Comment: One commenter believes that the GPRO requirement that physicians reassign their billing rights to the taxpayer identification number (TIN) could be problematic for some practices where individual physicians continue billing Medicare on their behalf rather than reassigning to the group practice. Yet, these practices still function as a group and use the same data systems. It was recommended that we reconsider the reassignment requirement, as well as continue to add more specialty-specific measures groups in an effort to make the GPRO a more viable and attractive option.

Response: We understand that there are various scenarios that may occur that would result in an individual eligible professional not reassigning his or her billing rights to a group TIN as required for inclusion in the GPRO I group. However, Physician Quality Reporting System GPRO I patient assignment, sample selection and incentive calculations are based at the TIN/NPI level. We believe it would be burdensome on the GPRO as well as the individual eligible professionals to track all individual NPIs who may practice periodically with their group while accounting for the instances when the NPI is not providing services to beneficiaries assigned to the group.

Comment: One commenter requested that we expand the definition of "group practice" to include non-physician providers.

Response: We are finalizing our proposal to define "group practice" as a single TIN with 2 or more eligible professionals, as identified by their individual NPI, who have reassigned their billing rights to the TIN, but as noted in the following discussion, we are modifying our definition with respect to group practices participating in Medicare demonstration projects approved by the Secretary. Therefore, although the term "physician group" may sometimes be used when referring to group practices, it is not intended to infer that group practices are only physicians.

Comment: A couple of commenters commended us for taking positive steps to reduce the reporting burden for eligible professionals. The commenters were specifically referring to our proposal to deem group practices participating in the PGP, MCMP, and EHR demonstrations to be participating in the Physician Quality Reporting System such that all eligible professionals participating in these demonstrations automatically will receive Physician Quality Reporting System bonus payments. The commenters requested that we extend this same waiver to all types of providers who participate in demonstrations. One commenter noted that the majority of participants in the PGP demonstration are hospitals and, like the Physician Quality Reporting System program, many of the measures that hospitals report to the RHQDAPU program overlap with the measures required for participation in the demonstration.

Response: We agree with trying to lessen the burden on eligible professionals who are participating in demonstrations when practical and feasible. We specifically focused on these three demonstrations because their participants are required to report on measures that are very similar to the Physician Quality Reporting System GPRO I measures and to do so using a process very similar to the Physician Quality Reporting System GPRO I process for their demonstrations. At this time, we are not aware of other demonstrations that require the same measures and reporting processes. Therefore, we are not granting waivers with regard to the group practice reporting option to providers who are participating in demonstrations other than the PGP, MCMP, and EHR demonstrations. In addition, this waiver does not apply to any quality reporting program other than the Physician Quality Reporting System. We also further note that demonstration participants will not automatically receive Physician Quality Reporting System incentive payments. Rather, they must meet the requirements for Physician Quality Reporting System incentive qualification under their respective approved demonstration project.

Comment: One commenter noted that practices participating in either the MCMP or EHR demonstrations could consist of solo practitioner practices. In addition, practices participating in the PGP, MCMP, or EHR demonstrations could consist of multiple TINs. The commenter requested clarification on whether such practices would still be considered a "group practice" for purposes of the Physician Quality Reporting System GPRO.

Response: Our intent, in proposing to include practices that are participating in these demonstrations in the definition of "group practice" was to reduce the burden on eligible professionals who are already reporting using a process similar to the Physician Quality Reporting System GPRO I method and on similar measures, regardless of the composition of the actual group. Therefore, we are modifying the definition of "group practice" with respect to group practices participating in Medicare demonstration projects approved by the Secretary." Rather than including such group practices in the definition of "group practice" at § 414.90(b), we are indicating that such practices are deemed to be participating in the Physician Quality Reporting System at § 414.90(g)(1). In addition, we are clarifying at § 414.90(g)(1) that such practices are "group practices of any size (including solo practitioners) or comprised of multiple TINs participating in a Medicare demonstration project approved by the Secretary."

Based on these comments, we are finalizing the proposed definition of "group practice" with the changes discussed previously for purposes of the 2011 Physician Quality Reporting System group practice reporting option. We recognize that a group's size can fluctuate throughout the year as professionals move from practice to practice. Therefore, a group practice's size, for purposes of determining which reporting criteria the group must satisfy, will be the size of the group at the time the group's participation in one of the 2011 GPRO options is approved by CMS.

We also recognize that, for various reasons, there potentially could be a discrepancy between the number of eligible professionals (that is, NPIs) submitted by the practice during the self-nomination process and the number of eligible professionals billing Medicare under the practice's TIN. Therefore, if we find more NPIs in the Medicare claims than the number of NPIs submitted by the practice during the self-nomination process and this would result in the practice being subject to different criteria for satisfactory reporting, then we will notify the practice of this finding as part of the self-nomination process. At this point, the practice will have the option of either agreeing to being subject to the different criteria for satisfactory reporting, justifying why they should not be subject to the different criteria for satisfactory reporting, or opting out of participation in the Physician Quality Reporting System as a group practice. For example, if we determine that a group practice that self-nominates for GPRO II has more than 199 eligible professionals billing Medicare under the practice's TIN, the practice would have the option of agreeing to participate in the Physician Quality Reporting System under GPRO I, explaining why the

practice actually has fewer than 200 eligible professionals (for example, some of the eligible professionals who billed Medicare have since retired), or opting out of participation in the Physician Quality Reporting System GPRO for 2011. If a group practice that self-nominates for GPRO I has fewer than 200 NPIs billing Medicare under the practice's TIN, then we will give the practice the opportunity to participate in GPRO II.

(3) Process for Physician Group Practices To Participate as Group Practices and Criteria for Satisfactory Reporting

(A) Group Practice Reporting Option for Physician Group Practices With 200 or More NPIs—GPRO I

As stated previously, we proposed that group practices interested in participating in GPRO I must self-nominate to do so. For group practices selected to participate in the Physician Quality Reporting System GPRO I for 2011, we proposed to retain the existing 12-month reporting period beginning January 1, 2011. We proposed that group practices participating in GPRO I submit information on a proposed common set of 26 NQF-endorsed quality measures using a data collection tool based on the GPRO Tool used in the 2010 Physician Quality Reporting System GPRO by 36 participating group practices to report quality measures under the Physician Quality Reporting System. As part of the data submission process for 2011 GPRO I, we proposed that during 2012, each group practice would be required to report quality measures with respect to services furnished during the 2011 reporting period (that is, January 1, 2011, through December 31, 2011) on an assigned sample of Medicare beneficiaries.

Once the beneficiary assignment has been made for each group practice, which we anticipate will be done during the fourth quarter of 2011, we proposed to provide each group practice selected to participate in the Physician Quality Reporting System GPRO I with access to a database (that is, a data collection tool) that will include the group's assigned beneficiary samples and the final GPRO I quality measures. We proposed to pre-populate the data collection tool with the assigned beneficiaries' demographic and utilization information based on all of their Medicare claims data. The group practice will be required to populate the remaining data fields necessary for capturing quality measure information on each of the assigned beneficiaries. Identical to the sampling method used in the PGP demonstration, we proposed that the random sample must consist of at least 411 assigned beneficiaries. If the pool of eligible assigned beneficiaries is less than 411, then the group practice must report on 100 percent, or all, of the assigned beneficiaries to satisfactorily participate in the group practice reporting option. For each disease module or preventive care measure, the group practice would be required to report information on the assigned patients in the order in which they appear in the group's sample (that is, consecutively). These proposed reporting criteria are identical to the reporting criteria used in the PGP demonstration and in the 2010 Physician Quality Reporting System GPRO.

For 2011, we proposed an exclusive reporting mechanism for eligible professionals identified as part of the group practice with respect to the group as identified by the TIN. However, eligible professionals who are part of the group practice, and who separately practice with respect to another TIN to which the eligible professional has reassigned benefits, could separately qualify as individual eligible professionals with respect to the other practice (TIN).

We invited comments on our proposal for 2011 to retain 200 as the number of NPIs for a TIN required for each group practice under the GPRO I. We also invited comment on our proposal to allow those "qualified" for 2010 GPRO to be rolled over for automatic qualification for 2011 GPRO I.

The following is a summary of the comments received regarding the proposed process for physician group practices with 200 or more NPIs (that is, GPRO I).

Comment: A commenter expressed support for continuation of GPRO I.

Response: We appreciate the commenter's support. We are finalizing the GPRO I as proposed. We believe that this process provides an effective means of collecting quality data from large group practices.

Comment: A commenter expressed support for our proposal that 2010 GPRO participants would not need to go through the self-nomination process to participate in 2011.

Response: We appreciate the time and effort taken by the commenter to state support of our proposal to not have 2010 GPRO participants go through self nomination process for GPRO I participation for 2011. We will not require 2010 GPRO participants to go through the self-nomination process for 2011 but they will need to inform us of their desire to participate in the 2011 GPRO I.

Comment: To encourage group reporting for large practices, and to reduce the risk to individual eligible professionals if the practices do not qualify for an incentive, one commenter requested that we allow the individual eligible professionals within GPRO I to continue reporting through traditional methods. Thus, those participants might be eligible for incentives if the group practice does not satisfactorily submit data.

Response: We considered the feasibility of analyzing Physician Quality Report System data submissions for GPRO I participants at the individual NPI level, but we decided against this option. Analyzing Physician Quality Reporting System data submissions for GPRO I participants at the individual NPI level would require individual eligible professionals who are part of a group practice participating in GPRO I to collect and report quality data in multiple ways, which would be inefficient. In addition, doing so would require additional CMS resources and potentially delay availability of the incentive payments for all participants. Furthermore, we believe that a group practice should have little difficulty in satisfactorily reporting under GPRO I since they will receive feedback prior to submission of the data to CMS.

Comment: We received a few comments on the proposed reporting criteria for GPRO I. One commenter suggested that the GPRO reporting requirements be limited to 411 patients in total, rather than 411 patients per measure, in order to reduce the associated resource burdens to participation. Another commenter was concerned with the considerable resources required to complete the data collection tool for this sample in such a short time frame. Given the methodology used, the commenter believes a smaller sample size would provide an accurate representation of a group's performance and urges us to reevaluate the sample sizes required.

Response: The sample size for GPRO I is based on research done through the PGP demonstration. Since 2010 is the first year that GPRO was used for the Physician Quality Reporting System, there is insufficient data to warrant changing the sample size at this time. We note, however, that the GPRO I is for group practices with 200 or more eligible professionals. On average, these group practices typically have 20,000 patients assigned to each group practice. Thus, the number of measures and the required sample size is considered to be equitable for practices with this volume of patients and eligible professionals. We will continue to evaluate the

number and types of measures and modules for future program years.

Comment: One commenter recommended that group practices with 50 or more eligible professionals be eligible to participate in GPRO I.

Response: The GPRO I is based on the methodology researched through the PGP demonstration project. We would like to further explore the impact of a smaller patient sample size before implementing GPRO I for group practices less than 200 NPI's. We are, however, finalizing a group practice option for groups with less than 200 eligible professionals (GPRO II) that group practices with 2–199 eligible professionals can participate in for 2011. With the implementation of GPRO II for 2011 it would be a potential drain on resources to also implement GPRO I for smaller practice at the same time.

For the reasons discussed previously and after taking into consideration the comments, we are finalizing the process group practices will be required to use to report data on quality measures for the 2011 as a group practice under GPRO I and the associated criteria for satisfactory reporting of data on quality measures by GPRO I practices, which are summarized in Table 75. Group practices participating in the Physician Quality Reporting System GPRO I as a group practice will be required to report on all of the measures listed in Table 75 of this final rule with comment period. These quality measures are grouped into preventive care measures and four disease modules: heart failure, diabetes, coronary artery disease, and hypertension.

TABLE 75—2011 PROCESS FOR PHYSICIAN GROUP PRACTICES TO PARTICIPATE AS GROUP PRACTICES AND CRITERIA FOR SATISFACTORY REPORTING OF DATA ON QUALITY MEASURES BY GROUP PRACTICES FOR GPRO I

Reporting mechanism	Reporting criteria	Reporting period
A pre-populated data collection tool provided by CMS.	• Report on all measures included in the data collection tool (26 measures); and. • Complete the tool for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.	January 1, 2011–December 31, 2011.

As stated in the CY 2011 PFS proposed rule (75 FR 40179), group practices interested in participating in GPRO I must submit a self-nomination letter accompanied by an electronic file submitted in a format specified by CMS (such as, a Microsoft Excel file) that includes the group practice's TIN(s) and name of the group practice, the name and e-mail address of a single point of contact for handling administrative issues, as well as the name and e-mail address of a single point of contact for technical support purposes. We will validate that the group practice consists of a minimum of 200 NPIs and will supply group practices with this list. The self-nomination letter must also indicate the group practice's compliance with the following requirements:

- Agree to attend and participate in all mandatory GPRO training sessions; and
- Have billed Medicare Part B on or after January 1, 2010 and prior to October 29, 2010.

We are not finalizing our proposal requiring group practices to indicate in their self-nomination letter that they have an active IACS user account. This was a requirement that we proposed to retain from the 2010 Physician Quality Reporting System GPRO self-nomination process. However, since an active IACS user account will not be needed to submit 2010 Physician Quality Reporting System GPRO data to us, we have decided not to require an IACS user account for the 2011 Physician Quality Reporting System GPRO I. Although access to a CMS identity management system will not be required for submitting 2011 PQRI GPRO I data to us, a group practice will need to have access to a CMS identity management system in order to access their 2011 PQRI feedback report.

We intend to post the final 2011 Physician Quality Reporting System GPRO I participation requirements for group practices, including instructions for submitting the self-nomination letter and other requested information, on the Physician Quality Reporting System section of the CMS Web site at *http://www.cms.gov/PQRI* by November 15, 2010 or shortly thereafter. Group practices that wish to self-nominate for 2011 will be required to do so by January 31, 2011. Upon receipt of the self-nomination letters we will assess whether the participation requirements were met by each self-nominated group practice using 2010 Medicare claims data. We will not preclude a group practice from participating in the GPRO I if we discover, from analysis of the 2010 Medicare claims data, that there are some eligible professionals (identified by NPIs) that are not established Medicare providers (that is, have not billed Medicare Part B on or after January 1, 2010 and prior to or on October 29, 2010) as long as the group has at least 200 established Medicare providers. NPIs who are not established Medicare providers, however, would not be included in our incentive payment calculations. Group practices that were selected to participate in the 2010 Physician Quality Reporting System GPRO will automatically be qualified to participate in the 2011 Physician Quality Reporting System GPRO I and will not need to complete the 2011 Physician Quality Reporting System GPRO I self-nomination process.

The 2010 Physician Quality Reporting System GPRO Tool will be updated as needed to include the 2011 Physician Quality Reporting System GPRO I measures. We believe that use of the GPRO data collection tool allows group practices the opportunity to calculate their own performance rates for reporting quality measures.

As stated in the CY 2011 PFS proposed rule (75 FR 40180 through 40181), we intend to provide the selected physician groups with access to this pre-populated database by no later than the first quarter of 2012. For purposes of pre-populating this GPRO I tool, we will assign beneficiaries to each group practice using a patient assessment methodology modeled after the patient assignment methodology used in the PGP demonstration. Based on our desire to model the Physician Quality Reporting System GPRO I after the PGP demonstration, we will also consider applying any refinements made to the methodology used in the PGP demonstration prior to January 1, 2011 to the 2011 Physician Quality Reporting System. We anticipate using Medicare claims data for dates of service

on or after January 1, 2011 and submitted and processed by approximately October 31, 2011 (that is, the last business day of October 2011) to assign Medicare beneficiaries to each group practice. Assigned beneficiaries will be limited to those Medicare Part B FFs beneficiaries with Medicare Parts A and B for whom Medicare is the primary payer. Assigned beneficiaries will not include Medicare Advantage enrollees. A beneficiary will be assigned to the group practice that provides the plurality of a beneficiary's office or other outpatient office evaluation and management allowed charges. Beneficiaries with only 1 office visit to the group practice will be eliminated from the group practice's assigned patient sample for purposes of the 2011 Physician Quality Reporting System GPRO I. We will pre-populate the GPRO I tool with the assigned beneficiaries' demographic and utilization information based on their Medicare claims data.

Upon receipt of the pre-populated data collection tool, the group practice will need to populate the remaining data fields necessary for capturing quality measure information on each of the assigned beneficiaries up to 411 beneficiaries for each disease module and preventive care measure. If the pool of eligible assigned beneficiaries for any disease module or preventive care measure is less than 411, then the group practice must populate the remaining data files for 100 percent of eligible assigned beneficiaries for that disease module or preventive care measure. For each disease module or preventive care measure, the group practice must report information on the assigned patients in the order in which they appear in the group's sample (that is, consecutively).

(B) Group Practice Reporting Option for Group Practices of 2–199 NPIs—GPRO–II

As discussed previously, section 1848(m)(3)(C) of the Act authorized us to define the term "group practice" and required us to establish a process under which eligible professionals in group practices shall be treated as satisfactorily submitting data on Physician Quality Reporting System quality measures, but was not prescriptive with regard to the characteristics of this process. Although for 2010 we did not provide a process for groups of less than 200 NPIs to report under the GPRO, we believe that there are significant potential benefits to allowing reporting at the group level generally. Thus, based on this authority we proposed a new group practice reporting option (GPRO II) for groups of 2–199 NPIs in a TIN for 2011 (75 FR 40181). For GPRO II in 2011, we proposed to require groups of eligible professionals who decide to report as a group to self-nominate. We did not propose to preclude a group practice from participating in the GPRO II if we discover, from analysis of the 2010 Medicare claims data, that there are some eligible professionals (identified by NPIs) that are not established Medicare providers (that is, have not billed Medicare Part B on or after January 1, 2010 and prior to or on) as long as the group has at least 2 established Medicare providers. October 29, 2010 NPIs who are not established Medicare providers, however, would not be included in our incentive payment calculations.

We also proposed that self-nominating groups would need to indicate in this letter if the group intends to report as a group for the eRx Incentive Program and the reporting mechanism the group intends to use to report as a group for the eRx Incentive Program.

Since GPRO II would be a new process available to groups in 2011, we proposed to initially pilot the GPRO II process with a limited number of groups. We proposed to select the first 500 groups that meet the proposed eligibility requirements to participate in the 2011 GPRO II. We proposed to use the postmark to determine the order in which groups self-nominated for GPRO II. We proposed to consider only self-nomination letters postmarked between January 3, 2011 and January 31, 2011. We did not propose to consider letters postmarked prior to January 3, 2011 to prevent groups from self-nominating before the GPRO II requirements are finalized and to discourage groups from self-nominating for GPRO II prior to reviewing the final GPRO II requirements.

For purposes of quality data submission, we proposed, for the GPRO II, to allow eligible professionals to submit their data through claims or through a qualified GPRO registry to the extent registries are technically capable of collecting, calculating and transmitting the required data to CMS and that we are able to accept such data from registries.

For GPRO II, we proposed that in addition to reporting a specific number of individual measures, the group would have to report one or more proposed 2011 Physician Quality Reporting System measures groups depending on the size of the group practice.

For purposes of satisfying the requirements under section 1848(m)(3)(C)(i) of the Act for groups of 2–199 NPIs, we proposed that in order to be treated as satisfactorily reporting under GPRO II, the group practice would be required to report on 50 percent or more (if submitting through claims) of all Medicare Part B patients who fit into the measures group denominator or 80 percent or more of Medicare patients if using a registry to report.

Additionally, to earn a Physician Quality Reporting System incentive payment for all allowed Medicare Part B services that are provided by the TIN, we proposed that a group practice must report on three to six individual 2011 Physician Quality Reporting System measures, depending on the size of the group. We proposed that the group practice may select from among any of the 2011 Physician Quality Reporting System measures on which to submit data, provided the measures selected are not duplicated in the measures group(s) reported.

We proposed that, to satisfactorily report individual Physician Quality Reporting System measures, a group must report each measure at the same rate (percentage) as determined by the method of submission as individual eligible professionals. For example, if reporting via claims, to satisfactorily report individual measures, each measure would need to be reported on at least 50 percent of eligible Medicare Part B FFS patients.

An alternative which we considered and sought comment on was to require that the individual measures be selected from a more limited set of measures, such as measures closely linked to improved population health, or other measures perceived to address the greatest potential benefit from improved performance. A second alternative that we considered and sought comment on was to require group practices, as part of the self-nomination process, to designate whether they were a multispecialty group with primary care, a multispecialty group without primary care, or a single specialty group, and if so, the specialty. Depending on what type of specialty the group is, we would identify a set of Physician Quality Reporting System measures pertaining to the group's specialty and require the group practice to report on the identified set of specialty-specific Physician Quality Reporting System measures.

If a group practice participating in the 2011 Physician Quality Reporting System GPRO II wants to also participate in the 2011 eRx Incentive Program as a small group, we proposed that the group would need to indicate

that preference in their self-nomination letter and would need to report on a specified number of unique encounters based on their group size. For GPRO II reporting in the 2011 eRx Incentive Program, we proposed the following reporting mechanisms: claims, a GPRO eRx qualified registry or a GPRO qualified EHR. As with the 2011 eRx Incentive Program for individual eligible professionals and the 2011 eRx Incentive Program GPRO I, at least 10 percent of a GPRO II group's charges would need to be comprised of codes in the denominator of the electronic prescribing measure and the group would need to use an electronic prescribing system that meets the requirements of the 2011 electronic prescribing measure. Similar to proposed GPRO I, if a GPRO II group self-nominates to report the electronic prescribing measure as a group, we proposed that all members of the group practicing under the group's TIN would be ineligible to report as an individual electronic prescriber.

The following is a summary of the comments received regarding our proposal on the GPRO II option and process for group practices to report Physician Quality Reporting System quality data measures.

Comment: We received favorable support for the proposed addition of GPRO II as a group reporting option, including the requirement to self-nominate and report a measures group along with 3 individual relevant performance measures. One commenter stated that GPRO II will help spur more eligible professionals, specifically those with 2–199 member practices, to participate in the Physician Quality Reporting System.

Response: We appreciate the commenters' support and are finalizing our proposal to add GPRO II as a group reporting option. We note, however, that the number of measures groups and individual measures on which a group practice will be required to report will vary by the group practice's sizes. The specific requirements are described in Table 76 of this final rule with comment period.

Comment: Some commenters opposed the proposed cap of the first 500 groups that self-nominate for GPRO II. Commenters were primarily concerned that this would be too limiting. Another commenter noted that this reporting option has the advantage of mid-year interim feedback reports to assist participating groups in determining whether their Physician Quality Reporting System data is being captured appropriately. One commenter recommended that all self-nominations postmarked in the month of January 2011 be accepted for this reporting option. Another commenter urged us to expand GPRO II quickly beyond the initial cap of 500 practices.

Response: We appreciate the commenters' enthusiasm for this new reporting option and would like to be able to make it available to as many groups as possible, but will need to initially limit the number of groups participating in GPRO II for operational reasons. We will accept at least 500 groups, but could potentially accept more depending on our ability to handle a higher volume of groups participating in this option. We expect that we will be able to expand this option further in future years to make it available to more groups. In addition, we would like to clarify that we did not propose to provide interim feedback reports for group practices participating in GPRO II. Rather, we proposed to provide interim feedback reports for individual eligible professionals who submitted measures group data via claims during the first 2 months of 2011. However, as noted in this section, we are not finalizing this proposal.

Comment: Since we proposed to limit participation in GPRO II to 500 groups in 2011, it was recommended that we strive for diversity of specialty representation rather than just a first-come, first-served approach.

Response: We appreciate the commenter's suggestions. As stated previously, we will accept as many groups as resources allow and select a minimum of 500 GPRO II practices for 2011.

Comment: One commenter requested that GPRO II be made available to groups of any size. The commenter believed this would allow group practices to decide whether to participate in GPRO I or GPRO II depending on which option works best for their practice.

Response: We appreciate the commenter's valuable input. As we explore ways to further expand the GPRO II in future years we may consider making it available to groups of any size.

Comment: One commenter suggested that we reduce the number of individual and group measures required to report for GPRO II. Other commenters stated that the requirement to report at least 1 measures group would disadvantage those group practices for which none of the existing measures groups applies or there are a limited number of applicable measures groups.

Response: We understand the commenters' concerns and are revising the criteria for satisfactory reporting. Whereas we proposed to require group practices to report on a specified percentage of patients for both individual measures and measures groups, we are requiring, for 2011, that group practices report on a specified percentage of patients for the individual measures only. For measures groups, group practices will need to report on only the specified minimum number of patients (see Table 76 of this final rule with comment period). In addition, we believe that, on average, the total reporting burden per eligible professional in a group practice is less than the reporting burden for eligible professionals reporting individually. For example, for a group of 5 eligible professionals that is required to report on 1 measures group and 3 individual measures, this means that the group is required to report on less than 2 measures per eligible professionals compared to 3 measures or 1 measures group per individual eligible professional.

With respect to the commenter's concerns that groups with a limited number of applicable measures groups could be disadvantaged, we believe that as we increase the numbers of measures groups available, this would be less of a concern over time. In the meantime, eligible professionals in group practices that do not have any applicable measures groups are still able to report individual measures as individual eligible professionals and meet the criteria for satisfactory reporting individually.

Comment: One commenter requested that we not restrict the selection of Physician Quality Reporting System measures (for example, only population health measures) for GPRO II, given that multi-specialty groups with primary care, multi-specialty groups without primary care, and single specialty groups will be participating in this reporting option. Restrictions to select Physician Quality Reporting System measures may limit the diversity of practices that elect to report through this option. Similarly, another commenter was concerned that requiring so many primary care measures will make it difficult for specialists, such as psychiatrists, to participate in large numbers.

Response: The commenters appear to be suggesting that we are placing restrictions on the selection of measures for the GPRO II, which is not correct. While GPRO I groups are required to report on a standard set of 26 measures, the GPRO II groups can select any 2011 Physician Quality Reporting System individual measures and measures groups that are relevant to their practice

as long as they report the required number of individual measures and measures groups for their group size (see Table 76 of this final rule with comment period). However, in future years and in future rulemaking we expect to reconsider alternative reporting requirements, including the alternatives of identifying a core set of measures for which broad reporting may be required.

Comment: One commenter requested that we clearly indicate how we derived the performance results for each individual professional if we post performance information derived from the GPRO II on the Physician Compare Web site. The commenter was concerned that the reported performance that will be attributed to an individual eligible professional through GPRO II will not necessarily reflect individual performance.

Response: We appreciate the commenter's feedback. To date, we have not made any Physician Quality Reporting System performance rates publicly available. We value input from external stakeholders. Opinions and alternatives that are provided will assist us in future policy decisions as we develop our plans for the Physician Compare Web site. With respect to the commenter's concern that performance information derived from GPRO II will be attributed to an individual eligible professional, group practice reporting is attributed to the entire group, not to the individual. Additionally, we do not intend to publicly report Physician Quality Reporting System performance results for 2011.

Upon consideration of the comments received, group practices that wish to participate in the GPRO II will need to self-nominate. The self-nomination process will consist of sending a letter with the name of the group, the TIN, an e-mail address of the contact person, and the names and NPIs of all of the eligible professionals practicing under that group's TIN. The self-nomination letter must also be accompanied by an electronic file submitted in a format specified by CMS (such as Microsoft Excel) with the group practice's TIN and NPIs. Self-nomination letters should be sent to: GPRO II, c/o CMS, 7500 Security Blvd., Mail Stop S3–02–01, Baltimore, MD 21244, and must be postmarked by January 31, 2011, for consideration in the program. We are also finalizing our proposal to initially limit the number of groups participating in GPRO II. We seek to make this option available to as many groups as possible but have limited resources. Therefore, as stated previously, we will accept at least 500 groups, but could potentially accept more depending on our ability to handle a higher volume of groups participating in this option. We expect that we will be able to expand this option further in future years to make it available to more groups.

Table 76 sets forth the final criteria for satisfactory reporting under the 2011 Physician Quality Reporting System GPRO II and requirements for each group based on their respective group size (number of eligible professionals). As stated previously, GPRO II groups will be required to report on a specified percentage of patients for reporting the individual measures only. To satisfactorily report measures groups for the 2011 Physician Quality Reporting System GPRO II, the group practice need only report on the minimum number of patients specified in Table 76 for their group size. In addition, since we will not have the ability to determine whether the registries can ensure that only unique patients are counted, GPRO II groups must report the 2011 Physician Quality Reporting System data via claims unless the only measures groups that apply to the practice are one of the four registry-only measures groups listed in section VII.F.2.(i).(5). of this final rule with comment period. Group practices that must report on one of the four registry-only measures groups in order to meet the criteria for satisfactory reporting will be able to use the registry-reporting mechanism to submit their 2011 Physician Quality Reporting System data and must submit all of their 2011 Physician Quality Reporting System GPRO II data via the registry reporting mechanism. However, we anticipate that the list of registries qualified to submit 2011 Physician Quality Reporting System GPRO II data will not be available until summer 2011. Group practices will need to indicate the reporting mechanism they intend to use for the 2011 Physician Quality Reporting System GPRO II in their self-nomination letter.

TABLE 76—2011 PROCESS FOR PHYSICIAN GROUP PRACTICES TO PARTICIPATE AS GROUP PRACTICES AND CRITERIA FOR SATISFACTORY REPORTING OF DATA ON QUALITY MEASURES BY GROUP PRACTICES FOR GPRO II

Group size (number of eligible professionals)	Number of measures groups required to be reported	Minimum number of medicare part b patients in denominator for satisfactory reporting of measures groups	Number of individual measures required to be reported	Percent of medicare part b patients in denominator for satisfactory reporting of individual measures via claims (%)	Percent of medicare part b patients in denominator for satisfactory reporting of individual measures via registries (%)	Required number of unique visits where an e-prescription was generated to be a successful electronic prescriber
2–10	1	35	3	50	80	75
11–25	1	50	3	50	80	225
26–50	2	50	4	50	80	475
51–100	3	60	5	50	80	925
101–199	4	100	6	50	80	1875

We are not finalizing our proposal to analyze the individual professional's data to see if they satisfactorily reported at the individual TIN/NPI level if the group does not satisfactorily report as a GPRO II group. We have determined that this is neither practical nor feasible for us. This should have no impact on how groups will report Physician Quality Reporting System data under GPRO since claims will identify both the TIN and the individual eligible professional rendering the service regardless of whether we analyze the claims at the group or individual level. Although there will be some risk to eligible professionals who are part of a GPRO II group if the group fails to satisfactorily report, we believe this risk is outweighed by the additional resources that would be required to process a group's data at both the group and individual levels and the fact that

all participants' incentive payments could potentially be delayed.

h. Statutory Requirements and Other Considerations for 2011 Physician Quality Reporting System Measures

(1) Statutory Requirements for 2011 Physician Quality Reporting System Measures

Under section 1848(k)(2)(C)(i) of the Act, the Physician Quality Reporting System quality measures shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under subsection 1890(a) of the Act (currently, that is the National Quality Forum, or NQF). However, in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the NQF, section 1848(k)(2)(C)(ii) of the Act authorizes the Secretary to specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance. In light of these statutory requirements, we believe that, except in the circumstances specified in the statute, each proposed 2011 Physician Quality Reporting System quality measure would need to be endorsed by the NQF. Additionally, section 1848(k)(2)(D) of the Act requires that for each 2011 Physician Quality Reporting System quality measure, "the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish."

The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted previously, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement were developed. The basic steps for developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards.

(2) Other Considerations for 2011 Physician Quality Reporting System Measures

As stated previously, in addition to reviewing the 2010 Physician Quality Reporting System measures for purposes of developing the proposed 2011 Physician Quality Reporting System measures, we reviewed and considered measure suggestions including comments received in response to the CY 2010 PFS proposed and final rules with comment period. Additionally, suggestions and input received through other venues, such as an invitation for measures suggestions via the Listening Session held February 2, 2010, were also reviewed and considered for purposes of our development of the list of proposed 2011 Physician Quality Reporting System quality measures.

With respect to the selection of new measures, we applied the following considerations, which include many of the same considerations applied to the selection of 2009 and 2010 Physician Quality Reporting System quality measures for inclusion in the 2011 Physician Quality Reporting System quality measure set previously described:

• High Impact on Healthcare.

++ Measures that are high impact and support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries. These current and long term priority topics include the following: Prevention; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections and other conditions; improved care coordination; improved outcomes; improved efficiency; improved patient and family experience of care; improved end-of-life/palliative care; effective management of acute and chronic episodes of care; reduced unwarranted geographic variation in quality and efficiency; and adoption and use of interoperable HIT.

• Measures that are included in, or facilitate alignment with, other Medicare, Medicaid, and CHIP programs in furtherance of overarching healthcare goals.

• NQF Endorsement.

++ Measures must be NQF-endorsed by June 1, 2010, in order to be considered for inclusion in the 2011 Physician Quality Reporting System quality measure set except as provided under section 1848(k)(2)(C)(ii) of the Act.

++ Section 1848(k)(2)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF).

++ The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted previously, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement are developed. The basic steps for developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards. The requirements under section 1848(k)(2)(C) of the Act pertain only to the selection of measures and not to the development of measures.

• Address Gaps in the Physician Quality Reporting System Measure Set.

++ Measures that increase the scope of applicability of the Physician Quality Reporting System measures to services furnished to Medicare beneficiaries and expand opportunities for eligible professionals to participate in the Physician Quality Reporting System.

• Measures of various aspects of clinical quality including outcome measures, where appropriate and feasible, process measures, structural measures, efficiency measures, and measures of patient experience of care.

Other considerations that we applied to the selection of measures for 2011, regardless of whether the measure was a 2010 Physician Quality Reporting System measure or not, were—

• Measures that are functional, which is to say measures that can be technically implemented within the capacity of the CMS infrastructure for data collection, analysis, and calculation of reporting and performance rates. For example, we proposed to replace existing 2010 Physician Quality Reporting System measures #114 and #115 with updated and improved measure #TBD

(Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention), which is less technically challenging to report.

• In the 2011 Physician Quality Reporting System, as in the 2010 Physician Quality Reporting System, for some measures that are useful, but where data submission is not feasible through all otherwise available Physician Quality Reporting System reporting mechanisms, a measure may be included for reporting solely through specific reporting mechanism(s) in which its submission is feasible.

In the proposed rule, we invited comments on the implication of including or excluding any given measure or measures for our proposed 2011 Physician Quality Reporting System quality measure set, as well as feedback relative to our proposed approach in selecting measures (75 FR 40185). We indicated that while we welcome all constructive comments and suggestions, and may consider such recommended measures for inclusion in future measure sets for the Physician Quality Reporting System and other programs to which such measures may be relevant, we were not able to consider such additional measures for inclusion in the final 2011 measure set.

As discussed previously, section 1848(k)(2)(D) of the Act requires that the public have the opportunity to provide input during the selection of measures. We also are required by other applicable statutes to provide opportunity for public comment on provisions of policy or regulation that are established via notice and comment rulemaking. Measures that were not included in the proposed rule for inclusion in the 2011 Physician Quality Reporting System that are recommended to CMS via comments on the proposed rule have not been placed before the public to comment on the selection of those measures within the rulemaking process. Even when measures have been published in the **Federal Register**, but in other contexts and not specifically proposed as Physician Quality Reporting System measures, such publication does not provide true opportunity for public comment on those measures' potential inclusion in the Physician Quality Reporting System. Thus, such additional measures recommended for selection for the 2011 Physician Quality Reporting System via comments on the CY 2011 PFS proposed rule cannot be included in the 2011 measure set. However, as discussed previously, we will consider comments and recommendations for measures, which may not be applicable to the final set of 2011 Physician Quality Reporting System measures, for purposes of identifying measures for possible use in the Physician Quality Reporting System in future years or other initiatives to which those measures may be pertinent.

In addition, as in prior years, we again note that we do not use notice and comment rulemaking as a means to update or modify measure specifications. Quality measures that have completed the consensus process have a designated party (usually, the measure developer/owner) who has accepted responsibility for maintaining the measure. In general, it is the role of the measure owner, developer, or maintainer to make changes to a measure. Therefore, comments requesting changes to a specific proposed Physician Quality Reporting System measure's title, definition, and detailed specifications or coding should be directed to the measure developer identified in Tables 78 through 96. Contact information for the 2010 Physician Quality Reporting System measure developers is listed in the "2010 PQRI Quality Measures List," which is available on the Physician Quality Reporting System section of the CMS Web site at *http://www.cms.gov/PQRI.*

However, we stress that inclusion of measures that are not NQF endorsed or AQA adopted is an exception to the requirement under section 1848(k)(2)(C)(i) of the Act that measures be endorsed by the NQF. We may exercise this exception authority in a specified area or medical topic for which a feasible and practical measure has not been endorsed by NQF, so long as due consideration is given to measures that have been endorsed by the NQF.

(3) Summary of Comments and Responses

The following is summary of the comments we received regarding the statutory requirements and other considerations for the selection of 2011 Physician Quality Reporting System measures.

Comment: Some commenters strongly support the adoption of NQF-endorsed measures only. One commenter stated that the AQA is no longer doing measure evaluation work and should not be allowed to approve measures for the Physician Quality Reporting System as a way to sidestep the well-designed and well-executed process of the NQF.

Response: We agree that endorsement of measures by the NQF is an important criteria for inclusion in the Physician Quality Reporting System. However, section 1848(k)(2)(C)(i) of the Act provides an exception to the requirement that measures be endorsed by the NQF. We may exercise this exception authority in a specified area or medical topic for which a feasible and practical measure has not been endorsed by NQF, so long as due consideration is given to measures that have been endorsed by the NQF. For this reason, we retain the ability to include non-NQF endorsed measures in the Physician Quality Reporting System. Once those measures work through the NQF process, we may remove those that were not endorsed by the NQF from the program.

Comment: A few commenters opposed our conclusion that any organization can develop quality measures. The AMA-specialty society quality consortium, the PCPI, should be recognized by us to specify the quality measures and adequately test them for inclusion in the Meaningful Use program.

Response: We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out the basic development of measures for physicians and other eligible professionals, such as restricting the initial development to physician-controlled organizations. While we agree that expertise in measure development is important in the measure development and consensus processes, any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards. In addition, physicians are not the only types of professionals eligible to participate in the Physician Quality Reporting System.

Comment: Another commenter encouraged us to allow for other means for measure endorsement due to NQF's lack of timeliness and consistency issues.

Response: As stated previously, section 1848(k)(2)(C)(i) of the Act provides an exception to the requirement that measures be endorsed by the NQF. We may exercise this exception authority in a specified area or medical topic for which a feasible and practical measure has not been endorsed by NQF, so long as due consideration is given to measures that have been endorsed by the NQF. In certain circumstance, we have exercised this exception authority to include measures that have not yet gone through the NQF endorsement process to address measure gaps.

Comment: Many commenters requested that we encourage the development and use of measures in

specific areas or topics. The specific areas or topics that commenters recommended as priorities included sub-specialty specific measures, measures that reflect the day-to-day treatment of cancer patients, risk-adjusted outcome measures (as opposed to process measures), measures that better reflect patient preferences, patient experience, functional status, and care coordination, measures that capture demographic data in ways that enable measures to be stratified and used to identify and address health disparities, measures that address high-burden disease areas especially prevalent in the Medicare beneficiary population, broader measures to enhance accurate identification and treatment of atrial fibrillation, measures that will be retooled for future use in EHR reporting, measures that must be retooled for the impending ICD–10–CM/PCS compliance date, and measures to capture whether patients have received preventive vaccinations.

Response: We appreciate the commenters' recommendations for expanding criteria for measure selection and prioritization. We note, however, that we largely depend on the development of measures by professional organizations and other measure developers and encourage professional organizations and other measure developers to fund and develop measures that address the priority areas identified by the commenters. In addition, if there are specific measures that commenters would like us to consider for future years to address these areas, we urge them to submit the specific measure suggestions via the 2012 Call for Measures. Information on the 2012 Call for Measures will be posted on the Physician Quality Reporting System section of the CMS Web site when it becomes available. We anticipate conducting the 2012 Call for Measures in late 2010 or early 2011.

Comment: One commenter suggested the proposed addition of Physician Quality Reporting System measures for 2011 be re-visited in context with the August 2010 publication of 69 NQF-endorsed® ambulatory performance measures.

Response: We appreciate the commenter's valuable input. As stated previously and in the proposed rule (75 FR 40185), we are not able to consider additional measures for inclusion in the final 2011 Physician Quality Reporting System measure set beyond what we proposed. However, we may consider them for inclusion in future measure sets for the Physician Quality Reporting System.

Comment: A few commenters recommended that we implement more meaningful and impactful measures. Some of the actions specifically recommended by the commenters include:

- Require the collection of patient experience surveys, if there is an NQF-endorsed survey available for that professional;
- Remove measures that "document" the presence of evaluation, assessment, and counseling as there is no relationship between such measures and patient outcome;
- Consider adding measures from NQF's Ambulatory Care Measures Using Clinically Enriched Administrative Data that are appropriate for the Medicare population; and
- Develop measures that will fill gaps in the Physician Quality Reporting System measure set and that adhere to key criteria for robust measures.

Response: We appreciate the commenter's feedback regarding the use of more meaningful and impactful measures in the Physician Quality Reporting System. We appreciate the time and effort taken in providing your recommendation and, as stated previously, we urge the commenter to work with professional organizations and other measure developers to fund and develop measures that address the priority areas identified by the commenter and/or submit recommendations for specific measures that the commenter would like us to consider for future years via the 2012 Call for Measures.

Comment: One commenter urged us to be mindful of the resources required to translate quality data into improved provider performance. Therefore, we should ensure appropriate phasing-in of new measures into our current quality reporting programs.

Response: We appreciate the commenter's valuable input. While we strive to identify gaps of care and ensure that specialties have measures to report, we also recognize that there is a level of effort associated with translating the quality data reported into better care. As such, we are adding a limited set of new measures that focuses on identified gaps and ensures specialties have measures to report.

Comment: One commenter requested that we further explore and discuss the phase-in dates in context with the ICD–10–CM/PCS transition date.

Response: We are planning for implementation of ICD–10 and are working in collaboration with the Physician Quality Reporting System measure developers/owners towards the coding transition. More information on the phase-in dates for this transition will be provided once it becomes available.

i. The Final 2011 Physician Quality Reporting System Quality Measures for Individual Eligible Professionals

For 2011, we proposed to include a total of 200 measures (this includes both individual measures and measures that are part of a proposed 2011 measures group) on which individual eligible professionals can report for the 2011 Physician Quality Reporting System (75 FR 40185 through 40198).

The following is a summary of the comments received on the proposed 2011 Physician Quality Reporting System measures in general and comments on the measures from the 2010 Physician Quality Reporting System not proposed for inclusion in the 2011 Physician Quality Reporting System.

Comment: One commenter suggested that we consider publishing a list of reportable measures for each eligible profession. This would make the reporting process more clear and accessible to professionals trying to participate in the program by helping them quickly determine which measures are relevant to their practices.

Response: In August 2010, we posted on the Analysis and Payment page of the Physician Quality Reporting System section of the CMS Web site *http://www.cms.gov/pqri,* a 1st quarter 2010 aggregate QDC error report by specialty. For each 2010 Physician Quality Reporting System measure, this report lists the specialties that submitted valid QDCs for the measure during the 1st quarter of 2010. Thus, an eligible professional could use this report to ascertain whether a measure is reportable by his or her profession.

Comment: One commenter suggested that it would be useful for participating eligible professionals, as well as other stakeholders, if we developed a table that clearly summarizes the status of a measure's NQF endorsement, AQA endorsement, owner, and how the measure aligns with meaningful use clinical quality measure requirements.

Response: Tables 78 through 97 of this final rule with comment period includes the status of each measure's NQF endorsement, as well as AQA endorsement if applicable and the measure is not NQF endorsed. In addition, Tables 55 and 56 of the CY 2011 PFS proposed rule (75 FR 40193), which lists the measures available for EHR reporting in 2011, includes information as to whether a measure is included in the EHR Incentive Program for program years 2011 and 2012. We

note, however, that the electronic specifications for measures that are included in the Physician Quality Reporting System and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.

Comment: We received numerous comments in support of the 2010 Physician Quality Reporting System quality measures proposed for inclusion in the 2011 Physician Quality Reporting System. Specific measures or measures topics on which we received favorable support include the measures on osteoporosis, audiology, speech-language pathology, and measures 9, 106, 107, 124, 126, 127, 128, 130, 131, 134, 148, 149, 150, 151, 154, 155, 173, 181, 188, 189, 190, and 200. Commenters often cited the applicability of a specific measure to their specialty and/or profession.

Response: We appreciate the feedback and are finalizing our proposals to include these measures in the 2011 Physician Quality Reporting System measure set. These measures address one or more of the considerations for measures selected for inclusion in the 2011 Physician Quality Reporting System previously discussed.

Comment: A couple of commenters asked us to reconsider the proposal to retire Measure #135, Chronic Kidney Disease (CKD): Influenza Immunization. Although the measure was considered for endorsement by NQF but was ultimately not endorsed, the measure is adopted by the AQA.

Response: On August 26, 2010, we published a correction notice in the **Federal Register** (75 FR 52487) indicating we inadvertently included this measure in the table that lists the 2010 Physician Quality Reporting System measures not proposed to be included in the 2011 Physician Quality Reporting System. As such, we are including Measure #135 in the 2011 Physician Quality Reporting System individual measures set only. We are not, however, finalizing our proposal to include Measure #135 from the CKD Measures Group. The reporting requirements for Measure #135 are different from the other measures in the CKD measures group.

Comment: A couple of commenters recommended keeping Measure #136, Melanoma: Follow-Up Aspects of Care, for purposes of reporting to the 2011 Physician Quality Reporting System. The commenters believe that although the measure is no longer endorsed by the National Quality Forum, it is still a valuable tool in clinician quality improvement. The commenters also noted that this measure is most effective as part of a set with Measures #137: Melanoma: Continuity of Care—Recall System and #138: Melanoma: Coordination of Care, which are maintained in the list of measures available for 2011 Physician Quality Reporting System.

Response: We are finalizing our proposal to not include Measure #136 in the 2011 Physician Quality Reporting System measure set. As stated in the proposed rule, (75 FR 40186) and by the commenter, Measure #136 was considered by NQF for possible endorsement but ultimately was not NQF-endorsed. We note, also, that we proposed and are finalizing a new melanoma measure, Melanoma: Overutilization of Imaging Studies in Stage 0–1A Melanoma, for the 2011 Physician Quality Reporting System. This measure meets one or more of the considerations for measures selected for inclusion in the 2011 Physician Quality Reporting System.

Comment: We received one comment in support of our proposal to retire Measure #139 Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement. Another commenter, however, requested that this measure be retained because it evaluates safe and appropriate use of cataract surgery.

Response: We appreciate the commenters' feedback. Based on the fact that the measure was reviewed for endorsement by the NQF and ultimately not endorsed, we are finalizing our proposal to not include this measure in the 2011 Physician Quality Reporting System measure set.

Comment: In addition to the quality measures and measures groups for individual eligible professionals we had proposed in Tables 52 through 54 of the CY 2011 PFS proposed rule (75 FR 40186 through 40192), several commenters suggested quality measures, measures groups, and/or topics for which additional measures or measures groups should be added for the 2011 Physician Quality Reporting System. Specifically, commenters recommended that we adopt—

- A measure for AAA ultrasound screening;
- A COPD measures group;
- A stroke measures group comprised of the following 5 measures: (1) Deep vein thrombosis (DVT) prophylaxis; (2) Discharged on antithrombotic therapy; (3) Patients with atrial fibrillation/flutter receiving anticoagulant therapy; (4) Thrombolytic therapy; and (5) Discharged on statin medication;
- A measures group that focuses on quality measures common to every long-term care resident, which could include Physician Quality Reporting System measures #47, 110, 111, 130, 154, and 155;
- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients; and
- Comprehensive Colonoscopy Documentation.

Response: As stated previously, we have not included in this final rule with comment period for the 2011 Physician Quality Reporting System any individual and measures groups that were not identified in the CY 2011 PFS proposed rule as proposed 2011 Physician Quality Reporting System measures. We are obligated by section 1848(k)(2)(D) of the Act to give eligible professionals an opportunity to provide input on measures recommended for selection, which we do via the proposed rule. Thus, such additional measures recommended via comments on the proposed rule cannot be included in the 2011 Physician Quality Reporting System quality measure set. However, we have captured these recommendations and will have them available for consideration in identifying measure sets/groups for the Physician Quality Reporting System for future years and other initiatives to which those measures or measures groups may apply.

Comment: Some commenters asked that we reconsider measures or measures groups that had been previously submitted to us as suggestions for 2011 Physician Quality Reporting System measures but were not proposed for inclusion in the 2011 Physician Quality Reporting System measure set. Specifically, commenters requested that we reconsider inclusion of the Parkinson's disease and epilepsy measurement sets in the Physician Quality Reporting System program, a diabetic retinopathy measures group with 2 measures, and a cataracts measures group with 2 measures.

Response: All measures or measures groups that were previously submitted to us as suggestions for 2011 Physician Quality Reporting System measures were reviewed for possible inclusion in the 2011 Physician Quality Reporting System measure set. Upon review, however, some measures either failed to meet the threshold criteria for inclusion in the 2011 Physician Quality Reporting system measure set (as described previously) or did not meet the definition of "measures group" proposed and finalized at 42 CFR 414.90. These measures that did not pass the review process were not proposed for inclusion in the 2011 Physician Quality Reporting System measure set.

Comment: Several commenters recommended changes to the detailed specifications or coding for one or more of the proposed measures or measures groups. Many of the requests were specifically concerned that measures be expanded to include additional professionals to whom the measure(s) may apply.

Specifically, one commenter requested that any measure used by primary care physicians be expanded to include not just the office, but home and domiciliary codes as well. One commenter requested that the denominator codes for the CAP measures group be expanded to include other infectious pneumonia ICD–9–CM diagnostic codes than "acute" pneumonia diagnosis codes so pulmonologists can have sufficient numbers of patients to report this measures group. A few commenters requested that the age range for the proposed asthma measures group be expanded, instead of being restricted to 5 to 50 years of age. One commenter requested that the Initial Hospital Admit Evaluation and Management codes (99221, 99222, and 99223) be removed from the denominators of measures #32, #33 and #36 and added to measures #56–59 for 2011. The commenter also requested that an exemption be given to eligible professionals penalized for not reaching an 80 percent reporting threshold on measures #32, #33, and #36 because of the unintended effect of substituting the 99221, 99222, and 99223 series codes for the consultation 99251–99255 series that had been eliminated from the Medicare program. Lastly, another commenter requested that allowable performance exclusion codes be created for measures #201 and #202.

Response: Although the Secretary is required to provide opportunities for public comment on selected measures and do so through notice and comment rulemaking, we do not use notice and comment rulemaking as a means to update or modify measure specifications. In general, it is the role of the measure owner, developer, or maintainer to make substantive changes to the measures, such as the changes suggested by the commenters. The measure maintainer and/or the developer/owner of a measure included in the final set of 2011 Physician Quality Reporting System measures is identified in the "Measure developer" column of Tables M6 through M24. In addition, for those measures which are NQF-endorsed, the NQF has an established maintenance process that could be accessed to recommend the changes suggested by the commenters.

Comment: One commenter supported our proposal to replace Physician Quality Reporting System Measures #114 and #115 with the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure (NQF Measure Number 0028). Another commenter, however, requested that Physician Quality Reporting System Measures #114 and #115 be included in the 2011 Physician Quality Reporting System as these measures are included in the EHR Incentive Program clinical quality measures and thus will be of great interest for eligible professionals to report on.

Response: Although Physician Quality Reporting System Measures #114 and #115 are included as clinical quality measures under the EHR Incentive Program, we have decided, for the Physician Quality Reporting System, to replace Physician Quality Reporting System Measures #114 Preventive Care and Screening: Inquiry Regarding Tobacco Use and #115 Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit with an NQF-endorsed measure, Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. We believe this measure is more comprehensive and less technically challenging than Physician Quality Reporting System Measures #114 and #115. We may consider aligning the preventive care and screening measures related to tobacco use and smoking under these 2 programs in future years.

