NA	090
21244	.....	A	Reconstruction of lower jaw	11.86	9.03	NA	0.95	21.84	NA	090
21245	.....	A	Reconstruction of jaw	11.86	10.15	16.56	0.88	22.89	29.30	090
21246	.....	A	Reconstruction of jaw	12.47	10.98	12.51	1.21	24.66	26.19	090
21247	.....	A	Reconstruct lower jaw bone	22.63	18.84	NA	2.21	43.68	NA	090
21248	.....	A	Reconstruction of jaw	11.48	8.01	8.86	1.01	20.50	21.35	090
21249	.....	A	Reconstruction of jaw	17.52	10.16	11.38	1.39	29.07	30.29	090
21255	.....	A	Reconstruct lower jaw bone	16.72	10.96	NA	1.13	28.81	NA	090
21256	.....	A	Reconstruction of orbit	16.19	13.20	NA	1.04	30.43	NA	090
21260	.....	A	Revise eye sockets	16.52	11.65	NA	1.25	29.42	NA	090
21261	.....	A	Revise eye sockets	31.49	19.12	NA	2.20	52.81	NA	090
21263	.....	A	Revise eye sockets	28.42	14.84	NA	2.16	45.42	NA	090
21267	.....	A	Revise eye sockets	18.90	14.43	NA	1.35	34.68	NA	090
21268	.....	A	Revise eye sockets	24.48	11.93	NA	0.79	37.20	NA	090
21270	.....	A	Augmentation, cheek bone	10.23	9.10	10.49	0.73	20.06	21.45	090
21275	.....	A	Revision, orbitofacial bones	11.24	11.24	NA	1.03	23.51	NA	090
21280	.....	A	Revision of eyelid	6.03	5.88	NA	0.27	12.18	NA	090
21282	.....	A	Revision of eyelid	3.49	5.04	NA	0.21	8.74	NA	090
21295	.....	A	Revision of jaw muscle/bone	1.53	3.55	NA	0.13	5.21	NA	090
21296	.....	A	Revision of jaw muscle/bone	4.25	5.17	NA	0.30	9.72	NA	090
21299	.....	C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21300	.....	A	Treatment of skull fracture	0.72	0.27	2.37	0.09	1.08	3.18	000
21310	.....	A	Treatment of nose fracture	0.58	0.15	2.54	0.05	0.78	3.17	000
21315	.....	A	Treatment of nose fracture	1.51	1.24	3.30	0.12	2.87	4.93	010
21320	.....	A	Treatment of nose fracture	1.85	1.99	4.85	0.15	3.99	6.85	010
21325	.....	A	Treatment of nose fracture	3.77	3.71	NA	0.31	7.79	NA	090
21330	.....	A	Treatment of nose fracture	5.38	5.50	NA	0.48	11.36	NA	090
21335	.....	A	Treatment of nose fracture	8.61	7.10	NA	0.64	16.35	NA	090
21336	.....	A	Treat nasal septal fracture	5.72	5.50	NA	0.45	11.67	NA	090
21337	.....	A	Treat nasal septal fracture	2.70	3.17	5.02	0.22	6.09	7.94	090
21338	.....	A	Treat nasoethmoid fracture	6.46	5.94	NA	0.53	12.93	NA	090
21339	.....	A	Treat nasoethmoid fracture	8.09	6.95	NA	0.76	15.80	NA	090
21340	.....	A	Treatment of nose fracture	10.77	9.36	NA	0.85	20.98	NA	090
21343	.....	A	Treatment of sinus fracture	12.95	9.99	NA	1.06	24.00	NA	090
21344	.....	A	Treatment of sinus fracture	19.72	13.42	NA	1.72	34.86	NA	090
21345	.....	A	Treat nose/jaw fracture	8.16	7.44	8.86	0.60	16.20	17.62	090
21346	.....	A	Treat nose/jaw fracture	10.61	10.35	NA	0.85	21.81	NA	090
21347	.....	A	Treat nose/jaw fracture	12.69	9.36	NA	1.14	23.19	NA	090
21348	.....	A	Treat nose/jaw fracture	16.69	10.37	NA	1.50	28.56	NA	090
21355	.....	A	Treat cheek bone fracture	3.77	2.41	4.84	0.29	6.47	8.90	010
21356	.....	A	Treat cheek bone fracture	4.15	3.25	NA	0.36	7.76	NA	010
21360	.....	A	Treat cheek bone fracture	6.46	5.77	NA	0.52	12.75	NA	090
21365	.....	A	Treat cheek bone fracture	14.95	11.37	NA	1.30	27.62	NA	090
21366	.....	A	Treat cheek bone fracture	17.77	12.08	NA	1.41	31.26	NA	090
21385	.....	A	Treat eye socket fracture	9.16	7.63	NA	0.64	17.43	NA	090
21386	.....	A	Treat eye socket fracture	9.16	8.03	NA	0.76	17.95	NA	090
21387	.....	A	Treat eye socket fracture	9.70	8.16	NA	0.78	18.64	NA	090
21390	.....	A	Treat eye socket fracture	10.13	8.38	NA	0.70	19.21	NA	090
21395	.....	A	Treat eye socket fracture	12.68	10.07	NA	1.09	23.84	NA	090
21400	.....	A	Treat eye socket fracture	1.40	1.08	2.93	0.12	2.60	4.45	090
21401	.....	A	Treat eye socket fracture	3.26	3.25	5.59	0.34	6.85	9.19	090
21406	.....	A	Treat eye socket fracture	7.01	6.60	NA	0.59	14.20	NA	090
21407	.....	A	Treat eye socket fracture	8.61	7.71	NA	0.67	16.99	NA	090
21408	.....	A	Treat eye socket fracture	12.38	9.70	NA	1.24	23.32	NA	090
21421	.....	A	Treat mouth roof fracture	5.14	6.35	7.45	0.42	11.91	13.01	090
