

the BBRA 1999 transitional corridor payments, changing from -3.4 percent to 2.4 percent on an annual basis, and from -3.5 percent to 2.5 percent on an annual basis, respectively. Similarly, rural hospitals in nearly all census regions experience net increases in payment relative to pre-PPS payments with the BBRA 1999 transitional corridor payments.

The impact on TEFRA hospitals is shown separately at the end of the table. The TEFRA hospitals were not included in determining the impact on any of the other categories discussed above (for example, geographic location, bed size, volume, etc.). These hospitals demonstrated a very low service mix, but an average unit cost that approximates the national average. We believe that undercoding or billing an all-inclusive rate could account for their low-volume, low-service mix, and average cost per unit. We expect that

once these hospitals begin to code services accurately under the PPS, payments will more closely approximate pre-PPS payments.

If the effect of the BBRA 1999 transition payments were removed, differences between pre-PPS payments and PPS payments among hospitals would still exist. These distributional differences are the result of many factors. First, cost variations among hospitals result in differences between pre-PPS payments and PPS payments, and charge structure variations result in differences between pre-PPS payments and PPS beneficiary copayment amounts. Hospitals whose costs are low relative to payment would gain under the PPS even without the BBRA 1999 transitional corridor payments. Because the transitional corridor payments are not budget neutral, these hospitals continue to gain relative to pre-PPS payments.

Redistributions may also occur as a result of current payment methods. Total Medicare outpatient payments are less than reported total costs because (in addition to the 5.8 and 10 percent reductions for operating and capital costs) the blended payment methods applicable to many surgical and diagnostic services often result in payments that are less than reported costs. Other services such as medical visits, chemotherapy services, and non-ASC approved surgeries are paid based on hospital costs. The new system redistributes the current total Medicare payments, based in part on cost-based payments and in part on blended payment amounts, across all services. Hospitals, in the aggregate, will receive proportionately less for services that are currently paid based on costs, and more for services that had been paid under blended payment methods.

TABLE 2. ANNUAL IMPACT OF HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM IN CY2000-CY2001

	Number of hospitals	Outpatient percent	Excluding BBRA transitional corridors ¹		Including BBRA transitional corridors	
			Percent change in Medicare outpatient payments ³	Percent change in total Medicare payments	Percent change in Medicare outpatient payments ³	Percent change in total Medicare payments
	(1)	(2)	(3)	(4)	(5)	(6)
ALL HOSPITALS	5,362	9.9	0.2	0.0	4.6	0.5
NON-TEFRA HOSPITALS	4,828	10	0.1	0.0	4.6	0.5
URBAN HOSPS ²	2,665	9.3	0.6	0.1	4.6	0.4
LARGE URBAN ² (GT 1 MILL.)	1,505	9.1	-0.3	0.0	4.3	0.4
OTHER URBAN ² (LE 1 MILL.)	1,160	9.7	1.8	0.2	5.1	0.5
RURAL HOSPS	2,160	14.7	-1.8	-0.3	4.4	0.6
BEDS (URBAN): ²						
0-99 BEDS	672	14.9	0.6	0.1	4.6	0.7
100-199 BEDS	924	10.5	1.3	0.1	5.2	0.5
200-299 BEDS	533	9.2	0.8	0.1	4.4	0.4
300-499 BEDS	399	8.5	1.8	0.2	5.2	0.4
500 + BEDS	137	8.4	-2.9	-0.2	2.8	0.2
BEDS (RURAL):						
0-49 BEDS	1,170	19.5	-8.5	-1.7	3.3	0.6
50-99 BEDS	615	15.5	-2.7	-0.4	4.4	0.7
100-149 BEDS	223	13.3	-0.2	0.0	3.8	0.5
150-199 BEDS	81	13	2.5	0.3	5.5	0.7
200 + BEDS	71	11.6	2.7	0.3	6.1	0.7
VOLUME (URBAN):						
LT 5,000	349	12	-7.7	-0.9	0.2	0.0
5,000-10,999	504	9.8	0.0	0.0	4.2	0.4
11,000-20,999	596	9.1	0.1	0.0	4.4	0.4
21,000-42,999	773	8.8	1.3	0.1	4.9	0.4
GT 42,999	443	9.7	0.4	0.0	4.6	0.4
VOLUME (RURAL):						
LT 5,000	1,049	18.5	-12.2	-2.3	2.5	0.5
5,000-10,999	595	15.2	-5.2	-0.8	2.9	0.4
11,000-20,999	322	13.8	0.1	0.0	4.7	0.6
21,000-42,999	173	13.6	2.4	0.3	5.7	0.8
GT 42,999	21	13.2	3.0	0.4	6.8	0.9
REGION (URBAN): ³						
NEW ENGLAND	146	10.7	3.8	0.4	6.7	0.7
MIDDLE ATLANTIC	393	8.4	-3.4	-0.3	2.4	0.2
SOUTH ATLANTIC	401	8.6	0.3	0.0	4.2	0.4
EAST NORTH CENT.	465	10.7	1.0	0.1	4.5	0.5

TABLE 2. ANNUAL IMPACT OF HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM IN CY2000–CY2001—Continued

	Number of hospitals	Outpatient percent	Excluding BBRA transitional corridors ¹		Including BBRA transitional corridors	
			Percent change in Medicare outpatient payments ³	Percent change in total Medicare payments	Percent change in Medicare outpatient payments ³	Percent change in total Medicare payments
	(1)	(2)	(3)	(4)	(5)	(6)
EAST SOUTH CENT.	161	7.9	1.8	0.1	4.6	0.4
WEST NORTH CENT.	183	9.5	0.9	0.1	4.9	0.5
WEST SOUTH CENT.	335	9.7	-2.7	-0.3	2.5	0.2
MOUNTAIN	123	10.2	3.1	0.3	6.1	0.6
PACIFIC	423	9.4	5.6	0.5	8.6	0.8
PUERTO RICO	35	6.6	10.8	0.7	13.2	0.9
REGION (RURAL):						
NEW ENGLAND	53	17.2	-3.2	-0.6	3.3	0.6
MIDDLE ATLANTIC	80	13.6	7.1	1.0	10.1	1.4
SOUTH ATLANTIC	285	11.8	-1.8	-0.2	3.6	0.4
EAST NORTH CENT.	282	15.7	-1.2	-0.2	4.3	0.7
EAST SOUTH CENT.	260	11.1	0.1	0.0	4.9	0.5
WEST NORTH CENT.	508	19.8	-5.2	-1.0	3.0	0.6
WEST SOUTH CENT.	337	14.2	-5.7	-0.8	3.0	0.4
MOUNTAIN	213	16.9	-3.4	-0.6	4.7	0.8
PACIFIC	140	15.9	0.7	0.1	6.3	1.0
PUERTO RICO	2	6.6	32.1	2.1	32.1	2.1
TEACHING STATUS:						
NON-TEACHING	3,738	11.3	0.5	0.1	5.0	0.6
MINOR	821	9.1	1.6	0.1	5.0	0.5
MAJOR	269	9.1	-3.7	-0.3	2.6	0.2
DSH PATIENT PERCENT:						
0	101	10.9	-5.8	-0.6	0.7	0.1
GT 0—0.10	1,139	10.5	0.8	0.1	4.6	0.5
0.10—0.16	986	11	2.0	0.2	5.6	0.6
0.16—0.23	880	10.1	0.8	0.1	4.9	0.5
0.23—0.35	855	9.5	-1.5	-0.1	3.7	0.4
GE 0.35	867	9.2	-2.5	-0.2	3.5	0.3
URBAN IME/DSH: ²						
IME & DSH	994	9	-0.4	0.0	4.1	0.4
IME/NO DSH	17	9.2	-3.6	-0.3	1.1	0.1
NO IME/DSH	1,611	9.9	1.9	0.2	5.4	0.5
NO IME/NO DSH	43	14.7	-8.2	-1.2	-0.3	0.0
RURAL HOSP. TYPES:						
NO SPECIAL STATUS	864	15	-2.2	-0.3	4.4	0.7
RRC	164	12.3	5.0	0.6	7.3	0.9
SCH/EACH	634	16.5	-7.7	-1.3	2.2	0.4
MDH	358	18.3	-5.4	-1.0	3.5	0.6
SCH AND RRC	56	13.9	-1.4	-0.2	3.1	0.4
TYPE OF OWNERSHIP:						
VOLUNTARY	2,816	9.9	0.6	0.1	4.7	0.5
PROPRIETARY	752	8.3	-0.1	0.0	4.7	0.4
GOVERNMENT	1,260	12.2	-2.3	-0.3	3.6	0.4
SPECIALTY HOSPITALS:						
EYE AND EAR	10	31.1	20.1	6.3	20.2	6.3
TRAUMA	159	9.1	-1.2	-0.1	4.0	0.4
CANCER	10	22	0.8	0.2	0.8	0.2
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES):						
REHAB	147	3.7	-9.4	-0.3	1.7	0.1
PSYCH	281	9	21.3	1.9	27.9	2.5
LTC	65	3.7	-15.3	-0.6	-1.7	-0.1
CHILDREN	41	16.5	-11.9	-2.0	-3.2	-0.5

Notes:¹ Includes all BBRA provisions except the transitional corridor provisions that expire 01/01/04.² Does not include impact of reclassifications as allowed under section 401 of the BBRA 1999.³ Estimate of change compared to pre-PPS payments, which reflect the payment methodologies in effect as of January 1, 2000, and prior to July 1, 2000.

X. Federalism

We have examined this rule in accordance with Executive Order 13132, Federalism, and have determined that this final rule will not have any negative impact on the rights, roles, and responsibilities of State, local or Tribal governments.

XI. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and its reasons in the rule. We find that the circumstances surrounding this rule make it impracticable to pursue a process of notice-and-comment rulemaking before the provisions of this rule take effect.

The BBRA 1999 was enacted on November 29, 1999. This final rule incorporates the following hospital outpatient PPS provisions in the BBRA 1999: outlier adjustment for high cost cases; transitional pass-through payment adjustments for additional costs (over the payments for APCs otherwise made) for new medical devices, drugs, and biologicals; definition of APCs so that the variation of costs of items within an APC is subject to certain limits; establishment of "transitional corridors" for the first 3½ years of the new system that limit losses hospitals might otherwise face; payment for implantable devices under the hospital outpatient PPS, rather than under the Durable Medical Equipment Fee Schedule; limitation of the copayment on an outpatient procedure to the amount of the inpatient hospital deductible; requirement to review annually the APC groups, relative weights, and wage and other adjustments; and calculation of the conversion factor in a budget-neutral manner, eliminating the 5.7 percent reduction indicated in the proposed rule.

As discussed earlier in this rule, July 1, 2000 is the earliest date on which we can feasibly implement the PPS. The provisions of the BBRA 1999, enacted on November 29, 1999, made numerous refinements to the PPS. With respect to the BBRA 1999 provisions, it would

have been impracticable to complete notice and comment procedures by July 1, 2000. Given the limited timeframe, given the nature and scope of the BBRA 1999 refinements, and given the time required to complete notice and comment rulemaking (to develop proposed policies, draft the proposed rule, provide a 60-day public comment period, consider public comments, develop final policies, draft a final rule), it would not have been possible to issue this document as a proposed rule and issue a final rule by July 1.

In addition, it would not be feasible to implement the hospital outpatient PPS *without* the BBRA 1999 provisions, not only because of the nature of the BBRA 1999 provisions, but also because section 201(m) of the BBRA 1999 states: "Except as provided in this section, the amendments made by this section shall be effective as if included in the enactment of BBA." Therefore, if we undertook prior notice and comment procedures with respect to the BBRA 1999 provisions, then (because such procedures could not be completed by July 1, 2000) the PPS would not be implemented by July 1, 2000.

Accordingly, we find good cause to waive the procedures for *prior* notice and comment with respect to the provisions of this document that implement the BBRA 1999 refinements to hospital outpatient PPS. We are providing a 60-day period for public comment with respect to the provisions of this final rule with comment period that implement the BBRA refinements. We are not accepting comments with respect to the other aspects of this document (for which the public has already had an extensive opportunity to comment).

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

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 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 419

Health facilities, Hospitals, Medicare.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 498

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

42 CFR Part 1003

Administrative practice and procedure, Archives and records, Grant program—social programs, Maternal and Child Health, Medicaid, Medicare, Penalties.

For the reasons set forth in the preamble, 42 CFR chapter IV is amended as follows:

PART 409—HOSPITAL INSURANCE BENEFITS

A. Part 409 is amended as set forth below:

1. The authority citation for part 409 continues to read as follows:

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

Subpart B—Inpatient Hospital Services and Inpatient Critical Access Hospital Services

2. In § 409.10, paragraph (b) is revised to read as follows:

§ 409.10 Inpatient services.

* * * * *

(b) *Inpatient hospital services* does not include the following types of services:

(1) Posthospital SNF care, as described in § 409.20, furnished by a hospital or a critical access hospital that has a swing-bed approval.

(2) Nursing facility services, described in § 440.155 of this chapter, that may be furnished as a Medicaid service under title XIX of the Act in a swing-bed hospital that has an approval to furnish nursing facility services.

(3) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(4) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(5) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(6) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(7) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(8) Services of an anesthetist, as defined in § 410.69 of this chapter.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

B. Part 410 is amended as set forth below:

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).

Subpart A—General Provisions

2. In § 410.2, the introductory text is republished, the definition of “Community mental health center (CMHC)” is revised, and the definitions of “Encounter” and “Outpatient” are added in alphabetical order to read as follows:

§ 410.2 Definitions.

As used in this part—

Community mental health center (CMHC) means an entity that—

(1) Provides outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility;

(2) Provides 24-hour-a-day emergency care services;

(3) Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services;

(4) Provides screening for patients being considered for admission to State mental health facilities to determine the appropriateness of this admission; and

(5) Meets applicable licensing or certification requirements for CMHCs in the State in which it is located.

Encounter means a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.

* * * * *

Outpatient means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies

alone) directly from the hospital or CAH.

* * * * *

Subpart B—Medical and Other Health Services

3. In § 410.27:

A. The section heading is revised;

B. The introductory text to paragraph (a) is revised;

C. The introductory text to paragraph (a)(1) is republished;

D. The word “and” at the end of paragraph (a)(1)(i) is removed; and

E. New paragraphs (a)(1)(iii), (e), and (f) are added to read as follows:

§ 410.27 Outpatient hospital services and supplies incident to a physician service: Conditions.

(a) Medicare Part B pays for hospital services and supplies furnished incident to a physician service to outpatients, including drugs and biologicals that cannot be self-administered, if—

(1) They are furnished—

* * * * *

(iii) In the hospital or at a location (other than an RHC or an FQHC) that HCFA designates as a department of a provider under § 413.65 of this chapter; and

* * * * *

(e) Services furnished by an entity other than the hospital are subject to the limitations specified in § 410.42(a).

(f) Services furnished at a location (other than an RHC or an FQHC) that HCFA designates as a department of a provider under § 413.65 of this chapter must be under the direct supervision of a physician. “Direct supervision” means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

4. In § 410.28, paragraph (a)(4) is removed, paragraph (c) is redesignated as paragraph (d), and new paragraphs (c) and (e) are added to read as follows:

§ 410.28 Hospital or CAH diagnostic services furnished to outpatients: Conditions.

* * * * *

(c) Diagnostic services furnished by an entity other than the hospital or CAH are subject to the limitations specified in § 410.42(a).

* * * * *

(e) Medicare Part B makes payment under section 1833(t) of the Act for diagnostic services furnished at a facility (other than an RHC or an FQHC)

that HCFA designates as having provider-based status only when the diagnostic services are furnished under the appropriate level of physician supervision specified by HCFA in accordance with the definitions in § 410.32(b)(3)(i), (b)(3)(ii), and (b)(3)(iii). Under general supervision at a facility accorded provider-based status, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the facility.

5. A new § 410.42 is added to read as follows:

§ 410.42 Limitations on coverage of certain services furnished to hospital outpatients.

(a) *General rule.* Except as provided in paragraph (b) of this section, Medicare Part B does not pay for any item or service that is furnished to a hospital outpatient (as defined in § 410.2) during an encounter (as defined in § 410.2) by an entity other than the hospital unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to its patients. As used in this paragraph, the term “hospital” includes a CAH.

(b) *Exception.* The limitations stated in paragraph (a) of this section do not apply to the following services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69.

(7) Services furnished to SNF residents as defined in § 411.15(p) of this chapter.

6. In § 410.43, paragraph (b) is revised to read as follows:

§ 410.43 Partial hospitalization services: Conditions and exclusions.

* * * * *

(b) The following services are separately covered and not paid as partial hospitalization services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(5) Services furnished to SNF residents as defined in § 411.15(p) of this chapter.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

C. Part 411 is amended as set forth below:

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).

Subpart A—General Exclusions and Exclusion of Particular Services

2. In § 411.15:

A. The introductory text is republished;

B. The section heading to paragraph (m) is revised;

C. Paragraph (m)(1) is revised;

D. Paragraph (m)(2) is redesignated as paragraph (m)(3);

E. The introductory text to newly redesignated paragraph (m)(3) is republished;

F. Newly redesignated paragraphs (m)(3)(iii), (m)(3)(iv), and (m)(3)(v) are redesignated as paragraphs (m)(3)(iv), (m)(3)(v), and (m)(3)(vi), respectively; and

G. New paragraphs (m)(2) and (m)(3)(iii) are added to read as follows:

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage:

* * * * *

(m) *Services to hospital patients*—(1) *Basic rule.* Except as provided in paragraph (m)(3) of this section, any service furnished to an inpatient of a hospital or to a hospital outpatient (as defined in § 410.2 of this chapter) during an encounter (as defined in § 410.2 of this chapter) by an entity other than the hospital unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to the hospital's patients. As used in this paragraph (m)(1), the term "hospital" includes a CAH.

(2) *Scope of exclusion.* Services subject to exclusion from coverage under the provisions of this paragraph

(m) include, but are not limited to, clinical laboratory services; pacemakers and other prostheses and prosthetic devices (other than dental) that replace all or part of an internal body organ (for example, intraocular lenses); artificial limbs, knees, and hips; equipment and supplies covered under the prosthetic device benefits; and services incident to a physician service.

(3) *Exceptions.* The following services are not excluded from coverage:

* * * * *

(iii) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

D. Part 412 is amended as set forth below:

1. The authority citation for part 412 continues to read as follows:

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

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

2. In § 412.50, paragraphs (a) and (b) are revised to read as follows:

§ 412.50 Furnishing of inpatient hospital services directly or under arrangements.

(a) The applicable payments made under the prospective payment systems, as described in subparts H and M of this part, are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter. Inpatient hospital services do not include the following types of services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this chapter.

(b) HCFA does not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for the services

described in paragraphs (a)(1) through (a)(6) of this section.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

E. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart A—Introduction and General Rules

§ 413.1 [Amended]

2. In § 413.1, paragraph (a)(2)(viii) is removed.

Subpart B—Accounting Records and Reports

3. In § 413.24, the heading to paragraph (d) is republished, and a new paragraph (d)(6) is added to read as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(d) *Cost finding methods.* * * *

(6) *Management contracts.* (i) If the main provider purchases services for a department of the provider or a provider-based entity through a management contract or otherwise directly assigns costs to the department or entity, the like costs of the main provider must be carved out to ensure that they are not allocated to the department of the provider or provider-based entity. However, if the like costs of the main provider cannot be separately identified, the costs of the services purchased through a management contract must be included in the main provider's administrative and general costs and allocated among the provider's overall statistics.

(ii) Costs of free-standing entities may not be shown in the provider's trial balance for purposes of stepping down overhead costs to these entities. The provider must develop detailed work papers showing the exact cost of the services (including overhead) provided to or by the free-standing entity and show those carved out costs as

nonreimbursable cost centers in the provider's trial balance.

* * * * *

Subpart E—Payments to Providers

4. A new § 413.65 is added to read as follows:

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) *Scope and definitions.* (1) *Scope.* This section applies to all facilities or organizations for which provider-based status is sought, including remote locations of hospitals, as defined in paragraph (a)(2) of this section and satellite facilities as defined in § 412.22(h)(1) and § 412.25(e)(1) of this chapter, other than ESRD facilities. Determinations for ESRD facilities are made under § 413.174 of this chapter.

(2) *Definitions.* In this subpart E, unless the context indicates otherwise—

Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the HCFA regional office, to be part of the provider's campus.

Department of a provider means a facility or organization or a physician office that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider may not be licensed to provide health care services in its own right, may not by itself be qualified to participate in Medicare as a provider under § 489.2 of this chapter, and Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term "department of a provider" does not include an RHC or, except as specified in paragraph (m)(1) of this section, an FQHC.

Free-standing facility means an entity that furnishes health care services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity.

Main provider means a provider that either creates, or acquires ownership of, another entity to deliver additional

health care services under its name, ownership, and financial and administrative control.

Provider-based entity means a provider of health care services, or an RHC or an FQHC as defined in § 405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section.

Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this section.

Remote location of a hospital means a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A remote location of a hospital may not be licensed to provide inpatient hospital services in its own right, and Medicare conditions of participation do not apply to a remote location of a hospital as an independent entity. For purposes of this part, the term "remote location of a hospital" does not include a satellite facility as defined in § 412.22(h)(1) and § 412.25(e)(1) of this chapter.

(b) *Responsibility for obtaining provider-based determinations.* (1) A facility or organization is not entitled to be treated as provider-based simply because it or the main provider believe it is provider-based.

(2) A main provider or a facility or organization must contact HCFA and the facility or organization must be determined by HCFA to be provider-based before the main provider bills for services of the facility or organization as if the facility or organization were provider-based, or before it includes costs of those services on its cost report.

(3) A facility that is not located on the campus of a hospital and is used as a site of physician services of the kind ordinarily furnished in physician offices will be presumed to be a free-standing facility, unless it is determined by HCFA to have provider-based status.

(c) *Reporting.* (1) A main provider that creates or acquires a facility or organization for which it wishes to claim provider-based status, including any physician offices that a hospital wishes to operate as a hospital

outpatient department or clinic, must report its acquisition of the facility or organization to HCFA if the facility or organization is located off the campus of the provider, or inclusion of the costs of the facility or organization in the provider's cost report would increase the total costs on the provider's cost report by at least 5 percent, and must furnish all information needed for a determination as to whether the facility or organization meets the requirements in paragraph (d) of this section for provider-based status.

(2) A main provider that has had one or more facilities or organizations considered provider-based also must report to HCFA any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization.

(d) *Requirements.* An entity must meet all of the following requirements to be determined by HCFA to have provider-based status.

(1) *Licensure.* The department of the provider, remote location of a hospital, or satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, remote location of a hospital, or satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, remote location of a hospital, or satellite facility under a single license. If a State health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, HCFA will determine that the facility or organization does not have provider-based status.

(2) *Operation under the ownership and control of the main provider.* The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

(i) The business enterprise that constitutes the facility or organization is 100 percent owned by the provider.

(ii) The main provider and the facility or organization seeking status as a department of the provider, remote location of a hospital, or satellite facility have the same governing body.

(iii) The facility or organization is operated under the same organizational documents as the main provider. For

example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the provider where it is based.

(iv) The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits/code of conduct), and final approval for medical staff appointments in the facility or organization.

(3) *Administration and supervision.* The reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its departments, as evidenced by compliance with all of the following requirements:

(i) The facility or organization is under the direct supervision of the main provider.

(ii) The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity—

(A) Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its departments; and

(B) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

(iii) The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are—

(A) Contracted out under the same contract agreement; or

(B) Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

(4) *Clinical services.* The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

(i) Professional staff of the facility or organization have clinical privileges at the main provider.

(ii) The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

(iii) The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the Chief Medical Officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the Chief Medical Officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

(iv) Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

(v) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

(vi) Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

(5) *Financial integration.* The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of the facility or organization are reported in a cost center of the provider, and the financial status of the facility or organization is incorporated and readily identified in the main provider's trial balance.

(6) *Public awareness.* The facility or organization seeking status as a department of a provider, remote

location of a hospital, or satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

(7) *Location in immediate vicinity.* The facility or organization and the main provider are located on the same campus, except where the following requirements are met:

(i) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria, and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with HCFA, and for each subsequent 12-month period—

(A) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(B) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(C) If the facility or organization is unable to meet the criteria in paragraph (d)(7)(i)(A) or (d)(7)(i)(B) of this section because it was not in operation during all of the 12-month period described in the previous sentence, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in the previous sentence, accounted for at least 75 percent of the patients served by the main provider.

(ii) A facility or organization is not considered to be in the "immediate vicinity" of the main provider unless the facility or organization and the main provider are located in the same State or, where consistent with the laws of both States, adjacent States.

(iii) A rural health clinic that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in § 412.62(f)(1)(iii) of this chapter, and has fewer than 50 beds, as determined under § 412.105(b) of this chapter, is not subject to the criterion in this paragraph (d)(7).

(e) *Provider-based status not applicable to joint ventures.* A facility or

organization cannot be considered provider-based if the entity is owned by two or more providers engaged in a joint venture. For example, where a hospital has jointly purchased or jointly created free-standing facilities under joint venture arrangements, neither party to the joint venture arrangement can claim the free-standing facility as a provider-based entity.

(f) *Management contracts.* Facilities and organizations that otherwise meet the requirements of paragraph (d) of this section, but are operated under management contracts, must also meet all of the following criteria:

(1) The staff of the facility or organization, other than management staff, are employed by the provider or by another organization, other than the management company, which also employs the staff of the main provider.

(2) The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph (d)(3)(iii) of this section.

(3) The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph (b)(3)(ii) of this section.

(4) The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

(g) *Obligations of hospital outpatient departments and hospital-based entities.* (1) Hospital outpatient departments located either on or off the campus of the hospital that is the main provider must comply with the anti-dumping rules in §§ 489.20(l), (m), (q), and (r) and § 489.24 of this chapter. If any individual comes to any hospital-based entity (including an RHC) located on the main hospital campus, and a request is made on the individual's behalf for examination or treatment of a medical condition, as described in § 489.24 of this chapter, the hospital must comply with the anti-dumping rules in § 489.24 of this chapter.

(2) Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service indicator, so that applicable site-of-service reductions to physician and practitioner payment amounts can be applied.

(3) Hospital outpatient departments must comply with all the terms of the hospital's provider agreement.

(4) Physicians who work in hospital outpatient departments or hospital-based entities are obligated to comply

with the non-discrimination provisions in § 489.10(b) of this chapter.

(5) Hospital outpatient departments (other than RHCs) must treat all Medicare patients, for billing purposes, as hospital outpatients. The department must not treat some Medicare patients as hospital outpatients and others as physician office patients.

(6) In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at § 412.2(c)(5) of this chapter and at § 413.40(c)(2), respectively.

(7) When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, the hospital has a duty to provide written notice to the beneficiary, prior to the delivery of services, of the amount of the beneficiary's potential financial liability (that is, of the fact that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability). The notice must be one that the beneficiary can read and understand. If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, prior to the delivery of services, to the beneficiary's authorized representative.

(8) Hospital outpatient departments must meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

(h) *Furnishing all services under arrangement.* A facility or organization may not qualify for provider-based status if all patient care services furnished at the facility are furnished under arrangement.

(i) *Inappropriate treatment of a facility or organization as provider-based.* (1) *Determination and review.* If HCFA learns that a provider has treated a facility or organization as provider-based and the provider had not obtained a determination of provider-based status under this section, HCFA will—

(i) Review current payments and, if necessary, take action in accordance with the rules on inappropriate billing in paragraph (j) of this section;

(ii) Investigate and determine whether the requirements in paragraph (d) of this section (or, for periods prior to October 10, 2000, the requirements in applicable program instructions) were met; and

(iii) Review all previous payments to that provider for all cost reporting periods subject to re-opening in accordance with § 405.1885 and § 405.1889 of this chapter.

(2) *Recovery of overpayments.* If HCFA finds that payments for services at the facility or organization have been made as if the facility or organization were provider-based, even though HCFA had not previously determined that the facility or organization qualified for provider-based status, HCFA will recover the difference between the amount of payments that actually were made and the amount of payments that HCFA estimates should have been made in the absence of a determination of provider-based status, except that recovery will not be made for any period prior to October 10, 2000 if during all of that period the management of the entity made a good faith effort to operate it as a provider-based facility or organization, as described in paragraph (h)(3) of this section.

(3) *Exception for good faith effort.* HCFA determines that the management of a facility or organization has made a good faith effort to operate it as a provider-based entity if—

(i) The requirements regarding licensure and public awareness in paragraphs (d)(1) and (d)(6) of this section are met;

(ii) All facility services were billed as if they had been furnished by a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity of the main provider; and

(iii) All professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described in paragraph (g)(2) of this section.

(j) *Inappropriate billing.* If HCFA finds that a facility or organization is being treated as provider-based without having obtained a determination of provider-based status under this section, HCFA will notify the provider, adjust future payments, review previous payments, determine whether the facility or organization qualifies for provider-based status under this paragraph, and continue payments only under specific conditions, as described in paragraphs (j)(1), (j)(2), (j)(3), and (j)(4) of this section.

(1) *Notice to provider.* If HCFA finds that inappropriate billing has occurred or is occurring since no provider-based

determination has been made by HCFA, HCFA will issue written notice to the provider that payments for past cost reporting periods may be reviewed and recovered as described in paragraph (i) of this section, that future payments for services in or of the facility or organization will be adjusted as described in paragraph (j)(2) of this section, and that a determination of provider-based status will be made.

(2) *Adjustment of payments.* If HCFA finds that inappropriate billing has occurred or is occurring since no provider-based determination has been made by HCFA, HCFA will adjust future payments to the provider, the facility or organization, or both, to approximate as closely as possible the amounts that would be paid, in the absence of a provider-based determination, if all other requirements for billing were met.

(3) *Review of previous payments.* If HCFA finds that inappropriate billing has occurred or is occurring since no provider-based determination has been made by HCFA, HCFA will review previous payments and, if necessary, take action in accordance with the rules on inappropriate treatment of a facility or organization as provider-based in paragraph (h) of this section.

(4) *Determination regarding provider-based status.* If HCFA finds that inappropriate billing has occurred or is occurring since no provider-based determination has been made by HCFA, HCFA will determine whether the facility or organization qualifies for provider-based status under the criteria in this section. If HCFA determines that the facility or organization qualifies for provider-based status, future payment for services at or by the facility or organization will be adjusted to reflect that determination. If HCFA determines that the facility or organization does not qualify for provider-based status, future payment for services at or by the facility or organization will be made only in accordance with the rules in paragraph (i)(5) of this section.

(5) *Continuation of payment.* The notice of denial of provider-based status sent to the provider will ask the provider to notify HCFA in writing, within 30 days of the date the notice is issued, of whether the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services in a free-standing facility. If the provider indicates that the facility, organization, or practitioners will not be seeking to enroll, or if HCFA does not receive a response within 30 days of the date the notice was issued, all payment under this paragraph (i)(5) will end as

of the 30th day after the date of notice. If the provider indicates that the facility or organization, or its practitioners, will be seeking to meet enrollment and other requirements for billing for services in a free-standing facility, payment for services of the facility or organization will continue, at the adjusted amounts described in paragraph (j)(2) of this section for as long as is required for all billing requirements to be met (but not longer than 6 months) if the facility or organization, or its practitioners, submit a complete enrollment application and provide all other required information within 90 days after the date of notice; and the facility or organization, or its practitioners, furnish all other information needed by HCFA to process the enrollment application and verify that other billing requirements are met. If the necessary applications or information are not provided, HCFA will terminate all payment to the provider, facility, or organization as of the date HCFA issues notice that necessary applications or information have not been submitted.

(k) *Correction of errors.* HCFA may review a past determination of provider-based status for a facility or organization or may review the status of a facility or organization (that is, whether the facility or organization is provider-based) if no determination regarding provider-based status has previously been made, if HCFA believes that status may be inappropriate, based on the provisions of this section. If HCFA determines that a previous determination was in error, and the entity should not be considered provider-based, HCFA notifies the main provider. Treatment of the facility or organization as provider-based ceases with the first day of the next cost report period following notification of the redetermination, but not less than 6 months after the date of notification.