Comment: One commenter stressed the importance of publishing the detailed Physician Quality Reporting System specifications for individual measures and measures groups by November 15, 2010.

Response: We will make every attempt to post the detailed specifications and specific instruction for reporting 2011 individual and measures groups on the Physician Quality Reporting System section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as close to November 15, 2010 as possible. In any event, the detailed specifications will be posted by no later than December 31, 2010.

Based on the criteria previously discussed and our review of these comments, we are including the individual measures listed in Tables M6 through M10 in the final 2011 Physician Quality Reporting System individual quality measure set. We are also including 14 measures groups in the final 2011 Physician Quality Reporting System quality measure set, which are listed in Tables M11 through M24. The individual measures selected for the 2011 Physician Quality Reporting System can be categorized as follows:

- 2011 Individual Quality Measures Selected From the 2010 Physician Quality Reporting System Quality Measures Set Available for Claims-based Reporting and Registry-based Reporting;
- 2011 Individual Quality Measures Selected From the 2010 Physician Quality Reporting System Quality Measures Set Available for Registry-based Reporting Only;
- New Individual Quality Measures for 2011; and
- 2011 Measures Available for EHR-based Reporting.

In addition, we are retiring the 5 measures in Table 77 because they did not meet one or more of the considerations for selection of 2011 measures. Specifically, we retired Physician Quality Reporting System Measures #136, #139, and #174 for 2011 because they were considered by NQF for possible endorsement but ultimately were not NQF-endorsed. In addition, we are replacing 2010 Physician Quality Reporting System Measures #114 and #115 with an updated and improved measure (#TBD "Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention"), which is less technically challenging to report.

TABLE 77—2011 PHYSICIAN QUALITY REPORTING SYSTEM QUALITY MEASURES NOT INCLUDED IN THE 2011 PHYSICIAN QUALITY REPORTING SYSTEM

Physician Quality Reporting System Measure No.	Measure title
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit.
136	Melanoma: Follow-Up Aspects of Care.
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement.

TABLE 77—2011 PHYSICIAN QUALITY REPORTING SYSTEM QUALITY MEASURES NOT INCLUDED IN THE 2011 PHYSICIAN QUALITY REPORTING SYSTEM—Continued

Physician Quality Reporting System Measure No.	Measure title
174	Pediatric End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis.

(1) 2011 Individual Quality Measures Selected From the 2010 Physician Quality Reporting System Quality Measures Set Available for Claims-Based Reporting and Registry-Based Reporting

For 2011, we proposed to retain 171 measures currently used in the 2010 Physician Quality Reporting System. These 171 proposed measures include 45 registry-only measures currently used in the 2010 Physician Quality Reporting System, and 126 individual quality measures for either claims-based reporting or registry-based reporting (75 FR 40186 through 40190 and 52489 through 52490). These 171 proposed measures did not include any measures that are proposed to be included as part of the 2011 Back Pain measures group. Similar to the 2010 Physician Quality Reporting System, for 2011, we proposed that any 2011 Physician Quality Reporting System measures that are included in the Back Pain measures group would not be reportable as individual measures through claims-based reporting or registry-based reporting.

Although they were ultimately not NQF-endorsed, we proposed to exercise our exception authority under section 1848(k)(2)(C)(ii) of the Act and include measures #188, #189, and #190, since we are not aware of any other NQF-endorsed measures that are available to audiologists.

The following is a summary of the comments received on the proposed 2011 individual quality measures selected from the 2010 Physician Quality Reporting System quality measures set available for claims-based reporting and registry-based reporting.

Comment: A commenter urged us to continue to allow reporting of measure #175, Plan of Care for Inadequate Hemodialysis in 2011, regardless of NQF endorsement since this was approved by the AQA in 2008.

Response: We are unclear whether the commenter is referring to measure #174, which is the Pediatric ESRD: Plan of Care for Inadequate Hemodialysis measure or measure #175, which is the Pediatric ESRD: Influenza Immunization measure since both of these are AQA adopted measures. For the reasons described previously, we are not retaining measure #174 for the 2011 Physician Quality Reporting System. We are, however, retaining measure #175 for the 2011 Physician Quality Reporting System.

Comment: A commenter supported the 2011 proposed measures selected from the 2010 Physician Quality Reporting System measure set available for either claims-based reporting or registry-based reporting but noted there have been inquiries about how the process component of Measure #193: Perioperative Temperature Management is defined. As a result, the commenter pointed out that this measure is undergoing revision.

Response: We appreciate the commenter's valuable input and will continue to monitor the status of this measure.

For the reasons discussed previously and based on the comments received, we are finalizing in the 2011 Physician Quality Reporting System quality measure set the 171 2010 Physician Quality Reporting System measures that were proposed to be available in the 2010 Physician Quality Reporting System for claims and registry reporting identified in Table 78. The 171 individual 2010 Physician Quality Reporting System measures selected for inclusion in the 2011 Physician Quality Reporting System quality measure set as individual quality measures for either claims-based reporting or registry-based reporting are listed by their Physician Quality Reporting System Measure Number and Title in Table 78, along with the name of the measure's developer/owner and NQF measure number, if applicable. The Physician Quality Reporting System Measure Number is a unique identifier assigned by CMS to all measures in the Physician Quality Reporting System measure set. Once a Physician Quality Reporting System Measure Number is assigned to a measure, it will not be used again to identify a different measure, even if the original measure to which the number was assigned is subsequently retired from the Physician Quality Reporting System measure set. A description of the measures listed in Table 78 can be found in the "2010 PQRI Quality Measures List," which is available on the Measures and Codes page of the Physician Quality Reporting System section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*.

BILLING CODE 4120–01–P

TABLE 78: 2011 Individual Measures Selected From the 2010 Physician Quality Reporting System Quality Measure Set Available for Either Claims-based Reporting or Registry-based Reporting

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA	0059
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	NCQA	0064
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA	0061
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	AMA-PCPI	0067
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD	NCQA	0105
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports	AMA-PCPI/NCQA	0246
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	AMA-PCPI/NCQA	0086
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	AMA-PCPI/NCQA	0087
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	AMA-PCPI/NCQA	0088
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care	AMA-PCPI/NCQA	0089
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician	AMA-PCPI/NCQA	0270
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	AMA-PCPI/NCQA	0268
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	AMA-PCPI/NCQA	0271
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	AMA-PCPI/NCQA	0239
24	Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	AMA-PCPI/NCQA	0045
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	AMA-PCPI/NCQA	0092
30	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics	AMA-PCPI/NCQA	0270
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	AMA-PCPI/NCQA	0240

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	AMA-PCPI/NCQA	0325
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	AMA-PCPI/NCQA	0243
36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	AMA-PCPI/NCQA	0244
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	AMA-PCPI/NCQA	0046
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	AMA-PCPI/NCQA	0045
41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	AMA-PCPI/NCQA	0049
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	Society of Thoracic Surgeons (STS)	0516
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	STS	0235
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	AMA-PCPI/NCQA	0637
46	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	AMA-PCPI/NCQA	0097
47	Advance Care Plan	AMA-PCPI/NCQA	0326
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA	0098
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA	0099
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA	0100
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	AMA-PCPI	0091
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	AMA-PCPI	0102
53	Asthma: Pharmacologic Therapy	AMA-PCPI	0047
54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	AMA-PCPI/NCQA	0090
55	12-Lead Electrocardiogram (ECG) Performed for Syncope	AMA-PCPI/NCQA	0093
56	Community-Acquired Pneumonia (CAP): Vital Signs	AMA-PCPI/NCQA	0232
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	AMA-PCPI/NCQA	0094
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status	AMA-PCPI/NCQA	0234
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic	AMA-PCPI/NCQA	0096
64	Asthma: Asthma Assessment	AMA-PCPI	0001

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
65	Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use	NCQA	0069
66	Appropriate Testing for Children with Pharyngitis	NCQA	0002
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	AMA-PCPI/American Society of Hematology (ASH)	0377
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	AMA-PCPI/ASH	0378
69	Multiple Myeloma: Treatment with Bisphosphonates	AMA-PCPI/ASH	0380
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	AMA-PCPI/ASH	0379
71	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	AMA-PCPI/American Society of Clinical Oncology (ASCO)/National Comprehensive Cancer Network (NCCN)	0387
72	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	AMA-PCPI/ASCO/NCCN	0385
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol	AMA-PCPI	0464
79	End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD	AMA-PCPI	0227
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	AMA-PCPI	0395
85	Hepatitis C: HCV Genotype Testing Prior to Treatment	AMA-PCPI	0396
86	Hepatitis C: Antiviral Treatment Prescribed	AMA-PCPI	0397
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	AMA-PCPI	0398
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	AMA-PCPI	0401
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	AMA-PCPI	0394
91	Acute Otitis Externa (AOE): Topical Therapy	AMA-PCPI	AQA adopted Currently under NQF review
92	Acute Otitis Externa (AOE): Pain Assessment	AMA-PCPI	AQA adopted Currently under NQF review

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	AMA-PCPI	AQA adopted Currently under NQF review
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility	AMA-PCPI	AQA adopted Currently under NQF review
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	AMA-PCPI/College of American Pathologists (CAP)	0391
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	AMA-PCPI/CAP	0392
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients	AMA-PCPI	0389
104	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients	AMA-PCPI	0390
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy	AMA-PCPI	0388
106	Major Depressive Disorder (MDD): Diagnostic Evaluation	AMA-PCPI	0103
107	Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	0104
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	NCQA	0054
109	Osteoarthritis (OA): Function and Pain Assessment	AMA-PCPI	0050
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA-PCPI	0041
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA	0043
112	Preventive Care and Screening: Screening Mammography	NCQA	0031
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA	0034
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	NCQA	0058
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA	0055
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	NCQA	0062
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorous, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	AMA-PCPI	Not applicable
122	Chronic Kidney Disease (CKD): Blood Pressure Management	AMA-PCPI	AQA adopted

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
123	Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	AMA-PCPI	AQA adopted
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	CMS/Quality Insights of Pennsylvania (QIP)	0488
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	American Podiatric Medical Association (APMA)	0417
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	APMA	0416
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS/QIP	0421
130	Documentation of Current Medications in the Medical Record	CMS/QIP	0419
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up	CMS/QIP	0420
134	Screening for Clinical Depression and Follow-Up Plan	CMS/QIP	0418
135	Chronic Kidney Disease (CKD): Influenza Immunization	AMA-PCPI	AQA adopted
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	AMA-PCPI/NCQA	0566
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of Plan of Care	AMA-PCPI/NCQA	0563
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications	AMA-PCPI	0051
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	AMA-PCPI/NCQA	0510
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	AMA-PCPI/NCQA	0508
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	AMA-PCPI	0511
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	AMA-PCPI	AQA adopted
154	Falls: Risk Assessment	AMA-PCPI/NCQA	AQA adopted
155	Falls: Plan of Care	AMA-PCPI/NCQA	AQA adopted
156	Oncology: Radiation Dose Limits to Normal Tissues	AMA-PCPI	0382
157	Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection	STS	0455

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
158	Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy	Society of Vascular Surgeons (SVS)	0466
163	Diabetes Mellitus: Foot Exam	NCQA	0056
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula	SVS	0259
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	AMA-PCPI	AQA adopted
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization	AMA-PCPI	AQA adopted
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	AMA-PCPI/NCQA	AQA adopted
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	AMA-PCPI/NCQA	AQA adopted
178	Rheumatoid Arthritis (RA): Functional Status Assessment	AMA-PCPI/NCQA	AQA adopted
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	AMA-PCPI/NCQA	AQA adopted
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	AMA-PCPI/NCQA	AQA adopted
181	Elder Maltreatment Screen and Follow-Up Plan	CMS/QIP	AQA adopted
182	Functional Outcome Assessment in Chiropractic Care	CMS/QIP	AQA adopted
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	AMA-PCPI	0399
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	AMA-PCPI	0400
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	AMA-PCPI/NCQA	AQA adopted Currently under NQF review
186	Wound Care: Use of Compression System in Patients with Venous Ulcers	AMA-PCPI/NCQA	AQA adopted
188	Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear	Audiology Quality Consortium (AQC)	Not applicable
189	Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear Within the Previous 90 days	AQC	Not applicable
190	Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progessive Hearing Loss	AQC	Not applicable
193	Perioperative Temperature Management	AMA-PCPI	0454
194	Oncology: Cancer Stage Documented	AMA-PCPI/ASCO	0386
195	Stenosis Measurement in Carotid Imaging Studies	AMA-PCPI/NCQA	0507

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
201	Ischemic Vascular Disease (IVD): Blood Pressure Management Control	NCQA	0073
202	Ischemic Vascular Disease (IVD): Complete Lipid Profile	NCQA	0075
203	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control	NCQA	0075
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NCQA	0068

BILLING CODE 4120–01–C

Please note that detailed measure specifications, including the measure's title, for 2010 individual Physician Quality Reporting System quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2011. The 2011 Physician Quality Reporting System quality measure specifications for any given individual quality measure may, therefore, be different from specifications for the same quality measure used in prior years. Specifications for all 2011 individual Physician Quality Reporting System quality measures, whether or not included in the 2010 Physician Quality Reporting System program, must be obtained from the specifications document for 2011 individual Physician Quality Reporting System quality measures, which will be available on the Physician Quality Reporting System section of the CMS Web site on or before December 31, 2010.

(2) 2011 Individual Quality Measures Selected From the 2010 Physician Quality Reporting System Quality Measures Set Available for Registry-Based Reporting Only

We proposed to include 45 registry-only individual measures from the 2010 Physician Quality Reporting System (75 FR 40191). As in the 2010 Physician Quality Reporting System, we proposed to designate these measures as registry-only measures for 2011 to relieve ongoing analytical difficulties encountered with claims-based reporting of these measures in prior program years. The following is a summary of the comments received on the proposed registry-only measures.

Comment: One commenter expressed concern over our proposal to limit measure #174, Pediatric End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis, to registry-based reporting for 2011. The commenter stated that since there are only two pediatric ESRD measures included in the Physician Quality Reporting System for 2010 and we require eligible professionals who report via a registry to report 3 measures, it is difficult for pediatric nephrologists to participate in this valuable program. Further, the commenter indicated that even if participation could be based on the reporting of two measures, the registry process itself is not available to the vast majority of pediatric nephrologists who practice in small, academic departments, none of whose other members care for Medicare beneficiaries. Thus, the commenter suggested that similar to the provision that allows one of the pediatric ESRD measures (influenza immunization) to be reported in this individual manner, a mechanism be made available allowing pediatric dialysis centers to report adequacy results separately. In the absence of changes in the requirement to report at least three measures, separate reporting of individual measures would allow more pediatric nephrologists to participate in the Physician Quality Reporting System and advance the ultimate goal of quality improvement.

Response: We appreciate the comment and interest expressed on behalf of the pediatric nephrology community. For the 2011 Physician Quality Reporting System, we have decided not to include Physician Quality Reporting System Measure #174, since this measure was recently reviewed by NQF but not endorsed. As a result, only 1 of the 2 individual measures identified by the commenter as being relevant to pediatric nephrologists, #175, Pediatric End-Stage Renal Disease (ESRD): Influenza Immunization, is included in the final 2011 Physician Quality Reporting System measure set. This measure is available for claims-based reporting. Eligible professionals who have fewer than 3 applicable measures can still participate in the 2011 Physician Quality Reporting System via claims. Such eligible professionals would need to report on the applicable measure available for claims-based reporting via claims and meet the appropriate criteria for satisfactory reporting of individual measures in order to qualify for a 2011 Physician Quality Reporting System incentive payment.

For the reasons discussed previously and based on the comments received, we are finalizing in the 2011 Physician Quality Reporting System quality measure set 44 of the 45 proposed 2010 Physician Quality Reporting System measures identified in Table 78 of the proposed rule for registry reporting only. As stated previously, we are not finalizing Physician Quality Reporting System Measure #174 because the measure was reviewed for endorsement by NQF but not ultimately endorsed.

The 44 2010 Physician Quality Reporting System measures selected for the 2011 Physician Quality Reporting System that are available for registry reporting only are listed in Table 79 of this final rule with comment period. These measures are listed by their Physician Quality Reporting System Measure Number and Title, along with the name of the measure's developer/owner and NQF endorsement status, if applicable. A description of the measures listed in Table 79 can be found in the "2010 PQRI Quality Measures List," which is available on the Measures and Codes page of the Physician Quality Reporting System section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

BILLING CODE 4120–01–P

TABLE 79: 2011 Individual Measures Selected From the 2010 Physician Quality Reporting System Quality Measure Set Available for Registry-based Reporting Only

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0081
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	AMA-PCPI	0070
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0083
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge	AMA-PCPI/NCQA	0241
81	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients	AMA-PCPI	0323
82	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis	AMA-PCPI	0321
83	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia	AMA-PCPI	0393
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0066
137	Melanoma: Continuity of Care – Recall System	AMA-PCPI/NCQA	0650
138	Melanoma: Coordination of Care	AMA-PCPI/NCQA	0561
143	Oncology: Medical and Radiation – Pain Intensity Quantified	AMA-PCPI	0384
144	Oncology: Medical and Radiation – Plan of Care for Pain	AMA-PCPI	0383
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	AMA-PCPI/NCQA	0404
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	AMA-PCPI/NCQA	0405
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	AMA-PCPI/NCQA	0406
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	AMA-PCPI/NCQA	0407
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)	STS	0129
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	STS	0130
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)	STS	0131
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency	STS	0114
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	STS	0115

Physician Quality Reporting System Measure Number	Measure Title	Measure Developer	NQF Measure Number
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	STS	0237
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	STS	0238
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling	STS	0118
187	Stroke and Stroke Rehabilitation: Thrombolytic Therapy	AHA/ASA/ TJC	0437
191	Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery	AMA-PCPI/NCQA	0565
192	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	AMA-PCPI/NCQA	0564
196	Coronary Artery Disease (CAD): Symptom and Activity Assessment	AMA-PCPI	0065
197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	AMA-PCPI	0074
198	Heart Failure: Left Ventricular Function (LVF) Assessment	AMA-PCPI	0079
199	Heart Failure: Patient Education	AMA-PCPI	0082
200	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation	AMA-PCPI	0084
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea	AMA-PCPI/NCQA	0409
206	HIV/AIDS: Screening for High Risk Sexual Behaviors	AMA-PCPI/NCQA	0413
207	HIV/AIDS: Screening for Injection Drug Use	AMA-PCPI/NCQA	0415
208	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis	AMA-PCPI/NCQA	0410
209	Functional Communication Measure - Spoken Language Comprehension	American Speech Language Haring Association (ASHA)	0445
210	Functional Communication Measure - Attention	ASHA	0449
211	Functional Communication Measure - Memory	ASHA	0448
212	Functional Communication Measure - Motor Speech	ASHA	0447
213	Functional Communication Measure - Reading	ASHA	0446
214	Functional Communication Measure - Spoken Language Expression	ASHA	0444
215	Functional Communication Measure - Writing	ASHA	0442
216	Functional Communication Measure - Swallowing	ASHA	0443

BILLING CODE 4120–01–C

Although we are designating certain measures as registry-only measures, we cannot guarantee that there will be a registry qualified to submit each registry-only measure for 2011. We rely on registries to self-nominate and identify the measures for which they would like to be qualified to submit quality measures results and numerator and denominator data on quality measures. If no registry self-nominates to submit measure results and numerator and denominator data on a particular measure for 2011, then an eligible professional would not be able to report that particular measure.

We note also that detailed measure specifications, including a measure's title, for 2010 Physician Quality Reporting System quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2011. Therefore, the 2011 Physician Quality Reporting System quality measure specifications for any given quality measure may be different from specifications for the same quality measure used for 2010. Specifications for all 2011 individual

Physician Quality Reporting System quality measures, whether or not included in the 2010 Physician Quality Reporting System, must be obtained from the specifications document for 2011 individual Physician Quality Reporting System quality measures, which will be available on the Physician Quality Reporting System section of the CMS Web site on or before December 31, 2010.

(3) New Individual Quality Measures for 2011

We proposed to include in the 2011 Physician Quality Reporting System quality measure set 20 measures that were not included in the 2010 Physician Quality Reporting System quality measures set provided that each measure obtains NQF endorsement by June 1, 2010 and its detailed specifications are completed and ready for implementation in the Physician Quality Reporting System by August 15, 2010 (75 FR 40192). Besides having NQF endorsement, we proposed that the development of a measure is considered complete for the purposes of the 2011 Physician Quality Reporting System if by August 15, 2010: (1) The final, detailed specifications for use in data collection for the Physician Quality Reporting System have been completed and are ready for implementation, and (2) all of the Category II Current Procedural Terminology (CPT II) codes required for the measure have been established and will be effective for CMS claims data submission on or before January 1, 2011.

Due to the complexity of their measure specifications, we proposed that 8 of these 20 measures would be available as registry-only measures for the 2011 Physician Quality Reporting System. The remaining 15 measures were proposed to be available for reporting through either claims-based reporting or registry-based reporting.

The following is a summary of the comments received on the 20 new individual quality measures proposed for 2011.

Comment: We received numerous comments in support of the proposed additional quality measures for the 2011 Physician Quality Reporting System. One commenter stated that the new Physician Quality Reporting System measures will help to spur additional eligible professional participation in the Physician Quality Reporting System. Several comments were received specifically in support of the following 'Change in Risk-Adjusted Functional Status' measures, developed by FOTO:

- Change in Risk-Adjusted Functional Status for Patients with Knee Impairments
- Change in Risk-Adjusted Functional Status for Patients with Hip Impairments
- Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments
- Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments
- Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments
- Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist or Hand Impairments
- Change in Risk-Adjusted Functional Status for Patients with a Functional Deficit of the Neck, Cranium, Mandible, Thoracic Spine, Ribs or other General Orthopedic Impairment

Commenters stated these measures support "improved quality and efficiency of care for Medicare beneficiaries including: High cost and high volume conditions; improved outcomes; improved efficiency; improved patient and family experience of care; reduced unwarranted variation in quality and efficiency." We also received support for the inclusion of the following measures:

- Hypertension (HTN): Plan of Care;
- Heart Failure (HF): Left Ventricular Function (LVF) Testing;
- Reminder System for Mammograms measure;
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention;
- Recording of Performance Status Prior to Lung or Esophageal Cancer Resection; and
- Pulmonary Function Tests Before Major Anatomic Lung Resection.

Response: We appreciated the commenters' support of the proposed measures and agree with the reasons stated by the commenters. We are finalizing all of the proposed new measures supported by the commenters. The new individual quality measures for the 2011 Physician Quality Reporting System are identified in Table 80 of this final rule with comment period.

Comment: Several commenters expressed support for the inclusion of the new care transitions measures developed by the AMA–PCPI as these measures are based on evidence-based processes that have been shown to reduce readmissions, limit medication errors, and improve the patient perspective of their care. The measures' developer, however, commented that the measures were not designed for individual physician level measurement. The measures are specified at the facility (hospital) level, using the UB04 administrative data to identify the denominator population.

Response: We appreciate the commenters' support for the new care transitions measures. Based on the measure developer's comments, however, we are not finalizing our proposal to include the following measures in the final 2011 Physician Quality Reporting System measure set:

- Care Transitions: Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care);
- Care Transitions: Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care);
- Care Transitions: Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care); and
- Care Transitions: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care.

Comment: One commenter recommended that the proposed Hypertension (HTN): Plan of Care measure not be included in the final set of 2011 Physician Quality Reporting System measures, claiming that this measure was developed as a "test measure" and was not designed for individual physician accountability, but rather internal quality improvement.

Response: We appreciate the commenter's input but are finalizing our proposal to include this measure in the 2011 Physician Quality Reporting System measure set. This measure meets the considerations for the selection of 2011 Physician Quality Reporting System measures and is also a clinical quality measure under the EHR Incentive Program.

Based on the reasons discussed previously and upon consideration of the comments received, we are finalizing in the 2011 Physician Quality Reporting System quality measure set 16 of the 20 proposed 2011 Physician Quality Reporting System measures identified in Table 80 of the proposed rule. In addition to not finalizing our proposal to include the 4 new care transitions measures previously listed, we note that 3 measures—Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection; Thoracic Surgery: Pulmonary Function Test Before Major Anatomic Lung Resection

(Pneumonectomy, Lobectomy, or Formal Segmentectomy); and Melanoma: Overutilization of Imaging Studies in Stage 0–1A Melanoma—that were proposed to be available for either registry or claims reporting will be made available for registry reporting only for the 2011 Physician Quality Reporting System. Upon further analysis of these measures, we have determined that these measures would be analytically challenging to collect via claims and, therefore, are not finalizing such measures for the claims-based reporting option for the 2011 Physician Quality Reporting System.

The titles of the 16 additional, or new, Physician Quality Reporting System measures for 2011 are listed in Table 80 along with the name of the measure developer, the reporting mechanism(s) available (that is, whether the measure will be reportable using claims, registries, or both), and the NQF Measure Number, if applicable.

TABLE 80—NEW INDIVIDUAL QUALITY MEASURES FOR 2011

Measure title	NQF measure number	Measure developer	Reporting mechanism(s)
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments.	0422	FOTO	Registry.
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments.	0423	FOTO	Registry.
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments.	0424	FOTO	Registry.
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments.	0425	FOTO	Registry.
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments.	0426	FOTO	Registry.
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist or Hand Impairments.	0427	FOTO	Registry.
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairment.	0428	FOTO	Registry.
Hypertension (HTN): Plan of Care	0017	AMA–PCPI	Claims, Registry.
Heart Failure (HF): Left Ventricular Function (LVF) Testing	0079	CMS	Registry.
Melanoma: Overutilization of Imaging Studies in Stage 0–IA Melanoma	0562	AMA–PCPI	Registry.
Radiology: Reminder System for Mammograms	0509	AMA–PCPI	Claims, Registry.
Asthma: Tobacco Use: Screening—Ambulatory Care Setting	Not applicable	AMA–PCPI	Claims, Registry.
Asthma: Tobacco Use: Intervention—Ambulatory Care Screening	Not applicable	AMA–PCPI	Claims, Registry.
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028	AMA–PCPI	Claims, Registry.
Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection.	0457	Society of Thoracic Surgery (STS)	Registry.
Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection	0458	Society of Thoracic Surgery (STS)	Registry.

(4) 2011 Measures Available for EHR-Based Reporting

For 2011, we proposed to again accept Physician Quality Reporting System data from EHRs for a limited subset (22) of the proposed 2011 Physician Quality Reporting System quality measures, contingent upon the successful completion of our 2010 EHR data submission process and a determination that accepting data from EHRs on quality measures for the 2011 Physician Quality Reporting System continues to be practical and feasible. The 22 measures we proposed to be available for EHR-based reporting in the 2011 Physician Quality Reporting System include the 10 measures available for EHR-based reporting in the 2010 Physician Quality Reporting System and 12 additional measures that overlap with the clinical quality measures used in the EHR incentive program established by the American Recovery and Reinvestment Act (ARRA) (75 FR 40193).

The following is a summary of the comments received on the proposed electronic submission of these 22 measures.

Comment: Commenters were pleased that we proposed the addition of new measures for EHR-based reporting as this will permit additional physician specialties to participate using this reporting mechanism. We specifically received support for the following proposed measures for EHR-based reporting:

- Measure #1: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus;
- Measure #2: Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus;
- Measure #3: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus;
- Measure #5: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD);
- Measure #7: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI);
- Measure #110: Preventive Care and Screening: Influenza Immunization for Patients ≥50 Years Old;
- Measure #111: Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older;
- Measure #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up;

• Measure #173: Preventive Care & Screening: Unhealthy Alcohol Use—Screening;
• Measure #TBD: Hypertension (HTN): Blood Pressure Measurement;
• Measure #TBD: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention;
• Measure #TBD: Body Mass Index (BMI) 2 Through 18 Years of Age.

Response: We appreciate the commenters' support of our proposal to expand the number of measures available for EHR reporting and for the measures previously listed. We are finalizing our proposal to have all of the measures previously listed available for 2011 Physician Quality Reporting System EHR reporting.

Comment: One commenter was concerned by the limited number of quality measures available for EHR reporting. The commenter stated that the current list of quality measures for reporting via EHR does not facilitate widespread participation because the 22 measures proposed for EHR reporting will restrict the number and type of eligible professionals able to report with their EHR system. This commenter believed the future requirements to align the Physician Quality Reporting System and EHR incentive programs highlight the importance of expanding this list.

Response: We agree with the commenter and are working to expand the list of electronically specified measures for future years. However, EHR-derived measures data will be accepted for the Physician Quality Reporting System directly from a qualified EHR for the first time in early 2011 (with 2010 Physician Quality Reporting System data). For this reason, we believe that a limited set of measures this early in the process will increase the program's chance of being successful in accepting this quality data.

Comment: A few commenters noted that many current measures are not specified for electronic reporting and that additional resources are needed to work with measure developers to re-specify or "retool" measures to be effectively collected via EHRs. One commenter noted that a hybrid approach of data collected via EHR and manual abstraction may potentially be needed.

Response: As noted previously, we are planning to continue to electronically specify measures to add to the list of those measures that are currently electronically specified for future years.

Comment: Because the following measures were not included in the Final Rule for Stage 1 of the EHR Incentive Program, one commenter suggested that they be removed from the list of 2011 EHR-based measures in favor of measures that are included in the EHR Incentive Program: Measures #39, 41, 47, 48, 142, 173, and Drugs to Be Avoided in the Elderly.

Response: While we are required to develop a plan to integrate the reporting of quality measures under the Physician Quality Reporting System with reporting under the EHR Incentive Program, they are two distinct programs. Therefore, we believe that it may be appropriate to have different measures in each of them and are retaining such measures in the Physician Quality Reporting System for 2011. However, we note that we are not finalizing our proposal to have Physician Quality Reporting System Measures #41 and #142 available for 2011 Physician Quality Reporting System EHR reporting. The electronic specifications and Quality Reporting Document Architecture (QRDA) for submitting these measures electronically were not fully developed.

Based on the reasons discussed previously and upon consideration of the comments received, we are finalizing the option of accepting clinical quality data extracted from qualified EHRs on 20 of the 22 proposed 2011 Physician Quality Reporting System quality measures identified in Tables 81 and 82 of the proposed rule. We are not finalizing our proposal to have Physician Quality Reporting System Measures #41 and #142 available for 2011 Physician Quality Reporting System EHR reporting because the specifications for submitting these measures electronically are not ready. The final 2011 measures available for EHR-based reporting are identified in Tables 81 and 82 of this final rule with comment period.

TABLE 81—2011 MEASURES AVAILABLE FOR EHR-BASED REPORTING FROM 2010 PHYSICIAN QUALITY REPORTING SYSTEM

Physician Quality Reporting System	Measure title	Measure developer	NQF Measure No.
1	*** Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	NCQA	0059
2	*** Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	NCQA	0064
3	*** Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA	0061
5	*** Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	AMA–PCPI	0081
7	*** Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	AMA–PCPI	0070
110	** Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	AMA–PCPI	0041
111	*** Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	NCQA	0043
112	*** Preventive Care and Screening: Screening Mammography	NCQA	0031
113	*** Preventive Care and Screening: Colorectal Cancer Screening	NCQA	0034
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR).	CMS/QIP	0488

* This measure is a Core clinical quality measure for the Electronic Health Record Incentive Program under the ARRA HITECH regulation for program years 2011–2012. The electronic specifications for measures that are included in the PQRI and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.

** This measure is an Alternate Core clinical quality measure for the Electronic Health Record Incentive Program under the ARRA HITECH regulation for program years 2011–2012. The electronic specifications for measures that are included in the PQRI and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.

*** This measure is included in the Electronic Health Record Incentive Program under the ARRA HITECH regulation for program years 2011–2012. The electronic specifications for measures that are included in the PQRI and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.

TABLE 82—ADDITIONAL MEASURES AVAILABLE FOR EHR-BASED REPORTING IN 2011

Physician Quality Reporting System	Measure title	Measure developer	NQF Measure No.
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older.	AMA–PCPI/NCQA	0046
47	Advance Care Plan	AMA–PCPI/NCQA	0326
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.	AMA–PCPI/NCQA	0098
128	* Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up.	CMS/Quality Insights of Pennsylvania.	0421
173	Preventive Care and Screening: Unhealthy Alcohol Use—Screening	AMA–PCPI	AQA Adopted
TBD	* Hypertension (HTN): Blood Pressure Measurement	AMA–PCPI	0013
TBD	Drugs to be Avoided in the Elderly	NCQA	0022
TBD	** Weight Assessment and Counseling for Children and Adolescents	NCQA	0024
TBD	* Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.	AMA–PCPI	0028
TBD	** Childhood Immunization Status	NCQA	0038

* This measure is a Core clinical quality measure for the Electronic Health Record Incentive Program under the ARRA HITECH regulation for program years 2011–2012. The electronic specifications for measures that are included in the PQRI and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.

** This measure is an Alternate Core clinical quality measure for the Electronic Health Record Incentive Program under the ARRA HITECH regulation for program years 2011–2012. The electronic specifications for measures that are included in the PQRI and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.

*** This measure is included in the Electronic Health Record Incentive Program under the ARRA HITECH regulation for program years 2011–2012. The electronic specifications for measures that are included in the PQRI and Electronic Health Record Incentive Program may be different. Eligible professionals should refer to the measure specifications for the appropriate program.

(5) Measures Proposed for Inclusion in 2011 Measures Groups

We proposed to retain the following 13 2010 Physician Quality Reporting System measures groups for the 2011 Physician Quality Reporting System: (1) Diabetes Mellitus; (2) CKD; (3) Preventive Care; (4) CABG; (5) Rheumatoid Arthritis; (6) Perioperative Care; (7) Back Pain; (8) CAD; (9) Heart Failure; (10) IVD; (11) Hepatitis C; (12) HIV/AIDS; and (13) CAP. For 2011, we proposed that the CABG, CAD, Heart Failure, and HIV/AIDS measures groups continue to be reportable through the registry-based reporting mechanism only, while the remaining Diabetes Mellitus, CKD, Preventive Care, Rheumatoid Arthritis, Perioperative Care, Back Pain, IVD, Hepatitis C, and CAP measures groups will continue to be reportable through either claims-based reporting or registry-based reporting for the 2011 Physician Quality Reporting System (75 FR 40193).

In addition to the 13 measures groups that we proposed to retain from the 2010 Physician Quality Reporting System, we proposed 1 new Asthma Measures Group, which could be reported through either claims-based reporting or registry-based reporting.

Finally, as in previous program years, for 2011, we proposed that the measures included in any proposed 2011 measures group be reportable either as individual measures or as part of a measures group, except for the Back Pain measures group, which will continue to be reportable only as part of a measures group and not as individual measures in 2011 (75 FR 40193 through 40197).

As with measures group reporting in the 2008, 2009, and 2010 Physician Quality Reporting System, we proposed that each eligible professional electing to report a group of measures for 2011 must report all measures in the group that are applicable to each patient or encounter to which the measures group applies at least up to the minimum number of patients required by the applicable reporting criteria. The following is a summary of the comments received on the proposed 2011 measures groups.

Comment: One commenter expressed support for the movement to greater use of measures groups as a method of Physician Quality Reporting System participation, as they are easier to manage and monitor.

Response: We appreciate the commenter's positive feedback and continue to encourage eligible professionals to report on measures groups. As we have stated in prior years, we believe that measures groups can present a more complete picture of the quality of care provided clinical condition or clinical focus than individual measures reporting.

Comment: We received favorable support for the proposed inclusion of the following measures groups:

- Asthma.
- Back Pain.
- CAD.
- CAP.
- CABG.
- Diabetes Mellitus.
- Heart failure.

Some of the reasons stated by commenters include that these are important chronic conditions and collecting information on the treatment of these conditions could lead to improved care and treatment, which would result in reduced costs.

Response: We agree. For these reasons, we are finalizing our proposal to include all of these measures groups in the 2011 Physician Quality Reporting System.

Comment: One commenter proposed the removal of Measure #135, Chronic Kidney Disease (CKD): Influenza Immunization, from the CKD Measures Group to ensure maximum satisfactory reporting. The commenter noted that Measure #135 differs from other measures in the CKD Measures Group in its method of reporting. Whereas measures in the CKD Measures Group are Patient Process (where the measures are reported once per reporting period), Measure #135 is now Patient Periodic (where the measure is reported during certain periods of time). The commenter is concerned that this difference in reporting methods may be too confusing for satisfactory reporting.

Response: We agree with the commenter's recommendation and are

removing Measure #135, Influenza, from the CKD Measures Group for the reasons cited by the commenter. However, the CKD Influenza Measure #135 will still be reportable as an individual measure.

Comment: One commenter supported the proposed retention of the 2010 HIV/AIDS Physician Quality Reporting System measures group for the 2011 Physician Quality Reporting System, but encouraged, to the extent feasible, HIV/AIDS quality measures that can be reported through the claims-based method in addition to the registry-based method.

Response: We are pleased with the commenter's support for the HIV/AIDS measures group. Based on the current processing of claims data, it was determined that the claims system will not accurately capture these measures. Registry reporting provides an intricate process to capture these measures accurately.

Comment: For the 2011 Physician Quality Reporting System measures group on preventive care, the addition of a process measure for HIV screening of "high-risk" patients, as endorsed by the National Quality Forum and USPSTF previously (level "A" recommendation), be added. The commenter urged that this measure be modified if and when coverage is expanded to include routine HIV screening, consistent with the recommendations of the Centers for Disease Control and Prevention (CDC).

Response: We appreciate the commenter's suggestion to add HIV screening of "high risk" patients into the Preventive Care Measures Group. Measure groups are created based on measures with a particular clinical condition or focus. The current Preventive Care Measures Group is intended for a more general patient population and would not be appropriate for the addition of the HIV measure(s) suggested by the commenter. The commenter should consider utilizing the 2012 Call for Measures as an avenue for submitting suggestions for possibly creating a new measure group for screening "high risk" patients. We also urge the commenter to direct such suggestions to the appropriate measure developer/owner(s) for consideration.

Based on the reasons discussed previously and upon consideration of the comments received, we are finalizing the following proposed 2011 measures groups: (1) Diabetes Mellitus; (2) Preventive Care; (3) CABG; (4) Rheumatoid Arthritis; (5) Perioperative Care; (6) Back Pain; (7) CAD; (8) Heart Failure; (9) IVD; (10) Hepatitis C; (11) HIV/AIDS; (12) CAP; and (13) Asthma. We are also finalizing the proposed CKD measures group for 2011 with one modification. As stated previously, we are removing Measure #135: Chronic Kidney Disease (CKD): Influenza Immunization from the CKD measures group for 2011 because the reporting requirements for this measure are different from the reporting requirements for the other measures in this measures group. The following 4 measures groups are reportable through the registry-based reporting mechanism only: (1) CABG; (2) CAD; (3) Heart Failure; and (4) HIV/AIDS.

The measures selected for inclusion in each of the 2011 measures groups are identified in Tables 83 through 96 of this final rule with comment period. Some measures selected for inclusion in these 14 measures groups are current 2010 individual Physician Quality Reporting System measures. The title of each such measure is preceded with its Physician Quality Reporting System Measure Number in Tables 83 through 96. As stated previously, the Physician Quality Reporting System Measure Number is a unique identifier assigned by CMS to all measures in the Physician Quality Reporting System measure set. Once a Physician Quality Reporting System Measure Number is assigned to a measure, it will not be used again, even if the measure is subsequently retired from the Physician Quality Reporting System measure set. Measures that are not preceded by a number (in other words, those preceded by "TBD") in Tables 83 through 96 were never part of a Physician Quality Reporting System measure set prior to 2011. A number will be assigned to such measures for 2011.

BILLING CODE 4120–01–P

TABLE 83: Measures Included in the 2011 Diabetes Mellitus Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	0059	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	0064	NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	0061	NCQA
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	0055	NCQA
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	0062	NCQA
163	Diabetes Mellitus: Foot Exam	0056	NCQA

TABLE 84: Measures Included in the 2011 CKD Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	Not applicable	AMA-PCPI
122	Chronic Kidney Disease (CKD): Blood Pressure Management	AQA adopted	AMA-PCPI
123	Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	AQA adopted	AMA-PCPI
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	AQA adopted	AMA-PCPI

TABLE 85: Measures Included in the 2011 Preventive Care Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	0046	AMA-PCPI/NCQA
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	0098	AMA-PCPI/NCQA
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	0041	AMA-PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	0043	NCQA
112	Preventive Care and Screening: Screening Mammography	0031	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening	0034	NCQA
128	Preventive Care and Screening: Body Mass	0421	CMS/QIP

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
	Index (BMI) Screening and Follow-Up		
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	AQA adopted	AMA-PCPI
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI

TABLE 86: Measures Included in the 2011 CABG Measures Group*

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	0516	Society of Thoracic Surgeons (STS)
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	0235	STS
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)	0129	STS
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	0130	STS
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)	0131	STS
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency	0114	STS
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	0115	STS
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	0237	STS
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	0238	STS
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling	0118	STS

* This measures group is reportable through registry-based reporting only.

TABLE 87: Measures Included in the 2011 Rheumatoid Arthritis Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	0054	NCQA
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	AQA adopted	AMA-PCPI/NCQA
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	AQA adopted	AMA-PCPI/NCQA
178	Rheumatoid Arthritis (RA): Functional Status Assessment	AQA adopted	AMA-PCPI/NCQA
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	AQA adopted	AMA-PCPI/NCQA
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	AQA adopted	AMA-PCPI/NCQA

TABLE 88: Measures Included in the 2011 Perioperative Care Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician	0270	AMA-PCPI/NCQA
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	0268	AMA-PCPI/NCQA
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	0271	AMA-PCPI/NCQA
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	0239	AMA-PCPI/NCQA

TABLE 89: Measures Included in the 2011 Back Pain Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
148	Back Pain: Initial Visit	0322	NCQA
149	Back Pain: Physical Exam	0319	NCQA
150	Back Pain: Advice for Normal Activities	0315	NCQA
151	Back Pain: Advice Against Bed Rest	0313	NCQA

TABLE 90: Measures Included in the 2011 CAD Measures Group*

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	0067	AMA-PCPI
196	Coronary Artery Disease (CAD): Symptom and Activity Assessment	0065	AMA-PCPI
197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	0074	AMA-PCPI
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI

* This measures group is reportable through registry-based reporting only.

TABLE 91: Measures Included in the 2011 Heart Failure Measures Group*

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	0081	AMA-PCPI
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	0083	AMA-PCPI
198	Heart Failure: Left Ventricular Function (LVF) Assessment	0079	AMA-PCPI
199	Heart Failure: Patient Education	0082	AMA-PCPI
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI

* This measures group is reportable through registry-based reporting only.

TABLE 92: Measures Included in the 2011 IVD Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
201	Ischemic Vascular Disease (IVD): Blood Pressure Management Control	0073	NCQA
202	Ischemic Vascular Disease (IVD): Complete Lipid Profile	0075	NCQA
203	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control	0075	NCQA
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	0068	NCQA
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI

TABLE 93: Measures Included in the 2011 Hepatitis C Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	0395	AMA-PCPI
85	Hepatitis C: HCV Genotype Testing Prior to Treatment	0396	AMA-PCPI
86	Hepatitis C: Antiviral Treatment Prescribed	0397	AMA-PCPI
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	0398	AMA-PCPI
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	0401	AMA-PCPI
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	0394	AMA-PCPI
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	0399	AMA-PCPI
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	0400	AMA-PCPI

TABLE 94: Measures Included in the 2011 HIV/AIDS Measures Group*

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	0404	AMA-PCPI/NCQA
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	0405	AMA-PCPI/NCQA
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	0406	AMA-PCPI/NCQA
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	0407	AMA-PCPI/NCQA
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea	0409	AMA-PCPI/NCQA
206	HIV/AIDS: Screening for High Risk Sexual Behaviors	0413	AMA-PCPI/NCQA
207	HIV/AIDS: Screening for Injection Drug Use	0415	AMA-PCPI/NCQA
208	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis	0410	AMA-PCPI/NCQA

* This measures group is selected to be reportable through registry-based reporting only.

TABLE 95: Measures Included in the 2011 CAP Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
56	Community-Acquired Pneumonia (CAP): Vital Signs	0232	AMA-PCPI/NCQA
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	0094	AMA-PCPI/NCQA
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status	0234	AMA-PCPI/NCQA
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic	0096	AMA-PCPI/NCQA

TABLE 96: Measures Included in the 2011 Asthma Measures Group

Physician Quality Reporting System	Measure Title	NQF Measure Number	Measure Developer
53	Asthma: Pharmacologic Therapy	0047	AMA-PCPI
64	Asthma: Asthma Assessment	0001	AMA-PCPI
TBD	Asthma: Tobacco Use: Screening – Ambulatory Setting	Not applicable	AMA-PCPI
TBD	Asthma: Tobacco Use: Intervention – Ambulatory Screening	Not applicable	AMA-PCPI

BILLING CODE 4120–01–C

As with measures group reporting in the 2008, 2009, and 2010 Physician Quality Reporting System, each eligible professional electing to report a group of measures for 2011 must report all measures in the group that are applicable to each patient or encounter to which the measures group applies at least up to the minimum number of patients required by the applicable reporting criteria. The measures selected for the Back Pain Measures Group continue to be reportable only as part of a measures group and not as individual measures for the 2011 Physician Quality Reporting System. Measures selected for inclusion in all other 2011 Physician Quality Reporting System measures groups are reportable either as individual measures or as part of a measures group.

We note that the specifications for measures groups do not necessarily contain all the specification elements of each individual measure making up the measures group. This is based on the need for a common set of denominator specifications for all the measures making up a measures group in order to define the applicability of the measures group. Therefore, the specifications and instructions for measures groups will be provided separately from the specifications and instructions for the individual 2011 Physician Quality Reporting System measures. We will post the detailed specifications and specific instructions for reporting measures groups on the Physician Quality Reporting System section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by no later than December 31, 2010.

Additionally, the detailed measure specifications and instructions for submitting data on those 2011 measures groups that were also included as 2010 Physician Quality Reporting System measures groups may be updated or modified prior to 2011.

Therefore, the 2011 Physician Quality Reporting System measure specifications for any given measures group could be different from specifications and submission instructions for the same measures group used for 2010. These measure specification changes do not materially impact the intended meaning of the measures or the strength of the measures.

j. 2011 Physician Quality Reporting System Quality Measures for Group Practices Selected To Participate in the Group Practice Reporting Option (GPRO I)

For 2011, we proposed that group practices selected to participate in the 2011 Physician Quality Reporting System GPRO I would be required to report on 26 proposed measures listed in Table 97 of the proposed rule (75 FR 40197 through 40198). We proposed these measures because they are NQF-endorsed measures currently collected as part of the PGP and/or MCMP demonstrations and in the 2010 Physician Quality Reporting System GPRO.

The following is a summary of the comments received on the proposed 2011 Physician Quality Reporting System quality measures for group practices selected to participate in the group practice reporting option (GPRO I).

Comment: We received a comment noting general support for the 26 proposed GPRO I measures. Another commenter expressed specific support for the diabetes measures proposed for the Group Practice Reporting Option (GPRO), "Diabetes Mellitus: Hemoglobin A1c Testing" and "Diabetes Mellitus: Lipid Profile."

Response: We appreciate the positive feedback and are finalizing the 26 GPRO I measures as proposed. We believe these measures target high-cost chronic conditions and preventive care.

Comment: A couple of commenters encouraged us to expand the list of GPRO I measures and/or develop different measure sets to address the care delivered in different group practices. One commenter encouraged us to adopt additional diabetes measures into the GPRO to ensure the

most comprehensive evidence-based assessment of diabetes care.

Response: We agree that in order to make GPRO I more broadly applicable we would need to expand the list of GPRO I measures and/or develop different measures to address the care delivered in different group practices. As we stated in the proposed rule (75 FR 40180), we hosted a listening session on February 2, 2010, to solicit input on a number of aspects of the Physician Quality Reporting System, including the measures for the 2011 Physician Quality Reporting System GPRO. We did not, however, receive any suggestions for additional disease modules for GPRO I. Therefore, we encourage commenters to use the 2012 Call for Measures as an avenue to submit specific measures for us to consider for future expansion of the GPRO I measure set. As stated previously, additional measures recommended for selection for the 2011 Physician Quality Reporting System via comments to the proposed rule cannot be included in the 2011 Physician Quality Reporting System measure set.

Comment: With regard to the 26 GPRO measures, one commenter asked us to consider whether some of the testing and patient education measures are sufficiently proximate to the desired clinical outcome to justify the effort of data collection, analysis, and comparative reporting.

Response: We value the commenter's thoughtful input and agree that as we expand the Physician Quality Reporting System measure set, including the GPRO I measure set, in future years we may want to consider whether the measures lead to the desired outcomes.

Based on the reasons discussed previously and after considering the comments, for the 2011 Physician Quality Reporting System, group practices selected to participate in the Physician Quality Reporting System GPRO I will be required to report on all measures listed in Table 97.

BILLING CODE 4120–01–P

TABLE 97: Measures for Physician Groups Participating in the 2011 Physician Quality Reporting System Group Practice Reporting Option (GPRO I)

Physician Quality Reporting System	Measure Title	Measure Developer	NQF Measure Number
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA	0059
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	NCQA	0064
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA	0061
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0081
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	AMA-PCPI	0067
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	AMA-PCPI	0070
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0083
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA-PCPI	0041
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA	0043
112	Preventive Care and Screening: Screening Mammography	NCQA	0031
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA	0034
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA	0055
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI	0066
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	NCQA	0062
163	Diabetes Mellitus: Foot Exam	NCQA	0056
229	Diabetes Mellitus: Hemoglobin A1c Testing	NCQA	0057
230	Diabetes Mellitus: Lipid Profile	NCQA	0063
228	Heart Failure: Left Ventricular Function (LVF) Testing	CMS	
198	Heart Failure: Left Ventricular Function (LVF) Assessment	AMA-PCPI	0079
227	Heart Failure: Weight Measurement	CMS AMA-PCPI not maintaining	0085
199	Heart Failure: Patient Education	AMA-PCPI	0082

Physician Quality Reporting System	Measure Title	Measure Developer	NQF Measure Number
200	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation	AMA-PCPI	0084
197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	AMA-PCPI	0074
TBD	Hypertension: Blood Pressure Measurement	AMA-PCPI	0013
TBD	Hypertension (HTN): Blood Pressure Control	NCQA	0018
TBD	Hypertension (HTN): Plan of Care	AMA-PCPI	0017

BILLING CODE 4120–01–C

A separate measures specifications manual and other supporting documents will be available for group practices participating in the 2011 Physician Quality Reporting System GPRO I. We anticipate that the group practice measures specifications manual will be available by November 15, 2010 or shortly thereafter on the Physician Quality Reporting System section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*.

k. Public Reporting of Physician Quality Reporting System Data

Section 1848(m)(5)(G) of the Act requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submitted data on quality measures for the Physician Quality Reporting System and the names of the eligible professionals (or group practices) who are successful electronic prescribers. In addition, section 10331(a)(1) of the ACA, requires the Secretary to develop a Physician Compare Internet Web site by January 1, 2011, on which information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting System would be posted.

In accordance with section 1848(m)(5)(G) of the Act, we proposed to continue to make public the names of eligible professionals and group practices that satisfactorily submit quality data for the 2011 Physician Quality Reporting System. Previously, we intended to post such information on the Healthcare Provider Directory. To meet the ACA deadline of January 1, 2011, we proposed to use the current Healthcare Provider Directory (previously known as the Physician and Other Health Care Professional Directory) as a foundation for the Physician Compare Web site. Therefore, we proposed to post the names of the 2011 Physician Quality Reporting System satisfactory reporters on the Physician Compare Web site that must be developed by January 1, 2011.

Specifically, we proposed to post the names of eligible professionals who: (1) Submit data on the 2011 Physician Quality Reporting System quality measures through one of the reporting mechanisms available for the 2011 Physician Quality Reporting System; (2) meet one of the proposed satisfactory reporting criteria of individual measures or measures groups for the 2011 Physician Quality Reporting System as previously described; and (3) qualify to earn a Physician Quality Reporting System incentive payment for covered professional services furnished during the applicable 2011 Physician Quality Reporting System reporting period, for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act, on the Physician Compare Web site (75 FR 40198). Similarly, for purposes of publicly reporting the names of group practices, on the Physician Compare Web site, for 2011, we proposed to post the names of group practices that: (1) Submit data on the 2011 Physician Quality Reporting System quality measures through one of the proposed group practice reporting options; (2) meet the proposed criteria for satisfactory reporting under the respective group practice reporting option; and (3) qualify to earn a Physician Quality Reporting System incentive payment for covered professional services furnished during the applicable 2011 Physician Quality Reporting System reporting period for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act.