21422	.....	A	Treat mouth roof fracture	8.32	7.21	NA	0.69	16.22	NA	090
21423	.....	A	Treat mouth roof fracture	10.40	8.19	NA	0.95	19.54	NA	090
21431	.....	A	Treat craniofacial fracture	7.05	5.25	NA	0.58	12.88	NA	090
21432	.....	A	Treat craniofacial fracture	8.61	7.40	NA	0.55	16.56	NA	090
21433	.....	A	Treat craniofacial fracture	25.35	17.86	NA	2.46	45.67	NA	090
21435	.....	A	Treat craniofacial fracture	17.25	11.71	NA	1.66	30.62	NA	090
21436	.....	A	Treat craniofacial fracture	28.04	18.98	NA	2.32	49.34	NA	090
21440	.....	A	Treat dental ridge fracture	2.70	3.38	5.43	0.22	6.30	8.35	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
21445	.....	A	Treat dental ridge fracture	5.38	5.37	7.07	0.55	11.30	13.00	090
21450	.....	A	Treat lower jaw fracture	2.97	2.67	6.70	0.23	5.87	9.90	090
21451	.....	A	Treat lower jaw fracture	4.87	5.49	6.58	0.39	10.75	11.84	090
21452	.....	A	Treat lower jaw fracture	1.98	3.84	9.04	0.14	5.96	11.16	090
21453	.....	A	Treat lower jaw fracture	5.54	6.28	7.56	0.49	12.31	13.59	090
21454	.....	A	Treat lower jaw fracture	6.46	6.01	NA	0.55	13.02	NA	090
21461	.....	A	Treat lower jaw fracture	8.09	7.83	9.74	0.73	16.65	18.56	090
21462	.....	A	Treat lower jaw fracture	9.79	7.91	11.11	0.80	18.50	21.70	090
21465	.....	A	Treat lower jaw fracture	11.91	7.37	NA	0.84	20.12	NA	090
21470	.....	A	Treat lower jaw fracture	15.34	9.83	NA	1.36	26.53	NA	090
21480	.....	A	Reset dislocated jaw	0.61	0.18	1.59	0.05	0.84	2.25	000
21485	.....	A	Reset dislocated jaw	3.99	3.49	3.80	0.31	7.79	8.10	090
21490	.....	A	Repair dislocated jaw	11.86	7.50	NA	1.31	20.67	NA	090
21493	.....	A	Treat hyoid bone fracture	1.27	3.05	NA	0.10	4.42	NA	090
21494	.....	A	Treat hyoid bone fracture	6.28	5.28	NA	0.44	12.00	NA	090
21495	.....	A	Treat hyoid bone fracture	5.69	4.83	NA	0.41	10.93	NA	090
21497	.....	A	Interdental wiring	3.86	3.78	4.72	0.31	7.95	8.89	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	3.81	3.57	4.31	0.36	7.74	8.48	090
21502	.....	A	Drain chest lesion	7.12	7.71	NA	0.79	15.62	NA	090
21510	.....	A	Drainage of bone lesion	5.74	6.86	NA	0.67	13.27	NA	090
21550	.....	A	Biopsy of neck/chest	2.06	1.22	2.24	0.13	3.41	4.43	010
21555	.....	A	Remove lesion, neck/chest	4.35	2.47	4.15	0.41	7.23	8.91	090
21556	.....	A	Remove lesion, neck/chest	5.57	3.24	NA	0.51	9.32	NA	090
21557	.....	A	Remove tumor, neck/chest	8.88	7.74	NA	0.85	17.47	NA	090
21600	.....	A	Partial removal of rib	6.89	7.59	NA	0.81	15.29	NA	090
21610	.....	A	Partial removal of rib	14.61	10.68	NA	1.85	27.14	NA	090
21615	.....	A	Removal of rib	9.87	8.29	NA	1.20	19.36	NA	090
21616	.....	A	Removal of rib and nerves	12.04	8.18	NA	1.31	21.53	NA	090
21620	.....	A	Partial removal of sternum	6.79	8.03	NA	0.77	15.59	NA	090
21627	.....	A	Sternal debridement	6.81	12.78	NA	0.82	20.41	NA	090
21630	.....	A	Extensive sternum surgery	17.38	13.87	NA	1.95	33.20	NA	090
21632	.....	A	Extensive sternum surgery	18.14	12.62	NA	2.16	32.92	NA	090
21700	.....	A	Revision of neck muscle	6.19	7.11	8.71	0.31	13.61	15.21	090
21705	.....	A	Revision of neck muscle/rib	9.60	7.18	NA	0.92	17.70	NA	090
21720	.....	A	Revision of neck muscle	5.68	7.01	7.61	0.80	13.49	14.09	090
21725	.....	A	Revision of neck muscle	6.99	6.89	NA	0.90	14.78	NA	090
21740	.....	A	Reconstruction of sternum	16.50	12.24	NA	2.03	30.77	NA	090
21750	.....	A	Repair of sternum separation	10.77	9.98	NA	1.35	22.10	NA	090
21800	.....	A	Treatment of rib fracture	0.96	1.01	2.21	0.09	2.06	3.26	090
21805	.....	A	Treatment of rib fracture	2.75	4.06	NA	0.29	7.10	NA	090
21810	.....	A	Treatment of rib fracture(s)	6.86	6.27	NA	0.60	13.73	NA	090
21820	.....	A	Treat sternum fracture	1.28	1.46	2.61	0.15	2.89	4.04	090
21825	.....	A	Treat sternum fracture	7.41	10.09	NA	0.84	18.34	NA	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	2.06	0.75	2.32	0.12	2.93	4.50	010
21925	.....	A	Biopsy soft tissue of back	4.49	4.47	10.95	0.44	9.40	15.88	090