(l) *Status of Indian Health Service and Tribal facilities and organizations.*

Facilities and organizations operated by the Indian Health Service or Tribes will be considered to be departments of hospitals operated by the Indian Health Service or Tribes if, on or before April 7, 2000, they furnished only services that were billed as if they had been furnished by a department of a hospital operated by the Indian Health Service or a Tribe and they are:

(1) Owned and operated by the Indian Health Service;

(2) Owned by the Tribe but leased from the Tribe by the IHS under the Indian Self-Determination Act (Pub. L. 93-638) in accordance with applicable regulations and policies of the Indian

Health Service in consultation with Tribes: or

(3) Owned by the Indian Health Service but leased and operated by the Tribe under the Indian Self-Determination Act (Pub. L. 93-638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes.

(m) *FQHCs and "look-alikes".* A facility that has, since April 7, 1995, furnished only services that were billed as if they had been furnished by a department of a provider will continue to be treated, for purposes of this section, as a department of the provider without regard to whether it complies with the criteria for provider-based status in this section, if the facility—

(1) Received a grant before 1995 under section 330 of the Public Health Service Act, or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under section 330 of the Public Health Service Act; or

(2) Based on the recommendation of the Public Health Service, was determined by HCFA before 1995 to meet the requirements for receiving such a grant.

(n) *Effective date of provider-based status.* Provider-based status for a facility or organization is effective on the earliest date on which a request for provider-based status has been made, and all requirements of this part have been met.

Subpart F—Specific Categories of Costs

5. In § 413.118, the heading to paragraph (d) is republished, and a new paragraph (d)(5) is added to read as follows:

§ 413.118 Payment for facility services related to covered ASC surgical procedures performed in hospitals on an outpatient basis.

* * * * *

(d) *Blended payment amount.* * * *

(5) For portions of cost reporting periods beginning on or after October 1, 1997, for purposes of calculating the blended payment amount under paragraph (d)(4) of this section, the ASC payment amount is the sum of the standard overhead amounts reduced by deductibles and coinsurance as defined in section 1866(a)(2)(ii) of the Act.

* * * * *

6. In § 413.122:

A. The heading to paragraph (b) is republished

B. A new paragraph (b)(5) is added

C. The heading to paragraph (c) is republished; and

D. A new paragraph (c)(4) is added to read as follows:

§ 413.122 Payment for hospital outpatient radiology services and other diagnostic procedures.

* * * * *

(b) *Payment for hospital outpatient radiology services.* * * *

(5) For hospital outpatient radiology services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 42 percent of the hospital-specific amount; and

(ii) 58 percent of the fee schedule amount calculated as 62 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality, less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

(c) *Payment for other diagnostic procedures.* * * *

(4) For other diagnostic services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 50 percent of the hospital-specific amount; and

(ii) 50 percent of the fee schedule amount calculated as 42 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

7. In § 413.124, paragraph (a) is revised to read as follows:

§ 413.124 Reduction to hospital outpatient operating costs.

(a) Except for sole community hospitals, as defined in § 412.92 of this chapter, and critical access hospitals, the reasonable costs of outpatient hospital services (other than capital-related costs of these services) are reduced by 5.8 percent for services furnished during portions of cost reporting periods occurring on or after October 1, 1990 and until the first date that the prospective payment system under part 419 of this chapter is implemented.

* * * * *

Subpart G—Capital-Related Costs

8. In § 413.130, the heading to paragraph (j) and the introductory text to paragraph (j)(1) are republished, and paragraph (j)(1)(ii) is revised to read as follows:

§ 413.130 Introduction to capital-related costs.

* * * * *

(j) *Reduction to capital-related costs.*

(1) Except for sole community hospitals and critical access hospitals, the amount of capital-related costs of all hospital outpatient services is reduced by—

* * * * *

(ii) 10 percent for portions of cost reporting periods occurring on or after October 1, 1991 and until the first date that the prospective payment system under part 419 of this chapter is implemented.

* * * * *

F. A new part 419, consisting of §§ 419.1, 419.2, 419.20, 419.21, 419.22, 419.30, 419.31, 419.32, 419.40, 419.41, 419.42, 419.43, 419.44, 419.50, 419.60, and 419.70, is added to read as follows:

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Subpart A—General Provisions

Sec.

419.1 Basis and scope.

419.2 Basis of payment.

Subpart B—Categories of Hospitals and Services Subject to and Excluded From the Hospital Outpatient Prospective Payment System

419.20 Hospitals subject to the hospital outpatient prospective payment system.

419.21 Hospital outpatient services subject to the outpatient prospective payment system.

419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

419.30 Base expenditure target for calendar year 1999.

419.31 Ambulatory payment classification (APC) system and payment weights.

419.32 Calculation of prospective payment rates for hospital outpatient services.

Subpart D—Payments to Hospitals

419.40 Payment concepts.

419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

419.42 Hospital election to reduce copayment.

419.43 Adjustments to national program payment and beneficiary copayment amounts.

419.44 Payment reductions for surgical procedures.

Subpart E—Updates

419.50 Annual updates.

Subpart F—Limitations on Review

419.60 Limitations on administrative and judicial review.

Subpart G—Transitional Corridors

419.70 Transitional adjustment to limit decline in payment.

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Subpart A—General Provisions

§ 419.1 Basis and scope.

(a) *Basis.* This part implements section 1833(t) of the Act by establishing a prospective payment system for services furnished on or after July 1, 2000 by hospital outpatient departments to Medicare beneficiaries who are registered on hospital records as outpatients.

(b) *Scope.* This subpart describes the basis of payment for outpatient hospital services under the prospective payment system. Subpart B sets forth the categories of hospitals and services that are subject to the outpatient hospital prospective payment system and those categories of hospitals and services that are excluded from the outpatient hospital prospective payment system. Subpart C sets forth the basic methodology by which prospective payment rates for hospital outpatient services are determined. Subpart D describes Medicare payment amounts, beneficiary copayment amounts, and methods of payment to hospitals under the hospital outpatient prospective payment system. Subpart E describes how the hospital outpatient prospective payment system may be updated. Subpart F describes limitations on administrative and judicial review. Subpart G describes the transitional payment adjustments that are made before 2004 to limit declines in payment for outpatient services.

§ 419.2 Basis of payment.

(a) *Unit of payment.* Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Health Care Financing Administration Common Procedure Coding System (HCPCS). The prospective payment rate for each service or procedure for which payment is allowed under the hospital outpatient prospective payment system is

determined according to the methodology described in subpart C of this part. The manner in which the Medicare payment amount and the beneficiary copayment amount for each service or procedure are determined is described in subpart D of this part.

(b) *Determination of hospital outpatient prospective payment rates: Included costs.* The prospective payment system establishes a national payment rate, standardized for geographic wage differences, that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis. In general, these costs include, but are not limited to—

- (1) Use of an operating suite, procedure room, or treatment room;
- (2) Use of recovery room;
- (3) Use of an observation bed;
- (4) Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations;
- (5) Supplies and equipment for administering and monitoring anesthesia or sedation;
- (6) Intraocular lenses (IOLs);
- (7) Incidental services such as venipuncture;
- (8) Capital-related costs;
- (9) Implantable items used in connection with diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- (10) Durable medical equipment that is implantable;
- (11) Implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of these devices; and
- (12) Costs incurred to procure donor tissue other than corneal tissue.

(c) *Determination of hospital outpatient prospective payment rates: Excluded costs.* The following costs are excluded from the hospital outpatient prospective payment rates:

- (1) Medical education costs for approved nursing and allied health education programs.
- (2) Corneal tissue acquisition costs incurred by hospitals that are paid for on a reasonable cost basis.
- (3) Costs for services listed in § 419.22.

Subpart B—Categories of Hospitals and Services Subject to and Excluded From the Hospital Outpatient Prospective Payment System

§ 419.20 Hospitals subject to the hospital outpatient prospective payment system.

(a) *Applicability.* The hospital outpatient prospective payment system is applicable to any hospital participating in the Medicare program, except those specified in paragraph (b) of this section, for services furnished on or after July 1, 2000.

(b) *Hospitals excluded from the outpatient prospective payment system.*

- (1) Those services furnished by Maryland hospitals that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act are excluded from the hospital outpatient prospective payment system.
- (2) Critical access hospitals (CAHs) are excluded from the hospital outpatient prospective payment system.

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

Except for services described in § 419.22, effective for services furnished on or after July 1, 2000, payment is made under the hospital outpatient prospective payment system for the following:

- (a) Medicare Part B services furnished to hospital outpatients designated by the Secretary under this part.
- (b) Services designated by the Secretary that are covered under Medicare Part B when furnished to hospital inpatients who are either not entitled to benefits under Part A or who have exhausted their Part A benefits but are entitled to benefits under Part B of the program.

(c) Partial hospitalization services furnished by community mental health centers (CMHCs).

(d) The following medical and other health services furnished by a comprehensive outpatient rehabilitation facility (CORF) when they are provided outside the patient's plan (of care); or by a home health agency (HHA) to patients who are not under an HHA plan or treatment; or by a hospice program furnishing services to patients outside the hospice benefit:

- (1) Antigens.
- (2) Splints and casts.
- (3) Pneumococcal vaccine, influenza vaccine, and hepatitis B vaccine.

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

The following services are not paid for under the hospital outpatient prospective payment system:

(a) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(b) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(c) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(d) Certified nurse-midwife services, as defined in section 1861(gg) of the Act.

(e) Services of qualified psychologists, as defined in section 1861(ii) of the Act.

(f) Services of an anesthetist as defined in § 410.69 of this chapter.

(g) Clinical social worker services as defined in section 1861(hh)(2) of the Act.

(h) Outpatient therapy services described in section 1833(a)(8) of the Act.

(i) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule established under section 1834(l).

(j) Except as provided in § 419.22(b)(11), prosthetic devices, prosthetics, prosthetic supplies, and orthotic devices.

(k) Except as provided in § 419.2(b)(10), durable medical equipment supplied by the hospital for the patient to take home.

(l) Clinical diagnostic laboratory services.

(m) Services for patients with ESRD that are paid under the ESRD composite rate and drugs and supplies furnished during dialysis but not included in the composite rate.

(n) Services and procedures that the Secretary designates as requiring inpatient care.

(o) Hospital outpatient services furnished to SNF residents (as defined in § 411.15(p) of this chapter) as part of the patient's resident assessment or comprehensive care plan (and thus included under the SNF PPS) that are furnished by the hospital "under arrangements" but billable only by the SNF, regardless of whether or not the patient is in a Part A SNF stay.

(p) Services that are not covered by Medicare by statute.

(q) Services that are not reasonable or necessary for the diagnosis or treatment of an illness or disease.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

§ 419.30 Base expenditure target for calendar year 1999.

(a) HCFA estimates the aggregate amount that would be payable for

hospital outpatient services in calendar year 1999 by summing—

(1) The total amounts that would be payable from the Trust Fund for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part; and

(2) The total amounts of coinsurance that would be payable by beneficiaries to hospitals for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part.

(b) The estimated aggregate amount under paragraph (a) of this section is determined as though the deductible required under section 1833(b) of the Act did not apply.

§ 419.31 Ambulatory payment classification (APC) system and payment weights.

(a) *APC groups.* (1) HCFA classifies outpatient services and procedures that are comparable clinically and in terms of resource use into APC groups. Except as specified in paragraph (a)(2) of this section, items and services within a group are not comparable with respect to the use of resources if the highest median cost for an item or service within the group is more than 2 times greater than the lowest median cost for an item or service within the group.

(2) HCFA may make exceptions to the requirements set forth in paragraph (a)(1) in unusual cases, such as low volume items and services, but may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.

(3) The payment rate determined for an APC group in accordance with § 419.32, and the copayment amount and program payment amount determined for an APC group in accordance with subpart D of this part, apply to every HCPCS code classified within an APC group.

(b) *APC weighting factors.* (1) Using hospital outpatient claims data from calendar year 1996 and data from the most recent available hospital cost reports, HCFA determines the median costs for the services and procedures within each APC group.

(2) HCFA assigns to each APC group an appropriate weighting factor to reflect the relative median costs for the services within the APC group compared to the median costs for the services in all APC groups.

(c) *Standardizing amounts.* (1) HCFA determines the portion of costs determined in paragraph (b)(1) of this section that is labor-related. This is

known as the “labor-related portion” of hospital outpatient costs.

(2) HCFA standardizes the median costs determined in paragraph (b)(1) of this section by adjusting for variations in hospital labor costs across geographic areas.

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

(a) *Conversion factor for 1999.* HCFA calculates a conversion factor in such a manner that payment for hospital outpatient services furnished in 1999 would have equaled the base expenditure target calculated in § 419.30, taking into account APC group weights and estimated service frequencies and reduced by the amounts that would be payable in 1999 as outlier payments under § 419.43(d) and transitional pass-through payments under § 419.43(e).

(b) *Conversion factor for calendar year 2000 and subsequent years.* (1) Subject to paragraph (b)(2) of this section, the conversion factor for a calendar year is equal to the conversion factor calculated for the previous year adjusted as follows:

(i) For calendar years 2000, 2001, and 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point.

(ii) For calendar years 2003 and subsequent years, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

(2) Beginning in calendar year 2000, HCFA may substitute for the hospital inpatient market basket percentage in paragraph (b) of this section a market basket percentage increase that is determined and applied to hospital outpatient services in the same manner that the hospital inpatient market basket percentage increase is determined and applied to inpatient hospital services.

(c) *Payment rates.* The payment rate for services and procedures for which payment is made under the hospital outpatient prospective payment system is the product of the conversion factor calculated under paragraph (a) or paragraph (b) of this section and the relative weight determined under § 419.31(b).

(d) *Budget neutrality.* HCFA adjusts the conversion factor as needed to ensure that updates and adjustments under § 419.50(a) are budget neutral.

Subpart D—Payments to Hospitals

§ 419.40 Payment concepts.

(a) In addition to the payment rate described in § 419.32, for each APC

group there is a predetermined beneficiary coinsurance amount as described in § 419.41(a). The Medicare program payment amount for each APC group is calculated by applying the program payment percentage as described in § 419.41(b).

(b) For purposes of this section—

(1) *Coinsurance percentage* is calculated as the difference between the program payment percentage and 100 percent. The coinsurance percentage in any year is thus defined for each APC group as the *greater* of the following: the ratio of the APC group unadjusted copayment amount to the annual APC group payment rate, or 20 percent.

(2) *Program payment percentage* is calculated as the *lower* of the following: the ratio of the APC group payment rate minus the APC group unadjusted coinsurance amount, to the APC group payment rate, or 80 percent.

(3) *Unadjusted coinsurance amount* is calculated as 20 percent of the wage-adjusted national median of charges for services within an APC group furnished during 1996, updated to 1999 using an actuarial projection of charge increases for hospital outpatient department services during the period 1996 to 1999.

(c) *Limitation of coinsurance amount to inpatient hospital deductible amount.* The coinsurance amount for a procedure performed in a year cannot exceed the amount of the inpatient hospital deductible established under section 1813(b) of the Act for that year.

§ 419.41 Calculation of national beneficiary coinsurance amounts and national Medicare program payment amounts.

(a) To calculate the unadjusted coinsurance amount for each APC group, HCFA—

(1) Standardizes 1996 hospital charges for the services within each APC group to offset variations in hospital labor costs across geographic areas;

(2) Identifies the median of the wage-neutralized 1996 charges for each APC group; and

(3) Determines the value equal to 20 percent of the wage-neutralized 1996 median charge for each APC group and multiplies that value by an actuarial projection of increases in charges for hospital outpatient department services during the period 1996 to 1999. The result is the unadjusted beneficiary coinsurance amount for the APC group.

(b) HCFA calculates annually the program payment percentage for every APC group on the basis of each group's unadjusted coinsurance amount and its payment rate after the payment rate is adjusted in accordance with § 419.32.

(c) To determine payment amounts due for a service paid under the hospital

outpatient prospective payment system, HCFA makes the following calculations:

(1) Makes the wage index adjustment in accordance with § 419.43.

(2) Subtracts the amount of the applicable Part B deductible provided under § 410.160 of this chapter.

(3) Multiplies the remainder by the program payment percentage for the group to determine the preliminary Medicare program payment amount.

(4) Subtracts the program payment amount from the amount determined in paragraph (c)(2) of this section to determine the coinsurance amount.

(i) The coinsurance amount for an APC cannot exceed the amount of the inpatient hospital deductible established under section 1813(b) of the Act for that year.

(ii) The coinsurance amount is computed as if the adjustments under § 419.43(d) and (e) (and any adjustment made under § 419.43(f) in relation to these adjustments) had not been paid.

(5) Adds the amount by which the coinsurance amount would have exceeded the inpatient hospital deductible for that year to the preliminary Medicare program payment amount determined in paragraph (c)(3) of this section to determine the final Medicare program payment amount.

§ 419.42 Hospital election to reduce coinsurance.

(a) A hospital may elect to reduce coinsurance for any or all APC groups on a calendar year basis. A hospital may *not* elect to reduce copayment for some, but not all, services within the same group.

(b) A hospital must notify its fiscal intermediary of its election to reduce coinsurance no later than—

(1) June 1, 2000, for coinsurance elections for the period July 1, 2000 through December 31, 2000; or

(2) December 1 preceding the beginning of each subsequent calendar year.

(c) The hospital's election must be properly documented. It must specifically identify the APCs to which it applies and the coinsurance amount (within the limits identified below) that the hospital has selected for each group.

(d) The election of reduced coinsurance remains in effect unchanged during the year for which the election was made.

(e) In electing reduced coinsurance, a hospital may elect a level that is less than that year's wage-adjusted coinsurance amount for the group but not less than 20 percent of the APC payment rate as determined in § 419.32.

(f) The hospital may advertise and otherwise disseminate information

concerning the reduced level of coinsurance that it has elected. All advertisements and information furnished to Medicare beneficiaries must specify that the coinsurance reductions advertised apply only to the specified services of that hospital and that coinsurance reductions are available only for hospitals that choose to reduce coinsurance for hospital outpatient services and are not allowed in any other ambulatory settings or physician offices.

§ 419.43 Adjustments to national program payment and beneficiary coinsurance amounts.

(a) *General rule.* HCFA determines national prospective payment rates for hospital outpatient department services and determines a wage adjustment factor to adjust the portion of the APC payment and national beneficiary coinsurance amount attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner.

(b) *Labor-related portion of payment and copayment rates for hospital outpatient services.* HCFA determines the portion of hospital outpatient costs attributable to labor and labor-related costs (known as the "labor-related portion" of hospital outpatient costs) in accordance with § 419.31(c)(1).

(c) *Wage index factor.* HCFA uses the hospital inpatient prospective payment system wage index established in accordance with part 412 of this chapter to make the adjustment referred to in paragraph (a) of this section.

(d) *Outlier adjustment—(1) General rule.* Subject to paragraph (d)(4) of this section, HCFA provides for an additional payment for each hospital outpatient service (or group of services) for which a hospital's charges, adjusted to cost, exceed the following:

(i) A fixed multiple of the sum of—

(A) The applicable Medicare hospital outpatient payment amount determined under § 419.32(c), as adjusted under § 419.43 (other than for adjustments under this paragraph (d) or paragraph (e) of this section); and

(B) Any transitional pass-through payment under paragraph (e) of this section.

(ii) At the option of HCFA, a fixed dollar amount.

(2) *Amount of adjustment.* The amount of the additional payment under paragraph (d)(1) of this section is determined by HCFA and approximates the marginal cost of care beyond the applicable cutoff point under paragraph (d)(1) of this section.

(3) *Limit on aggregate outlier adjustments—(i) In general.* The total of the additional payments made under this paragraph (d) for covered hospital outpatient department services furnished in a year (as estimated by HCFA before the beginning of the year) may not exceed the applicable percentage specified in paragraph (d)(3)(ii) of this section of the total program payments (sum of both the Medicare and beneficiary payments to the hospital) estimated to be made under this part for all hospital outpatient services furnished in that year. If this paragraph is first applied to less than a full year, the limit applies only to the portion of the year.

(ii) *Applicable percentage.* For purposes of paragraph (d)(3)(i) of this section, the term "applicable percentage" means a percentage specified by HCFA up to (but not to exceed)—

(A) For a year (or portion of a year) before 2004, 2.5 percent; and

(B) For 2004 and thereafter, 3.0 percent.

(4) *Transitional authority.* In applying paragraph (d)(1) of this section for hospital outpatient services furnished before January 1, 2002, HCFA may—

(i) Apply paragraph (d)(1) of this section to a bill for these services related to an outpatient encounter (rather than for a specific service or group of services) using hospital outpatient payment amounts and transitional pass-through payments covered under the bill; and

(ii) Use an appropriate cost-to-charge ratio for the hospital or CMHC (as determined by HCFA), rather than for specific departments within the hospital.

(e) *Transitional pass-through for additional costs of innovative medical devices, drugs, and biologicals—(1) General rule.* HCFA provides for an additional payment under this

paragraph for any of the following that are provided as part of a hospital outpatient service (or group of services):

(i) *Current orphan drugs.* A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this part is implemented.

(ii) *Current cancer therapy drugs and biologicals and brachytherapy.* A drug or biological that is used in cancer therapy, including, but not limited to, a chemotherapeutic agent, an antiemetic,

a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of brachytherapy, if payment for the drug, biological, or device as an outpatient hospital service under this part was being made on the first date that the system under this part is implemented.

(iii) *Current radiopharmaceutical drugs and biological products.* A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this part is implemented.

(iv) *New medical devices, drugs, and biologicals.* A medical device, drug, or biological not described in paragraph (e)(1)(i), (e)(1)(ii), or (e)(1)(iii) of this section if—

(A) Payment for the device, drug, or biological as an outpatient hospital service under this part was not being made as of December 31, 1996; and

(B) The cost of the device, drug, or biological is not insignificant (as defined in paragraph (e)(1)(iv)(C) of this section) in relation to the hospital outpatient fee schedule amount (as calculated under § 419.32(c)) payable for the service (or group of services) involved.

(C) The cost of the device, drug, or biological is considered not insignificant if it meets all of the following thresholds:

(1) Its expected reasonable cost exceeds 25 percent of the applicable fee schedule amount for the associated service.

(2) The expected reasonable cost of the new drug, biological, or device must exceed the current portion of the fee schedule amount determined to be associated with the drug, biological, or device by 25 percent.

(3) The difference between the expected reasonable cost of the item and the portion of the hospital outpatient fee schedule amount determined to be associated with the item exceeds 10 percent of the applicable hospital outpatient fee schedule amount.

(2) *Limited period of payment.* The payment under this paragraph (e) with respect to a medical device, drug, or biological applies during a period of at least 2 years, but not more than 3 years, that begins—

(i) On the first date this section is implemented in the case of a drug, biological, or device described in paragraphs (e)(2)(i), (e)(2)(ii), or (e)(2)(iii) of this section and in the case of a device, drug, or biological described

in paragraph (e)(1)(iv) of this section and for which payment under this part is made as an outpatient hospital service before the first date; or

(ii) In the case of a device, drug, or biological described in paragraph (e)(1)(iv) of this section not described in paragraph (e)(2)(i) of this section, on the first date on which payment is made under this part for the device, drug, or biological as an outpatient hospital service.

(3) *Amount of additional payment.* Subject to paragraph (e)(4)(iii) of this section, the amount of the payment under this paragraph is—

(i) In the case of a drug or biological, the amount by which the amount determined under section 1842(o) of the Act for the drug or biological exceeds the portion of the otherwise applicable Medicare hospital outpatient fee schedule amount that HCFA determines is associated with the drug or biological; or

(ii) In the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable Medicare hospital outpatient fee schedule amount that HCFA determines is associated with the device.

(4) *Limit on aggregate annual adjustment—(i) General rule.* The total of the additional payments made under this paragraph for hospital outpatient services furnished in a year, as estimated by HCFA before the beginning of the year, may not exceed the applicable percentage specified in paragraph (e)(4)(ii) of this section of the total program payments estimated to be made under this section for all hospital outpatient services furnished in that year. If this paragraph is first applied to less than a full year, the limit applies only to the portion of the year.

(ii) *Applicable percentage.* For purposes of paragraph (e)(4)(i) of this section, the term “applicable percentage” means—

(A) For a year (or portion of a year) before 2004, 2.5 percent; and

(B) For 2004 and thereafter, a percentage specified by HCFA up to (but not to exceed) 2.0 percent.

(iii) *Uniform prospective reduction if aggregate limit projected to be exceeded.* If HCFA estimates before the beginning of a year that the amount of the additional payments under this paragraph (e) for the year (or portion thereof) as determined under paragraph (e)(4)(i) of this section without regard to this paragraph (e)(4)(iii) would exceed the limit established under this paragraph (e)(4)(iii), HCFA reduces pro rata the amount of each of the additional payments under this paragraph for that

year (or portion thereof) in order to ensure that the aggregate additional payments under this paragraph (as so estimated) do not exceed the limit.

(f) *Budget neutrality.* Outlier adjustments under paragraph (d) of this section and transitional pass-through payments under paragraph (e) of this section are established in a budget-neutral manner.

§ 419.44 Payment reductions for surgical procedures.

(a) *Multiple surgical procedures.* When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts for the procedure with the highest APC payment rate; and

(2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.

(b) *Terminated procedures.* When a surgical procedure is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts if the procedure is discontinued after the induction of anesthesia or after the procedure is started; or

(2) One-half of the full program and the beneficiary coinsurance amounts if the procedure is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed but before anesthesia is induced.

Subpart E—Updates

§ 419.50 Annual review.

(a) *General rule.* Not less often than annually, HCFA reviews and updates groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

(b) *Consultation requirement.* HCFA will consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise HCFA concerning) the clinical integrity of the groups and weights. The panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting the review.

(c) *Effective dates.* HCFA conducts the first annual review under paragraph (a) of this section in 2001 for payments made in 2002.

Subpart F—Limitations on Review

§ 419.60 Limitations on administrative and judicial review.

There can be no administrative or judicial review under sections 1869 and 1878 of the Act or otherwise of the following:

(a) The development of the APC system, including—

- (1) Establishment of the groups and relative payment weights;
- (2) Wage adjustment factors;
- (3) Other adjustments; and
- (4) Methods for controlling unnecessary increases in volume.

(b) The calculation of base amounts described in section 1833(t)(3) of the Act.

(c) Periodic adjustments described in section 1833(t)(9) of the Act.

(d) The establishment of a separate conversion factor for hospitals described in section 1886(d)(1)(B)(v) of the Act.

(e) The determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under § 419.43(d) or the determination of insignificance of cost, the duration of the additional payments (consistent with § 419.43(e)), the portion of the Medicare hospital outpatient fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under § 419.43(e).

Subpart G—Transitional Corridors

§ 419.70 Transitional adjustment to limit decline in payment.

(a) *Before 2002.* Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished before January 1, 2002, for which the prospective payment system amount (as defined in paragraph (e) of this section) is—

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in paragraph (f) of this section), the amount of payment under this part is increased by 80 percent of the amount of this difference;

(2) At least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.71 and the pre-BBA amount exceeds the product of 0.70 and the prospective payment system amount;

(3) At least 70 percent, but less than 80 percent, of the pre-BBA amount, the

amount of payment under this part is increased by the amount by which the product of 0.63 and the pre-BBA amount, exceeds the product of 0.60 and the PPS amount; or

(4) Less than 70 percent of the pre-BBA amount, the amount of payment under this part shall be increased by 21 percent of the pre-BBA amount.

(b) *For 2002.* Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished during 2002, for which the prospective payment system amount is—

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this part is increased by 70 percent of the amount of this difference;

(2) At least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.61 and the pre-BBA amount exceeds the product of 0.60 and the prospective payment system amount; or

(3) Less than 80 percent of the pre-BBA amount, the amount of payment under this part is increased by 13 percent of the pre-BBA amount.

(c) *For 2003.* Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished during 2003, for which the prospective payment system amount is—

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this part is increased by 60 percent of the amount of this difference; or

(2) Less than 90 percent of the pre-BBA amount, the amount of payment under this part is increased by 6 percent of the pre-BBA amount.

(d) *Hold harmless provisions—(1) Temporary treatment for small rural hospitals.* For covered hospital outpatient services furnished in a calendar year before January 1, 2004 for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by the amount of that difference if the hospital—

(i) Is located in a rural area as defined in § 412.63(b) of this chapter or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act; and

(ii) Has 100 or fewer beds as defined in § 412.105(b) of this chapter.

(2) *Permanent treatment for cancer hospitals.* In the case of a hospital described in § 412.23(f) of this chapter for which the prospective payment system amount is less than the pre-BBA amount for covered hospital outpatient services, the amount of payment under

this part is increased by the amount of this difference.

(e) *Prospective payment system amount defined.* In this paragraph, the term “prospective payment system amount” means, with respect to covered hospital outpatient services, the amount payable under this part for these services (determined without regard to this paragraph or any reduction in coinsurance elected under § 419.42), including amounts payable as copayment under § 419.41, coinsurance under section 1866(a)(2)(A)(ii) of the Act, and the deductible under section 1833(b) of the Act.

(f) *Pre-BBA amount defined—(1) General rule.* In this paragraph, the “pre-BBA amount” means, with respect to covered hospital outpatient services furnished by a hospital or a community mental health center (CMHC) in a year, an amount equal to the product of the reasonable cost of the provider for these services for the portions of the provider’s cost reporting period (or periods) occurring in the year and the base provider outpatient payment-to-cost ratio for the provider (as defined in paragraph (f)(2) of this section).

(2) *Base payment-to-cost-ratio defined.* For purposes of this paragraph, HCFA shall determine these ratios as if the amendments to sections 1833(i)(3)(B)(i)(II) and 1833(n)(1)(B)(i) of the Act made by section 4521 of the BBA, to require that the full amount beneficiaries paid as coinsurance under section 1862(a)(2)(A) of the Act are taken into account in determining Medicare Part B Trust Fund payment to the hospital, were in effect in 1996. The “base payment-to-cost ratio” for a hospital or CMHC means the ratio of—

(i) The provider’s payment under this part for covered outpatient services furnished during the cost reporting period ending in 1996, including any payment for these services through cost-sharing described in paragraph (e) of this section; and

(ii) The reasonable cost of these services for this period, without applying the cost reductions under section 1861(v)(1)(S) of the Act.

(g) *Interim payments.* HCFA makes payments under this paragraph to hospitals and CMHCs on an interim basis, subject to retrospective adjustments based on settled cost reports.

(h) *No effect on coinsurance.* No payment made under this section affects the unadjusted coinsurance amount or the coinsurance amount described in § 419.41.

(i) *Application without regard to budget neutrality.* The additional payments made under this paragraph—

- (1) Are not considered an adjustment under § 419.43(f); and
- (2) Are not implemented in a budget neutral manner.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

G. Part 424 is amended as set forth below:

1. The authority citation for part 424 continues to read as follows:

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

2. In § 424.24, the heading to paragraph (e) is republished, and a new paragraph (e)(3) is added to read as follows:

§ 424.24 Requirements for medical and other health services furnished by providers under Medicare Part B.

* * * * *

(e) *Partial hospitalization services: Content of certification and plan of treatment requirements—*

* * * * *

(3) *Recertification requirements.*

(i) *Signature.* The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.

(ii) *Timing.* The first recertification is required as of the 18th day of partial hospitalization services. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.

(iii) *Content.* The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the partial hospitalization program and describe the following:

(A) The patient's response to the therapeutic interventions provided by the partial hospitalization program.

(B) The patient's psychiatric symptoms that continue to place the patient at risk of hospitalization.

(C) Treatment goals for coordination of services to facilitate discharge from the partial hospitalization program.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

H. Part 489 is amended as set forth below:

1. The authority citation to part 489 continues to read as follows:

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

Subpart B—Essentials of Provider Agreements

2. In § 489.20, the introductory text to the section is republished; the introductory text to paragraph (d) is revised; paragraphs (d)(3), (d)(4), and (d)(5) are redesignated as paragraphs (d)(4), (d)(5), and (d)(6), respectively; and a new paragraph (d)(3) is added to read as follows:

§ 489.20 Basic commitments.