We did not propose to make performance information publicly available at either the group practice or individual level for 2011 Physician Quality Reporting System. However, we note that section 10331 of the ACA requires that not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, we implement a plan for making publicly available through Physician Compare, information on physician performance, including measures collected under the Physician Quality Reporting System. Consistent with section 10331 of the ACA, we expect, in the future, to publicly report performance information based on the Physician Quality Reporting System.

The following is a summary of the comments we received regarding the public reporting of Physician Quality Reporting System data required under section 1848(m)(5)(G)(i) of the Act and Physician Compare Web site required under section 10331 of the ACA.

Comment: Many commenters supported the development of a Physician Compare Web site. Some commenters supported public reporting of the names of eligible professionals who satisfactorily report Physician Quality Reporting System measures and/or who are successful e-prescribers, noting that this is an appropriate first step in CMS' efforts to further transparency. Another commenter supported public reporting of the names of eligible professionals who participate in the Physician Quality Reporting System or Maintenance of Certification Programs as a way to enhance informed consumer choice based on quality and outcomes.

Response: We appreciate the commenters' support. We note, however, that we did not propose to publicly report the names of eligible professionals who participate in the Physician Quality Reporting System or Maintenance of Certification Programs. Instead, we proposed to publicly report the names of eligible professionals who satisfactorily report 2011 Physician Quality Reporting System measures and are finalizing our proposal to post the names of eligible professionals who satisfactorily report 2011 Physician Quality Reporting System measures on the Physician Compare Web site.

Comment: Some commenters agreed with CMS' decision to not publicly report individual or group level Physician Quality Reporting System performance results at this time. Many

of the commenters believe that it would be premature to do so. One commenter believed that CMS' decision to not post 2011 Physician Quality Reporting System performance data will allow eligible professionals to analyze their 2010 data and resolve any identified concerns with the GPRO reporting and analysis process. Another commenter noted that a different level of scrutiny is required to report performance rates. A commenter generally opposes the use of quality data for the purpose of physician profiling because it could exacerbate gaps in quality and access through risk avoidance and by inhibiting collaborative efforts by the profession to improve care for all patients.

Response: Although we are not planning to post 2011 Physician Quality Reporting System performance results, we note that section 10331 of the ACA requires that not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, we implement a plan for making publicly available through Physician Compare, information on physician performance, including measures collected under the Physician Quality Reporting System. Therefore, consistent with section 10331 of the ACA, we expect, in the future, to publicly report performance information based on the Physician Quality Reporting System. It is conceivable that we could begin publicly reporting performance information based on the Physician Quality Reporting System starting with 2012 Physician Quality Reporting System performance results. If and when we move towards public reporting of physician performance information, as contemplated under section 10331 of the ACA, we will need to consider and address the commenters' concerns.

Comment: As we move towards posting performance information, one commenter urged us to start with posting measure results on group practices only until there is sufficient experience and data to determine which, if any, measures can be reported at the individual practitioner level with relative certainty that the information portrayed is accurate. Specifically, we should monitor the group practice level reporting for unintended consequences before reporting performance information at the individual practitioner level.

Response: We appreciate the commenter's valuable input. We are committed to taking steps to ensure that the information portrayed is accurate. As we develop our plans for posting performance information on the Physician Compare Web site, we may consider initially limiting the performance information to measure results at the group practice level as suggested by the commenter. As stated previously, we will discuss our plans for posting performance information in more detail in future notice and comment rulemaking.

Comment: Some commenters suggested that we work with stakeholders to—

• Identify how best to relay this information in a user-friendly manner to the public;

• Develop reliable, comparable benchmarks, with a sufficient sample size to ensure validity;

• Ensure that specific reporting and performance results are indeed quality indicators;

• Ensure that the site accurately represents physician performance and facilitates consumer decision-making;

• Provide an opportunity for physicians, other eligible professionals, and group practices to review their data before it is made public. As with Hospital Compare, eligible professionals should have the right to suppress any data that are inaccurate; and

• Establish a method for ensuring that any publicly reported information is—

++ Correctly attributed to those involved in the care;

++ Appropriately risk-adjusted; and

++ Accurate, user-friendly, relevant and helpful to the consumer/patient. CMS must educate consumers/patients about the publicly reported performance measures and corresponding benchmarks.

Response: We agree with commenters on the importance of receiving stakeholder input on the Physician Compare Web site. We are required, by section 10331(d) of the ACA to take into consideration input provided by multi-stakeholder groups, consistent with section 1890(b)(7) and 1890(A) of the Act, as added by section 3014 of the ACA, in selecting quality measures for the Physician Compare Web site. In addition, on October 27, 2010, we held a Town Hall Meeting to solicit input from stakeholders on the further expansion of the Physician Compare Web site (75 FR 58411 and 58412). Finally, as we stated in the CY 2011 PFS proposed rule, we will be working on a plan to expand the information that is publicly reported on the Physician Compare in future years, which will be described in future rulemaking. Stakeholders would have an opportunity to comment on any plans described in future rulemaking as well.

Comment: One commenter voiced concerns about various issues and challenges that need to be resolved before any performance information is made public. Specific issues include measure gaps, challenges associated with risk adjustment and attribution, accuracy of the data, and eligible professionals' ability to control the factors that influence their performance.

Response: We agree that these issues will need to be addressed as we move towards public reporting of performance information on individual eligible professionals. We look forward to receiving input from stakeholders on these and other important methodological considerations as we develop our plans for the expansion of the Physician Compare Web site to include performance information.

Comment: A few commenters suggested that physicians be given an opportunity to review and appeal any data that will be made public prior to the data being made public. Commenters stated that physicians also should be given an opportunity to comment and make changes to the data on the Physician Compare Web site should the information be incorrect.

Response: With respect to the development and implementation of a plan for making physician performance information publicly available on the Physician Compare Web site, section 10331(b) of the ACA specifically requires the Secretary, to the extent practicable, to include processes by which a physician or other eligible professional whose performance measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public. Thus, as we describe our plans for making physician performance information publicly available on the Physician Compare Web site in future notice and comment rulemaking, we anticipate addressing the commenter's suggestions in further detail.

Comment: Some commenters had concerns about the posting of the names of eligible professionals and group practices who satisfactorily report Physician Quality Reporting System measures. Some commenters requested that CMS delay posting this information until problems with the Physician Quality Reporting System are addressed and both success rates and participation rates improve significantly. Commenters were concerned that this information could be misinterpreted or misperceived by the public. Some commenters noted that successful reporting of the mostly process measures that comprise the Physician Quality Reporting System would not be a valid surrogate for patients to evaluate the actual quality of

care or quality of service provided by an individual practitioner. Furthermore, consumers already face a challenge when attempting to evaluate providers. The commenter thinks it will be even more confusing for consumers to understand the difference between claims-based or registry reporting and which is more accurate or reflects actual quality of care. Commenters stressed the importance of educating consumers about why eligible professionals may choose not to participate in the Physician Quality Reporting System. Another commenter noted that consumers must be made aware that non-participation in the Physician Quality Reporting System is not an indication that an eligible professional or group practice provides low quality care. Finally, a commenter also suggested that this information be accompanied with explanatory language regarding the limitations of posting this data.

Response: While we understand the commenters' concerns, section 1848(m)(5)(G)(i) of the Act requires us to post on a CMS Web site the names of eligible professionals and group practices that satisfactorily submit data on quality measures under the Physician Quality Reporting System. We intend to provide explanatory language on the Web site that would address many of the commenters' concerns, including information about the intended uses and/or limitations of the information being presented in the form of a disclaimer.

Comment: One commenter urged CMS to consider how the appeals process will be connected to the Physician Compare Web site. The commenter questioned whether the Web site would be updated if professionals are successful during the appeals process.

Response: We are assuming that the commenter is referring to the informal appeals process required under section 1848(m)(5)(I) of the Act and discussed in section VII.F.1.e. of this final rule with comment period. To the extent that an eligible professional seeks a review of our determination that he or she did not satisfactorily report and our review results in a determination that the professional did satisfactorily report, we anticipate that we would update the Physician Compare Web site to indicate that the professional satisfactorily reported Physician Quality Reporting System quality measures.

Comment: We received a few comments related to public reporting and maintenance of certification. One commenter offered to work with us to provide information on Maintenance of Certification Program status for posting on the Physician Compare Web site and the value as it relates to quality, safety, efficiency, and patient experiences of physician care. The commenter would also like the Physician Compare Web site to include a link to ABMS. Another commenter urged us to make available information on whether a physician received an additional bonus for successfully meeting Maintenance of Certification Program requirements. A third commenter was concerned that public reporting of physicians who satisfy the Physician Quality Reporting System requirements through the Maintenance of Certification Program Part IV pathway could inadvertently lead to confusion about whether those same physicians have satisfied all of the requirements of the Boards' Maintenance of Certification Program programs.

Response: We agree that it may be valuable to consumers to have information on an eligible professional's Maintenance of Certification Program status and would be interested in exploring the feasibility of posting this information on the Physician Compare Web site in the future. We could also explore posting information on whether a physician or other eligible professional received the additional 0.5 percent incentive associated with participation in a Maintenance of Certification Program. However, as noted by one of the commenters, we feel that this information could be misinterpreted and would not be as valuable as information on an eligible professional's Maintenance of Certification Program status. As we describe in section VII.F.1.l.(1) of this final rule with comment period, in order for an eligible professional to qualify for this additional 0.5 percent incentive, not only does he or she have to satisfactorily participate in the Physician Quality Reporting System, participate in a qualified Maintenance of Certification Program, and successfully complete a Maintenance of Certification Program practice assessment, but he or she must participate in the qualified Maintenance of Certification Program and successfully complete a Maintenance of Certification Program practice assessment more frequently than is required to qualify for or maintain board certification status.

After considering the comments, we intend to post the names of eligible professionals who: (1) Submit data on the 2011 Physician Quality Reporting System quality measures through one of the reporting mechanisms available for the 2011 Physician Quality Reporting System; (2) meet one of the satisfactory reporting criteria of individual measures or measures groups for the 2011 Physician Quality Reporting System; and (3) qualify to earn a Physician Quality Reporting System incentive payment for covered professional services furnished during the applicable 2011 Physician Quality Reporting System reporting period for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act, on the Physician Compare Web site that will be developed by January 1, 2011.

Similarly, for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act with respect to group practices, on the Physician Compare Web site, we intend to post the names of group practices that: (1) Submit data on the 2011 Physician Quality Reporting System quality measures through GPRO I or GPRO II; (2) meet the criteria for satisfactory reporting under the GPRO I or GPRO II; and (3) qualify to earn a Physician Quality Reporting System incentive payment for covered professional services furnished during the applicable 2011 Physician Quality Reporting System reporting period for group practices.

We will discuss our plans for further expansion of the Physician Compare Web site in future notice and comment rulemaking.

l. Other Relevant ACA Provisions

(1) Section 3002(b)—Incentive Payment Adjustment for Quality Reporting

Beginning 2015, a payment adjustment will apply under the Physician Quality Reporting System. Specifically, under section 1848(a)(8) of the Act, as added by section 3002(b) of the ACA, with respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year, the fee schedule amount for services furnished by such professionals during the year shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services. The applicable percent for 2015 is 98.5 percent and for 2016 and each subsequent year it is 98.0 percent. In the proposed rule, we stated that we will address this provision of the ACA in future notice and comment rulemaking (75 FR 40199).

The following is a summary of comments received regarding the incentive payment adjustment for

quality reporting required under section 3002(b) of the ACA.

Comment: Some commenters expressed opposition to the use of payment adjustments under the Physician Quality Reporting System program. One commenter believes participation should remain voluntary as the Physician Quality Reporting System has not yet been shown to improve patient outcomes and therefore does not warrant penalties for nonparticipating eligible professionals. Other commenters stated that, to be successful, performance measurement should be nonpunitive and transparent.

Response: While we acknowledge the commenters' concerns, we note that section 1848(a)(8) of the Act, as added by the ACA, requires us to implement a payment adjustment for eligible professionals who do not satisfactorily report Physician Quality Reporting System measures beginning in 2015. In the meantime, we will continue to assess whether we can make additional improvements to the Physician Quality Reporting System to facilitate satisfactory reporting and to encourage greater participation prior to implementation of the payment adjustments required under section 1848(a)(8) of the Act beginning for 2015. We will address our plans for implementing the payment adjustment that begins in 2015 in future notice and comment rulemaking.

(2) Section 3002(c)—Maintenance of Certification Programs and Section 10327 Improvements to the Physician Quality Reporting System

Section 3002(c) of the ACA amends section 1848(k)(4) of the Act to require a mechanism whereby an eligible professional may provide data on quality measures through a maintenance of certification program (Maintenance of Certification Program) operated by a specialty body of the American Board of Medical Specialties (ABMS). In addition, section 1848(m)(7) of the Act ("Additional Incentive Payment"), as added by section 10327(a) of the ACA, provides for an additional 0.5 percent incentive payment for years 2011 through 2014 if certain requirements are met. In accordance with section 1848(m)(7)(B) of the Act, in order to qualify for the additional incentive payment, an eligible professional must—

• Satisfactorily submit data on quality measures under the Physician Quality Reporting System for a year and have such data submitted—

++ On their behalf through a Maintenance of Certification Program that meets the criteria for a registry under the Physician Quality Reporting System; or

++ In an alternative form and manner determined appropriate by the Secretary; and

• More frequently than is required to qualify for or maintain board certification status:

++ Participate in such a Maintenance of Certification Program for a year and

++ Successfully completes a qualified Maintenance of Certification Program practice assessment for such year.

Section 1848(m)(7)(C)(i) of the Act defines "Maintenance of Certification Program" as a continuous assessment program, such as a qualified ABMS Maintenance of Certification Program, or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communications skills and professionalism. Such a program shall require a physician to do the following:

(1) Maintain a valid, unrestricted medical license in the United States;

(2) Participate in educational and self-assessment programs that require an assessment of what was learned;

(3) Demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty;

(4) Successful completion of a qualified Maintenance of Certification Program practice assessment.

As defined in section 1848(m)(7)(C)(ii) of the Act, a "qualified Maintenance of Certification Program practice assessment" means an assessment of a physician's practice that—

(1) Includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

(2) Includes a survey of patient experience with care; and

(3) Requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment and then to remeasure to assess performance after such intervention.

To qualify for the additional incentive payment, section 1848(m)(7)(B)(iii) of the Act also requires the Maintenance of Certification Program to submit to CMS, on behalf of the eligible professional, information:

(1) In a form and manner specified by the Secretary, that the eligible professional more frequently than is required to qualify for or maintain board certification status, participates in the Maintenance of Certification Program for a year and successfully completes a qualified Maintenance of Certification Program practice assessment for such year;

(2) If requested by the Secretary, information on the survey of patient experience with care; and

(3) As the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

Section 1848(m)(7) of the Act ("Additional Incentive Payment") further specifies that the additional 0.5 percent incentive payment is available only for years 2011, 2012, 2013, and 2014. For years after 2014, if the Secretary determines it to be appropriate, the Secretary may incorporate participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality for care furnished pursuant to the physician fee schedule payment modifier.

To implement the provisions under sections 1848(k)(4) and 1848(m)(7) of the Act ("Additional Incentive Payment"), we proposed for 2011 to require the following (75 FR 40199 and 40200):

• An eligible professional wishing to be eligible for the additional Physician Quality Reporting System incentive payment of 0.5 percent must meet the proposed requirements for satisfactory Physician Quality Reporting System reporting, for program year 2011, based on the 12-month reporting period, due to the statutory language that the eligible professional must satisfactorily report "for a year." For purposes of satisfactory reporting under the Physician Quality Reporting System, we proposed that the eligible professional may participate as an individual eligible professional using either individual Physician Quality Reporting System measures or measures groups and submitting the Physician Quality Reporting System data via claims, a registry, or an EHR or participate under one of the GPRO options (I or II). Alternatively, eligible professionals may satisfactorily report under the Physician Quality Reporting System based on submission of Physician Quality Reporting System data by a Maintenance of Certification Program, provided that the Maintenance of Certification Program has qualified as a

Physician Quality Reporting System registry for 2011. As indicated previously, an eligible professional would not necessarily have to qualify for the Physician Quality Reporting System through a Maintenance of Certification Program serving as a registry. Rather, we proposed that an eligible professional may qualify for the additional incentive, without regard to the method by which the eligible professional has met the basic requirement of satisfactory reporting under the Physician Quality Reporting System.

• In addition to meeting the proposed requirements for satisfactory reporting for the Physician Quality Reporting System for program year 2011, the eligible professional must have data submitted on his or her behalf through a Maintenance of Certification Program, for the Maintenance of Certification Program in which the eligible professional participates. Although the Maintenance of Certification Program need not become a qualified registry for data submission for Physician Quality Reporting System purposes, the Maintenance of Certification Program must meet the criteria for a registry for submission of the Maintenance of Certification Program data as specified below.

• An eligible professional must, more frequently than is required to qualify for or maintain board certification, participate in a Maintenance of Certification Program for a year and successfully complete a qualified Maintenance of Certification Program practice assessment for such year. We believe that the "more frequently" requirement applies both to the elements of the Maintenance of Certification Program itself and the requirement to successfully complete a qualified Maintenance of Certification Program practice assessment. With regard to the elements other than completing a qualified Maintenance of Certification Program practice assessment, we proposed to require that the Maintenance of Certification Program certify that the eligible professional has "more frequently" than is required to qualify for or maintain board certification "participated in a Maintenance of Certification Program for a year" as required by section 10327 of the ACA. We did not propose to specify with respect to participation how an eligible professional must meet the "more frequently" requirement, but rather that the Maintenance of Certification Program so certify that the eligible professional has met this requirement. We noted that we did not believe that the "more frequently" requirement is applicable to the licensure requirement, given that one cannot be licensed "more frequently" than is required. However, we stated that the eligible professional must "more frequently" than is required to qualify for or maintain board certification, participate in educational and self-assessment programs that require an assessment of what was learned; demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty; and successfully complete a qualified Maintenance of Certification Program practice assessment.

With respect to the Maintenance of Certification Program practice assessment, which is specifically delineated in section 1848(m)(7)(B)(ii) of the Act as being required more often than is necessary to qualify for or maintain board certification, we stated that we believe we needed to be more specific regarding our interpretation of the phrase "more frequently" (75 FR 40200). Additionally, we stated that we were aware that some specialty boards have varying Maintenance of Certification Program requirements for physicians to maintain board certification, based on the date of original certification. Some, we believe, may not be required to participate in a Maintenance of Certification Program at all in order to maintain board certification. Accordingly, we recognize that "more often" may vary among physicians certified by the same specialty board. We interpreted the statutory provisions as requiring participation in and successful completion of at least one Maintenance of Certification Program practice assessment. Therefore, we proposed, as a basic requirement, participation in and successful completion in at least one Maintenance of Certification Program practice assessment. For physicians who are not required to participate in a Maintenance of Certification Program to maintain board certification, "more often" would be more than 0, and therefore only once. For physicians, however, who are otherwise required by the specialty board to participate in a Maintenance of Certification Program to maintain board certification status, these physicians would need to complete the Maintenance of Certification Program practice assessment a second time in order to qualify for the additional incentive payment. If a Maintenance of Certification Program practice assessment were required more than once during a particular cycle, the eligible professional would be required to complete the Maintenance of Certification Program practice assessment a third time in order to qualify for the additional incentive.

We are also aware that ABMS boards are at various stages in implementing the practice assessment modules, and some may not have such assessment modules in place. However, inasmuch as we interpret the statute to require a Maintenance of Certification Program practice assessment at least once as part of the Maintenance of Certification Program, eligible professionals who do not have available, through their boards or otherwise, a Maintenance of Certification Program practice assessment are not eligible for the 0.5 percent incentive.

We believe that the experience of care survey provides particularly valuable information and proposed that a qualified Maintenance of Certification Program practice assessment must include a survey of patient experience with care. The Secretary may request information on the survey of patient experience with care, under section 1848(m)(7)(B)(iii) of the Act. In view of the importance of this information, and the lack of readily available alternative sources, we proposed to require that Maintenance of Certification Programs submit information as to the survey of patient experience with care for the eligible professional regarding whom information is being submitted by the Maintenance of Certification Program.

We proposed that Maintenance of Certification Programs wishing to enable their members to be eligible for an additional Physician Quality Reporting System incentive payment for the 2011 Physician Quality Reporting System will need to go through a self-nomination process by January 31, 2011. We proposed the board will need to include all of the following information in their self-nomination letter to CMS:

• Provide detailed information regarding the Maintenance of Certification Program with reference to the statutory requirements for such program.

• Indicate the organization sponsoring the Maintenance of Certification Program, and whether the Maintenance of Certification Program is sponsored by an ABMS board. If not an ABMS board, indicate whether the program is substantially equivalent to the ABMS Maintenance of Certification Program process.

• The frequency of a cycle of Maintenance of Certification Program for the specific Maintenance of

Certification Program of the sponsoring organization; including what constitutes "more frequently" for the Maintenance of Certification Program practice assessment for the specific Maintenance of Certification Program of the sponsoring organization.

- What was, is, or will be the first year of availability of the Maintenance of Certification Program practice assessment for completion by an eligible professional.
- What data is collected under the patient experience of care survey and how this information would be provided to CMS.
- How the Maintenance of Certification Program monitors that an eligible professional has implemented a quality improvement process for their practice.
- Describe the methods, and data used under the Maintenance of Certification Program, and provide a list of all measures used in the Maintenance of Certification Program for 2010 and to be used for 2011, including the title and descriptions of each measure, the owner of the measure, whether the measure is NQF endorsed, and a link to a Web site containing the detailed specifications of the measures, or an electronic file containing the detailed specifications of the measures.

We proposed that sponsoring organizations who desire to participate as a Maintenance of Certification Program will need to be able to provide CMS the following information in a CMS-specified file format by no later than the end of the first quarter of 2012:

- The name, NPI and applicable TIN(s) of the eligible professional who would like to participate in this process;
- Attestation from the board that the information provided to CMS is accurate and complete;
- The board has signed documentation from the eligible professional that the eligible professional wishes to have the information released to CMS;
- Information from the experience of care survey;
- Information certifying that the eligible professional has participated in a Maintenance of Certification Program for a year, more frequently than is required to qualify for or maintain board certification status, including the year that the physician met the board certification requirements for the Maintenance of Certification Program, and the year the eligible professional participated in a Maintenance of Certification Program "more frequently" than is required to maintain or qualify for board certification; and
- Information certifying that the eligible professional has completed the Maintenance of Certification Program practice assessment one additional time more than is required to qualify for or maintain board certification, including the year of the original Maintenance of Certification Program practice assessment or that a Maintenance of Certification Program practice assessment is not required for the eligible professional, and the year of the additional Maintenance of Certification Program practice assessment completion.

We proposed that specialty boards that also desire to send Physician Quality Reporting System information to CMS on behalf of eligible professionals should be able to meet the proposed requirements for registry data submission and should follow the directions for self-nomination to become a qualified registry. Boards may also participate as registries for Physician Quality Reporting System data provided that they meet the registry requirements. As an alternative to requiring boards to either operate a qualified Physician Quality Reporting System registry or to self-nominate to submit Maintenance of Certification Program data to CMS on behalf of their members, we also considered having the various boards submit the Maintenance of Certification Program data to the ABMS and having ABMS channel the information from the various boards to CMS (75 FR 40200).

The following is a summary of the comments received on the proposed requirements for qualifying for the additional 0.5 percent incentive for 2011, the proposed mechanism for receiving Maintenance of Certification Program data from the specialty boards, as well as on the alternative mechanism that we considered.

Comment: Commenters raised concerns as to whether the CY 2011 PFS proposed rule uses the term "Maintenance of Certification Program" in a manner that may be confusing to the public and unnecessarily raises trademark concerns. Specifically, the commenter recommended changes related to the use of the acronym "MOCP," such as referring to "maintenance of certification program" (all lower-case letters) or using different letters for the acronym.

Response: We appreciate the commenter's input. We will not use any acronym, including "MOCP." Instead, we will spell out the term "Maintenance of Certification Program" using capital letters as it is done in section 1848(m)(7) of the Act ("Additional Incentive Payment").

Comment: Several commenters provided positive feedback regarding the availability of an additional 0.5 percent incentive payment for meeting specific maintenance of certification requirements, including support for the inclusion of patient experience of care surveys as a required element of the Maintenance of Certification Program practice assessment component.

Response: We appreciate the commenter's support of the additional Maintenance of Certification Program incentive for eligible professionals participating in the 2011 Physician Quality Reporting System, authorized by the ACA.

Comment: One commenter believes that the "maintenance of certification" reporting option is premature. The commenter noted that the state of New Jersey may not currently have operational and tested "practice assessment" capability and funding for this program may not be available.

Response: While we recognize that this option may not be a feasible option for all eligible professionals, we are required to have this option available for the 2011 Physician Quality Reporting System under section 1848(m)(7) of the Act ("Additional Incentive Payment"). We note that participation in this option is voluntary and is not required to participate in the Physician Quality Reporting System or earn the Physician Quality Reporting System incentive. Therefore, eligible professionals who do not have the ability to participate in a maintenance of certification program can still participate in the Physician Quality Reporting System for 2011 and potentially qualify for a 1 percent incentive payment by satisfactorily reporting 2011 Physician Quality Reporting System measures. Participation in a maintenance of certification program provides eligible professionals an opportunity to earn an additional 0.5 percent incentive above and beyond what they could earn by satisfactorily reporting Physician Quality Reporting System measures.

Comment: One commenter urged us to implement regulations that would ensure that all eligible professionals have access to the additional 0.5 percent incentive.

Response: While we appreciate the commenter's support for the additional 0.5 percent incentive, we note that section 1848(m)(7) of the Act ("Additional Incentive Payment") explicitly ties the additional 0.5 percent incentive to participation in a Maintenance of Certification Program. Section 1848(m)(7)(C)(i) of the Act specifies that the term "Maintenance of

Certification Program" means "a continuous assessment program * * * that advances quality and the lifelong learning and self-assessment of board certified specialty physicians * * *." This suggests that Maintenance of Certification Programs apply only to physicians and only physicians can participate in a Maintenance of Certification Program and qualify for this additional 0.5 percent incentive payment. We do not believe we have the authority to broaden the applicability of this additional 0.5 percent incentive payment.

Comment: One commenter recommended that we allow eligible professionals who complete a Part IV Maintenance of Certification practice assessment be eligible for an additional 0.5 percent bonus if they are also satisfactorily report Physician Quality Reporting System measures, regardless of whether they satisfactorily reported through claims or another registry method. In contrast, other commenters believe the requirements for receiving a Maintenance of Certification Program payment are too onerous for both eligible professionals and Maintenance of Certification Program boards and should not be tied to satisfactorily reporting Physician Quality Reporting System measures.

Response: Section 1848(m)(7)(B)(i)(I) of the Act specifically requires that "* * * in order to qualify for the additional incentive payment* * *, an eligible professional shall* * *satisfactorily submit data on quality measures for [the Physician Quality Reporting System] for a year." As stated in the proposed rule (75 FR 40199), we proposed that an eligible professional "* * * may participate as an individual eligible professional using either individual Physician Quality Reporting System measures or measures groups and submitting the Physician Quality Reporting System data via claims, a registry, or an EHR or participate under one of the GPRO options (I or II)." We also proposed that an eligible professional "may qualify for the additional incentive, without regard to the method by which the [eligible professional] has met the basic requirement of satisfactorily reporting under the PQRI [that is, the Physician Quality Reporting System]." Therefore, eligible professionals wishing to qualify for the additional 0.5 percent incentive payment can satisfactorily report Physician Quality Reporting System measures using any available Physician Quality Reporting System method and are not limited to a specific one.

Comment: Although the ABMS has issued guidelines for Maintenance of Certification Program, one commenter believes that the individual boards have a fair amount of latitude in how they implement those guidelines. As a result, the commenter favors the plan to have individual specialty boards meet the CMS criteria if they wish to be deemed to verify individual eligible professional qualification for Physician Quality Reporting System incentives.

Response: We recognize the variability in the boards' maintenance of certification program requirements and appreciate the commenter's support of our proposal to allow individual boards to verify that their eligible professionals have met the appropriate maintenance of certification program requirements for the additional 0.5 percent incentive. Accordingly, we are finalizing the requirement to have the various boards submit information to us on eligible professionals' behalf attesting that an eligible professional has more frequently than is required to qualify for or maintain board certification status, participated in a maintenance of certification program for a year and successfully completed a qualified Maintenance of Certification Program practice assessment for such year.

Comment: Some commenters requested additional clarification on the requirements for qualifying for the additional 0.5 percent incentive so that eligible professionals can understand the necessary processes needed to qualify. One commenter requested more information on how Maintenance of Certification Program would work for specialty boards, such as the American Board of Internal Medicine (ABIM), that oversee the maintenance of certification processes for multiple subspecialties.

Response: As discussed previously, we recognize that there is variability in the boards' maintenance of certification program requirements. Therefore, eligible professionals will need to work with their specific Maintenance of Certification Program for information as to the processes of that program as it relates to qualifying for the additional 0.5 percent incentive.

We did not propose any requirements for self-nomination of each subspecialty of a board. Rather the board would have to provide information to CMS on each Maintenance of Certification Program that the board sponsors, where it sponsors more than one.

Comment: In response to the request in the proposed rule for input on an alternative to requiring Boards to either operate a qualified Physician Quality Reporting System registry or to self-nominate to submit Maintenance of Certification Program data to CMS on behalf of their members (75 FR 40201), one commenter noted that many of the ABMS member boards do not have the capacity to develop and implement CMS-approved registries to support their diplomates' participation in the Maintenance of Certification Program pathway for Physician Quality Reporting System reporting. The commenter suggested that developing a registry that can be shared across multiple Boards will allow for an efficient and cost-effective approach to facilitate participation in Physician Quality Reporting System reporting for their diplomates. Such a registry could collect and submit physician quality improvement data, provide attestation that the quality improvement data was collected as part of a qualified ABMS MOC® Part IV activity, and also serve as an intermediary in transmitting successful maintenance of certification participation in the Physician Quality Reporting System to CMS. Depending upon the vendor(s) identified to support the registry function, the commenter felt that this may also provide a mechanism for submission of patient experience of care surveys.

Response: We note that we did not propose to require boards to implement Physician Quality Reporting System qualified registries to support their diplomates' participation in the Maintenance of Certification Program pathway for Physician Quality Reporting System reporting. We merely highlighted that boards may wish to self-nominate to become a qualified Physician Quality Reporting System registry to facilitate eligible professionals' reporting of Physician Quality Reporting System data, as well as participation in the Maintenance of Certification Pathway. To the extent that a board or other entity wishes to become a qualified registry for the purposes of Physician Quality Reporting System data submission, the board or other entity must self-nominate to do so and meet all of the registry qualification requirements described in section VII.F.1.(4). of this final rule with comment period. In addition, to the extent an entity wishes to submit Physician Quality Reporting System data and/or data regarding participation in Maintenance of Certification Program(s) on behalf multiple boards, the entity will need to comply with the appropriate registry and/or Maintenance of Certification Program qualification requirements. More specifically, in order to submit data on participation in the Maintenance of Certification Pathway for multiple boards, the entity, must include the following information for each Maintenance of Certification

Program that it wishes to submit data on in their self-nomination letter to CMS:

- Provide detailed information regarding the Maintenance of Certification Program with reference to the statutory requirements for such program.
- Indicate the organization sponsoring the Maintenance of Certification Program, and whether the Maintenance of Certification Program is sponsored by an ABMS board. If not an ABMS board, indicate whether the program is substantially equivalent to the ABMS Maintenance of Certification Program process.
- The frequency and cycle of Maintenance of Certification for the specific Maintenance of Certification Program of the sponsoring organization; including what constitutes "more frequently" for the Maintenance of Certification Program practice assessment for the specific Maintenance of Certification Program of the organization.
- What was, is, or will be the first year of availability of the Maintenance of Certification Program practice assessment for completion by an eligible professional.
- What data is collected under the patient experience of care survey and how information on the survey would be provided to CMS.
- How the Maintenance of Certification Program monitors that an eligible professional has implemented a quality improvement process for their practice.
- Describe the methods, and data used under the Maintenance of Certification Program, and provide a list of all measures used in the Maintenance of Certification Program for 2010 and to be used in 2011, including the title and descriptions of each measure, the owner of the measure, whether the measure is NQF-endorsed, and a link to a Web site containing the detailed specifications of the measures, or an electronic file containing the detailed specifications of the measures.

With respect to submitting data on Maintenance of Certification Program participation, the qualified entity must submit:

- The name, NPI, and applicable TIN(s) of the eligible professional who would like to participate in this process;
- Attestation from each board that the information provided to CMS is accurate and complete;
- Signed documentation from the eligible professional that the eligible professional wishes to have their information released to CMS;
- Information on the patient experience of care survey;
- Information from the appropriate board attesting that the eligible professional has participated in a Maintenance of Certification Program for a year, more frequently than is required to qualify for or maintain board certification status, including the year that the physician met the board certification requirements for the Maintenance of Certification Program and the year the eligible professional participated in a Maintenance of Certification Program "more frequently" than is required to qualify for board certification; and
- Information from the appropriate board certifying that the eligible professional has completed the Maintenance of Certification Program practice assessment one additional time more than is required to qualify or maintain board certification, including the year of the original Maintenance of Certification Program practice assessment or that a Maintenance of Certification Program practice assessment is not required for the eligible professional, and the year of the additional Maintenance of Certification Program practice assessment completion.

Comment: Several comments indicated that we misinterpreted the intent of the "more frequently" requirement under section 1848(m)(7)(B)(ii) of the Act. Specifically, some commenters believe the intent of the "more frequently" requirement applies specifically to the Maintenance of Certification Program Part IV, practice assessment, requirement only and not to Parts II or III of the Maintenance of Certification Program (that is, the educational and self-assessment programs and the formalized, secure examination portion of the Maintenance of Certification Program). To that end, commenters requested the final rule provide additional clarification regarding the implementation of the "more frequently" requirement. One commenter also requested that we work closely with the ABMS to determine a means for implementing this provision which would be the least disruptive to existing maintenance of certification programs. One commenter noted that adding a requirement to participate in a maintenance of certification program "more frequently" than is required by the specialty board undermines the boards' standards and their expertise.

Response: As discussed in the proposed rule (75 FR 40199 through 40201), we believe that, as constructed, sections 1848(m)(7)(C)(i)(II) and 1848(m)(7)(C)(i)(III) of the Act applies the "more frequently" requirement to both the Maintenance of Certification Program itself and the successful completion of a Maintenance of Certification Program practice assessment. While we understand the commenter's question of this interpretation, we do not interpret the legislation as applying the "more frequently" requirement simply to the practice assessment activity. Rather we interpret the legislation as providing an additional incentive for eligible professionals who are actively pursuing activities involved in a continuous assessment program, such as a qualified ABMS Maintenance of Certification Program or an equivalent program. However, with respect to the "more frequently" requirement as it relates to the Maintenance of Certification Program itself, as opposed to the "more frequently" requirement for the practice assessment, we do not specify how an eligible professional must meet the more frequently requirement. Rather, we require only that the Maintenance of Certification Program indicate that the eligible professional has met the requirement.

Comment: A few comments opposed linking payers to the Maintenance of Certification Program.

Response: We are unclear what the commenters mean with respect to linking Medicare to the Maintenance of Certification Program. As we noted previously, participation in a Maintenance of Certification Program is not required for an eligible professional to earn a Physician Quality Reporting System incentive. Rather, participation in a Maintenance of Certification Program provides eligible professionals an opportunity to earn an additional 0.5 percent incentive above and beyond what they could earn under the Physician Quality Reporting System.

Comment: Several commenters suggested the "more frequently" requirement be based on the March 2009 ABMS MOC® Standards adopted by the ABMS, which applies to the 24 ABMS member boards. Under these standards, "more frequently" would mean that a Part IV activity must be completed every 1 to 4 years, by physicians who voluntarily decide to participate in the Maintenance of Certification Program Physician Quality Reporting System pathway. One of the commenters believes that diplomates should not be expected to participate more frequently than once a year in a process of collecting and reporting performance data and then acting on those results.

Response: With regard to the commenters' suggestion to adopt the standards adopted by ABMS in 2009,

we believe that by requiring the Maintenance of Certification Program to confirm that their eligible professionals meet the requirements "more frequently" than required will allow flexibility for the Maintenance of Certification Programs that have differing cycles of completion. Since we are looking to see that both the Maintenance of Certification Program itself and the practice assessment completed once more than required, we feel that a broader interpretation rather than an exact instance provides a greater opportunity for participation. For example, if an eligible professional's cycle states that they must complete one practice assessment activity every two to five years, more frequently would be completion of an additional activity within that cycle. If an eligible professional's cycle states they must complete two practice assessment activities during a cycle (for example, every two to five years), they would have to complete an additional activity (total of three) within their cycle.

Comment: Although several commenters favor measuring patients' experience with care, some suggested that we waive the requirement for reporting patient experience until 2012, once a definitive ABMS standard has been adopted. One commenter suggested that we work with the Boards to monitor the adoption of accurate and applicable patient experience methodologies. Another commenter requested clarification on why the patient experience is required for the Physician Quality Reporting System Maintenance of Certification Program practice assessment when many specialty boards do not require a survey of patient experience to satisfy practice assessment or maintenance of certification requirements.

Response: We agree that the survey of patient experience is an important mechanism for improving quality of care. While we appreciate the intent of the comments of ensuring a standard is available under ABMS Maintenance of Certification Programs, this additional 0.5 percent incentive is also available to non-ABMS boards as long as the process is substantially similar to the ABMS Maintenance of Certification Program process. The survey of patient experience with care is a required part of the practice assessment as defined under section 1848(m)(7)(B)(iii) of the Act. Therefore, we will finalize this requirement of a survey of patient experience with care as a required element of the practice assessment.

Comment: One commenter requested that we provide CRNAs with the opportunity to report quality measures through a nursing maintenance of certification program mechanism. Conversely, other commenters expressed that the rule should clearly state that physicians who are not participating in the ABMS MOC® are not eligible for the additional 0.5 percent incentive via the Maintenance of Certification pathway. One commenter specifically objected to the proposed rule language that, if not an ABMS Board, a program that is "substantially equivalent" to the ABMS Maintenance of Certification Program process may participate. The commenter noted that to be "substantially equivalent" to the ABMS Maintenance of Certification Program, any other program would have to first assure that its physicians had (1) successfully completed an Accreditation Council for Graduate Medical Education (ACGME)-approved training in their specialty, (2) successfully completed all the requirements of the ABMS Member Board to be certified, and (3) engaged in the ABMS Maintenance of Certification® program that is sponsored by the relevant Member Board. Items one and two are essential and should be included in any reference to the concept of "substantially equivalent."

Response: Under section 1848(m)(7)(C)(i) of the Act, a Maintenance of Certification Program is "a continuous assessment program such as a qualified American Board of Medical Specialties Maintenance of Certification Program or an equivalent program (as determined by the Secretary)." Therefore, eligible professionals participating in an equivalent program (that is, one that satisfies the definition of "Maintenance of Certification Program" under section 1848(m)(7)(C)(i) of the Act and § 414.90(b), that has a "qualified Maintenance of Certification Program practice assessment" as defined under section 1848(m)(7)(ii) of the Act and § 414.90(b), and meets the self-nomination process as proposed and previously described) will be able to submit Maintenance of Certification Program data on behalf of eligible professionals for purposes of the eligible professional qualifying for the additional 0.5 percent incentive. This additional 0.5 percent incentive payment is not limited to only those eligible professionals who participate in an ABMS MOC®. However, as previously stated, we believe that the definition of the term "Maintenance of Certification Program" under section 1848(m)(7)(C)(i) of the Act limits applicability of Maintenance of Certification Programs to physicians. Therefore, this additional 0.5 percent incentive would not apply to other eligible professionals, such as CRNAs.

Comment: One commenter supports creation of a mechanism whereby an eligible professional may provide data on quality measures through a Maintenance of Certification Program operated by a member specialty body of the American Board of Medical Specialties or American Osteopathic Association. Specifically, the commenter expressed support for the American Board of Radiology (ABR) and American Osteopathic Board of Radiology (AOBR) Maintenance of Certification Programs.

Response: We appreciate the commenter's support of the additional 0.5 incentive for eligible professionals participating in the 2011 Physician Quality Reporting System, authorized by the ACA. With respect to the specific Maintenance of Certification Programs that the commenter is in support of, these entities must follow the self-nomination process finalized in this final rule with comment period.

After considering the comments received and for the reasons we previously articulated, we are implementing the requirements that an eligible professional must meet to qualify for the additional 0.5 percent incentive authorized by section 1848(m)(7) of the Act ("Additional Incentive Payment"), previously described. We are also implementing the requirements for entities to self-nominate to submit Maintenance of Certification Program data on behalf of eligible professionals as proposed and previously described. We do not anticipate completing the qualification process until mid-2011. We will conditionally qualify entities until we complete testing of the entities' ability to submit Maintenance of Certification Program data to us in the specified manner. We anticipate posting the names of these conditionally qualified entities on the Physician Quality Reporting System section of the CMS Web site in Spring 2011 and we will update this list with the entities qualified for 2011 as soon as we finish testing the entities' ability to submit Maintenance of Certification Program data to us in the specified manner.

To the extent an eligible professional participates in multiple Maintenance of Certification Programs and meets the requirements under section 1848(m)(7) of the Act (Additional Incentive Payment) under multiple programs, the eligible professional can qualify for only one additional 0.5 percent incentive per year.

(3) Section 3002(d)—Integration of Physician Quality Reporting and EHR Reporting

Section 1848(m)(7) of the Act ("Integration of Physician Quality Reporting and EHR Reporting"), as added by section 3002(d) of the ACA requires us to move towards the integration of EHR measures with respect to the Physician Quality Reporting System. Section 1848(m)(7) of the Act specifies that by no later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under the Physician Quality Reporting System with reporting requirements under subsection (o) relating to the meaningful use of EHRs. Such integration shall consist of the following:

(A) The selection of measures, the reporting of which would both demonstrate—

(i) Meaningful use of an EHR for purposes of the EHR incentive program; and

(ii) Quality of care furnished to an individual; and

(B) Such other activities as specified by the Secretary.

In an effort to align the Physician Quality Reporting System with the EHR Incentive Program, we proposed and finalized many ARRA core clinical quality measures for inclusion in the 2011 Physician Quality Reporting System (see section VII.F.1.i.(4)) of this final rule with comment period), to demonstrate meaningful use of EHR and quality of care furnished to individuals. We are working towards a plan to integrate reporting on quality measures to make available by January 1, 2012.

The following is a summary of comments received regarding the integration of Physician Quality Reporting System and EHR reporting.

Comment: With respect to the integration of the Physician Quality Reporting System and the EHR Incentive Program, one commenter requested clarification on how we will deal with eligible professionals excluded from one program or the other in the alignment process. The commenter noted that we have not provided a feasible way for physicians excluded from the EHR Incentive Program to be able to participate in a program that combines these two initiatives. For example, pathologists employed at independent laboratories may be eligible for the EHR incentive but cannot participate in the Physician Quality Reporting System because of the billing mechanism they use.

Response: While we appreciate the commenter's interest in participating in both the Physician Quality Reporting System and the EHR Incentive Program, we note that these are two different, distinct programs. In addition, the term "eligible professional" is defined differently under these programs. We understand that, as a consequence, professionals may be eligible for one program but not the other. While we encourage participation in both the Physician Quality Reporting System and the EHR Incentive Program, we are not able to change the criteria for participation eligibility in each program in order to accommodate professionals who would like to participate in both programs, but do not meet the eligibility requirements for both.

Regarding the specific concern that pathologists who bill through independent laboratories are unable to participate in the Physician Quality Reporting System, independent laboratories are suppliers and do not fit into the Physician Quality Reporting System definition of "eligible professional" under section 1848(k)(3)(B) of the Act. Pathologists who bill directly to Medicare, however, are eligible to participate in the Physician Quality Reporting System.

Comment: Many commenters expressed support for linking the Physician Quality Reporting System with the EHR Incentive Program as it will reduce the burden and variability of reporting and streamline administrative processes for health care providers and for CMS and offered suggestions for us to consider as we develop our plan to integrate quality measures reporting under the two programs. One commenter, while favoring alignment of measures between the Physician Quality Reporting System and EHR Incentive Program, points out that the purpose of each is different, which will make it difficult to achieve this integration. The commenter stated that quality reporting is only one of the meaningful use features, so Physician Quality Reporting System measures should qualify for that objective. Commenters stated that Physician Quality Reporting System incentives should not require participation in meaningful use, and meaningful use incentives should not specifically require participation in the Physician Quality Reporting System. Commenters particularly supported alignment of the quality measures, noting that the degree to which any of the measures could share a dual purpose would be an added advantage for those who are trying to implement these programs. Another commenter suggested that we consult with specialty societies on a phased-in approach for integrating Physician Quality Reporting System and meaningful use measures that allow attestation in 2012 followed by incremental targeted percentage requirements would promote a smooth transition to full integration of Physician Quality Reporting System and meaningful use measures. Another commenter requested that we make it clear how we plan to update the outpatient measures required for meaningful use based on any changes implemented in the Physician Quality Reporting System.

Response: We appreciate the commenters' valuable input and will take the opinion offered by the commenters into consideration as we work towards making a plan to integrate reporting on quality measures available by January 1, 2012.

Comment: One commenter expressed concern that if we use the same proposed methodology for excluding measures with a zero percent performance rate in the Physician Quality Reporting System program that it does for assessing compliance with HITECH Meaningful Use measures then many physicians will be deemed "not capable" when attempting to demonstrate reporting capability of quality data. This is because eligible professionals are allowed the flexibility to demonstrate compliance with meaningful use capability when reporting clinical quality measures by reporting a zero denominator.

Response: A zero percent performance rate indicates that the eligible professional is reporting on a measure that is not clinically relevant to their practice. We do not preclude practices from doing this. However, since the Physician Quality Reporting System does not mandate a certain core set of measures and eligible professionals can select which measures apply to them, eligible professionals should be able to find 3 measures which pertain to their practice. We do recognize that eligible professionals may be somewhat limited for 2011 as there are only 20 measures available for Physician Quality Reporting System EHR reporting and those eligible professionals who wish to report measures without electronic specifications for the Physician Quality Reporting System will need to do so using a qualified registry or through claims (if claims-based reporting is permitted for the selected measure). We intend to discuss our plan to integrate reporting on quality measures under the Physician Quality Reporting System with reporting requirements under the EHR Incentive Program in future notice and comment rulemaking prior to implementation of the plan.

(4) Section 3002(e)—Feedback

Section 3002(e) of the ACA amends section 1848(m)(5) of the Act by adding subparagraph (H), which requires the Secretary to provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures. Since the inception of the program in 2007, the Physician Quality Reporting System has provided eligible professionals who have reported Physician Quality Reporting System data on quality measures feedback reports at the TIN/NPI level detailing participation in the Physician Quality Reporting System, including reporting rate and performance rate information. For 2008, we improved the format and content of feedback reports based on stakeholder input. We also developed an alternate report distribution method whereby each eligible professional can directly request and receive a feedback report. We will continue to provide feedback reports to individuals and group practices that satisfactorily submit Physician Quality Reporting System quality measure and thus qualify to earn a Physician Quality Reporting System incentive.

We believe that the requirements under section 1848(m)(5)(H) of the Act, as added by section 3002(e) of the ACA, for "timely" feedback reports is met by providing the feedback reports on or about the time of issuance of the incentive payments. Thus, we proposed to provide 2011 feedback reports on or about the time of issuance of the 2011 incentive payments in 2012, consistent with our current practice. In addition, we proposed to provide interim feedback reports for eligible professionals reporting 2011 measures groups through the claims-based reporting mechanism. These reports would be similar in content and format to the reports that we currently provide for such eligible professionals using claims for dates of service between January 1, 2011 and February 28, 2011. We indicated that we expected that we would be able to make these interim feedback reports available to eligible professionals in June 2011. We stated that we believe interim feedback reports would be particularly valuable to eligible professionals reporting measures groups, because it would let an eligible professional know how many more cases he or she needs to report to satisfy the criteria for satisfactory reporting for claims-based reporting of measures groups. We also indicated that we intend to continue to explore methods to facilitate Physician Quality Reporting System feedback report distribution, as discussed in the proposed rule (75 FR 40201).

The following is a summary of comments received regarding our proposal to provide timely feedback reports for the Physician Quality Reporting System.

Comment: We received some positive comments regarding our proposal to provide timely feedback. One commenter stated that eligible professionals will benefit from timely feedback reports on whether they are satisfactorily submitting data on quality measures. While some commenters supported our proposal to provide interim feedback reports for those who are reporting measures groups via claims, other commenters urged us to focus our efforts on providing other options for interim feedback. One commenter stated that the timeframe for feedback should be revised to a point during the reporting period so that eligible providers can act on the information they receive and that this was the legislation's intention. Commenters indicated that providing feedback after the close of the reporting period or just ahead of incentive payments is of minimal value since eligible professionals are not able to assess their reporting status and revise their reporting practices as needed. Commenters specifically recommended receiving quarterly or monthly feedback reports or upon request.

Response: We appreciate the commenters' suggestions to provide more interim feedback reports in a timely manner. Although section 1848(m)(5) of the Act requires us to provide "timely feedback" to eligible professionals on satisfactorily submitting data on quality measures, it is not a requirement to distribute "interim" feedback reports. While we agree that eligible professionals would benefit from timely, interim feedback, we have determined that we will not be able to complete the programming and development work necessary to provide the proposed interim feedback reports for eligible professionals who report 2011 measures groups using the claims-based reporting mechanism in the time frame that we proposed for the 2011 Physician Quality Reporting System. If we were to provide these interim feedback reports for 2011, they would more than likely not be available until late 2011. Since receiving interim feedback this late in the reporting period would be of little utility to eligible professionals, we are not finalizing our proposal to provide eligible professionals who report measures groups using the claims-based reporting mechanism with interim feedback reports for 2011. We intend, instead, to provide these interim feedback reports for 2012. In addition, as discussed further in section VII.F.2 of this final rule, we plan to provide an interim eRx report in the fall of 2011, which will include 2012 eRx payment adjustment information. We also will continue to provide timely annual feedback reports and anticipate providing additional interim reports for 2012. Furthermore, we are working internally to improve eligible professionals' electronic access to Physician Quality Reporting System and eRx reports by report type, program, and year for 2011.

Comment: Several commenters were disappointed by our proposal and suggested that it does not meet the statutory requirements and requested that we revise our proposal to increase the timeliness and frequency of the reports. One commenter suggested we revise the feedback report proposal to expedite the reports and ensure that the process improves successful participation in the Physician Quality Reporting System. Several comments specifically recommended that interim feedback reports be provided to all Physician Quality Reporting System participants, regardless of reporting mechanism used, rather than only to those reporting measures groups via claims-based reporting, as proposed. Other commenters specifically requested that interim feedback reports be provided to those reporting individual quality measures. Other commenters recommended we provide more frequent, or real-time, feedback reports to ensure that this process improves successful participation in the Physician Quality Reporting System. One commenter specifically encouraged CMS to provide feedback reports throughout the process, so that participants are aware of their progress in the program. Another commenter recommended that the system be redesigned to automatically generate a report as soon as the requirements for an individual eligible professional have been satisfied, much like what most of the registry systems do and why they have such a high level of successful completion. Another commenter suggested including the most recent Physician Quality Reporting System data available in the confidential feedback reports. Issuing the reports at the time of the incentive payment, as proposed, may discourage many from participating in the program the following year given that they are not certain whether or not they were

successful the previous year and renders the reports not useful for quality improvement. The commenters believe the lack of timeliness of feedback reports is one of the major reasons for dissatisfaction with the Physician Quality Reporting System.