21930	.....	A	Remove lesion, back or flank	5.00	2.65	4.56	0.49	8.14	10.05	090
21935	.....	A	Remove tumor, back	17.96	13.26	NA	1.87	33.09	NA	090
22100	.....	A	Remove part of neck vertebra	9.73	8.67	NA	1.55	19.95	NA	090
22101	.....	A	Remove part, thorax vertebra	9.81	8.49	NA	1.51	19.81	NA	090
22102	.....	A	Remove part, lumbar vertebra	9.81	8.70	NA	1.46	19.97	NA	090
22103	.....	A	Remove extra spine segment	2.34	1.30	NA	0.37	4.01	NA	ZZZ
22110	.....	A	Remove part of neck vertebra	12.74	10.53	NA	2.20	25.47	NA	090
22112	.....	A	Remove part, thorax vertebra	12.81	10.60	NA	1.96	25.37	NA	090
22114	.....	A	Remove part, lumbar vertebra	12.81	10.34	NA	1.98	25.13	NA	090
22116	.....	A	Remove extra spine segment	2.32	1.19	NA	0.40	3.91	NA	ZZZ
22210	.....	A	Revision of neck spine	23.82	16.94	NA	4.23	44.99	NA	090
22212	.....	A	Revision of thorax spine	19.42	14.35	NA	2.78	36.55	NA	090
22214	.....	A	Revision of lumbar spine	19.45	14.92	NA	2.78	37.15	NA	090
22216	.....	A	Revise, extra spine segment	6.04	3.31	NA	0.98	10.33	NA	ZZZ
22220	.....	A	Revision of neck spine	21.37	15.46	NA	3.65	40.48	NA	090
22222	.....	A	Revision of thorax spine	21.52	13.62	NA	3.08	38.22	NA	090
22224	.....	A	Revision of lumbar spine	21.52	15.68	NA	3.20	40.40	NA	090
22226	.....	A	Revise, extra spine segment	6.04	3.30	NA	1.01	10.35	NA	ZZZ
22305	.....	A	Treat spine process fracture	2.05	1.87	3.03	0.29	4.21	5.37	090
22310	.....	A	Treat spine fracture	2.61	3.28	4.38	0.37	6.26	7.36	090
22315	.....	A	Treat spine fracture	8.84	8.89	NA	1.37	19.10	NA	090
22318	.....	A	Treat odontoid fx w/o graft	21.50	14.60	NA	4.26	40.36	NA	090
22319	.....	A	Treat odontoid fx w/graft	24.00	16.89	NA	4.76	45.65	NA	090
22325	.....	A	Treat spine fracture	18.30	14.45	NA	2.61	35.36	NA	090
22326	.....	A	Treat neck spine fracture	19.59	15.28	NA	3.54	38.41	NA	090
22327	.....	A	Treat thorax spine fracture	19.20	14.83	NA	2.75	36.78	NA	090
22328	.....	A	Treat each add spine fx	4.61	2.30	NA	0.66	7.57	NA	ZZZ

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
22505	.....	A	Manipulation of spine	1.87	3.01	4.59	0.27	5.15	6.73	010
22520	.....	A	Percut vertebroplasty thor	8.91	3.91	NA	0.89	13.71	NA	010
22521	.....	A	Percut vertebroplasty lumb	8.34	3.68	NA	0.84	12.86	NA	010
22522	.....	A	Percut vertebroplasty addl	3.00	1.19	NA	0.30	4.49	NA	ZZZ
22548	.....	A	Neck spine fusion	25.82	17.74	NA	4.98	48.54	NA	090
22554	.....	A	Neck spine fusion	18.62	13.65	NA	3.51	35.78	NA	090
22556	.....	A	Thorax spine fusion	23.46	16.42	NA	3.78	43.66	NA	090
22558	.....	A	Lumbar spine fusion	22.28	14.36	NA	3.18	39.82	NA	090
22585	.....	A	Additional spinal fusion	5.53	2.92	NA	0.98	9.43	NA	ZZZ
22590	.....	A	Spine & skull spinal fusion	20.51	15.33	NA	3.81	39.65	NA	090
22595	.....	A	Neck spinal fusion	19.39	14.31	NA	3.62	37.32	NA	090
22600	.....	A	Neck spine fusion	16.14	12.58	NA	2.89	31.61	NA	090
22610	.....	A	Thorax spine fusion	16.02	12.54	NA	2.66	31.22	NA	090
22612	.....	A	Lumbar spine fusion	21.00	15.36	NA	3.28	39.64	NA	090
22614	.....	A	Spine fusion, extra segment	6.44	3.53	NA	1.04	11.01	NA	ZZZ
22630	.....	A	Lumbar spine fusion	20.84	15.57	NA	3.79	40.20	NA	090
22632	.....	A	Spine fusion, extra segment	5.23	2.82	NA	0.90	8.95	NA	ZZZ
22800	.....	A	Fusion of spine	18.25	13.64	NA	2.71	34.60	NA	090
22802	.....	A	Fusion of spine	30.88	21.30	NA	4.42	56.60	NA	090
22804	.....	A	Fusion of spine	36.27	24.04	NA	5.23	65.54	NA	090
22808	.....	A	Fusion of spine	26.27	18.18	NA	4.36	48.81	NA	090
22810	.....	A	Fusion of spine	30.27	19.81	NA	4.49	54.57	NA	090
22812	.....	A	Fusion of spine	32.70	21.83	NA	4.67	59.20	NA	090
22818	.....	A	Kyphectomy, 1–2 segments	31.83	21.14	NA	5.01	57.98	NA	090
22819	.....	A	Kyphectomy, 3 or more	36.44	20.86	NA	5.20	62.50	NA	090
22830	.....	A	Exploration of spinal fusion	10.85	9.57	NA	1.73	22.15	NA	090
22840	.....	A	Insert spine fixation device	12.54	8.37	NA	2.03	22.94	NA	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	12.58	6.87	NA	2.04	21.49	NA	ZZZ