The provider agrees to the following:

* * * * *

(d) In the case of a hospital or a CAH that furnishes services to Medicare beneficiaries, either to furnish directly or to make arrangements (as defined in § 409.3 of this chapter) for all Medicare-covered services to inpatients and outpatients of a hospital or a CAH except the following:

* * * * *

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

* * * * *

3. In § 489.24, the definition for "Comes to the emergency department" in paragraph (b) is revised, and a new paragraph (i) is added to read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

* * * * *

(b) * * *

Comes to the emergency department means, with respect to an individual requesting examination or treatment, that the individual is on the hospital property. For purposes of this section, "property" means the entire main hospital campus as defined in § 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, as well as any facility or organization that is located off the main hospital campus but has been determined under § 413.65 of this chapter to be a department of the hospital. The responsibilities of hospitals with respect to these off-campus facilities or organizations are described in paragraph (i) of this section. Property also includes ambulances owned and operated by the hospital even if the ambulance is not on hospital grounds. An individual in a nonhospital-owned ambulance on hospital property is considered to have come to the hospital's emergency department. An individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications

and informs the hospital that they want to transport the individual to the hospital for examination and treatment. In these situations, the hospital may deny access if it is in "diversionary status," that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's instructions and transports the individual on to hospital property, the individual is considered to have come to the emergency department.

* * * * *

(i) *Off-campus departments.* If an individual comes to a facility or organization that is located off the main hospital campus but has been determined under § 416.35 of this chapter to be a department of the hospital and a request is made on the individual's behalf for examination or treatment of a potential emergency medical condition as otherwise described in paragraph (a) of this section, the hospital is obligated in accordance with the rules in this paragraph to provide the individual with an appropriate medical screening examination and any necessary stabilizing treatment or an appropriate transfer.

(1) *Capability of the hospital.* The capability of the hospital includes that of the hospital as a whole, not just the capability of the off-campus department. Except for cases described in paragraph (i)(3)(ii) of this section, the obligation of a hospital under this section must be discharged within the hospital as a whole. However, the hospital is not required to locate additional personnel or staff to off-campus departments to be on standby for possible emergencies.

(2) *Protocols for off-campus departments.* The hospital must establish protocols for the handling of individuals with potential emergency conditions at off-campus departments. These protocols must provide for direct contact between personnel at the off-campus department and emergency personnel at the main hospital campus and may provide for dispatch of practitioners, when appropriate, from the main hospital campus to the off-campus department to provide screening or stabilization services.

(i) If the off-campus department is an urgent care center, primary care center, or other facility that is routinely staffed by physicians, RNs, or LPNs, these department personnel must be trained, and given appropriate protocols, for the handling of emergency cases. At least one individual on duty at the off-campus department during its regular hours of operation must be designated

as a qualified medical person as described in paragraph (d) of this section. The qualified medical person must initiate screening of individuals who come to the off-campus department with a potential emergency medical condition, and may be able to complete the screening and provide any necessary stabilizing treatment at the off-campus department, or to arrange an appropriate transfer.

(ii) If the off-campus department is a physical therapy, radiology, or other facility not routinely staffed with physicians, RNs, or LPNs, the department's personnel must be given protocols that direct them to contact emergency personnel at the main hospital campus for direction. Under this direction, and in accordance with protocols established in advance by the hospital, the personnel at the off-campus department must describe patient appearance and report symptoms and, if appropriate, either arrange transportation of the individual to the main hospital campus in accordance with paragraph (i)(3)(i) of this section or assist in an appropriate transfer as described in paragraphs (i)(3)(ii) and (d)(2) of this section.

(3) *Movement or appropriate transfer from off-campus departments*—(i) If the main hospital campus has the capability required by the individual and movement of the individual to the main campus would not significantly jeopardize the life or health of the individual, the personnel at the off-campus department must assist in arranging this movement. Movement of the individual to the main campus of the hospital is not considered a transfer under this section, since the individual is simply being moved from one department of a hospital to another department or facility of the same hospital.

(ii) If transfer of an individual with a potential emergency condition to a medical facility other than the main hospital campus is warranted, either because the main hospital campus does not have the specialized capability or facilities required by the individual, or because the individual's condition is deteriorating so rapidly that taking the time needed to move the individual to the main hospital campus would significantly jeopardize the life or health of the individual, personnel at the off-campus department must, in accordance with protocols established in advance by the hospital, assist in arranging an appropriate transfer of the individual to a medical facility other than the main hospital. The protocols must include procedures and agreements established in advance with other hospitals or

medical facilities in the area of the off-campus department to facilitate these appropriate transfers. Such a transfer would require—

(A) That there be either a request by or on behalf of the individual as described in paragraph (d)(1)(ii)(A) of this section or a certification by a physician or a qualified medical person as described in paragraph (d)(1)(ii)(B) or (d)(1)(ii)(C) of this section; and

(B) That the transfer comply with the requirements described in paragraph (d)(2) of this section.

(iii) If the individual is being appropriately transferred to another medical facility from the off-campus department, the requirement for the provision of medical treatment in paragraph (d)(2)(i) of this section would be met by provision of medical treatment within the capability of the transferring off-campus department.

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/MR AND CERTAIN NFs IN THE MEDICAID PROGRAM

I. Part 498 is amended as set forth below:

1. The authority citation for part 498 continues to read as follows:

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

2. In § 498.2, the introductory text is republished, and the definition of "Provider" is revised to read as follows:

§ 498.2 Definitions.

As used in this part—

Provider means a hospital, critical access hospital (CAH), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, that has in effect an agreement to participate in Medicare, that has in effect an agreement to participate in Medicaid, or a clinic, rehabilitation agency, or public health agency that has a similar agreement but only to furnish outpatient physical therapy or outpatient speech pathology services, and *prospective provider* means any of the listed entities that seeks to participate in Medicare as a provider or to have any facility or organization determined to be a department of the provider or provider-based entity under § 413.65 of this chapter.

* * * * *

3. In § 498.3, the introductory text to paragraph (b) is republished; paragraphs (b)(2) through (b)(15) are redesignated as paragraphs (b)(3) through (b)(16), respectively; and a new paragraph (b)(2) is added to read as follows:

§ 498.3 Scope and applicability.

* * * * *

(b) *Initial determinations by HCFA.* HCFA makes initial determinations with respect to the following matters:

* * * * *

(2) Whether a prospective department of a provider, remote location of a hospital, satellite facility, or provider-based entity qualifies for provider-based status under § 413.65 of this chapter, or whether such a facility or entity currently treated as a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity no longer qualifies for that status under § 413.65 of this chapter.

* * * * *

PART 1003—CIVIL MONEY PENALTIES, ASSESSMENTS AND EXCLUSIONS

J. Part 1003 is amended as set forth below:

1. The authority citation for part 1003 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1320–7, 1320a–7a, 1320a–7e, 1320b–10, 1395u(j), 1395u(k), 1395cc(g), 1395dd(d)(1), 1395mm, 1395nn(g), 1395ss(d), 1396(m), 11131(c), and 11137(b)(2).

2. Section 1003.100 is amended by revising paragraph (a), by republishing the introductory text to paragraphs (b) and (b)(1), by revising paragraphs (b)(1)(xi) and (b)(1)(xii), and by adding paragraph (b)(1)(xiii) to read as follows:

§ 1003.100 Basis and purpose.

(a) *Basis.* This part implements sections 1128(c), 1128A, 1128E, 1140, 1866(g), 1876(i), 1877(g), 1882(d) and 1903(m)(5) of the Social Security Act, and sections 421(c) and 427(b)(2) of Pub. L. 99–660 (42 U.S.C. 1320a–7, 1320a–7a, 1320a–7e, 1320a–7c, 1320b–10, 1395cc(g), 1395mm, 1395ss(d), 1396(m), 11131(c), and 11137(b)(2)).

(b) *Purpose.* This part—

(1) Provides for the imposition of civil money penalties and, as applicable, assessments against persons who—

* * * * *

(xi) Are physicians or entities that enter into an arrangement or scheme that they know or should know has as a principal purpose the assuring of referrals by the physician to a particular entity that, if made directly, would violate the provisions of § 411.353 of this title;

(xii) Violate the Federal health care programs' anti-kickback statute as set forth in section 1128B of the Act; or

(xiii) Knowingly and willfully present, or cause to be presented, a bill or request for payment for nonphysician services furnished to hospital patients (unless the services are furnished by the hospital, either directly or under an arrangement) in violation of sections 1862(a)(14) and 1866(a)(1)(H) of the Act.

3. Section 1003.102 is amended by republishing the introductory text to paragraph (b), by adding and reserving paragraphs (b)(12) through (b)(14), and by adding a new paragraph (b)(15) to read as follows:

§ 1003.102 Basis for civil money penalties and assessments.

(b) The OIG may impose a penalty, and where authorized, an assessment against any person (including an insurance company in the case of paragraphs (b)(5) and (b)(6) of this section) whom it determines in accordance with this part—

(15) Has knowingly and willfully presented, or caused to be presented, a bill or request for payment for items and services furnished to a hospital patient for which payment may be made under the Medicare or another Federal health care program, if that bill or request is inconsistent with an arrangement under section 1866(a)(1)(H) of the Act, or violates the requirements for such an arrangement.

4. Section 1003.103 is amended by revising paragraph (a), by adding and reserving paragraphs (i) and (j), and by adding a new paragraph (k) to read as follows:

§ 1003.103 Amount of penalty.

(a) Except as provided in paragraphs (b) and (d) through (k) of this section,

the OIG may impose a penalty of not more than \$10,000 for each item or service that is subject to a determination under § 1003.102.

(k) For violations of section 1862(a)(14) of the Act and § 1003.102(b)(15), the OIG may impose a penalty of not more than \$2,000 for each bill or request for payment for items and services furnished to a hospital patient.

5. Section 1003.105 is amended by republishing the introductory text to paragraph (a)(1) and by revising paragraph (a)(1)(i) to read as follows:

§ 1003.105 Exclusion from participation in Medicare, Medicaid and other Federal health care programs.

(a)(1) Except as set forth in paragraph (b) of this section, in lieu of or in addition to any penalty or assessment, the OIG may exclude from participation in Medicare, Medicaid and other Federal health care programs the following persons for a period of time determined under § 1003.107—

(i) Any person who is subject to a penalty or assessment under § 1003.102(a), (b)(1) through (b)(4), or (b)(15).

(Catalog of Federal Domestic Assistance 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: March 3, 2000.

Nancy-Ann Min DeParle,
Administrator, Health Care Financing Administration.

Dated: March 28, 2000.

June G. Brown,
Inspector General, Department of Health and Human Services.

Approved: March 29, 2000.

Donna E. Shalala,
Secretary.

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

Note to Addenda A, B, C, E and F: Addenda A, B, and C have a number of errors in the following columns: APC, status indicator, payment rate, and national unadjusted coinsurance and minimum unadjusted coinsurance. We identified these errors too late in preparing this rule for publication to correct them. Some of the errors are related to the status codes assigned to the HCPCS codes and APCs.

Some errors affect addenda B, C, and E. Several of these errors involve procedures incorrectly identified as inpatient procedures, and one inpatient procedure incorrectly identified as an outpatient procedure. Certain PET scan codes and other codes are shown in incorrect APCs. Screening sigmoidoscopy and colonoscopy APCs have the wrong HCPCS codes and incorrect payment rates and coinsurance amounts. Certain dental codes were inadvertently identified as errors, so their correct APC assignments, payment rate and coinsurance amounts were not shown in the addenda. Two breath tests are subject to the clinical diagnostic lab fee schedule. We have listed below the corrections that have payment implications.

Addendum F does not include status indicators G and H which identify items that are eligible for pass-through payments. (See section III.B.3 of the preamble for a complete description of all status indications used in conjunction with this final rule.)

We also note that the word "proposed" should not appear on any Addenda contained in this final rule such as on Addendum A or C.

The fiscal intermediaries will receive the necessary changes to process outpatient PPS claims correctly. We will post the corrected Addendum B on our Website and publish a correction document in the **Federal Register**.

Our Website address is <http://www.hcfa.gov/medicare/hopsmain.htm>.

LIST ACCOMPANYING NOTE TO ADDENDA A, B, C, E AND F

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Proposed Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
20979	E	US bone stimulation.					
31375	C	Partial removal of larynx.					
35481	T	Atherectomy, open	0081	19.36	\$938.71	\$434.25	\$187.74
61795	S	Brain surgery using computer	0302	8.21	\$398.08	\$216.55	\$79.62
61886	T	Implant neurostim arrays	0222	25.48	\$1,235.45	\$780.07	\$247.09
75945	S	Intravascular us	0267	2.72	\$131.88	\$80.06	\$26.38
75946	S	Intravascular us add-on	0267	2.72	\$131.88	\$80.06	\$26.38
78267	A	Breath test attain/anal, c-14.					
78268	A	Breath test analysis, c-14.					
92978	S	Intravasc us, heart add-on	0267	2.72	\$131.88	\$80.06	\$26.38
92979	S	Intravasc us, heart add-on	0267	2.72	\$131.88	\$80.06	\$26.38
96570	T	Photodynamic Tx, 30 min	0973	5.16	\$250.19		\$50.04
96571	T	Photodynamic Tx, addl 15 min	0973	5.16	\$250.19		\$50.04
D0277	S	Vert bitewings-sev to eight	0330	1.51	\$73.22	\$14.64	\$14.64
D0472	S	Gross exam, prep & report	0330	1.51	\$73.22	\$14.64	\$14.64

LIST ACCOMPANYING NOTE TO ADDENDA A, B, C, E AND F—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Proposed Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
D0473	S	Micro exam, prep & report	0330	1.51	\$73.22	\$14.64	\$14.64
D0474	S	Micro w exam of surg margins	0330	1.51	\$73.22	\$14.64	\$14.64
D0480	S	Cytopath smear prep & report	0330	1.51	\$73.22	\$14.64	\$14.64
D4268	S	Surgical revision procedure	0330	1.51	\$73.22	\$14.64	\$14.64
G0104	S	CA screen; flexible sigmoidoscope	0159	2.83	\$137.22	.....	\$34.31
G0105	S	Colorectal screen; high risk ind	0158	7.98	\$386.93	.....	\$96.73
G0122	S	Colon ca scrn; barium enema	0157	1.79	\$86.79	.....	\$17.36
G0125	S	Lung Image (PET)	0981	46.40	\$2,249.80	.....	\$449.96
G0126	S	Lung Image (PET) staging	0981	46.40	\$2,249.80	.....	\$449.96
G0163	S	PET for rec of colorectal cancer	0981	46.40	\$2,249.80	.....	\$449.96
G0164	S	PET for lymphoma staging	0981	46.40	\$2,249.80	.....	\$449.96
G0165	S	PET, rec of melanoma/met cancer	0981	46.40	\$2,249.80	.....	\$449.96
G0168	T	Wound closure by adhesive	0970	0.52	\$25.21	.....	\$5.04
G0169	T	Removal tissue; no anesthesia	0013	0.91	\$44.12	\$17.66	\$8.82
G0170	T	Skin biograft	0025	3.74	\$181.34	\$70.66	\$36.27
G0171	T	Skin biograft add-on	0025	3.74	\$181.34	\$70.66	\$36.27

ADDENDUM A.—LIST OF HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0001	Photochemotherapy	S	0.47	\$22.79	\$8.49	\$4.56
0002	Fine needle Biopsy/Aspiration	T	0.62	\$30.06	\$17.66	\$6.01
0003	Bone Marrow Biopsy/Aspiration	T	0.98	\$47.52	\$27.99	\$9.50
0004	Level I Needle Biopsy/Aspiration Except Bone Marrow	T	1.84	\$89.22	\$32.57	\$17.84
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	5.41	\$262.32	\$119.75	\$52.46
0006	Level I Incision & Drainage	T	2.00	\$96.97	\$33.95	\$19.39
0007	Level II Incision & Drainage	T	3.68	\$178.43	\$72.03	\$35.69
0008	Level III Incision & Drainage	T	6.15	\$298.20	\$113.67	\$59.64
0009	Nail Procedures	T	0.74	\$35.88	\$9.63	\$7.18
0010	Level I Destruction of Lesion	T	0.55	\$26.67	\$9.86	\$5.33
0011	Level II Destruction of Lesion	T	2.72	\$131.88	\$50.01	\$26.38
0012	Level I Debridement & Destruction	T	0.53	\$25.70	\$9.18	\$5.14
0013	Level II Debridement & Destruction	T	0.91	\$44.12	\$17.66	\$8.82
0014	Level III Debridement & Destruction	T	1.50	\$72.73	\$24.55	\$14.55
0015	Level IV Debridement & Destruction	T	1.77	\$85.82	\$31.20	\$17.16
0016	Level V Debridement & Destruction	T	3.53	\$171.16	\$74.67	\$34.23
0017	Level VI Debridement & Destruction	T	12.45	\$603.66	\$289.16	\$120.73
0018	Biopsy Skin, Subcutaneous Tissue or Mucous Membrane	T	0.94	\$45.58	\$17.66	\$9.12
0019	Level I Excision/Biopsy	T	4.00	\$193.95	\$78.91	\$38.79
0020	Level II Excision/Biopsy	T	6.51	\$315.65	\$130.53	\$63.13
0021	Level III Excision/Biopsy	T	10.49	\$508.63	\$236.51	\$101.73
0022	Level IV Excision/Biopsy	T	12.49	\$605.60	\$292.94	\$121.12
0023	Exploration Penetrating Wound	T	1.98	\$96.00	\$40.37	\$19.20
0024	Level I Skin Repair	T	2.43	\$117.82	\$44.50	\$23.56
0025	Level II Skin Repair	T	3.74	\$181.34	\$70.66	\$36.27
0026	Level III Skin Repair	T	12.11	\$587.18	\$277.92	\$117.44
0027	Level IV Skin Repair	T	15.80	\$766.10	\$383.10	\$153.22
0029	Incision/Excision Breast	T	12.85	\$623.06	\$303.50	\$124.61
0030	Breast Reconstruction/Mastectomy	T	20.19	\$978.95	\$523.95	\$195.79
0031	Hyperbaric Oxygen	S	3.00	\$145.46	\$140.85	\$29.09
0032	Placement Transvenous Catheters/Arterial Cutdown	T	5.40	\$261.83	\$119.52	\$52.37
0033	Partial Hospitalization	P	4.17	\$202.19	\$48.17	\$40.44
0040	Arthrocentesis & Ligament/Tendon Injection	T	2.11	\$102.31	\$40.60	\$20.46
0041	Arthroscopy	T	24.57	\$1,191.33	\$592.08	\$238.27
0042	Arthroscopically-Aided Procedures	T	29.22	\$1,416.79	\$804.74	\$283.36
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.64	\$79.52	\$25.46	\$15.90
0044	Closed Treatment Fracture/Dislocation Except Finger/Toe/Trunk	T	2.17	\$105.22	\$38.08	\$21.04
0045	Bone/Joint Manipulation Under Anesthesia	T	11.02	\$534.33	\$277.12	\$106.87
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	22.29	\$1,080.78	\$535.76	\$216.16
0047	Arthroplasty without Prosthesis	T	22.09	\$1,071.08	\$537.03	\$214.22
0048	Arthroplasty with Prosthesis	T	29.06	\$1,409.03	\$725.94	\$281.81
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	15.04	\$729.25	\$356.95	\$145.85
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	21.13	\$1,024.53	\$513.86	\$204.91
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	27.76	\$1,346.00	\$675.24	\$269.20
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	36.16	\$1,753.29	\$930.91	\$350.66
0053	Level I Hand Musculoskeletal Procedures	T	11.32	\$548.87	\$253.49	\$109.77
0054	Level II Hand Musculoskeletal Procedures	T	19.66	\$953.26	\$472.33	\$190.65
0055	Level I Foot Musculoskeletal Procedures	T	15.47	\$750.10	\$355.34	\$150.02
0056	Level II Foot Musculoskeletal Procedures	T	17.30	\$838.83	\$405.81	\$167.77

¹ Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The Payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

² Not subject to national coinsurance.

³ Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM A.—LIST OF HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0057	Bunion Procedures	T	21.00	\$1,018.23	\$496.65	\$203.65
0058	Level I Strapping and Cast Application	S	1.09	\$52.85	\$19.27	\$10.57
0059	Level II Strapping and Cast Application	S	1.74	\$84.37	\$29.59	\$16.87
0060	Manipulation Therapy	S	0.77	\$37.34	\$7.80	\$7.47
0070	Thoracentesis/Lavage Procedures	T	3.64	\$176.49	\$79.60	\$35.30
0071	Level I Endoscopy Upper Airway	T	0.55	\$26.67	\$14.22	\$5.33
0072	Level II Endoscopy Upper Airway	T	1.26	\$61.09	\$41.52	\$12.22
0073	Level III Endoscopy Upper Airway	T	4.11	\$199.28	\$91.07	\$39.86
0074	Level IV Endoscopy Upper Airway	T	13.61	\$659.91	\$347.54	\$131.98
0075	Level V Endoscopy Upper Airway	T	18.55	\$899.44	\$467.29	\$179.89
0076	Endoscopy Lower Airway	T	8.06	\$390.81	\$197.05	\$78.16
0077	Level I Pulmonary Treatment	S	0.43	\$20.85	\$12.62	\$4.17
0078	Level II Pulmonary Treatment	S	1.34	\$64.97	\$29.13	\$12.99
0079	Ventilation Initiation and Management	S	3.18	\$154.19	\$107.70	\$30.84
0080	Diagnostic Cardiac Catheterization	T	25.77	\$1,249.51	\$713.89	\$249.90
0081	Non-Coronary Angioplasty or Atherectomy	T	19.36	\$938.71	\$434.25	\$187.74
0082	Coronary Atherectomy	T	40.34	\$1,955.97	\$859.56	\$391.19
0083	Coronary Angioplasty	T	45.79	\$2,220.22	\$1,322.95	\$444.04
0084	Level I Electrophysiologic Evaluation	S	10.70	\$518.81	\$177.79	\$103.76
0085	Level II Electrophysiologic Evaluation	S	27.06	\$1,312.06	\$654.48	\$262.41
0086	Ablate Heart Dysrhythm Focus	S	47.62	\$2,308.95	\$1,265.37	\$461.79
0087	Cardiac Electrophysiologic Recording/Mapping	S	9.53	\$462.08	\$214.72	\$92.42
0088	Thrombectomy	T	26.49	\$1,284.42	\$678.68	\$256.88
0089	Level I Implantation/Removal/Revision of Pacemaker, AICD or Vascular Device.	T	6.49	\$314.68	\$130.07	\$62.94
0090	Level II Implantation/Removal/Revision of Pacemaker, AICD or Vascular Device.	T	20.96	\$1,016.29	\$573.04	\$203.26
0091	Level I Vascular Ligation	T	14.79	\$717.12	\$348.23	\$143.42
0092	Level II Vascular Ligation	T	20.21	\$979.92	\$505.37	\$195.98
0093	Vascular Repair/Fistula Construction	T	17.95	\$870.34	\$422.33	\$174.07
0094	Resuscitation and Cardioversion	S	4.51	\$218.68	\$105.29	\$43.74
0095	Cardiac Rehabilitation	S	0.64	\$31.03	\$16.98	\$6.21
0096	Non-Invasive Vascular Studies	S	2.06	\$99.88	\$61.48	\$19.98
0097	Cardiovascular Stress Test	S	1.62	\$78.55	\$62.40	\$15.71
0098	Injection of Sclerosing Solution	T	1.19	\$57.70	\$20.88	\$11.54
0099	Continuous Cardiac Monitoring	S	0.38	\$18.43	\$14.68	\$3.69
0100	Continuous ECG	S	1.70	\$82.43	\$71.57	\$16.49
0101	Tilt Table Evaluation	S	4.47	\$216.74	\$128.84	\$43.35
0102	Electronic Analysis of Pacemakers/other Devices	S	0.45	\$21.82	\$12.62	\$4.36
0109	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	4.13	\$200.25	\$40.05	\$40.05
0110	Transfusion	S	5.83	\$282.68	\$122.73	\$56.54
0111	Blood Product Exchange	S	14.17	\$687.06	\$300.74	\$137.41
0112	Extracorporeal Photopheresis	S	39.60	\$1,920.09	\$663.65	\$384.02
0113	Excision Lymphatic System	T	13.89	\$673.49	\$326.55	\$134.70
0114	Thyroid/Lymphadenectomy Procedures	T	19.56	\$948.41	\$493.78	\$189.68
0116	Chemotherapy Administration by Other Technique Except Infusion	S	2.34	\$113.46	\$22.69	\$22.69
0117	Chemotherapy Administration by Infusion Only	S	1.84	\$89.22	\$71.80	\$17.84
0118	Chemotherapy Administration by Both Infusion and Other Technique	S	2.90	\$140.61	\$72.03	\$28.12
0120	Infusion Therapy Except Chemotherapy	S	1.66	\$80.49	\$42.67	\$16.10
0121	Level I Tube changes and Repositioning	T	2.36	\$114.43	\$52.53	\$22.89
0122	Level II Tube changes and Repositioning	T	5.04	\$244.37	\$114.93	\$48.88
0123	Level III Tube changes and Repositioning	T	13.89	\$673.49	\$350.75	\$134.70
0130	Level I Laparoscopy	T	25.36	\$1,229.63	\$659.53	\$245.93
0131	Level II Laparoscopy	T	41.81	\$2,027.24	\$1,089.88	\$405.45
0132	Level III Laparoscopy	T	48.91	\$2,371.50	\$1,239.22	\$474.30
0140	Esophageal Dilation without Endoscopy	T	4.74	\$229.83	\$107.24	\$45.97
0141	Upper GI Procedures	T	7.15	\$346.68	\$184.67	\$69.34
0142	Small Intestine Endoscopy	T	7.45	\$361.23	\$162.42	\$72.25
0143	Lower GI Endoscopy	T	7.98	\$386.93	\$199.12	\$77.39
0144	Diagnostic Anoscopy	T	2.23	\$108.13	\$49.32	\$21.63
0145	Therapeutic Anoscopy	T	7.46	\$361.71	\$179.39	\$72.34
0146	Level I Sigmoidoscopy	T	2.83	\$137.22	\$65.15	\$27.44
0147	Level II Sigmoidoscopy	T	6.26	\$303.53	\$149.11	\$60.71
0148	Level I Anal/Rectal Procedure	T	2.34	\$113.46	\$43.59	\$22.69
0149	Level II Anal/Rectal Procedure	T	12.86	\$623.54	\$293.06	\$124.71
0150	Level III Anal/Rectal Procedure	T	17.68	\$857.25	\$437.12	\$171.45
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	10.53	\$510.57	\$245.46	\$102.11
0152	Percutaneous Biliary Endoscopic Procedures	T	8.22	\$398.56	\$207.38	\$79.71
0153	Peritoneal and Abdominal Procedures	T	19.62	\$951.32	\$496.31	\$190.26
0154	Hernia/Hydrocele Procedures	T	22.43	\$1,087.57	\$556.98	\$217.51
² 0157	Colorectal Cancer Screening: Barium Enema	S	1.79	\$86.79	.....	\$17.36
¹ 0158	Colorectal Cancer Screening: Colonoscopy	S	7.98	\$386.93	.....	\$96.73
¹ 0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	7.98	\$137.22	\$34.31

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ADDENDUM A.—LIST OF HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	5.43	\$263.28	\$110.11	\$52.66
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	10.94	\$530.45	\$249.36	\$106.09
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	17.49	\$848.04	\$427.49	\$169.61
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	28.98	\$1,405.16	\$792.58	\$281.03
0164	Level I Urinary and Anal Procedures	T	2.17	\$105.23	\$33.03	\$21.05
0165	Level II Urinary and Anal Procedures	T	3.89	\$188.61	\$91.76	\$37.72
0166	Level I Urethral Procedures	T	10.17	\$493.11	\$218.73	\$98.62
0167	Level II Urethral Procedures	T	21.06	\$1,021.14	\$555.84	\$204.23
0168	Level III Urethral Procedures	T	24.94	\$1,209.27	\$536.11	\$241.85
0169	Lithotripsy	T	46.72	\$2,265.32	\$1,384.20	\$453.06
0170	Dialysis for Other Than ESRD Patients	S	6.68	\$323.89	\$72.26	\$64.78
0180	Circumcision	T	13.62	\$660.39	\$304.87	\$132.08
0181	Penile Procedures	T	32.37	\$1,569.53	\$906.36	\$313.91
0182	Insertion of Penile Prosthesis	T	52.11	\$2,526.66	\$1,525.05	\$505.33
0183	Testes/Epididymis Procedures	T	18.26	\$885.37	\$448.94	\$177.07
0184	Prostate Biopsy	T	4.94	\$239.53	\$122.96	\$47.91
0190	Surgical Hysterectomy	T	17.85	\$865.49	\$443.89	\$173.10
0191	Level I Female Reproductive Procedures	T	1.19	\$57.70	\$17.43	\$11.54
0192	Level II Female Reproductive Procedures	T	2.38	\$115.40	\$35.33	\$23.08
0193	Level III Female Reproductive Procedures	T	8.93	\$432.99	\$171.13	\$86.60
0194	Level IV Female Reproductive Procedures	T	16.21	\$785.98	\$395.94	\$157.20
0195	Level V Female Reproductive Procedures	T	18.68	\$905.74	\$483.80	\$181.15
0196	Dilatation & Curettage	T	14.47	\$701.61	\$357.98	\$140.32
0197	Infertility Procedures	T	2.40	\$116.37	\$49.55	\$23.27
0198	Pregnancy and Neonatal Care Procedures	T	1.34	\$64.97	\$33.03	\$12.99
0199	Vaginal Delivery	T	11.20	\$543.06	\$157.83	\$108.61
0200	Therapeutic Abortion	T	13.89	\$673.49	\$373.23	\$134.70
0201	Spontaneous Abortion	T	13.00	\$630.33	\$329.65	\$126.07
0210	Spinal Tap	T	3.00	\$145.46	\$62.40	\$29.09
0211	Level I Nervous System Injections	T	3.32	\$160.98	\$74.78	\$32.20
0212	Level II Nervous System Injections	T	3.64	\$176.49	\$88.78	\$35.30
0213	Extended EEG Studies and Sleep Studies	S	11.15	\$540.63	\$290.42	\$108.13
0214	Electroencephalogram	S	2.32	\$112.49	\$58.50	\$22.50
0215	Level I Nerve and Muscle Tests	S	1.15	\$55.76	\$30.05	\$11.15
0216	Level II Nerve and Muscle Tests	S	2.87	\$139.16	\$64.69	\$27.83
0217	Level III Nerve and Muscle Tests	S	5.87	\$284.62	\$156.68	\$56.92
0220	Level I Nerve Procedures	T	13.96	\$676.88	\$326.21	\$135.38
0221	Level II Nerve Procedures	T	18.36	\$890.22	\$463.62	\$178.04
0222	Implantation of Neurological Device	T	25.48	\$1,235.45	\$780.07	\$247.09
0223	Level I Revision/Removal Neurological Device	T	6.34	\$307.41	\$153.24	\$61.48
0224	Level II Revision/Removal Neurological Device	T	15.94	\$772.88	\$374.61	\$154.58
0225	Implantation of Neurostimulator Electrodes	T	3.43	\$166.31	\$64.46	\$33.26
0230	Level I Eye Tests	S	0.98	\$47.52	\$22.48	\$9.50
0231	Level II Eye Tests	S	2.64	\$128.01	\$59.87	\$25.60
0232	Level I Anterior Segment Eye	T	6.04	\$292.86	\$134.66	\$58.57
0233	Level II Anterior Segment Eye	T	13.79	\$668.64	\$331.60	\$133.73
0234	Level III Anterior Segment Eye Procedures	T	20.64	\$1,000.77	\$502.16	\$200.15
0235	Level I Posterior Segment Eye Procedures	T	2.94	\$142.55	\$78.91	\$28.51
0236	Level II Posterior Segment Eye Procedures	T	6.70	\$324.86	\$147.96	\$64.97
0237	Level III Posterior Segment Eye Procedures	T	33.96	\$1,646.62	\$852.68	\$329.32
0238	Level I Repair and Plastic Eye Procedures	T	2.80	\$135.76	\$58.96	\$27.15
0239	Level II Repair and Plastic Eye Procedures	T	6.26	\$303.53	\$123.42	\$60.71
0240	Level III Repair and Plastic Eye Procedures	T	13.47	\$653.12	\$315.31	\$130.62
0241	Level IV Repair and Plastic Eye Procedures	T	16.60	\$804.89	\$384.47	\$160.98
0242	Level V Repair and Plastic Eye Procedures	T	23.70	\$1,149.14	\$597.36	\$229.83
0243	Strabismus/Muscle Procedures	T	17.99	\$872.28	\$431.39	\$174.46
0244	Corneal Transplant	T	32.88	\$1,594.26	\$851.42	\$318.85
0245	Cataract Procedures without IOL Insert	T	26.55	\$1,287.33	\$623.85	\$257.47
0246	Cataract Procedures with IOL Insert	T	26.55	\$1,287.33	\$623.85	\$257.47
0247	Laser Eye Procedures Except Retinal	T	4.89	\$237.10	\$112.86	\$47.42
0248	Laser Retinal Procedures	T	4.19	\$203.16	\$94.05	\$40.63
0250	Nasal Cauterization/Packing	T	2.21	\$107.16	\$38.54	\$21.43
0251	Level I ENT Procedures	T	1.68	\$81.46	\$27.99	\$16.29
0252	Level II ENT Procedures	T	5.18	\$251.16	\$114.24	\$50.23
0253	Level III ENT Procedures	T	12.02	\$582.81	\$284.00	\$116.56
0254	Level IV ENT Procedures	T	12.45	\$603.66	\$272.41	\$120.73
0256	Level V ENT Procedures	T	25.40	\$1,231.57	\$623.05	\$246.31
0257	Implantation of Cochlear Device	T	115.31	\$5,591.04	\$3,498.58	\$1,118.21
0258	Tonsil and Adenoid Procedures	T	18.62	\$902.83	\$462.81	\$180.57
0260	Level I Plain Film Except Teeth	X	0.79	\$38.30	\$22.02	\$7.66
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.38	\$66.91	\$38.77	\$13.38
0262	Plain Film of Teeth	X	0.40	\$19.39	\$10.90	\$3.88