Response: Section 1848(m)(5)(HH) of the Act requires that we provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on Physician Quality Reporting System measures but does not define the term "timely" or specify a deadline for providing feedback. As we stated in the proposed rule (75 FR 40201), we believe that this requirement is met by providing a timely, annual feedback report at or about the time of issuance of the incentive payments. In addition to providing an annual feedback report, we also proposed to provide an interim feedback report for eligible professionals who submit measures groups via claims. Although, for the reasons discussed previously, we are not finalizing our proposal to provide this interim feedback report for 2011, we intend to do so for 2012. The processing of claims data from the NCH file, along with the necessary programming required to produce reports and subsequently distribute to eligible professionals is time intensive. We are actively working to facilitate this process so that the interim feedback reports for claims-based reporting of measures groups and other interim feedback reports can be available for the 2012 Physician Quality Reporting System. We are continuing to work on ways to provide eligible professionals with timely and accurate feedback reports while working with the limitations of the claims-based reporting method. We also intend to work with registries and EHR vendors to explore ways in which we can leverage these alternative reporting mechanisms to provide interim feedback reports.

Comment: One commenter suggested that the interim feedback reports be provided for the first quarter of data instead of 2 months of data as proposed.

Response: While we agree that interim feedback reports for the first quarter of data would be valuable, we do not, for the reasons stated previously, have the technical ability to make interim feedback reports based on just the first 2 months of data available before July 1, 2011. We agree with commenters that interim feedback reports need to be issued at a point during the reporting period that eligible professionals can act upon the information to increase their chances of reporting satisfactorily, especially when they are required to report on percentage of applicable cases or patients. As stated previously, since the utility of receiving feedback reports in late 2011, (at the earliest) is minimal, we are not finalizing our proposal to provide eligible professionals who report measures groups using the claims-based reporting mechanism with interim feedback reports for 2011.

Comment: While we received favorable comments regarding our efforts to streamline and simplify distribution of Physician Quality Reporting System feedback reports, some commenters suggested that we continue to improve access to the feedback reports. Commenters noted that many individual eligible professionals and small practices still have difficulty obtaining their feedback reports. Commenters noted the numerous problems and issues using the Physician Quality Reporting System portal to download these reports. One commenter suggested that the feedback reports should be published for all eligible professionals without requiring them to submit a request.

Response: We are preparing, in the near future, to launch tools to provide eligible professionals access to all reporting years and report types via the CMS portal. We anticipate this level of access to be ready in mid- to late 2011. CMS security system access requirements are mandated by the information systems and security component of CMS and unfortunately cannot be changed by the Physician Quality Reporting System or eRx program requirements. A quick reference guide on IACS accounts, which is the current identity management system required for accessing feedback reports, is currently under development to assist eligible professionals with accessing their feedback reports.

Comment: One commenter recommended providing aggregate data to specialty societies so that they can assist in educating members on the program and potential issues. Another commenter suggested that we improve upon the aggregate quality data error reports by individual measures, currently distributed 4 times per year, by increasing their frequency to monthly.

Response: We appreciate the commenter's valuable input. As we explore ways to provide more timely feedback, we will also evaluate commenter's suggestion and explore its feasibility.

Comment: One commenter requested clarification as to whether eligible professionals could utilize the informal appeals process to dispute data contained in the interim feedback reports.

Response: We would expect that initial questions arising from the interim reports would be addressed by the QualityNet Help Desk, as is done today with the annual feedback reports. As discussed below, the main difference between the current inquiry process via the QualityNet Help Desk and the informal appeals process is that we have established timeframes around when requests for an informal review must be submitted and when a response must be provided.

Upon consideration of the comments and for the reasons we discussed previously, we are finalizing our proposal to provide feedback reports to all Physician Quality Reporting System participants on or about the time of issuance of the incentive payments. We also finalize our proposal to provide interim feedback reports for eligible professionals reporting measures groups through the claims-based reporting mechanism. For the 2011 Physician Quality Reporting System, however, we do not believe that we will have the technical capability needed to issue these interim feedback reports until the second half of the year. Since we do not believe that these interim feedback reports would be of much value at that point, we do not anticipate generating interim feedback reports for eligible professionals reporting measures groups until the 2012 Physician Quality Reporting System. For 2012, we also anticipate being able to provide additional interim feedback reports.

(5) Section 3002(f)—Appeals

Section 1848(m)(5)(I) of the Act, as amended and added by section 3002(f)(2) of the ACA, requires that the Secretary establish and have in place, no later than January 1, 2011, an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under the Physician Quality Reporting System. We note that except as provided under the informal process under section 1848(m)(5)(I) of the Act, section 1848(m)(5)(E) of the Act, as amended by section 3002(f) of the ACA, specifies that, with respect to the Physician Quality Reporting System, there shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(1) The determination of measures applicable to services furnished by eligible professionals under the Physician Quality Reporting System;

(2) The determination of satisfactory reporting under the Physician Quality Reporting System; and

(3) The determination of any Physician Quality Reporting System incentive payment and Physician Quality Reporting System payment adjustment.

We proposed to base the informal process on our current inquiry process whereby an eligible professional can contact the Quality Net Help Desk (via phone or e-mail) for general Physician Quality Reporting System and eRx Incentive Program information, information on Physician Quality Reporting System feedback report availability and access, and/or information on Physician Quality Reporting System Portal password issues (75 FR 40201). For purposes of the informal process required under section 1848(m)(5)(E) of the Act, we proposed the following inquiry process:

- An eligible professional electing to utilize the informal process must request an informal review within 90 days of the release of his or her feedback report.
- An eligible professional can request the informal review by notifying the Quality Net Help Desk via e-mail at qnetsupport@sdps.org. The e-mail requesting the initiation of the informal review process should summarize the concern(s) of the eligible professional and the reason(s) for requesting an informal review.
- We proposed to provide the eligible professional with a response to his or her request for an informal review within 60 days of receiving the original request.
- As this process is informal and the statute does not require a formal appeals process, we will not include a hearing or evidence submission process, although the eligible professional may submit information to assist in the review.
- Based on our informal review, we will provide a written response. Where we find that the eligible professional did satisfactorily report, we proposed to provide the applicable incentive payment.
- Given that this is an informal review process and given the limitations on review under section 1848(m)(5)(E) of the Act, decisions based on the informal review will be final, and there will be no further review or appeal.

The following is a summary of comments received on the proposed informal appeals process and our responses.

Comment: Several comments expressed support for the establishment of an informal appeals process, believing that eligible professionals' ability to challenge the results of the program is a necessary step to encouraging participation in the program and in promoting transparency. One commenter specifically indicated that having 90 days to electronically file an "informal appeal" is a sufficient amount of time and that having the ability to electronically submit these requests will help to ensure a timely, streamlined process. Another commented that the current lack of recourse for eligible professionals has contributed to a lack of interest in, and even skepticism, about the Physician Quality Reporting System.

Response: We appreciate the commenters' support of the informal appeals process and are hopeful that providing eligible professionals with an avenue to request an informal review of the determination that they did not satisfactorily report will encourage greater participation in the Physician Quality Reporting System.

Comment: Some commenters felt the period for requesting an informal review should be extended. One commenter suggested extending the timeframe to file an appeal through the end of the following year. Another commenter recommended extending the timeframe to the end of the reporting year, as those in large practices may not see their Physician Quality Reporting System report for a month or two after CMS sends it. Some commenters suggested that any results that are successfully appealed should be incorporated in public reporting of physician performance.

Response: While we understand the commenters' desire to extend the timeframe for submitting a request for an informal review, doing so could potentially impact the timeliness of future years' Physician Quality Reporting System incentive payments, because we would not be able to start analyzing the next year's data until we have completed our analysis of the current year's data. Therefore, we are requiring eligible professionals to submit their requests for an informal review within 90 days of the feedback reports becoming available, as proposed.

Comment: One commenter indicated that eligible professionals who successfully obtain an incentive payment are unlikely to a request a review. The commenter believes the review for those who are unsuccessful is unlikely to overturn the initial adjudication, since it can only be based on data present in the CMS system as there is no opportunity for evidence submission. The commenter feels that eligible professionals submitting data could easily be given feedback immediately about whether the data set was complete or not, both in terms of the individual data points and the number of eligible patients.

Response: We agree with the commenter's assertion that eligible professionals who are successful in obtaining a Physician Quality Reporting System incentive are unlikely to request an informal review. With respect to the claim that the "review for those who are unsuccessful is unlikely to overturn the initial adjudication, since it can only be based on data present in the CMS system as there is no opportunity for evidence submission," we disagree. CMS strives to ensure the accuracy of our initial determinations. However, recognizing errors may arise, CMS implemented the informal review process whereby Physician Quality Reporting System participants may request via the Quality Net Help Desk a review of the determination that the eligible professional did not satisfactorily submit data. In prior program years, the informal review method has resulted in supplemental payments for some eligible professionals despite the restriction on submitting additional evidence. This informal process has proven to be successful in finding errors in prior years, and we believe it will continue to do so. While we agree that it would be ideal to be able to provide immediate feedback as to whether the data set was complete or not both in terms of the individual data points and the number of eligible patients, this would not be technically feasible under the current claims processing system. However, we do intend to provide interim feedback reports as previously described.

Comment: In support of implementing a successful informal review process, some commenters recommended that the Quality Net Help Desk be expanded with additional telephone lines and more trained, experienced, and qualified staff. Commenters reported that some eligible professionals have faced challenges getting through to a CMS staff person and/or accessing the information they need through the existing Quality Net Help Desk. Another commenter stated that they believe the Quality Net Help Desk should be able to help eligible professionals and their staff immediately.

Response: We agree that in implementing an informal review process that utilizes the existing inquiry support framework additional resources will be needed and anticipate putting additional resources towards the Quality Net Help Desk.

Comment: Some commenters felt the proposed process was too informal to provide a fair and appropriate appeal. One commenter suggested the agency consider basing the informal process on the current inquiry process as merely a starting point and plan to expand the process in the future. Similarly, other commenters indicated that the appeals process needs to be a structured, transparent, and user-friendly appeals process so that eligible professionals have an avenue to quickly remedy erroneous determinations.

Response: We note that section 1848(m)(5)(I) of the Act does not require a formal appeals process; rather, it only requires an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under the Physician Quality Reporting System. We believe that the process that we proposed and are finalizing adequately allows an eligible professional to seek an informal review of the determination that the professional did not satisfactorily report. However, we agree that a timely response to eligible professionals who are questioning the outcome of their Physician Quality Reporting System reporting rate calculation will benefit the eligible professional. We plan to communicate the informal review process to eligible professionals through education and outreach. We also agree that the process needs to be user friendly and are using the lessons learned from inquiries received related to previous program years in determining the most timely and user-friendly method for the informal appeals process.

Comment: Another commenter suggested as payment adjustments begin to apply in 2015, we work with Congress to implement a more formal appeals process that includes standardized and transparent rules for submitting and reviewing evidence.

Response: For the 2011 Physician Quality Reporting System, we plan to implement the informal review process as described previously and required under section 1848(m)(5)(I) of the act. We plan to use any lessons learned from this process to make further enhancements to the process in future years.

Upon consideration of the comments, we are finalizing the informal review process as proposed and previously described. As stated in the proposed rule, we anticipate posting, by December 31, 2011 (75 FR 40202) on the CMS Physician Quality Reporting System Web site, further information regarding the operational aspects of the informal review process for the 2011 Physician Quality Reporting System. As we are implementing this informal review process beginning with the 2011 Physician Quality Reporting System and our expectation that we will be unable to generate 2011 Physician Quality Reporting System interim feedback reports prior to the start of the July 1, 2011 reporting period, we anticipate that eligible professionals will first have an opportunity to avail themselves of this informal process when the 2011 Physician Quality Reporting System feedback reports are made available in 2012.

2. Section 132: Incentives for Electronic Prescribing (eRx)—The Electronic Prescribing Incentive Program

a. Program Background and Statutory Authority

As described in the CY 2011 PFS proposed rule (75 FR 40202 through 40203), Electronic Prescribing (eRx) is the transmission using electronic media, of prescription or prescription-related information between prescriber, dispenser, pharmacy benefit manager (PBM), or health plan, either directly or through an intermediary, including an eRx network. The intention of the 2011 eRx Incentive Program, which is separate from, and in addition to, incentive payments that eligible professionals may earn through the Physician Quality Reporting System, is to continue to encourage significant expansion of the use of electronic prescribing by authorizing a combination of financial incentives and payment adjustments. Individual eligible professionals do not have to participate in the Physician Quality Reporting System in order to participate in the eRx Incentive Program (and vice versa). We proposed to add § 414.92 to title 42 of the Code of Federal Regulations to implement and codify the provisions of the eRx Incentive Program.

For 2011, which is the third year of the eRx Incentive Program, the Secretary is authorized to provide eligible professionals who are successful electronic prescribers an incentive payment equal to 1.0 percent of the total estimated Medicare Part B PFS allowed charges (based on claims submitted not later than 2 months after the end of the reporting period) for all covered professional services furnished by the eligible professional during the 2011 reporting period. The applicable electronic prescribing percent (1.0 percent) authorized for the 2011 eRx Incentive Program is different from that (2.0 percent) authorized for the 2009 and 2010 eRx Incentive Program. Under section 1848(m)(2)(C) of the Act, the incentive payments for successful electronic prescribers for future years are authorized as follows:

- 1.0 percent for 2012.
- 0.5 percent for 2013.

In addition, section 1848(m)(2)(D) of the Act, as added by section 4101(f)(2)(B) of Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) (ARRA–HITECH) which authorized the Medicare EHR Incentive Program, specifies that the eRx incentive does not apply to an eligible professional (or group practice), if, for the EHR reporting period, the eligible professional (or group practice) earns an incentive payment under the Medicare EHR Incentive Program beginning in 2011.

For the eRx Incentive Program, when reporting the G-codes for purposes of qualifying for the incentive payment for electronic prescribing in 2011, we proposed that the eligible professional must have and regularly use a "qualified" electronic prescribing system, as defined in the electronic prescribing measure specifications.

In addition, under section 1848(a)(5)(A) of the Act, a PFS payment adjustment applies beginning in 2012 to those professionals who are not successful electronic prescribers. Specifically, for 2012, 2013, and 2014, if the eligible professional is not a successful electronic prescriber for the reporting period for the year, the PFS amount for covered professional services furnished by such professionals during the year as previously referenced shall be less than the PFS amount that would otherwise apply over the next several years by—

- 1.0 percent for 2012.
- 1.5 percent for 2013.
- 2.0 percent for 2014.

We believe that the criteria for determination of successful electronic prescriber for the eRx incentive payment are not required to be identical to the criteria that will be used to determine the applicability of the payment adjustment that begins in 2012. In general, we believe that an incentive should be broadly available to encourage the widest possible adoption of eRx, even for low volume prescribers. On the other hand, we believe that a payment adjustment should be applied primarily to assure that those who have a large volume of prescribing do so electronically, without penalizing those for whom the adoption and use of an electronic prescribing system may be impractical given the low volume of prescribing. Under section 1848(m)(6)(A) of the Act, the definition

of "eligible professional" for purposes of eligibility for the eRx Incentive Program is identical to that for the Physician Quality Reporting System under section 1848(k)(3)(B) of the Act. Eligible professionals include physicians, other practitioners, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. However, as we have noted in prior years, for purposes of the eRx Incentive Program, eligibility is further restricted by scope of practice to those professionals who have prescribing authority. Detailed information about the types of professionals that are eligible to participate in the eRx Incentive Program is available on the eRx Incentive Program section of the CMS Web site at *http://www.cms.gov/ERXIncentive.*

As in the 2010 eRx Incentive Program, we proposed for 2011 that the eRx Incentive Program continue to be an incentive program in which determination of whether an eligible professional is a successful electronic prescriber will be made at the individual professional level, based on the NPI. Inasmuch as some individuals (identified by NPIs) may be associated with more than one practice or TIN, the determination of whether an eligible professional is a successful electronic prescriber will be made to the holder of each unique TIN/NPI combination (75 FR 40202). Then, as in previous years, payment will be made to the applicable holder of the TIN. For 2011, the determination of whether an eligible professional is a successful electronic prescriber will continue to be made for each unique TIN/NPI combination. However, section 1848(m)(3)(C) of the Act required the Secretary by January 1, 2010 to establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) would be treated as meeting the requirements for submitting data on electronic prescribing quality measures for covered professional services for a reporting period (or, for purposes of the payment adjustment under section 1848(a)(5) of the Act, for a reporting period for a year) if, in lieu of reporting the electronic prescribing measure, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary. Therefore, in addition to making incentive payments for 2011 to individual eligible professionals based on separately analyzing whether the individual eligible professionals are successful electronic prescribers, we proposed to also make incentive payments to group practices based on the determination that the group practice, as a whole, is a successful electronic prescriber in accordance with section 1848(m)(3)(C) of the Act (75 FR 40203).

The following is a summary of the general comments received on the CY 2011 PFS proposed rule related to the eRx Incentive Program and our responses.

Comment: Some commenters provided overall support for the eRx Incentive Program. Specific aspects of the program for which the commenters voiced support include the numerator and denominator codes, the reporting mechanisms, what constitutes a "qualified" electronic prescribing system, the criteria for being a successful electronic prescriber for purposes of the 2011 incentive payment, and the 10 percent limitation under section 1848(m)(2)(B) of the Act.

Response: We appreciate the commenters' positive feedback.

Comment: A couple of commenters highlighted the importance of providing eligible professionals feedback on whether they have successfully completed all requirements for this program and establishing an appeals process to allow eligible professionals to appeal decisions that affect their eligibility to take part in the eRx Incentive Program or that affect their ability to get eRx incentives.

Response: We agree with the commenters on the importance of feedback to eligible professionals. In addition to providing an annual feedback report, we anticipate making interim feedback reports for the program available to any eligible professional who bills for a denominator-eligible case during the first half of 2011. We anticipate that interim feedback reports will be available in the fall of 2011 and will include information related to the 2012 eRx payment adjustment. Although there is a required informal review process for the Physician Quality Reporting System, we are not establishing such a process for the eRx Incentive Program (nor are we required to do so). We expect that any questions arising from the interim feedback reports or the eligibility for an eRx incentive will be addressed by the Quality Net Help Desk as is currently done.

Comment: One commenter urged us to make available to individual eligible professionals the percentage of their prior year's Medicare charges that resulted from the outpatient CPT codes included in the electronic prescribing measure's specifications.

Response: Unfortunately, we do not have resources to calculate and provide feedback to eligible professionals regarding the composition of their charges. Most electronic billing systems, however, will have this functionality and should be able to provide eligible professional who use such billing systems with this information. In addition, eligible professionals who participate in the eRx Incentive Program will receive feedback reports with information on the percentage of an eligible professional's charges that resulted from the denominator codes included in the electronic prescribing's specifications.

Comment: One commenter sought guidance for physicians whose patients participate in the Medicaid PACE program and use a contracted pharmacy that may not be able to receive electronic prescriptions. The commenter asked whether these visits would be excluded from the requirements of the eRx Incentive Program.

Response: The eRx Incentive Program requires that an eligible professional use a qualified eRx system to electronically prescribe during the office visit. Hence, if the qualified system used by the eligible professional meets the requirements for a qualified eRx system, as described below and listed on the CMS eRx Incentive Web site at *http://www.cms.gov/erxincentive,* and the prescription is sent electronically, then the eligible professional will be able to report the electronic prescribing event even if the pharmacy was not able to receive the prescription electronically. The use of a pharmacy that cannot receive an electronic prescription does not invalidate the electronic prescribing event and the eligible professional would still get credit for electronically prescribing as long as he or she reports this event for a denominator-eligible visit.

Upon consideration of the comments, we are finalizing our proposal to add § 414.92 to title 42 of the Code of Federal Regulations to implement and codify the provisions of the eRx Incentive Program. Details regarding the specific aspects of the eRx Incentive Program that are being finalized, including our rationale, are described below. We have made some technical changes to the regulations at § 414.92, such as eliminating the unnecessary use of acronyms and inserting or revising cross-references as needed.

b. The 2011 eRx Incentive

(1) The 2011 Reporting Period for the eRx Incentive Program

Section 1848(m)(6)(C)(i)(II) of the Act defines "reporting period" for the 2011 eRx Incentive Program to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, however, authorizes the Secretary to revise the reporting period if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. We proposed the 2011 eRx Incentive Program reporting period for purposes of the 2011 incentive payment to be the entire calendar year (January 1, 2011 through December 31, 2011) based on the definition of "reporting period" specified under section 1848(m)(6)(C)(i)(II) of the Act. We proposed that successful electronic prescribers would be eligible to receive an incentive payment equal to 1.0 percent of the total estimated allowed Medicare Part B charges (based on claims submitted by no later than February 28, 2012) for all covered professional services furnished January 1, 2011 through December 31, 2011.

We did not receive any comments related to the proposed reporting period for the 2011 eRx incentive. Therefore, the reporting period for the 2011 eRx incentive will be the entire 2011 calendar year, or January 1, 2011 through December 31, 2011.

(2) Criteria for Determination of Successful Electronic Prescriber for Eligible Professionals

Under section 1848(m)(3)(B) of the Act, in order to qualify for the incentive payment, an eligible professional must be a "successful electronic prescriber," which the Secretary is authorized to identify using 1 of 2 possible criteria. One criterion, under section 1848(m)(3)(B)(ii) of the Act, is based on the eligible professional's reporting, in at least 50 percent of the reportable cases, on any electronic prescribing quality measures that have been established under the physician reporting system, under subsection 1848(k) of the Act and are applicable to services furnished by the eligible professional during a reporting period. We applied this criterion in 2009. However, for years after 2009, section 1848(m)(3)(D) of the Act permits the Secretary in consultation with stakeholders and experts to revise the criteria for submitting data on electronic prescribing measures under section 1848(m)(3)(B)(ii) of the Act.

The second criterion, under section 1848(m)(3)(B)(iii) of the Act, is based on the electronic submission by the eligible professional of a sufficient number (as determined by the Secretary) of prescriptions under Part D during the reporting period. If the Secretary decides to use the latter standard, then, in accordance with section 1848(m)(3)(B)(iv) of the Act, the Secretary is authorized to use Part D drug claims data to assess whether a "sufficient" number of prescriptions have been submitted by eligible professionals. However, under section 1848(m)(3)(B)(i) of the Act, if the standard based on a sufficient number (as determined by the Secretary) of electronic Part D prescriptions is applied for a particular reporting period, then the standard based on the reporting on electronic prescribing measures would no longer apply.

For 2011, we proposed to continue to require eligible professionals to report on the electronic prescribing measure used in the 2009 and 2010 eRx Incentive Program to determine whether an eligible professional is a successful electronic prescriber, but we also proposed to again use modified measure specifications and to use modified reporting criteria based on the authority provided under section 1848(m)(3)(D) of Act, as discussed below (75 FR 40203).

(A) Reporting the Electronic Prescribing Measure

We proposed, for purposes of the 2011 incentive payment and 2012 and 2013 payment adjustments, to retain the 3 reporting mechanisms available to individual eligible professionals to report the electronic prescribing measure in 2010 to maintain program stability. First, we proposed to again retain the claims-based reporting mechanism that is used in the 2009 and 2010 eRx Incentive Program. In addition, similar to the Physician Quality Reporting System, for the eRx Incentive Program, we proposed to continue the registry-based reporting mechanism and, we also proposed that the EHR-based reporting mechanism be available for the electronic prescribing measure for 2011 (75 FR 40203).

We proposed that only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2011 Physician Quality Reporting System would be qualified to submit measure results and numerator and denominator data on the electronic prescribing measure on behalf of eligible professionals for the 2011 eRx Incentive Program (75 FR 40204).

We proposed that qualified registries would need to submit the electronic prescribing measure for the 2011 eRx Incentive Program to CMS in two separate transmissions. Such qualified registries would first need to submit 2011 data on the electronic prescribing measure between July 1, 2011 and August 19, 2011, following the end of the 2012 payment adjustment reporting period (which is the first 6 months of 2011), for purposes of the eRx payment adjustment described in section VII.F.2.c. of this final rule with comment period. The second submission for purposes of the 2011 incentive would occur following the end of the 2011 incentive payment reporting period (which is the whole calendar year of 2011).

Similarly, we proposed that only EHR products "qualified" to potentially be able to submit clinical quality data extracted from the EHR to CMS for the 2011 Physician Quality Reporting System would be considered "qualified" for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2011 eRx Incentive Program (75 FR 40204). The self-nomination process and requirements for EHR vendors for the Physician Quality Reporting System would continue to apply to the EHR vendors for the 2011 eRx Incentive Program.

We proposed that eligible professionals who want to use a qualified EHR to submit the electronic prescribing measure for the 2011 eRx Incentive Program would be required to transmit 2011 electronic prescribing measure data to CMS in two separate transmissions. Such eligible professionals would first need to submit 2011 data on the electronic prescribing measure between July 1, 2011 and August 19, 2011, following the end of the 2012 payment adjustment reporting period, for purposes of the eRx payment adjustment described in section VII.F.2.c. of this final rule with comment period. The second submission for purposes of the 2011 incentive would occur following the end of the 2011 incentive payment reporting period.

The following is a summary of the comments received regarding the proposed mechanisms for reporting the electronic prescribing measure in 2011 for purposes of the 2011 incentive payment, and for purposes of the 2012 and 2013 payment adjustments described in sections VII.F.2.c. and d. of this final rule with comment period.

Comment: Some commenters agreed with retaining the same reporting

mechanisms for 2011 that were in place for 2010, particularly our decision to continue offering claims-based reporting and the inclusion of an EHR-based reporting mechanism.

Response: We appreciate the commenters' positive feedback and are finalizing our proposal to include a claims, registry, and EHR reporting for the 2011 eRx incentive.

Comment: One commenter thinks the requirement to submit electronic prescribing measure data in two submissions is burdensome for eligible professionals and suggests exploring alternatives where only one submission is required.

Response: We proposed two data submissions during 2011 for EHR-based reporting and registry-based reporting for different purposes. One was a submission between July 1, 2011 and August 19, 2011, that was intended to be solely for purposes of the 2012 payment adjustment. The second submission, which was to occur following the end of the 2011 incentive payment reporting period, was solely for purposes of the 2011 incentive payment. For purposes of the 2012 payment adjustment, we will not be able to finalize the registry and EHR-based reporting mechanisms because it will not be operationally feasible for us to accept the data submissions from the EHRs and registries in the timeframe needed for us to be able to have sufficient time to be analyze the data and make the determination whether an eligible professional is subject to the 2012 payment adjustment prior to January 1, 2012. Therefore, there will not be two submissions of electronic prescribing measure data from registries and EHRs during 2011.

Eligible professionals who intend to use the EHR-based reporting mechanism to submit data on the electronic prescribing measure for purposes of the 2011 incentive payment will need to submit the electronic prescribing measure data via their EHR following the end of the 2011 incentive payment reporting period. Similarly, registries that are submitting electronic prescribing data on behalf of eligible professionals or group practices for purposes of the 2011 incentive payment will need to do so following the end of the 2011 incentive reporting period. If an eligible professional chooses to use a qualified registry or qualified EHR for purposes of submitting electronic prescribing measure data for the 2011 incentive, we will not combine data from multiple reporting mechanisms. Therefore, an eligible professional must make sure that the required number of eRx events for purposes of the 2011 incentive payment is reported to us via a single reporting mechanism.

After considering the comments and for the reasons previously explained, we are finalizing our proposal to provide a claims, registry, and EHR reporting mechanism for the 2011 eRx incentive. As in 2010, not all registries qualified to submit quality measures on behalf of eligible professionals for the 2011 Physician Quality Reporting System will be qualified to submit quality measures results and numerator and denominator data on the electronic prescribing measure under the eRx Incentive Program. The electronic prescribing measure is reportable by an eligible professional any time he or she bills for one of the procedure codes for Part B services included in the measure's denominator. Some registries that self-nominate to become a qualified registry for the Physician Quality Reporting System may not choose to self-nominate to become a qualified registry for submitting electronic prescribing measures that require reporting at each eligible visit, such as the electronic prescribing measure. Registries need to indicate their desire to qualify to submit measure results and numerator and denominator data on the electronic prescribing measure for the 2011 eRx Incentive program at the time that they submit their self-nomination letter for the 2011 Physician Quality Reporting System. The self-nomination process and requirements for registries for the Physician Quality Reporting System, which also will apply to the registries for the 2011 eRx Incentive Program, are discussed in section VII.F.1. of this final rule with comment period. We will post a final list of qualified registries for the 2011 eRx Incentive Program on the eRx Incentive Program section of the CMS Web site at *http://www.cms.gov/ERXIncentive* when we post the final list of qualified registries for the 2011 Physician Quality Reporting System on the Physician Quality Reporting System section of the CMS Web site.

Similarly, EHR vendors are required to indicate their desire to have one or more of their EHR products qualified for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2011 eRx Incentive Program at the time when they submit their self-nomination letter for the 2011 Physician Quality Reporting System. A list of qualified EHR vendors and their products (including the version that is qualified) for the 2011 eRx Incentive Program will be posted on the eRx Incentive Program section of the CMS Web site at *http://www.cms.gov/ERXIncentive* when we post the list of qualified EHR products for the 2011 Physician Quality Reporting System on the Physician Quality Reporting System section of the CMS Web site.

Although we are finalizing three reporting mechanisms for use by eligible professionals for the 2011 eRx incentive, for purposes of the 2012 eRx payment adjustment, we are finalizing only the claims-based reporting mechanism given that, for operational reasons, we will not have the ability to accept registry and EHR data in the timeframe that we need to be able to complete our analysis of the data and make the determination of whether an eligible professional is subject to the 2012 payment adjustment prior to January 1, 2012. As discussed in the proposed rule (75 FR 40208), all claims for services furnished between January 1, 2011 and June 30, 2011, must be processed by no later than one month after the reporting period to be included in our analysis for purposes of the 2012 payment adjustment. Accordingly, to the extent an eligible professional intends to use a registry or EHR to submit electronic prescribing measure data for purposes of qualifying for the 2011 incentive, the eligible professional would still need to submit electronic prescribing measure data on claims for services furnished between January 1, 2011 and June 30, 2011, in order to avoid the 2012 payment adjustment.

(B) The Reporting Denominator for the Electronic Prescribing Measure

The electronic prescribing measure, similar to the Physician Quality Reporting System measures, has two basic elements, which include: (1) a reporting denominator that defines the circumstances when the measure is reportable; and (2) a reporting numerator.

The denominator for the electronic prescribing measure consists of specific billing codes for covered professional services. The measure becomes reportable when any one of these procedure codes is billed by an eligible professional for Part B covered professional services. As initially required under section 1848(k)(2)(A)(ii) of the Act, and further established through rulemaking and under section 1848(m)(2)(B) of the Act, we may modify the codes making up the denominator of the electronic prescribing measure. As such, we expanded the scope of the denominator codes for 2010 to covered professional services outside the professional office and outpatient setting, such as professional services furnished in

skilled nursing facilities or the home care setting.

For 2011, we proposed to retain the 2010 electronic prescribing measure's denominator codes. The following is a summary of the comments received regarding the proposed denominator codes for the 2011 electronic prescribing measure.

Comment: A couple of commenters supported our proposal to retain the denominator codes from denominator of the 2010 electronic prescribing measure denominator. Conversely, other commenters opposed retaining the 2010 electronic prescribing denominator codes because they do not allow for surgeons to effectively participate in the eRx Incentive Program. The commenters did not suggest additional codes for inclusion in the electronic prescribing measure's denominator though.

Response: With respect to the commenters' suggestions to add other denominator codes that were not proposed, we are not able to do so since the public would not have had an opportunity to comment on these additional codes. We welcome, however, specific suggestions for additional codes for consideration for the 2012 electronic prescribing measure. We believe that the existing denominator codes are representative of the types of services in which prescriptions are most often generated.

Comment: Another commenter was concerned that we have unnecessarily restricted the electronic prescribing's denominator by associating a prescription with a patient visit. The commenter noted that a vast majority of prescriptions in an internal medicine or family practice office are generated outside of a patient visit through the prescription renewal workflow while new prescriptions—the minority—are often coincident with the patient visit. The commenter believes that this sets up a cascade of filters that may prevent many otherwise successful providers from meeting the denominator criteria. The commenter stated that pharmacies either have, or can easily acquire, the capability to report the manner in which the prescription was received and CMS should consider a determined number of pharmacy claims of electronic prescriptions for Medicare beneficiaries, where the prescriber and manner of prescription delivery are clearly defined, as acceptable minimum criteria to determine a successful electronic prescriber. The commenter believes that the infrastructure to support this is laid in the requirements that Medicare D claims be submitted electronically to CMS and would allow CMS to identify successful electronic prescribers independent of the office-generated claims.

Response: As we stated in the proposed rule (75 FR 40203), we believe that the completeness and accuracy of the Part D data with respect to whether a prescription was submitted electronically is unknown, which is why we are continuing to require reporting on an electronic prescribing measure. As stated previously, we welcome suggestions for additional denominator codes for use in future years but believe that the existing denominator codes are generally representative of the types of services in which prescriptions are often generated.

Comment: One commenter supported the proposal to "expand the scope of the denominator codes for 2010 to professional services outside the professional office and outpatient setting, such as professional services furnished in skilled nursing facilities or the home-care setting."

Response: We are unclear why the commenter is providing feedback on the 2010 denominator codes as the scope of the rule is limited to the 2011 electronic prescribing measure. The 2010 denominator codes were finalized in the 2010 PFS final rule with comment period (74 FR 61852). Since the 2010 denominator codes already reflected our desire to include some professional services outside the professional office and outpatient setting, for 2011, we did not propose any changes to the denominator codes. Therefore, for 2011, we are retaining the 2010 denominator codes for the reasons listed by the commenter. Accordingly, after considering the comments, we are finalizing the following CPT codes in the denominator of the electronic prescribing measure for 2011: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109. We believe these codes represent the types of services for which prescriptions are likely to be generated.

There are no diagnosis codes in the measure's denominator and there are no age/gender requirements in order for a patient to be included in the measure's denominator (that is, reporting of the electronic prescribing measure is not further limited to certain ages or a specific gender). For purposes of both the incentive payment and payment adjustments discussed in sections VII.F.2.c. and d. of this final rule with comment period, eligible professionals who do not bill for one of the procedure codes for Part B covered professional services included in the measure's denominator will have no occasion to report the electronic prescribing measure. In other words, the measure is not applicable unless the professional bills for one of the codes included in the measure's denominator. In addition, in order to qualify for an incentive or avoid the payment adjustment, eligible professionals are not required to report this measure in all cases in which the measure is applicable. There are specific reporting thresholds, or reported electronic prescribing events, that an eligible professional must meet in order to be considered a "successful electronic prescriber" for purposes of the 2011 incentive payments, which are described in section VII.F.2.b.(2).(E). of this final rule with comment period. In addition, there are specific reporting thresholds that an eligible professional must meet in order to be considered a "successful electronic prescriber" for purposes of the 2012 and 2013 payment adjustments, which are described in sections VII.F.2.c. and d. of this final rule with comment period, respectively.

By no later than December 31, 2010, we will post the final specifications of the measure on the "eRx Measure" page of the eRx Incentive Program section of the CMS Web site at *http://www.cms.gov/ERXIncentive.*

(C) Qualified Electronic Prescribing System—Required Functionalities and Part D eRx Standards

To report the electronic prescribing measure in 2011, we again proposed that the eligible professional must report one of the measure's numerator G-codes, as discussed below. However, when reporting any of the G-codes in 2011, we proposed that the professional must have and regularly use a "qualified" electronic prescribing system, as defined in the electronic prescribing measure specifications. If the professional does not have general access to an eRx system in the practice setting, then the eligible professional does not have any data to report for purposes of the incentive payment. For 2011, we proposed to retain what constitutes a "qualified" electronic prescribing system as a system based upon certain required functionalities that the system can perform. We proposed to retain the same functionalities that were required in 2010.

In addition, section 1848(m)(3)(B)(v) of the Act specifies that to the extent

practicable, in determining whether an eligible professional is a successful electronic prescriber, "the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D–4(e)." The Part D standards for electronic prescribing systems establish which electronic standards Part D sponsors, providers, and dispensers must use when they electronically transmit prescriptions and certain prescription related information for Part D covered drugs that are prescribed for Part D eligible individuals. For 2011, we proposed that to be a qualified electronic prescribing system, electronic systems must convey the information for the required functionalities using the standards currently in effect for the Part D electronic prescribing program.

We did not receive any comments on the proposed required functionalities or Part D eRx standards. For this reason, we are finalizing the required functionalities and Part D eRx standards as described below.

Required Functionalities for a "Qualified" Electronic Prescriber System

For 2011, a "qualified" electronic prescribing system is one that can do the following:

(a) Generate a complete active medication list incorporating electronic data received from applicable pharmacies and PBMs, if available.

(b) Allow eligible professionals to select medications, print prescriptions, electronically transmit prescriptions, and conduct alerts (written or acoustic signals to warn the prescriber of possible undesirable or unsafe situations including potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions). This functionality must be enabled.

(c) Provide information related to lower cost, therapeutically appropriate alternatives (if any). The ability of an electronic prescribing system to receive tiered formulary information, if available, would again suffice for this requirement for 2011 and until this function is more widely available in the marketplace.

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

Part D Electronic Prescribing Standards.

To be a qualified electronic prescribing system under the 2011 eRx Incentive Program, electronic systems must convey the information listed previously under (a) through (d) using the standards currently in effect for the Part D electronic prescribing program. Additional Part D electronic prescribing standards were implemented April 1, 2009. These latest Part D electronic prescribing standards, and those that had previously been adopted, can be found on the CMS Web site at *http://www.cms.gov/eprescribing.*

To ensure that eligible professionals utilize electronic prescribing systems that meet these requirements, the electronic prescribing measure requires that those functionalities required for a "qualified" electronic prescribing system utilize the adopted Part D electronic prescribing standards. The Part D electronic prescribing standards relevant to the four functionalities for a "qualified" system in the electronic prescribing measure described previously and listed as (a), (b), (c), and (d), currently are as follows:

(a) Generate medication list—Use the National Council for Prescription Drug Programs (NCPDP) Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide, Version 8, Release 1, October 2005 (hereinafter "NCPDP SCRIPT 8.1") Medication History Standard;

(b) Transmit prescriptions electronically—Use the NCPDP SCRIPT 8.1 for the transactions listed at § 423.160(b)(2);

(c) Provide information on lower cost alternatives—Use the NCPDP Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0 (Version 1.0), October 2005 (hereinafter "NCPDP Formulary and Benefits 1.0");

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan—use—

(1) NCPDP Formulary and Benefits 1.0 for communicating formulary and benefits information between prescribers and plans;

(2) Accredited Standards Committee (ASC) X12N 270/271-Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092 and Addenda to Health Care Eligibility Benefit Inquiry and Response, Version 4010A1, October 2002, Washington Publishing Company, 004010X092A1 for communicating eligibility information between the plan and prescribers; and

(3) NCPDP Telecommunication Standard Specification, Version 5, Release 1 (Version 5.1), September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000 for communicating eligibility information between the plan and dispensers.

However, there are Part D electronic prescribing standards that are in effect for functionalities that are not commonly utilized at this time. One example is Rx Fill Notification, which is discussed in the Part D electronic prescribing final rule (73 FR 18926). For purposes of the 2011 Electronic Prescribing Program, we again are not requiring that an electronic prescribing system contain all functionalities for which there are available Part D electronic prescribing standards since many of these functionalities are not commonly available. For those required functionalities previously described, a "qualified" system must use the adopted Part D electronic prescribing standards for electronic messaging.

There are other aspects of the functionalities for a "qualified" system that are not dependent on electronic messaging and are part of the software of the electronic prescribing system, for which Part D standards for electronic prescribing do not pertain and are not required for purposes of the eRx Incentive Program. For example, the requirements in qualification (b) that require the system to allow professionals to select medications, print prescriptions, and conduct alerts are functions included in the particular software, for which Part D standards for electronic messaging do not apply.

We are aware that there are significant numbers of eligible professionals who are interested in participating in the eRx Incentive Program but currently do not have an electronic prescribing system. The electronic prescribing measure does not require the use of any particular system or transmission network; only that the system be a "qualified" system having the functionalities previously described based on Part D electronic prescribing standards. If the professional does not have general access to an electronic prescribing system in the practice setting, the eligible professional would not be able to report the 2011 electronic prescribing measure. In addition to not being eligible for a 2011 incentive payment, an eligible professional who does not report the electronic prescribing measure for 2011 may be subject to the 2012 eRx payment adjustment discussed in section VII.F.2.c. of this final rule with comment period.

(D) The Reporting Numerator for the Electronic Prescribing Measure

The proposed criteria for reporting for purposes of being a 2011 successful electronic prescriber are designed to reward those eligible professionals who demonstrate that they have adopted a qualified electronic prescribing system and used the system in a substantial way to electronically prescribe. Accordingly, for the 2011 electronic prescribing measure, we proposed to retain the following numerator G-code from the 2010 electronic prescribing measure's numerator: G8553 (At least 1 prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system) (75 FR 40206).

We did not receive any comments related to the proposed electronic prescribing measure numerator G-code for 2011. Therefore, we are finalizing G-code G8553 for the 2011 electronic prescribing measure's numerator.

We intend to post the final 2011 electronic prescribing measure specifications on the "eRx Measure" page of the eRx Incentive Program section of the CMS Web site at *http://www.cms.gov/ERXIncentive* by no later than December 31, 2010.

Because the electronic prescribing quality measure will apply only when an eligible professional furnishes services indicated by one of the codes included in the measure's denominator, for claims-based reporting, for example, it will not be necessary for an eligible professional to report G-codes for the electronic prescribing measure on claims not containing one of the denominator codes. However, if reporting a G-code, the G-code data submission will only be considered valid if it appears on the same Medicare Part B claim containing one of the electronic prescribing quality measure's denominator codes.

In addition, if the eligible professional submits a Medicare Part B claim containing one of the electronic prescribing measure's denominator codes, he or she can report the numerator G-code only when the eligible professional furnishes services indicated by the G-code included in the measure's numerator. That is, only when at least 1 prescription created during the encounter is generated and transmitted electronically using a qualified electronic prescribing system.

(E) Criteria for Successful Reporting of the Electronic Prescribing Measure

As discussed previously, section 1848(m)(3)(D) of the Act authorizes the Secretary to revise the criteria for submitting data on the electronic prescribing measure from the criteria specified under section 1848(m)(3)(B)(ii) of the Act, which requires the measure to be reported in at least 50 percent of the cases in which the measure is reportable. For the 2010 eRx incentive, we revised the criteria for successful electronic prescriber such that an eligible professional shall be treated as a successful electronic prescriber for a reporting period based on the eligible professional's reporting of the electronic prescribing measure which counts the generation and reporting of one or more prescriptions associated with a patient visit electronically for a minimum of 25 unique visits per year of applicable cases in the denominator of the electronic prescribing for 2010. For 2011, we again proposed to make the determination of whether an eligible professional is a successful electronic prescriber for purposes of the eRx incentive based on a count of the number of times (minimum threshold of 25) an eligible professional reports that at least one prescription created during the encounter is generated using a qualified electronic prescribing system (that is, reports the G8553 code).

The following is a summary of comments received regarding the criteria for the determination of a successful electronic prescriber for eligible professionals for the 2011 eRx incentive payment.

Comment: One commenter requested that we define and share for public comment the actual number of Part D prescriptions that would suffice to document successful electronic prescribing.

Response: We did not propose to use Part D prescriptions as the standard to determine whether an eligible professional is a successful e-prescriber for purposes of the 2011 eRx incentive payment. As stated in the proposed rule (75 FR 40203), we may consider doing so in the future. At such time, we would define the actual number of Part D prescriptions that would be required to be prescribed electronically via notice and comment rulemaking.

Comment: Several commenters supported the electronic prescribing measure reporting threshold of 25, while others stated that they support our plan to reduce the electronic prescribing measure reporting burden from 50 percent of all applicable services to reporting just 25 times.

Response: We appreciate the commenters' feedback regarding the proposed electronic prescribing measure reporting threshold for purposes of the 2011 eRx incentive payment. For 2011, we are finalizing our proposal to require that professionals report on 25 unique electronic prescribing events in order to be considered a successful e-prescriber for the purpose of qualifying for a 2011 eRx incentive payment. We believe that this reporting threshold simplifies the reporting burden and encourages participation.

Comment: Some commenters expressed concern that the reporting threshold of 25 unique visits is too low a standard for incentive payments as it is unclear how this threshold will drive improvements for all Medicare beneficiaries. A more robust standard was recommended. One commenter specifically recommended a reporting threshold of between 250–500 prescriptions per year per eligible professional and 25,000–50,000 per year per GPRO I group practice. Another commenter recommended that we require eligible professionals to transmit more than 40 percent of written prescriptions electronically, which is in line with the EHR Incentive Program.

Response: We appreciate the commenters' valuable input. We have reviewed several eRx Incentive Program management reports in order to determine the feasibility of using the "25" visit threshold and we believe that this threshold simplifies the eRx reporting burden. In establishing this threshold we also took into account the many valid circumstances that would prevent eligible professionals who have adopted a qualified electronic prescribing system from having 25 unique electronic prescribing events during the calendar year and variations in practice characteristics. Our goal is to increase participation in the eRx Incentive Program and, more importantly, to encourage the continued adoption and use of electronic prescribing systems.

After considering the comments received and for the reasons previously explained, we are finalizing our proposal to make the determination of whether an eligible professional is a successful electronic prescriber for purposes of the CY 2011 incentive payment based on a count of the number of times (minimum threshold of 25) an eligible professional reports that at least one prescription created during the encounter is generated using a qualified electronic prescribing system (that is, reports the G8553 code) during the 2011 reporting period (that is, January 1, 2011 through December 31, 2011).

(3) Determination of the 2011 Incentive Payment Amount for Individual Eligible Professionals Who Are Successful Electronic Prescribers

Section 1848(m)(2)(B) of the Act imposes a limitation on the electronic prescribing incentive payment. The Secretary is authorized to choose 1 of 2 possible criteria for determining whether or not the limitation applies to a successful electronic prescriber. The first criterion is based upon whether the Medicare Part B allowed charges for covered professional services to which the electronic prescribing quality measure applies are less than 10 percent of the total Medicare Part B PFS allowed charges for all covered professional services furnished by the eligible professional during the reporting period. The second criterion is based on whether the eligible professional submits (both electronically and non-electronically) a sufficient number (as determined by the Secretary) of prescriptions under Part D (which can, again, be assessed using Part D drug claims data). If the Secretary decides to use the latter criterion, then, in accordance with section 1848(m)(2)(B) of the Act, the criterion based on the reporting on electronic prescribing measures would no longer apply. The statutory limitation also applies with regard to the application of the payment adjustment. Based on our proposal to make the determination of whether an eligible professional is a "successful electronic prescriber" based on submission of the electronic prescribing measure, we proposed to apply the criterion under section 1848(m)(2)(B)(i) of the Act for the limitation for both the 2011 incentive payment and the 2012 payment adjustment (the application of the limitation with regard to the 2012 eRx payment adjustment is discussed in section VII.F.2.c.(3). of this final rule with comment period).

Since, as discussed previously, we proposed for 2011 to make the determination of whether an eligible professional is a "successful electronic prescriber" based on submission of the electronic prescribing measure, we also proposed to retain the requirement to analyze the claims submitted by the eligible professional at the TIN/NPI level to determine whether the 10 percent threshold is met in determining the receipt of an electronic prescribing incentive payment for 2011 by an eligible professional (75 FR 40206). For purposes of the 2011 eRx incentive payment, this calculation is expected to take place in the first quarter of 2012 and will be performed by dividing the eligible professional's total 2011 Medicare Part B PFS allowed charges for all such covered professional services submitted for the measure's denominator codes by the eligible professional's total Medicare Part B PFS allowed charges for all covered professional services (as assessed at the TIN/NPI level). If the result is 10 percent or more, then the statutory limitation will not apply and a successful electronic prescriber will qualify to earn the electronic prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the eligible professional will not earn an electronic prescribing incentive payment even if he or she electronically prescribes and reports a G-code indicating that he or she generated and transmitted a prescription electronically at least 25 times for those eligible cases that occur during the 2011 reporting period. Although an individual eligible professional may decide to conduct his or her own assessment of how likely this statutory limitation is expected to apply to him or her before deciding whether or not to report the electronic prescribing measure, an individual eligible professional may report the electronic prescribing measure without regard to the statutory limitation for the incentive payment.

The following is a summary of the comments received on the determination of the 2011 incentive payment amount for individual eligible professionals who are successful electronic prescribers.

Comment: Several commenters felt we should allow eligible professionals to earn an incentive both for the eRx Incentive Program as well as for the Medicare EHR Incentive Program. The commenters did not think these incentives should be mutually exclusive, claiming that the eRx payment adjustment applies even if the eligible professional is participating in both programs.

Response: We do not have the authority to allow eligible professionals to earn an incentive under the eRx Incentive Program and the Medicare EHR Incentive Program. Section 1848(m)(2)(D) of the Act specifies that the incentive under the eRx Incentive Program shall not apply to an eligible professional (or, in the case of a group practice) if, for the EHR reporting period the eligible professional (or group practice) receives an incentive payment under the EHR Incentive Program with respect to a certified EHR technology that has the capability of electronic prescribing.

We will, however, be developing a plan, as described under section 1848(m)(7) of the Act ("Integration of Physician Quality Reporting and EHR Reporting"), to integrate measure reporting requirements under the Physician Quality Reporting System, eRx Incentive Program, and the EHR Incentive Program, with respect to selection of measures to demonstrate meaningful use under the EHR Incentive Program, quality of care furnished to an individual, and such other activities as specified by the Secretary.

With regards to the commenters' statement that the eRx payment adjustment still applies even if an eligible professional participates in both programs, this is not accurate. The eRx payment adjustment applies only to the extent that the eligible professional is not a successful electronic prescriber. We would also like to clarify that the limitation under section 1848(m)(2)(D) of the Act with respect to EHR incentive payments does not preclude the 10 percent limitation under section 1848(m)(2)(B)(i) of the Act from applying with regard to the eRx payment adjustment to an eligible professional who earns an EHR incentive.

Comment: One commenter requested that we clarify the way in which we intend to calculate the group eRx incentives if individual members of the group have received Medicare EHR incentives.

Response: We will assess the group practice's data first to determine eRx incentive eligibility. If the group practice is eligible for an eRx incentive, then we will filter out the allowed charges for all NPIs who earn an EHR incentive before calculating the group's incentive amount.

Comment: We also received feedback pertaining to the eRx Incentive Program and EHR Incentive Program having different threshold criteria. Specifically, the commenter was concerned that the in order to qualify for the EHR incentive, eligible professionals must use a qualified EHR to generate and transmit 40 percent of all permissible prescriptions electronically but for the eRx Incentive Program, the threshold is 25 successful electronic prescriptions during the reporting period for purposes of the incentive payment. Since eligible professionals must still participate in the eRx Incentive Program to avoid the 2012 payment adjustment, a commenter stated that having different threshold criteria for the two programs causes confusion and recommended the establishment of a consistent threshold for electronic prescriptions. Another commenter felt that different thresholds are appropriate given that the EHR Incentive Program is voluntary and the

eRx Incentive Program is mandatory to maintain full payment.

Response: We note that the EHR Incentive Program and the eRx Incentive Program are two separate, distinct programs with different purposes and underlying statutory provisions. Professionals eligible for the eRx Incentive Program are encouraged to be successful electronic prescribers using qualified electronic prescribing systems. The Medicare EHR Incentive Program will provide incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that are meaningful users of certified EHR technology. Electronic prescribing is merely one component of the EHR Incentive Program.

As such, we believe, at this time that it is appropriate to have different reporting thresholds. However, as noted previously, we will be developing a plan, as described under section 1848(m)(7) of the Act ("Integration of Physician Quality Reporting and EHR Reporting"), to integrate measure reporting requirements under the Physician Quality Reporting System, eRx Incentive Program, and the EHR Incentive Program. In the plan, we will study potential ways to address the commenters' concerns.