22843	.....	A	Insert spine fixation device	13.46	8.86	NA	2.10	24.42	NA	ZZZ
22844	.....	A	Insert spine fixation device	16.44	10.54	NA	2.42	29.40	NA	ZZZ
22845	.....	A	Insert spine fixation device	11.96	7.95	NA	2.22	22.13	NA	ZZZ
22846	.....	A	Insert spine fixation device	12.42	8.21	NA	2.26	22.89	NA	ZZZ
22847	.....	A	Insert spine fixation device	13.80	8.97	NA	2.36	25.13	NA	ZZZ
22848	.....	A	Insert pelv fixation device	6.00	4.75	NA	0.88	11.63	NA	ZZZ
22849	.....	A	Reinsert spinal fixation	18.51	13.72	NA	2.87	35.10	NA	090
22850	.....	A	Remove spine fixation device	9.52	8.41	NA	1.51	19.44	NA	090
22851	.....	A	Apply spine prosth device	6.71	5.08	NA	1.11	12.90	NA	ZZZ
22852	.....	A	Remove spine fixation device	9.01	8.18	NA	1.40	18.59	NA	090
22855	.....	A	Remove spine fixation device	15.13	11.28	NA	2.74	29.15	NA	090
22899	.....	C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
22900	.....	A	Remove abdominal wall lesion	5.80	4.29	NA	0.58	10.67	NA	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	4.36	6.59	8.98	0.50	11.45	13.84	090
23020	.....	A	Release shoulder joint	8.93	10.02	NA	1.23	20.18	NA	090
23030	.....	A	Drain shoulder lesion	3.43	4.18	5.88	0.42	8.03	9.73	010
23031	.....	A	Drain shoulder bursa	2.74	3.82	5.81	0.33	6.89	8.88	010
23035	.....	A	Drain shoulder bone lesion	8.61	14.53	NA	1.19	24.33	NA	090
23040	.....	A	Exploratory shoulder surgery	9.20	10.87	NA	1.28	21.35	NA	090
23044	.....	A	Exploratory shoulder surgery	7.12	9.79	NA	0.97	17.88	NA	090
23065	.....	A	Biopsy shoulder tissues	2.27	1.29	2.53	0.14	3.70	4.94	010
23066	.....	A	Biopsy shoulder tissues	4.16	6.04	7.42	0.50	10.70	12.08	090
23075	.....	A	Removal of shoulder lesion	2.39	3.08	5.25	0.25	5.72	7.89	010
23076	.....	A	Removal of shoulder lesion	7.63	8.03	NA	0.87	16.53	NA	090
23077	.....	A	Remove tumor of shoulder	16.09	14.40	NA	1.81	32.30	NA	090
23100	.....	A	Biopsy of shoulder joint	6.03	8.01	NA	0.81	14.85	NA	090
23101	.....	A	Shoulder joint surgery	5.58	8.10	NA	0.77	14.45	NA	090
23105	.....	A	Remove shoulder joint lining	8.23	9.64	NA	1.13	19.00	NA	090
23106	.....	A	Incision of collarbone joint	5.96	8.29	NA	0.82	15.07	NA	090
23107	.....	A	Explore treat shoulder joint	8.62	9.61	NA	1.19	19.42	NA	090
23120	.....	A	Partial removal, collar bone	7.11	8.86	NA	0.99	16.96	NA	090
23125	.....	A	Removal of collar bone	9.39	10.24	NA	1.27	20.90	NA	090
23130	.....	A	Remove shoulder bone, part	7.55	9.11	NA	1.06	17.72	NA	090
23140	.....	A	Removal of bone lesion	6.89	8.21	NA	0.82	15.92	NA	090
23145	.....	A	Removal of bone lesion	9.09	11.52	NA	1.24	21.85	NA	090
23146	.....	A	Removal of bone lesion	7.83	9.97	NA	1.11	18.91	NA	090
23150	.....	A	Removal of humerus lesion	8.48	9.44	NA	1.14	19.06	NA	090
23155	.....	A	Removal of humerus lesion	10.35	10.88	NA	1.20	22.43	NA	090
23156	.....	A	Removal of humerus lesion	8.68	9.69	NA	1.18	19.55	NA	090
23170	.....	A	Remove collar bone lesion	6.86	10.32	NA	0.84	18.02	NA	090
23172	.....	A	Remove shoulder blade lesion	6.90	10.73	NA	0.95	18.58	NA	090
23174	.....	A	Remove humerus lesion	9.51	10.99	NA	1.30	21.80	NA	090
23180	.....	A	Remove collar bone lesion	8.53	14.68	NA	1.18	24.39	NA	090
23182	.....	A	Remove shoulder blade lesion	8.15	15.09	NA	1.08	24.32	NA	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
23184	.....	A	Remove humerus lesion	9.38	14.91	NA	1.24	25.53	NA	090
23190	.....	A	Partial removal of scapula	7.24	8.12	NA	0.97	16.33	NA	090
23195	.....	A	Removal of head of humerus	9.81	10.47	NA	1.38	21.66	NA	090
23200	.....	A	Removal of collar bone	12.08	13.34	NA	1.48	26.90	NA	090
23210	.....	A	Removal of shoulder blade	12.49	13.73	NA	1.61	27.83	NA	090
23220	.....	A	Partial removal of humerus	14.56	14.41	NA	2.03	31.00	NA	090
23221	.....	A	Partial removal of humerus	17.74	16.13	NA	2.51	36.38	NA	090
23222	.....	A	Partial removal of humerus	23.92	19.80	NA	3.37	47.09	NA	090