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ADDENDUM A.—LIST OF HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0263	Level I Miscellaneous Radiology Procedures	X	1.68	\$81.46	\$45.88	\$16.29
0264	Level II Miscellaneous Radiology Procedures	X	3.83	\$185.71	\$108.97	\$37.14
0265	Level I Diagnostic Ultrasound Except Vascular	S	1.17	\$56.73	\$38.08	\$11.35
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.79	\$86.79	\$57.35	\$17.36
0267	Vascular Ultrasound	S	2.72	\$131.88	\$80.06	\$26.38
0268	Guidance Under Ultrasound	X	2.23	\$108.13	\$69.51	\$21.63
0269	Echocardiogram Except Transesophageal	S	4.40	\$213.34	\$114.01	\$42.67
0270	Transesophageal Echocardiogram	S	5.55	\$269.10	\$150.26	\$53.82
0271	Mammography	S	0.70	\$33.94	\$19.50	\$6.79
0272	Level I Fluoroscopy	X	1.40	\$67.88	\$39.00	\$13.58
0273	Level II Fluoroscopy	X	2.49	\$120.73	\$61.02	\$24.15
0274	Myelography	S	4.83	\$234.19	\$128.12	\$46.84
0275	Arthrography	S	2.74	\$132.85	\$72.26	\$26.57
0276	Level I Digestive Radiology	S	1.79	\$86.79	\$49.78	\$17.36
0277	Level II Digestive Radiology	S	2.47	\$119.76	\$69.28	\$23.95
0278	Diagnostic Urography	S	2.85	\$138.19	\$81.67	\$27.64
0279	Level I Diagnostic Angiography and Venography Except Extremity ...	S	6.30	\$305.47	\$174.57	\$61.09
0280	Level II Diagnostic Angiography and Venography Except Extremity ..	S	14.98	\$726.34	\$380.12	\$145.27
0281	Venography of Extremity	S	4.40	\$213.34	\$115.16	\$42.67
0282	Level I Computerized Axial Tomography	S	2.38	\$115.40	\$94.51	\$23.08
0283	Level II Computerized Axial Tomography	S	4.89	\$237.10	\$179.39	\$47.42
0284	Magnetic Resonance Imaging	S	8.02	\$388.87	\$257.39	\$77.77
0285	Positron Emission Tomography (PET)	S	15.06	\$730.22	\$415.21	\$146.04
0286	Myocardial Scans	S	7.28	\$352.99	\$200.04	\$70.60
0290	Standard Non-Imaging Nuclear Medicine	S	1.94	\$94.06	\$55.51	\$18.81
0291	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	3.15	\$152.73	\$93.14	\$30.55
0292	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	4.36	\$211.40	\$126.63	\$42.28
0294	Level I Therapeutic Nuclear Medicine	S	5.13	\$248.74	\$144.06	\$49.75
0295	Level II Therapeutic Nuclear Medicine	S	19.85	\$962.47	\$609.17	\$192.49
0296	Level I Therapeutic Radiologic Procedures	S	3.57	\$173.10	\$100.25	\$34.62
0297	Level II Therapeutic Radiologic Procedures	S	6.13	\$297.23	\$172.51	\$59.45
0300	Level I Radiation Therapy	S	1.98	\$96.00	\$47.72	\$19.20
0301	Level II Radiation Therapy	S	2.21	\$107.16	\$52.53	\$21.43
0302	Level III Radiation Therapy	S	8.21	\$398.08	\$216.55	\$79.62
0303	Treatment Device Construction	X	2.83	\$137.22	\$69.28	\$27.44
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.49	\$72.25	\$41.52	\$14.45
0305	Level II Therapeutic Radiation Treatment Preparation	X	4.06	\$196.86	\$97.50	\$39.37
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.98	\$677.85	\$339.05	\$135.57
0311	Radiation Physics Services	X	1.32	\$64.00	\$31.66	\$12.80
0312	Radioelement Applications	S	4.09	\$198.31	\$109.65	\$39.66
0313	Brachytherapy	S	7.89	\$382.56	\$164.02	\$76.51
0314	Hyperthermic Therapies	S	5.88	\$285.10	\$150.95	\$57.02
0320	Electroconvulsive Therapy	S	3.68	\$178.43	\$80.06	\$35.69
0321	Biofeedback and Other Training	S	1.26	\$61.09	\$29.25	\$12.22
0322	Brief Individual Psychotherapy	S	1.32	\$64.00	\$14.22	\$12.80
0323	Extended Individual Psychotherapy	S	1.85	\$89.70	\$22.48	\$17.94
0324	Family Psychotherapy	S	1.87	\$90.67	\$20.19	\$18.13
0325	Group Psychotherapy	S	1.55	\$75.16	\$19.96	\$15.03
0330	Dental Procedures	S	1.51	\$73.22	\$14.64	\$14.64
0340	Minor Ancillary Procedures	X	1.04	\$50.43	\$12.85	\$10.09
0341	Immunology Tests	X	0.13	\$6.30	\$3.67	\$1.26
0342	Level I Pathology	X	0.26	\$12.61	\$8.03	\$2.52
0343	Level II Pathology	X	0.45	\$21.82	\$12.16	\$4.36
0344	Level III Pathology	X	0.79	\$38.30	\$23.63	\$7.66
² 0354	Administration of Influenza Vaccine	X	0.13	\$6.19	.....	.....
0355	Level I Immunizations	X	0.19	\$9.21	\$5.05	\$1.84
0356	Level II Immunizations	X	0.36	\$17.46	\$4.82	\$3.49
0357	Level III Immunizations	X	1.85	\$89.70	\$38.31	\$17.94
0358	Level IV Immunizations	X	6.98	\$338.44	\$126.74	\$67.69
0359	Injections	X	0.96	\$46.55	\$9.31	\$9.31
0360	Level I Alimentary Tests	X	1.38	\$66.91	\$34.75	\$13.38
0361	Level II Alimentary Tests	X	3.53	\$171.16	\$88.09	\$34.23
0362	Fitting of Vision Aids	X	0.51	\$24.73	\$9.63	\$4.95
0363	Otorhinolaryngologic Function Tests	X	2.83	\$137.22	\$53.22	\$27.44
0364	Level I Audiometry	X	0.68	\$32.97	\$13.31	\$6.59
0365	Level II Audiometry	X	1.47	\$71.28	\$22.48	\$14.26
0366	Electrocardiogram (ECG)	X	0.38	\$18.43	\$15.60	\$3.69
0367	Level I Pulmonary Test	X	0.83	\$40.24	\$20.65	\$8.05
0368	Level II Pulmonary Tests	X	1.66	\$80.49	\$42.44	\$16.10
0369	Level III Pulmonary Tests	X	2.34	\$113.46	\$58.50	\$22.69
0370	Allergy Tests	X	0.57	\$27.64	\$11.81	\$5.53
0371	Allergy Injections	X	0.32	\$15.52	\$3.67	\$3.10
0372	Therapeutic Phlebotomy	X	0.43	\$20.85	\$10.09	\$4.17

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ADDENDUM A.—LIST OF HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0373	Neuropsychological Testing	X	3.21	\$155.64	\$44.96	\$31.13
0374	Monitoring Psychiatric Drugs	X	1.17	\$56.73	\$13.08	\$11.35
0600	Low Level Clinic Visits	V	0.98	\$47.52	\$9.50	\$9.50
0601	Mid Level Clinic Visits	V	1.00	\$48.49	\$9.70	\$9.70
0602	High Level Clinic Visits	V	1.66	\$80.49	\$16.29	\$16.10
0603	Interdisciplinary Team Conference	V	1.66	\$80.49	\$16.29	\$16.10
0610	Low Level Emergency Visits	V	1.34	\$64.97	\$20.65	\$12.99
0611	Mid Level Emergency Visits	V	2.11	\$102.31	\$36.47	\$20.46
0612	High Level Emergency Visits	V	3.19	\$154.67	\$54.14	\$30.93
0620	Critical Care	S	8.60	\$416.99	\$152.78	\$83.40
³ 0701	Strontium	X				\$84.76
³ 0702	Samarium	X				\$139.06
³ 0704	Satumomab Pendetide	X				\$63.13
³ 0705	Tc99 Tetrofosmin	X				\$71.08
³ 0725	Leucovorin Calcium	X				\$1.07
³ 0726	Dexrazoxane Hydrochloride	X				\$18.81
³ 0727	Injection, Etidronate Disodium	X				\$9.31
³ 0728	Filgrastim (G-CSF)	X				\$25.21
³ 0730	Pamidronate Disodium	X				\$30.93
³ 0731	Sargramostim (GM-CSF)	X				\$16.97
³ 0732	Mesna	X				\$2.42
³ 0733	Epoetin Alpha	X				\$1.75
³ 0750	Dolasetron Mesylate 10 mg	X				\$1.94
³ 0754	Metoclopramide HCL	X				\$1.19
³ 0755	Thiethylperazine Maleate	X				\$0.68
³ 0761	Oral Substitute for IV Antiemetic	X				\$1.10
³ 0762	Dronabinol	X				\$0.48
³ 0763	Dolasetron Mesylate 100 mg Oral	X				\$8.53
³ 0764	Granisetron HCL, 100 mcg	X				\$2.33
³ 0765	Granisetron HCL, 1mg Oral	X				\$3.20
³ 0768	Ondansetron Hydrochloride per 1 mg Injection	X				\$0.87
³ 0769	Ondansetron Hydrochloride 8 mg oral	X				\$2.62
³ 0800	Leuprolide Acetate per 3.75 mg	X				\$68.56
³ 0801	Cyclophosphamide	X				\$1.19
³ 0802	Etoposide	X				\$3.10
³ 0803	Melphalan	X				\$1.19
³ 0807	Aldesleukin single use vial	X				\$65.07
³ 0809	BCG (Intravesical) one vial	X				\$19.78
³ 0810	Goserelin Acetate Implant, per 3.6 mg	X				\$59.74
³ 0811	Carboplatin 50 mg	X				\$13.96
³ 0812	Carbustine 100 mg	X				\$10.57
³ 0813	Cisplatin 10 mg	X				\$4.56
³ 0814	Asparaginase, 10,000 units	X				\$8.34
³ 0815	Cyclophosphamide 100 mg	X				\$0.48
³ 0816	Cyclophosphamide, Lyophilized 100 mg	X				\$1.16
³ 0817	Cytarabine 100 mg	X				\$0.68
³ 0818	Dactinomycin 0.5 mg	X				\$1.75
³ 0819	Dacarbazine 100 mg	X				\$1.26
³ 0820	Daunorubicin HCl 10 mg	X				\$11.64
³ 0821	Daunorubicin Citrate, Liposomal Formulation, 10 mg	X				\$7.76
³ 0822	Diethylstilbestrol Diphosphate 250 mg	X				\$2.13
³ 0823	Docetaxel 20 mg	X				\$34.72
³ 0824	Etoposide 10 mg	X				\$0.58
³ 0826	Methotrexate Oral 2.5 mg	X				\$0.29
³ 0827	Floxuridine 500 mg	X				\$18.81
³ 0828	Gemcitabine HCL 200 mg	X				\$9.31
³ 0830	Irinotecan 20 mg	X				\$14.16
³ 0831	Ifosfamide per 1 gram	X				\$13.58
³ 0832	Idarubicin Hydrochloride 5 mg	X				\$46.45
³ 0833	Interferon Alfacon-1, Recombinant, 1 mcg	X				\$1.19
³ 0834	Interferon, Alfa-2A, Recombinant 3 million units	X				\$3.20
³ 0836	Interferon, Alfa-2B, Recombinant, 1 million units	X				\$1.36
³ 0838	Interferon, Gamma 1-B, 3 million units	X				\$22.79
³ 0839	Mechlorethamine HCl 10 mg	X				\$1.65
³ 0840	Melphalan HCl 50 mg	X				\$44.71
³ 0841	Methotrexate Sodium 5 mg	X				\$1.10
³ 0842	Fludarabine Phosphate 50 mg	X				\$30.84
³ 0843	Pegaspargase per single dose vial	X				\$178.72
³ 0844	Pentostatin 10 mg	X				\$133.73
³ 0847	Doxorubicin HCL 10 mg	X				\$2.81
³ 0849	Rituximab, 100 mg	X				\$51.40
³ 0850	Streptozocin 1 gm	X				\$14.64
³ 0851	Thiotepa 15 mg	X				\$9.50

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
3 0852	Topotecan 4 mg	X				\$73.22
3 0853	Vinblastine Sulfate 1 mg	X				\$.39
3 0854	Vincristine Sulfate 1 mg	X				\$2.23
3 0855	Vinorelbine Tartrate per 10 mg	X				\$9.60
3 0856	Porfimer Sodium 75 mg	X				\$34.62
3 0857	Bleomycin Sulfate 15 units	X				\$48.29
3 0858	Cladribine, 1mg	X				\$8.24
3 0859	Fluorouracil	X				\$.19
3 0860	Plicamycin 2.5 mg	X				\$1.36
3 0861	Leuprolide Acetate 1 mg	X				\$19.39
3 0862	Mitomycin, 5mg	X				\$19.88
3 0863	Paclitaxel, 30mg	X				\$30.16
3 0864	Mitoxantrone HCl, per 5mg	X				\$25.80
3 0865	Interferon alfa-N3, 250,000 IU	X				\$1.07
3 0884	Rho (D) Immune Globulin, Human one dose pack	X				\$3.78
2 0886	Azathioprine, 50 mg oral	X	0.02	\$.97		\$.19
2 0887	Azathioprine, Parenteral 100 mg, 20 ml each injection	X	1.40	\$67.88		\$13.58
2 0888	Cyclosporine, Oral 100 mg	X	0.08	\$3.88		\$.78
2 0889	Cyclosporine, Parenteral	X	0.36	\$17.46		\$3.49
2 0890	Lymphocyte Immune Globulin 50 mg/ml, 5 ml each	X	3.79	\$183.77		\$36.75
2 0891	Tacrolimus per 1 mg oral	X	3.15	\$152.73		\$30.55
3 0892	Daclizumab, Parenteral, 25 mg	X				\$54.11
3 0900	Injection, Alglucerase per 10 units	X				\$5.14
3 0901	Alpha I, Proteinase Inhibitor, Human per 10mg	X				\$15.22
3 0902	Botulinum Toxin, Type A per unit	X				\$56.05
3 0903	CMV Immune Globulin	X				\$54.11
3 0905	Immune Globulin per 500 mg	X				\$6.40
3 0906	RSV Immune Globulin	X				\$85.53
2 0907	Ganciclovir Sodium 500 mg injection	X	0.51	\$24.73		\$4.95
2 0908	Tetanus Immune Globulin, Human, up to 250 units	X	0.90	\$43.64		\$8.73
3 0909	Interferon Beta—1a 33 mcg	X				\$28.70
3 0910	Interferon Beta—1b 0.25 mg	X				\$8.44
2 0911	Streptokinase per 250,000 iu	X	1.64	\$79.69		\$15.94
3 0913	Ganciclovir 4.5 mg, Implant	X				\$701.51
2 0914	Retepase, 37.6 mg (Two Single Use Vials)	X	38.20	\$1,852.21		\$370.44
2 0915	Alteplase recombinant, 10mg	X	5.85	\$283.70		\$56.74
3 0916	Imiglucerase per unit	X				\$.58
2 0917	Dipyridamole, 10mg Adenosine 6MG	X	0.36	\$17.46		\$3.49
3 0918	Brachytherapy Seeds, Any type, Each	S				\$9.99
3 0925	Factor VIII (Antihemophilic Factor, Human) per iu	X				\$.19
3 0926	Factor VIII (Antihemophilic Factor, Porcine) per iu	X				\$.19
3 0927	Factor VIII (Antihemophilic Factor, Recombinant) per iu	X				\$.19
3 0928	Factor IX, Complex	X				\$.08
3 0929	Other Hemophilia Clotting Factors per iu	X				\$.27
3 0930	Antithrombin III (Human) per iu	X				\$.19
3 0931	Factor IX (Antihemophilic Factor, Purified, Non-Recombinant)	X				\$.04
3 0932	Factor IX (Antihemophilic Factor, Recombinant)	X				\$.10
2 0949	Plasma, Pooled Multiple Donor, Solvent/Detergent Treated, Frozen ..	S	3.49	\$169.22		\$33.84
2 0950	Blood (Whole) For Transfusion	S	2.08	\$101.02		\$20.20
2 0952	Cryoprecipitate	S	0.70	\$33.92		\$6.78
2 0953	Fibrinogen Unit	S	0.48	\$23.27		\$4.65
2 0954	Leukocyte Poor Blood	S	2.83	\$137.21		\$27.44
2 0955	Plasma, Fresh Frozen	S	2.26	\$109.35		\$21.87
2 0956	Plasma Protein Fraction	S	1.26	\$61.09		\$12.22
2 0957	Platelet Concentrate	S	0.98	\$47.46		\$9.49
2 0958	Platelet Rich Plasma	S	1.16	\$56.25		\$11.25
2 0959	Red Blood Cells	S	2.04	\$99.04		\$19.81
2 0960	Washed Red Blood Cells	S	3.81	\$184.53		\$36.91
2 0961	Infusion, Albumin (Human) 5%, 500 ml	X	2.77	\$134.31		\$26.86
2 0962	Infusion, Albumin (Human) 25%, 50 ml	X	1.38	\$66.91		\$13.38
2 0970	New Technology—Level I (\$0–\$50)	T	0.52	\$25.21		\$5.04
2 0971	New Technology—Level II (\$50–\$100)	S	1.55	\$75.16		\$15.03
2 0972	New Technology—Level III (\$100–\$200)	T	3.09	\$149.83		\$29.97
2 0973	New Technology—Level IV (\$200–\$300)	T	5.16	\$250.19		\$50.04
2 0974	New Technology—Level V (\$300–\$500)	T	8.25	\$400.02		\$80.00
2 0975	New Technology—Level VI (\$500–\$750)	T	12.90	\$625.48		\$125.10
2 0976	New Technology—Level VII (\$750–\$1000)	T	18.05	\$875.19		\$175.04
2 0977	New Technology—Level VIII (\$1000–\$1250)	T	23.20	\$1,124.90		\$224.98
2 0978	New Technology—Level IX (\$1250–\$1500)	T	28.36	\$1,375.09		\$275.02
2 0979	New Technology—Level X (\$1500–\$1750)	T	33.51	\$1,624.80		\$324.96
2 0980	New Technology—Level XI (\$1750–\$2000)	S	38.67	\$1,875.00		\$375.00
2 0981	New Technology—Level XII (\$2000–\$2500)	T	46.40	\$2,249.80		\$449.96
2 0982	New Technology—Level XIII (\$2500–\$3500)	T	61.87	\$2,999.90		\$599.98

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ADDENDUM A.—LIST OF HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
² 0983	New Technology—Level XIV (\$3500–\$5000)	T	87.65	\$4,249.89	.....	\$849.98
² 0984	New Technology—Level XV (\$5000–\$6000)	T	113.43	\$5,499.89	.....	\$1,099.98
³ 7000	Amifostine, 500 mg	X	.....	.....	.....	\$41.99
³ 7001	Amphotericin B lipid complex, 50 mg, Inj	X	.....	.....	.....	\$12.12
³ 7002	Clonidine, HCl, 1 MG	X	.....	.....	.....	\$4.17
³ 7003	Epoprostenol, 0.5 MG, inj	X	.....	.....	.....	\$2.23
³ 7004	Immune globulin intravenous human 5g, inj	X	.....	.....	.....	\$45.48
³ 7005	Gonadorelin hcl, 100 mcg	X	.....	.....	.....	\$9.12
² 7007	Millrinone lactate, per 5 ml, inj	X	0.47	\$22.79	.....	\$4.56
³ 7010	Morphine sulfate concentrate (preservative free) per 10 mg	X	.....	.....	.....	\$.68
³ 7011	Oprelevakin, inj, 5 mg	X	.....	.....	.....	\$30.35
³ 7012	Pentamidine isethionate, 300 mg	X	.....	.....	.....	\$8.73
³ 7014	Fentanyl citrate, inj, up to 2 ml	X	.....	.....	.....	\$.19
³ 7015	Busulfan, oral 2 mg	X	.....	.....	.....	\$.19
³ 7019	Aprotinin, 10,000 kiu	X	.....	.....	.....	\$2.42
³ 7021	Baclofen, intrathecal, 50 mcg	X	.....	.....	.....	\$.10
³ 7022	Elliotts B Solution, per ml	X	.....	.....	.....	\$19.20
³ 7023	Treatment for bladder calculi, i.e. Renacidin per 500 ml	X	.....	.....	.....	\$4.46
³ 7024	Corticotrin ovine trifluate, 0.1 mg	X	.....	.....	.....	\$45.77
³ 7025	Digoxin immune FAB (Ovine), 10 mg	X	.....	.....	.....	\$14.06
³ 7026	Ethanolamine oleate, 1000 ml	X	.....	.....	.....	\$2.13
³ 7027	Fomepizole, 1.5 G	X	.....	.....	.....	\$141.29
³ 7028	Fosphenytoin, 50 mg	X	.....	.....	.....	\$.78
³ 7029	Glatiramer acetate, 25 mg	X	.....	.....	.....	\$3.59
³ 7030	Hemin, 1 mg	X	.....	.....	.....	\$.10
³ 7031	Octreotide Acetate, 500 mcg	X	.....	.....	.....	\$5.43
³ 7032	Sermorelin acetate, 0.5 mg	X	.....	.....	.....	\$53.34
³ 7033	Somatrem, 5 mg	X	.....	.....	.....	\$28.03
³ 7034	Somatropin, 1 mg	X	.....	.....	.....	\$5.04
³ 7035	Teniposide, 50 mg	X	.....	.....	.....	\$20.85
² 7036	Urokinase, inj, IV, 250,000 I.U.	X	0.73	\$35.40	.....	\$7.08
³ 7037	Urofollitropin, 75 I.U.	X	.....	.....	.....	\$8.24
³ 7038	Muromonab-CD3, 5 mg	X	.....	.....	.....	\$89.60
³ 7039	Pegademase bovine inj 25 I.U.	X	.....	.....	.....	\$1.16
³ 7040	Pentastarch 10% inj, 100 ml	X	.....	.....	.....	\$2.04
² 7041	Tirofiban HCL, 0.5 mg	X	0.02	\$.97	.....	\$.19
³ 7042	Capecitabine, oral 150 mg	X	.....	.....	.....	\$.19
³ 7043	Infliximab, 10 MG	X	.....	.....	.....	\$6.89
³ 7045	Trimetrexate Glucuronate	X	.....	.....	.....	\$8.15
³ 7046	Doxorubicin Hcl Liposome	X	.....	.....	.....	\$39.18

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
00100	N	Anesth, salivary gland .....	.....	.....	.....	.....	.....
00102	N	Anesth, repair of cleft lip .....	.....	.....	.....	.....	.....
00103	N	Anesth, blepharoplasty .....	.....	.....	.....	.....	.....
00104	N	Anesth, electroshock .....	.....	.....	.....	.....	.....
00120	N	Anesth, ear surgery .....	.....	.....	.....	.....	.....
00124	N	Anesth, ear exam .....	.....	.....	.....	.....	.....
00126	N	Anesth, tympanotomy .....	.....	.....	.....	.....	.....
00140	N	Anesth, procedures on eye .....	.....	.....	.....	.....	.....
00142	N	Anesth, lens surgery .....	.....	.....	.....	.....	.....
00144	N	Anesth, corneal transplant .....	.....	.....	.....	.....	.....
00145	N	Anesth, vitrectomy .....	.....	.....	.....	.....	.....
00147	N	Anesth, iridectomy .....	.....	.....	.....	.....	.....
00148	N	Anesth, eye exam .....	.....	.....	.....	.....	.....
00160	N	Anesth, nose/sinus surgery .....	.....	.....	.....	.....	.....
00162	N	Anesth, nose/sinus surgery .....	.....	.....	.....	.....	.....
00164	N	Anesth, biopsy of nose .....	.....	.....	.....	.....	.....
00170	N	Anesth, procedure on mouth .....	.....	.....	.....	.....	.....
00172	N	Anesth, cleft palate repair .....	.....	.....	.....	.....	.....
00174	C	Anesth, pharyngeal surgery .....	.....	.....	.....	.....	.....
00176	C	Anesth, pharyngeal surgery .....	.....	.....	.....	.....	.....
00190	N	Anesth, facial bone surgery .....	.....	.....	.....	.....	.....
00192	C	Anesth, facial bone surgery
00210	N	Anesth, open head surgery
00212	N	Anesth, skull drainage