(4) Reporting Option for Satisfactory Reporting of the Electronic Prescribing Measure by Group Practices

Section 1848(m)(3)(C) of the Act required that we establish and have in place a process under which eligible professionals in a group practice shall be treated as a successful electronic prescriber. In addition, we are prohibited from making double payments under section 1848(m)(3)(C)(iii) of the Act, which requires that payments to a group practice shall be in lieu of the payments that would otherwise be made under the eRx Incentive Program to eligible professionals in the group practice for being a successful electronic prescriber. For 2011, we proposed to make incentive payments to group practices based on the determination that the group practice, as a whole, is a successful electronic prescriber for 2011 (75 FR 40207). An individual eligible professional who is affiliated with a group practice participating in the group practice reporting option that successfully meets the requirements for group practices would not be eligible to earn a separate eRx incentive payment for 2011 on the basis of his or her successfully reporting the electronic prescribing measure at the individual level.

The following is a summary of the comments received regarding the two group practice options for reporting the electronic prescribing measure in 2011.

Comment: One commenter supports the proposed eRx GPRO II, including the proposed reporting criteria for GPRO II groups.

Response: We appreciate the commenter's positive feedback and are finalizing the eRx GPRO II as proposed. We believe that the eRx GPRO II will expand opportunities for group practices to participate in the eRx Incentive Program.

Comment: One commenter appreciated that we have recognized the burden of claims-based reporting for the Physician Quality Reporting System and the eRx Incentive Program but the commenter was "disappointed that a GPRO-specific alternative for the eRx Incentive Program was not proposed. Most groups using [electronic prescribing technology] can readily obtain detailed information on physician utilization of the system." The commenter felt that this data could be easily reported, in detail, on the GPRO I data collection tool and urges CMS to consider this alternative for 2011 reporting.

Response: We assume that the "GPRO-specific alternative" that the commenter is referring to is the addition of the electronic prescribing measure to the GPRO I data collection tool so that the groups participating in GPRO I can use this data collection tool to submit quality measures data for both the Physician Quality Reporting System and the eRx Incentive Program. Similar suggestions have been considered in the past but were not implemented due to fiscal concerns and concerns about the timing of when an updated GPRO I data collection tool could be available. We will continue to explore the feasibility of adding the electronic prescribing measure to the GPRO I data collection tool so that practices can use the data collection tool to submit the electronic prescribing measure instead of claims, a qualified registry, or a qualified EHR.

Based on these comments, we are finalizing two group practice reporting options for the eRx Incentive Program for 2011—GPRO I and GPRO II. GPRO I is the reporting option for large group practices with 200 or more eligible professionals and GPRO II is the reporting option for group practices with fewer than 200 eligible professionals. The reporting criteria under these 2 options differ depending on the size of the group practice. Eligibility and reporting requirements for the 2011 eRx GPRO I and GPRO II are described below. We believe that these 2 options will encourage greater participation in the eRx Incentive Program by reducing overall reporting burden for eligible professionals who are part of a group practice.

(A) Definition of "Group Practice"

Section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define "group practice." For purposes of determining whether a group practice is a successful electronic prescriber for 2011, we proposed that consistent with the definition of group practice proposed for the Physician Quality Reporting System group practice reporting option (GPRO), a "group practice" would be defined as a single Taxpayer Identification Number (TIN) with 2 or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN. "Group practice" would also include group practices participating in Medicare demonstration projects approved by the Secretary (75 FR 40207).

In addition, we proposed to restrict participation in the 2011 eRx GPRO to group practices participating in the 2011 Physician Quality Reporting System GPRO (either through GPRO I or GPRO II) or group practices that are deemed to be participating in the 2011 Physician Quality Reporting System GPRO (that is, group practices participating in a CMS-approved Medicare demonstration) that have indicated their desire to participate in the 2011 eRx GPRO (75 FR 40207).

We also proposed that a group practice that wishes to participate in the 2011 eRx Incentive Program under the group practice reporting option will have to indicate how the group practice intends to report the electronic prescribing measure. That is, the group practice will need to indicate in its self-nomination letter which reporting mechanism (that is, claims, registries or EHRs) the group practice intends to use for purposes of participating in the 2011 eRx Incentive Program group practice reporting option.

We did not receive any comments related to the proposed definition of "group practice" for purposes of the eRx Incentive Program. For this reason, we are finalizing our proposal as previously described.

Unlike individual eligible professionals who may choose not to participate in the Physician Quality Reporting System, to be eligible to earn an electronic prescribing incentive in 2011, group practices that wish to participate in the electronic prescribing group practice reporting option will be required to participate in the Physician

Quality Reporting System group practice reporting option or be deemed to be participating in the Physician Quality Reporting System group practice reporting option based on the practice's participation in an approved Medicare demonstration project. Participation in the eRx Incentive Program, including participation in the electronic prescribing group practice reporting option is, however, optional for group practices that are participating in the Physician Quality Reporting System under the group practice reporting option. If a group practice wishes to participate in the 2011 eRx Incentive Program under the group practice reporting option, the group practice must indicate its desire to do so at the time that the group practice self-nominates to participate in the 2011 Physician Quality Reporting System group practice reporting option. However, group practices are not required to indicate their intent to participate in the 2011 eRx Incentive Program as individual eligible professionals, when the group practice self-nominates to participate in the 2011 Physician Quality Reporting System group practice reporting option.

As discussed in section VII.F.1.g. of this final rule with comment period, group practices interested in participating in the 2011 Physician Quality Reporting System through the group practice reporting option will be required to submit a self-nomination letter to CMS, requesting to participate in the 2011 Physician Quality Reporting System group practice reporting option. Instructions for submitting the self-nomination letter will be posted on the Physician Quality Reporting System section of the CMS Web site by November 15, 2010. A group practice that had indicated their desire to participate in the eRx Incentive Program group practice reporting option when they self-nominated to participate in the 2011 Physician Quality Reporting System group practice reporting option will be notified of the selection decision with respect to participation in the eRx Incentive Program at the same time that it is notified of the selection decision for the Physician Quality Reporting System group practice reporting option.

(B) Process for Group Practices To Participate as Group Practices and Criteria for Successful Reporting of the Electronic Prescribing Measure by Group Practices

For group practices selected to participate in the electronic prescribing group practice reporting option for purposes of the 2011 eRx incentive payment, we proposed that the reporting period would be January 1, 2011 to December 31, 2011 (75 FR 40207). We proposed that group practices selected to participate in the 2011 eRx Incentive Program and qualify for the eRx incentive payment through the group practice reporting option would be able to choose to report the electronic prescribing measure through the claims-based, the registry-based, or, the EHR-based reporting mechanism.

In order for a group practice participating in the Physician Quality Reporting System GPRO I to be considered a successful electronic prescriber for purposes of the 2011 eRx incentive, we proposed that the group practice would have to report that at least 1 prescription during an encounter was generated and transmitted electronically using a qualified electronic prescribing system in at least 2,500 instances during the reporting period. In order for a group practice participating in the Physician Quality Reporting System GPRO II to be considered a successful electronic prescriber, we proposed that the group practice would have to report that at least 1 prescription during an encounter was generated and transmitted electronically using a qualified electronic prescribing system for 75–1,875 instances, based on the group's size (75 FR 40208).

Section 1848(m)(2)(B) of the Act specifies that the 10 percent threshold limitation on the applicability of the electronic prescribing incentive applies to group practices as well as individual eligible professionals. Therefore, in determining whether a group practice will receive an electronic prescribing incentive payment for 2011 by meeting the proposed reporting criteria previously described, we would determine based on the claims, whether 10 percent of a group practice's charges comprised of codes in the denominator of the electronic prescribing measure.

We did not receive any comments related to the proposed process for group practices to participate as group practices and the proposed criteria for successful reporting of the electronic prescribing measure by group practices for purposes of the 2011 eRx Incentive. Therefore, for purposes of the 2011 eRx incentive, we are finalizing our proposal to require GPRO I practices to report the electronic prescribing measure for 2,500 instances during the January 1, 2011 through December 31, 2011. We are also finalizing our proposal to require GPRO II practices to report the electronic prescribing measure for the number of instances specified in Table 76 (see section VII.F.1.g.(3).(B). of this final rule with comment period) during the January 1, 2011 through December 31, 2011 reporting period. We believe these are reasonable thresholds to demonstrate use of electronic prescribing technology.

In addition, we are finalizing our proposal to allow group practices participating in the 2011 eRx Incentive Program under GPRO I and GPRO II to submit data on the electronic prescribing measure using claims, a qualified registry, or a qualified EHR for purposes of qualifying for the 2011 eRx incentive payment. In addition, for purposes of the 2011 eRx incentive, we will not combine data on the electronic prescribing submitted via multiple reporting mechanisms. That is, a group practice must meet the relevant 2011 GPRO reporting criteria for the 2011 incentive using a single reporting mechanism. Combining data received via multiple reporting mechanisms would add significant complexity to our analytics and potentially delay incentive payments.

c. The 2012 eRx Payment Adjustment

Section 1848(a)(5) of the Act requires that with respect to covered professional services furnished by an eligible professional in 2012, if the eligible professional is not a successful electronic prescriber for the reporting period for the year, the fee schedule amount for such services furnished by such professional during 2012 shall be equal to 99 percent of the fee schedule amount that would otherwise apply to such PFS services.

The following is a summary of general comments received regarding the eRx payment adjustment and our responses.

Comment: Some commenters were opposed to implementation of the eRx payment adjustment because of the eRx Incentive Program is relatively new. Commenters noted that we have not released any summary results regarding how many eligible professionals are reporting and how many are earning incentives, eligible professionals have not received feedback reports on their progress for 2009 or 2010, and there is no evidence that the program is working. As a result, commenters suggested that CMS should ensure that eligible professionals who attempt to report but are unsuccessful due to the data submission process are not penalized.

Response: Section 1848(a)(5) of the Act requires us to implement a payment adjustment beginning with covered professional services furnished by an eligible professional during 2012, if the eligible professional is not a successful electronic prescriber. We do not have

the authority to delay implementation of this payment adjustment.

Comment: One commenter suggested that we exercise additional flexibility in assigning payment adjustments carefully by reviewing each eligible professional's circumstances prior to assigning any payment adjustments.

Response: Although we value the commenter's input, this suggestion is not technically feasible. Given the short period of time between the end of the data submission period for the 2012 eRx payment adjustment and when we would have to begin adjusting eligible professional's 2012 payments, it would not be feasible for us to review every eligible professional's circumstances individually. In addition, section 1848(a)(5) (A)(i) of the Act requires us to apply the payment adjustment "if the eligible professional is not a successful electronic prescriber." We believe that the criteria for becoming a successful electronic prescriber for purposes of the payment adjustment that we have proposed and are finalizing below are reasonable in that we have limited the number of electronic prescribing events required to avoid the payment adjustment. Furthermore, as discussed further in section VII.F.2.c.(4). of this final rule with comment period we have provided a process whereby eligible professionals can request a significant hardship exception on a case-by-case basis under section 1848(a)(5)(B) of the Act.

Comment: Several commenters urged us to synchronize the eRx Incentive Program and EHR Incentive Program so that eligible professionals who receive Medicare EHR incentives will be exempt from the eRx payment adjustments. Commenters stated that the EHR Incentive Program provides an opportunity and payment adjustment that did not exist when the original eRx Incentive Program regulations were put in place, and adjustments should be made due to the amount of overlap between programs. As it is, the eRx Incentive Program and the EHR Incentive Program represent a form of "double jeopardy" for physicians. For instance, a physician who gets the first year "meaningful use" subsidy via Medicaid could also be penalized for not using electronic prescribing. Also, commenters claimed that in some cases, in order to avoid the eRx payment adjustment, a physician would have to purchase a stand-alone electronic prescribing program and then transition to a full EHR once the certification standards are determined. Furthermore, the list of "certified" EHRs for the EHR Incentive Program will not be available until January 2011. Another commenter stated that it is unfair to penalize eligible professionals who are working in good faith to adopt a comprehensive EHR under the EHR Incentive Program. Another commenter suggested that every effort be made to align the EHR Incentive Program and the eRx payment adjustment to remove the burden from eligible professionals of having to submit electronic prescribing measure data more than once.

Response: We agree with the desire to align the EHR Incentive Program and the eRx payment adjustment and understand the commenters' concerns. The EHR Incentive Program and the eRx Incentive Program are governed by different laws, and have different reporting requirements. While section 1848(m)(2)(D) explicitly limits eligible professionals or group practices that receive an EHR incentive from qualifying for an eRx incentive payment in the same year, there is not a similar statutory provision that explicitly limits an eligible professional or group practice that receives an EHR incentive from being subject to the eRx payment adjustment. At this time an eligible professional who wishes to participate in the EHR Incentive Program would also have to participate in the eRx Incentive Program during 2011 to avoid an eRx payment adjustment in 2012 since the two programs have different requirements with respect to electronic prescribing. Eligible professionals, however, are not penalized for participating in both programs. Rather, an eligible professional who qualifies for an eRx incentive and a Medicare EHR incentive cannot earn an eRx incentive for the same year. However, we are making the effort to study possible methods of aligning the two programs by developing a plan, as described under section 1848(m)(7) of the Act ("Integration of Physician Quality Reporting and EHR Reporting"), to integrate measure reporting requirements under Physician Quality Reporting System, eRx Incentive Program and the EHR Incentive Program.

We note that although section 1848(m)(2) precludes an eligible professional who has earned an incentive payment under the EHR Incentive Program from also earning an eRx incentive payment, the statute does not preclude the eligible professional from being subject to the eRx payment adjustment. In order to avoid the eRx payment adjustment, an eligible professional participating in the Medicare EHR Incentive Program still must meet the relevant eRx payment adjustment criteria for being a successful electronic prescriber.

(1) The eRx Payment Adjustment Reporting Period

For purposes of the 2012 eRx payment adjustment, we proposed to make a determination of whether an eligible professional or a group practice is a successful electronic prescriber based on the January 1, 2011 through June 30, 2011 reporting period (75 FR 40208). For eligible professionals and group practices using the claims-based reporting mechanism, we proposed that all claims for services furnished between January 1, 2011 and June 30, 2011 must be processed by no later than one month after the reporting period, for the claim to be included in our data analysis.

The following is a summary of comments received on the proposed reporting period for the 2012 eRx payment adjustment and our proposal to require claims to be submitted by no later than 1 month after the reporting period.

Comment: Several commenters expressed a desire for us to revise or delay the 2012 eRx payment adjustment reporting period, asserting that basing the 2012 eRx payment adjustment on electronic prescribing activity in 2011 conflicts with the law. Although some commenters acknowledged the need for time to complete a data analysis to determine if an eligible professional was a successful electronic prescriber prior to 2012, these commenters expressed opposition to the shorter reporting period. Other commenters believed that payment adjustments for 2012 should be based on a reporting period in 2012 rather than a reporting period in 2011. Commenters preferred that the reporting period for the 2012 and 2013 payment adjustments be the full 2012 and 2013 calendar years, respectively. One commenter requested an April 1 through September 30, 2011 for the 2012 payment adjustment. One commenter noted that some organizations might have planned an implementation of a qualified electronic prescribing system prior to January 1, 2012, to avoid the 2012 eRx payment adjustment. Such organizations would now have to complete that implementation more than six months in advance, potentially causing a significant financial burden for the organization. Another commenter stated that the 2012 eRx payment adjustment may cause some practices to reduce their Medicare patient roster (or refuse to accept new Medicare patients) in order to reduce the size of the payment adjustment, because they claim they would not have adequate time to meet

the proposed 2011 requirements to avoid the payment adjustment in 2012.

Response: With respect to commenters' claims that the proposed reporting period for purposes of applying the 2012 eRx payment adjustment conflicts with the law, section 1848(a)(5) of the Act requires that the PFS amount for covered professional services furnished by an eligible professional during 2012, be reduced by 1 percent during 2012, if the eligible professional is not a successful electronic prescriber for the reporting period for the year. Under section 1848(a)(5)(D) of the Act, we have the discretion to define the "reporting period" for purposes of the payment adjustment with respect to a year.

While we appreciate the commenters' suggestions to use data from the entire 2011 calendar year, a later part of 2011, or from 2012 for such an assessment for purposes of applying the 2012 eRx payment adjustment for services furnished in 2012, we believe it is necessary to reduce the PFS amount concurrently with claims submissions in 2012. The alternatives to reducing the PFS amount concurrently with claims submissions in 2012 would be having to recoup payments after the determination is made about whether the payment adjustment applies, providing added payments if the claims are paid at the reduced amount before the determination is made about whether the payment adjustment applies, or holding claims until the determination is made about whether the payment adjustment applies. As a result, we need to determine whether eligible professionals are successful electronic prescribers prior to 2012, based on a reporting period that also takes place prior to 2012. We believe that the proposed reporting period of the first six months of 2011 will allow sufficient time for eligible professionals to report the electronic prescribing measure, allow us to collect and analyze the data submitted by eligible professionals, and avoid retroactive adjustments of payments in 2012. Avoiding retroactive adjustments would not be possible if the determination of a successful electronic prescriber for purposes of the 2012 payment adjustment was based on reporting for the entire 2011 calendar year or a later portion of the 2011 calendar year. After the end of the reporting period, we must allow some time for claims for services furnished during the reporting period to be submitted and processed before it is available for analysis. Once we have completed our analysis we also need time to make the necessary system changes to begin applying the payment adjustments to the appropriate individuals. All of this must occur prior to January 1, 2012.

Comment: One commenter suggested we be consistent with EHR Incentive Program submission guidelines by allowing electronic prescribing measure data to be submitted for up to two months after the close of the reporting period, rather than the proposed one month.

Response: As we explained previously, we need sufficient time following the close of the 6-month reporting period to determine whether an eligible professional is a successful electronic prescriber and must do so prior to 2012, when the eRx payment adjustment would be assessed (if applicable). Accordingly, we cannot allow claims to be submitted for up to two months after the close of the reporting period.

After considering the comments and for the reasons we explained previously, we are finalizing a 6-month reporting period, from January 1, 2011 through June 30, 2011, for the 2012 eRx payment adjustment.

(2) Criteria for Determining Applicability of the 2012 eRx Payment Adjustment to Individual Eligible Professionals

As we explained previously, section 1848(a)(5) of the Act requires a payment adjustment be applied with respect to covered professional services furnished by an eligible professional in 2012, if the eligible professional is not a successful electronic prescriber for the reporting period for the year. Section 1848(m)(3)(B) of the Act sets forth the requirements for being a successful electronic prescriber. As we discussed in section VII.F.2.b.(2). of this final rule with comment period, for the 2011 eRx Incentive Program, we decided to continue to require eligible professionals to report on the electronic prescribing measure to determine whether an eligible professional is a successful electronic prescriber. Details about the electronic prescribing quality measure are discussed in section VII.F.2.b.(2).(C) and (D) of this final rule with comment period.

In addition, based on the authority under section 1848(m)(3)(D) of the Act to revise the criteria for submitting data on the electronic prescribing quality measure, we proposed that the 2012 eRx payment adjustment would *not* apply to the following:

(1) An eligible professional who is not a physician (includes MDs, DOs, and podiatrists), nurse practitioner, or physician assistant as of June 30, 2011.

(2) An eligible professional who does not have at least 100 cases (that is, claims for patient services) containing an encounter code that falls within the denominator of the electronic prescribing measure for dates of service between January 1, 2011 through June 30, 2011.

(3) An eligible professional who is a successful electronic prescriber for the January 1, 2011 through June 30, 2011 reporting period. Specifically, we proposed that to be a successful electronic prescriber for purposes of avoiding the 2012 eRx payment adjustment, the eligible professional must report that at least 1 prescription for Medicare Part B FFS patients created during an encounter that is represented by 1 of the codes in the denominator of the 2011 electronic prescribing measure was generated and transmitted electronically using a qualified eRx system at least 10 times during the 2012 eRx payment adjustment reporting period (that is, January 1, 2011 through June 30, 2011). (75 FR 40208).

The limitation with respect to the electronic prescribing measures required under section 1848(m)(2)(B)(i) of the Act also applies to the eRx payment adjustment. Therefore, we proposed that if less than 10 percent of the eligible professional's estimated total allowed charges for the January 1, 2011 through June 30, 2011 reporting period are comprised of services which appear in the denominator of the 2011 electronic prescribing measure, then the eligible professional would not be subject to the 2012 eRx payment adjustment (75 FR 40209). As with the 2011 eRx incentive payment, we proposed that the determination of whether an eligible professional is subject to the payment adjustment will be made at the individual professional level, based on the NPI and for each unique TIN/NPI combination.

The following is a summary of the comments received on the proposed criteria for determining the applicability of the 2012 eRx payment adjustment to individual eligible professionals and our responses.

Comment: A couple of commenters suggested that regardless of the payment adjustment exemption criteria, any eligible professional who qualifies for the incentive payment should be exempt from the payment adjustment. The commenters specifically requested an exemption for eligible professionals who are successful electronic prescribers for the 2011 eRx incentive.

Response: As discussed previously, section 1848(a)(5) of the Act requires that the PFS amount for covered professional services furnished by an

eligible professional, who is not a successful electronic prescriber, must be reduced by 1 percent for services furnished during 2012. With regard to applying the required 2012 eRx payment adjustment, we believe it is necessary to reduce the PFS amount concurrently with claims submissions in 2012, and so we need to determine if the 2012 eRx payment adjustment is applicable to eligible professionals prior to 2012. This assessment would not be possible if the successful electronic prescriber determination was based on eRx incentive payment eligibility criteria for 2011, given that we cannot determine successful electronic prescribers for purposes of the 2011 eRx incentive until 2012.

After considering the comments received, we are finalizing the criteria for determining applicability of the 2012 eRx payment adjustment to individual eligible professionals as proposed and previously described. As stated in the proposed rule (75 FR 40208 and 40209), we believe that that limiting the application of the payment adjustment to those professionals who generally have prescribing privileges and who have a sufficient number of denominator-eligible cases is appropriate. We also believe that the reporting threshold of 10 unique electronic prescribing events between January 1, 2011 and June 30, 2011 is achievable. As stated previously, although we proposed to allow reporting of the electronic prescribing measure via claims, a qualified registry, or a qualified EHR, we are finalizing only the claims-based reporting mechanism for purposes of the 2012 payment adjustment. It is not operationally feasible for us to accept the data submissions from the EHRs and registries in the timeframe needed for us to be able to have sufficient time to be analyze the data and make the determination whether an eligible professional is subject to the 2012 payment adjustment prior to January 1, 2012.

For purposes of determining whether an eligible professional is a physician (includes MDs, DOs, and podiatrists), nurse practitioner, or physician assistant we will use National Plan & Provider Enumeration System (NPPES) data. It is an eligible professional's responsibility to ensure that his or her primary taxonomy code in NPPES is accurate. Since there are concerns about the reliability of the specialty information contained in NPPES, we are also establishing a G-code that eligible professionals can use to report to us that they do not have prescribing privileges. Eligible professionals who do not have prescribing privileges must report this G-code on at least one claim with dates of service between January 1, 2011 and June 30, 2011, and processed by no later than one month after the reporting period.

(3) Criteria for Determining Applicability of the 2012 eRx Payment Adjustment to Group Practices

As required by section 1848(m)(3)(C) of the Act, we are also required to establish and have in place a process under which eligible professionals in a group practice shall be treated as a successful electronic prescriber for purposes of the eRx payment adjustment. Thus, we proposed that for purposes of the 2012 eRx payment adjustment, a payment adjustment would not be applied to a group practice participating in the 2011 eRx GPRO if the group practice is participating in either the 2011 Physician Quality Reporting System GPRO I or the 2011 Physician Quality Reporting System GPRO II and meets the proposed 2011 criteria for successful electronic prescribing for the 2011 eRx incentive (75 FR 40209). For purposes of the 2012 eRx payment adjustment, however, we proposed that the 2011 eRx incentive criteria for successful electronic prescribing would need to be satisfied during the 2012 eRx payment adjustment reporting period of January 1, 2011 through June 30, 2011, for the same operational reasons that we proposed a 6-month reporting period for the payment adjustment for individual eligible professionals.

For purposes of determining whether the eRx payment adjustment applies to a group practice, we proposed to analyze each unique TIN/NPI combination so as not to disadvantage eligible professionals who may have joined the group practice after January 1, 2011 (75 FR 40209).

In addition, in accordance with the limitation under section 1848(m)(2)(B)(i) of the Act, we proposed that the 2012 eRx payment adjustment would not apply to an eRx GPRO in which less than 10 percent of the group practice's estimated total allowed charges for the January 1, 2011 through June 30, 2011 reporting period are comprised of services which appear in the denominator of the 2011 electronic prescribing measure. To be consistent with how this limitation is applied to group practices for purposes of the incentive, we proposed to determine whether this limitation applies to a group practice for the payment adjustment at the TIN level.

For the same reasons that we proposed a 6-month reporting period for the 2012 eRx payment adjustment for group practices, we also proposed to use only claims processed by no later than 1 month after the reporting period in our analysis, consistent with our proposed approach for analyzing individual eligible professional claims. Similarly, we proposed that registries would need to submit eRx data for services furnished January 1, 2011 through June 30, 2011 to CMS between July 1, 2011 and August 19, 2011, so that we may include registry data in our analysis. We also proposed that group practices participating in the eRx group practice reporting option via EHR-based reporting would be required to submit eRx data for services furnished January 1, 2011 through June 30, 2011 to CMS between July 1, 2011 and August 19, 2011 (75 FR 40209).

The following is a summary of the comments received on the proposed criteria for determining applicability of the 2012 eRx payment adjustment to group practices, including the proposed criteria for successful reporting of the electronic prescribing measure for group practices, and our proposed analytical approach.

Comment: One commenter suggested that we lower the reporting criteria for group practices if we finalize our proposal to use the 6-month reporting period beginning January 1, 2011 to determine whether a group practice is subject to the 2012 payment adjustment. The commenter noted that in determining the volume for the group incentive payment, we assume that not all eligible professionals in the practice would be electronically prescribing. The commenter believes that the same assumption should be applied for purposes of the payment adjustment determination.

Response: As we stated in the proposed rule (75 FR 40209), we do not believe that group practices would be disadvantaged by having to satisfy the criteria for being a successful e-prescriber for the 2011 eRx incentive in 6 months to avoid the 2012 eRx payment adjustment. When compared to the criteria for individual eligible professionals reporting the electronic prescribing measure for purposes of the payment adjustment, the criteria for being a successful electronic prescriber for the 2011 eRx payment adjustment for group practices enable group practices, on average, to avoid the incentive by electronically prescribing a fewer number of prescriptions per eligible professionals than what individual eligible professionals are required to do. Therefore, we are not lowering the reporting criteria for successful electronic prescribers for

purposes of determining applicability of the 2012 eRx payment adjustment to group practices. By having the same reporting criteria for purposes of both the payment adjustment and incentive payment, group practices have the added advantage of knowing that they have successfully electronically prescribed for purposes of the 2011 incentive payment once they have successfully electronically prescribed for purposes of the 2012 payment adjustment, since the reporting periods for the 2011 incentive and 2012 payment adjustment overlap.

After consideration of the comments received and for the reasons we discussed previously, we are finalizing the criteria for determining applicability of the 2012 eRx payment adjustment to group practices. However, for the reasons discussed previously with regard to the reporting mechanisms for submitting data on the electronic prescribing measure during 2011 for purposes of the 2012 payment adjustment, we are finalizing only the claims-based reporting mechanism. Thus, for the 2012 eRx payment adjustment, we are not finalizing eRx data submission by group practices via a qualified registry or qualified EHR.

In addition, while we had proposed to analyze each unique TIN/NPI combination to see whether the payment adjustment applies on an individual basis if the group practice fails to satisfy the criteria that would exempt the group practice from being subject to the 2012 eRx payment adjustment, we are unable to finalize this proposal as this would add significant time to our data analyses and could delay our ability to determine applicability of the 2012 payment adjustment in a timely fashion.

(4) Significant Hardship Exemption

Section 1848(a)(5)(B) of the Act provides that the Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment, if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship, such in the case of an eligible professional who practices in a rural area without sufficient Internet access. Therefore, we proposed that in addition to meeting the criteria for a successful electronic prescriber, an eligible professional or group practice may also be exempt from application of the 2012 eRx payment adjustment, if, during the 2012 eRx payment adjustment reporting period (that is, January 1, 2011 through June 30, 2011), one of the following circumstances applies to the eligible professional or group practice:

- The eligible professional or group practice practices in a rural area with limited high speed internet access; or
- The eligible professional or group practice practices in an area with limited available pharmacies for electronic prescribing.

We proposed to add two additional "G" codes to the 2011 electronic prescribing measure's specifications describing these 2 circumstances. Eligible professionals or group practices to whom one or more of these circumstances apply would be required to report the appropriate G-code at least once between January 1, 2011 and June 30, 2011 using their selected 2011 eRx reporting mechanism. Reporting of one of these two G-codes prior to June 30, 2011 will indicate to us that the eligible professional or group practice would like to be considered for an exemption from the 2012 payment adjustment under the significant hardship exception (75 FR 40209).

The following is a summary on the comments we received regarding our proposal for the significant hardship exemption and our responses.

Comment: One commenter supported the proposed process for the significant hardship exemption and did not offer any other circumstances that should also be considered a significant hardship.

Response: We appreciate the commenter's supportive comments.

Comment: While our acknowledgement of hardship circumstances was appreciated, several commenters suggested we add more hardship exemption categories, or offered additional hardship circumstances for our consideration. Specifically, commenters requested that the following hardship circumstances be added to the payment adjustment exemption list: (1) Physicians who are nearing the end of their careers, (2) physicians who are currently eligible for Social Security benefits or will be eligible for Social Security benefits by 2014, (3) physicians who plan on participating in the EHR incentive program beginning in 2012, 2013, or 2014, (4) DEA e-prescribers, (5) small practices (that is, 1 to 2 physicians), (6) practices located in Health Professional Shortage Areas (HPSAs), (7) physicians who cannot meet the requirements due to patient preference, and (8) hospital-based eligible professionals. Commenters stated that physicians nearing retirement age or in small practices may find it difficult to justify the cost of implementing these systems. Several commenters noted that many physicians have postponed purchasing electronic prescribing software in order to take advantage of the EHR incentives. Finally, commenters argued that physicians who electronically prescribe controlled substances should have additional time to comply with the eRx Incentive Program requirements as the DEA compliant electronic prescribing applications are not yet available.

Response: We appreciate the commenters' feedback and are actively working on G-codes for eligible professionals to report the significant hardship categories we proposed for the 2012 eRx payment adjustment. We do not believe, however, that any of the suggested additional hardship categories constitute a circumstance that limits an eligible professional's access to electronic prescribing in the way that the two hardship exemptions we proposed do. We also believe that eligible professionals who are nearing retirement or are eligible for Social Security benefits still have the opportunity to purchase and use electronic prescribing technology even though they may not have a business case for doing so. With respect to the other hardship exemptions specifically requested by commenters (such as, hospital-based eligible professionals, DEA e-prescribers and physicians who cannot meet the requirements due to patient preferences), we believe that we have already taken these circumstances into account when we established the reporting threshold for the electronic prescribing and the other criteria that would subject an eligible professional to the eRx payment adjustment. Therefore, we are finalizing the two hardship exemption G-codes that we proposed.

Comment: A couple of commenters requested that we further define terms such as "rural areas," areas with "limited high speed internet access," and "limited availability of pharmacies."

Response: We are actively working to develop G-codes for eligible professionals to report the eRx hardship. Once we finalize the G-codes, we will provide additional guidance with regards to the hardship exemptions categories associated with the eRx payment adjustment along with education and outreach with regard to the 2012 payment adjustment under the eRx Incentive Program.

After considering the comments received, we are finalizing the following hardship exemptions for purposes of the 2012 eRx payment adjustment:

- Eligible professionals who practice in a rural area without sufficient high speed internet access; and

• Eligible professionals who practice in an area without sufficient available pharmacies for electronic prescribing.

We are creating G-codes to address these 2 situations. Since the hardship exception must be renewed on an annual basis, we have deleted the proposed language at § 414.92(c)(2)(ii) that listed specific circumstances that constitute a "significant hardship." For future years and in future rulemaking, we will address the circumstances that will constitute a significant hardship for each year.

Eligible professionals for whom one or more of these circumstances apply must report the appropriate G-code at least once between January 1, 2011 and June 30, 2011 using claims. Group practices who wish to participate in the 2011 eRx GPRO and for whom one or more of these circumstances apply must request a hardship exemption at the time they self-nominate by indicating the appropriate G-code in their self-nomination letter to CMS. Reporting of one of these G-codes prior to June 30, 2011 will indicate to us that the eligible professional or group practice would like to be considered for an exemption from the eRx 2012 payment adjustment under the significant hardship exception.

d. The 2013 eRx Payment Adjustment

Section 1848(a)(5) of the Act also requires that with respect to covered professional services furnished by an eligible professional in 2013, if the eligible professional is not a successful electronic prescriber for the reporting period for the year, the fee schedule amount for such services furnished by such professional during 2013 shall be equal to 98.5 percent of the fee schedule amount that would otherwise apply to such PFS services. Under section 1848(m)(3)(C) of the Act, we are also required to establish and have in place a process under which eligible professionals in a group practice shall be treated as a successful electronic prescriber for purposes of the eRx payment adjustment.

For purposes of the 2013 eRx payment adjustment, we proposed to use the proposed criteria for successful electronic prescriber for the proposed 2011 eRx incentive payment to determine whether an eligible professional or a group practice is a successful electronic prescriber for purposes of the 2013 eRx payment adjustment. In addition, we proposed that the reporting period for the 2013 eRx payment adjustment would be January 1, 2011 through December 31, 2011 (75 FR 40210). We believe that matching the criteria that will be applied for the 2013 eRx payment adjustment with the criteria that will be applied for the 2011 eRx incentive payment in an earlier year would be the most effective means of encouraging eligible professionals and group practices to adopt and use electronic prescribing systems since anyone who does not qualify for an incentive in 2011 would be subject to a payment adjustment in 2013.

The following is a summary of the comments received on our proposal for the 2013 eRx payment adjustment.

Comment: We received comments similar to the ones opposing the proposed 2012 eRx payment adjustment reporting period, with regard to the proposed 2013 eRx payment adjustment reporting period. One commenter suggested that the proposed reporting period for purposes of the 2013 eRx payment adjustment be changed so the 2012 and 2013 eRx payment adjustments do not overlap. Another commenter suggested that the 2013 payment adjustment be based on claims reported during the first half of 2012 to better reflect expected increases in eRx adoption, including increases due to the EHR Incentive Program.

Response: We understand the commenters' concerns that the reporting periods for purposes of the 2012 and 2013 eRx payment adjustments overlap. We note that section 1848(a)(5)(C)(D) gives us the authority to specify the reporting period with respect to a year. As such, we may consider revisiting in the 2012 PFS rulemaking process additional reporting periods in 2012 for purposes of the 2013 eRx payment adjustment since having multiple reporting periods for purposes of the payment adjustment will maximize opportunities for eligible professionals to avoid the 2013 payment adjustment.

After considering the comments received and for the reasons we previously explained, we are finalizing our proposal to use the 2011 eRx incentive payment criteria for successful electronic prescriber as described in section VII.F.2.b. of this final rule with comment period to determine whether an eligible professional or a group practice is a successful electronic prescriber for purposes of the 2013 eRx payment adjustment based on the January 1, 2011 through December 31, 2011 reporting period. However, we may consider revisiting the criteria for the 2013 payment adjustment in the context of 2012 reporting periods in the 2012 PFS proposed and final rules.

e. Public Reporting of Names of Successful Electronic Prescribers

Section 1848(m)(5)(G) of the Act requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submit data on quality measures for the Physician Quality Reporting System and the names of the eligible professionals (or group practices) who are successful electronic prescribers. As required by section 1848(m)(5)(G) of the Act, we proposed to make public the names of eligible professionals and group practices who are successful electronic prescribers for the 2011 eRx Incentive Program on the Physician Compare Web site that we are required to establish by January 1, 2011 under section 10331 of the ACA.

The following is a summary of the comments received regarding public reporting of successful electronic prescribers.

Comment: A few commenters expressed concerns about posting the names of successful e-prescribers. One commenter was concerned that the public would not be able to correctly identify a successful e-prescriber as a professional who has met the reporting requirements for the eRx Incentive Program. One commenter was concerned that individuals using this information to make health care decisions may do so without fully understanding the methodology and the program requirements. The commenters suggested that CMS take appropriate measures to ensure the accuracy of the list of successful e-prescribers and to provide the appropriate disclaimers for the Web site listing.

Response: We will make every effort to ensure that the list of successful e-prescribers that we will post on the Physician Compare Web site is accurate. We also intend to include explanatory language with information on the intended uses and/or limitations of this data.

Based on the comments received, we are finalizing our proposal to post the names of eligible professionals and group practices who are successful electronic prescribers for purposes of the 2011 eRx incentive on the Physician Compare Web site. We anticipate that the names of individual eligible professionals and group practices who are successful electronic prescribers for the 2011 eRx Incentive Program will be available in 2012 after the 2011 incentive payments are paid.

To comply with section 1848(m)(5)(G) of the Act, we specifically intend to post

the names of individual eligible professionals who report the electronic prescribing measure at least 25 times during the 2011 reporting period for patient encounters included in the measure's denominator, without regard to whether the limitation under section 1848(m)(2)(B) of the Act applies to the eligible professional and without regard to whether the eligible professional actually qualifies to earn an incentive payment. In addition, since the Physician Quality Reporting System and the eRx Incentive Program are two separate programs and individual eligible professionals are not required to participate in both programs to earn an incentive under either program, we point out that it is possible for an eligible professional who participates in both incentive programs to be listed both as an individual eligible professional who satisfactorily submits data on quality measures for the Physician Quality Reporting System and is a successful electronic prescriber under the eRx Incentive Program. Likewise, if an eligible professional participated in both incentive programs but did not meet the respective requirements for both programs, he or she may be listed as an individual eligible professional who satisfactorily submits data on quality measures for the Physician Quality Reporting System only or as a successful electronic prescriber under the eRx Incentive Program only.

Similarly, for purposes of publicly reporting the names of group practices, on the Physician Compare Web site, we intend to post the names of group practices that report the electronic prescribing measure the required number of times during the 2011 reporting period for patient encounters included in the measure's denominator without regard to whether the limitation under section 1848(m)(2)(B) of the Act applies to the group practice or whether the group practice actually qualifies to earn an incentive payment. Although any group practice participating in the eRx Incentive Program under the group practice reporting option would also have to participate in a Physician Quality Reporting System group practice reporting option, the criteria for satisfactory reporting of Physician Quality Reporting System measures for group practices are different from the criteria for successful reporting of the electronic prescribing measure by group practices. Therefore, it is possible for a group practice to be listed as a group practice that satisfactorily submits data on quality measures for the Physician Quality Reporting System but not as a successful electronic prescriber under the eRx Incentive Program, or vice versa.

G. DMEPOS Provisions

1. Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP)

a. Legislative and Regulatory History of DMEPOS CBP

Medicare pays for most DMEPOS furnished after January 1, 1989 pursuant to fee schedule methodologies set forth in section 1834 of the Act, as added by section 4062 of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100–203). Specifically, sections 1834(a)(1)(A) and (B), and 1834 (h)(1)(A) of the Act provide that Medicare payment for these items is equal to 80 percent of the lesser of the actual charge for the item or the fee schedule amount for the item. We implemented this payment methodology at 42 CFR Part 414, Subpart D of our regulations. Sections 1834(a)(2) through (a)(5) and 1834(a)(7) of the Act, and implementing regulations at § 414.200 through § 414.232 (with the exception of § 414.228), set forth separate payment categories of durable medical equipment (DME) and describe how the fee schedule for each of the following categories is established:

- Inexpensive or other routinely purchased items (section 1834(a)(2) of the Act and § 414.220 of the regulations);
- Items requiring frequent and substantial servicing (sections 1834(a)(3) of the Act and § 414.222 of the regulations);
- Customized items (section 1834(a)(4) of the Act and § 414.224 of the regulations);
- Oxygen and oxygen equipment (section 1834(a)(5) of the Act and § 414.226 of the regulations);
- Other items of DME (section 1834(a)(7) of the Act and § 414.229 of the regulations).

For a detailed discussion of payment for DMEPOS under fee schedules, see the final rule published in the April 10, 2007 **Federal Register** (72 FR 17992).

Blood glucose testing strips or diabetic testing strips are covered under the Medicare DME benefit in accordance with section 1861(n) of the Act. Other supplies that are necessary for the effective use of DME are also covered under the Medicare DME benefit in accordance with longstanding program instructions at section 110.3 of chapter 15 of the Medicare Benefit Policy Manual.

Section 1847 of the Act, as amended by section 302(b)(1) of the MMA, requires the Secretary to establish and implement a DMEPOS CBP. Under the DMEPOS CBP, Medicare sets payment amounts for selected DMEPOS items and services furnished to beneficiaries in competitive bidding areas (CBAs) based on bids submitted by qualified suppliers and accepted by Medicare. For competitively bid items, these new payment amounts, referred to as "single payment amounts (SPA)," replace the fee schedule payment methodology. Section 1847(b)(5) of the Act provides that Medicare payment for these competitively bid items and services is made on an assignment-related basis equal to 80 percent of the applicable SPA, less any unmet Part B deductible described in section 1833(b) of the Act. Section 1847(b)(2)(A)(iii) of the Act prohibits the awarding of contracts to any entity unless the total amounts to be paid to contractors in a CBA are expected to be less than the total amounts that would otherwise be paid under the fee schedule methodologies set forth in section 1834(a) of the Act. This requirement guarantees savings to both the Medicare program and beneficiaries under the program. The fee schedule methodologies will continue to set payment amounts for noncompetitively bid DMEPOS items and services. The program also includes provisions to ensure beneficiary access to quality DMEPOS items and services. Section 1847(b)(2)(A) and 1847(b)(4)(B) of the Act, respectively, limits participation in the program to suppliers who have met applicable quality and financial standards and requires the Secretary to maintain beneficiary access to multiple suppliers.

When first enacted by the Congress, section 1847(a)(1)(B) of the Act required the Secretary to phase in the DMEPOS CBP in a manner so that the competition under the program occurred in 10 of the largest metropolitan statistical areas (MSAs) in 2007. The program was to be expanded into 70 additional MSAs in 2009, and then into additional areas after 2009.

In the May 1, 2006 **Federal Register** (72 FR 25654), we issued a proposed rule that would implement the DMEPOS CBP for certain DMEPOS items and services and solicited public comment on our proposals. In the April 10, 2007 **Federal Register** (72 FR 17992), we issued a final rule addressing the comments on the proposed rule and establishing the regulatory framework for the DMEPOS CBP in accordance with section 1847 of the Act.

Consistent with the requirements of section 1847 of the Act and the

competitive bidding regulations, we began implementation of the program by conducting the first round of competition in 10 of the largest MSAs in 2007. We limited competition during this first round of the program to DMEPOS items and services included in 10 selected product categories, including mail order diabetic supplies. The bidding window opened on May 15, 2007 and was extended to allow bidders adequate time to prepare and submit their bids. We then evaluated each submission and awarded contracts consistent with the requirements of section 1847(b)(2) of the Act and § 414.414. Following the bid evaluation process, we awarded over 329 contracts to qualified suppliers.

The DMEPOS CBP was effective on July 1, 2008. Beginning on that date, Medicare coverage for competitively bid DMEPOS items and services furnished in the first 10 CBAs was limited to items and services furnished by contract suppliers and/or grandfathered suppliers of oxygen and oxygen equipment and rented DME, unless an exemption applies as stated in the regulation. For further discussion of the DMEPOS CBP and the bid evaluation process, see the final rule published in the April 10, 2007 **Federal Register** (72 FR 17992).

On July 15, 2008, the MIPPA was enacted. Section 154 of the MIPPA amended section 1847 of the Act to make certain limited changes to the DMEPOS CBP. Section 154(a) of the MIPPA delayed competition under the program and amended section 1847(a)(1)(D)(i) of the Act to terminate the competitive bidding contracts effective June 30, 2008 and prohibit payment based on the contracts.

Section 154(a) of the MIPPA required the Secretary to conduct a second competition to select suppliers for Round 1 in 2009 ("Round 1 Rebid"). The Round 1 Rebid includes the "same items and services" and is to be conducted in the "same areas" as the 2007 Round 1 competition, with certain limited exceptions. Specifically, we were required to exclude the product category of negative pressure wound therapy (NPWT) items and services and the San Juan, Puerto Rico CBA from the Round 1 Rebid. In addition, section 154(a) of the MIPPA permanently excluded group 3 complex, rehabilitative wheelchairs from the DMEPOS CBP by amending the definition of "items and services" in section 1847(a)(2) of the Act. Section 154(a) of the MIPPA delayed competition for Round 2 of the DMEPOS CBP from 2009 to 2011, and subsequent competitions under the program to after 2011. Finally, section 154(a) of the MIPPA specifically addresses the phase in of a competition for national mail order items and services by specifying that such competitions may be phased in after 2010.

b. Implementation of a National Mail Order DMEPOS Competitive Bidding Program (CBP) for Diabetic Testing Supplies

Section 1847(a)(2)(A) of the Act mandates competitive bidding programs for supplies used in conjunction with durable medical equipment, such as blood glucose monitors used by beneficiaries with diabetes to test their blood glucose levels. Replacement of supplies used with these monitors are referred to under the DMEPOS CBP as diabetic supplies or diabetic testing supplies such as blood glucose test strips and lancets. In the April 10, 2007 final rule (72 FR 17992) implementing the DMEPOS CBP, we established regulations to implement competitions on a regional or national level for certain items such as diabetic testing supplies that are furnished on a mail order basis. We explained our rationale for establishing a national DMEPOS CBP for items furnished on a mail order basis in the May 1, 2006 proposed rule (71 FR 25669) and April 10, 2007 final rule (72 FR 18018). In the case of diabetic supplies and other items furnished by local neighborhood pharmacies, establishing a competition for items furnished on a mail order basis would exempt local pharmacies from competing with national mail order suppliers while preserving the choice of the beneficiary to go to any local pharmacy to pick up their diabetic supplies. Manufacturers and suppliers have stated to CMS at different meetings on numerous occasions that the choice for beneficiaries to obtain diabetic supplies from local pharmacies with licensed pharmacists in house who can provide instructions and guidance to beneficiaries related to their testing needs is important and needs to be preserved.

In the January 16, 2009 **Federal Register** (74 FR 2873), we published an interim final rule implementing certain changes to the DMEPOS CBP. Specifically, the rule implemented certain MIPPA provisions that delayed implementation of Round 1 of the program, required CMS to conduct a second Round 1 competition in 2009, and mandated certain changes for both the Round 1 Rebid and subsequent rounds of the program. In the January 16, 2009 interim final rule, we indicated that we would be considering alternatives for competition of diabetic testing supplies in future notice and comment rulemaking. We explained that we believed it was consistent with section 1847(a) to employ competitive bidding for diabetic suppliers in both the mail order and traditional retail markets, in part due to concerns raised about the bifurcation of the method of delivery of diabetic supplies and the difficulty in defining what constitutes "mail order" for purposes of competition.

In the July 13, 2010, proposed rule (75 FR 40211), we discussed alternatives for competition of diabetic testing supplies and proposed the implementation of a revised national mail order DMEPOS CBP for diabetic testing supplies. Under the proposed mail order DMEPOS CBP, we would award contracts to suppliers to furnish these items across the nation to beneficiaries who elect to have replacement diabetic testing supplies delivered to their residence. Suppliers wishing to furnish these items through mail order to Medicare beneficiaries would be required to submit bids to participate in the national mail order DMEPOS CBP for diabetic testing supplies. In addition, we proposed to revise the national mail order program for diabetic testing supplies DMEPOS CBP by implementing the following changes:

- Revision of § 414.402 to include definitions of: "National mail order DMEPOS CBP," "Mail order item," and "Non-mail order item." We proposed these new definitions to establish a clear distinction between mail order items and non-mail order items. These revised definitions would apply to all future competitions for mail order items and services.

- Addition of § 414.411 to implement the special rule mandated by section 1847(b)(10)(A) of the Act for competitions for diabetic testing strips following the Round 1 Rebid. Section 1847(b)(10)(A) requires suppliers bidding in competitions to furnish diabetic testing strips after the Round 1 Rebid to demonstrate that their bid covers at least 50 percent of all types of diabetic testing strips furnished by suppliers. If the supplier is not able to satisfy this requirement, the Secretary must reject that bid.

- Revision of § 414.422 to include an additional term in contracts of mail order suppliers of diabetic testing supplies following the Round 1 Rebid. The proposed term would prohibit suppliers from influencing or incentivizing beneficiaries to change their brand of glucose monitor and test strips.

(1) Future Competitions for Diabetic Testing Supplies

Section 1847(a)(1)(A) of the Act mandates the establishment of DMEPOS CBP for items described in section 1847(a)(2)(A) of the Act, including diabetic testing supplies. Section 1847(a)(1)(B)(ii) of the Act authorizes the phase in of items and services under these programs beginning with the highest cost and highest volume items and services or those items and services that are determined to have the largest savings potential. Current Medicare claims data from fiscal year 2009 shows that over 62 percent of beneficiaries currently receive their replacement diabetic testing supplies from mail order suppliers. Mail order diabetic testing supplies account for approximately one billion dollars in allowed charges per year and are therefore high volume items. We believe that a national mail order DMEPOS CBP for diabetic testing supplies would result in large savings as a result of competition between entities that would factor into their bids savings from volume discount purchasing of quantities of supplies needed on a national rather than local basis. Therefore, we believe that implementing a national mail order DMEPOS CBP for diabetic testing supplies is the best option for meeting the requirements of the statute referenced above as long as certain refinements discussed below are made to the program to address concerns about the mail order/non-mail order bifurcation.

We have heard from industry groups and suppliers that furnish diabetic testing supplies on a national mail order basis of their concerns that national chain pharmacies that furnish diabetic testing supplies through both a national mail order business and local retail pharmacies will encourage beneficiaries to obtain these items from local retail locations by offering certain incentives to Medicare beneficiaries for switching from mail order to local retail. Based on our experience from Round 1, we believe DMEPOS CBP for mail order diabetic testing supplies would be subject to manipulation without a clearer definition of what we mean by mail order. We agree with the industry groups and suppliers that have indicated that this practice will harm businesses that only furnish diabetic testing supplies on a mail order basis. In order to address these concerns, we are proposing to add to § 414.402 a definition of "National mail order DMEPOS CBP." We proposed to define that term as a program whereby contracts are awarded to suppliers for the furnishing of mail order items across the nation. We believe that implementing a national competitive bidding program for diabetic supplies would preserve beneficiary choice to purchase testing supplies in person from any local pharmacy that is an enrolled Medicare supplier that furnishes diabetic supplies, while clarifying the definition of mail order will provide significant savings potential for beneficiaries and the program. Savings would be generated in the near future from national SPAs for supplies furnished on a mail order or home delivery basis and on a long term basis for all diabetic supplies as a result of the requirement of section 1834(a)(1)(F) of the Act (as amended by section 6410(b) of the ACA) to either competitively bid in all areas or adjust prices in all areas by January 1, 2016. We believe that more beneficiaries will elect to choose the mail order/home delivery option, thereby further increasing short term savings under the program. Even if this is not the case, and the percentage of beneficiaries choosing the mail order/home delivery option remains at the current rate of 62 percent, savings for the remaining 38 percent must be achieved by no later than January 1, 2016, as a result of the requirements of section 1834(a)(1)(F) of the Act.