23330	.....	A	Remove shoulder foreign body	1.85	4.11	5.58	0.18	6.14	7.61	010
23331	.....	A	Remove shoulder foreign body	7.38	8.97	NA	1.02	17.37	NA	090
23332	.....	A	Remove shoulder foreign body	11.62	11.35	NA	1.62	24.59	NA	090
23350	.....	A	Injection for shoulder x-ray	1.00	0.35	9.72	0.05	1.40	10.77	000
23395	.....	A	Muscle transfer,shoulder/arm	16.85	13.51	NA	2.29	32.65	NA	090
23397	.....	A	Muscle transfers	16.13	14.01	NA	2.24	32.38	NA	090
23400	.....	A	Fixation of shoulder blade	13.54	12.98	NA	1.91	28.43	NA	090
23405	.....	A	Incision of tendon & muscle	8.37	8.93	NA	1.12	18.42	NA	090
23406	.....	A	Incise tendon(s) & muscle(s)	10.79	10.89	NA	1.48	23.16	NA	090
23410	.....	A	Repair of tendon(s)	12.45	11.71	NA	1.72	25.88	NA	090
23412	.....	A	Repair of tendon(s)	13.31	12.29	NA	1.86	27.46	NA	090
23415	.....	A	Release of shoulder ligament	9.97	9.62	NA	1.39	20.98	NA	090
23420	.....	A	Repair of shoulder	13.30	13.10	NA	1.86	28.26	NA	090
23430	.....	A	Repair biceps tendon	9.98	10.45	NA	1.40	21.83	NA	090
23440	.....	A	Remove/transplant tendon	10.48	10.69	NA	1.47	22.64	NA	090
23450	.....	A	Repair shoulder capsule	13.40	12.40	NA	1.86	27.66	NA	090
23455	.....	A	Repair shoulder capsule	14.37	12.91	NA	2.01	29.29	NA	090
23460	.....	A	Repair shoulder capsule	15.37	13.57	NA	2.17	31.11	NA	090
23462	.....	A	Repair shoulder capsule	15.30	13.41	NA	2.16	30.87	NA	090
23465	.....	A	Repair shoulder capsule	15.85	12.40	NA	1.61	29.86	NA	090
23466	.....	A	Repair shoulder capsule	14.22	12.83	NA	2.00	29.05	NA	090
23470	.....	A	Reconstruct shoulder joint	17.15	14.42	NA	2.40	33.97	NA	090
23472	.....	A	Reconstruct shoulder joint	21.10	16.66	NA	2.37	40.13	NA	090
23480	.....	A	Revision of collar bone	11.18	11.16	NA	1.56	23.90	NA	090
23485	.....	A	Revision of collar bone	13.43	12.42	NA	1.84	27.69	NA	090
23490	.....	A	Reinforce clavicle	11.86	10.64	NA	1.11	23.61	NA	090
23491	.....	A	Reinforce shoulder bones	14.21	12.60	NA	2.00	28.81	NA	090
23500	.....	A	Treat clavicle fracture	2.08	2.38	3.55	0.26	4.72	5.89	090
23505	.....	A	Treat clavicle fracture	3.69	3.78	5.48	0.50	7.97	9.67	090
23515	.....	A	Treat clavicle fracture	7.41	7.70	NA	1.03	16.14	NA	090
23520	.....	A	Treat clavicle dislocation	2.16	2.42	3.49	0.26	4.84	5.91	090
23525	.....	A	Treat clavicle dislocation	3.60	3.65	5.36	0.44	7.69	9.40	090
23530	.....	A	Treat clavicle dislocation	7.31	8.24	NA	0.85	16.40	NA	090
23532	.....	A	Treat clavicle dislocation	8.01	8.09	NA	1.13	17.23	NA	090
23540	.....	A	Treat clavicle dislocation	2.23	2.40	4.13	0.24	4.87	6.60	090
23545	.....	A	Treat clavicle dislocation	3.25	3.46	4.74	0.39	7.10	8.38	090
23550	.....	A	Treat clavicle dislocation	7.24	7.74	NA	0.94	15.92	NA	090
23552	.....	A	Treat clavicle dislocation	8.45	8.31	NA	1.18	17.94	NA	090
23570	.....	A	Treat shoulder blade fx	2.23	2.49	3.53	0.29	5.01	6.05	090
23575	.....	A	Treat shoulder blade fx	4.06	4.00	5.61	0.53	8.59	10.20	090
23585	.....	A	Treat scapula fracture	8.96	8.85	NA	1.25	19.06	NA	090
23600	.....	A	Treat humerus fracture	2.93	3.37	5.09	0.39	6.69	8.41	090
23605	.....	A	Treat humerus fracture	4.87	6.04	7.59	0.67	11.58	13.13	090
23615	.....	A	Treat humerus fracture	9.35	9.54	NA	1.31	20.20	NA	090
23616	.....	A	Treat humerus fracture	21.27	15.63	NA	2.98	39.88	NA	090
23620	.....	A	Treat humerus fracture	2.40	3.11	4.79	0.32	5.83	7.51	090
23625	.....	A	Treat humerus fracture	3.93	5.07	6.64	0.53	9.53	11.10	090
23630	.....	A	Treat humerus fracture	7.35	7.69	NA	1.03	16.07	NA	090
23650	.....	A	Treat shoulder dislocation	3.39	3.37	5.22	0.31	7.07	8.92	090
23655	.....	A	Treat shoulder dislocation	4.57	4.06	NA	0.52	9.15	NA	090
23660	.....	A	Treat shoulder dislocation	7.49	7.67	NA	1.01	16.17	NA	090
23665	.....	A	Treat dislocation/fracture	4.47	5.35	6.96	0.60	10.42	12.03	090
23670	.....	A	Treat dislocation/fracture	7.90	8.14	NA	1.10	17.14	NA	090
23675	.....	A	Treat dislocation/fracture	6.05	6.26	7.75	0.83	13.14	14.63	090