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
00214	C	Anesth, skull drainage					
00215	C	Anesth, skull fracture					
00216	N	Anesth, head vessel surgery					
00218	N	Anesth, special head surgery					
00220	N	Anesth, spinal fluid shunt					
00222	N	Anesth, head nerve surgery					
00300	N	Anesth, head/neck/trunk					
00320	N	Anesth, neck organ surgery					
00322	N	Anesth, biopsy of thyroid					
00350	N	Anesth, neck vessel surgery					
00352	N	Anesth, neck vessel surgery					
00400	N	Anesth, skin, ext/per/atrukn					
00402	N	Anesth, surgery of breast					
00404	C	Anesth, surgery of breast					
00406	C	Anesth, surgery of breast					
00410	N	Anesth, correct heart rhythm					
00450	N	Anesth, surgery of shoulder					
00452	C	Anesth, surgery of shoulder					
00454	N	Anesth, collar bone biopsy					
00470	N	Anesth, removal of rib					
00472	N	Anesth, chest wall repair					
00474	C	Anesth, surgery of rib(s)					
00500	N	Anesth, esophageal surgery					
00520	N	Anesth, chest procedure					
00522	N	Anesth, chest lining biopsy					
00524	C	Anesth, chest drainage					
00528	N	Anesth, chest partition view					
00530	C	Anesth, pacemaker insertion					
00532	N	Anesth, vascular access					
00534	N	Anesth, cardioverter/defib					
00540	C	Anesth, chest surgery					
00542	C	Anesth, release of lung					
00544	C	Anesth, chest lining removal					
00546	C	Anesth, lung, chest wall surg					
00548	N	Anesth, trachea, bronchi surg					
00560	C	Anesth, open heart surgery					
00562	C	Anesth, open heart surgery					
00580	C	Anesth heart/lung transplant					
00600	N	Anesth, spine, cord surgery					
00604	C	Anesth, surgery of vertebra					
00620	N	Anesth, spine, cord surgery					
00622	C	Anesth, removal of nerves					
00630	N	Anesth, spine, cord surgery					
00632	C	Anesth, removal of nerves					
00634	C	Anesth for chemonucleolysis					
00670	C	Anesth, spine, cord surgery					
00700	N	Anesth, abdominal wall surg					
00702	N	Anesth, for liver biopsy					
00730	N	Anesth, abdominal wall surg					
00740	N	Anesth, upper gi visualize					
00750	N	Anesth, repair of hernia					
00752	N	Anesth, repair of hernia					
00754	N	Anesth, repair of hernia					
00756	N	Anesth, repair of hernia					
00770	N	Anesth, blood vessel repair					
00790	N	Anesth, surg upper abdomen					
00792	C	Anesth, part liver removal					
00794	C	Anesth, pancreas removal					
00796	C	Anesth, for liver transplant					
00800	N	Anesth, abdominal wall surg					
00802	C	Anesth, fat layer removal					
00810	N	Anesth, low intestine scope					
00820	N	Anesth, abdominal wall surg					
00830	N	Anesth, repair of hernia					
00832	N	Anesth, repair of hernia					
00840	N	Anesth, surg lower abdomen					
00842	N	Anesth, amniocentesis					
00844	C	Anesth, pelvis surgery					
00846	C	Anesth, hysterectomy					
00848	C	Anesth, pelvic organ surg					
00850	C	Anesth, cesarean section					
00855	C	Anesth, hysterectomy					
00857	C	Analgesia, labor & c-section					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
00860	N	Anesth, surgery of abdomen					
00862	N	Anesth, kidney/ureter surg					
00864	C	Anesth, removal of bladder					
00865	C	Anesth, removal of prostate					
00866	C	Anesth, removal of adrenal					
00868	C	Anesth, kidney transplant					
00870	N	Anesth, bladder stone surg					
00872	N	Anesth kidney stone destruct					
00873	N	Anesth kidney stone destruct					
00880	N	Anesth, abdomen vessel surg					
00882	C	Anesth, major vein ligation					
00884	C	Anesth, major vein revision					
00900	N	Anesth, perineal procedure					
00902	N	Anesth, anorectal surgery					
00904	C	Anesth, perineal surgery					
00906	N	Anesth, removal of vulva					
00908	C	Anesth, removal of prostate					
00910	N	Anesth, bladder surgery					
00912	N	Anesth, bladder tumor surg					
00914	N	Anesth, removal of prostate					
00916	N	Anesth, bleeding control					
00918	N	Anesth, stone removal					
00920	N	Anesth, genitalia surgery					
00922	N	Anesth, sperm duct surgery					
00924	N	Anesth, testis exploration					
00926	N	Anesth, removal of testis					
00928	C	Anesth, removal of testis					
00930	N	Anesth, testis suspension					
00932	C	Anesth, amputation of penis					
00934	C	Anesth, penis, nodes removal					
00936	C	Anesth, penis, nodes removal					
00938	N	Anesth, insert penis device					
00940	N	Anesth, vaginal procedures					
00942	N	Anesth, surgery on vagina					
00944	C	Anesth, vaginal hysterectomy					
00946	N	Anesth, vaginal delivery					
00948	N	Anesth, repair of cervix					
00950	N	Anesth, vaginal endoscopy					
00952	N	Anesth, hysteroscope/graph					
00955	C	Analgesia, vaginal delivery					
01120	N	Anesth, pelvis surgery					
01130	N	Anesth, body cast procedure					
01140	C	Anesth, amputation at pelvis					
01150	C	Anesth, pelvic tumor surgery					
01160	N	Anesth, pelvis procedure					
01170	N	Anesth, pelvis surgery					
01180	N	Anesth, pelvis nerve removal					
01190	C	Anesth, pelvis nerve removal					
01200	N	Anesth, hip joint procedure					
01202	N	Anesth, arthroscopy of hip					
01210	N	Anesth, hip joint surgery					
01212	C	Anesth, hip disarticulation					
01214	C	Anesth, replacement of hip					
01220	N	Anesth, procedure on femur					
01230	N	Anesth, surgery of femur					
01232	C	Anesth, amputation of femur					
01234	C	Anesth, radical femur surg					
01250	N	Anesth, upper leg surgery					
01260	N	Anesth, upper leg veins surg					
01270	N	Anesth, thigh arteries surg					
01272	C	Anesth, femoral artery surg					
01274	C	Anesth, femoral embolectomy					
01320	N	Anesth, knee area surgery					
01340	N	Anesth, knee area procedure					
01360	N	Anesth, knee area surgery					
01380	N	Anesth, knee joint procedure					
01382	N	Anesth, knee arthroscopy					
01390	N	Anesth, knee area procedure					
01392	N	Anesth, knee area surgery					
01400	N	Anesth, knee joint surgery					
01402	C	Anesth, replacement of knee					
01404	C	Anesth, amputation at knee					
01420	N	Anesth, knee joint casting					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
01430	N	Anesth, knee veins surgery					
01432	N	Anesth, knee vessel surg					
01440	N	Anesth, knee arteries surg					
01442	C	Anesth, knee artery surg					
01444	C	Anesth, knee artery repair					
01462	N	Anesth, lower leg procedure					
01464	N	Anesth, ankle arthroscopy					
01470	N	Anesth, lower leg surgery					
01472	N	Anesth, achilles tendon surg					
01474	N	Anesth, lower leg surgery					
01480	N	Anesth, lower leg bone surg					
01482	N	Anesth, radical leg surgery					
01484	N	Anesth, lower leg revision					
01486	C	Anesth, ankle replacement					
01490	N	Anesth, lower leg casting					
01500	N	Anesth, leg arteries surg					
01502	C	Anesth, lwr leg embolectomy					
01520	N	Anesth, lower leg vein surg					
01522	N	Anesth, lower leg vein surg					
01610	N	Anesth, surgery of shoulder					
01620	N	Anesth, shoulder procedure					
01622	N	Anesth, shoulder arthroscopy					
01630	N	Anesth, surgery of shoulder					
01632	C	Anesth, surgery of shoulder					
01634	C	Anesth, shoulder joint amput					
01636	C	Anesth, forequarter amput					
01638	C	Anesth, shoulder replacement					
01650	N	Anesth, shoulder artery surg					
01652	C	Anesth, shoulder vessel surg					
01654	C	Anesth, shoulder vessel surg					
01656	C	Anesth, arm-leg vessel surg					
01670	N	Anesth, shoulder vein surg					
01680	N	Anesth, shoulder casting					
01682	N	Anesth, airplane cast					
01710	N	Anesth, elbow area surgery					
01712	N	Anesth, uppr arm tendon surg					
01714	N	Anesth, uppr arm tendon surg					
01716	N	Anesth, biceps tendon repair					
01730	N	Anesth, uppr arm procedure					
01732	N	Anesth, elbow arthroscopy					
01740	N	Anesth, upper arm surgery					
01742	N	Anesth, humerus surgery					
01744	N	Anesth, humerus repair					
01756	C	Anesth, radical humerus surg					
01758	N	Anesth, humeral lesion surg					
01760	N	Anesth, elbow replacement					
01770	N	Anesth, uppr arm artery surg					
01772	C	Anesth, uppr arm embolectomy					
01780	N	Anesth, upper arm vein surg					
01782	C	Anesth, uppr arm vein repair					
01784	N	Anesth, av fistula repair					
01810	N	Anesth, lower arm surgery					
01820	N	Anesth, lower arm procedure					
01830	N	Anesth, lower arm surgery					
01832	N	Anesth, wrist replacement					
01840	N	Anesth, lwr arm artery surg					
01842	C	Anesth, lwr arm embolectomy					
01844	N	Anesth, vascular shunt surg					
01850	N	Anesth, lower arm vein surg					
01852	C	Anesth, lwr arm vein repair					
01860	N	Anesth, lower arm casting					
01904	C	Anesth, skull x-ray inject					
01906	N	Anesth, lumbar myelography					
01908	N	Anesth, cervical myelography					
01910	N	Anesth, skull myelography					
01912	N	Anesth, lumbar diskography					
01914	N	Anesth, cervical diskography					
01916	N	Anesth, head arteriogram					
01918	N	Anesth, limb arteriogram					
01920	N	Anesth, catheterize heart					
01921	N	Anesth, vessel surgery					
01922	N	Anesth, cat or MRI scan					
01990	C	Support for organ donor					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
01995	N	Regional anesthesia, limb					
01996	N	Manage daily drug therapy					
01999	N	Unlisted anesthes procedure					
10040	T	Acne surgery of skin abscess	0006	2.00	\$96.97	\$33.95	\$19.39
10060	T	Drainage of skin abscess	0006	2.00	\$96.97	\$33.95	\$19.39
10061	T	Drainage of skin abscess	0006	2.00	\$96.97	\$33.95	\$19.39
10080	T	Drainage of pilonidal cyst	0006	2.00	\$96.97	\$33.95	\$19.39
10081	T	Drainage of pilonidal cyst	0007	3.68	\$178.43	\$72.03	\$35.69
10120	T	Remove foreign body	0006	2.00	\$96.97	\$33.95	\$19.39
10121	T	Remove foreign body	0020	6.51	\$315.65	\$130.53	\$63.13
10140	T	Drainage of hematoma/fluid	0007	3.68	\$178.43	\$72.03	\$35.69
10160	T	Puncture drainage of lesion	0006	2.00	\$96.97	\$33.95	\$19.39
10180	T	Complex drainage, wound	0007	3.68	\$178.43	\$72.03	\$35.69
11000	T	Debride infected skin	0015	1.77	\$85.82	\$31.20	\$17.16
11001	T	Debride infected skin add-on	0015	1.77	\$85.82	\$31.20	\$17.16
11010	T	Debride skin, fx	0022	12.49	\$605.60	\$292.94	\$121.12
11011	T	Debride skin/muscle, fx	0022	12.49	\$605.60	\$292.94	\$121.12
11012	T	Debride skin/muscle/bone, fx	0022	12.49	\$605.60	\$292.94	\$121.12
11040	T	Debride skin, partial	0015	1.77	\$85.82	\$31.20	\$17.16
11041	T	Debride skin, full	0015	1.77	\$85.82	\$31.20	\$17.16
11042	T	Debride skin/tissue	0016	3.53	\$171.16	\$74.67	\$34.23
11043	T	Debride tissue/muscle	0016	3.53	\$171.16	\$74.67	\$34.23
11044	T	Debride tissue/muscle/bone	0017	12.45	\$603.66	\$289.16	\$120.73
11055	T	Trim skin lesion	0015	1.77	\$85.82	\$31.20	\$17.16
11056	T	Trim skin lesions, 2 to 4	0015	1.77	\$85.82	\$31.20	\$17.16
11057	T	Trim skin lesions, over 4	0015	1.77	\$85.82	\$31.20	\$17.16
11100	T	Biopsy of skin lesion	0018	0.94	\$45.58	\$17.66	\$9.12
11101	T	Biopsy, skin add-on	0018	0.94	\$45.58	\$17.66	\$9.12
11200	T	Removal of skin tags	0015	1.77	\$85.82	\$31.20	\$17.16
11201	T	Remove skin tags add-on	0015	1.77	\$85.82	\$31.20	\$17.16
11300	T	Shave skin lesion	0013	0.91	\$44.12	\$17.66	\$8.82
11301	T	Shave skin lesion	0013	0.91	\$44.12	\$17.66	\$8.82
11302	T	Shave skin lesion	0014	1.50	\$72.73	\$24.55	\$14.55
11303	T	Shave skin lesion	0015	1.77	\$85.82	\$31.20	\$17.16
11305	T	Shave skin lesion	0013	0.91	\$44.12	\$17.66	\$8.82
11306	T	Shave skin lesion	0013	0.91	\$44.12	\$17.66	\$8.82
11307	T	Shave skin lesion	0014	1.50	\$72.73	\$24.55	\$14.55
11308	T	Shave skin lesion	0015	1.77	\$85.82	\$31.20	\$17.16
11310	T	Shave skin lesion	0013	0.91	\$44.12	\$17.66	\$8.82
11311	T	Shave skin lesion	0013	0.91	\$44.12	\$17.66	\$8.82
11312	T	Shave skin lesion	0015	1.77	\$85.82	\$31.20	\$17.16
11313	T	Shave skin lesion	0016	3.53	\$171.16	\$74.67	\$34.23
11400	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11401	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11402	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11403	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11404	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11406	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11420	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11421	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11422	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11423	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11424	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11426	T	Removal of skin lesion	0022	12.49	\$605.60	\$292.94	\$121.12
11440	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11441	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11442	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11443	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11444	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11446	T	Removal of skin lesion	0022	12.49	\$605.60	\$292.94	\$121.12
11450	T	Removal, sweat gland lesion	0022	12.49	\$605.60	\$292.94	\$121.12
11451	T	Removal, sweat gland lesion	0022	12.49	\$605.60	\$292.94	\$121.12
11462	T	Removal, sweat gland lesion	0022	12.49	\$605.60	\$292.94	\$121.12
11463	T	Removal, sweat gland lesion	0022	12.49	\$605.60	\$292.94	\$121.12
11470	T	Removal, sweat gland lesion	0022	12.49	\$605.60	\$292.94	\$121.12
11471	T	Removal, sweat gland lesion	0022	12.49	\$605.60	\$292.94	\$121.12
11600	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11601	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11602	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11603	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11604	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11606	T	Removal of skin lesion	0021	10.49	\$508.63	\$236.51	\$101.73
11620	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79

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² Not subject to national coinsurance.

³ Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
11621	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11622	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11623	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11624	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11626	T	Removal of skin lesion	0022	12.49	\$605.60	\$292.94	\$121.12
11640	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11641	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11642	T	Removal of skin lesion	0019	4.00	\$193.95	\$78.91	\$38.79
11643	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11644	T	Removal of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
11646	T	Removal of skin lesion	0022	12.49	\$605.60	\$292.94	\$121.12
11719	T	Trim nail(s)	0009	0.74	\$35.88	\$9.63	\$7.18
11720	T	Debride nail, 1–5	0009	0.74	\$35.88	\$9.63	\$7.18
11721	T	Debride nail, 6 or more	0009	0.74	\$35.88	\$9.63	\$7.18
11730	T	Removal of nail plate	0013	0.91	\$44.12	\$17.66	\$8.82
11732	T	Remove nail plate, add-on	0012	0.53	\$25.70	\$9.18	\$5.14
11740	T	Drain blood from under nail	0009	0.74	\$35.88	\$9.63	\$7.18
11750	T	Removal of nail bed	0019	4.00	\$193.95	\$78.91	\$38.79
11752	T	Remove nail bed/finger tip	0022	12.49	\$605.60	\$292.94	\$121.12
11755	T	Biopsy, nail unit	0019	4.00	\$193.95	\$78.91	\$38.79
11760	T	Repair of nail bed	0024	2.43	\$117.82	\$44.50	\$23.56
11762	T	Reconstruction of nail bed	0024	2.43	\$117.82	\$44.50	\$23.56
11765	T	Excision of nail fold, toe	0015	1.77	\$85.82	\$31.20	\$17.16
11770	T	Removal of pilonidal lesion	0021	10.49	\$508.63	\$236.51	\$101.73
11771	T	Removal of pilonidal lesion	0022	12.49	\$605.60	\$292.94	\$121.12
11772	T	Removal of pilonidal lesion	0022	12.49	\$605.60	\$292.94	\$121.12
11900	T	Injection into skin lesions	0012	0.53	\$25.70	\$9.18	\$5.14
11901	T	Added skin lesions injection	0013	0.91	\$44.12	\$17.66	\$8.82
11920	T	Correct skin color defects	0024	2.43	\$117.82	\$44.50	\$23.56
11921	T	Correct skin color defects	0024	2.43	\$117.82	\$44.50	\$23.56
11922	T	Correct skin color defects	0024	2.43	\$117.82	\$44.50	\$23.56
11950	T	Therapy for contour defects	0024	2.43	\$117.82	\$44.50	\$23.56
11951	T	Therapy for contour defects	0024	2.43	\$117.82	\$44.50	\$23.56
11952	T	Therapy for contour defects	0024	2.43	\$117.82	\$44.50	\$23.56
11954	T	Therapy for contour defects	0024	2.43	\$117.82	\$44.50	\$23.56
11960	T	Insert tissue expander(s)	0026	12.11	\$587.18	\$277.92	\$117.44
11970	T	Replace tissue expander	0026	12.11	\$587.18	\$277.92	\$117.44
11971	T	Remove tissue expander(s)	0022	12.49	\$605.60	\$292.94	\$121.12
11975	E	Insert contraceptive cap .....	.....	.....	.....	.....	.....
11976	T	Removal of contraceptive cap	0019	4.00	\$193.95	\$78.91	\$38.79
11977	E	Removal/reinsert contra cap .....	.....	.....	.....	.....	.....
11980	E	Implant hormone pellet(s) .....	.....	.....	.....	.....	.....
12001	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12002	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12004	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12005	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12006	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12007	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12011	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12013	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12014	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12015	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12016	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12017	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12018	T	Repair superficial wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12020	T	Closure of split wound	0024	2.43	\$117.82	\$44.50	\$23.56
12021	T	Closure of split wound	0024	2.43	\$117.82	\$44.50	\$23.56
12031	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12032	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12034	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12035	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12036	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12037	T	Layer closure of wound(s)	0026	12.11	\$587.18	\$277.92	\$117.44
12041	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12042	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12044	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12045	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12046	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12047	T	Layer closure of wound(s)	0026	12.11	\$587.18	\$277.92	\$117.44
12051	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12052	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12053	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12054	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56

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³ Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
12055	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12056	T	Layer closure of wound(s)	0024	2.43	\$117.82	\$44.50	\$23.56
12057	T	Layer closure of wound(s)	0026	12.11	\$587.18	\$277.92	\$117.44
13100	T	Repair of wound or lesion	0025	3.74	\$181.34	\$70.66	\$36.27
13101	T	Repair of wound or lesion	0025	3.74	\$181.34	\$70.66	\$36.27
13102	T	Repair wound/lesion add-on	0025	3.74	\$181.34	\$70.66	\$36.27
13120	T	Repair of wound or lesion	0025	3.74	\$181.34	\$70.66	\$36.27
13121	T	Repair of wound or lesion	0025	3.74	\$181.34	\$70.66	\$36.27
13122	T	Repair wound/lesion add-on	0025	3.74	\$181.34	\$70.66	\$36.27
13131	T	Repair of wound or lesion	0025	3.74	\$181.34	\$70.66	\$36.27
13132	T	Repair of wound or lesion	0025	3.74	\$181.34	\$70.66	\$36.27
13133	T	Repair wound/lesion add-on	0025	3.74	\$181.34	\$70.66	\$36.27
13150	T	Repair of wound or lesion	0026	12.11	\$587.18	\$277.92	\$117.44
13151	T	Repair of wound or lesion	0025	3.74	\$181.34	\$70.66	\$36.27
13152	T	Repair of wound or lesion	0025	3.74	\$181.34	\$70.66	\$36.27
13153	T	Repair wound/lesion add-on	0025	3.74	\$181.34	\$70.66	\$36.27
13160	T	Late closure of wound	0026	12.11	\$587.18	\$277.92	\$117.44
14000	T	Skin tissue rearrangement	0026	12.11	\$587.18	\$277.92	\$117.44
14001	T	Skin tissue rearrangement	0026	12.11	\$587.18	\$277.92	\$117.44
14020	T	Skin tissue rearrangement	0026	12.11	\$587.18	\$277.92	\$117.44
14021	T	Skin tissue rearrangement	0026	12.11	\$587.18	\$277.92	\$117.44
14040	T	Skin tissue rearrangement	0026	12.11	\$587.18	\$277.92	\$117.44
14041	T	Skin tissue rearrangement	0026	12.11	\$587.18	\$277.92	\$117.44
14060	T	Skin tissue rearrangement	0026	12.11	\$587.18	\$277.92	\$117.44
14061	T	Skin tissue rearrangement	0026	12.11	\$587.18	\$277.92	\$117.44
14300	T	Skin tissue rearrangement	0026	12.11	\$587.18	\$277.92	\$117.44
14350	T	Skin tissue rearrangement	0026	12.11	\$587.18	\$277.92	\$117.44
15000	T	Skin graft	0026	12.11	\$587.18	\$277.92	\$117.44
15001	T	Skin graft add-on	0026	12.11	\$587.18	\$277.92	\$117.44
15050	T	Skin pinch graft	0026	12.11	\$587.18	\$277.92	\$117.44
15100	T	Skin split graft	0026	12.11	\$587.18	\$277.92	\$117.44
15101	T	Skin split graft add-on	0026	12.11	\$587.18	\$277.92	\$117.44
15120	T	Skin split graft	0026	12.11	\$587.18	\$277.92	\$117.44
15121	T	Skin split graft add-on	0026	12.11	\$587.18	\$277.92	\$117.44
15200	T	Skin full graft	0026	12.11	\$587.18	\$277.92	\$117.44
15201	T	Skin full graft add-on	0026	12.11	\$587.18	\$277.92	\$117.44
15220	T	Skin full graft	0026	12.11	\$587.18	\$277.92	\$117.44
15221	T	Skin full graft add-on	0026	12.11	\$587.18	\$277.92	\$117.44
15240	T	Skin full graft	0026	12.11	\$587.18	\$277.92	\$117.44
15241	T	Skin full graft add-on	0026	12.11	\$587.18	\$277.92	\$117.44
15260	T	Skin full graft	0026	12.11	\$587.18	\$277.92	\$117.44
15261	T	Skin full graft add-on	0026	12.11	\$587.18	\$277.92	\$117.44
15350	T	Skin homograft	0026	12.11	\$587.18	\$277.92	\$117.44
15351	T	Skin homograft add-on	0026	12.11	\$587.18	\$277.92	\$117.44
15400	T	Skin heterograft	0026	12.11	\$587.18	\$277.92	\$117.44
15401	T	Skin heterograft add-on	0026	12.11	\$587.18	\$277.92	\$117.44
15570	T	Form skin pedicle flap	0026	12.11	\$587.18	\$277.92	\$117.44
15572	T	Form skin pedicle flap	0026	12.11	\$587.18	\$277.92	\$117.44
15574	T	Form skin pedicle flap	0026	12.11	\$587.18	\$277.92	\$117.44
15576	T	Form skin pedicle flap	0026	12.11	\$587.18	\$277.92	\$117.44
15600	T	Skin graft	0026	12.11	\$587.18	\$277.92	\$117.44
15610	T	Skin graft	0026	12.11	\$587.18	\$277.92	\$117.44
15620	T	Skin graft	0026	12.11	\$587.18	\$277.92	\$117.44
15630	T	Skin graft	0026	12.11	\$587.18	\$277.92	\$117.44
15650	T	Transfer skin pedicle flap	0026	12.11	\$587.18	\$277.92	\$117.44
15732	T	Muscle-skin graft, head/neck	0027	15.80	\$766.10	\$383.10	\$153.22
15734	T	Muscle-skin graft, trunk	0027	15.80	\$766.10	\$383.10	\$153.22
15736	T	Muscle-skin graft, arm	0027	15.80	\$766.10	\$383.10	\$153.22
15738	T	Muscle-skin graft, leg	0027	15.80	\$766.10	\$383.10	\$153.22
15740	T	Island pedicle flap graft	0027	15.80	\$766.10	\$383.10	\$153.22
15750	T	Neurovascular pedicle graft	0027	15.80	\$766.10	\$383.10	\$153.22
15756	C	Free muscle flap, microvasc .....	.....	.....	.....	.....	.....
15757	C	Free skin flap, microvasc .....	.....	.....	.....	.....	.....
15758	C	Free fascial flap, microvasc .....	.....	.....	.....	.....	.....
15760	T	Composite skin graft	0027	15.80	\$766.10	\$383.10	\$153.22
15770	T	Derma-fat-fascia graft	0027	15.80	\$766.10	\$383.10	\$153.22
15775	T	Hair transplant punch grafts	0026	12.11	\$587.18	\$277.92	\$117.44
15776	T	Hair transplant punch grafts	0026	12.11	\$587.18	\$277.92	\$117.44
15780	T	Abrasion treatment of skin	0022	12.49	\$605.60	\$292.94	\$121.12
15781	T	Abrasion treatment of skin	0022	12.49	\$605.60	\$292.94	\$121.12
15782	T	Abrasion treatment of skin	0022	12.49	\$605.60	\$292.94	\$121.12
15783	T	Abrasion treatment of skin	0015	1.77	\$85.82	\$31.20	\$17.16
15786	T	Abrasion, lesion, single	0013	0.91	\$44.12	\$17.66	\$8.82

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
15787	T	Abrasion, lesions, add-on	0016	3.53	\$171.16	\$74.67	\$34.23
15788	T	Chemical peel, face, epiderm	0013	0.91	\$44.12	\$17.66	\$8.82
15789	T	Chemical peel, face, dermal	0015	1.77	\$85.82	\$31.20	\$17.16
15792	T	Chemical peel, nonfacial	0016	3.53	\$171.16	\$74.67	\$34.23
15793	T	Chemical peel, nonfacial	0016	3.53	\$171.16	\$74.67	\$34.23
15810	T	Salabrasion	0016	3.53	\$171.16	\$74.67	\$34.23
15811	T	Salabrasion	0022	12.49	\$605.60	\$292.94	\$121.12
15819	T	Plastic surgery, neck	0026	12.11	\$587.18	\$277.92	\$117.44
15820	T	Revision of lower eyelid	0026	12.11	\$587.18	\$277.92	\$117.44
15821	T	Revision of lower eyelid	0026	12.11	\$587.18	\$277.92	\$117.44
15822	T	Revision of upper eyelid	0026	12.11	\$587.18	\$277.92	\$117.44
15823	T	Revision of upper eyelid	0026	12.11	\$587.18	\$277.92	\$117.44
15824	T	Removal of forehead wrinkles	0027	15.80	\$766.10	\$383.10	\$153.22
15825	T	Removal of neck wrinkles	0026	12.11	\$587.18	\$277.92	\$117.44
15826	T	Removal of brow wrinkles	0027	15.80	\$766.10	\$383.10	\$153.22
15828	T	Removal of face wrinkles	0027	15.80	\$766.10	\$383.10	\$153.22
15829	T	Removal of skin wrinkles	0026	12.11	\$587.18	\$277.92	\$117.44
15831	T	Excise excessive skin tissue	0027	15.80	\$766.10	\$383.10	\$153.22
15832	T	Excise excessive skin tissue	0027	15.80	\$766.10	\$383.10	\$153.22
15833	T	Excise excessive skin tissue	0027	15.80	\$766.10	\$383.10	\$153.22
15834	T	Excise excessive skin tissue	0027	15.80	\$766.10	\$383.10	\$153.22
15835	T	Excise excessive skin tissue	0026	12.11	\$587.18	\$277.92	\$117.44
15836	T	Excise excessive skin tissue	0027	15.80	\$766.10	\$383.10	\$153.22
15837	T	Excise excessive skin tissue	0027	15.80	\$766.10	\$383.10	\$153.22
15838	T	Excise excessive skin tissue	0022	12.49	\$605.60	\$292.94	\$121.12
15839	T	Excise excessive skin tissue	0027	15.80	\$766.10	\$383.10	\$153.22
15840	T	Graft for face nerve palsy	0027	15.80	\$766.10	\$383.10	\$153.22
15841	T	Graft for face nerve palsy	0027	15.80	\$766.10	\$383.10	\$153.22
15842	T	Graft for face nerve palsy	0027	15.80	\$766.10	\$383.10	\$153.22
15845	T	Skin and muscle repair, face	0027	15.80	\$766.10	\$383.10	\$153.22
15850	T	Removal of sutures	0013	0.91	\$44.12	\$17.66	\$8.82
15851	T	Removal of sutures	0013	0.91	\$44.12	\$17.66	\$8.82
15852	T	Dressing change, not for burn	0012	0.53	\$25.70	\$9.18	\$5.14
15860	N	Test for blood flow in graft					
15876	T	Suction assisted lipectomy	0027	15.80	\$766.10	\$383.10	\$153.22
15877	T	Suction assisted lipectomy	0027	15.80	\$766.10	\$383.10	\$153.22
15878	T	Suction assisted lipectomy	0027	15.80	\$766.10	\$383.10	\$153.22
15879	T	Suction assisted lipectomy	0027	15.80	\$766.10	\$383.10	\$153.22
15920	T	Removal of tail bone ulcer	0022	12.49	\$605.60	\$292.94	\$121.12
15922	T	Removal of tail bone ulcer	0027	15.80	\$766.10	\$383.10	\$153.22
15931	T	Remove sacrum pressure sore	0022	12.49	\$605.60	\$292.94	\$121.12
15933	T	Remove sacrum pressure sore	0022	12.49	\$605.60	\$292.94	\$121.12
15934	T	Remove sacrum pressure sore	0027	15.80	\$766.10	\$383.10	\$153.22
15935	T	Remove sacrum pressure sore	0027	15.80	\$766.10	\$383.10	\$153.22
15936	T	Remove sacrum pressure sore	0027	15.80	\$766.10	\$383.10	\$153.22
15937	T	Remove sacrum pressure sore	0027	15.80	\$766.10	\$383.10	\$153.22
15940	T	Remove hip pressure sore	0022	12.49	\$605.60	\$292.94	\$121.12
15941	T	Remove hip pressure sore	0022	12.49	\$605.60	\$292.94	\$121.12
15944	T	Remove hip pressure sore	0027	15.80	\$766.10	\$383.10	\$153.22
15945	T	Remove hip pressure sore	0027	15.80	\$766.10	\$383.10	\$153.22
15946	T	Remove hip pressure sore	0027	15.80	\$766.10	\$383.10	\$153.22
15950	T	Remove thigh pressure sore	0022	12.49	\$605.60	\$292.94	\$121.12
15951	T	Remove thigh pressure sore	0022	12.49	\$605.60	\$292.94	\$121.12
15952	T	Remove thigh pressure sore	0027	15.80	\$766.10	\$383.10	\$153.22
15953	T	Remove thigh pressure sore	0027	15.80	\$766.10	\$383.10	\$153.22
15956	T	Remove thigh pressure sore	0027	15.80	\$766.10	\$383.10	\$153.22
15958	T	Remove thigh pressure sore	0027	15.80	\$766.10	\$383.10	\$153.22
15999	T	Removal of pressure sore	0022	12.49	\$605.60	\$292.94	\$121.12
16000	T	Initial treatment of burn(s)	0015	1.77	\$85.82	\$31.20	\$17.16
16010	T	Treatment of burn(s)	0015	1.77	\$85.82	\$31.20	\$17.16
16015	T	Treatment of burn(s)	0017	12.45	\$603.66	\$289.16	\$120.73
16020	T	Treatment of burn(s)	0015	1.77	\$85.82	\$31.20	\$17.16
16025	T	Treatment of burn(s)	0014	1.50	\$72.73	\$24.55	\$14.55
16030	T	Treatment of burn(s)	0015	1.77	\$85.82	\$31.20	\$17.16
16035	T	Incision of burn scab	0020	6.51	\$315.65	\$130.53	\$63.13
17000	T	Destroy benign/premal lesion	0010	0.55	\$26.67	\$9.86	\$5.33
17003	T	Destroy lesions, 2–14	0010	0.55	\$26.67	\$9.86	\$5.33
17004	T	Destroy lesions, 15 or more	0011	2.72	\$131.88	\$50.01	\$26.38
17106	T	Destruction of skin lesions	0011	2.72	\$131.88	\$50.01	\$26.38
17107	T	Destruction of skin lesions	0011	2.72	\$131.88	\$50.01	\$26.38
17108	T	Destruction of skin lesions	0011	2.72	\$131.88	\$50.01	\$26.38
17110	T	Destruct lesion, 1–14	0010	0.55	\$26.67	\$9.86	\$5.33
17111	T	Destruct lesion, 15 or more	0011	2.72	\$131.88	\$50.01	\$26.38

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
17250	T	Chemical cautery, tissue	0014	1.50	\$72.73	\$24.55	\$14.55
17260	T	Destruction of skin lesions	0013	0.91	\$44.12	\$17.66	\$8.82
17261	T	Destruction of skin lesions	0013	0.91	\$44.12	\$17.66	\$8.82
17262	T	Destruction of skin lesions	0013	0.91	\$44.12	\$17.66	\$8.82
17263	T	Destruction of skin lesions	0013	0.91	\$44.12	\$17.66	\$8.82
17264	T	Destruction of skin lesions	0015	1.77	\$85.82	\$31.20	\$17.16
17266	T	Destruction of skin lesions	0016	3.53	\$171.16	\$74.67	\$34.23
17270	T	Destruction of skin lesions	0015	1.77	\$85.82	\$31.20	\$17.16
17271	T	Destruction of skin lesions	0013	0.91	\$44.12	\$17.66	\$8.82
17272	T	Destruction of skin lesions	0013	0.91	\$44.12	\$17.66	\$8.82
17273	T	Destruction of skin lesions	0015	1.77	\$85.82	\$31.20	\$17.16
17274	T	Destruction of skin lesions	0015	1.77	\$85.82	\$31.20	\$17.16
17276	T	Destruction of skin lesions	0015	1.77	\$85.82	\$31.20	\$17.16
17280	T	Destruction of skin lesions	0015	1.77	\$85.82	\$31.20	\$17.16
17281	T	Destruction of skin lesions	0015	1.77	\$85.82	\$31.20	\$17.16
17282	T	Destruction of skin lesions	0015	1.77	\$85.82	\$31.20	\$17.16
17283	T	Destruction of skin lesions	0015	1.77	\$85.82	\$31.20	\$17.16
17284	T	Destruction of skin lesions	0016	3.53	\$171.16	\$74.67	\$34.23
17286	T	Destruction of skin lesions	0016	3.53	\$171.16	\$74.67	\$34.23
17304	T	Chemosurgery of skin lesion	0020	6.51	\$315.65	\$130.53	\$63.13
17305	T	2nd stage chemosurgery	0020	6.51	\$315.65	\$130.53	\$63.13
17306	T	3rd stage chemosurgery	0020	6.51	\$315.65	\$130.53	\$63.13
17307	T	Followup skin lesion therapy	0020	6.51	\$315.65	\$130.53	\$63.13
17310	T	Extensive skin chemosurgery	0020	6.51	\$315.65	\$130.53	\$63.13
17340	T	Cryotherapy of skin	0012	0.53	\$25.70	\$9.18	\$5.14
17360	T	Skin peel therapy	0016	3.53	\$171.16	\$74.67	\$34.23
17380	T	Hair removal by electrolysis	0016	3.53	\$171.16	\$74.67	\$34.23
17999	T	Skin tissue procedure	0004	1.84	\$89.22	\$32.57	\$17.84
19000	T	Drainage of breast lesion	0004	1.84	\$89.22	\$32.57	\$17.84
19001	T	Drain breast lesion add-on	0004	1.84	\$89.22	\$32.57	\$17.84
19020	T	Incision of breast lesion	0008	6.15	\$298.20	\$113.67	\$59.64
19030	N	Injection for breast x-ray					
19100	T	Biopsy of breast	0005	5.41	\$262.32	\$119.75	\$52.46
19101	T	Biopsy of breast	0029	12.85	\$623.06	\$303.50	\$124.61
19110	T	Nipple exploration	0029	12.85	\$623.06	\$303.50	\$124.61
19112	T	Excise breast duct fistula	0029	12.85	\$623.06	\$303.50	\$124.61
19120	T	Removal of breast lesion	0029	12.85	\$623.06	\$303.50	\$124.61
19125	T	Excision, breast lesion	0029	12.85	\$623.06	\$303.50	\$124.61
19126	T	Excision, addl breast lesion	0029	12.85	\$623.06	\$303.50	\$124.61
19140	T	Removal of breast tissue	0029	12.85	\$623.06	\$303.50	\$124.61
19160	T	Removal of breast tissue	0030	20.19	\$978.95	\$523.95	\$195.79
19162	T	Remove breast tissue, nodes	0030	20.19	\$978.95	\$523.95	\$195.79
19180	T	Removal of breast	0030	20.19	\$978.95	\$523.95	\$195.79
19182	T	Removal of breast	0030	20.19	\$978.95	\$523.95	\$195.79
19200	C	Removal of breast					
19220	C	Removal of breast					
19240	C	Removal of breast					
19260	C	Removal of chest wall lesion					
19271	C	Revision of chest wall					
19272	C	Extensive chest wall surgery					
19290	T	Place needle wire, breast	0029	12.85	\$623.06	\$303.50	\$124.61
19291	T	Place needle wire, breast	0029	12.85	\$623.06	\$303.50	\$124.61
19316	T	Suspension of breast	0030	20.19	\$978.95	\$523.95	\$195.79
19318	T	Reduction of large breast	0030	20.19	\$978.95	\$523.95	\$195.79
19324	T	Enlarge breast	0030	20.19	\$978.95	\$523.95	\$195.79
19325	T	Enlarge breast with implant	0030	20.19	\$978.95	\$523.95	\$195.79
19328	T	Removal of breast implant	0030	20.19	\$978.95	\$523.95	\$195.79
19330	T	Removal of implant material	0030	20.19	\$978.95	\$523.95	\$195.79
19340	T	Immediate breast prosthesis	0030	20.19	\$978.95	\$523.95	\$195.79
19342	T	Delayed breast prosthesis	0030	20.19	\$978.95	\$523.95	\$195.79
19350	T	Breast reconstruction	0030	20.19	\$978.95	\$523.95	\$195.79
19355	T	Correct inverted nipple(s)	0030	20.19	\$978.95	\$523.95	\$195.79
19357	T	Breast reconstruction	0030	20.19	\$978.95	\$523.95	\$195.79
19361	C	Breast reconstruction					
19364	C	Breast reconstruction					
19366	T	Breast reconstruction	0030	20.19	\$978.95	\$523.95	\$195.79
19367	C	Breast reconstruction					
19368	C	Breast reconstruction					
19369	C	Breast reconstruction					
19370	T	Surgery of breast capsule	0030	20.19	\$978.95	\$523.95	\$195.79
19371	T	Removal of breast capsule	0030	20.19	\$978.95	\$523.95	\$195.79
19380	T	Revise breast reconstruction	0030	20.19	\$978.95	\$523.95	\$195.79
19396	T	Design custom breast implant	0029	12.85	\$623.06	\$303.50	\$124.61

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² Not subject to national coinsurance.