We considered other alternatives for establishing DMEPOS CBP for diabetic testing supplies that would eliminate the mail order/non-mail order bifurcation and associated concerns. These alternatives include the following:

- A national competition among all types of suppliers for all replacement diabetic supplies. Under this alternative, all beneficiaries would receive their replacement diabetic supplies from contract suppliers responsible for furnishing diabetic supplies throughout the nation using any method of delivery as long as the supplies are delivered on a timely basis.
- Competitions in regional CBAs among all types of suppliers for all replacement diabetic supplies. Under this alternative, all beneficiaries would receive their replacement diabetic supplies from contract suppliers responsible for furnishing diabetic supplies throughout a designated region of the country using any method of delivery to a beneficiary's home as long as the supplies are delivered on a timely basis.
- Competitions in local CBAs among all types of suppliers for all replacement diabetic supplies. Under this alternative, all beneficiaries would receive their replacement diabetic supplies from contract suppliers responsible for furnishing diabetic supplies throughout the local area using any method of delivery to a beneficiary's home as long as the supplies are delivered on a timely basis.

We believe that the first option to bid on a national basis for all diabetic supplies, would result in most beneficiaries using mail order and might generate more savings than a national competition for diabetic supplies furnished on a mail order basis only. However, this first option would likely eliminate the beneficiary choice to obtain replacement diabetic supplies on a non-mail order basis from any enrolled supplier that is a pharmacy or other local supplier storefront where a licensed pharmacist is on hand to offer guidance and consultation to the beneficiary. We believe the other two options would also diminish this choice. In addition, the alternatives of regional or local competitions are not likely to result in savings at or above the level that can be generated from a national competition for mail order supplies. Suppliers participating in a national program may be able to obtain volume purchasing discounts for the quantities of supplies needed nationwide. Therefore, we did not propose any of these alternatives but we solicited public comment on alternatives for establishing DMEPOS CBP for diabetic testing supplies.

In § 414.411, we proposed to establish a national mail order DMEPOS CBP with competitions taking place after 2010 for the purpose of awarding contracts to suppliers to furnish replacement diabetic testing supplies across the nation, with additional program refinements described below. We note that the decision to proceed with a national mail order competition after 2010 does not prevent us from phasing in competitions for non-mail order diabetic supplies or from conducting competitions for diabetic supplies in general in the future consistent with section 1847(a)(1) of the Act.

Comment: We received 31 comments in response to our proposed regulation to implement a national mail order DMEPOS CBP for diabetic testing supplies. There were several commenters that supported the proposal made by CMS and a few commenters that were opposed to our proposal. The commenters in favor of our proposal stated they wanted CMS to preserve the local storefront option for the beneficiary. A few commenters specifically stated that CMS should maintain retail pharmacies as a necessary safety valve, ensuring that beneficiaries will have immediate local

access to their specific diabetic testing supplies. In addition, several commenters who supported our conducting separate auctions stated that our proposal to conduct one competition between mail order companies and those with a local storefront would not be fair because these companies have different business models, different overhead costs and different operational structures. Numerous commenters stated that beneficiaries get better service from a local storefront than they would get from a mail order company because local storefronts preserve a face-to-face pharmacy/patient relationship.

We also received several comments opposed to our proposal to conduct separate competitions because they believed that gives the local storefronts an unfair advantage because they are paid more than mail order companies for the same product. They suggest that CMS should conduct a competition for both mail order and non mail order under one program.

Response: We agree with those commenters who stated that we need to preserve beneficiary choice and access to local storefronts to get their diabetic testing supplies. We believe that our proposal preserves the beneficiaries' choice to go to their local pharmacy to pick up their diabetic supplies or request that they be sent through the mail by a national mail order DMEPOS contract supplier. Also, we believe that both mail order suppliers and storefront suppliers are able to provide the necessary services and education to their beneficiaries. Therefore, we believe our proposal to bid diabetic testing supplies when provided through the mail will preserve beneficiaries' choice while ensuring they receive quality services. We also agree that to bid storefronts and mail order companies in the same auction may make it difficult for small storefronts to compete against large mail order suppliers. We also believe the difference in payment between mail order companies and retail stores will not harm mail order companies because we expect that more beneficiaries will choose to obtain their test strips from mail order companies to lower their co-insurance payment, generating more business for mail order suppliers. In addition, non-mail order diabetic supplies were not included the first round of the competitive bidding program and the issue with regard to payment for these items under the program will be addressed in the future as additional items subject to the program are phased in.

Comment: One commenter stated that CMS should phase in a regional program, rather than moving immediately into a national program, since CMS and mail order suppliers are without sufficient knowledge base or experience with the operation of a large-scale competitive bidding program and its impact on beneficiaries' access to quality care.

Response: We disagree with this comment. We believe that the option to bid on a national basis for all mail order diabetic supplies would result in large savings because of the volume purchase power of bidders providing these items on a national basis. Currently our data shows that over 62 percent of Medicare beneficiaries receive their testing supplies through the mail, we see no real benefit of bidding on a regional basis because most mail order suppliers operate nationally. We also believe that we have experience conducting the DMEPOS CBP since we have successfully completed the bidding and contract offers for Round 1 Rebid and the program will begin January 1, 2011. We have established a process and will evaluate and monitor contract suppliers to ensure beneficiaries' have access to quality products.

Comment: One commenter stated that diabetic testing supplies should be excluded from DMEPOS CBP because CMS does not have any experience with this product category with respect to competitive bidding, as diabetic supplies were not included in any prior demonstration project. Several commenters suggested that CMS should not initiate the bidding process for the national mail order DMEPOS CBP until it has had sufficient time to evaluate the rebid of Round 1.

Response: Section 1847(a)(1)(A) of the Act mandates the establishment of DMEPOS CBP for items described in section 1847(a)(2)(A) of the Act, including diabetic testing supplies. Section 1847(a)(1)(B)(ii) of the Act authorizes the phase in of items and services under these programs beginning with the highest cost and highest volume items and services or those items and services that are determined to have the largest savings potential. Current Medicare claims data identifies diabetic testing supplies as a high cost/high volume item. Mail order diabetic testing supplies account for approximately one billion dollars in allowed charges per year and the majority of these payments are for mail order diabetic testing supplies. In addition, CMS does have experience bidding these items as they were included in both Round 1 and the Round 1 rebid.

Comment: One commenter stated that section 1834(a)(1)(F) of the Act does not compel CMS to adjust prices for all items by January 1, 2016, or any other specific date. The commenter stated that CMS could elect to continue to exclude diabetic testing supplies provided through local retail storefronts.

Response: We are required by section 1834(a)(1)(F) of the Act to either competitively bid in all areas of the country or adjust prices for all phased in items in areas where competitive bidding programs are not implemented by January 1, 2016. We intend to address specific issues related to implementation of clauses (ii) and (iii) of section 1834(a)(1)(F) of the Act as part of separate rulemaking mandated by section 1834(a)(1)(G) of the Act.

After consideration of the public comments we received, we are not making any changes to this section of the proposed rule on the future competitions of diabetic testing supplies.

(2) Definition of Mail Order Item

We proposed to define "mail order item" in § 414.402 to mean any item (for example, diabetic testing supplies) shipped or delivered to the beneficiary's home, regardless of the method of delivery. We also proposed to define "non-mail order item" as any item (for example, diabetic testing supplies) that a beneficiary or caregiver purchases at a local pharmacy or supplier storefront rather than having the item delivered to the beneficiary's home. For round 1 of the program, this means that beneficiaries that do not obtain their testing supplies through mail order may purchase these items at a local pharmacy or local storefront. Therefore, the only items excluded from the mail order definition and mail order competition would be those that a beneficiary or caregiver purchases at a local pharmacy or local supplier storefront and are not delivered to the beneficiary's home. These revised definitions of mail order item and non-mail order item are intended to clearly identify which items is truly mail order. In addition, we believe this definition will preserve the choice of the beneficiary to obtain replacement diabetic supplies in person from a local pharmacy and eliminate the circumvention of the mail order program.

As previously discussed, for Round 1 and the Round 1 Rebid of the DMEPOS CBP, we defined mail order contract supplier in our regulations at § 414.402 to mean a contract supplier that furnishes items through the mail. We further defined mail order in program

instructions to mean "items ordered remotely (that is, by telephone, e-mail, internet or mail) and delivered to beneficiary's residence by common carriers (for example, U.S. Postal Service, Federal Express, United Parcel Service) and does not include items obtained by beneficiaries from local storefronts." The intent of the Round 1 definition was to distinguish between mail order supplies (items shipped or delivered directly to the beneficiary's home, regardless of the method of delivery) and non-mail order supplies (items that a beneficiary or caregiver picks up in person at a local pharmacy or storefront). Manufacturers and suppliers of blood glucose monitors and test strips have expressed on numerous occasions the importance of maintaining the patient option of obtaining diabetic testing supplies from a local pharmacy that provides full time access to a licensed pharmacist who can provide instructions and guidance to the beneficiary or caregiver related to the use of the diabetic supplies (the pharmacy pickup option). This is the "non-mail order" option we attempted to separate from the mail order option with the Round 1 definition of mail order.

During implementation of Round 1 of the program, we discovered that suppliers that did not successfully compete and win a contract under the program tried to adopt certain approaches to circumvent the mail order definition. In the first round of competitive bidding, suppliers that lost their bid to be a contract supplier for mail order diabetic testing supplies considered ways to change their delivery methods to circumvent the mail order DMEPOS CBP. For example, some mail order suppliers considered purchasing a fleet of cars to deliver these items to the beneficiary's home so as not to be considered a mail order supplier. Other suppliers attempted to enter into special "private" arrangements with well known delivery services and claimed that because of such arrangements they should not be considered mail order suppliers. These alternative home delivery methods do not provide any benefits to the patient beyond what the traditional mail order home delivery method offers. They are simply ways to continue furnishing diabetic supplies on a home delivery basis after submitting a bid for mail order that does not result in the award of a contract under the DMEPOS CBP. Without a clear distinction between mail order (home delivery option) and non-mail order (pharmacy pickup option), suppliers could continue to attempt to make arrangements as they did in the initial Round 1 competition to circumvent the DMEPOS CBP. We consider these practices to be inconsistent with the DMEPOS CBP statute and regulations currently in effect, and our proposal is intended to further clarify the existing definition of mail order. Such arrangements prevent beneficiaries and the Medicare program from realizing savings afforded by the mail order DMEPOS CBP and is unfair to winning suppliers who bid in good faith for a contract for furnishing supplies to the home delivery market.

This proposed definition of mail order item would not apply to the Round 1 Rebid competition because of the specific requirement of MIPPA to rebid Round 1 in 2009 for the same items and services included in the initial Round 1 competition. However, for a national competition, it is imperative that the new definition of mail order item be in place because of the implications such a program would have on the entire mail order delivery market in the United States. In these future competitions, we will continue to emphasize in our educational efforts the basic distinction between mail order (items shipped or delivered to the beneficiary's home, regardless of the method of delivery) and non-mail order (items that a beneficiary or caregiver picks up in person at a local pharmacy or storefront). In addition, we will continue to take appropriate and necessary action against suppliers that furnish mail order items and bill for them as if they were non-mail order items.

As previously mentioned, an alternative DMEPOS CBP for replacement diabetic supplies would be to hold a national competition among all types of suppliers for all replacement diabetic supplies. One benefit to this approach is that it would eliminate the need to differentiate between mail order and non-mail order supplies; however, it would likely eliminate the pharmacy pickup choice since most local pharmacies would not be able to service the entire CBA if they did not also operate a national mail order service.

We solicited comment on our proposed definition of "mail order" and its impact on future rounds of bidding. We received several comments regarding the proposed definition of mail order both in favor of and against the definition.

Comment: Several commenters agreed with the proposed definition because they believe it will result in a clear distinction between mail order and non-mail order and reduce the ability of suppliers to game the program. A few commenters opposed the proposed change in definition stating that the definition is too broad and therefore, could be applied to any DMEPOS item delivered to a patient's home.

Response: We agree that it is important to revise the definition of mail order to make a clear distinction between mail order and non mail order. We believe we cannot make the necessary distinction between mail order and non-mail order under our current definition. With the revised definition, beneficiaries will have a clear choice to make; they or their caregiver can either go to a retail store or get their items shipped or delivered to their home by any means. If they choose to get their items delivered to their home they would have their supplies delivered by a DMEPOS contract supplier who meets our qualifications to be a mail order supplier of diabetic testing supplies. We agree that the definition is broad with respect to DMEPOS items in general. However, for the reasons previously stated, we believe it is necessary to have this specific definition of mail order item for diabetic testing supplies that includes any item shipped or delivered to the beneficiary's home, regardless of the method of delivery. However, competitions for mail order items may not be necessary or appropriate for rented equipment or for items that require the presence of the supplier in the home for inspection, equipment set up, and other purposes. We believe that mail order competitions may be more appropriate for purchased items that do not require these in home services.

Comment: Several commenters advocated for exemption from bidding as a local storefront and from the program when providing diabetic testing supplies delivered to the patient's home. These commenters believe that this service is necessary for some beneficiaries who have difficulty getting to a pharmacy. The commenters stated that the proposed definition of mail order prevents them from continuing to service snow bird beneficiaries. The commenter supported the policy that independent pharmacies do not have to bid to continue to provide diabetic testing supplies to beneficiaries that come into their store, but they would also like to continue to provide supplies to these beneficiaries via mail when they temporarily relocate as a snowbird. Several commenters also stated that they would like CMS to exempt from competitive bidding companies that deliver diabetic testing supplies directly to a beneficiary's home using their specially trained employees.

Response: We disagree. We do not believe that such an exception is

warranted because contract suppliers will be able to deliver these items to the beneficiary's home in these situations. If the beneficiary or their caregiver would normally pick up the beneficiary's supplies in person at a local pharmacy they may switch for any reason or any period of time and obtain these items from a contract mail order supplier. Delivery of the supplies from a local store is no different than delivery thru the mail or some other means from a remote location. It would be unfair to exempt these companies from competitive bidding while still allowing them to provide these items when they deliver them to the patient's home. We believe that home delivery companies should have to bid in the DMEPOS CBP and be awarded a contract to continue to deliver these items to the home. We are not aware of what services are being provided by the specially trained employees that commenters refer to that are different than services that a mail order contract supplier would perform. The contract suppliers must meet all of the supplier and quality standards necessary for furnishing the items. The supplier of the glucose monitor is responsible for ensuring that the beneficiary is educated and trained on the use of their monitor. Since there are no in-home services necessary for furnishing replacement diabetic testing supplies, we do not understand the point these commenters are trying to make. We believe that mail order suppliers are qualified and capable of providing any education and services related to the furnishing of the replacement diabetic testing supplies. Finally, it is important to note that our current rules provide great flexibility in arranging for the furnishing of replacement diabetic testing supplies. The program allows beneficiaries to receive a 3-month supply of diabetic test strips and beneficiaries can order and obtain their supplies 5 days in advance of the start of the next 3-month period.

Comment: Several commenters stated that mail order companies provide the same type of instruction and guidance that local pharmacies provide by offering hotlines, working with patients to educate and coach them on the use of glucose monitors, and continued patient counseling and monitoring.

Response: As previously discussed, we believe that mail order suppliers are qualified and capable of providing any necessary services related to the furnishing of replacement diabetic testing supplies. The same supplier standards and quality standards that apply to local storefronts that furnish these items also apply to mail order suppliers. Local home delivery companies state that because they have local presence they can offer better service from specially trained employees to meet the needs of the beneficiaries. We believe that employees of mail order companies are also well trained and both companies train their employees to address beneficiaries' needs.

After consideration of the public comments received, we are finalizing our proposal without modification.

(3) Special Rule in Case of Competition for Diabetic Testing Strips

Following Round 1 Rebid of the program, any competition for diabetic testing strips, such as a national mail order program for diabetic testing supplies proposed in this rule, must include the special rule set forth in section 1847(b)(10)(A) of the Act. Under that section, a supplier must demonstrate that their bid to furnish diabetic testing strips covers the furnishing of a sufficient number of different types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, account for at least 50 percent of all such types of products on the market. Section 1847(a)(10)(A) of the Act also specifies that the volume for the different products may be determined in accordance with data (which may include market based data) recognized by the Secretary. When a beneficiary needs to obtain replacement test strips, they must obtain the specific brand of test strips products that work with their brand and model of blood glucose monitor. The test strips are not manufactured in a way that allows use of different brands of test strips in different brands of monitors. Therefore, when replacement test strips are furnished, the supplier must ensure that the specific brand and model of test strips that the patient requires for use with their purchased monitor is furnished.

Section 1847(b)(10)(B) of the Act mandates the DHHS OIG conduct a study before 2011 to generate volume data for the various products that could be used for this purpose.

Under the DMEPOS CBP, bidding suppliers are required to provide information on the products they plan to furnish if awarded a contract. We proposed to use this information and information on the market share (volume) of the various diabetic testing strip products to educate suppliers on meeting the requirements of this special rule. In addition, it may be necessary to obtain additional information from suppliers such as invoices or purchase orders to verify that the requirements in the statute have been met.

We proposed that suppliers be required to demonstrate that their bids cover the minimum 50-percent threshold provided in the statute, but we invited comments on whether a higher threshold should be used. We have proposed the 50-percent threshold in part because we believe that all suppliers have an inherent incentive to furnish a wide variety of types of diabetic testing products to generate a wider customer referral base. The 50-percent threshold would ensure that beneficiaries have access to mail order delivery of the top-selling diabetic test strip products. In addition, as explained below, we proposed an "anti-switching provision" that we believe should obviate the need to establish a threshold of greater than 50 percent for the purpose of implementing this special rule because the contract suppliers would not be able to carry a limited variety of products and switch beneficiaries to those products.

For purposes of implementing the special rule in section 1847(b)(10)(A) of the Act, we proposed to define "diabetic testing strip product" as a specific brand and model of test strip, as that is the best way to distinguish among different products. Therefore, we plan to use market based data for specific brands and models of diabetic test strips to determine the relative market share or volume of the various products on the market that are available to Medicare beneficiaries. We plan to review a variety of data, including but not limited to data furnished in the OIG report, to determine the market share of the various products. The special rule mandated by section 1847(b)(10)(A) of the Act applies to all competitions for diabetic testing strips after the Round 1 Rebid of the DMEPOS CBP. Therefore, we would apply this rule to non-mail order competitions and local competitions conducted for diabetic testing strips after the Round 1 Rebid of the DMEPOS CBP.

Comment: Several commenters supported the requirement for suppliers to demonstrate that their bids cover 50 percent of the diabetic testing strips on the market. Other commenters noted problems associated with implementing the 50-percent rule. A few commenters stated that this rule provides an advantage to large manufacturers by encouraging suppliers to carry more of their products and disadvantages small manufacturers with limited product lines.

Response: This special rule is mandated by the statute which stipulates a supplier must demonstrate

that its bid to furnish diabetic testing strips covers the furnishing of a sufficient number of different types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, to account for at least 50 percent of all such types of products on the market. Suppliers are able to decide from which manufacturers to obtain their diabetic testing supplies from, but we are required to ensure that suppliers are in compliance with the special rule before awarding a contract to them under the DMEPOS CBP.

Comment: Several commenters are concerned that products developed between bidding cycles will be frozen out of the program for up to 3 years and suppliers could be discouraged from offering new products until the next bidding cycle or up to 3 years after the product's release.

Response: We disagree that the 50-percent rule creates a disincentive for manufacturers and innovators to develop new and progressive technology. This rule does not prevent suppliers from offering new products to their customers. In fact, suppliers may choose to offer new products in order to gain market share under the DMEPOS CBP. In addition, we believe that the anti-switching rule would create a strong incentive for contract suppliers to carry a wide range of products well beyond the 50-percent threshold in order to increase their volume of business. Contract supplier would have to carry the brand test strips that work with new products that are successfully marketed to Medicare beneficiaries.

Comment: Several commenters stated that the minimum 50-percent threshold required by the statute may be insufficient to ensure that suppliers carry a wide array of available products. Other commenters recommended that CMS require suppliers to carry a more clinically diverse array of products. Without this change they believe suppliers could limit the range of diabetic testing supplies by only offering the lowest cost versions of those supplies.

Response: We disagree. We believe that the 50-percent threshold is sufficient to ensure that contract suppliers offer the products that physicians and beneficiaries prefer because it will be extremely difficult for suppliers to limit the number of products they offer to the lowest cost versions unless those are also the top selling products. We believe that the top selling products are widely used because physicians and beneficiaries prefer them rather than because they are the cheapest products available. We do not believe that physicians and pharmacists would continue to recommend products to beneficiaries if they did not meet the needs of the specific beneficiaries. Likewise, we do not believe that beneficiaries who choose certain products would continue to use those products and make them top-selling products if they did not adequately meet their needs. Due to widespread manufacturer rebates, trade-ins, and other discounts, beneficiaries and other consumers are able to purchase new glucose monitor products at little or no cost. Therefore, beneficiaries who are unhappy with their choice of glucose monitor product, can easily switch to another brand of monitor. It would be extremely difficult for suppliers who only elect to furnish products that are not top-selling products to reach the 50-percent threshold.

Comment: One commenter stated that the 50-percent rule is a strong beneficiary protection and that the 50-percent rule will not work without enforcement of the anti-switching rule.

Response: We agree that the 50-percent threshold would ensure that beneficiaries have access to mail order delivery of the top-selling diabetic test strip brands and models. We also agree that the 50-percent rule would be more effective with implementation of the anti-switching rule.

Comment: One commenter recommended that when CMS determines the product list they should identify the brands and products that have been furnished through the mail. This is important because market share data for mail order and retail medical supply establishments are not the same.

Response: We agree. The DHHS OIG is conducting a study to generate volume data for various diabetic testing strip products furnished on a mail order basis. We will use this data in providing guidance to implement this special rule for mail order contract suppliers to ensure that their bids cover at least 50 percent of the volume of testing strip products currently furnished to beneficiaries via mail order. The OIG is required to complete their study before 2011 and will make their data available to the public.

Comment: A few commenters believe that the proposed rule does not indicate how CMS will determine compliance with the percentage standard. The commenters urge CMS to do more than analyze a supplier's bid to determine compliance. They suggest CMS develop mechanisms to "look back" at a supplier's actual performance over a period of time, preferably on a monthly basis for the first year of the program's operation. Also, CMS could review supplier's records, such as invoices and purchase orders, to verify compliance with the requirement.

Response: We agree with this comment and the need for CMS to ensure compliance with the special rule. Suppliers will be required to submit information to document that their bid covers at least 50 percent of the products available to beneficiaries. In addition, contract suppliers will be required to submit quarterly reports that include information on the items that the contract supplier has furnished for the quarter. These quarterly reports will indicate the approximate number of items furnished, manufacturer, model and model number of the items furnished. The quarterly reports will enable us to monitor access to different products under the program.

Comment: One commenter stated that the 50-percent rule fails to meets the non-discrimination requirement.

Response: We disagree. The non-discrimination requirement does not conflict with the 50-percent rule. Contract suppliers must furnish the same products to Medicare patients that they furnish to their other customers and these products must make up at least 50 percent of the volume of items available. Neither requirement prevents the supplier from meeting the other requirement. The non-discrimination requirement will be fully enforced along with the special 50-percent rule.

Comment: A commenter recommended that CMS consult with patient advocates, providers, and industry experts to determine whether the methodology used by CMS for determining the different types and amounts of products on the market is consistent with what is actually available to Medicare beneficiaries today.

Response: We agree and will consider whether or not it is necessary to consult with patient advocates, providers, and industry experts to determine the types and volume products available to Medicare beneficiaries. The statute also mandates that the OIG conduct a study to generate volume data for various diabetic testing strip products that could be used to make this determination.

Comment: A commenter suggested that CMS should consider adopting a generic substitution requirement for diabetic testing supplies.

Response: This comment is outside the scope of this rulemaking.

After consideration of the public comments we received, we are finalizing our proposal without modification.

(4) Anti-Switching Rule in Case of Competition for Diabetic Test Strips

As previously noted, we believe that an anti-switching requirement will help ensure compliance with the 50-percent rule and creates an incentive for contract suppliers to offer a wide variety of testing strip products. Therefore, we proposed to prohibit suppliers awarded contracts for diabetic testing supplies from influencing or incentivizing the beneficiary by persuading, pressuring, or advising them to switch from their current brand or for new beneficiaries from their preferred brand of glucose monitor and testing supplies. The contract supplier may not furnish information about alternative brands to the beneficiary to influence the beneficiary's decision unless the beneficiary requests such information. We proposed that contract suppliers for diabetic testing supplies must furnish the brand of diabetic testing supplies that work with the home blood glucose monitor selected by the beneficiary. In the case where the beneficiary is receiving a monitor for the first time or a replacement monitor, the contract supplier would be subject to the requirements of § 414.420 in order to protect beneficiaries from feeling forced or incentivized to use a particular type or brand of monitor. We continue to believe the proper role of the contract supplier is to furnish diabetic testing strips and other supplies to beneficiaries, not to interfere with the beneficiary's selection of the type of monitor and supplies. This requires the supplier to furnish the brand of testing supplies that work with the blood glucose monitor product that the beneficiary, and not the supplier of the testing supplies, selects. If the beneficiary needs a blood glucose monitor for the first time, or needs to replace their existing blood glucose monitor, and neither the beneficiary nor their physician has determined which brand or type of monitor to obtain, the beneficiary may continue to ask for assistance from the supplier to select a monitor and the supplier should show them the full range of products. However, if the beneficiary has already selected a monitor and simply needs replacement diabetic testing supplies, the supplier must furnish the brands of testing supplies that work with the brand monitor that the beneficiary has selected. We believed that our proposal would preserve the integrity of the clinical decision regarding choice of glucose monitoring system and would result in contract suppliers offering a wide variety of diabetic testing supply products.

We proposed to amend § 414.422 to add the anti-switching requirement to the terms of the contract for a supplier of diabetic testing supplies. A supplier would be in breach of their contract and subject to the sanctions set forth under § 414.423(g), including termination, if they violate this term.

Comment: Numerous commenters stated that CMS should adopt a strong anti-switching rule and stated that this rule is an important improvement to the DMEPOS CBP and will protect beneficiaries' access to supplies.

Response: We agree that the anti-switching rule will help protect beneficiaries from being influenced or incentivized to use a particular type of brand of glucose monitor.

Comment: One commenter also recommended that the anti-switching rule should be actively monitored to ensure that beneficiaries are adequately protected.

Response: We agree. The anti-switching rule will be actively monitored by requiring contract suppliers to submit quarterly reports that include information of the items that the contract supplier has furnished for the quarter. We will be analyzing the quarterly reports to determine changes in the rates that various brands are provided. We will also be monitoring beneficiary complaints to determine if this is an issue.

Comment: One commenter stated suppliers should be required to submit evidence to CMS such as copies of agreements with manufactures to demonstrate how they will obtain adequate quantities of testing supplies in order to furnish the supplies sought by beneficiaries in a timely manner. This is to prevent suppliers from influencing a beneficiary's choice of products by not being able to fill certain orders.

Response: We disagree. The anti-switching rule does not require the supplier to increase their capacity for furnishing sufficient quantities of all of the various products available. It is intended to prevent the supplier from actively influencing or incentivizing the beneficiary to switch to a different glucose monitor product. If the contract supplier does not stock a specific product or is out of inventory of a specific product they carry and which the beneficiary needs, the beneficiary can go to any other contract supplier to see if they carry the product they need in stock.

Comment: A few commenters were concerned about the anti-switching rule because they believe that this rule will prevent suppliers from consulting with beneficiaries regarding the various features of the different products and the selection of diabetic supplies that best meet the patient's needs.

Response: The anti-switching policy impacts those beneficiaries who are already using a specific monitor or whose physician ordered a specific brand. The anti-switching policy prevents suppliers from influencing or incentivizing beneficiaries to switch monitors. This policy has no impact on situations where the beneficiary has not yet selected a monitor or initiates discussions with the supplier about changing to a new type of monitor.

Comment: One commenter stated that the anti-switching rule prevents beneficiaries from having access to lower cost glucose monitors and test strips, unless they specifically request information about less costly alternatives from their supplier. In addition, the commenter stated that the DMEPOS CBP should provide incentives to use lower cost alternatives and not prohibit their use.

Response: We disagree. The purpose of this policy is to prevent beneficiaries from being influenced to switch from their current brand to a lower cost brand to increase a supplier's profit. The beneficiary's choice should not be influenced by the supplier's ability to obtain the product at a lower cost, rather than the product that the beneficiary prefers. This policy does not prevent a beneficiary from initiating a discussion with suppliers or their physician to determine the most appropriate brand. The contract supplier can discuss the features or how to operate the glucose monitor selected by the beneficiary, even if information is not requested by the beneficiary.

Comment: One commenter stated that CMS should enforce the anti-switching rule by prohibiting mail order suppliers from counseling patients on blood glucose monitors and supplies, pre-approving suppliers' marketing materials and establishing a hotline for beneficiaries.

Response: We disagree. As previously stated, the contract supplier can discuss the features or how to operate the glucose monitor selected by the beneficiary even if this information is not requested by the beneficiary. We established a 1–800 Medicare number which is a beneficiary dedicated hotline that beneficiaries are to call when they have questions or concerns related to their Medicare needs. In addition, the presence of local ombudsman will be available for beneficiaries and suppliers for their Medicare related needs when the DMEPOS CBP is implemented.

Comment: One commenter recommended that CMS take steps to

appropriately inform and educate beneficiaries in advance about their rights under the anti-switching provisions. The commenter also recommended that a special education effort be implemented during the new Round 1 Rebid and any future rounds of bidding aimed at eliminating any confusion that beneficiaries have regarding their ability to continue receiving their replacement supplies at their retail pharmacies.

Response: We agree. We have designed and will conduct an extensive beneficiary educational campaign on the Round 1 Rebid. In addition, for future rounds of competition we will continue to conduct future educational campaigns to educate beneficiaries on all aspects of the program, including the anti-switching provisions and the 50-percent rule.

After consideration of the public comments we received, we are finalizing our proposal without modification

c. Off-the-Shelf (OTS) Orthotics Exemption

In the April 10, 2007 final rule (72 FR 17992), we established § 414.404(b)(1), which sets forth several exemptions to the DMEPOS CBP. These exceptions are applicable to providers, physicians, and treating practitioners that furnish certain DMEPOS items under Medicare Part B. The exempted items are limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps that are DME. For an explanation as to why these items were exempt see the DMEPOS Competitive Bidding final rule (CMS–1270–F) published April 10, 2007, (72 FR 17992). For the exemptions to apply, the items must be furnished by a physician or treating practitioner to his or her own patients as part of his or her professional service. The items are to be billed under a billing number assigned to the physician, the treating practitioner (if possible), or a group practice to which the physician or treating practitioner has reassigned the right to receive Medicare payment.

The April 10, 2007 final rule also established an exemption for a physical therapist in private practice (as defined in § 410.60(c)) or an occupational therapist in private practice (as defined in § 410.59(c)) to furnish competitively bid OTS orthotics without submitting a bid and being awarded a contract under the DMEPOS CBP, provided that the items are furnished only to the therapist's own patients as part of a physical or occupational therapy service.

Section 154(d) of MIPPA amended section 1847(a) of the Act by adding paragraph (7), which expands the exemptions from the DMEPOS CBP for certain OTS orthotics to physicians or other practitioners (as defined by the Secretary) if furnished to their own patients as part of their professional service. Section 1847(a)(7) of the Act, as added by MIPPA, also expanded the exemption from the program to hospitals for certain OTS orthotics, crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps if these items are furnished to the hospital's own patients during an admission or on the date of discharge.

The DMEPOS CBP Round 1 Rebid interim final rule with comment period (IFC) included the expanded exemption for certain DMEPOS items as provided by MIPPA for hospitals. We noted in the IFC that we would address the expanded exemption of OTS orthotics for hospitals, physicians and other practitioners in future rulemaking.

We proposed to revise current provisions at § 414.404(b)(1)(i) to incorporate the provision of section 1847(a)(7)(A)(i) and (ii) of the Act that exempts from the program OTS orthotics furnished by physicians and other practitioners to their own patients as part of their professional service or by hospitals to the hospital's own patients during an admission or on the date of discharge.

Comment: One commenter submitted a question requesting clarification on whether a supplier owned by a hospital or provider affiliated with a hospital would qualify for the hospital exemption.

Response: The OTS orthotics exemption for hospitals is limited to hospitals that furnish OTS orthotics to their own patients during an admission or on the date of discharge. The exemption for a hospital does not apply to suppliers or providers owned by or affiliated with a hospital. This exemption applies only to entities that meet the definition at section 1861(e) of the Act.

Comment: One commenter suggested that CMS include small independent pharmacies in the definition of "other practitioners" and exempt OTS orthotics furnished by small independent pharmacies from bidding and contract requirements under the DMEPOS CBP.

Response: We disagree. There are several factors we consider in determining which suppliers qualify for an exemption. As discussed in the April 10, 2007, **Federal Register** (72 FR 18029) we exempted physical and occupational therapists, from bidding in the DMEPOS CBP and being awarded a contract so that they could continue to provide competitively bid OTS orthotics to their own patients when these items are furnished as part of their professional service. MIPPA has extended this exemption to include OTS orthotics furnished by physicians, certain other practitioners, and hospitals to their own patients. The MIPPA expanded exemption does not include OTS orthotics furnished to the general public by suppliers such as pharmacies. Therefore, we do not agree that this exemption should be applied to small independent pharmacies who sell these products to the general public and they are not furnished as an integral part of a treatment service furnished by the pharmacy. Also, the term treating practitioner is defined at § 414.402 of the regulations and includes physician assistants, nurse practitioners, and clinical nurse specialists in accordance with the definition of these terms as defined at section 1861(aa)(5) of the Act. We do not believe that the statutory language that extended the OTS orthotic exemption to physicians, certain other practitioners, and hospitals was intended to extend the exemption to small independent pharmacies that provide products to the general public.

Comment: One commenter supported the OTS orthotics exemption for physicians, practitioners, and hospitals.

Response: We agree.

After consideration of the public comments we received, we are finalizing our proposal without modification.

d. Grandfathering Rules Resulting in Additional Payments to Contract Suppliers Under the DMEPOS Competitive Bidding Program (CBP)

Section 1847(a)(4) of the Act requires that in the case of rented DME and oxygen and oxygen equipment, the Secretary shall establish a "grandfathering" process. This requirement was implemented through regulations at § 414.408(j) that were published in the April 10, 2007 **Federal Register** (72 FR 17992). The grandfathering process allows beneficiaries who were renting DME items or receiving oxygen and oxygen equipment prior to the start of a DMEPOS CBP from a supplier who did not win a contract to continue to rent the equipment from that noncontract supplier if that supplier chooses to become a grandfathered supplier. Under § 414.408(i)(2), when the beneficiary decides to use a contract supplier instead of a grandfathered supplier to receive their oxygen equipment and supplies, the contract supplier receives

a minimum of 10 monthly payments for taking over the furnishing of oxygen and oxygen equipment. When a beneficiary decides to use a contract supplier to furnish capped rental DME, section § 414.408(h)(2) restarts the 13-month capped rental period. These rules were established, in part, based on advice from the Program Advisory and Oversight Committee (PAOC) and are intended to give bidding suppliers an assurance that they would be compensated in these situations and would not have to factor into their bids the cost of receiving as few as one monthly payment for beneficiaries near the end of the 13-month cap for capped rental items and 36-month cap for oxygen equipment.

At the time these rules were developed, the supplier was mandated by the statute to transfer title to the equipment to the beneficiary after the both the 13-month cap for capped rental items and the 36-month cap for oxygen equipment. Section 144(b) of the MIPPA repealed the transfer of title requirement for oxygen equipment, as established by DRA, replacing that requirement with the 36-month rental cap. Under the revised oxygen payment provisions, suppliers now get the equipment back when the beneficiary no longer needs it. Also, at the time these rules were developed, the beneficiary had the option to acquire standard power wheelchairs on a lump sum purchase basis, an option which greater than 95 percent of the beneficiaries selected, based upon historic claims data. Therefore, those items generally would not be affected by the grandfathering rules. However, as discussed in section VI.V. of this final rule with comment period, section 3136 of the Affordable Care Act eliminates the lump sum purchase option for standard power wheelchairs. This new policy applies to items furnished under the DMEPOS CBP beginning with Round 2 of the program. Over 200,000 beneficiaries received standard power wheelchairs nationwide in 2009, and the Medicare allowed charges for these wheelchairs was over $650 million, including both rental and purchase options. Therefore, this large volume of capped rental items will be subject to the grandfathering rules effective with Round 2 of the DMEPOS CBP, thus increasing the overall magnitude of the effect these rules have on the program and beneficiaries.

In some cases, the grandfathering rules described above place a financial burden on beneficiaries who are near the end of the 13 or 36-month rental cap periods. If a beneficiary's existing supplier chooses not to be a grandfathered supplier, the beneficiary will be required to switch to a contract supplier in order for Medicare to continue to pay for the furnishing of the rental equipment. In such cases, the beneficiary will be responsible for additional co-insurance amounts. Based on experience from the initial Round 1 competition in 2008, we believe that most suppliers will choose to grandfather and therefore these rules will have no impact on these situations. However, in those limited situations in which the beneficiary does not use a grandfathered supplier and the beneficiary is near the end of the 13 or 36-month rental cap period, the impact on the beneficiary could be significant. As mentioned above, our current grandfathering rules will result in a limited number of beneficiaries facing additional co-insurance payments. To illustrate the impact some beneficiaries may face as a result of these rules, a beneficiary who has already made 12 coinsurance payments for a capped rental item could make as many as 12 additional copayments as a result of restarting the capped rental period when they transition from a noncontract supplier to a contract supplier at the beginning of a DMEPOS CBP. In another example, a beneficiary who has already made 35 coinsurance payments for oxygen and oxygen equipment could make as many as 9 additional copayments as a result of the rule that provides a minimum of 10 monthly payments when they transition from a noncontract supplier to a contract supplier at the beginning of a DMEPOS CBP. As stated above, we expect that most noncontract suppliers will choose to become grandfathered suppliers, therefore limiting the number of instances where these rules would apply. However, in light of the beneficiary impact in the those extreme cases illustrated above, and in light of the recent legislative changes by the MIPPA and the Affordable Care Act as explained above, we are reevaluating whether or not changes to these grandfathering rules are necessary. As discussed above, as a result of the MIPPA, suppliers of oxygen equipment no longer lose title to the equipment after receiving the 36th payment and this may warrant reconsideration of the minimum number of payments they should receive as contract suppliers when a beneficiary transitions to them from a noncontract supplier at the beginning of a DMEPOS CBP. In addition, we believe it is important to reevaluate the policy that restarts the 13-month capped rental period in situations where a beneficiary transitions from a noncontract supplier to a contract supplier at the beginning of a DMEPOS CBP.

We received nine public comments on the grandfathering rules resulting in additional payments to contract suppliers under the DMEPOS CBP. In the proposed rule we solicited public comments on whether or not the current rules should be changed to reduce the number of payments the contract supplier would receive in these situations above the 13 and 36-month limits set forth under the standard payment rules in section 1834(a) of the Act. We requested comments only and did not propose any regulation changes. Therefore, the comments received will be taken into consideration in future proposed rulemaking.

e. Appeals Process

The April 10, 2007 DMEPOS CBP final rule finalized § 414.422(g)(1), which states that "any deviation from contract requirements, including a failure to comply with governmental agency or licensing organization requirements, constitutes a breach of contract." In the event we determine that a contract supplier's actions constitute a breach of contract, § 414.422(g)(2) authorizes us to take one or more of the following actions:

- Require the contract supplier to submit a corrective action plan.
- Suspend the contract supplier's contract.
- Terminate the contract.
- Preclude the contract supplier from participating in the DMEPOS CBP.
- Revoke the supplier number of the contract supplier, or
- Avail itself of other remedies allowed by the statute.

We proposed to add a new § 414.423 to establish an appeals process for contracts terminated under section 1847(a) and (b) of the Act. Proposed § 414.423 would set forth policies and procedures relating to our determinations of a breach of contract and the appeals process for contract suppliers that are considered to be in breach of contract. In addition, we proposed to add new definitions to § 414.402 that are used in the proposed § 414.423.

Given the impact that termination has on a contract supplier, we believe it is appropriate for contract suppliers whose contract(s) may be terminated due to a breach of contract to have access to an appeals process that will reconsider that termination. In establishing this process we reviewed other appeals processes, such as the appeals process under Part D located at § 423.641 through § 423.668, Subpart N—Medicare

Contract Determinations and Appeals, to consider essential steps to ensure suppliers have access to an appropriate review of certain CMS decisions. We proposed a simplified process that would not result in disruption to the program by having suppliers going in and out of the program. For this reason, we proposed a process for review and reconsideration before the contract is actually terminated. This proposal would avoid the necessity to reinstate retroactively suppliers because the contracts would generally not be terminated before the full review process has occurred. This would protect the supplier because we generally would not terminate a supplier until a final decision is made. Another feature of this process that may be beneficial to some suppliers is allowing them to submit a corrective action plan (CAP) depending upon the nature of the breach. We believe our proposal would allow most suppliers to correct identified deficiencies.

(1) Purpose and Definitions: (§ 414.402)

We are proposed to amend § 414.402 to define the following terms:

• *Affected party* means a contract supplier that has been notified that their DMEPOS CBP contract will be terminated for a breach of contract.

• *Breach of contract* means any deviation from contract requirements, including a failure to comply with a governmental agency or licensing organization requirements.

• *Corrective Action Plan (CAP)* means a contract supplier's written document with supporting information that describes the actions the contract supplier would take within a specified timeframe to remedy the breach of contract.

• *Hearing Officer (HO)* means an individual, who was not involved with the CBIC recommendation to terminate a DMEPOS Competitive Bidding Program contract, who is designated by CMS to review and make an unbiased and independent recommendation when there is an appeal of CMS's initial determination to terminate a DMEPOS Competitive Bidding Program contract.

• *Parties to the hearing* means the DMEPOS contract supplier and CMS.

(2) Applicability

The appeals process proposed in this regulation would allow contract suppliers the opportunity for a review of the following:

• A CMS determination under § 414.422(g)(1) that the contract supplier breached its contract entered into as part of the DMEPOS CBP; and

• Certain agency actions taken under § 414.422(g)(2).

The proposed appeals process would not apply to any other actions made by CMS, nor would the existence of other appeals processes preclude us from terminating a DMEPOS CBP contract. In other words, the proposed appeals process would be in addition to—and would not replace—existing CMS regulations regarding other appeals mechanisms. For example, a contract may be terminated because a supplier's National Supplier Clearinghouse (NSC) number has been revoked or inactivated. In this case, the supplier would not appeal the decision to inactivate or revoke its number through this appeals process. Instead, the supplier would continue to appeal the inactivation or revocation of its supplier number through the NSC's appeals process. We would postpone the contract termination decision until the supplier completes the NSC appeals process unless there are multiple findings of breach of contract.

Under our proposal, when we issue a termination decision, it would be final and binding unless a postponement of the termination decision is allowed by proposed § 414.423.

(3) Contract Termination

We proposed that this appeals process applies in situations where the supplier has received a notice that we have determined that they are in breach of contract and that their contract is therefore subject to termination. A contract may be terminated for any violation of the terms of the contract. Examples of violations include, but are not limited to, situations where the contract supplier—

• Has committed or participated in false, fraudulent, or abusive activities affecting the Medicare program, including the submission of false or fraudulent data or claims;

• Experiences financial difficulties so that they are unable to effectively provide the necessary services to a Medicare beneficiary; or

• Fails to meet the non-discrimination policy and provides different items to beneficiaries located in a competitive bidding area (CBA) than it provides to its non-Medicare beneficiaries at § 414.422(c).

(4) Notice of Termination

We proposed that the CBIC would work with suppliers to informally resolve performance deficiencies under its DMEPOS CBP contract prior to sending a recommendation to CMS that the supplier's contract be terminated. If the CBIC cannot informally resolve the supplier's deficiencies and recommends that we terminate the supplier's contract, we will review the CBIC's recommendation to terminate the supplier's contract. If we find that a breach occurred, we would begin the contract termination process by sending out a notice of termination to the supplier.

We also proposed requirements for the notice of termination so that suppliers are informed of the basis for CMS's action as well as their options to respond to this action. The notice would explain all actions we plan to take in response to the supplier's breach, such as the ability to submit a CAP or our determination to preclude a supplier from participating in future rounds of competitive bidding if found in breach of contract. If the supplier decides to appeal any of these decisions the supplier would submit an appeal in response to the notice to terminate. If we consider a supplier to be in breach of its contract, either in part or in whole, we would notify the contract supplier of the termination by certified mail. The notice would indicate that the contract supplier has been found to be in breach of contract and that the supplier's contract will be terminated within 45 days of the date of the notification of termination. The notice would be sent by the CBIC using certified mail on the same date that the notification is signed. The notification will be mailed on the date that it is signed. This is the same date as indicated on the notification.

Our proposal required the notice to include, at a minimum, the following information:

• The reasons for the termination in sufficient detail to allow the contract supplier to understand the nature of its breach of contract;

• Depending on the nature of the breach, whether the supplier may be allowed to submit a CAP in lieu of requesting a hearing by the HO;

• The right to request a hearing by the HO;

• The address to which the written request for a hearing must be mailed;

• The address to which the CAP must be mailed; and

• The effective date of the termination of the contract, if a CAP is not submitted or if a request for a hearing has not been filed timely.

We believe that this information will be sufficient to provide the supplier with the basis for CMS's action, as well as their options in responding to our decision.

In addition, our proposal required the notice to indicate any additional penalties that may result from the termination, such as, not being eligible

to bid in future rounds of competitive bidding. An appeal of the termination would include the appeal of any other results from the termination that are permissible under § 414.423, such as preclusion from participation in future rounds of the DMEPOS CBP. We believe this information may help the supplier to decide whether to appeal the notice of termination.

(5) Corrective Action Plan

We proposed a process by which a contract supplier may be able to submit a CAP to address the breach of contract. Depending on the nature of the breach of contract, we proposed that the notice to the supplier would indicate whether a contract supplier would be allowed to provide the CBIC with a written CAP instead of submitting a request for a hearing by a HO. For example, under this proposal we would not allow a CAP if the supplier has been excluded from any federal program, debarred by any federal agency, or convicted of a healthcare-related crime. We may also not allow a CAP that would result in negative consequences to the beneficiaries or the program caused by delaying the termination of the contract.

We proposed the following timelines for situations where the contract supplier is allowed to provide a written CAP:

- If the supplier decides to submit a CAP, the CAP must be received by the CBIC within 30 days from the date on the notice of termination.
- If the supplier decides not to submit a CAP, the supplier retains the right to request a review by a HO within 30 days from the date of the notice of termination. While the CAP is being evaluated, the termination action would be postponed. We believe that 30 days is a sufficient amount of time for suppliers to prepare and submit a CAP and this would also ensure that there are no unnecessary delays in the appeals process.

We proposed to require the CAP to demonstrate that the contract supplier has a plan to remedy all of the deficiencies that were identified in its notice of termination and must specify the timeframes for correcting these deficiencies. The CBIC would review the CAP to ensure that the contract supplier would be taking the appropriate measures in a timely manner to remedy the breach of contract. What constitutes a timely manner is dependent on the type of deficiency that is being corrected. Once the nature of the deficiency is identified the CBIC and CMS would make a case-by-case determination concerning what constitutes a timely manner for correcting the deficiency. However, we expect most deficiencies to be corrected within 90 days or less. Further guidance of what constitutes a timely manner would be communicated to the contract supplier by the CBIC as part of the review process.

As part of the review process, the CBIC would provide guidance, in accordance with CMS instructions, regarding the type of documentation that the CAP and the follow up report must provide to substantiate that the deficiencies have been corrected. To make a determination if a CAP would be considered acceptable, we would discuss any deficiencies related to the CAP with the supplier, and as a result of these discussions, the CBIC may allow a supplier to make revisions to its CAP during the review process. Suppliers will only revise their CAP one-time during the review process. The timeframe for the review process would vary upon the circumstances for each case. If the supplier does not submit an acceptable CAP during the review process, the supplier would receive a new notice that their CAP is not acceptable or has not been implemented consistent with the supplier's original submission and its contract would be terminated within 45 days. Every supplier that submits a CAP will have a one-time opportunity to revise their CAP based upon deficiencies identified by the CBIC. Failure to develop and implement an approved CAP would result in a new notice to the supplier of the termination of the DMEPOS CBP contract and provide notice that the supplier may request a hearing on this termination. We proposed that once an acceptable CAP has been completed the contract supplier must provide a follow-up report within 5 days of the agreed upon date for the completion of the CAP to verify that all of the deficiencies identified in the CAP have been corrected consistent with the timeframes specified in the CAP, as approved by the CMS. We believe that 5 days is a sufficient time for a supplier to submit a report to the CBIC outlining all steps that have been completed to correct the identified deficiencies.

(6) Right To Request a Hearing by the CBIC Hearing Officer (HO)

We proposed that a contract supplier that has received a notice that we consider the supplier in breach of contract has the right to request a hearing before a HO who was not involved with the original breach of contract determination. We consider this process to be a reconsideration of the original decision, and, consistent with other Medicare appeals provisions, we believe it is important that an individual not involved in making the initial recommendation conduct the reconsideration of the initial decision. As mentioned previously, the HO would be an individual who is designated by CMS to review and to make an unbiased and independent recommendation of whether to terminate the supplier's DMEPOS CBP contract. The notice to the contract supplier would also identify the location to which a request for hearing must be sent.

We proposed that a contract supplier may appeal the notice of termination by submitting a written request to the CBIC for a hearing by a HO. The written request should include any evidence to support its appeal. The HO is not required to allow evidence submitted in addition to evidence beyond the evidence submitted along with the written request. The hearing request must be received by the CBIC within 30 days from the date of the termination letter. A request for a hearing must be sent to the address identified on the notice. Failure to request a hearing within the allotted 30 days would result in a termination of the supplier's contract, as of the effective date of termination identified in the notice to the supplier. There would be no extension to this 30-day timeframe. We believe suppliers have sufficient time to decide whether or not to request a hearing and the deficiencies identified in the notice may pose a risk to the DMEPOS CBP. The date the request is received by the CBIC determines if the hearing request was timely filed.

We would require that the request for hearing be filed by a supplier's authorized official, because an authorized official of the company signed the contract and this ensures the validity of the request. The authorized official must be an official of the company who is identified on the supplier's CMS 855-S form as an authorized official of the supplier. A supplier may appoint someone other than the authorized official to be a representative for them at the hearing. However, the representative may not be an individual who has been disqualified or suspended from acting as a representative by the Secretary or otherwise prohibited by law. The request for a hearing must be filed with the CBIC at the address identified on the notice of termination.

(7) Scheduling of the Hearing

We proposed that within 30 days from the receipt of a supplier's timely hearing request the HO would contact the parties to schedule a hearing. The request for a hearing would result in the

postponement of the date of the contract termination. The only exception to this rule is when a supplier has been excluded from any federal program, debarred by any federal agency, or convicted of a healthcare related crime; in that situation the supplier's contract would be terminated immediately. In the hearing request the contract supplier may ask for the hearing to be held in person or by telephone. The HO would send a notice to the parties to the hearing indicating the time and place for the hearing at least 30 days before the date of the hearing. The HO may, on his or her own motion, or at the request of a party, change the time and place for the hearing, but must give the parties to the hearing a 30 day notice of the change.

We proposed to require that the HO's notice scheduling the hearing must provide, at a minimum, the following information:

- Date, time, and location of the scheduled hearing;
- Description of the hearing procedure;
- Issues to be resolved;
- Requirement that the contract supplier bears the burden of proof to demonstrate that it is not in breach of contract; and
- Provide an opportunity for the supplier to submit additional evidence if requested by the HO.

We believe this information provides the supplier with sufficient information regarding the hearing date, time, and matters that would be addressed at that time. We solicited comment on the content of this notice and the procedures for scheduling a hearing.

(8) Burden of Proof

We proposed that the contract supplier would present to the HO the basis for its disagreement with the termination notice and would have the burden of proof to demonstrate to the HO with supporting evidence that it is not in breach of its contract and that the termination action is not appropriate. The supplier's supporting evidence must be submitted with its request for a hearing. The supporting evidence and the request for a hearing must be submitted together and received by the HO within 30 days from the date identified on the notice of termination. In the absence of good cause, the HO may not allow evidence to be submitted in addition to the evidence submitted along with the written request. We also have the opportunity to submit evidence to the HO within 30 days of receiving the notice announcing the hearing. The HO will share all evidence submitted, both from the supplier and CMS, in preparation for the hearing with all affected parties within 15 days prior to the scheduled date of the hearing.