23680	.....	A	Treat dislocation/fracture	10.06	9.35	NA	1.39	20.80	NA	090
23700	.....	A	Fixation of shoulder	2.52	3.22	NA	0.35	6.09	NA	010
23800	.....	A	Fusion of shoulder joint	14.16	13.57	NA	1.97	29.70	NA	090
23802	.....	A	Fusion of shoulder joint	16.60	15.04	NA	2.34	33.98	NA	090
23900	.....	A	Amputation of arm & girdle	19.72	14.75	NA	2.47	36.94	NA	090
23920	.....	A	Amputation at shoulder joint	14.61	13.93	NA	1.92	30.46	NA	090
23921	.....	A	Amputation follow-up surgery	5.49	6.54	NA	0.78	12.81	NA	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	2.94	3.86	5.96	0.32	7.12	9.22	010
23931	.....	A	Drainage of arm bursa	1.79	3.38	5.50	0.21	5.38	7.50	010
23935	.....	A	Drain arm/elbow bone lesion	6.09	11.98	NA	0.84	18.91	NA	090
24000	.....	A	Exploratory elbow surgery	5.82	5.71	NA	0.77	12.30	NA	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
24006	.....	A	Release elbow joint	9.31	8.16	NA	1.27	18.74	NA	090
24065	.....	A	Biopsy arm/elbow soft tissue	2.08	3.25	5.41	0.14	5.47	7.63	010
24066	.....	A	Biopsy arm/elbow soft tissue	5.21	6.39	8.70	0.61	12.21	14.52	090
24075	.....	A	Remove arm/elbow lesion	3.92	5.87	8.10	0.43	10.22	12.45	090
24076	.....	A	Remove arm/elbow lesion	6.30	6.92	NA	0.70	13.92	NA	090
24077	.....	A	Remove tumor of arm/elbow	11.76	13.74	NA	1.32	26.82	NA	090
24100	.....	A	Biopsy elbow joint lining	4.93	5.51	NA	0.62	11.06	NA	090
24101	.....	A	Explore/treat elbow joint	6.13	6.33	NA	0.84	13.30	NA	090
24102	.....	A	Remove elbow joint lining	8.03	7.45	NA	1.09	16.57	NA	090
24105	.....	A	Removal of elbow bursa	3.61	4.84	NA	0.49	8.94	NA	090
24110	.....	A	Remove humerus lesion	7.39	9.03	NA	0.99	17.41	NA	090
24115	.....	A	Remove/graft bone lesion	9.63	9.42	NA	1.15	20.20	NA	090
24116	.....	A	Remove/graft bone lesion	11.81	11.23	NA	1.66	24.70	NA	090
24120	.....	A	Remove elbow lesion	6.65	6.33	NA	0.87	13.85	NA	090
24125	.....	A	Remove/graft bone lesion	7.89	6.60	NA	0.88	15.37	NA	090
24126	.....	A	Remove/graft bone lesion	8.31	7.22	NA	0.90	16.43	NA	090
24130	.....	A	Removal of head of radius	6.25	6.43	NA	0.87	13.55	NA	090
24134	.....	A	Removal of arm bone lesion	9.73	15.45	NA	1.31	26.49	NA	090
24136	.....	A	Remove radius bone lesion	7.99	6.71	NA	0.85	15.55	NA	090
24138	.....	A	Remove elbow bone lesion	8.05	7.37	NA	1.12	16.54	NA	090
24140	.....	A	Partial removal of arm bone	9.18	15.93	NA	1.23	26.34	NA	090
24145	.....	A	Partial removal of radius	7.58	10.30	NA	1.01	18.89	NA	090
24147	.....	A	Partial removal of elbow	7.54	10.34	NA	1.04	18.92	NA	090
24149	.....	A	Radical resection of elbow	14.20	10.85	NA	1.90	26.95	NA	090
24150	.....	A	Extensive humerus surgery	13.27	13.78	NA	1.81	28.86	NA	090
24151	.....	A	Extensive humerus surgery	15.58	15.36	NA	2.19	33.13	NA	090
24152	.....	A	Extensive radius surgery	10.06	8.95	NA	1.19	20.20	NA	090
24153	.....	A	Extensive radius surgery	11.54	7.34	NA	0.64	19.52	NA	090
24155	.....	A	Removal of elbow joint	11.73	8.81	NA	1.42	21.96	NA	090
24160	.....	A	Remove elbow joint implant	7.83	7.33	NA	1.07	16.23	NA	090
24164	.....	A	Remove radius head implant	6.23	6.36	NA	0.84	13.43	NA	090
24200	.....	A	Removal of arm foreign body	1.76	3.16	5.90	0.15	5.07	7.81	010
24201	.....	A	Removal of arm foreign body	4.56	6.75	8.45	0.56	11.87	13.57	090
24220	.....	A	Injection for elbow x-ray	1.31	0.47	10.76	0.07	1.85	12.14	000
24301	.....	A	Muscle/tendon transfer	10.20	8.94	NA	1.30	20.44	NA	090
24305	.....	A	Arm tendon lengthening	7.45	7.15	NA	0.98	15.58	NA	090
24310	.....	A	Revision of arm tendon	5.98	7.77	NA	0.74	14.49	NA	090
24320	.....	A	Repair of arm tendon	10.56	10.12	NA	1.00	21.68	NA	090
24330	.....	A	Revision of arm muscles	9.60	8.44	NA	1.21	19.25	NA	090
24331	.....	A	Revision of arm muscles	10.65	8.80	NA	1.41	20.86	NA	090
24340	.....	A	Repair of biceps tendon	7.89	7.23	NA	1.08	16.20	NA	090
24341	.....	A	Repair arm tendon/muscle	7.90	7.30	NA	1.08	16.28	NA	090