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
19499	T	Breast surgery procedure	0029	12.85	\$623.06	\$303.50	\$124.61
20000	T	Incision of abscess	0006	2.00	\$96.97	\$33.95	\$19.39
20005	T	Incision of deep abscess	0049	15.04	\$729.25	\$356.95	\$145.85
20100	T	Explore wound, neck	0023	1.98	\$96.00	\$40.37	\$19.20
20101	T	Explore wound, chest	0026	12.11	\$587.18	\$277.92	\$117.44
20102	T	Explore wound, abdomen	0026	12.11	\$587.18	\$277.92	\$117.44
20103	T	Explore wound, extremity	0023	1.98	\$96.00	\$40.37	\$19.20
20150	T	Excise epiphyseal bar	0051	27.76	\$1,346.00	\$675.24	\$269.20
20200	T	Muscle biopsy	0020	6.51	\$315.65	\$130.53	\$63.13
20205	T	Deep muscle biopsy	0021	10.49	\$508.63	\$236.51	\$101.73
20206	T	Needle biopsy, muscle	0005	5.41	\$262.32	\$119.75	\$52.46
20220	T	Bone biopsy, trocar/needle	0019	4.00	\$193.95	\$78.91	\$38.79
20225	T	Bone biopsy, trocar/needle	0020	6.51	\$315.65	\$130.53	\$63.13
20240	T	Bone biopsy, excisional	0022	12.49	\$605.60	\$292.94	\$121.12
20245	T	Bone biopsy, excisional	0022	12.49	\$605.60	\$292.94	\$121.12
20250	T	Open bone biopsy	0049	15.04	\$729.25	\$356.95	\$145.85
20251	T	Open bone biopsy	0049	15.04	\$729.25	\$356.95	\$145.85
20500	T	Injection of sinus tract	0252	5.18	\$251.16	\$114.24	\$50.23
20501	N	Inject sinus tract for x-ray					
20520	T	Removal of foreign body	0019	4.00	\$193.95	\$78.91	\$38.79
20525	T	Removal of foreign body	0022	12.49	\$605.60	\$292.94	\$121.12
20550	T	Inject tendon/ligament/cyst	0040	2.11	\$102.31	\$40.60	\$20.46
20600	T	Drain/inject, joint/bursa	0040	2.11	\$102.31	\$40.60	\$20.46
20605	T	Drain/inject, joint/bursa	0040	2.11	\$102.31	\$40.60	\$20.46
20610	T	Drain/inject, joint/bursa	0040	2.11	\$102.31	\$40.60	\$20.46
20615	T	Treatment of bone cyst	0004	1.84	\$89.22	\$32.57	\$17.84
20650	T	Insert and remove bone pin	0049	15.04	\$729.25	\$356.95	\$145.85
20660	C	Apply, remove fixation device					
20661	C	Application of head brace					
20662	C	Application of pelvis brace					
20663	C	Application of thigh brace					
20664	C	Halo brace application					
20665	N	Removal of fixation device					
20670	T	Removal of support implant	0021	10.49	\$508.63	\$236.51	\$101.73
20680	T	Removal of support implant	0022	12.49	\$605.60	\$292.94	\$121.12
20690	T	Apply bone fixation device	0050	21.13	\$1,024.53	\$513.86	\$204.91
20692	T	Apply bone fixation device	0050	21.13	\$1,024.53	\$513.86	\$204.91
20693	T	Adjust bone fixation device	0049	15.04	\$729.25	\$356.95	\$145.85
20694	T	Remove bone fixation device	0049	15.04	\$729.25	\$356.95	\$145.85
20802	C	Replantation, arm, complete					
20805	C	Replant, forearm, complete					
20808	C	Replantation hand, complete					
20816	C	Replantation digit, complete					
20822	C	Replantation digit, complete					
20824	C	Replantation thumb, complete					
20827	C	Replantation thumb, complete					
20838	C	Replantation foot, complete					
20900	T	Removal of bone for graft	0050	21.13	\$1,024.53	\$513.86	\$204.91
20902	T	Removal of bone for graft	0050	21.13	\$1,024.53	\$513.86	\$204.91
20910	T	Remove cartilage for graft	0026	12.11	\$587.18	\$277.92	\$117.44
20912	T	Remove cartilage for graft	0026	12.11	\$587.18	\$277.92	\$117.44
20920	T	Removal of fascia for graft	0026	12.11	\$587.18	\$277.92	\$117.44
20922	T	Removal of fascia for graft	0026	12.11	\$587.18	\$277.92	\$117.44
20924	T	Removal of tendon for graft	0050	21.13	\$1,024.53	\$513.86	\$204.91
20926	T	Removal of tissue for graft	0026	12.11	\$587.18	\$277.92	\$117.44
20930	C	Spinal bone allograft					
20931	C	Spinal bone allograft					
20936	C	Spinal bone autograft					
20937	C	Spinal bone autograft					
20938	C	Spinal bone autograft					
20950	T	Fluid pressure, muscle	0008	6.15	\$298.20	\$113.67	\$59.64
20955	C	Fibula bone graft, microvasc					
20956	C	Iliac bone graft, microvasc					
20957	C	Mt bone graft, microvasc					
20962	C	Other bone graft, microvasc					
20969	C	Bone/skin graft, microvasc					
20970	C	Bone/skin graft, iliac crest					
20972	C	Bone/skin graft, metatarsal					
20973	C	Bone/skin graft, great toe					
20974	A	Electrical bone stimulation					
20975	T	Electrical bone stimulation	0049	15.04	\$729.25	\$356.95	\$145.85
20979	T	Us bone stimulation	0049	15.04	\$729.25	\$356.95	\$145.85
20999	N	Musculoskeletal surgery					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
21010	T	Incision of jaw joint	0254	12.45	\$603.66	\$272.41	\$120.73
21015	T	Resection of facial tumor	0254	12.45	\$603.66	\$272.41	\$120.73
21025	T	Excision of bone, lower jaw	0256	25.40	\$1,231.57	\$623.05	\$246.31
21026	T	Excision of facial bone(s)	0256	25.40	\$1,231.57	\$623.05	\$246.31
21029	T	Contour of face bone lesion	0256	25.40	\$1,231.57	\$623.05	\$246.31
21030	T	Removal of face bone lesion	0254	12.45	\$603.66	\$272.41	\$120.73
21031	T	Remove exostosis, mandible	0253	12.02	\$582.81	\$284.00	\$116.56
21032	T	Remove exostosis, maxilla	0253	12.02	\$582.81	\$284.00	\$116.56
21034	T	Removal of face bone lesion	0256	25.40	\$1,231.57	\$623.05	\$246.31
21040	T	Removal of jaw bone lesion	0253	12.02	\$582.81	\$284.00	\$116.56
21041	T	Removal of jaw bone lesion	0256	25.40	\$1,231.57	\$623.05	\$246.31
21044	T	Removal of jaw bone lesion	0256	25.40	\$1,231.57	\$623.05	\$246.31
21045	C	Extensive jaw surgery					
21050	T	Removal of jaw joint	0256	25.40	\$1,231.57	\$623.05	\$246.31
21060	T	Remove jaw joint cartilage	0256	25.40	\$1,231.57	\$623.05	\$246.31
21070	T	Remove coronoid process	0256	25.40	\$1,231.57	\$623.05	\$246.31
21076	T	Prepare face/oral prosthesis	0254	12.45	\$603.66	\$272.41	\$120.73
21077	T	Prepare face/oral prosthesis	0256	25.40	\$1,231.57	\$623.05	\$246.31
21079	T	Prepare face/oral prosthesis	0256	25.40	\$1,231.57	\$623.05	\$246.31
21080	T	Prepare face/oral prosthesis	0256	25.40	\$1,231.57	\$623.05	\$246.31
21081	T	Prepare face/oral prosthesis	0256	25.40	\$1,231.57	\$623.05	\$246.31
21082	T	Prepare face/oral prosthesis	0256	25.40	\$1,231.57	\$623.05	\$246.31
21083	T	Prepare face/oral prosthesis	0256	25.40	\$1,231.57	\$623.05	\$246.31
21084	T	Prepare face/oral prosthesis	0256	25.40	\$1,231.57	\$623.05	\$246.31
21085	T	Prepare face/oral prosthesis	0253	12.02	\$582.81	\$284.00	\$116.56
21086	T	Prepare face/oral prosthesis	0256	25.40	\$1,231.57	\$623.05	\$246.31
21087	T	Prepare face/oral prosthesis	0256	25.40	\$1,231.57	\$623.05	\$246.31
21088	T	Prepare face/oral prosthesis	0256	25.40	\$1,231.57	\$623.05	\$246.31
21089	T	Prepare face/oral prosthesis	0253	12.02	\$582.81	\$284.00	\$116.56
21100	T	Maxillofacial fixation	0256	25.40	\$1,231.57	\$623.05	\$246.31
21110	T	Interdental fixation	0254	12.45	\$603.66	\$272.41	\$120.73
21116	N	Injection, jaw joint x-ray					
21120	T	Reconstruction of chin	0254	12.45	\$603.66	\$272.41	\$120.73
21121	T	Reconstruction of chin	0254	12.45	\$603.66	\$272.41	\$120.73
21122	T	Reconstruction of chin	0254	12.45	\$603.66	\$272.41	\$120.73
21123	T	Reconstruction of chin	0254	12.45	\$603.66	\$272.41	\$120.73
21125	T	Augmentation, lower jaw bone	0254	12.45	\$603.66	\$272.41	\$120.73
21127	T	Augmentation, lower jaw bone	0256	25.40	\$1,231.57	\$623.05	\$246.31
21137	T	Reduction of forehead	0254	12.45	\$603.66	\$272.41	\$120.73
21138	T	Reduction of forehead	0256	25.40	\$1,231.57	\$623.05	\$246.31
21139	T	Reduction of forehead	0256	25.40	\$1,231.57	\$623.05	\$246.31
21141	C	Reconstruct midface, left					
21142	C	Reconstruct midface, left					
21143	C	Reconstruct midface, left					
21145	C	Reconstruct midface, left					
21146	C	Reconstruct midface, left					
21147	C	Reconstruct midface, left					
21150	C	Reconstruct midface, left					
21151	C	Reconstruct midface, left					
21154	C	Reconstruct midface, left					
21155	C	Reconstruct midface, left					
21159	C	Reconstruct midface, left					
21160	C	Reconstruct midface, left					
21172	C	Reconstruct orbit/forehead					
21175	C	Reconstruct orbit/forehead					
21179	C	Reconstruct entire forehead					
21180	C	Reconstruct entire forehead					
21181	T	Contour cranial bone lesion	0254	12.45	\$603.66	\$272.41	\$120.73
21182	C	Reconstruct cranial bone					
21183	C	Reconstruct cranial bone					
21184	C	Reconstruct cranial bone					
21188	C	Reconstruction of midface					
21193	C	Reconstruct lower jaw bone					
21194	C	Reconstruct lower jaw bone					
21195	C	Reconstruct lower jaw bone					
21196	C	Reconstruct lower jaw bone					
21198	T	Reconstruct lower jaw bone	0256	25.40	\$1,231.57	\$623.05	\$246.31
21206	T	Reconstruct upper jaw bone	0256	25.40	\$1,231.57	\$623.05	\$246.31
21208	T	Augmentation of facial bones	0256	25.40	\$1,231.57	\$623.05	\$246.31
21209	T	Reduction of facial bones	0256	25.40	\$1,231.57	\$623.05	\$246.31
21210	T	Face bone graft	0256	25.40	\$1,231.57	\$623.05	\$246.31
21215	T	Lower jaw bone graft	0256	25.40	\$1,231.57	\$623.05	\$246.31
21230	T	Rib cartilage graft	0256	25.40	\$1,231.57	\$623.05	\$246.31

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
21235	T	Ear cartilage graft	0254	12.45	\$603.66	\$272.41	\$120.73
21240	T	Reconstruction of jaw joint	0256	25.40	\$1,231.57	\$623.05	\$246.31
21242	T	Reconstruction of jaw joint	0256	25.40	\$1,231.57	\$623.05	\$246.31
21243	T	Reconstruction of jaw joint	0256	25.40	\$1,231.57	\$623.05	\$246.31
21244	T	Reconstruction of lower jaw	0256	25.40	\$1,231.57	\$623.05	\$246.31
21245	T	Reconstruction of jaw	0256	25.40	\$1,231.57	\$623.05	\$246.31
21246	T	Reconstruction of jaw	0256	25.40	\$1,231.57	\$623.05	\$246.31
21247	C	Reconstruct lower jaw bone					
21248	T	Reconstruction of jaw	0256	25.40	\$1,231.57	\$623.05	\$246.31
21249	T	Reconstruction of jaw	0256	25.40	\$1,231.57	\$623.05	\$246.31
21255	C	Reconstruct lower jaw bone					
21256	C	Reconstruction of orbit					
21260	T	Revise eye sockets	0256	25.40	\$1,231.57	\$623.05	\$246.31
21261	T	Revise eye sockets	0256	25.40	\$1,231.57	\$623.05	\$246.31
21263	T	Revise eye sockets	0256	25.40	\$1,231.57	\$623.05	\$246.31
21267	T	Revise eye sockets	0256	25.40	\$1,231.57	\$623.05	\$246.31
21268	C	Revise eye sockets					
21270	T	Augmentation, cheek bone	0256	25.40	\$1,231.57	\$623.05	\$246.31
21275	T	Revision, orbitofacial bones	0256	25.40	\$1,231.57	\$623.05	\$246.31
21280	T	Revision of eyelid	0256	25.40	\$1,231.57	\$623.05	\$246.31
21282	T	Revision of eyelid	0253	12.02	\$582.81	\$284.00	\$116.56
21295	T	Revision of jaw muscle/bone	0253	12.02	\$582.81	\$284.00	\$116.56
21296	T	Revision of jaw muscle/bone	0254	12.45	\$603.66	\$272.41	\$120.73
21299	T	Cranio/maxillofacial surgery	0253	12.02	\$582.81	\$284.00	\$116.56
21300	T	Treatment of skull fracture	0253	12.02	\$582.81	\$284.00	\$116.56
21310	T	Treatment of nose fracture	0253	12.02	\$582.81	\$284.00	\$116.56
21315	T	Treatment of nose fracture	0253	12.02	\$582.81	\$284.00	\$116.56
21320	T	Treatment of nose fracture	0253	12.02	\$582.81	\$284.00	\$116.56
21325	T	Treatment of nose fracture	0253	12.02	\$582.81	\$284.00	\$116.56
21330	T	Treatment of nose fracture	0254	12.45	\$603.66	\$272.41	\$120.73
21335	T	Treatment of nose fracture	0254	12.45	\$603.66	\$272.41	\$120.73
21336	T	Treat nasal septal fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
21337	T	Treat nasal septal fracture	0253	12.02	\$582.81	\$284.00	\$116.56
21338	T	Treat nasoethmoid fracture	0254	12.45	\$603.66	\$272.41	\$120.73
21339	T	Treat nasoethmoid fracture	0254	12.45	\$603.66	\$272.41	\$120.73
21340	T	Treatment of nose fracture	0256	25.40	\$1,231.57	\$623.05	\$246.31
21343	C	Treatment of sinus fracture					
21344	C	Treatment of sinus fracture					
21345	T	Treat nose/jaw fracture	0254	12.45	\$603.66	\$272.41	\$120.73
21346	C	Treat nose/jaw fracture					
21347	C	Treat nose/jaw fracture					
21348	C	Treat nose/jaw fracture					
21355	T	Treat cheek bone fracture	0256	25.40	\$1,231.57	\$623.05	\$246.31
21356	C	Treat cheek bone fracture					
21360	C	Treat cheek bone fracture					
21365	C	Treat cheek bone fracture					
21366	C	Treat cheek bone fracture					
21385	C	Treat eye socket fracture					
21386	C	Treat eye socket fracture					
21387	C	Treat eye socket fracture					
21390	C	Treat eye socket fracture					
21395	C	Treat eye socket fracture					
21400	T	Treat eye socket fracture	0252	5.18	\$251.16	\$114.24	\$50.23
21401	T	Treat eye socket fracture	0253	12.02	\$582.81	\$284.00	\$116.56
21406	T	Treat eye socket fracture	0256	25.40	\$1,231.57	\$623.05	\$246.31
21407	T	Treat eye socket fracture	0256	25.40	\$1,231.57	\$623.05	\$246.31
21408	C	Treat eye socket fracture					
21421	T	Treat mouth roof fracture	0254	12.45	\$603.66	\$272.41	\$120.73
21422	C	Treat mouth roof fracture					
21423	C	Treat mouth roof fracture					
21431	C	Treat craniofacial fracture					
21432	C	Treat craniofacial fracture					
21433	C	Treat craniofacial fracture					
21435	C	Treat craniofacial fracture					
21436	C	Treat craniofacial fracture					
21440	T	Treat dental ridge fracture	0253	12.02	\$582.81	\$284.00	\$116.56
21445	T	Treat dental ridge fracture	0254	12.45	\$603.66	\$272.41	\$120.73
21450	T	Treat lower jaw fracture	0251	1.68	\$81.46	\$27.99	\$16.29
21451	T	Treat lower jaw fracture	0254	12.45	\$603.66	\$272.41	\$120.73
21452	T	Treat lower jaw fracture	0253	12.02	\$582.81	\$284.00	\$116.56
21453	T	Treat lower jaw fracture	0256	25.40	\$1,231.57	\$623.05	\$246.31
21454	T	Treat lower jaw fracture	0254	12.45	\$603.66	\$272.41	\$120.73
21461	T	Treat lower jaw fracture	0256	25.40	\$1,231.57	\$623.05	\$246.31

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
21462	T	Treat lower jaw fracture	0256	25.40	\$1,231.57	\$623.05	\$246.31
21465	T	Treat lower jaw fracture	0256	25.40	\$1,231.57	\$623.05	\$246.31
21470	T	Treat lower jaw fracture	0256	25.40	\$1,231.57	\$623.05	\$246.31
21480	T	Reset dislocated jaw	0251	1.68	\$81.46	\$27.99	\$16.29
21485	T	Reset dislocated jaw	0253	12.02	\$582.81	\$284.00	\$116.56
21490	T	Repair dislocated jaw	0256	25.40	\$1,231.57	\$623.05	\$246.31
21493	T	Treat hyoid bone fracture	0252	5.18	\$251.16	\$114.24	\$50.23
21494	T	Treat hyoid bone fracture	0252	5.18	\$251.16	\$114.24	\$50.23
21495	C	Treat hyoid bone fracture					
21497	T	Interdental wiring	0253	12.02	\$582.81	\$284.00	\$116.56
21499	T	Head surgery procedure	0253	12.02	\$582.81	\$284.00	\$116.56
21501	T	Drain neck/chest lesion	0008	6.15	\$298.20	\$113.67	\$59.64
21502	T	Drain chest lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
21510	C	Drainage of bone lesion					
21550	T	Biopsy of neck/chest	0019	4.00	\$193.95	\$78.91	\$38.79
21555	T	Remove lesion, neck/chest	0022	12.49	\$605.60	\$292.94	\$121.12
21556	T	Remove lesion, neck/chest	0022	12.49	\$605.60	\$292.94	\$121.12
21557	C	Remove tumor, neck/chest					
21600	T	Partial removal of rib	0050	21.13	\$1,024.53	\$513.86	\$204.91
21610	T	Partial removal of rib	0050	21.13	\$1,024.53	\$513.86	\$204.91
21615	C	Removal of rib					
21616	C	Removal of rib and nerves					
21620	C	Partial removal of sternum					
21627	C	Sternal debridement					
21630	C	Extensive sternum surgery					
21632	C	Extensive sternum surgery					
21700	T	Revision of neck muscle	0008	6.15	\$298.20	\$113.67	\$59.64
21705	C	Revision of neck muscle/rib					
21720	T	Revision of neck muscle	0008	6.15	\$298.20	\$113.67	\$59.64
21725	T	Revision of neck muscle	0008	6.15	\$298.20	\$113.67	\$59.64
21740	C	Reconstruction of sternum					
21750	C	Repair of sternum separation					
21800	T	Treatment of rib fracture	0043	1.64	\$79.52	\$25.46	\$15.90
21805	T	Treatment of rib fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
21810	C	Treatment of rib fracture(s)					
21820	T	Treat sternum fracture	0043	1.64	\$79.52	\$25.46	\$15.90
21825	C	Treat sternum fracture					
21899	T	Neck/chest surgery procedure	0252	5.18	\$251.16	\$114.24	\$50.23
21920	T	Biopsy soft tissue of back	0020	6.51	\$315.65	\$130.53	\$63.13
21925	T	Biopsy soft tissue of back	0022	12.49	\$605.60	\$292.94	\$121.12
21930	T	Remove lesion, back or flank	0022	12.49	\$605.60	\$292.94	\$121.12
1935	T	Remove tumor, back	0022	12.49	\$605.60	\$292.94	\$121.12
22100	C	Remove part of neck vertebra					
22101	C	Remove part, thorax vertebra					
22102	C	Remove part, lumbar vertebra					
22103	C	Remove extra spine segment					
22110	C	Remove part of neck vertebra					
22112	C	Remove part, thorax vertebra					
22114	C	Remove part, lumbar vertebra					
22116	C	Remove extra spine segment					
22210	C	Revision of neck spine					
22212	C	Revision of thorax spine					
22214	C	Revision of lumbar spine					
22216	C	Revise, extra spine segment					
22220	C	Revision of neck spine					
22222	C	Revision of thorax spine					
22224	C	Revision of lumbar spine					
22226	C	Revise, extra spine segment					
22305	T	Treat spine process fracture	0043	1.64	\$79.52	\$25.46	\$15.90
22310	T	Treat spine fracture	0043	1.64	\$79.52	\$25.46	\$15.90
22315	T	Treat spine fracture	0043	1.64	\$79.52	\$25.46	\$15.90
22318	C	Treat odontoid fx w/o graft					
22319	C	Treat odontoid fx w/graft					
22325	C	Treat spine fracture					
22326	C	Treat neck spine fracture					
22327	C	Treat thorax spine fracture					
22328	C	Treat each add spine fx					
22505	T	Manipulation of spine	0045	11.02	\$534.33	\$277.12	\$106.87
22548	C	Neck spine fusion					
22554	C	Neck spine fusion					
22556	C	Thorax spine fusion					
22558	C	Lumbar spine fusion					
22585	C	Additional spinal fusion					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
22590	C	Spine & skull spinal fusion					
22595	C	Neck spinal fusion					
22600	C	Neck spine fusion					
22610	C	Thorax spine fusion					
22612	C	Lumbar spine fusion					
22614	C	Spine fusion, extra segment					
22630	C	Lumbar spine fusion					
22632	C	Spine fusion, extra segment					
22800	C	Fusion of spine					
22802	C	Fusion of spine					
22804	C	Fusion of spine					
22808	C	Fusion of spine					
22810	C	Fusion of spine					
22812	C	Fusion of spine					
22818	C	Kyphectomy, 1–2 segments					
22819	C	Kyphectomy, 3 or more					
22830	C	Exploration of spinal fusion					
22840	C	Insert spine fixation device					
22841	C	Insert spine fixation device					
22842	C	Insert spine fixation device					
22843	C	Insert spine fixation device					
22844	C	Insert spine fixation device					
22845	C	Insert spine fixation device					
22846	C	Insert spine fixation device					
22847	C	Insert spine fixation device					
22848	C	Insert pelv fixation device					
22849	C	Reinsert spinal fixation					
22850	C	Remove spine fixation device					
22851	C	Apply spine prosth device					
22852	C	Remove spine fixation device					
22855	C	Remove spine fixation device					
22899	T	Spine surgery procedure	0043	1.64	\$79.52	\$25.46	\$15.90
22900	T	Remove abdominal wall lesion	0022	12.49	\$605.60	\$292.94	\$121.12
22999	T	Abdomen surgery procedure	0022	12.49	\$605.60	\$292.94	\$121.12
23000	T	Removal of calcium deposits	0021	10.49	\$508.63	\$236.51	\$101.73
23020	T	Release shoulder joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
23030	T	Drain shoulder lesion	0008	6.15	\$298.20	\$113.67	\$59.64
23031	T	Drain shoulder bursa	0008	6.15	\$298.20	\$113.67	\$59.64
23035	C	Drain shoulder bone lesion					
23040	T	Exploratory shoulder surgery	0050	21.13	\$1,024.53	\$513.86	\$204.91
23044	T	Exploratory shoulder surgery	0050	21.13	\$1,024.53	\$513.86	\$204.91
23065	T	Biopsy shoulder tissues	0021	10.49	\$508.63	\$236.51	\$101.73
23066	T	Biopsy shoulder tissues	0022	12.49	\$605.60	\$292.94	\$121.12
23075	T	Removal of shoulder lesion	0021	10.49	\$508.63	\$236.51	\$101.73
23076	T	Removal of shoulder lesion	0022	12.49	\$605.60	\$292.94	\$121.12
23077	T	Remove tumor of shoulder	0022	12.49	\$605.60	\$292.94	\$121.12
23100	T	Biopsy of shoulder joint	0049	15.04	\$729.25	\$356.95	\$145.85
23101	T	Shoulder joint surgery	0050	21.13	\$1,024.53	\$513.86	\$204.91
23105	T	Remove shoulder joint lining	0050	21.13	\$1,024.53	\$513.86	\$204.91
23106	T	Incision of collarbone joint	0050	21.13	\$1,024.53	\$513.86	\$204.91
23107	T	Explore treat shoulder joint	0050	21.13	\$1,024.53	\$513.86	\$204.91
23120	T	Partial removal, collar bone	0051	27.76	\$1,346.00	\$675.24	\$269.20
23125	C	Removal of collar bone					
23130	T	Remove shoulder bone, part	0051	27.76	\$1,346.00	\$675.24	\$269.20
23140	T	Removal of bone lesion	0049	15.04	\$729.25	\$356.95	\$145.85
23145	T	Removal of bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
23146	T	Removal of bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
23150	T	Removal of humerus lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
23155	T	Removal of humerus lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
23156	T	Removal of humerus lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
23170	T	Remove collar bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
23172	T	Remove shoulder blade lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
23174	T	Remove humerus lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
23180	T	Remove collar bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
23182	T	Remove shoulder blade lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
23184	T	Remove humerus lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
23190	T	Partial removal of scapula	0050	21.13	\$1,024.53	\$513.86	\$204.91
23195	C	Removal of head of humerus					
23200	C	Removal of collar bone					
23210	C	Removal of shoulder blade					
23220	C	Partial removal of humerus					
23221	C	Partial removal of humerus					
23222	C	Partial removal of humerus					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
23330	T	Remove shoulder foreign body	0019	4.00	\$193.95	\$78.91	\$38.79
23331	T	Remove shoulder foreign body	0022	12.49	\$605.60	\$292.94	\$121.12
23332	C	Remove shoulder foreign body					
23350	N	Injection for shoulder x-ray					
23395	C	Muscle transfer, shoulder/arm					
23397	C	Muscle transfers					
23400	C	Fixation of shoulder blade					
23405	T	Incision of tendon & muscle	0050	21.13	\$1,024.53	\$513.86	\$204.91
23406	T	Incise tendon(s) & muscle(s)	0050	21.13	\$1,024.53	\$513.86	\$204.91
23410	T	Repair of tendon(s)	0052	36.16	\$1,753.29	\$930.91	\$350.66
23412	T	Repair of tendon(s)	0052	36.16	\$1,753.29	\$930.91	\$350.66
23415	T	Release of shoulder ligament	0051	27.76	\$1,346.00	\$675.24	\$269.20
23420	T	Repair of shoulder	0052	36.16	\$1,753.29	\$930.91	\$350.66
23430	T	Repair biceps tendon	0052	36.16	\$1,753.29	\$930.91	\$350.66
23440	C	Remove/transplant tendon					
23450	T	Repair shoulder capsule	0052	36.16	\$1,753.29	\$930.91	\$350.66
23455	T	Repair shoulder capsule	0052	36.16	\$1,753.29	\$930.91	\$350.66
23460	T	Repair shoulder capsule	0052	36.16	\$1,753.29	\$930.91	\$350.66
23462	T	Repair shoulder capsule	0052	36.16	\$1,753.29	\$930.91	\$350.66
23465	T	Repair shoulder capsule	0052	36.16	\$1,753.29	\$930.91	\$350.66
23466	T	Repair shoulder capsule	0052	36.16	\$1,753.29	\$930.91	\$350.66
23470	C	Reconstruct shoulder joint					
23472	C	Reconstruct shoulder joint					
23480	T	Revision of collar bone	0051	27.76	\$1,346.00	\$675.24	\$269.20
23485	T	Revision of collar bone	0051	27.76	\$1,346.00	\$675.24	\$269.20
23490	T	Reinforce clavicle	0051	27.76	\$1,346.00	\$675.24	\$269.20
23491	T	Reinforce shoulder bones	0051	27.76	\$1,346.00	\$675.24	\$269.20
23500	T	Treat clavicle fracture	0043	1.64	\$79.52	\$25.46	\$15.90
23505	T	Treat clavicle fracture	0043	1.64	\$79.52	\$25.46	\$15.90
23515	T	Treat clavicle fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
23520	T	Treat clavicle dislocation	0043	1.64	\$79.52	\$25.46	\$15.90
23525	T	Treat clavicle dislocation	0043	1.64	\$79.52	\$25.46	\$15.90
23530	T	Treat clavicle dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
23532	T	Treat clavicle dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
23540	T	Treat clavicle dislocation	0043	1.64	\$79.52	\$25.46	\$15.90
23545	T	Treat clavicle dislocation	0043	1.64	\$79.52	\$25.46	\$15.90
23550	T	Treat clavicle dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
23552	T	Treat clavicle dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
23570	T	Treat shoulder blade fx	0043	1.64	\$79.52	\$25.46	\$15.90
23575	T	Treat shoulder blade fx	0043	1.64	\$79.52	\$25.46	\$15.90
23585	T	Treat scapula fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
23600	T	Treat humerus fracture	0044	2.17	\$105.22	\$38.08	\$21.04
23605	T	Treat humerus fracture	0044	2.17	\$105.22	\$38.08	\$21.04
23615	T	Treat humerus fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
23616	T	Treat humerus fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
23620	T	Treat humerus fracture	0044	2.17	\$105.22	\$38.08	\$21.04
23625	T	Treat humerus fracture	0044	2.17	\$105.22	\$38.08	\$21.04
23630	T	Treat humerus fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
23650	T	Treat shoulder dislocation	0043	1.64	\$79.52	\$25.46	\$15.90
23655	T	Treat shoulder dislocation	0045	11.02	\$534.33	\$277.12	\$106.87
23660	T	Treat shoulder dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
23665	T	Treat dislocation/fracture	0044	2.17	\$105.22	\$38.08	\$21.04
23670	T	Treat dislocation/fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
23675	T	Treat dislocation/fracture	0044	2.17	\$105.22	\$38.08	\$21.04
23680	T	Treat dislocation/fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
23700	T	Fixation of shoulder	0045	11.02	\$534.33	\$277.12	\$106.87
23800	T	Fusion of shoulder joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
23802	T	Fusion of shoulder joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
23900	C	Amputation of arm & girdle					
23920	C	Amputation at shoulder joint					
23921	T	Amputation follow-up surgery	0026	12.11	\$587.18	\$277.92	\$117.44
23929	T	Shoulder surgery procedure	0043	1.64	\$79.52	\$25.46	\$15.90
23930	T	Drainage of arm lesion	0008	6.15	\$298.20	\$113.67	\$59.64
23931	T	Drainage of arm bursa	0008	6.15	\$298.20	\$113.67	\$59.64
23935	T	Drain arm/elbow bone lesion	0049	15.04	\$729.25	\$356.95	\$145.85
24000	T	Exploratory elbow surgery	0050	21.13	\$1,024.53	\$513.86	\$204.91
24006	T	Release elbow joint	0050	21.13	\$1,024.53	\$513.86	\$204.91
24065	T	Biopsy arm/elbow soft tissue	0020	6.51	\$315.65	\$130.53	\$63.13
24066	T	Biopsy arm/elbow soft tissue	0020	6.51	\$315.65	\$130.53	\$63.13
24075	T	Remove arm/elbow lesion	0021	10.49	\$508.63	\$236.51	\$101.73
24076	T	Remove arm/elbow lesion	0022	12.49	\$605.60	\$292.94	\$121.12
24077	T	Remove tumor of arm/elbow	0022	12.49	\$605.60	\$292.94	\$121.12
24100	T	Biopsy elbow joint lining	0049	15.04	\$729.25	\$356.95	\$145.85