(9) Role of the Hearing Officer (HO)

Our proposal requires that the HO conduct a thorough and independent review. Such a review requires the consideration of all information and documentation relevant to the hearing and submitted consistent with this proposal. Consistent with this goal, we propose that the HO is responsible for all of the following:

- Sharing all evidence submitted, from both the supplier and CMS, in preparation for the hearing with all affected parties within 15 days prior to the scheduled date of the hearing.
- Conducting the hearing and deciding the order in which the evidence and the arguments of the parties would be presented.
- Determining the rules on admissibility of the evidence.
- Examining the witnesses, in addition to the examinations conducted by CMS and the contract supplier.
- Determining the rules for requesting documents and other evidence from other parties.
- Ensuring a complete recording of the hearing is available and provided to all parties to the hearing and the CBIC.
- Preparing a file of the record of the hearing which includes all evidence submitted as well as any relevant documents identified by the HO and considered as part of the hearing.
- Complying with all applicable provisions of 42 USC Title 18 and related provisions of the Act, the applicable regulations issued by the Secretary, and manual instructions issued by CMS.

The HO would make a recommendation based on the information presented and submitted. The HO would issue a written recommendation to CMS within 30 days of the close of the hearing, unless the HO requests an extension from CMS and demonstrates to CMS that he or she needs an extension due to complexity of the matter or heavy work load. The HO's recommendation would include the rationale for his or her recommendation regarding the termination of the supplier's contract and the HO would submit this recommendation to CMS for its determination.

(10) CMS's Final Determination

We proposed that the HO's recommendation is submitted to CMS, and the agency would make the final determination regarding whether the supplier's contract would be terminated. Our determination would be based upon on the record of the hearing, evidence, and documents considered by the HO as part of the HO recommendation. Information submitted after the hearing would not be considered. Our decision would be made within 30 days of the receipt of the HO's recommendation. If our decision is to terminate the contract, the supplier would be notified of the effective date of termination by certified mail. Our decision regarding the termination of the contract is final and binding.

(11) Effective Date of the Contract Termination

We proposed that suppliers who submit a CAP or request a hearing would have the termination date identified on the notice delayed. The only exception to this rule is when a supplier has been excluded from any federal program, debarred by any federal agency, or convicted of a healthcare related crime; in that situation the contract would be terminated immediately. For terminations that do not meet these exceptions, the effective date of a final termination would be determined as follows:

- The termination of a supplier's DMEPOS CBP contract is effective on the date specified in the initial notice of termination, which will be 45 days from the date of the notice, unless the supplier requests a hearing with the HO or the supplier submits a CAP.
- After reviewing the HO recommendation, if we terminate a supplier's contract the effective date of the termination would be the date specified in the post-hearing notice sent to the supplier indicating CMS's final determination to terminate the contract.

(12) Effect of Contract Termination

Under our proposal, once a supplier's contract is terminated for breach of contract under the DMEPOS CBP, the contract supplier is no longer a DMEPOS CBP contract supplier for any DMEPOS CBP product category for which it was awarded a contract. This termination applies to all areas and product categories because there is only one contract that encompasses all CBAs and product categories for which the supplier was awarded a contract. We would not make payment and would reject claims for DMEPOS competitive bid items and services furnished by a supplier whose contract has been terminated after the effective date of the termination for the remainder of the contract period.

We recognize that a supplier's termination would impact beneficiaries within the CBA. Therefore, we proposed that terminated suppliers must notify all

beneficiaries within the CBA who are receiving rented competitively bid items of the termination of their contract status so that the beneficiaries can make arrangements to receive equipment and suppliers through other contract suppliers. After we have made our final determination and sent notification to the supplier, the supplier must notify beneficiaries within 5 days of receipt of the contract supplier's final notice of termination. This notice must inform beneficiaries that they will have to select a new contract supplier to furnish their DMEPOS items in order for Medicare to pay for these items. For beneficiary protection, we also proposed that contract suppliers who fail to give proper notification to beneficiaries may be prevented from participating in future rounds of DMEPOS CBP. We also proposed that rental items may not be picked up from the beneficiary's home until after the last day of the rental month for which the supplier has already received payment. We proposed both of these policies to protect the beneficiary and to ensure that suppliers do not pick up equipment from a beneficiary for a time period for which they have already been paid to provide the service.

Comment: A commenter supported CMS's appeals process for contract suppliers whose competitive bidding contract was terminated due to breach of contract. The commenter stated that "including an appeals process under DMEPOS CBP protects contract providers from arbitrary or mistaken decisions by CMS or its contractors and preserves the continuity of care for the beneficiaries they are serving."

Response: We agree that the appeals process does provide protection for contract suppliers and preserves continuity of care for the beneficiaries they serve.

Comment: A commenter who was concerned with the timeline required for communication between terminated suppliers and beneficiaries. The commenter suggested that CMS lengthen the period of time to afford providers ample opportunity to develop, mail and disseminate this critical information.

Response: We agree and have increased the period of time from 5 to 15 days of receipt of contract suppliers' final notice of termination. We believe that 15 days would be a good balance to ensure the beneficiaries receive information timely and suppliers will have enough time to notify the beneficiaries. Therefore, a contract supplier, whose contract was terminated, has 15 days from the receipt of the final notice of termination to notify each beneficiary currently renting a competitive bid item. This change will not impact any other of the timeframes or provisions described in this regulation. We also proposed that rental items may not be picked up from the beneficiary's home until after the last day of the rental month for which the supplier has already received payment. We proposed both of these policies to protect the beneficiary and to ensure that suppliers do not pick up equipment from a beneficiary for a time period for which they have already been paid to provide the service.

Comment: A commenter opposed the proposed appeals process because they believed, "the proposed process is biased and burdened with inherent CMS conflict of interests that disadvantage suppliers." This commenter recommended CMS adopt the appeals process used for DMEPOS claims which includes a hearing by an administrative law judge (ALJ) and the Departmental Appeals Board (DAB) or the process used under government contracting and FAR requirements." In addition, the commenter questioned whether the termination occurs at the supplier number level or the product category level. The commenter has questioned if a supplier has contracts for more than one of the product categories, and is determined to be in breach of contract in one category, does the termination apply to just that one product or to all? The commenter also stated that the process should include an appeal to a federal court.

Response: We disagree with this comment and feel that our process does provide for an independent and unbiased review by the CBIC hearing officer who was not involved in the original recommendation. It is not in the best interest of the program to terminate contracts if the supplier has not breached their contract; therefore, this action will not be taken lightly. This process allows CMS contractor's hearing officers to conduct an independent review of the issues. Only after considering the HO's recommendation will CMS make a final determination regarding these issues. We believe this process provides suppliers with ample opportunities to have their positions reviewed and considered. Therefore, we are not including review by the ALJ or the DAB. Our process provides for different levels of review of breach of contract, one at the recommendation level, one at the CBIC hearing officer level, and one at the CMS Administrator level. We believe this process does provide for an extensive review by allowing for reconsideration before a contract is actually terminated, which may include the use of a corrective action plan. As stated in the final regulation, these contracts are not procurement contracts are not subject to the FAR requirements; therefore, the FAR is not applicable. The rule does not address federal court review that might otherwise exist. As we stated in the proposed rule § 414.423(k)(4) CMS's decisions regarding contract terminations are final and binding. In response to the question regarding the scope of the termination, if a supplier is terminated due to a breach of contract all locations associated with that contract will be terminated, regardless of the competitive bid product category they provide. In addition, we have added clarifying language to § 414.423(l)(1).

After consideration of the public comments we received, we are revising the time for the supplier to notify the beneficiary once the supplier has been notified of their contract termination. Therefore, we have revised § 414.423(l)(2)(i) of the regulation to state that the supplier whose contract was terminated must notify the beneficiary within 15 days of receipt of the final notice of termination. In addition, we are clarifying the regulation language by adding language to § 414.423(l)(1) to state that "all locations of the contract supplier" may no longer furnish competitive bid items to beneficiaries within a CBA and be reimbursed by Medicare for these items after the effective date of the termination.

2. Changes to Payment Rules for Oxygen and Oxygen Equipment

a. Background

The general Medicare payment rules for DME are set forth in section 1834(a) of the Act and 42 CFR part 414, subpart D of our regulations. Section 1834(a)(1) of the Act and § 414.210(a) of our regulations establish the Medicare payment for a DME item as equal to 80 percent of either the lower of the actual charge or the fee schedule amount for the item. The beneficiary coinsurance is equal to 20 percent of either the lower of the actual charge or the fee schedule amount for the item once the deductible is met.

The specific payment rules for oxygen and oxygen equipment under the existing fee schedules are set forth in section 1834(a)(5) of the Act and § 414.226 of our regulations. Suppliers are paid a monthly payment amount for furnishing medically necessary oxygen contents (for both stationary and portable) and stationary oxygen equipment described under the class

described in § 414.226(c)(1)(i). Equipment in the stationary class includes stationary oxygen concentrators, which concentrate oxygen from room air; stationary liquid oxygen systems, which use oxygen stored as a very cold liquid in cylinders and tanks; and gaseous oxygen systems, which administer compressed oxygen directly from cylinders.

A monthly add-on payment is also made to suppliers furnishing medically necessary portable oxygen equipment falling under one of two classes described in § 414.226(c)(1)(ii) and (iii). Equipment in these classes includes traditional portable equipment, that is, portable liquid oxygen systems and portable gaseous oxygen systems, and oxygen generating portable equipment (OGPE), that is, portable oxygen concentrators and oxygen transfilling equipment used to fill portable tanks or cylinders in the home. Both the liquid and gaseous oxygen systems (for stationary and traditional portable systems) require on-going delivery of oxygen contents.

Section 1834(a)(5)(F) of the Act, as amended by section 144(b) of MIPPA, limits the monthly rental payments to suppliers for oxygen equipment to 36 months of continuous use, although monthly payments for furnishing gaseous or liquid oxygen contents continue after the 36-month equipment rental cap is reached for gaseous or liquid systems. In the CY 2009 PFS final rule with comment period (73 FR 69875 through 69876), we discussed section 144(b) of MIPPA and included a detailed discussion of how section 5101(b) of the DRA previously required suppliers to transfer title to oxygen equipment to the beneficiary at the end of the 36-month rental period. Section 144(b) of the MIPPA repealed this requirement to transfer title to the oxygen equipment to the beneficiary and allows suppliers to retain title to the oxygen equipment after 36 monthly rental payments are made for the equipment.

Section 414.210 establishes the requirements for the replacement of DME, including oxygen equipment. Section 414.210(f)(1) states that if an item of DME, which includes oxygen equipment, has been in continuous use by the patient for the equipment's reasonable useful lifetime or if the original equipment is lost, stolen, or irreparably damaged, the patient may elect to obtain a new piece of equipment. In such circumstances, § 414.420(f)(2) authorizes payment for the new oxygen equipment in accordance with § 414.226(a). Section 414.210(f)(1) states that the reasonable useful lifetime for DME, which includes oxygen equipment, is determined through program instructions. In the absence of CMS program instructions, the carrier may determine the reasonable useful lifetime for equipment, but in no case can it be less than 5 years. Computation is based on when the equipment is delivered to the beneficiary, not the age of the equipment. If the beneficiary elects to obtain new oxygen equipment after the reasonable useful lifetime, the payment is made for a new 36-month rental period in accordance with § 414.226(a).

We proposed to revise the payment rule for oxygen and oxygen equipment at § 414.226(g)(1) to address situations where beneficiaries relocate outside the service area of a supplier during the 36-month rental payment cap period for the oxygen equipment.

Beneficiaries are experiencing great difficulties in finding suppliers willing to furnish oxygen equipment in situations where only a few months are left in the 36-month rental payment period at the time they relocate. For example, if a beneficiary is in the 30th rental month, the new supplier would be entitled to only 6 months of rental payments and then would have to continue to furnish the oxygen and oxygen equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment. This creates a financial disincentive for oxygen suppliers to furnish oxygen and oxygen equipment to beneficiaries in these situations.

The proposed changes to the payment rules for oxygen and oxygen equipment would apply to oxygen and oxygen equipment furnished under Part B and would also apply to oxygen and oxygen equipment furnished under programs implemented in accordance with section 1847(a) of the Act.

b. Furnishing Oxygen Equipment After the 36-Month Rental Period (Cap)

In the CY 2010 PFS final rule with comment period (74 FR 61887 through 61890), we finalized § 414.226(g)(1) which, in accordance with section 1834(a)(5)(F)(ii)(I) of the Act, requires the supplier that furnishes oxygen equipment during the 36-month rental period to continue furnishing the oxygen equipment after the 36-month rental period. The supplier is required to continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment. As we noted when finalizing this rule, section 1834(a)(5)(F)(ii)(I) does not provide any exceptions to this requirement. If the beneficiary relocates outside the supplier's normal service area at some time after the 36-month rental period but before the end of the reasonable useful lifetime of the equipment, the supplier must make arrangements for the beneficiary to continue receiving the equipment at his or her new place of residence. This responsibility for furnishing the equipment does not transfer to another supplier.

We revised § 414.226(f) to conform our regulations to this new MIPPA requirement. We deleted the transfer of ownership requirement and added the new requirement that the supplier must continue furnishing the oxygen equipment after the 36-month rental period during any period of medical need for the remainder of the reasonable useful lifetime of the equipment. It is important to note that § 414.226(g)(1)(ii) does not apply this same requirement in situations where the beneficiary relocates outside of the supplier's normal service area during the 36-month rental period.

c. Furnishing Oxygen Equipment During the 36-Month Rental Period (CAP)

Section § 414.226(g)(1) contains the requirement that the supplier that furnishes oxygen and oxygen equipment for the first month of the 36th month of the rental cap period must continue to furnish the equipment for the entire 36-month period of continuous use, with limited exceptions. One exception at § 414.226(g)(1)(ii) applies when a beneficiary permanently relocates his or her residence during the 36-month rental period outside of the current supplier's normal service area. This exception was proposed in the "Home Health Prospective Payment System Rate Update for Calendar Year 2007 and Deficit Reduction Act of 2005 Changes to Medicare Payment for Oxygen Equipment and Capped Rental Durable Medical Equipment; Proposed Rule" published in the August 3, 2006 **Federal Register** (71 FR 44094) and was intended to reduce the burden on the supplier in these situations. This approach is also consistent with the regulations addressing capped rental items described in § 414.229. We addressed this issue in the context of other capped rental DME, not including oxygen and oxygen equipment, in the July 10, 1995 **Federal Register** (60 FR 35494) in response to comments. The discussion states that since the implementation of the capped rental payment methodology on January 1, 1989, we received no reports of beneficiaries having difficulty obtaining access to capped rental DME after relocating outside the supplier's service area. Since enactment of the capped

rental DME payment category in section 4062 of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100–203), representatives of the DME industry indicated that suppliers would be able to accommodate beneficiaries in these situations, and this has proven to be true for capped rental items. In fact, we have found this to be the case to this day.

For this reason, we believed that beneficiaries would not encounter problems obtaining access to oxygen and oxygen equipment in similar situations, that is, following the 36-month cap imposed by section 144(b) of MIPPA. However, since the changes to the payment rules for oxygen and oxygen equipment mandated by the DRA became effective in 2006 and the 36-month rental cap imposed by MIPPA was reached for the first time in January 2009, we have received many reports of beneficiaries relocating prior to the end of the 36-month rental payment cap period and having difficulty finding an oxygen supplier in the new location. We have learned that many suppliers are unwilling to provide services in situations where there are a few number of months left in the 36-month rental payment period.

We do not believe that beneficiaries have encountered similar issues following the 36-month rental cap, which most likely is the result of different statutory requirements for these two periods (that is, during and after the 36-month rental period). Section 1834(a)(5)(F)(ii) of the Act requires the supplier that furnishes the oxygen equipment during the 36-month rental payment period to continue furnishing the equipment after the 36-month rental payment period. Consistent with this requirement, we established regulations at § 414.226(f)(1) that require the supplier to furnish the equipment or make arrangements for furnishing the equipment in situations where the beneficiary relocates outside the supplier's normal service area. Since no such requirement currently applies in situations where the beneficiary relocates prior to the end of the 36-month rental payment period, and in fact current regulations at § 414.226(g)(1)(ii) absolve the supplier of the obligation to continue furnishing oxygen equipment in these situations, beneficiaries are experiencing difficulties finding suppliers of oxygen equipment in their new locations that are willing to accommodate them. As noted above, we have not seen this problem in the capped rental DME context. The requirement at § 414.226(g)(1) to furnish oxygen equipment for the entire 36-month rental cap period was established in the course of implementing section 5101(b) of the DRA in order to safeguard the beneficiary from situations where suppliers might discontinue service and pick up oxygen equipment prior to the end of the 36-month rental cap in order to avoid losing title to the equipment. As mentioned earlier, the transfer of title of oxygen and oxygen equipment after the 36th paid rental month was repealed. The exception to this rule at § 414.226(g)(1)(ii) was established based on our experience that suppliers of capped rental DME have accommodated beneficiaries in these situations, which, unfortunately, has not been our experience in the context of oxygen equipment.

In order to address this vulnerability facing beneficiaries as a result of regulations currently in effect, we proposed to revise the exception at § 414.226(g)(1)(ii) to apply only to situations where the beneficiary relocates before the 18th paid rental month to an area that is outside the normal service area of the supplier that initially furnished the equipment. We proposed to revise the regulation to require the supplier that furnishes the oxygen equipment and receives payment for month 18 or later to either furnish the equipment for the remainder of the 36-month rental payment period or, in the case where the beneficiary has relocated outside the service area of the supplier, make arrangements for furnishing the oxygen equipment with another supplier for the remainder of the 36-month rental payment period. The supplier that is required to furnish the equipment on the basis of this requirement must also furnish the equipment after the 36-month rental payment period in accordance with the requirements of section 1834(a)(5)(F)(ii) and § 414.226(f).

The proposed revision would mean that a supplier does not have to continue to furnish the oxygen equipment if the beneficiary relocates outside the normal service area before the 18th paid rental month during a period of continuous use. Under the current rule, a supplier does not have to furnish the oxygen equipment if the beneficiary relocated before the 36th paid rental month during a period of continuous use. The current rule was established based on the long term, demonstrated ability of suppliers of capped rental DME to accommodate beneficiaries in situations where they relocate near the end of a capped rental payment period.

Comment: We received a total of 8 comments on our proposal to require oxygen suppliers to continue to furnish medically necessary oxygen equipment for the remainder of the reasonable useful lifetime of the equipment to beneficiaries who relocate on or after the 18th rental month. All the comments were opposed to the proposed requirement. Some of the commenters questioned whether the statute gives us the authority to establish this requirement before the 36th month rental payment. Others objected to the financial and coordination-of-benefits burden they believe that this requirement would cause for suppliers. Other objections were that the proposed requirement did not consider the effect on beneficiaries who relocate on a temporary basis during winter months ("snow birds"), or the access problems that it might cause in rural areas. Recommended alternatives included starting the rental period over at the time of relocation or keeping the current policy that only requires suppliers to continue furnishing oxygen equipment to beneficiaries who relocate outside of their service area if 36 rental amounts have already been paid.

Response: In addition to considering the comments on the proposed rule, we analyzed complaint data from beneficiaries from January 2009 to September 2010 which is data collected by the regional offices. In the limited situations where beneficiaries receiving oxygen equipment for less than 36 months relocated during this time and initially had trouble locating an oxygen supplier in their new location, CMS caseworkers in the CMS Regional Offices and the Office of the Medicare Beneficiary Ombudsman were able to locate suppliers to serve each and every beneficiary, usually within a matter of days. This means that, although supply arrangements and/or access to oxygen and oxygen equipment in these situations may have been briefly delayed, suppliers stepped forward to provide access to oxygen and oxygen equipment in these situations. Based on this information and certain comments received, we have decided not to finalize this proposed revision at this time. If in the future, beneficiaries' access to oxygen equipment becomes a problem following the relocation of beneficiaries, we may consider this proposal or similar proposals.

H. Provider and Supplier Enrollment Issue: Air Ambulance Provision

The National Transportation Safety Board (NTSB) is an independent Federal agency charged by the Congress with investigating transportation accidents, determining their probable cause, and making recommendations to prevent

similar accidents from occurring. Based on information derived from testimony provided at the NTSB public hearing and investigations into recent helicopter air ambulance accidents, the NTSB made several specific recommendations to the Secretary on September 24, 2009.

Specifically, the NTSB recommended that the Secretary develop minimum safety accreditation standards for helicopter air ambulance operators that augment the operating standards of 14 CFR 135 by including for all flights with medical personnel on board: (a) Scenario-based pilot training; (b) implementation of preflight risk evaluation programs; and (c) the installation of FAA-approved terrain awareness warning systems, night vision imaging systems, flight data recording systems for monitoring and autopilots if a second pilot is not used.

In response to the NTSB concerns, the Secretary noted that the recommendations to CMS were similar to those being made to the Federal Aviation Administration (FAA). While we have expertise to regulate health and safety requirements that suppliers and providers of healthcare should meet, we do not have the expertise to determine aircraft safety requirements. The Secretary stated that, "we believe the FAA should determine the minimum level of safety that HEMS operators should meet and CMS should adopt regulations that require any HEMS operator that enrolls in Medicare to meet those requirements." The Secretary also added that, "while we do not believe CMS should augment FAA regulations, we do believe that CMS' regulations should ensure that only those HEMS operators that maintain the minimum level of requirements established by the FAA through its regulations are enrolled or maintain enrollment in the Medicare program." The FAA proposed Federal regulations to address the NTSB's concerns in their October 12, 2010 proposed rule (75 FR 62640) entitled "Air Ambulance and Commercial Helicopter Operations, Part 91 Helicopter Operations, and Part 135 Aircraft Operations; Safety Initiatives and Miscellaneous Amendments."

In the April 21, 2006 **Federal Register**, we published the "Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment" final rule. This final rule implemented section 1866(j)(1)(A) of the Act. In this final rule, we required that all providers and suppliers (other than physicians or practitioners who have elected to "opt-out" of the Medicare program) must complete an enrollment form and submit specific information to CMS in order to obtain Medicare billing privileges. Section 424.515 required that ambulance service providers continue to resubmit enrollment information in accordance with § 410.41(c)(2), which states, "Upon a carrier's request, complete and return the ambulance supplier form designated by CMS and provide the Medicare carrier with documentation of compliance with emergency vehicle and staff licensure and certification requirements in accordance with State and local laws." This final rule also established § 424.510(d)(2)(iii) which states, "Submission of all documentation, including all applicable Federal and State licensure and regulatory requirements that apply to the specific provider or supplier type related to providing health care services, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program."

While the Airline Deregulation Act (Pub. L. 95–504) preempts a State, political subdivision of a State, or political authority of at least two States from enacting or enforcing a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation, air ambulances remain subject to Federal laws and regulations. In accordance with § 424.516(a)(2), providers and suppliers must adhere to all Federal regulations and State laws and regulations, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare.

In § 424.510(d)(iii), we proposed to clarify that ambulance suppliers and other providers and suppliers include documentation regarding all applicable Federal and State certifications. Accordingly we proposed to revise § 424.510(d)(iii) from "Submission of all documentation, including all applicable Federal and State licenses and regulatory requirements that apply to the specific provider or supplier type that relate to providing health care service, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program," to "Submission of all documentation, including all applicable Federal and State licenses, certifications (including, but not limited to FAA certifications), and regulatory requirements that apply to the specific provider or supplier type that relate to providing health care service, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program." When revoked or suspended, we are requiring that the specific pilot certifications (for example, instrumentation and medical), and the airworthiness certifications be reported. We proposed to add new paragraph (e)(3) to clarify that Medicare enrolled providers and suppliers must report a revocation or suspension of a Federal or State license or certification, including but not limited to FAA certifications. The certifications, when revoked, that need to be reported are the specific pilot certifications, such as instrument and medical certified; as well as airworthiness certificates. This revision will clarify that fixed-wing ambulance operators and helicopter air ambulance operators are responsible for notifying the designated Medicare contractor for their State when FAA revokes or suspends any license or certification. Moreover, fixed-wing ambulance operators and helicopter air ambulance operators must maintain all requirements as specified in 14 CFR parts 91, 119, and 135.

We stated our belief that requiring fixed wing ambulance and helicopter air ambulance operators to notify their Medicare contractor of a suspension or revocation of a license or certification will ensure that any action taken by the FAA or other regulating authority will have a direct link to the operator's ability to maintain their Medicare enrollment. We also stated that such a policy will help improve aircraft safety for operators that are enrolled in Medicare and providing services to Medicare beneficiaries. We believe that allowing providers and suppliers to self-report licensure or certification revocations and suspensions within a 30 day period via the Medicare enrollment application (such as, the Internet-based Provider Enrollment Chain and Ownership System (PECOS) or the paper CMS–855) promotes compliance with the Medicare reporting requirements found in § 424.516. In addition, by reporting a licensure or certification revocation or suspension within 30 days, the provider or supplier avoids the Medicare contractor bringing an action to revoke its Medicare billing privileges and establishing a Medicare enrollment bar, see § 424.535(c). Thus,

by complying with the reporting responsibilities found in § 424.516 and voluntarily terminating from the Medicare program, the air ambulance supplier can submit an initial application to enroll in the Medicare program as soon as the licensure or certification revocation or suspension action is resolved with the applicable licensing or certification organization. If the supplier does not self-report a licensure, certification revocation or a suspension action, then the supplier's enrollment in the Medicare program will be automatically revoked for a period of one to three years.

In § 424.502, we proposed to define the term, "voluntary termination" as it is currently used in the Medicare program and throughout this regulation in the context of the provider enrollment requirements: We proposed that the term, "voluntary termination" means an air ambulance supplier that submits written confirmation to CMS of its decision to discontinue enrollment in the Medicare program.

Furthermore, we stated our belief that an air ambulance supplier can make the decision to voluntarily terminate their business relationship with the Medicare program at any time, including when the provider or supplier makes the decision that they will no longer furnish services to Medicare beneficiaries. In those situations, where an air ambulance supplier does not meet their reporting responsibilities and notify the Medicare program of a Federal or State licensure or certification revocation or suspension within 30 days of the reportable event, we believe that it is appropriate that CMS or the Medicare contractor revoke the supplier's Medicare billing privileges using § 424.535(a)(1). We believe that this change will clarify that CMS or our Medicare contractor may revoke Medicare billing privileges when these types of suppliers do not report a revocation or suspension of a Federal or State license or certification.

Comment: Several comments received agreed with CMS' enrollment requirements and believe the FAA has the appropriate resources to develop, monitor, and enforce aviation or aviation safety related standards. The commenters believe that the sole authority of the FAA to regulate matters of aviation safety assures continuity in regulations and further believe any change to the authority would have serious consequences for safe operations since CMS lacks the expertise and resources to develop and enforce such standards.

Response: We agree with the commenters; and therefore, are finalizing the proposal without modification.

Comment: Several commenters believe CMS missed an opportunity through this proposed rule to improve system safety for Medicare beneficiaries through an accreditation process.

Response: Currently, we do not have the statutory authority to establish an accreditation program for fixed-wing air ambulance operators and air ambulance operators.

Comment: Several commenters noted that the preamble language might cause confusion as stated, "fixed-wing air ambulance operators and HEMS operators must maintain all requirements as specified in 14 CFR part 135."

Response: We are clarifying that all fixed-wing air ambulance operators and helicopter air ambulance operators must adhere to all applicable FAA regulations as specified in 14 CFR parts 91, 119 and 135 or risk having their Medicare enrollment revoked or suspended.

I. Technical Corrections

1. Physical Therapy, Occupational Therapy and Speech-Language Pathology

We proposed to revise § 409.23(c) by making a minor technical correction to remove an extraneous cross-reference which was initially proposed in the CY 2008 PFS proposed rule (72 FR 38122, 72 FR 38193, and 72 FR 38221). This cross-reference refers the reader to "paragraph (c)(1)(ii) of this section," a paragraph also proposed in the CY 2008 PFS proposed rule, but never finalized. In the CY 2008 PFS final rule with comment period, we inadvertently neglected to remove the associated cross-reference from the regulations text. Therefore, we proposed to rectify that oversight by making an appropriate correction in the regulations text, along with other minor formatting revisions by making the following changes:

- To make a minor clarification to the section heading and introductory text of § 409.23 (along with a conforming revision to the corresponding regulations text at § 409.20(a)(3)) by revising the existing phrase "speech therapy" to read "speech-language pathology services," so that it more accurately reflects the currently used terminology for this type of therapeutic treatment.
- To make a minor wording change in the provision at § 409.17(d) (which is incorporated by reference in § 409.23(c)(2)), in order to clarify that the former provision's reference to "hospital" policies and procedures can alternatively refer, depending on the particular context, to SNF policies and procedures.

We did not receive public comment on this proposal; and therefore, are finalizing this proposal without modification.

2. Scope of Benefits

Currently, § 410.3(b)(2) states that the specific rules on payment are set forth in subpart E of part 410. However, the specific payment rules are actually listed in subpart I of part 410. Therefore, we proposed correct this referencing error by making a technical correction to § 410.3(b)(2).

We did not receive public comment on this proposal; and therefore, are finalizing this proposal without modification.

J. Physician Self-Referral Prohibition: Annual Update to the List of CPT/HCPCS Codes

1. General

Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain designated health services (DHS) to an entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare or billing the beneficiary or any other entity for Medicare DHS that are furnished as a result of a prohibited referral.

Section 1877(h)(6) of the Act and § 411.351 of our regulations specify that the following services are DHS:

- Clinical laboratory services.
- Physical therapy services.
- Occupational therapy services.
- Outpatient speech-language pathology services.
- Radiology services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

2. Annual Update to the Code List

a. Background

In § 411.351, we specify that the entire scope of four DHS categories is defined in a list of CPT/HCPCS codes (the Code List), which is updated annually to account for changes in the most recent CPT and HCPCS

publications. The DHS categories defined and updated in this manner are:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.

The Code List also identifies those items and services that may qualify for either of the following two exceptions to the physician self-referral prohibition:

- Dialysis-related drugs furnished in or by an ESRD facility (§ 411.355(g)).
- Preventive screening tests, immunizations, or vaccines (§ 411.355(h)).

The Code List was last updated in Addendum I of the CY 2010 PFS final rule with comment period (74 FR 62177 through 62188) and revised in a subsequent correction notice (75 FR 26350).

b. Response to Comments

We received no public comments relating to the Code List that became effective January 1, 2010.

c. Revisions Effective for 2011

The updated, comprehensive Code List effective January 1, 2011 appears as Addendum J in this final rule with comment period and is available on our Web site at *http://www.cms.gov/PhysicianSelfReferral/40_List_of_Codes.asp#TopOfPage.* Additions and deletions to the Code List conform the Code List to the most recent publications of CPT and HCPCS and to changes in Medicare coverage policy and payment status.

Tables 98 and 99 identify the additions and deletions, respectively, to the comprehensive Code List that became effective January 1, 2010. Tables 98 and 99 also identify the additions and deletions to the list of codes used to identify the items and services that may qualify for the exception in § 411.355(g) (regarding dialysis-related outpatient prescription drugs furnished in or by an ESRD facility) and in § 411.355(h) (regarding preventive screening tests, immunizations, and vaccines).

In Table 98, we specify additions that reflect new CPT and HCPCS codes that become effective January 1, 2011, or that became effective since our last update. We also include additions that reflect changes in Medicare coverage policy or payment status that become effective January l, 2011, or that became effective since our last update.

Table 99 reflects the deletions necessary to conform the Code List to the most recent publications of the CPT and HCPCS and to changes in Medicare coverage policy and payment status. In addition, we are deleting CPT codes 94667 and 94668 (Chest wall manipulation) from the category of "physical therapy, occupational therapy, and outpatient speech-language pathology services" because these services are not generally considered to be physical therapy services. Also, we are deleting CPT code 77014 (CT scan for therapy guide) from the category "radiology and certain other imaging services." This service is always integral to the performance of, and performed during, a non-radiological medical procedure. Therefore, under § 411.351, this service is excluded from the definition of "radiology and certain other imaging services."

Lastly, we are deleting the drugs currently listed as qualifying for the exception for "EPO and other dialysis-related drugs" furnished in or by an ESRD facility. Beginning January 1, 2011, EPO and other dialysis-related drugs furnished by an ESRD facility (except drugs for which there are no injectable equivalents or other forms of administration) will be paid under the ESRD PPS promulgated in the final rule published on August 12, 2010 in the **Federal Register** (75 FR 49030). Drugs for which there are no injectable equivalents or other forms of administration will be payable under the ESRD PPS beginning January 1, 2014. The definition of DHS at § 411.351 excludes services that are reimbursed by Medicare as part of a composite rate (unless the services are specifically identified as DHS and are themselves payable through a composite rate, such as home health and inpatient and outpatient hospital services). Accordingly, EPO and other dialysis-related outpatient prescription drugs furnished by an ESRD facility (except drugs for which there are no injectable equivalents or other forms of administration) will not be DHS beginning January 1, 2011. When dialysis-related drugs for which there are no injectable equivalents or other forms of administration are bundled into the ESRD PPS beginning January 1, 2014, and furnished by an ESRD facility, they will no longer meet the definition of DHS and, therefore, will not be subject to the physician self-referral prohibition. In the meantime, those drugs remain DHS. If we determine that any of those drugs may qualify for the exception for dialysis-related drugs at 411.355(g), we will announce them through the annual update to the Code List that appears in the PFS final rule.

We will consider comments regarding the codes listed in Tables 98 and 99. Comments will be considered if we receive them by the date specified in the DATES section of this final rule with comment period. We will not consider any comment that advocates a substantive change to any of the DHS defined in § 411.351.

TABLE 98 ADDITIONS TO THE PHYSICIAN SELF-REFERRAL LIST OF CPT[1]/HCPCS CODES

Code	Description
CLINICAL LABORATORY SERVICES	
0058T	Cryopreservation ovary tiss.
0059T	Cryopreservation oocyte.
G0432	EIA HIV–1/HIV–2 screen.
G0433	ELISA HIV–1/HIV–2 screen.
G0434	Drug screen multi drug class.
G0435	Oral HIV–1/HIV–2 screen.
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
95992	Canalith repositioning proc.
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
72159	Mr angio spine w/o&w/dye.
73225	Mr angio upr extr w/o&w/dye.
74176	Ct angio abd & pelvis.
74177	Ct angio abd&pelv w/contrast.
74178	Ct angio abd & pelv 1+ regns.
76881	Us xtr non-vasc complete.
76882	Us xtr non-vasc lmtd.
92132	Cmptr ophth dx img ant segmt.
92133	Cmptr ophth img optic nerve.
92134	Cptr ophth dx img post segmt.
92227	Remote dx retinal imaging.
92228	Remote retinal imaging mgmt.
RADIATION THERAPY SERVICES AND SUPPLIES	
49327	Lap ins device for rt.
49412	Ins device for rt guide open.
57156	Ins vag brachytx device.
A4650	Implant radiation dosimeter.
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
[No additions]	
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
90662	Flu vacc prsv free inc antig.
90670	Pneumococcal vacc 13 val im.
G0432	EIA HIV–1/HIV–2 screen.
G0433	ELISA HIV–1/HIV–2 screen.
G0435	Oral HIV–1/HIV–2 screen.
Q2035	Afluria vacc, 3 yrs & >, im.
Q2036	Flulaval vacc, 3 yrs & >, im.
Q2037	Fluvirin vacc, 3 yrs & >, im.
Q2038	Fluzone vacc, 3 yrs & >, im.
Q2039	NOS flu vacc, 3 yrs & >, im.

[1] CPT codes and descriptions only are copyright 2010 AMA. All rights are reserved and applicable FARS/DFARS clauses apply.

TABLE 99—DELETIONS TO THE PHYSICIAN SELF-REFERRAL LIST OF CPT[1] HCPCS CODES

CLINICAL LABORATORY SERVICES	
0104T	At rest cardio gas rebreathe.
0140T	Exhaled breath condensate ph.
G0430	Drug screen multi class.
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
94667	Chest wall manipulation.
94668	Chest wall manipulation.
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
76150	X-ray exam, dry process.
76880	Us exam, extremity.
77014	Ct scan for therapy guide.
RADIATION THERAPY SERVICES AND SUPPLIES	
[No deletions].	
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
J0630	Calcitonin salmon injection.
J0636	Inj calcitriol per 0.1 mcg.
J0882	Darbepoetin alfa, esrd use.
J0895	Deferoxamine mesylate inj.
J1270	Injection, doxercalciferol.
J1750	Inj iron dextran.
J1756	Iron sucrose injection.
J1955	Inj levocarnitine per 1 gm.
J2501	Paricalcitol.
J2916	Na ferric gluconate complex.
J2993	Reteplase injection.
J2995	Inj streptokinase/250000 IU.
J2997	Alteplase recombinant.
J3364	Urokinase 5000 IU injection.
P9041	Albumin (human), 5%, 50 ml.
P9045	Albumin (human), 5%, 250 ml.
P9046	Albumin (human), 25%, 20 ml.
P9047	Albumin (human), 25%, 50 ml.
Q0139	Ferumoxytol, esrd use.
Q4081	Epoetin alfa, 100 units ESRD.
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
90658	Flu vaccine, 3 yrs & >, im.

[1] CPT codes and descriptions only are copyright 2010 AMA. All rights are reserved and applicable FARS/DFARS clauses apply.

VIII. Waiver of Proposed Rulemaking and Delay in Effective Date

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

We utilize HCPCS codes for Medicare payment purposes. The HCPCS is a national drug coding system comprised of Level I (CPT) codes and Level II (HCPCS National Codes) that are intended to provide uniformity to coding procedures, services, and supplies across all types of medical providers and suppliers. Level I (CPT) codes are copyrighted by the AMA and consist of several categories, including Category I codes which are 5-digit numeric codes, and Category III codes which are temporary codes to track emerging technology, services, and procedures.

The AMA issues an annual update of the CPT code set each Fall, with January 1 as the effective date for implementing the updated CPT codes. The HCPCS, including both Level I and Level II codes, is similarly updated annually on a CY basis. Annual coding changes are not available to the public until the Fall immediately preceding the annual January update of the PFS. Because of the timing of the release of these new codes, it is impracticable for us to provide prior notice and solicit comment on these codes and the RVUs assigned to them in advance of publication of the final rule that implements the PFS. Yet, it is imperative that these coding changes be accounted for and recognized timely under the PFS for payment because services represented by these codes will be provided to Medicare beneficiaries by physicians during the CY in which they become effective. Moreover, regulations implementing HIPAA (42 CFR parts 160 and 162) require that the HCPCS be used to report health care services, including services paid under the PFS. We also assign interim RVUs to any new codes based on a review of the AMA RUC recommendations for valuing these services. By reviewing these AMA RUC recommendations for the new codes, we are able to assign RVUs to services based on input from the medical community and to establish payment for them, on an interim basis, that corresponds to the relative resources associated with furnishing the services. We are also able to determine, on an interim final basis, whether the codes will be subject other payment policies. If we did not assign RVUs to new codes on an interim basis, the alternative would be to either not pay for these services during the initial CY or have each Medicare contractor establish a payment rate for these new codes. We believe both of these alternatives are contrary to the public interest, particularly since the AMA RUC process allows for an assessment of the valuation of these services by the medical community prior to our establishing payment for these codes on an interim basis. Therefore, we believe it would be contrary to the public interest to delay establishment of fee schedule payment amounts for these codes.

For the reasons outlined above in this section, we find good cause to waive the notice of proposed rulemaking for the interim RVUs for selected procedure codes identified in Addendum C and to establish RVUs for these codes on an interim final basis. We are providing a 60-day public comment period.

Section II.C. of this final rule with comment period discusses the identification and review of potentially misvalued codes by the AMA RUC, as well as our review and decisions regarding the AMA RUC recommendations. Similar to the AMA RUC recommendations for new and revised codes discussed above, due to the timing of the AMA RUC recommendations for the potentially misvalued codes, it was impracticable for CMS to solicit public comment regarding specific proposals for revision prior to this final rule with comment period. We believe it is in the public interest to implement the revised RVUs for the codes that were identified as misvalued, and that have been reviewed and re-evaluated by the AMA RUC, on an interim final basis for CY 2011. The revisions of RVUs for these codes will establish a more appropriate payment that better corresponds to the relative resources associated with furnishing these services. A delay in implementing revised values for these misvalued codes would not only perpetuate the known misvaluation for these services, it would also perpetuate a distortion in the payment for other services under the PFS. Implementing the changes now allows for a more equitable distribution of payments across all PFS services. We believe a delay in implementation of these revisions would be contrary to the public interest, particularly since the AMA RUC process allows for an assessment of the valuation of these services by the medical community prior to the AMA RUC's recommendation to CMS. For the reasons described above, we find good cause to waive notice and comment procedures with respect to the misvalued codes identified in Tables 53, 54, and 55, and to revise RVUs for these codes on an interim final basis. We are

providing a 60-day public comment period.

Furthermore, in this final rule with comment period, we are making a technical revision to § 410.64 (Additional Preventive Services) to conform with section 1861(ddd)(1), as amended by section 4104 of the ACA. We are revising § 410.64(a) by removing the words "not otherwise described in this subpart" and adding the words "not described in subparagraphs (1) or (3) of § 410.2 of this subpart" in their place. This change reflects section 1861(ddd)(1) of the Act (as amended by section 4104(a)(2) of the ACA). While this change was not discussed in the CY 2011 PFS proposed rule (74 FR 40129), we are making this change pursuant to the "good cause" exception to APA notice and comment rulemaking. Under the good cause exception, public participation procedures are not required "when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefore in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest" (5 U.S.C. 553(b)). Section 410.64(a) previously reflected section 1861(ddd)(1) of the Act, which was subsequently amended. The revision to the regulations merely incorporates the new statutory language for consistency, and is not an interpretation or clarification. Therefore, we believe it is appropriate to waive advanced notice and public comment on this change for good cause, due to the technical nature of the revision to the regulations.

We ordinarily provide a 60-day delay in the effective date of the provisions of a rule in accordance with the Administrative Procedure Act (APA) (5 U.S.C. 553(d)), which requires a 30-day delayed effective date, and the Congressional Review Act (5 U.S.C. 801(a)(3)), which requires a 60-day delayed effective date for major rules. However, we can waive the delay in the effective date if the Secretary finds, for good cause, that the delay is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons in the rule issued (5 U.S.C. 553(d)(3); 5 U.S.C. 808(2)).

IX. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

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

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

A. ICRs Regarding Diagnostic X-ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions (§ 410.32)

Section 410.32(d)(2)(i) requires the physician or qualified nonphysician practitioner (as defined in § 410.32(a)(2)) who orders the service must maintain documentation of medical necessity in the beneficiary's medical record. In addition, both the medical record and the laboratory requisition (or order) would be required to be signed by the physician or qualified nonphysician practitioner (as defined in § 410.32(a)(2)) who orders the service. The burden associated with these requirements would be the time and effort necessary for a physician or qualified nonphysician practitioner to sign the medical record or laboratory requisition (or order). There is also a recordkeeping requirement associated with maintaining the documentation of medical necessity in the beneficiary medical record. While these recordkeeping and reporting requirements are subject to the PRA, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with the aforementioned information collection requirements is incurred by persons in the normal course of their activities and therefore considered to be usual and customary business practices.

B. ICRs Regarding General Exceptions to the Referral Prohibition Related to Both Ownership/Investment and Compensation (§ 411.355)

Section 411.355(b)(7)(i) states that with respect to magnetic resonance imaging, computed tomography, and positron emission tomography, the referring physician must provide written notice to the patient at the time of the referral that the patient may receive the same services from a person other than one described in § 411.355(b)(1). The written notice must include a list of other suppliers (as defined in § 400.202 of this title) that provide the services for which the individual is being referred. In response to public comments received, we are finalizing this provision to require that the list must include a minimum of 5 suppliers within a 25-mile radius of the referring physician's office location at the time of the referral, rather than the proposed 10 suppliers. The notice should be written in a manner sufficient to be reasonably understood by all patients and should include for each supplier on the list, at a minimum, the supplier's name, address, and telephone number.

This rule finalizes section 411.355(b)(7)(ii) to state that if the referring physician makes a referral within an area with fewer than 5 other suppliers within the 25-mile radius of the physician's office location at the time of the referral, the physician shall list all of the other suppliers of the imaging service that are present within a 25-mile radius of the referring physician's office location. Provision of the written list of alternate suppliers will not be required if no other suppliers provide the services for which the individual is being referred within the 25-mile radius. These physicians must still disclose to the patient that the patient may receive these services from a person other than one described in § 411.355(b)(1) in a manner sufficient to reasonably be understood by all patients.

The burden associated with the requirements contained in this section would be the time and effort necessary for a physician to develop a standard disclosure. There would also be burden associated with the time and effort necessary for a physician to provide the disclosure to the patient. Based upon public comments received, we have removed the requirement that a physician must obtain the patient's signature on the disclosure and maintain a copy of this document in the medical record. Physicians must retain adequate assurance that the information was shared with the patient so that this information can be verified.

Our estimate that it would take 1 hour for a physician's office to develop a standard disclosure remains the same in this final rule with comment to account for physicians drafting the disclosure notice and listing the 5 alternate

suppliers. Our estimate that 71,000 physicians will be required to comply with these requirements remains unchanged from the proposed rule. The total burden associated with the development of the standard disclosure remains 71,000 hours at a cost of $1,042,280. Although the physician no longer must have the patient sign the disclosure and enter it into the medical record, we have not changed the estimate that it will take each physician 1 minute to provide the disclosure to the patient. Each provider will make approximately 106 disclosures. The total estimated annual burden for this requirement remains 125,433 hours at a cost of $10,536,400.

C. ICRs Regarding Appeals Process for Termination of Competitive Bidding Contract (§ 414.423)

Section 414.423(c)(1)(i) states that CMS has the option to allow a DMEPOS supplier to provide a written CAP to remedy the deficiencies identified in the notice, when CMS determines that the delay in the termination date caused by allowing a CAP will not cause harm to beneficiaries. As stated in § 414.423(c)(2)(i) a CAP must be submitted within 30 calendar days from the date on the notification letter. If the supplier decides not to submit a CAP the supplier may within 30 days of the date on the termination letter request a hearing by a CBIC hearing officer.

The burden associated with this requirement is the time and effort necessary for a supplier that has received a termination notice to develop and submit a CAP. We estimate that 10 suppliers will need to comply with this requirement annually. Similarly, we estimate that it will take a supplier an average of 3 hours to develop a CAP. The total estimated annual burden associated with this requirement is 30 hours at a cost of $2,250.

Section 414.423(e)(2) requires that if CMS accepts the CAP, including supplier's designated timeframe for its completion, the supplier must provide a follow-up report within 5 days after the supplier has fully implemented the CAP that verifies that all of the deficiencies identified in the CAP have been corrected in accordance with the timeframes accepted by CMS. The burden associated with this requirement is the time and effort necessary for a supplier to develop and submit a follow-up report. While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.3(h)(6). In accordance with 5 CFR 1320.3(h)(6), a request for facts or opinions addressed to a single person is not defined as information collection requirements and is therefore exempt from the PRA.

Section 414.423(f)(1) states that a supplier who has received a notice that CMS considers them in breach of contract or that their CAP is not acceptable has the right to request a hearing before a CBIC HO who was not involved with the original determination. Section 414.423(f)(2) further specifies that a supplier who wishes to appeal the termination notice must submit a written request to the CBIC. The request for a hearing must be received by the CBIC within 30 calendar days from the date of the notice to terminate.

The burden associated with this section is the time and effort necessary for a supplier to develop and submit a written request for a hearing by a CBIC Hearing Officer. We estimate that it will take a supplier 8 hours to develop and submit a request for a hearing. We believe 5 suppliers will be subject to this requirement on an annual basis. The total estimated annual burden associated with developing and submitting a written request for a hearing by a CBIC Hearing Officer is 40 hours at a cost of $3,000.

Section 414.423 requires a contract supplier whose contract has been terminated to notify all beneficiaries who are receiving rented competitive bid items or competitive bid items received on a recurring basis, of the termination of their contract. The notice to the beneficiary from the supplier whose contract was terminated must be provided within 5 days of receipt of the notice of termination. The notification to the beneficiaries must inform the beneficiaries that they are going to have to select a new contract supplier for these items.

The burden associated with this section is the time and effort necessary for a supplier to develop and distribute notification of its termination to all beneficiaries receiving rented competitive bid items or competitive bid items received on a recurring basis. We estimate that it will take a supplier 3 hours to develop and distribute a notice announcing its termination to all of its beneficiaries receiving rented competitive bid items or competitive bid items received on a recurring basis. We believe 2 suppliers will be subject to this requirement on an annual basis. The total estimated annual burden associated with this requirement is 6 hours at a cost of $450.

D. ICRs Regarding Additional Provider and Supplier Requirements for Enrolling and Maintaining Active Enrollment Status in the Medicare Program (§ 424.516)

Section 424.516(e)(2) would require a provider or supplier to report a revocation or suspension to the applicable Medicare contractor within 30 days of any revocation or suspension of a Federal or State license or certification. Similarly, proposed § 424.516(e)(2) states that within 30 days of a voluntary withdrawal or involuntary termination from the Medicare program, the provider or supplier must report a voluntary withdrawal or involuntary termination to the applicable Medicare contractor. The burden associated with the requirements in § 424.516(e)(2) and (3) is the time and effort necessary for a provider or supplier to report the required information to the applicable Medicare contractor. While these requirements are subject to the PRA, each submission will be evaluated on a case-by-case basis.

TABLE 100—ESTIMATED ANNUAL RECORDKEEPING AND REPORTING BURDEN

Regulation section(s)	OMB control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting (in $)	Total labor cost of reporting (in $)	Total capital/maintenance costs (in $)	Total cost (in $)
§ 411.355	0938–New	71,000	71,000	1	71,000	14.68	1,042,280	0	1,042,280
		71,000	7,454,760	0.0167	125,433	83.79	*10,536,400	0	10,536,400
§ 414.423	0938–New	10	10	3	30	75.00	2,250	0	2,250
		5	5	8	40	75.00	3000	0	3000
		2	2	3	6	75.00	450	0	450

TABLE 100—ESTIMATED ANNUAL RECORDKEEPING AND REPORTING BURDEN—Continued

Regulation section(s)	OMB control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting (in $)	Total labor cost of reporting (in $)	Total capital/ maintenance costs (in $)	Total cost (in $)
Total	....	71,017	7,525,777	....	196,509	....	....	....	11,584,380

* The annual cost burden for this provision was calculated by taking 106 disclosures per year per physician x $1.40 per disclosure = $148.40 a year per physician x 71,000 physicians = $10,536,400.

E. Additional Information Collection Requirements

This final rule with comment period imposes collection of information requirements as outlined in the regulation text and specified above. However, this final rule with comment period also makes reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

1. Part B Drug Payment

The discussion of average sales price (ASP) issues in section VII.A.1 of this final rule with comment period does not contain any new information collection requirements with respect to payment for Medicare Part B drugs and biologicals under the ASP methodology. Drug manufacturers are required to submit ASP data to us on a quarterly basis. The ASP reporting requirements are set forth in section 1927(b) of the Act. The burden associated with this requirement is the time and effort required by manufacturers of Medicare Part B drugs and biologicals to calculate, record, and submit the required data to CMS. While the burden associated with this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0921 with a June 31, 2012, expiration date.

2. The Physician Quality Reporting System (Formerly the Physician Quality Reporting Initiative (PQRI))

Section VII.F.1. of this final rule with comment period discusses the background of the Physician Quality Reporting System, provides information about the measures and reporting mechanisms that will be available to eligible professionals and group practices who choose to participate in the 2011 Physician Quality Reporting System, and the criteria for satisfactory reporting in 2011.

With respect to satisfactory submission of data on quality measures by eligible professionals, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(c) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. Eligible professionals may choose whether to participate and, to the extent they satisfactorily submit data on quality measures for covered professional services, they can qualify to receive an incentive payment. To qualify to receive an incentive payment for 2011, the eligible professional (or group practice) must meet one of the criteria for satisfactory reporting described in section VII.F.1.e. or VII.F.1.f. of this final rule with comment period (or section VII.F.1.g. for group practices).