24342	.....	A	Repair of ruptured tendon	10.62	8.91	NA	1.48	21.01	NA	090
24350	.....	A	Repair of tennis elbow	5.25	5.91	NA	0.72	11.88	NA	090
24351	.....	A	Repair of tennis elbow	5.91	6.34	NA	0.82	13.07	NA	090
24352	.....	A	Repair of tennis elbow	6.43	6.61	NA	0.90	13.94	NA	090
24354	.....	A	Repair of tennis elbow	6.48	6.55	NA	0.88	13.91	NA	090
24356	.....	A	Revision of tennis elbow	6.68	6.74	NA	0.90	14.32	NA	090
24360	.....	A	Reconstruct elbow joint	12.34	9.65	NA	1.69	23.68	NA	090
24361	.....	A	Reconstruct elbow joint	14.08	10.36	NA	1.95	26.39	NA	090
24362	.....	A	Reconstruct elbow joint	14.99	10.93	NA	1.92	27.84	NA	090
24363	.....	A	Replace elbow joint	18.49	13.26	NA	2.52	34.27	NA	090
24365	.....	A	Reconstruct head of radius	8.39	7.62	NA	1.11	17.12	NA	090
24366	.....	A	Reconstruct head of radius	9.13	8.06	NA	1.28	18.47	NA	090
24400	.....	A	Revision of humerus	11.06	11.89	NA	1.53	24.48	NA	090
24410	.....	A	Revision of humerus	14.82	13.84	NA	1.89	30.55	NA	090
24420	.....	A	Revision of humerus	13.44	15.43	NA	1.82	30.69	NA	090
24430	.....	A	Repair of humerus	12.81	12.15	NA	1.80	26.76	NA	090
24435	.....	A	Repair humerus with graft	13.17	13.11	NA	1.84	28.12	NA	090
24470	.....	A	Revision of elbow joint	8.74	7.17	NA	1.23	17.14	NA	090
24495	.....	A	Decompression of forearm	8.12	9.47	NA	0.92	18.51	NA	090
24498	.....	A	Reinforce humerus	11.92	11.60	NA	1.67	25.19	NA	090
24500	.....	A	Treat humerus fracture	3.21	3.11	4.67	0.41	6.73	8.29	090
24505	.....	A	Treat humerus fracture	5.17	6.31	8.09	0.72	12.20	13.98	090
24515	.....	A	Treat humerus fracture	11.65	10.79	NA	1.63	24.07	NA	090
24516	.....	A	Treat humerus fracture	11.65	11.17	NA	1.63	24.45	NA	090
24530	.....	A	Treat humerus fracture	3.50	4.44	5.64	0.47	8.41	9.61	090
24535	.....	A	Treat humerus fracture	6.87	6.38	8.13	0.96	14.21	15.96	090
24538	.....	A	Treat humerus fracture	9.43	9.79	NA	1.25	20.47	NA	090
24545	.....	A	Treat humerus fracture	10.46	9.60	NA	1.47	21.53	NA	090
24546	.....	A	Treat humerus fracture	15.69	13.03	NA	2.18	30.90	NA	090
24560	.....	A	Treat humerus fracture	2.80	2.89	4.48	0.35	6.04	7.63	090
24565	.....	A	Treat humerus fracture	5.56	5.62	7.40	0.74	11.92	13.70	090
24566	.....	A	Treat humerus fracture	7.79	9.23	NA	1.10	18.12	NA	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.

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

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Facility PE RVUs	Non-Facility PE RVUs	Mal-Practice RVUs	Facility Total	Non-Facility Total	Global
24575	.....	A	Treat humerus fracture	10.66	8.03	NA	1.44	20.13	NA	090
24576	.....	A	Treat humerus fracture	2.86	3.01	4.25	0.38	6.25	7.49	090
24577	.....	A	Treat humerus fracture	5.79	5.75	7.51	0.81	12.35	14.11	090
24579	.....	A	Treat humerus fracture	11.60	10.69	NA	1.62	23.91	NA	090
24582	.....	A	Treat humerus fracture	8.55	9.72	NA	1.20	19.47	NA	090
24586	.....	A	Treat elbow fracture	15.21	10.77	NA	2.12	28.10	NA	090
24587	.....	A	Treat elbow fracture	15.16	10.55	NA	2.14	27.85	NA	090
24600	.....	A	Treat elbow dislocation	4.23	4.70	6.32	0.49	9.42	11.04	090
24605	.....	A	Treat elbow dislocation	5.42	4.75	NA	0.72	10.89	NA	090
24615	.....	A	Treat elbow dislocation	9.42	7.58	NA	1.31	18.31	NA	090
24620	.....	A	Treat elbow fracture	6.98	6.21	NA	0.90	14.09	NA	090
24635	.....	A	Treat elbow fracture	13.19	15.10	NA	1.84	30.13	NA	090
24640	.....	A	Treat elbow dislocation	1.20	1.70	3.24	0.11	3.01	4.55	010
24650	.....	A	Treat radius fracture	2.16	2.65	4.13	0.28	5.09	6.57	090
24655	.....	A	Treat radius fracture	4.40	4.90	6.70	0.58	9.88	11.68	090
24665	.....	A	Treat radius fracture	8.14	8.79	NA	1.13	18.06	NA	090
24666	.....	A	Treat radius fracture	9.49	9.53	NA	1.32	20.34	NA	090
24670	.....	A	Treat ulnar fracture	2.54	2.85	4.10	0.33	5.72	6.97	090
24675	.....	A	Treat ulnar fracture	4.72	5.12	6.84	0.65	10.49	12.21	090
24685	.....	A	Treat ulnar fracture	8.80	9.15	NA	1.23	19.18	NA	090