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³ Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
24101	T	Explore/treat elbow joint	0050	21.13	\$1,024.53	\$513.86	\$204.91
24102	T	Remove elbow joint lining	0050	21.13	\$1,024.53	\$513.86	\$204.91
24105	T	Removal of elbow bursa	0049	15.04	\$729.25	\$356.95	\$145.85
24110	T	Remove humerus lesion	0049	15.04	\$729.25	\$356.95	\$145.85
24115	T	Remove/graft bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
24116	T	Remove/graft bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
24120	T	Remove elbow lesion	0049	15.04	\$729.25	\$356.95	\$145.85
24125	T	Remove/graft bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
24126	T	Remove/graft bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
24130	T	Removal of head of radius	0050	21.13	\$1,024.53	\$513.86	\$204.91
24134	T	Removal of arm bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
24136	T	Remove radius bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
24138	T	Remove elbow bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
24140	T	Partial removal of arm bone	0050	21.13	\$1,024.53	\$513.86	\$204.91
24145	T	Partial removal of radius	0050	21.13	\$1,024.53	\$513.86	\$204.91
24147	T	Partial removal of elbow	0050	21.13	\$1,024.53	\$513.86	\$204.91
24149	C	Radical resection of elbow					
24150	C	Extensive humerus surgery					
24151	C	Extensive humerus surgery					
24152	C	Extensive radius surgery					
24153	C	Extensive radius surgery					
24155	T	Removal of elbow joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
24160	T	Remove elbow joint implant	0050	21.13	\$1,024.53	\$513.86	\$204.91
24164	T	Remove radius head implant	0050	21.13	\$1,024.53	\$513.86	\$204.91
24200	T	Removal of arm foreign body	0019	4.00	\$193.95	\$78.91	\$38.79
24201	T	Removal of arm foreign body	0021	10.49	\$508.63	\$236.51	\$101.73
24220	N	Injection for elbow x-ray					
24301	T	Muscle/tendon transfer	0050	21.13	\$1,024.53	\$513.86	\$204.91
24305	T	Arm tendon lengthening	0050	21.13	\$1,024.53	\$513.86	\$204.91
24310	T	Revision of arm tendon	0049	15.04	\$729.25	\$356.95	\$145.85
24320	T	Repair of arm tendon	0051	27.76	\$1,346.00	\$675.24	\$269.20
24330	T	Revision of arm muscles	0051	27.76	\$1,346.00	\$675.24	\$269.20
24331	T	Revision of arm muscles	0051	27.76	\$1,346.00	\$675.24	\$269.20
24340	T	Repair of biceps tendon	0051	27.76	\$1,346.00	\$675.24	\$269.20
24341	T	Repair arm tendon/muscle	0051	27.76	\$1,346.00	\$675.24	\$269.20
24342	T	Repair of ruptured tendon	0051	27.76	\$1,346.00	\$675.24	\$269.20
24350	T	Repair of tennis elbow	0050	21.13	\$1,024.53	\$513.86	\$204.91
24351	T	Repair of tennis elbow	0050	21.13	\$1,024.53	\$513.86	\$204.91
24352	T	Repair of tennis elbow	0050	21.13	\$1,024.53	\$513.86	\$204.91
24354	T	Repair of tennis elbow	0050	21.13	\$1,024.53	\$513.86	\$204.91
24356	T	Revision of tennis elbow	0050	21.13	\$1,024.53	\$513.86	\$204.91
24360	T	Reconstruct elbow joint	0047	22.09	\$1,071.08	\$537.03	\$214.22
24361	T	Reconstruct elbow joint	0048	29.06	\$1,409.03	\$725.94	\$281.81
24362	T	Reconstruct elbow joint	0048	29.06	\$1,409.03	\$725.94	\$281.81
24363	T	Replace elbow joint	0048	29.06	\$1,409.03	\$725.94	\$281.81
24365	T	Reconstruct head of radius	0047	22.09	\$1,071.08	\$537.03	\$214.22
24366	T	Reconstruct head of radius	0048	29.06	\$1,409.03	\$725.94	\$281.81
24400	T	Revision of humerus	0050	21.13	\$1,024.53	\$513.86	\$204.91
24410	T	Revision of humerus	0050	21.13	\$1,024.53	\$513.86	\$204.91
24420	T	Revision of humerus	0051	27.76	\$1,346.00	\$675.24	\$269.20
24430	T	Repair of humerus	0051	27.76	\$1,346.00	\$675.24	\$269.20
24435	T	Repair humerus with graft	0051	27.76	\$1,346.00	\$675.24	\$269.20
24470	T	Revision of elbow joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
24495	T	Decompression of forearm	0050	21.13	\$1,024.53	\$513.86	\$204.91
24498	T	Reinforce humerus	0051	27.76	\$1,346.00	\$675.24	\$269.20
24500	T	Treat humerus fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24505	T	Treat humerus fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24515	T	Treat humerus fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24516	T	Treat humerus fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24530	T	Treat humerus fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24535	T	Treat humerus fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24538	T	Treat humerus fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24545	T	Treat humerus fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24546	T	Treat humerus fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24560	T	Treat humerus fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24565	T	Treat humerus fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24566	T	Treat humerus fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24575	T	Treat humerus fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24576	T	Treat humerus fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24577	T	Treat humerus fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24579	T	Treat humerus fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24582	T	Treat humerus fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24586	T	Treat elbow fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
24587	T	Treat elbow fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24600	T	Treat elbow dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
24605	T	Treat elbow dislocation	0045	11.02	\$534.33	\$277.12	\$106.87
24615	T	Treat elbow dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
24620	T	Treat elbow fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24635	T	Treat elbow fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24640	T	Treat elbow dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
24650	T	Treat radius fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24655	T	Treat radius fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24665	T	Treat radius fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24666	T	Treat radius fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24670	T	Treat ulnar fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24675	T	Treat ulnar fracture	0044	2.17	\$105.22	\$38.08	\$21.04
24685	T	Treat ulnar fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
24800	T	Fusion of elbow joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
24802	T	Fusion/graft of elbow joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
24900	C	Amputation of upper arm					
24920	C	Amputation of upper arm					
24925	T	Amputation follow-up surgery	0049	15.04	\$729.25	\$356.95	\$145.85
24930	C	Amputation follow-up surgery					
24931	C	Amputate upper arm & implant					
24935	T	Revision of amputation	0052	36.16	\$1,753.29	\$930.91	\$350.66
24940	C	Revision of upper arm					
24999	T	Upper arm/elbow surgery	0044	2.17	\$105.22	\$38.08	\$21.04
25000	T	Incision of tendon sheath	0049	15.04	\$729.25	\$356.95	\$145.85
25020	T	Decompression of forearm	0049	15.04	\$729.25	\$356.95	\$145.85
25023	T	Decompression of forearm	0050	21.13	\$1,024.53	\$513.86	\$204.91
25028	T	Drainage of forearm lesion	0049	15.04	\$729.25	\$356.95	\$145.85
25031	T	Drainage of forearm bursa	0049	15.04	\$729.25	\$356.95	\$145.85
25035	T	Treat forearm bone lesion	0049	15.04	\$729.25	\$356.95	\$145.85
25040	T	Explore/treat wrist joint	0050	21.13	\$1,024.53	\$513.86	\$204.91
25065	T	Biopsy forearm soft tissues	0020	6.51	\$315.65	\$130.53	\$63.13
25066	T	Biopsy forearm soft tissues	0022	12.49	\$605.60	\$292.94	\$121.12
25075	T	Removal of forearm lesion	0020	6.51	\$315.65	\$130.53	\$63.13
25076	T	Removal of forearm lesion	0022	12.49	\$605.60	\$292.94	\$121.12
25077	T	Remove tumor, forearm/wrist	0022	12.49	\$605.60	\$292.94	\$121.12
25085	T	Incision of wrist capsule	0049	15.04	\$729.25	\$356.95	\$145.85
25100	T	Biopsy of wrist joint	0049	15.04	\$729.25	\$356.95	\$145.85
25101	T	Explore/treat wrist joint	0050	21.13	\$1,024.53	\$513.86	\$204.91
25105	T	Remove wrist joint lining	0050	21.13	\$1,024.53	\$513.86	\$204.91
25107	T	Remove wrist joint cartilage	0050	21.13	\$1,024.53	\$513.86	\$204.91
25110	T	Remove wrist tendon lesion	0049	15.04	\$729.25	\$356.95	\$145.85
25111	T	Remove wrist tendon lesion	0053	11.32	\$548.87	\$253.49	\$109.77
25112	T	Reremove wrist tendon lesion	0053	11.32	\$548.87	\$253.49	\$109.77
25115	T	Remove wrist/forearm lesion	0049	15.04	\$729.25	\$356.95	\$145.85
25116	T	Remove wrist/forearm lesion	0049	15.04	\$729.25	\$356.95	\$145.85
25118	T	Excise wrist tendon sheath	0050	21.13	\$1,024.53	\$513.86	\$204.91
25119	T	Partial removal of ulna	0050	21.13	\$1,024.53	\$513.86	\$204.91
25120	T	Removal of forearm lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
25125	T	Remove/graft forearm lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
25126	T	Remove/graft forearm lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
25130	T	Removal of wrist lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
25135	T	Remove & graft wrist lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
25136	T	Remove & graft wrist lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
25145	T	Remove forearm bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
25150	T	Partial removal of ulna	0050	21.13	\$1,024.53	\$513.86	\$204.91
25151	T	Partial removal of radius	0050	21.13	\$1,024.53	\$513.86	\$204.91
25170	C	Extensive forearm surgery					
25210	T	Removal of wrist bone	0054	19.66	\$953.26	\$472.33	\$190.65
25215	T	Removal of wrist bones	0054	19.66	\$953.26	\$472.33	\$190.65
25230	T	Partial removal of radius	0050	21.13	\$1,024.53	\$513.86	\$204.91
25240	T	Partial removal of ulna	0050	21.13	\$1,024.53	\$513.86	\$204.91
25246	N	Injection for wrist x-ray					
25248	T	Remove forearm foreign body	0049	15.04	\$729.25	\$356.95	\$145.85
25250	T	Removal of wrist prosthesis	0050	21.13	\$1,024.53	\$513.86	\$204.91
25251	T	Removal of wrist prosthesis	0050	21.13	\$1,024.53	\$513.86	\$204.91
25260	T	Repair forearm tendon/muscle	0050	21.13	\$1,024.53	\$513.86	\$204.91
25263	T	Repair forearm tendon/muscle	0050	21.13	\$1,024.53	\$513.86	\$204.91
25265	T	Repair forearm tendon/muscle	0050	21.13	\$1,024.53	\$513.86	\$204.91
25270	T	Repair forearm tendon/muscle	0050	21.13	\$1,024.53	\$513.86	\$204.91
25272	T	Repair forearm tendon/muscle	0050	21.13	\$1,024.53	\$513.86	\$204.91
25274	T	Repair forearm tendon/muscle	0050	21.13	\$1,024.53	\$513.86	\$204.91
25280	T	Revise wrist/forearm tendon	0050	21.13	\$1,024.53	\$513.86	\$204.91

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
25290	T	Incise wrist/forearm tendon	0050	21.13	\$1,024.53	\$513.86	\$204.91
25295	T	Release wrist/forearm tendon	0049	15.04	\$729.25	\$356.95	\$145.85
25300	T	Fusion of tendons at wrist	0050	21.13	\$1,024.53	\$513.86	\$204.91
25301	T	Fusion of tendons at wrist	0050	21.13	\$1,024.53	\$513.86	\$204.91
25310	T	Transplant forearm tendon	0051	27.76	\$1,346.00	\$675.24	\$269.20
25312	T	Transplant forearm tendon	0051	27.76	\$1,346.00	\$675.24	\$269.20
25315	T	Revise palsy hand tendon(s)	0051	27.76	\$1,346.00	\$675.24	\$269.20
25316	T	Revise palsy hand tendon(s)	0051	27.76	\$1,346.00	\$675.24	\$269.20
25320	T	Repair/revise wrist joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
25332	T	Revise wrist joint	0047	22.09	\$1,071.08	\$537.03	\$214.22
25335	T	Realignment of hand	0051	27.76	\$1,346.00	\$675.24	\$269.20
25337	T	Reconstruct ulna/radioulnar	0051	27.76	\$1,346.00	\$675.24	\$269.20
25350	T	Revision of radius	0051	27.76	\$1,346.00	\$675.24	\$269.20
25355	T	Revision of radius	0051	27.76	\$1,346.00	\$675.24	\$269.20
25360	T	Revision of ulna	0050	21.13	\$1,024.53	\$513.86	\$204.91
25365	T	Revise radius & ulna	0050	21.13	\$1,024.53	\$513.86	\$204.91
25370	T	Revise radius or ulna	0051	27.76	\$1,346.00	\$675.24	\$269.20
25375	T	Revise radius & ulna	0051	27.76	\$1,346.00	\$675.24	\$269.20
25390	C	Shorten radius or ulna					
25391	C	Lengthen radius or ulna					
25392	C	Shorten radius & ulna					
25393	C	Lengthen radius & ulna					
25400	T	Repair radius or ulna	0050	21.13	\$1,024.53	\$513.86	\$204.91
25405	C	Repair/graft radius or ulna					
25415	T	Repair radius & ulna	0050	21.13	\$1,024.53	\$513.86	\$204.91
25420	C	Repair/graft radius & ulna					
25425	T	Repair/graft radius or ulna	0051	27.76	\$1,346.00	\$675.24	\$269.20
25426	T	Repair/graft radius & ulna	0051	27.76	\$1,346.00	\$675.24	\$269.20
25440	T	Repair/graft wrist bone	0051	27.76	\$1,346.00	\$675.24	\$269.20
25441	T	Reconstruct wrist joint	0048	29.06	\$1,409.03	\$725.94	\$281.81
25442	T	Reconstruct wrist joint	0048	29.06	\$1,409.03	\$725.94	\$281.81
25443	T	Reconstruct wrist joint	0048	29.06	\$1,409.03	\$725.94	\$281.81
25444	T	Reconstruct wrist joint	0048	29.06	\$1,409.03	\$725.94	\$281.81
25445	T	Reconstruct wrist joint	0048	29.06	\$1,409.03	\$725.94	\$281.81
25446	T	Wrist replacement	0048	29.06	\$1,409.03	\$725.94	\$281.81
25447	T	Repair wrist joint(s)	0047	22.09	\$1,071.08	\$537.03	\$214.22
25449	T	Remove wrist joint implant	0047	22.09	\$1,071.08	\$537.03	\$214.22
25450	T	Revision of wrist joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
25455	T	Revision of wrist joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
25490	T	Reinforce radius	0051	27.76	\$1,346.00	\$675.24	\$269.20
25491	T	Reinforce ulna	0051	27.76	\$1,346.00	\$675.24	\$269.20
25492	T	Reinforce radius and ulna	0051	27.76	\$1,346.00	\$675.24	\$269.20
25500	T	Treat fracture of radius	0044	2.17	\$105.22	\$38.08	\$21.04
25505	T	Treat fracture of radius	0044	2.17	\$105.22	\$38.08	\$21.04
25515	T	Treat fracture of radius	0046	22.29	\$1,080.78	\$535.76	\$216.16
25520	T	Treat fracture of radius	0044	2.17	\$105.22	\$38.08	\$21.04
25525	T	Treat fracture of radius	0046	22.29	\$1,080.78	\$535.76	\$216.16
25526	T	Treat fracture of radius	0046	22.29	\$1,080.78	\$535.76	\$216.16
25530	T	Treat fracture of ulna	0044	2.17	\$105.22	\$38.08	\$21.04
25535	T	Treat fracture of ulna	0044	2.17	\$105.22	\$38.08	\$21.04
25545	T	Treat fracture of ulna	0046	22.29	\$1,080.78	\$535.76	\$216.16
25560	T	Treat fracture radius & ulna	0044	2.17	\$105.22	\$38.08	\$21.04
25565	T	Treat fracture radius & ulna	0044	2.17	\$105.22	\$38.08	\$21.04
25574	T	Treat fracture radius & ulna	0046	22.29	\$1,080.78	\$535.76	\$216.16
25575	T	Treat fracture radius/ulna	0046	22.29	\$1,080.78	\$535.76	\$216.16
25600	T	Treat fracture radius/ulna	0044	2.17	\$105.22	\$38.08	\$21.04
25605	T	Treat fracture radius/ulna	0044	2.17	\$105.22	\$38.08	\$21.04
25611	T	Treat fracture radius/ulna	0046	22.29	\$1,080.78	\$535.76	\$216.16
25620	T	Treat fracture radius/ulna	0046	22.29	\$1,080.78	\$535.76	\$216.16
25622	T	Treat wrist bone fracture	0044	2.17	\$105.22	\$38.08	\$21.04
25624	T	Treat wrist bone fracture	0044	2.17	\$105.22	\$38.08	\$21.04
25628	T	Treat wrist bone fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
25630	T	Treat wrist bone fracture	0044	2.17	\$105.22	\$38.08	\$21.04
25635	T	Treat wrist bone fracture	0044	2.17	\$105.22	\$38.08	\$21.04
25645	T	Treat wrist bone fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
25650	T	Treat wrist bone fracture	0044	2.17	\$105.22	\$38.08	\$21.04
25660	T	Treat wrist dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
25670	T	Treat wrist dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
25675	T	Treat wrist dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
25676	T	Treat wrist dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
25680	T	Treat wrist fracture	0044	2.17	\$105.22	\$38.08	\$21.04
25685	T	Treat wrist fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
25690	T	Treat wrist dislocation	0044	2.17	\$105.22	\$38.08	\$21.04

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² Not subject to national coinsurance.

³ Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
25695	T	Treat wrist dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
25800	T	Fusion of wrist joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
25805	T	Fusion/graft of wrist joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
25810	T	Fusion/graft of wrist joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
25820	T	Fusion of hand bones	0053	11.32	\$548.87	\$253.49	\$109.77
25825	T	Fuse hand bones with graft	0054	19.66	\$953.26	\$472.33	\$190.65
25830	T	Fusion, radioulnar jnt/ulna	0051	27.76	\$1,346.00	\$675.24	\$269.20
25900	C	Amputation of forearm					
25905	C	Amputation of forearm					
25907	T	Amputation follow-up surgery	0049	15.04	\$729.25	\$356.95	\$145.85
25909	C	Amputation follow-up surgery					
25915	C	Amputation of forearm					
25920	C	Amputate hand at wrist					
25922	T	Amputate hand at wrist	0049	15.04	\$729.25	\$356.95	\$145.85
25924	C	Amputation follow-up surgery					
25927	C	Amputation of hand					
25929	T	Amputation follow-up surgery	0026	12.11	\$587.18	\$277.92	\$117.44
25931	C	Amputation follow-up surgery					
25999	T	Forearm or wrist surgery	0044	2.17	\$105.22	\$38.08	\$21.04
26010	T	Drainage of finger abscess	0006	2.00	\$96.97	\$33.95	\$19.39
26011	T	Drainage of finger abscess	0007	3.68	\$178.43	\$72.03	\$35.69
26020	T	Drain hand tendon sheath	0053	11.32	\$548.87	\$253.49	\$109.77
26025	T	Drainage of palm bursa	0053	11.32	\$548.87	\$253.49	\$109.77
26030	T	Drainage of palm bursa(s)	0053	11.32	\$548.87	\$253.49	\$109.77
26034	T	Treat hand bone lesion	0053	11.32	\$548.87	\$253.49	\$109.77
26035	T	Decompress fingers/hand	0053	11.32	\$548.87	\$253.49	\$109.77
26037	T	Decompress fingers/hand	0053	11.32	\$548.87	\$253.49	\$109.77
26040	T	Release palm contracture	0054	19.66	\$953.26	\$472.33	\$190.65
26045	T	Release palm contracture	0054	19.66	\$953.26	\$472.33	\$190.65
26055	T	Incise finger tendon sheath	0053	11.32	\$548.87	\$253.49	\$109.77
26060	T	Incision of finger tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26070	T	Explore/treat hand joint	0053	11.32	\$548.87	\$253.49	\$109.77
26075	T	Explore/treat finger joint	0053	11.32	\$548.87	\$253.49	\$109.77
26080	T	Explore/treat finger joint	0053	11.32	\$548.87	\$253.49	\$109.77
26100	T	Biopsy hand joint lining	0053	11.32	\$548.87	\$253.49	\$109.77
26105	T	Biopsy finger joint lining	0053	11.32	\$548.87	\$253.49	\$109.77
26110	T	Biopsy finger joint lining	0053	11.32	\$548.87	\$253.49	\$109.77
26115	T	Removal of hand lesion	0022	12.49	\$605.60	\$292.94	\$121.12
26116	T	Removal of hand lesion	0022	12.49	\$605.60	\$292.94	\$121.12
26117	T	Remove tumor, hand/finger	0022	12.49	\$605.60	\$292.94	\$121.12
26121	T	Release palm contracture	0054	19.66	\$953.26	\$472.33	\$190.65
26123	T	Release palm contracture	0054	19.66	\$953.26	\$472.33	\$190.65
26125	T	Release palm contracture	0054	19.66	\$953.26	\$472.33	\$190.65
26130	T	Remove wrist joint lining	0053	11.32	\$548.87	\$253.49	\$109.77
26135	T	Revise finger joint, each	0054	19.66	\$953.26	\$472.33	\$190.65
26140	T	Revise finger joint, each	0053	11.32	\$548.87	\$253.49	\$109.77
26145	T	Tendon excision, palm/finger	0053	11.32	\$548.87	\$253.49	\$109.77
26160	T	Remove tendon sheath lesion	0053	11.32	\$548.87	\$253.49	\$109.77
26170	T	Removal of palm tendon, each	0053	11.32	\$548.87	\$253.49	\$109.77
26180	T	Removal of finger tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26185	T	Remove finger bone	0053	11.32	\$548.87	\$253.49	\$109.77
26200	T	Remove hand bone lesion	0053	11.32	\$548.87	\$253.49	\$109.77
26205	T	Remove/graft bone lesion	0054	19.66	\$953.26	\$472.33	\$190.65
26210	T	Removal of finger lesion	0053	11.32	\$548.87	\$253.49	\$109.77
26215	T	Remove/graft finger lesion	0053	11.32	\$548.87	\$253.49	\$109.77
26230	T	Partial removal of hand bone	0053	11.32	\$548.87	\$253.49	\$109.77
26235	T	Partial removal, finger bone	0053	11.32	\$548.87	\$253.49	\$109.77
26236	T	Partial removal, finger bone	0053	11.32	\$548.87	\$253.49	\$109.77
26250	T	Extensive hand surgery	0053	11.32	\$548.87	\$253.49	\$109.77
26255	T	Extensive hand surgery	0054	19.66	\$953.26	\$472.33	\$190.65
26260	T	Extensive finger surgery	0053	11.32	\$548.87	\$253.49	\$109.77
26261	T	Extensive finger surgery	0053	11.32	\$548.87	\$253.49	\$109.77
26262	T	Partial removal of finger	0053	11.32	\$548.87	\$253.49	\$109.77
26320	T	Removal of implant from hand	0020	6.51	\$315.65	\$130.53	\$63.13
26350	T	Repair finger/hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26352	T	Repair/graft hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26356	T	Repair finger/hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26357	T	Repair finger/hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26358	T	Repair/graft hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26370	T	Repair finger/hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26372	T	Repair/graft hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26373	T	Repair finger/hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26390	T	Revise hand/finger tendon	0054	19.66	\$953.26	\$472.33	\$190.65

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
26392	T	Repair/graft hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26410	T	Repair hand tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26412	T	Repair/graft hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26415	T	Excision, hand/finger tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26416	T	Graft hand or finger tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26418	T	Repair finger tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26420	T	Repair/graft finger tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26426	T	Repair finger/hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26428	T	Repair/graft finger tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26432	T	Repair finger tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26433	T	Repair finger tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26434	T	Repair/graft finger tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26437	T	Realignment of tendons	0053	11.32	\$548.87	\$253.49	\$109.77
26440	T	Release palm/finger tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26442	T	Release palm & finger tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26445	T	Release hand/finger tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26449	T	Release forearm/hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26450	T	Incision of palm tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26455	T	Incision of finger tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26460	T	Incise hand/finger tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26471	T	Fusion of finger tendons	0053	11.32	\$548.87	\$253.49	\$109.77
26474	T	Fusion of finger tendons	0053	11.32	\$548.87	\$253.49	\$109.77
26476	T	Tendon lengthening	0053	11.32	\$548.87	\$253.49	\$109.77
26477	T	Tendon shortening	0053	11.32	\$548.87	\$253.49	\$109.77
26478	T	Lengthening of hand tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26479	T	Shortening of hand tendon	0053	11.32	\$548.87	\$253.49	\$109.77
26480	T	Transplant hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26483	T	Transplant/graft hand tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26485	T	Transplant palm tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26489	T	Transplant/graft palm tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26490	T	Revise thumb tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26492	T	Tendon transfer with graft	0054	19.66	\$953.26	\$472.33	\$190.65
26494	T	Hand tendon/muscle transfer	0054	19.66	\$953.26	\$472.33	\$190.65
26496	T	Revise thumb tendon	0054	19.66	\$953.26	\$472.33	\$190.65
26497	T	Finger tendon transfer	0054	19.66	\$953.26	\$472.33	\$190.65
26498	T	Finger tendon transfer	0054	19.66	\$953.26	\$472.33	\$190.65
26499	T	Revision of finger	0054	19.66	\$953.26	\$472.33	\$190.65
26500	T	Hand tendon reconstruction	0053	11.32	\$548.87	\$253.49	\$109.77
26502	T	Hand tendon reconstruction	0054	19.66	\$953.26	\$472.33	\$190.65
26504	T	Hand tendon reconstruction	0054	19.66	\$953.26	\$472.33	\$190.65
26508	T	Release thumb contracture	0053	11.32	\$548.87	\$253.49	\$109.77
26510	T	Thumb tendon transfer	0054	19.66	\$953.26	\$472.33	\$190.65
26516	T	Fusion of knuckle joint	0054	19.66	\$953.26	\$472.33	\$190.65
26517	T	Fusion of knuckle joints	0054	19.66	\$953.26	\$472.33	\$190.65
26518	T	Fusion of knuckle joints	0054	19.66	\$953.26	\$472.33	\$190.65
26520	T	Release knuckle contracture	0053	11.32	\$548.87	\$253.49	\$109.77
26525	T	Release finger contracture	0053	11.32	\$548.87	\$253.49	\$109.77
26530	T	Revise knuckle joint	0047	22.09	\$1,071.08	\$537.03	\$214.22
26531	T	Revise knuckle with implant	0048	29.06	\$1,409.03	\$725.94	\$281.81
26535	T	Revise finger joint	0047	22.09	\$1,071.08	\$537.03	\$214.22
26536	T	Revise/implant finger joint	0048	29.06	\$1,409.03	\$725.94	\$281.81
26540	T	Repair hand joint	0053	11.32	\$548.87	\$253.49	\$109.77
26541	T	Repair hand joint with graft	0054	19.66	\$953.26	\$472.33	\$190.65
26542	T	Repair hand joint with graft	0053	11.32	\$548.87	\$253.49	\$109.77
26545	T	Reconstruct finger joint	0054	19.66	\$953.26	\$472.33	\$190.65
26546	T	Repair nonunion hand	0054	19.66	\$953.26	\$472.33	\$190.65
26548	T	Reconstruct finger joint	0054	19.66	\$953.26	\$472.33	\$190.65
26550	T	Construct thumb replacement	0054	19.66	\$953.26	\$472.33	\$190.65
26551	C	Great toe-hand transfer .....	.....	.....	.....	.....	.....
26553	C	Single transfer, toe-hand .....	.....	.....	.....	.....	.....
26554	C	Double transfer, toe-hand .....	.....	.....	.....	.....	.....
26555	T	Positional change of finger	0054	19.66	\$953.26	\$472.33	\$190.65
26556	C	Toe joint transfer .....	.....	.....	.....	.....	.....
26560	T	Repair of web finger	0053	11.32	\$548.87	\$253.49	\$109.77
26561	T	Repair of web finger	0054	19.66	\$953.26	\$472.33	\$190.65
26562	T	Repair of web finger	0054	19.66	\$953.26	\$472.33	\$190.65
26565	T	Correct metacarpal flaw	0054	19.66	\$953.26	\$472.33	\$190.65
26567	T	Correct finger deformity	0054	19.66	\$953.26	\$472.33	\$190.65
26568	T	Lengthen metacarpal/finger	0054	19.66	\$953.26	\$472.33	\$190.65
26580	T	Repair hand deformity	0054	19.66	\$953.26	\$472.33	\$190.65
26585	T	Repair finger deformity	0054	19.66	\$953.26	\$472.33	\$190.65
26587	T	Reconstruct extra finger	0053	11.32	\$548.87	\$253.49	\$109.77
26590	T	Repair finger deformity	0054	19.66	\$953.26	\$472.33	\$190.65