24800	.....	A	Fusion of elbow joint	11.20	9.43	NA	1.41	22.04	NA	090
24802	.....	A	Fusion/graft of elbow joint	13.69	11.22	NA	1.89	26.80	NA	090
24900	.....	A	Amputation of upper arm	9.60	10.69	NA	1.18	21.47	NA	090
24920	.....	A	Amputation of upper arm	9.54	12.12	NA	1.22	22.88	NA	090
24925	.....	A	Amputation follow-up surgery	7.07	8.94	NA	0.95	16.96	NA	090
24930	.....	A	Amputation follow-up surgery	10.25	11.17	NA	1.23	22.65	NA	090
24931	.....	A	Amputate upper arm & implant	12.72	11.41	NA	1.56	25.69	NA	090
24935	.....	A	Revision of amputation	15.56	11.97	NA	1.58	29.11	NA	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	3.38	6.63	NA	0.45	10.46	NA	090
25020	.....	A	Decompression of forearm	5.92	10.41	NA	0.75	17.08	NA	090
25023	.....	A	Decompression of forearm	12.96	16.09	NA	1.50	30.55	NA	090
25028	.....	A	Drainage of forearm lesion	5.25	9.40	NA	0.61	15.26	NA	090
25031	.....	A	Drainage of forearm bursa	4.14	9.13	NA	0.50	13.77	NA	090
25035	.....	A	Treat forearm bone lesion	7.36	15.24	NA	0.98	23.58	NA	090
25040	.....	A	Explore/treat wrist joint	7.18	8.62	NA	0.96	16.76	NA	090
25065	.....	A	Biopsy forearm soft tissues	1.99	2.42	2.42	0.12	4.53	4.53	010
25066	.....	A	Biopsy forearm soft tissues	4.13	7.44	NA	0.49	12.06	NA	090
25075	.....	A	Removal of forearm lesion	3.74	6.93	NA	0.40	11.07	NA	090
25076	.....	A	Removal of forearm lesion	4.92	11.70	NA	0.59	17.21	NA	090
25077	.....	A	Remove tumor, forearm/wrist	9.76	15.47	NA	1.10	26.33	NA	090
25085	.....	A	Incision of wrist capsule	5.50	9.97	NA	0.71	16.18	NA	090
25100	.....	A	Biopsy of wrist joint	3.90	6.70	NA	0.50	11.10	NA	090
25101	.....	A	Explore/treat wrist joint	4.69	7.29	NA	0.60	12.58	NA	090
25105	.....	A	Remove wrist joint lining	5.85	10.15	NA	0.77	16.77	NA	090
25107	.....	A	Remove wrist joint cartilage	6.43	10.29	NA	0.82	17.54	NA	090
25110	.....	A	Remove wrist tendon lesion	3.92	7.83	NA	0.48	12.23	NA	090
25111	.....	A	Remove wrist tendon lesion	3.39	6.12	NA	0.42	9.93	NA	090
25112	.....	A	Reremove wrist tendon lesion	4.53	7.02	NA	0.54	12.09	NA	090
25115	.....	A	Remove wrist/forearm lesion	8.82	15.64	NA	1.11	25.57	NA	090
25116	.....	A	Remove wrist/forearm lesion	7.11	14.57	NA	0.90	22.58	NA	090
25118	.....	A	Excise wrist tendon sheath	4.37	7.29	NA	0.55	12.21	NA	090
25119	.....	A	Partial removal of ulna	6.04	10.04	NA	0.80	16.88	NA	090
25120	.....	A	Removal of forearm lesion	6.10	13.32	NA	0.81	20.23	NA	090
25125	.....	A	Remove/graft forearm lesion	7.48	14.60	NA	1.02	23.10	NA	090
25126	.....	A	Remove/graft forearm lesion	7.55	13.98	NA	1.00	22.53	NA	090
25130	.....	A	Removal of wrist lesion	5.26	7.58	NA	0.66	13.50	NA	090
25135	.....	A	Remove & graft wrist lesion	6.89	8.35	NA	0.89	16.13	NA	090
25136	.....	A	Remove & graft wrist lesion	5.97	6.45	NA	0.58	13.00	NA	090
25145	.....	A	Remove forearm bone lesion	6.37	14.15	NA	0.82	21.34	NA	090
25150	.....	A	Partial removal of ulna	7.09	11.10	NA	0.96	19.15	NA	090
25151	.....	A	Partial removal of radius	7.39	13.87	NA	0.93	22.19	NA	090
25170	.....	A	Extensive forearm surgery	11.09	16.11	NA	1.52	28.72	NA	090
25210	.....	A	Removal of wrist bone	5.95	8.13	NA	0.73	14.81	NA	090
25215	.....	A	Removal of wrist bones	7.89	11.22	NA	1.02	20.13	NA	090
25230	.....	A	Partial removal of radius	5.23	7.50	NA	0.66	13.39	NA	090
25240	.....	A	Partial removal of ulna	5.17	9.65	NA	0.69	15.51	NA	090
25246	.....	A	Injection for wrist x-ray	1.45	0.51	10.21	0.07	2.03	11.73	000
25248	.....	A	Remove forearm foreign body	5.14	9.18	NA	0.54	14.86	NA	090
25250	.....	A	Removal of wrist prosthesis	6.60	8.22	NA	0.84	15.66	NA	090
25251	.....	A	Removal of wrist prosthesis	9.57	11.59	NA	1.15	22.31	NA	090
25260	.....	A	Repair forearm tendon/muscle	7.80	15.87	NA	0.97	24.64	NA	090
25263	.....	A	Repair forearm tendon/muscle	7.82	15.18	NA	0.94	23.94	NA	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payments.
[4] PE RVUs = Practice Expense Relative Value Units.