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
26591	T	Repair muscles of hand	0054	19.66	\$953.26	\$472.33	\$190.65
26593	T	Release muscles of hand	0053	11.32	\$548.87	\$253.49	\$109.77
26596	T	Excision constricting tissue	0054	19.66	\$953.26	\$472.33	\$190.65
26597	T	Release of scar contracture	0054	19.66	\$953.26	\$472.33	\$190.65
26600	T	Treat metacarpal fracture	0044	2.17	\$105.22	\$38.08	\$21.04
26605	T	Treat metacarpal fracture	0044	2.17	\$105.22	\$38.08	\$21.04
26607	T	Treat metacarpal fracture	0044	2.17	\$105.22	\$38.08	\$21.04
26608	T	Treat metacarpal fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
26615	T	Treat metacarpal fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
26641	T	Treat thumb dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
26645	T	Treat thumb fracture	0044	2.17	\$105.22	\$38.08	\$21.04
26650	T	Treat thumb fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
26665	T	Treat thumb fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
26670	T	Treat hand dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
26675	T	Treat hand dislocation	0045	11.02	\$534.33	\$277.12	\$106.87
26676	T	Pin hand dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
26685	T	Treat hand dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
26686	T	Treat hand dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
26700	T	Treat knuckle dislocation	0043	1.64	\$79.52	\$25.46	\$15.90
26705	T	Treat knuckle dislocation	0045	11.02	\$534.33	\$277.12	\$106.87
26706	T	Pin knuckle dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
26715	T	Treat knuckle dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
26720	T	Treat finger fracture, each	0043	1.64	\$79.52	\$25.46	\$15.90
26725	T	Treat finger fracture, each	0043	1.64	\$79.52	\$25.46	\$15.90
26727	T	Treat finger fracture, each	0046	22.29	\$1,080.78	\$535.76	\$216.16
26735	T	Treat finger fracture, each	0046	22.29	\$1,080.78	\$535.76	\$216.16
26740	T	Treat finger fracture, each	0043	1.64	\$79.52	\$25.46	\$15.90
26742	T	Treat finger fracture, each	0044	2.17	\$105.22	\$38.08	\$21.04
26746	T	Treat finger fracture, each	0046	22.29	\$1,080.78	\$535.76	\$216.16
26750	T	Treat finger fracture, each	0043	1.64	\$79.52	\$25.46	\$15.90
26755	T	Treat finger fracture, each	0043	1.64	\$79.52	\$25.46	\$15.90
26756	T	Pin finger fracture, each	0046	22.29	\$1,080.78	\$535.76	\$216.16
26765	T	Treat finger fracture, each	0046	22.29	\$1,080.78	\$535.76	\$216.16
26770	T	Treat finger dislocation	0043	1.64	\$79.52	\$25.46	\$15.90
26775	T	Treat finger dislocation	0045	11.02	\$534.33	\$277.12	\$106.87
26776	T	Pin finger dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
26785	T	Treat finger dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
26820	T	Thumb fusion with graft	0054	19.66	\$953.26	\$472.33	\$190.65
26841	T	Fusion of thumb	0054	19.66	\$953.26	\$472.33	\$190.65
26842	T	Thumb fusion with graft	0054	19.66	\$953.26	\$472.33	\$190.65
26843	T	Fusion of hand joint	0054	19.66	\$953.26	\$472.33	\$190.65
26844	T	Fusion/graft of hand joint	0054	19.66	\$953.26	\$472.33	\$190.65
26850	T	Fusion of knuckle	0054	19.66	\$953.26	\$472.33	\$190.65
26852	T	Fusion of knuckle with graft	0054	19.66	\$953.26	\$472.33	\$190.65
26860	T	Fusion of finger joint	0054	19.66	\$953.26	\$472.33	\$190.65
26861	T	Fusion of finger jnt, add-on	0054	19.66	\$953.26	\$472.33	\$190.65
26862	T	Fusion/graft of finger joint	0054	19.66	\$953.26	\$472.33	\$190.65
26863	T	Fuse/graft added joint	0054	19.66	\$953.26	\$472.33	\$190.65
26910	T	Amputate metacarpal bone	0054	19.66	\$953.26	\$472.33	\$190.65
26951	T	Amputation of finger/thumb	0053	11.32	\$548.87	\$253.49	\$109.77
26952	T	Amputation of finger/thumb	0053	11.32	\$548.87	\$253.49	\$109.77
26989	T	Hand/finger surgery	0043	1.64	\$79.52	\$25.46	\$15.90
26990	T	Drainage of pelvis lesion	0049	15.04	\$729.25	\$356.95	\$145.85
26991	T	Drainage of pelvis bursa	0049	15.04	\$729.25	\$356.95	\$145.85
26992	C	Drainage of bone lesion .....	.....	.....	.....	.....	.....
27000	T	Incision of hip tendon	0049	15.04	\$729.25	\$356.95	\$145.85
27001	T	Incision of hip tendon	0050	21.13	\$1,024.53	\$513.86	\$204.91
27003	T	Incision of hip tendon	0050	21.13	\$1,024.53	\$513.86	\$204.91
27005	C	Incision of hip tendon .....	.....	.....	.....	.....	.....
27006	C	Incision of hip tendons .....	.....	.....	.....	.....	.....
27025	C	Incision of hip/thigh fascia .....	.....	.....	.....	.....	.....
27030	C	Drainage of hip joint .....	.....	.....	.....	.....	.....
27033	T	Exploration of hip joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
27035	C	Deneration of hip joint .....	.....	.....	.....	.....	.....
27036	C	Excision of hip joint/muscle .....	.....	.....	.....	.....	.....
27040	T	Biopsy of soft tissues	0021	10.49	\$508.63	\$236.51	\$101.73
27041	T	Biopsy of soft tissues	0022	12.49	\$605.60	\$292.94	\$121.12
27047	T	Remove hip/pelvis lesion	0022	12.49	\$605.60	\$292.94	\$121.12
27048	T	Remove hip/pelvis lesion	0022	12.49	\$605.60	\$292.94	\$121.12
27049	T	Remove tumor, hip/pelvis	0022	12.49	\$605.60	\$292.94	\$121.12
27050	T	Biopsy of sacroiliac joint	0049	15.04	\$729.25	\$356.95	\$145.85
27052	T	Biopsy of hip joint	0049	15.04	\$729.25	\$356.95	\$145.85
27054	C	Removal of hip joint lining

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
27060	T	Removal of ischial bursa	0049	15.04	\$729.25	\$356.95	\$145.85
27062	T	Remove femur lesion/bursa	0049	15.04	\$729.25	\$356.95	\$145.85
27065	T	Removal of hip bone lesion	0049	15.04	\$729.25	\$356.95	\$145.85
27066	T	Removal of hip bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
27067	T	Remove/graft hip bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
27070	C	Partial removal of hip bone					
27071	C	Partial removal of hip bone					
27075	C	Extensive hip surgery					
27076	C	Extensive hip surgery					
27077	C	Extensive hip surgery					
27078	C	Extensive hip surgery					
27079	C	Extensive hip surgery					
27080	T	Removal of tail bone	0050	21.13	\$1,024.53	\$513.86	\$204.91
27086	T	Remove hip foreign body	0019	4.00	\$193.95	\$78.91	\$38.79
27087	T	Remove hip foreign body	0049	15.04	\$729.25	\$356.95	\$145.85
27090	C	Removal of hip prosthesis					
27091	C	Removal of hip prosthesis					
27093	N	Injection for hip x-ray					
27095	N	Injection for hip x-ray					
27096	N	Inject sacroiliac joint					
27097	T	Revision of hip tendon	0050	21.13	\$1,024.53	\$513.86	\$204.91
27098	T	Transfer tendon to pelvis	0050	21.13	\$1,024.53	\$513.86	\$204.91
27100	T	Transfer of abdominal muscle	0051	27.76	\$1,346.00	\$675.24	\$269.20
27105	T	Transfer of spinal muscle	0051	27.76	\$1,346.00	\$675.24	\$269.20
27110	T	Transfer of iliopsoas muscle	0051	27.76	\$1,346.00	\$675.24	\$269.20
27111	T	Transfer of iliopsoas muscle	0051	27.76	\$1,346.00	\$675.24	\$269.20
27120	C	Reconstruction of hip socket					
27122	C	Reconstruction of hip socket					
27125	C	Partial hip replacement					
27130	C	Total hip replacement					
27132	C	Total hip replacement					
27134	C	Revise hip joint replacement					
27137	C	Revise hip joint replacement					
27138	C	Revise hip joint replacement					
27140	C	Transplant femur ridge					
27146	C	Incision of hip bone					
27147	C	Revision of hip bone					
27151	C	Incision of hip bones					
27156	C	Revision of hip bones					
27158	C	Revision of pelvis					
27161	C	Incision of neck of femur					
27165	C	Incision/fixation of femur					
27170	C	Repair/graft femur head/neck					
27175	C	Treat slipped epiphysis					
27176	C	Treat slipped epiphysis					
27177	C	Treat slipped epiphysis					
27178	C	Treat slipped epiphysis					
27179	C	Revise head/neck of femur					
27181	C	Treat slipped epiphysis					
27185	C	Revision of femur epiphysis					
27187	C	Reinforce hip bones					
27193	T	Treat pelvic ring fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27194	T	Treat pelvic ring fracture	0045	11.02	\$534.33	\$277.12	\$106.87
27200	T	Treat tail bone fracture	0043	1.64	\$79.52	\$25.46	\$15.90
27202	T	Treat tail bone fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27215	C	Treat pelvic fracture(s)					
27216	C	Treat pelvic ring fracture					
27217	C	Treat pelvic ring fracture					
27218	C	Treat pelvic ring fracture					
27220	T	Treat hip socket fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27222	C	Treat hip socket fracture					
27226	C	Treat hip wall fracture					
27227	C	Treat hip fracture(s)					
27228	C	Treat hip fracture(s)					
27230	T	Treat thigh fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27232	C	Treat thigh fracture					
27235	C	Treat thigh fracture					
27236	C	Treat thigh fracture					
27238	T	Treat thigh fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27240	C	Treat thigh fracture					
27244	C	Treat thigh fracture					
27245	C	Treat thigh fracture					
27246	T	Treat thigh fracture	0044	2.17	\$105.22	\$38.08	\$21.04

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
27248	C	Treat thigh fracture					
27250	T	Treat hip dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
27252	T	Treat hip dislocation	0045	11.02	\$534.33	\$277.12	\$106.87
27253	C	Treat hip dislocation					
27254	C	Treat hip dislocation					
27256	T	Treat hip dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
27257	T	Treat hip dislocation	0045	11.02	\$534.33	\$277.12	\$106.87
27258	C	Treat hip dislocation					
27259	C	Treat hip dislocation					
27265	T	Treat hip dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
27266	T	Treat hip dislocation	0047	22.09	\$1,071.08	\$537.03	\$214.22
27275	T	Manipulation of hip joint	0045	11.02	\$534.33	\$277.12	\$106.87
27280	C	Fusion of sacroiliac joint					
27282	C	Fusion of pubic bones					
27284	C	Fusion of hip joint					
27286	C	Fusion of hip joint					
27290	C	Amputation of leg at hip					
27295	C	Amputation of leg at hip					
27299	T	Pelvis/hip joint surgery	0043	1.64	\$79.52	\$25.46	\$15.90
27301	T	Drain thigh/knee lesion	0008	6.15	\$298.20	\$113.67	\$59.64
27303	C	Drainage of bone lesion					
27305	T	Incise thigh tendon & fascia	0049	15.04	\$729.25	\$356.95	\$145.85
27306	T	Incision of thigh tendon	0049	15.04	\$729.25	\$356.95	\$145.85
27307	T	Incision of thigh tendons	0049	15.04	\$729.25	\$356.95	\$145.85
27310	T	Exploration of knee joint	0050	21.13	\$1,024.53	\$513.86	\$204.91
27315	T	Partial removal, thigh nerve	0220	13.96	\$676.88	\$326.21	\$135.38
27320	T	Partial removal, thigh nerve	0220	13.96	\$676.88	\$326.21	\$135.38
27323	T	Biopsy, thigh soft tissues	0021	10.49	\$508.63	\$236.51	\$101.73
27324	T	Biopsy, thigh soft tissues	0022	12.49	\$605.60	\$292.94	\$121.12
27327	T	Removal of thigh lesion	0022	12.49	\$605.60	\$292.94	\$121.12
27328	T	Removal of thigh lesion	0022	12.49	\$605.60	\$292.94	\$121.12
27329	T	Remove tumor, thigh/knee	0022	12.49	\$605.60	\$292.94	\$121.12
27330	T	Biopsy, knee joint lining	0050	21.13	\$1,024.53	\$513.86	\$204.91
27331	T	Explore/treat knee joint	0050	21.13	\$1,024.53	\$513.86	\$204.91
27332	T	Removal of knee cartilage	0050	21.13	\$1,024.53	\$513.86	\$204.91
27333	T	Removal of knee cartilage	0050	21.13	\$1,024.53	\$513.86	\$204.91
27334	T	Remove knee joint lining	0050	21.13	\$1,024.53	\$513.86	\$204.91
27335	T	Remove knee joint lining	0050	21.13	\$1,024.53	\$513.86	\$204.91
27340	T	Removal of kneecap bursa	0049	15.04	\$729.25	\$356.95	\$145.85
27345	T	Removal of knee cyst	0049	15.04	\$729.25	\$356.95	\$145.85
27347	T	Remove knee cyst	0049	15.04	\$729.25	\$356.95	\$145.85
27350	T	Removal of kneecap	0050	21.13	\$1,024.53	\$513.86	\$204.91
27355	T	Remove femur lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
27356	T	Remove femur lesion/graft	0050	21.13	\$1,024.53	\$513.86	\$204.91
27357	T	Remove femur lesion/graft	0050	21.13	\$1,024.53	\$513.86	\$204.91
27358	T	Remove femur lesion/fixation	0050	21.13	\$1,024.53	\$513.86	\$204.91
27360	T	Partial removal, leg bone(s)	0050	21.13	\$1,024.53	\$513.86	\$204.91
27365	C	Extensive leg surgery					
27370	N	Injection for knee x-ray					
27372	T	Removal of foreign body	0022	12.49	\$605.60	\$292.94	\$121.12
27380	T	Repair of kneecap tendon	0049	15.04	\$729.25	\$356.95	\$145.85
27381	T	Repair/graft kneecap tendon	0049	15.04	\$729.25	\$356.95	\$145.85
27385	T	Repair of thigh muscle	0049	15.04	\$729.25	\$356.95	\$145.85
27386	T	Repair/graft of thigh muscle	0049	15.04	\$729.25	\$356.95	\$145.85
27390	T	Incision of thigh tendon	0049	15.04	\$729.25	\$356.95	\$145.85
27391	T	Incision of thigh tendons	0049	15.04	\$729.25	\$356.95	\$145.85
27392	T	Incision of thigh tendons	0049	15.04	\$729.25	\$356.95	\$145.85
27393	T	Lengthening of thigh tendon	0050	21.13	\$1,024.53	\$513.86	\$204.91
27394	T	Lengthening of thigh tendons	0050	21.13	\$1,024.53	\$513.86	\$204.91
27395	T	Lengthening of thigh tendons	0051	27.76	\$1,346.00	\$675.24	\$269.20
27396	T	Transplant of thigh tendon	0050	21.13	\$1,024.53	\$513.86	\$204.91
27397	T	Transplants of thigh tendons	0051	27.76	\$1,346.00	\$675.24	\$269.20
27400	T	Revise thigh muscles/tendons	0051	27.76	\$1,346.00	\$675.24	\$269.20
27403	T	Repair of knee cartilage	0050	21.13	\$1,024.53	\$513.86	\$204.91
27405	T	Repair of knee ligament	0051	27.76	\$1,346.00	\$675.24	\$269.20
27407	T	Repair of knee ligament	0051	27.76	\$1,346.00	\$675.24	\$269.20
27409	T	Repair of knee ligaments	0051	27.76	\$1,346.00	\$675.24	\$269.20
27418	T	Repair degenerated kneecap	0051	27.76	\$1,346.00	\$675.24	\$269.20
27420	T	Revision of unstable kneecap	0051	27.76	\$1,346.00	\$675.24	\$269.20
27422	T	Revision of unstable kneecap	0051	27.76	\$1,346.00	\$675.24	\$269.20
27424	T	Revision/removal of kneecap	0051	27.76	\$1,346.00	\$675.24	\$269.20
27425	T	Lateral retinacular release	0050	21.13	\$1,024.53	\$513.86	\$204.91
27427	T	Reconstruction, knee	0052	36.16	\$1,753.29	\$930.91	\$350.66

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
27428	T	Reconstruction, knee	0052	36.16	\$1,753.29	\$930.91	\$350.66
27429	T	Reconstruction, knee	0052	36.16	\$1,753.29	\$930.91	\$350.66
27430	T	Revision of thigh muscles	0051	27.76	\$1,346.00	\$675.24	\$269.20
27435	T	Incision of knee joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
27437	T	Revise kneecap	0047	22.09	\$1,071.08	\$537.03	\$214.22
27438	T	Revise kneecap with implant	0048	29.06	\$1,409.03	\$725.94	\$281.81
27440	T	Revision of knee joint	0047	22.09	\$1,071.08	\$537.03	\$214.22
27441	T	Revision of knee joint	0047	22.09	\$1,071.08	\$537.03	\$214.22
27442	T	Revision of knee joint	0047	22.09	\$1,071.08	\$537.03	\$214.22
27443	T	Revision of knee joint	0047	22.09	\$1,071.08	\$537.03	\$214.22
27445	C	Revision of knee joint					
27446	C	Revision of knee joint					
27447	C	Total knee replacement					
27448	C	Incision of thigh					
27450	C	Incision of thigh					
27454	C	Realignment of thigh bone					
27455	C	Realignment of knee					
27457	C	Realignment of knee					
27465	C	Shortening of thigh bone					
27466	C	Lengthening of thigh bone					
27468	C	Shorten/lengthen thighs					
27470	C	Repair of thigh					
27472	C	Repair/graft of thigh					
27475	C	Surgery to stop leg growth					
27477	C	Surgery to stop leg growth					
27479	C	Surgery to stop leg growth					
27485	C	Surgery to stop leg growth					
27486	C	Revise/replace knee joint					
27487	C	Revise/replace knee joint					
27488	C	Removal of knee prosthesis					
27495	C	Reinforce thigh					
27496	T	Decompression of thigh/knee	0049	15.04	\$729.25	\$356.95	\$145.85
27497	T	Decompression of thigh/knee	0049	15.04	\$729.25	\$356.95	\$145.85
27498	T	Decompression of thigh/knee	0049	15.04	\$729.25	\$356.95	\$145.85
27499	T	Decompression of thigh/knee	0049	15.04	\$729.25	\$356.95	\$145.85
27500	T	Treatment of thigh fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27501	T	Treatment of thigh fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27502	T	Treatment of thigh fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27503	T	Treatment of thigh fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27506	C	Treatment of thigh fracture					
27507	C	Treatment of thigh fracture					
27508	T	Treatment of thigh fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27509	T	Treatment of thigh fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27510	T	Treatment of thigh fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27511	C	Treatment of thigh fracture					
27513	C	Treatment of thigh fracture					
27514	C	Treatment of thigh fracture					
27516	T	Treat thigh fx growth plate	0044	2.17	\$105.22	\$38.08	\$21.04
27517	T	Treat thigh fx growth plate	0044	2.17	\$105.22	\$38.08	\$21.04
27519	C	Treat thigh fx growth plate					
27520	T	Treat kneecap fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27524	C	Treat kneecap fracture					
27530	T	Treat knee fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27532	T	Treat knee fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27535	C	Treat knee fracture					
27536	C	Treat knee fracture					
27538	T	Treat knee fracture(s)	0044	2.17	\$105.22	\$38.08	\$21.04
27540	C	Treat knee fracture					
27550	T	Treat knee dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
27552	T	Treat knee dislocation	0045	11.02	\$534.33	\$277.12	\$106.87
27556	T	Treat knee dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
27557	C	Treat knee dislocation					
27558	C	Treat knee dislocation					
27560	T	Treat kneecap dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
27562	T	Treat kneecap dislocation	0045	11.02	\$534.33	\$277.12	\$106.87
27566	T	Treat kneecap dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
27570	T	Fixation of knee joint	0045	11.02	\$534.33	\$277.12	\$106.87
27580	C	Fusion of knee					
27590	C	Amputate leg at thigh					
27591	C	Amputate leg at thigh					
27592	C	Amputate leg at thigh					
27594	T	Amputation follow-up surgery	0049	15.04	\$729.25	\$356.95	\$145.85
27596	C	Amputation follow-up surgery					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
27598	C	Amputate lower leg at knee					
27599	T	Leg surgery procedure	0044	2.17	\$105.22	\$38.08	\$21.04
27600	T	Decompression of lower leg	0049	15.04	\$729.25	\$356.95	\$145.85
27601	T	Decompression of lower leg	0049	15.04	\$729.25	\$356.95	\$145.85
27602	T	Decompression of lower leg	0049	15.04	\$729.25	\$356.95	\$145.85
27603	T	Drain lower leg lesion	0008	6.15	\$298.20	\$113.67	\$59.64
27604	T	Drain lower leg bursa	0049	15.04	\$729.25	\$356.95	\$145.85
27605	T	Incision of achilles tendon	0055	15.47	\$750.10	\$355.34	\$150.02
27606	T	Incision of achilles tendon	0049	15.04	\$729.25	\$356.95	\$145.85
27607	T	Treat lower leg bone lesion	0049	15.04	\$729.25	\$356.95	\$145.85
27610	T	Explore/treat ankle joint	0050	21.13	\$1,024.53	\$513.86	\$204.91
27612	T	Exploration of ankle joint	0050	21.13	\$1,024.53	\$513.86	\$204.91
27613	T	Biopsy lower leg soft tissue	0020	6.51	\$315.65	\$130.53	\$63.13
27614	T	Biopsy lower leg soft tissue	0022	12.49	\$605.60	\$292.94	\$121.12
27615	T	Remove tumor, lower leg	0046	22.29	\$1,080.78	\$535.76	\$216.16
27618	T	Remove lower leg lesion	0021	10.49	\$508.63	\$236.51	\$101.73
27619	T	Remove lower leg lesion	0022	12.49	\$605.60	\$292.94	\$121.12
27620	T	Explore/treat ankle joint	0050	21.13	\$1,024.53	\$513.86	\$204.91
27625	T	Remove ankle joint lining	0050	21.13	\$1,024.53	\$513.86	\$204.91
27626	T	Remove ankle joint lining	0050	21.13	\$1,024.53	\$513.86	\$204.91
27630	T	Removal of tendon lesion	0049	15.04	\$729.25	\$356.95	\$145.85
27635	T	Remove lower leg bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
27637	T	Remove/graft leg bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
27638	T	Remove/graft leg bone lesion	0050	21.13	\$1,024.53	\$513.86	\$204.91
27640	T	Partial removal of tibia	0051	27.76	\$1,346.00	\$675.24	\$269.20
27641	T	Partial removal of fibula	0050	21.13	\$1,024.53	\$513.86	\$204.91
27645	C	Extensive lower leg surgery					
27646	C	Extensive lower leg surgery					
27647	T	Extensive ankle/heel surgery	0051	27.76	\$1,346.00	\$675.24	\$269.20
27648	N	Injection for ankle x-ray					
27650	T	Repair achilles tendon	0051	27.76	\$1,346.00	\$675.24	\$269.20
27652	T	Repair/graft achilles tendon	0051	27.76	\$1,346.00	\$675.24	\$269.20
27654	T	Repair of achilles tendon	0051	27.76	\$1,346.00	\$675.24	\$269.20
27656	T	Repair leg fascia defect	0049	15.04	\$729.25	\$356.95	\$145.85
27658	T	Repair of leg tendon, each	0049	15.04	\$729.25	\$356.95	\$145.85
27659	T	Repair of leg tendon, each	0049	15.04	\$729.25	\$356.95	\$145.85
27664	T	Repair of leg tendon, each	0049	15.04	\$729.25	\$356.95	\$145.85
27665	T	Repair of leg tendon, each	0050	21.13	\$1,024.53	\$513.86	\$204.91
27675	T	Repair lower leg tendons	0049	15.04	\$729.25	\$356.95	\$145.85
27676	T	Repair lower leg tendons	0050	21.13	\$1,024.53	\$513.86	\$204.91
27680	T	Release of lower leg tendon	0050	21.13	\$1,024.53	\$513.86	\$204.91
27681	T	Release of lower leg tendons	0050	21.13	\$1,024.53	\$513.86	\$204.91
27685	T	Revision of lower leg tendon	0050	21.13	\$1,024.53	\$513.86	\$204.91
27686	T	Revise lower leg tendons	0050	21.13	\$1,024.53	\$513.86	\$204.91
27687	T	Revision of calf tendon	0050	21.13	\$1,024.53	\$513.86	\$204.91
27690	T	Revise lower leg tendon	0051	27.76	\$1,346.00	\$675.24	\$269.20
27691	T	Revise lower leg tendon	0051	27.76	\$1,346.00	\$675.24	\$269.20
27692	T	Revise additional leg tendon	0051	27.76	\$1,346.00	\$675.24	\$269.20
27695	T	Repair of ankle ligament	0050	21.13	\$1,024.53	\$513.86	\$204.91
27696	T	Repair of ankle ligaments	0050	21.13	\$1,024.53	\$513.86	\$204.91
27698	T	Repair of ankle ligament	0050	21.13	\$1,024.53	\$513.86	\$204.91
27700	T	Revision of ankle joint	0047	22.09	\$1,071.08	\$537.03	\$214.22
27702	C	Reconstruct ankle joint					
27703	C	Reconstruction, ankle joint					
27704	T	Removal of ankle implant	0049	15.04	\$729.25	\$356.95	\$145.85
27705	T	Incision of tibia	0051	27.76	\$1,346.00	\$675.24	\$269.20
27707	T	Incision of fibula	0049	15.04	\$729.25	\$356.95	\$145.85
27709	T	Incision of tibia & fibula	0050	21.13	\$1,024.53	\$513.86	\$204.91
27712	C	Realignment of lower leg					
27715	C	Revision of lower leg					
27720	C	Repair of tibia					
27722	C	Repair/graft of tibia					
27724	C	Repair/graft of tibia					
27725	C	Repair of lower leg					
27727	C	Repair of lower leg					
27730	T	Repair of tibia epiphysis	0050	21.13	\$1,024.53	\$513.86	\$204.91
27732	T	Repair of fibula epiphysis	0050	21.13	\$1,024.53	\$513.86	\$204.91
27734	T	Repair lower leg epiphyses	0050	21.13	\$1,024.53	\$513.86	\$204.91
27740	T	Repair of leg epiphyses	0050	21.13	\$1,024.53	\$513.86	\$204.91
27742	T	Repair of leg epiphyses	0051	27.76	\$1,346.00	\$675.24	\$269.20
27745	T	Reinforce tibia	0051	27.76	\$1,346.00	\$675.24	\$269.20
27750	T	Treatment of tibia fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27752	T	Treatment of tibia fracture	0044	2.17	\$105.22	\$38.08	\$21.04

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² Not subject to national coinsurance.

³ Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
27756	T	Treatment of tibia fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27758	T	Treatment of tibia fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27759	T	Treatment of tibia fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27760	T	Treatment of ankle fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27762	T	Treatment of ankle fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27766	T	Treatment of ankle fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27780	T	Treatment of fibula fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27781	T	Treatment of fibula fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27784	T	Treatment of fibula fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27786	T	Treatment of ankle fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27788	T	Treatment of ankle fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27792	T	Treatment of ankle fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27808	T	Treatment of ankle fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27810	T	Treatment of ankle fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27814	T	Treatment of ankle fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27816	T	Treatment of ankle fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27818	T	Treatment of ankle fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27822	T	Treatment of ankle fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27823	T	Treatment of ankle fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27824	T	Treat lower leg fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27825	T	Treat lower leg fracture	0044	2.17	\$105.22	\$38.08	\$21.04
27826	T	Treat lower leg fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27827	T	Treat lower leg fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27828	T	Treat lower leg fracture	0046	22.29	\$1,080.78	\$535.76	\$216.16
27829	T	Treat lower leg joint	0046	22.29	\$1,080.78	\$535.76	\$216.16
27830	T	Treat lower leg dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
27831	T	Treat lower leg dislocation	0045	11.02	\$534.33	\$277.12	\$106.87
27832	T	Treat lower leg dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
27840	T	Treat ankle dislocation	0044	2.17	\$105.22	\$38.08	\$21.04
27842	T	Treat ankle dislocation	0045	11.02	\$534.33	\$277.12	\$106.87
27846	T	Treat ankle dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
27848	T	Treat ankle dislocation	0046	22.29	\$1,080.78	\$535.76	\$216.16
27860	T	Fixation of ankle joint	0045	11.02	\$534.33	\$277.12	\$106.87
27870	T	Fusion of ankle joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
27871	T	Fusion of tibiofibular joint	0051	27.76	\$1,346.00	\$675.24	\$269.20
27880	C	Amputation of lower leg .....	.....	.....	.....	.....	.....
27881	C	Amputation of lower leg .....	.....	.....	.....	.....	.....
27882	C	Amputation of lower leg .....	.....	.....	.....	.....	.....
27884	T	Amputation follow-up surgery	0049	15.04	\$729.25	\$356.95	\$145.85
27886	C	Amputation follow-up surgery .....	.....	.....	.....	.....	.....
27888	C	Amputation of foot at ankle .....	.....	.....	.....	.....	.....
27889	T	Amputation of foot at ankle	0050	21.13	\$1,024.53	\$513.86	\$204.91
27892	T	Decompression of leg	0049	15.04	\$729.25	\$356.95	\$145.85
27893	T	Decompression of leg	0049	15.04	\$729.25	\$356.95	\$145.85
27894	T	Decompression of leg	0049	15.04	\$729.25	\$356.95	\$145.85
27899	T	Leg/ankle surgery procedure	0044	2.17	\$105.22	\$38.08	\$21.04
28001	T	Drainage of bursa of foot	0008	6.15	\$298.20	\$113.67	\$59.64
28002	T	Treatment of foot infection	0049	15.04	\$729.25	\$356.95	\$145.85
28003	T	Treatment of foot infection	0049	15.04	\$729.25	\$356.95	\$145.85
28005	T	Treat foot bone lesion	0055	15.47	\$750.10	\$355.34	\$150.02
28008	T	Incision of foot fascia	0055	15.47	\$750.10	\$355.34	\$150.02
28010	T	Incision of toe tendon	0055	15.47	\$750.10	\$355.34	\$150.02
28011	T	Incision of toe tendons	0055	15.47	\$750.10	\$355.34	\$150.02
28020	T	Exploration of foot joint	0055	15.47	\$750.10	\$355.34	\$150.02
28022	T	Exploration of foot joint	0055	15.47	\$750.10	\$355.34	\$150.02
28024	T	Exploration of toe joint	0055	15.47	\$750.10	\$355.34	\$150.02
28030	T	Removal of foot nerve	0220	13.96	\$676.88	\$326.21	\$135.38
28035	T	Decompression of tibia nerve	0220	13.96	\$676.88	\$326.21	\$135.38
28043	T	Excision of foot lesion	0021	10.49	\$508.63	\$236.51	\$101.73
28045	T	Excision of foot lesion	0055	15.47	\$750.10	\$355.34	\$150.02
28046	T	Resection of tumor, foot	0055	15.47	\$750.10	\$355.34	\$150.02
28050	T	Biopsy of foot joint lining	0055	15.47	\$750.10	\$355.34	\$150.02
28052	T	Biopsy of foot joint lining	0055	15.47	\$750.10	\$355.34	\$150.02
28054	T	Biopsy of toe joint lining	0055	15.47	\$750.10	\$355.34	\$150.02
28060	T	Partial removal, foot fascia	0056	17.30	\$838.83	\$405.81	\$167.77
28062	T	Removal of foot fascia	0056	17.30	\$838.83	\$405.81	\$167.77
28070	T	Removal of foot joint lining	0056	17.30	\$838.83	\$405.81	\$167.77
28072	T	Removal of foot joint lining	0056	17.30	\$838.83	\$405.81	\$167.77
28080	T	Removal of foot lesion	0055	15.47	\$750.10	\$355.34	\$150.02
28086	T	Excise foot tendon sheath	0055	15.47	\$750.10	\$355.34	\$150.02
28088	T	Excise foot tendon sheath	0055	15.47	\$750.10	\$355.34	\$150.02
28090	T	Removal of foot lesion	0055	15.47	\$750.10	\$355.34	\$150.02
28092	T	Removal of toe lesions	0055	15.47	\$750.10	\$355.34	\$150.02

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