Because this is a voluntary program, it is difficult to accurately estimate how many eligible professionals will opt to participate in the Physician Quality Reporting System in CY 2011. Information from the "Physician Quality Reporting System 2007 Reporting Experience Report," which is available on the Physician Quality Reporting System section of the CMS Web site at *http://www.cms.hhs.gov/pqri,* indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit Physician Quality Reporting System quality measures data via claims for the 2007 Physician Quality Reporting System. Therefore, for purposes of conducting a burden analysis for the 2011 Physician Quality Reporting System, we will assume that all eligible professionals who attempted to participate in the 2007 Physician Quality Reporting System will also attempt to participate in the 2011 Physician Quality Reporting System. Furthermore, we believe that the burden for eligible professionals who are participating in the Physician Quality Reporting System for the first time in 2011 will be considerably higher than the burden for eligible professionals who have participated in the Physician Quality Reporting System in prior years.

For individual eligible professionals, the burden associated with the requirements of this reporting initiative is the time and effort associated with eligible professionals identifying applicable Physician Quality Reporting System quality measures for which they can report the necessary information, collecting the necessary information, and reporting the information needed to report the eligible professional's or group practice's measures. We believe it is difficult to accurately quantify the burden because eligible professionals may have different processes for integrating the Physician Quality Reporting System into their practice's work flows. Moreover, the time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them, and incorporate the use of quality data codes into the office work flows is expected to vary along with the number of measures that are potentially applicable to a given professional's practice. Since eligible professionals are generally required to report on at least 3 measures to earn a Physician Quality Reporting System incentive, we will assume that each eligible professional who attempts to submit Physician Quality Reporting System quality measures data is attempting to earn a Physician Quality Reporting System incentive payment and reports on an average of 3 measures for this burden analysis.

Because we anticipate even greater participation in the 2011 Physician Quality Reporting System than in previous years, including participation by eligible professionals who are participating in the Physician Quality Reporting System for the first time in 2011, we will assign 5 hours as the amount of time needed for eligible professionals to review the 2011 Physician Quality Reporting System Measures List, review the various reporting options, select the most appropriate reporting option, identify the applicable measures or measures groups for which they can report the necessary information, review the measure specifications for the selected measures or measures groups, and incorporate reporting of the selected measures or measures groups into the office work flows. This estimate is based on our assumption that an eligible professional will need up to 2 hours to review the 2011 Physician Quality Reporting System Measures List, review the reporting options, and select a reporting option and measures on which

to report and 3 hours to review the measure specifications for up to 3 selected measures or up to 1 selected measures group and to develop a mechanism for incorporating reporting of the selected measures or measures group into the office work flows.

Information from the PVRP, which was a predecessor to the Physician Quality Reporting System, indicated an average labor cost of $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $58 per hour in our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we estimate the cost for an eligible professional associated with preparing to report Physician Quality Reporting System quality measures would be approximately $290 per eligible professional ($58 per hour x 5 hours).

We continue to expect the ongoing costs associated with Physician Quality Reporting System participation to decline based on an eligible professional's familiarity with and understanding of the Physician Quality Reporting System, experience with participating in the Physician Quality Reporting System, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices.

We believe the burden associated with actually reporting the Physician Quality Reporting System quality measures will vary depending on the reporting mechanism selected by the eligible professional. For claims-based reporting, eligible professionals must gather the required information, select the appropriate QDCs, and include the appropriate QDCs on the claims they submit for payment. The Physician Quality Reporting System will collect QDCs as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500 (OCN: 0938–0999). We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 2011.

Based on our experience with the PVRP, we continue to estimate that the time needed to perform all the steps necessary to report each measure (that is, reporting the relevant quality data code(s) for a measure) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/or measures, with the median time being 1.75 minutes. At an average labor cost of $58 per hour per practice, the cost associated with this burden ranges from $0.24 in labor to about $11.60 in labor time for more complicated cases and/or measures, with the cost for the median practice being $1.69.

The total estimated annual burden for this requirement will also vary along with the volume of claims on which quality data is reported. In previous years, when we required reporting on 80 percent of eligible cases for claims-based reporting, we found that on average, the median number of reporting instances for each of the Physician Quality Reporting System measures was 9. Since we proposed to reduce the required reporting rate by over one-third to 50 percent, then for purposes of this burden analysis we will assume that an eligible professional will need to report each selected measure for 6 reporting instances. The actual number of cases on which an eligible professional would be required to report quality measures data will vary, however, with the eligible professional's patient population and the types of measures on which the eligible professional chooses to report (each measure's specifications includes a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual reporting burden per eligible professional associated with claims-based reporting to range from 4.5 minutes (0.25 minutes per measure × 3 measures × 6 cases per measure) to 180 minutes (12 minutes per measure × 3 measures × 6 cases per measure), with the burden to the median practice being 31.5 minutes (1.75 minutes per measure × 3 measures × 6 cases). We estimate the total annual reporting cost per eligible professional associated with claims-based reporting to range from $4.32 ($0.24 per measure × 3 measures × 6 cases per measure) to $208.80 ($11.60 per measure × 3 measures × 6 cases per measure), with the cost to the median practice being $30.42 per eligible professional ($1.69 per measure × 3 measures × 6 cases per measure).

For registry-based reporting, there would be no additional time burden for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes and the registry would merely be re-packaging the data for use in the Physician Quality Reporting System. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2011 Physician Quality Reporting System. However, eligible professionals would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes per eligible professional.

Registries interested in submitting quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf in 2011 will need to complete a self-nomination process in order to be considered "qualified" to submit on behalf of eligible professionals unless the registry was qualified to submit on behalf of eligible professionals for prior years and did so successfully. We estimate that the self-nomination process for qualifying additional registries to submit on behalf of eligible professionals for the 2011 Physician Quality Reporting System involves approximately 1 hour per registry to draft the letter of intent for self-nomination. It is estimated that each self-nominated entity will also spend 2 hours for the interview with CMS officials and 2 hours calculating numerators, denominators, and measure results for each measure the registry wishes to report using a CMS-provided measure flow. However, the time it takes to complete the measure flow could vary depending on the registry's experience and the number and type of measures for which the registry wishes to submit on behalf of eligible professionals. Additionally, part of the self-nomination process involves the completion of an XML submission by the registry, which is estimated to take approximately 5 hours, but may vary depending on the registry's experience. We estimate that the registry staff involved in the registry self-nomination process have an average labor cost of $50 per hour. Therefore, assuming the total burden hours per registry associated with the registry self-nomination process is 10 hours, we estimate the total cost to a registry associated with the registry self-nomination process to be approximately $500 ($50 per hour × 10 hours per registry).

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating quality measures results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measures results, and submit the measures results and numerator and denominator data on the quality

measures on their participants' behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, we believe that registries already perform many of these activities for their participants. The number of measures that the registry intends to report to CMS and how similar the registry's measures are to CMS' Physician Quality Reporting System measures will determine the time burden to the registry.

For EHR-based reporting, the eligible professional must have access to a CMS-specified identity management system, such as IACS, which we believe takes less than 1 hour to obtain. Once an eligible professional has an account for this CMS-specified identity management system, he or she must extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. With respect to our requirement for an eligible professional to submit a test file, we believe that doing so would take less than 1 hour. With respect to submitting the actual 2011 data file in 2012, we believe that this would take an eligible professional no more than 2 hours, depending on the number of patients on which the eligible professional is submitting. We believe that once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on Physician Quality Reporting System quality measures should be minimal. Because this manner of reporting quality data to CMS was new to the Physician Quality Reporting System for 2010 and no EHR data submissions have taken place yet, it is difficult to estimate how many eligible professionals will opt to participate in the Physician Quality Reporting System through the EHR mechanism in CY 2011.

An EHR vendor interested in having their product(s) be used by eligible professionals to submit Physician Quality Reporting System quality measures data to CMS was required to complete a self-nomination process in order for the vendor's product(s) to be considered "qualified" for 2011. It is difficult to accurately quantify the burden associated with the EHR self-nomination process as there is variation regarding the technical capabilities and experience among vendors. For purposes of this burden analysis, however, we estimate that the time required for an EHR vendor to complete the self-nomination process will be similar to the time required for registries to self-nominate, that is approximately 10 hours at $50 per hour for a total of $500 per EHR vendor ($50 per hour × 10 hours per EHR vendor).

The burden associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2010 Physician Quality Reporting System quality measures will be dependent on the EHR vendor's familiarity with the Physician Quality Reporting System, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total burden hours to be 40 hours at a rate of $50 per hour for a total burden estimate of $2,000 ($50 per hour × 40 hours per vendor). However, given the variability in the capabilities of the vendors, those vendors with minimal experience would have a burden of approximately 200 hours at $50 per hour, for a total estimate of $10,000 per vendor ($50 per hour × 200 hours per EHR vendor).

With respect to the process for group practices to be treated as satisfactorily submitting quality measures data under the 2011 Physician Quality Reporting System discussed in section VII.F.1. of this final rule with comment, group practices interested in participating in the 2011 Physician Quality Reporting System through one of the group practice reporting options (GPRO I or GPRO II) will need to complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. Therefore, assuming 2 hours for a group practice to decide whether to participate as a group or individually, approximately 2 hours per group practice to draft the letter of intent for self-nomination, gather the requested information, and provide this requested information, and an additional 2 hours undergoing the vetting process with CMS officials, we estimate a total of 6 hours associated with the self-nomination process. Assuming that the group practice staff involved in the group practice self-nomination process have the same average practice labor cost as the average practice labor cost estimates we used for individual eligible professionals of $58 per hour, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately $348 ($58 per hour × 6 hours per group practice).

The burden associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For practices participating under the GPRO I process, this would be the time associated with the physician group completing the data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011, for use in the Physician Group Practice, Medicare Care Management Performance (MCMP), and EHR demonstrations. Based on burden estimates for the PGP demonstration, which uses the same data submission methods, we estimate the burden associated with a physician group completing the data collection tool would be approximately 79 hours per physician group. Based on an average labor cost of $58 per physician group, we estimate the cost of data submission per physician group associated with participating in the Physician Quality Reporting System GPRO I would be $4,582 ($58 per hour × 79 hours per group practice).

For group practices participating under the GPRO II process, the burden associated with submitting the Physician Quality Reporting System quality measures data would be the time associated with the group practice submitting the required data to CMS via claims or a registry. We would expect that data submission under GPRO II would take no more time than the time it would take an individual eligible professional to submit via claims or registry. We believe it would be appropriate to multiply the appropriate burden estimates for each reporting mechanism for individual eligible professionals by the number of eligible professionals in a group to obtain the burden estimates for data submission under GPRO II. For example, based on our estimate of 15.75 minutes per eligible professional under claims-based reporting, we would expect that a 2-person group would have a burden of 31.50 minutes for claims-based submission under GPRO II.

Eligible professionals who wish to qualify for the additional 0.5 percent incentive payment authorized under section 1848(m)(7) of the Act ("Additional Incentive Payments") for 2011 will need to more frequently than is required to qualify for or maintain board certification status participate in a qualified Maintenance of Certification Program for 2011 and successfully complete a qualified Maintenance of Certification Program practice assessment for 2011. We believe that a majority of the eligible professionals who would attempt to qualify for this

additional 0.5 percent incentive payment would be those who are already enrolled and participating in a Maintenance of Certification Board. The amount of time that it would take for the eligible professional to participate in the Maintenance of Certification Program more frequently than is required to qualify for or maintain board certification status would vary based on what each individual board determines constitutes "more frequently." The amount of time needed to complete a qualified Maintenance of Certification Program practice assessment is expected to be spread out over time since a quality improvement component is often required. Information from an informal poll of a few ABMS member boards indicates that the time an individual eligible professional spends to complete the practice assessment component of the Maintenance of Certification ranges from 8 to 12 hours.

We invited comments on this burden analysis, including the underlying assumptions used in developing our burden estimates and received no comments.

3. Electronic Prescribing (eRx) Incentive Program

We believe it is difficult to accurately estimate how many eligible professionals will opt to participate in the eRx Incentive Program in CY 2011. Information from the 2009 eRx Incentive Program indicates that nearly 90,000 eligible professionals participated in the first year of the program. We believe, however, that the number of participants will increase in light of the payment adjustment that will start in 2012. Therefore, for purposes of conducting a burden analysis for the 2011 eRx Incentive Program, we will assume that as many eligible professionals who attempted to participate in the 2007 Physician Quality Reporting System will attempt to participate in the 2011 eRx Incentive Program. As such, we can estimate that nearly 110,000 unique TIN/NPI combinations will participate in the 2011 eRx Incentive Program (see the "PQRI 2007 Reporting Experience Report," which is available on the Physician Quality Reporting System section of the CMS Web site at *http://www.cms.hhs.gov/pqri*).

Section VII.F.2 of this final rule with comment discusses the background of the eRx Incentive Program. Section VII.F.2.b.(2) of this final rule with comment provides information on how eligible professionals and group practices can qualify to be considered a successful electronic prescriber in 2011 in order to earn an incentive payment. For 2011, eligible professionals and group practices may choose whether to participate and, to the extent they meet— (1) certain thresholds with respect to the volume of covered professional services furnished; and (2) the criteria to be considered a successful electronic prescriber described in section VII.F.2.b.(2) of this final rule with comment, they can qualify to receive an incentive payment for 2011 and/or avoid being subject to the payment adjustment that goes into effect in 2012.

For the 2011 eRx Incentive Program, as discussed in section VII.F.2. of this final rule with comment, each eligible professional will need to report the G-code indicating that at least one prescription generated during an encounter was electronically submitted at least 25 instances during the reporting period. We expect the ongoing costs associated with participation in the eRx Incentive Program to decline based on an eligible professional's familiarity with and understanding of the eRx Incentive Program, experience with participating in the eRx Incentive Program, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices.

Similar to the Physician Quality Reporting System, one factor in the burden to individual eligible professionals is the time and effort associated with individual eligible professionals reviewing the electronic prescribing measure to determine whether it is applicable to them, reviewing the available reporting options (for purposes of the 2011 incentive, this measure will be reportable through claims-based reporting, registry-based reporting, or through EHRs) and selecting one, gathering the required information, and incorporating reporting of the measure into their office work flows. Since the eRx Incentive Program consists of only 1 measure to report, we estimate 2 hours as the amount of time needed for individual eligible professionals to prepare for participation in the eRx Incentive Program. At an average cost of approximately $58 per hour per practice, we estimate the total preparation costs to individual eligible professionals to be approximately $116 (2 hours × $58 per hour).

Another factor that influences the burden to eligible professionals is how they choose to report the electronic prescribing measure. For eligible professionals who choose to do so via claims, we estimate that the burden associated with the requirements of this incentive program is the time and effort associated with gathering the required information, selecting the appropriate quality data codes (QDCs), and including the appropriate QDCs on the claims they submit for payment. For claims-based reporting, the QDCs will be collected as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 201.

Based on the information from the PVRP described above for the amount of time it takes a median practice to report one measure one time on claims (1.75 minutes) and our requirement that eligible professionals to report the measure 25 times for purposes of the incentive payment, we estimate the burden associated with claims-based data submission to be 43.75 minutes (1.75 minutes per case × 1 measure × 25 cases per measure). This equates to a cost of approximately $42.29 (1.75 minutes per case × 1 measure × 25 cases per measure × $58 per hour) per individual eligible professional. For purposes of the 2012 eRx payment adjustment, where an eligible professional is required to report the measure only 10 times, we estimate the burden associated with claims-based submission to be 17.5 minutes (1.75 minutes per case × 1 measure × 10 cases per measure). This equates to a cost of approximately $16.92 (1.75 minutes per case × 1 measure × 10 cases per measure × $58 per hour) per individual eligible professional.

Because registry-based reporting of the electronic prescribing measure to CMS was added to the eRx Incentive Program for 2010 and eligible professionals are not required to indicate to us how they plan to report the electronic prescribing measure each year, it is difficult to accurately estimate how many eligible professionals will opt to participate in the eRx Incentive Program through the registry-based reporting mechanism in CY 2011. We do not anticipate, however, any additional burden for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2011 eRx Incentive Program. However, eligible professionals would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic

prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

Based on our decision to consider only registries qualified to submit Physician Quality Reporting System quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2011 Physician Quality Reporting System to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2011 eRx Incentive Program, there would be no need for a registry to undergo a separate self-nomination process for the eRx Incentive Program and therefore, no additional burden associated with the registry self-nomination process.

There would also be a burden to the registry associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the electronic prescribing quality measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants behalf is expected to vary along with the number of eligible professionals reporting data to whom the measure applies. However, we believe that registries already perform many of these activities for their participants. Since the eRx Incentive Program consists of only one measure, we believe that the burden associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting, the eligible professional must extract the necessary clinical data from his or her EHR and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS was first added to the eRx Incentive Program in 2010 and eligible professionals are not required to indicate to us how they intend to report the electronic prescribing measure, it is difficult to estimate how many eligible professionals will opt to participate in the eRx Incentive Program through the EHR-based reporting mechanism in CY 2011. We believe that once an eligible professional's EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on the electronic prescribing measure should be minimal.

Since we are considering only EHR products qualified for the 2010 Physician Quality Reporting System to be qualified for the 2011 eRx Incentive Program, there will be no need for EHR vendors to undergo a separate self-nomination process for the 2011 eRx Incentive Program and therefore, no additional burden associated with the self-nomination process.

There will also be a burden to the EHR vendor associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting the proposed 2011 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable eligible professionals to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2011 Physician Quality Reporting System will be qualified for the 2011 eRx Incentive Program and the eRx Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable eligible professionals to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

Finally, with respect to the process for group practices to be treated as successful electronic prescribers under the 2011 eRx Incentive Program discussed in section VII.F.2. of this final rule with comment, group practices will have the same options as individual eligible professionals in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices would have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). There are only 2 differences between the requirements for an individual eligible professional and a group practice: (1) The fact that a group practice will have to self-nominate; and (2) the number of times that a group practice will be required to report the electronic prescribing measure.

We do not anticipate any additional burden associated with the group practice self-nomination practice since we are limiting the group practices to those selected to participate in the 2011 Physician Quality Reporting System GPRO I or Physician Quality Reporting System GPRO II. The practice only will need to indicate their desire to participate in the eRx GPRO at the same time they self-nominate for either Physician Quality Reporting System GPRO I or Physician Quality Reporting System GPRO II and indicate how they intend to report the electronic prescribing measure.

In terms of the burden to group practices associated with submission of the electronic prescribing measure, we believe that this would be similar to the burden to individual eligible professionals for submitting the electronic prescribing measure. In fact, overall, there could be less burden associated with a practice participating as a group rather than as individual eligible professionals because the total number of reporting instances required by the group could be less than the total number of reporting instances that would be required if each member of the group separately reported the electronic prescribing measure. Thus, we believe that the burden to a group practice associated with reporting the electronic prescribing measure could range from almost no burden (for groups who choose to do so through a qualified EHR or registry) to 72.92 hours (1.75 minutes per measure $\times$ 1 measure $\times$ 2500 cases per measure) for a GPRO I group who chooses to report the electronic prescribing measures through claims submission. Consequently, the total estimated cost per group practice to report the electronic prescribing measure could be as high as $4,225 ($1.69 per measure $\times$ 1 measure $\times$ 2500 cases per measure).

As with individual eligible professionals, we believe that group practices that choose to participate in the 2011 eRx GPRO through registry-based reporting of the electronic prescribing measure would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2011 eRx Incentive Program beyond authorizing or instructing the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for

each group practice that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

For group practices that choose to participate in the 2011 eRx Incentive Program through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

We invited comments on this burden analysis, including the underlying assumptions used in developing our burden estimates and received none.

X. Response to Comments

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

XI. Regulatory Impact Analysis

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate, as discussed below in this section, that the PFS provisions included in this final rule with comment period will redistribute more than $100 million in 1 year. Therefore, we estimate that this rulemaking is "economically significant" as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that most hospitals and most other providers are small entities as that term is used in the RFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $34.5 million in any 1 year) (for details see the SBA's Web site at *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series). Individuals and States are not included in the definition of a small entity. The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

For purposes of the RFA, physicians, NPPs, and suppliers including IDTFs are considered small businesses if they generate revenues of $10 million or less based on SBA size standards. Approximately 95 percent of physicians are considered to be small entities. There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS.

For purposes of the RFA approximately 85 percent of suppliers of DMEPOS are considered small businesses according to the SBA size standards. Our most recent claims information includes 47,000 entities billing Medicare for DMEPOS each year. Total annual estimated Medicare expenditures for DMEPOS suppliers are approximately $10.1 billion in CY 2009, for which $8.1 billion was fee-for-service (FFS) and $2 billion was for managed care.

For purposes of the RFA, approximately 80 percent of clinical diagnostic laboratories are considered small businesses according to the SBA size standards.

Ambulance providers and suppliers for purposes of the RFA are also considered to be small entities.

In addition, most ESRD facilities are considered small entities for purposes of the RFA, either based on nonprofit status or by having revenues of $34.5 million or less in any year. We note that a considerable number of ESRD facilities are owned and operated by large dialysis organizations (LDOs) or regional chains, which would have total revenues more than $34.5 million in any year if revenues from all locations are combined. However, the claims data we use to estimate payments for this RFA and RIA does not identify which dialysis facilities are parts of an LDO, regional chain, or other type of ownership. Each individual dialysis facility has its own provider number and bills Medicare using this number. Therefore, we consider each ESRD facility to be a small entity for purposes of the RFA. We consider a substantial number of entities to be significantly affected if the final rule with comment period has an annual average impact on small entities of 3 to 5 percent or more. The majority of ESRD facilities will experience impacts of approximately 2 percent of total revenues. There are 976 nonprofit ESRD facilities with a combined increase of 2.1 percent in overall payments relative to current overall payments. We note that although the overall effect of the wage index changes is budget neutral, there are increases and decreases based on the location of individual facilities. The analysis and discussion provided in this section and elsewhere in this final rule with comment period complies with the RFA requirements.

Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this final rule with comment period constitutes our regulatory flexibility analysis for the remaining provisions and addresses comments received on these issues.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis, if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Any such regulatory impact analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We do not believe this final rule with comment period has impact on

significant operations of a substantial number of small rural hospitals because most dialysis facilities are freestanding. While there are 180 rural hospital-based dialysis facilities, we do not know how many of them are based at hospitals with fewer than 100 beds. However, overall, the 180 rural hospital-based dialysis facilities will experience an estimated 2.1 percent increase in payments. As a result, this rule will not have a significant impact on small rural hospitals. Therefore, the Secretary has determined that this final rule with comment period will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2010, that threshold is approximately $135 million. This final rule with comment period will not mandate any requirements for State, local, or tribal governments in the aggregate, or by the private sector, of $135 million. Medicare beneficiaries are considered to be part of the private sector and as a result a more detailed discussion is presented on the Impact of Beneficiaries in section XI.G. of this regulatory impact analysis.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have examined this final rule with comment period in accordance with Executive Order 13132 and have determined that this regulation would not have any substantial direct effect on State or local governments, preempt States, or otherwise have a Federalism implication.

We have prepared the following analysis, which together with the information provided in the rest of this preamble, meets all assessment requirements. The analysis explains the rationale for and purposes of this final rule with comment period; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we will use to minimize the burden on small entities. As indicated elsewhere in this rule, we are implementing a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections of this final rule with comment period. We are unaware of any relevant Federal rules that duplicate, overlap, or conflict with this final rule with comment period. The relevant sections of this rule contain a description of significant alternatives if applicable.

A. RVU Impacts

1. Resource-Based Work, PE, and Malpractice RVUs

Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve budget neutrality.

Our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2010 with final payment rates for CY 2011 using CY 2009 Medicare utilization for all years. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown in Table 101. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician furnishes. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the PFS. For instance, independent laboratories receive approximately 85 percent of their Medicare revenues from clinical laboratory services that are not paid under the PFS.

Table 101 shows only the payment impact on PFS services. We note that these impacts do not include the effect of the December 2010 and January 2011 conversion factor changes under current law. The following is an explanation of the information represented in Table 101:

- *Column A (Specialty):* The Medicare specialty code as reflected in our physician/supplier enrollment files.
- *Column B (Allowed Charges):* The aggregate estimated PFS allowed charges for the specialty based on CY 2009 utilization and CY 2010 rates. That is, allowed charges are the PFS amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services furnished by physicians, practitioners, and suppliers within a specialty to arrive at the total allowed charges for the specialty.
- *Column C (Impact of Work and Malpractice (MP) RVU Changes):* This column shows the estimated CY 2011 impact on total allowed charges of the changes in the work and malpractice RVUs, including the impact of changes due to new, revised, and potentially misvalued codes.
- *Column D (Impact of PE RVU and Multiple Procedure Payment Reduction Changes—Full):* This column shows the estimated CY 2011 impact on total allowed charges of the changes in the PE RVUs if there were no remaining transition to the full use of the new PPIS data. This column also includes the impact of the various MPPR and imaging equipment utilization polices, and the impact of changes due to new, revised, and potentially misvalued codes.
- *Column E (Impact of PE RVU and Multiple Procedure Payment Reduction Changes—Tran):* This column shows the estimated CY 2011 impact on total allowed charges of the changes in the PE RVUs under the second year of the 4-year transition to the full use of the new PPIS data. This column also includes the impact of the various MPPR and imaging equipment utilization policies, and the impact of changes due to new, revised, and potentially misvalued codes.
- *Column F (Impact of MEI Rebasing):* This column shows the estimated CY 2011 impact on total allowed charges of the CY 2011 rescaling of the RVUs so that the proportions of total payments based on the work, PE, and malpractice RVUs match the proportions in the final revised and rebased MEI for CY 2011.
- *Column G (Combined Impact—Full):* This column shows the estimated CY 2011 combined impact on total allowed charges of all the changes in the previous columns if there were no remaining transition to the new PE RVUs using the PPIS data.
- *Column H (Combined Impact—Tran):* This column shows the estimated CY 2011 combined impact on total allowed charges of all the changes in the previous columns under the second year of the 4-year transition to the new PE RVUs using the PPIS data.

BILLING CODE 4120–01–P

TABLE 101: CY 2011 PFS Final Rule Total Allowed Charge Estimated Impact for RVU, MPPR, and MEI Rebasing Changes*

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Specialty	Allowed Charges (mil)	Impact of Work and MP RVU Changes	Impact of PE RVU and MPPR Changes		Impact of MEI Rebasing	Combined Impact	
			Full	Tran		Full	Tran
TOTAL	$81,980	0%	0%	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$181	0%	0%	1%	4%	4%	5%
ANESTHESIOLOGY	$1,793	0%	4%	2%	-3%	2%	-1%
CARDIAC SURGERY	$382	0%	-1%	0%	0%	-1%	0%
CARDIOLOGY	$6,951	0%	-5%	-2%	1%	-5%	-2%
COLON AND RECTAL SURGERY	$138	0%	4%	2%	0%	5%	3%
CRITICAL CARE	$240	0%	3%	2%	-2%	1%	0%
DERMATOLOGY	$2,749	0%	2%	2%	3%	5%	4%
EMERGENCY MEDICINE	$2,600	0%	2%	1%	-3%	-2%	-3%
ENDOCRINOLOGY	$395	1%	4%	2%	0%	4%	2%
FAMILY PRACTICE	$5,512	0%	4%	2%	0%	4%	2%
GASTROENTEROLOGY	$1,800	0%	3%	1%	-1%	2%	1%
GENERAL PRACTICE	$728	0%	3%	1%	0%	3%	1%
GENERAL SURGERY	$2,286	0%	3%	1%	0%	3%	1%
GERIATRICS	$188	0%	5%	2%	-2%	4%	1%
HAND SURGERY	$103	0%	4%	2%	2%	6%	4%
HEMATOLOGY/ONCOLOGY	$1,912	0%	-4%	-2%	2%	-2%	0%
INFECTIOUS DISEASE	$584	0%	4%	2%	-2%	3%	0%
INTERNAL MEDICINE	$10,696	0%	3%	2%	-1%	3%	1%
INTERVENTIONAL PAIN MGMT	$390	-1%	3%	1%	1%	2%	0%
INTERVENTIONAL RADIOLOGY	$224	-2%	-8%	-4%	0%	-9%	-5%
MULTISPECIALTY CLINIC/OTHER	$46	0%	-7%	-5%	1%	-5%	-4%
NEPHROLOGY	$1,946	1%	1%	1%	-1%	1%	1%
NEUROLOGY	$1,457	0%	5%	2%	0%	5%	2%
NEUROSURGERY	$642	-2%	1%	0%	1%	0%	-1%
NUCLEAR MEDICINE	$59	0%	-7%	-4%	0%	-6%	-4%
OBSTETRICS/GYNECOLOGY	$670	0%	1%	1%	1%	2%	2%
OPHTHALMOLOGY	$5,287	-1%	4%	0%	1%	4%	0%
ORTHOPEDIC SURGERY	$3,432	0%	3%	1%	1%	4%	3%
OTOLARNGOLOGY	$941	0%	3%	2%	1%	5%	3%
PATHOLOGY	$1,069	-1%	-1%	0%	0%	-2%	-1%
PEDIATRICS	$68	0%	2%	1%	0%	2%	1%
PHYSICAL MEDICINE	$895	0%	4%	2%	-1%	4%	1%
PLASTIC SURGERY	$317	0%	4%	2%	1%	5%	3%
PSYCHIATRY	$1,149	1%	2%	1%	-3%	0%	-1%
PULMONARY DISEASE	$1,786	-1%	2%	1%	-1%	1%	-1%

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Specialty	Allowed Charges (mil)	Impact of Work and MP RVU Changes	Impact of PE RVU and MPPR Changes		Impact of MEI Rebasing	Combined Impact	
			Full	Tran		Full	Tran
RADIATION ONCOLOGY	$1,939	-2%	-9%	-3%	4%	-7%	-1%
RADIOLOGY	$5,052	-2%	-12%	-7%	-1%	-14%	-10%
RHEUMATOLOGY	$511	0%	1%	0%	2%	2%	2%
THORACIC SURGERY	$398	0%	-1%	0%	0%	-1%	0%
UROLOGY	$1,950	-1%	-6%	-3%	1%	-7%	-3%
VASCULAR SURGERY	$708	-1%	-3%	-2%	0%	-4%	-2%
AUDIOLOGIST	$54	0%	-6%	-1%	2%	-5%	0%
CHIROPRACTOR	$756	0%	4%	2%	-2%	2%	0%
CLINICAL PSYCHOLOGIST	$577	0%	-6%	-2%	-4%	-10%	-6%
CLINICAL SOCIAL WORKER	$390	0%	-5%	-2%	-4%	-9%	-5%
DIAGNOSTIC TESTING FACILITY	$909	0%	-27%	-16%	2%	-23%	-15%
INDEPENDENT LABORATORY	$1,039	-1%	-7%	-3%	5%	-4%	1%
NURSE ANES / ANES ASST	$726	0%	4%	2%	-4%	1%	-1%
NURSE PRACTITIONER	$1,212	0%	4%	2%	-1%	4%	1%
OPTOMETRY	$970	0%	4%	1%	1%	6%	2%
ORAL/MAXILLOFACIAL SURGERY	$40	0%	5%	3%	2%	7%	5%
PHYSICAL/OCCUPATIONAL THERAPY	$2,204	0%	0%	-3%	-2%	-1%	-5%
PHYSICIAN ASSISTANT	$893	0%	3%	2%	0%	3%	1%
PODIATRY	$1,801	0%	6%	3%	1%	7%	4%
PORTABLE X-RAY	$94	0%	2%	0%	6%	7%	6%
RADIATION THERAPY CENTERS	$71	0%	-13%	-5%	8%	-6%	3%
OTHER	$69	2%	3%	1%	0%	5%	3%

* Table 101 shows only the payment impact on PFS services. We note that these impacts do not include the effects of the December 2010 and January 2011 conversion factor changes under current law.

BILLING CODE 4120–01–C

2. CY 2011 PFS Impact Discussion

a. Changes in RVUs

The most widespread specialty impacts of the RVU changes are generally related to several factors. First, as discussed in section II.A.2. of this final rule with comment period, we are currently implementing the second year of the 4-year transition to new PE RVUs using the new PPIS data that were adopted in the CY 2010 PFS final rule with comment period (74 FR 61751). The impacts of using the new PPIS data are generally consistent with the impacts discussed in the CY 2010 PFS final rule with comment period (74 FR 61983 through 61984).

The second general factor contributing to the CY 2011 impacts shown in Table 101 is the CY 2011 rescaling of the RVUs so that in the aggregate they match the work, PE, and malpractice proportions in the revised and rebased MEI for CY 2011. That is, as discussed in section II.E.5. of this final rule with comment period, the revised and rebased MEI has a greater proportion attributable to malpractice and PE and, correspondingly, a lesser proportion attributable to work. Specialties that have a high proportion of total RVUs attributable to work, such as anesthesiology, are estimated to experience a decrease in aggregate payments as a result of this rescaling, while specialties that have a high proportion attributable to PE, such as radiation oncology, are estimated to experience an increase in aggregate payments. Malpractice generally represents a small proportion of total payments and the rescaling of the malpractice RVUs is not the primary driver of the specialty impacts. As discussed in section II.E.7. of this final rule with comment period, the rescaling of the RVUs to match the rebased MEI is budget neutral overall.

Finally, another significant factor contributing to the impacts shown in Table 101 (but on a specialty-specific rather than widespread level) is the final policies regarding new, revised, and potentially revised codes resulting from our CY 2011 acceptance of 70 percent of the AMA RUC work RVU recommendations and the majority of the direct PE input recommendations. We have incorporated alternative RVUs and direct PE inputs for some codes in accordance with our recommended policies. We note that some specialties, such as radiation oncology, ophthalmology, and IDTFs that commonly furnish potentially misvalued codes that have been examined by the AMA RUC and newly

valued for CY 2011, experience decreases in aggregate payment as a result of these changes.

Table 101 also includes the impacts resulting from our regulatory change to expand the current 50 percent MPPR policy to therapy services, but at an MPPR rate of 25 percent on the PE component payment for therapy services. Under the PFS, we estimate that this change would primarily reduce payments to the specialties of physical therapy and occupational therapy. In order to maintain budget neutrality, we redistributed the PFS savings back into other services paid under the PFS by increasing all PE RVUs by approximately 0.5 percent.

Because providers in settings outside of the PFS, such as outpatient hospital departments, are also paid using the PFS payment rates and policies for physical therapy services, we estimated that this will reduce (not redistribute) payments in those settings for therapy services by approximately 7 percent in CY 2011.

In addition, Table 101 includes the impacts resulting from the regulatory change to the scope of the current contiguous body area MPPR policy for imaging services from contiguous body areas to include noncontiguous body areas. We estimate that this change would primarily reduce payments to the specialties of IDTF and radiology. In order to maintain budget neutrality, we redistributed these savings back into other services paid under the PFS by increasing all PE RVUs by approximately 0.1 percent.

Table 101 also reflects the impacts resulting from certain ACA provisions, including reductions in payment under section 3135 of the ACA which amends section 1848(b)(4) of the Act to increase the equipment utilization rate assumption for expensive diagnostic imaging equipment, and, effective July 1, 2010, to increase the level of the MPPR for contiguous body areas from 25 percent to 50 percent. The expansion of the MPPR policy is further discussed in section II.C.4. of this final rule with comment period, while the discussions of the provisions of section 3135 of the ACA are found in sections VI.M. and II.A.3.a. of this final rule with comment period. As required by sections 1848(c)(2)(B)(v)(V) and (VI) of the Act (as added by sections 3135(a) and (b) of the ACA), these changes are not budget neutral and result in program savings.

We note that in section XI.D of this final rule with comment period, we provide discussions of the budget impacts of individual ACA provisions not elsewhere discussed in this section. Additionally, while column H in Table 101 illustrates the estimated combined CY 2011 impact on total allowed charges by specialty of all the final RVU and MPPR changes and the MEI rebasing, including several ACA provisions that directly affect the determination of PFS payments as discussed previously, we note that other ACA provisions discussed in section XI.D. of this final rule with comment period could also result in additional impacts on individual practitioners or specialties, depending on their practice patterns. Since the effects of a number of the ACA provisions are dependent on the practice patterns of practitioners, we would expect these impacts to be non-uniform among specialties. For example, as discussed further in section XI.D.19 of this final rule with comment period, section 1833(x) of the Act (as added by section 5501(a) of the ACA) provides for a 10 percent incentive payment for primary care services furnished by primary care practitioners. Accordingly, potentially eligible primary care specialties designated under the statute (including family practice and geriatric medicine), are expected to experience an estimated aggregate increase in payment of between 4 and 9 percent, which includes the estimated impacts under the PFS displayed in column H of Table 101 and the new primary care incentive payments. We note that in general the payment impact for an individual physician may be different from the average, based on the mix of services the physician furnishes and his or her eligibility for the primary care incentive payment program.

b. Combined Impact

Column H of Table 101 displays the estimated CY 2011 combined impact on total allowed charges by specialty of all the final RVU and MPPR changes. These impacts range from an increase of 6 percent for portable x-ray suppliers to a decrease of 15 percent for diagnostic testing facilities. There is generally a slightly positive net effect of our final policies on primary care specialties, such as family practice, internal medicine, and geriatrics. Again, these impacts are estimated prior to the application of the negative CY 2011 CF update applicable under the current statute.

Comment: One commenter requested that the specialty impact table incorporate the impact of payment changes for other Medicare Part B services that are not paid under the PFS.

Response: The purpose of Table 101 is to isolate the impacts by specialty for services paid under the PFS. To the extent that changes in payment for other Part B services are adopted in this final rule with comment period and have significant impacts upon providers, those impacts are discussed elsewhere in this section.

Table 102 shows the estimated impact on total payments for selected high-volume procedures of all of the changes discussed previously, including the effect of the CY 2011 negative PFS CF update. We selected these procedures because they are the most commonly furnished by a broad spectrum of physician specialties. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility PE, we refer readers to Addendum A of this final rule with comment period.

BILLING CODE 4120–01–P

TABLE 102: Impact of Final Rule With Comment Period and Estimated Physician Update on CY 2011

Payment for Selected Procedures

CPT/ HCPCS Code	MOD	Short Descriptor	Facility			Nonfacility		
			CY 2010[1]	CY 2011[2]	Percent Change	CY 2010[1]	CY 2011[2]	Percent Change
11721		Debride nail, 6 or more	$20.72	$19.40	-7%	$31.23	$31.39	1%
17000		Destruct premalg lesion	$40.88	$41.60	2%	$57.91	$59.72	3%
27130		Total hip arthroplasty	$1,084.09	$1,083.40	0%	NA	NA	NA
27244		Treat thigh fracture	$918.31	$921.08	0%	NA	NA	NA
27447		Total knee arthroplasty	$1,159.32	$1,157.92	0%	NA	NA	NA
33533		CABG, arterial, single	$1,536.01	$1,491.74	-3%	NA	NA	NA
35301		Rechanneling of artery	$869.49	$848.34	-2%	NA	NA	NA
43239		Upper GI endoscopy, biopsy	$133.42	$131.44	-2%	$256.05	$260.07	2%
66821		After cataract laser surgery	$216.59	$223.57	3%	$228.80	$236.84	3%
66984		Cataract surg w/iol, 1 stage	$549.57	$558.41	2%	NA	NA	NA
67210		Treatment of retinal lesion	$479.17	$487.21	2%	$494.21	$503.29	2%
71010		Chest x-ray	NA	NA	NA	$18.17	$17.87	-2%
71010	26	Chest x-ray	$7.10	$6.64	-7%	$7.10	$6.64	-7%
77056		Mammogram, both breasts	NA	NA	NA	$82.61	$83.46	1%
77056	26	Mammogram, both breasts	$34.63	$32.67	-6%	$34.63	$32.67	-6%
77057		Mammogram, screening	NA	NA	NA	$61.60	$61.25	-1%
77057	26	Mammogram, screening	$27.82	$26.29	-6%	$27.82	$26.29	-6%
77427		Radiation tx management, x5	$153.00	$120.97	-26%	$153.00	$120.97	-26%
88305	26	Tissue exam by pathologist	$28.67	$27.31	-5%	$28.67	$27.31	-5%

CPT/ HCPCS Code	MOD	Short Descriptor	Facility			Nonfacility		
			CY 2010[1]	CY 2011[2]	Percent Change	CY 2010[1]	CY 2011[2]	Percent Change
90801		Psy dx interview	$100.21	$92.64	-8%	$120.93	$115.61	-5%
90862		Medication management	$35.77	$33.69	-6%	$44.28	$43.39	-2%
90935		Hemodialysis, one evaluation	$53.08	$56.15	5%	NA	NA	NA
92012		Eye exam established pat	$38.32	$38.28	0%	$58.48	$60.23	3%
92014		Eye exam & treatment	$58.48	$58.19	0%	$85.44	$87.28	2%
92980		Insert intracoronary stent	$689.80	$656.42	-5%	NA	NA	NA
93000		Electrocardiogram, complete	NA	NA	NA	$15.61	$15.06	-4%
93010		Electrocardiogram report	$7.10	$6.64	-7%	$7.10	$6.64	-7%
93015		Cardiovascular stress test	NA	$69.67	NA	$72.67	$69.67	-4%
93307	26	Echo exam of heart	$38.32	$35.73	-7%	$38.32	$35.73	-7%
93458	26	Left heart artery/ventricle angiography[3]	NA[4]	$240.41	NA	NA	$240.41	NA
98941		Chiropractic manipulation	$24.13	$23.22	-4%	$27.25	$26.80	-2%
99203		Office/outpatient visit, new	$57.34	$56.15	-2%	$76.93	$77.59	1%
99213		Office/outpatient visit, est	$38.04	$37.26	-2%	$51.38	$51.81	1%
99214		Office/outpatient visit, est	$58.48	$56.91	-3%	$76.93	$77.08	0%
99222		Initial hospital care	$101.62	$99.28	-2%	NA	NA	NA
99223		Initial hospital care	$149.60	$145.73	-3%	NA	NA	NA
99231		Subsequent hospital care	$29.81	$28.84	-3%	NA	NA	NA
99232		Subsequent hospital care	$53.93	$52.32	-3%	NA	NA	NA
99233		Subsequent hospital care	$77.50	$75.03	-3%	NA	NA	NA
99236		Observ/hosp same date	$166.06	$160.79	-3%	NA	NA	NA
99239		Hospital discharge day	$77.78	$76.31	-2%	NA	NA	NA
99283		Emergency dept visit	$48.26	$45.94	-5%	NA	NA	NA

CPT/ HCPCS Code	MOD	Short Descriptor	Facility			Nonfacility		
			CY 2010[1]	CY 2011[2]	Percent Change	CY 2010[1]	CY 2011[2]	Percent Change
99284		Emergency dept visit	$91.41	$86.77	-5%	NA	NA	NA
99291		Critical care, first hour	$170.04	$163.34	-4%	$203.25	$198.81	-2%
99292		Critical care, addl 30 min	$85.16	$81.92	-4%	$91.97	$89.33	-3%
99348		Home visit, est patient	NA	NA	NA	$63.59	$61.76	-3%
99350		Home visit, est patient	NA	NA	NA	$130.58	$127.61	-2%
G0008		Admin influenza virus vac	NA	NA	NA	$16.75	$17.35	3%

[1] Payments based upon corrected CY 2010 conversion factor of $28.3868 under the statute as of October 30, 2009 that would be in effect on December 31, 2010 under current law.
[2]Payments based upon the CY 2011 conversion factor of $25.5217.
[3]New code for CY 2011. No CY 2010 payment rate is provided as the code did not exist in CY 2010. Prior coding has been completely revised for this service.

BILLING CODE 4120–01–C

B. Geographic Practice Cost Indices (GPCIs)

As discussed in section II.D. of this final rule with comment period, we are required to update the GPCI values at least every 3 years and phase in the adjustment over 2 years (if there has not been an adjustment in the past year). For CY 2011, we are finalizing new GPCIs for each Medicare locality. The updated GPCIs reflect the first year of the 2-year phase-in. The new GPCIs rely upon the 2010 HUD data for determining the relative cost differences in the office rent component of the PE GPCIs, as well as the 2006 through 2007 professional malpractice premium data for determining the malpractice GPCIs. The 2006 through 2008 Bureau of Labor and Statistics (BLS) Occupational Employment Statistics (OES) data were used as a replacement for 2000 Census data for determining the physician work GPCIs and the employee compensation component of the PE GPCIs. However, as discussed in section II.D. of this final rule with comment period, we are continuing to use the current cost share weights for determining the PE GPCI values and locality GAFs.

Additionally, the updated GPCIs reflect several provisions required by changes included in the ACA. Section 1848(e)(1)(H) of the Act (as added by section 3102(b) of the ACA) specifies that for CYs 2010 and 2011, the employee wage and rent portions of the PE GPCIs reflect only one-half of the relative cost differences for each locality compared to the national average and includes a "hold harmless" provision for any PFS locality that would receive a reduction to its PE GPCI resulting from the limited recognition of cost differences. Section 1848(e)(1)(E) of the Act (as amended by section 3102(a) of the ACA) extends the 1.000 work GPCI floor only through December 31, 2010. Therefore, the CY 2011 GPCIs reflect the sunset of the 1.000 work GPCI floor. Section 1848(e)(1)(G) of the Act (as amended by section 134(b) of the MIPPA) established a permanent 1.500 work GPCI floor in Alaska, beginning January 1, 2009 and, therefore, the 1.500 work GPCI floor in Alaska will remain in place for CY 2011. Moreover, section 1848(e)(1)(I) of the Act (as added by section 10324(c) of the ACA) establishes a 1.000 PE GPCI floor for services furnished in frontier states effective January 1, 2011. We estimate the combined impact of these provisions on a fiscal year cash basis to be $580 million for FY 2011.

As required by the statute, the updated GPCIs would be phased in over a 2-year period. Addendum D to this final rule with comment period shows the estimated effects of the revised GPCIs on locality GAFs for the transitional year (CY 2011) by State and Medicare locality. The GAFs reflect the use of updated underlying GPCI data and the ACA provisions. The GAFs are a weighted composite of each area's work, PE, and malpractice GPCIs using the national GPCI cost share weights. While we do not actually use the GAFs in computing the PFS payment for a specific service, they are useful in comparing the estimated overall costs and payments for different localities. The actual effect on payment for any specific service would deviate from the estimated payment based on the GAF to the extent that the proportions of work, PE, and malpractice expense RVUs for the specific service differ from those of the GAF. The most significant changes would occur in 12 payment localities, where the GAF increases or decreases by more than 2 percent. The cumulative effects of all of the GPCI revisions, including the updated underlying GPCI data and provisions of the ACA, are reflected in the CY 2012 GPCI values that are displayed in Addendum E to this final rule with comment period.

C. Rebasing and Revising of the MEI

As discussed in section II.E.5. of this final rule with comment period, we finalized the rebasing and revision of the MEI for the CY 2011 PFS. Using the new 2006 MEI weights in place of the 2000 weights and implementing the revisions to the MEI results in a slightly higher projected MEI increase for CY 2011 than would have been the case without the rebasing and revision of the MEI. The MEI update for CY 2011 is 0.4 percent under the 2006-based MEI, while the MEI update for CY 2011 would have been 0.3 percent under the 2000-based MEI. After CY 2011, the 2006-based MEI updates are forecasted to be either the same or slightly lower (0.1 to 0.2 percentage point) than the forecasted 2000-based MEI updates.

D. The Affordable Care Act Provisions

1. Section 3002: Improvements to the Physician Quality Reporting System

For the impact of this provision see section XI.E.6. of this final rule with comment period.

2. Sections 3003 and 3007: Improvements to the Physician Feedback Program and Value-Based Payment Under the Physician Fee Schedule

As discussed in section VI.B. of this final rule with comment period, these provisions: (1) continue the confidential feedback program and requires the Secretary, beginning in 2012, to provide reports that compare patterns of resource use of individual physicians to other physicians; and (2) require the Secretary to apply a separate, budget-neutral, value-based payment modifier to the payment calculation for PFS services furnished by certain practitioners beginning in CY 2015. There is no budgetary impact associated with these provisions for CY 2011.

3. Section 3102: Extension of the Work Geographic Index Floor and Revisions to the Practice Expense Geographic Adjustment under the Medicare Physician Fee Schedule, and Protections for Frontier States as Amended by Section 10324

For the impact of this provision see section XI.B. of this final rule with comment period.

4. Section 3103: Extension of Exceptions Process for Medicare Therapy Caps

This provision extends the exceptions process for therapy caps through December 31, 2010. Therapy caps are discussed in detail in section III.A.1. of this final rule with comment period. We estimate the impact on a fiscal year cash basis to be $1.16 billion for FY 2011.

5. Section 3104: Extension of Payment for Technical Component of Certain Physician Pathology Services

As discussed in section VI.E. of this final rule with comment period, this provision continues payment to independent laboratories for the TC of physician pathology services for fee-for-service Medicare beneficiaries who are inpatients or outpatients of a covered hospital through CY 2010. We estimate the impact on a fiscal year cash basis to be $80 million for FY 2011.

6. Sections 3105 and 10311: Extension of Ambulance Add-Ons

As discussed in section VI.F. of this final rule with comment period, these provisions require the extension of certain add-on payments for ground ambulance services, and the extension of certain rural area designations for purposes of air ambulance payment. As further discussed in section VI.F. of this final rule with comment period, we are amending the Medicare program regulations to conform the regulations to these provisions of the ACA. These statutory provisions are essentially prescriptive and do not allow for discretionary alternatives on the part of the Secretary.

As discussed in the July 1, 2004 interim final rule (69 FR 40288), in

determining the super-rural bonus amount under section 1834(l)(12) of Act, we followed the statutory guidance of using the data from the Comptroller General (GAO) of the U.S. We obtained the same data as the data that were used in the GAO's September 2003 Report titled "Ambulance Services: Medicare Payments Can Be Better Targeted to Trips in Less Densely Populated Rural Areas" (GAO report number GAO–03–986) and used the same general methodology in a regression analysis as was used in that report. The result was that the average cost per trip in the lowest quartile of rural county populations was 22.6 percent higher than the average cost per trip in the highest quartile. As required by section 1834(l)(12) of the Act, this percent increase is applied to the base rate for ground ambulance transports that originate in qualified rural areas, which were identified using the methodology set forth in the statute. Payments for ambulance services under Medicare are determined by the point of pick-up (by zip code area) where the beneficiary is loaded on board the ambulance. We determined that ground ambulance transports originating in 7,842 zip code areas (which were determined to be in "qualified rural areas") out of 42,879 zip code areas, according to the July 2010 zip code file, will realize increased base rate payments under this provision. However, the number and level of services that might occur in these areas for CY 2011 is unknown at this time. While many elements may factor into the final impact of sections 3105(a) through (c) and 10311(a) through (c) of the ACA, we estimate the impact of all these provisions to be $10 million for FY 2011.

7. Section 3107: Extension of Physician Fee Schedule Mental Health Add-On

As discussed in section VI.G. of this final rule with comment period, this provision extends application of the five percent increase in Medicare payment for specified mental health services only through CY 2010. We estimate the impact on a fiscal year cash basis to be $20 million for FY 2011.

8. Section 3108: Permitting Physician Assistants to Order Post-Hospital Extended Care Services

As discussed in section VI.H. of this final rule with comment period, this provision adds PAs to the list of practitioners (that is, physicians, nurse practitioners (NPs), and clinical nurse specialists) that can perform the required initial certification and periodic recertifications under section 1814(a)(2)(B) of the Act with respect to the SNF level of care. There is no budgetary impact associated with this provision.

9. Section 3111: Payment for Bone Density Tests

As discussed in section VI.I. of this final rule with comment period, this provision requires payment for dual-energy x-ray absorptiometry (DXA) services furnished during CYs 2010 and 2011 at 70 percent of the Medicare rate paid in CY 2006, with the applicable geographic adjustment for CY 2011. We estimate the impact on a fiscal year cash basis to be $60 million for FY 2011.

10. Section 3114: Improved Access for Certified Nurse-Midwife Services

As discussed in section VI.J. of this final rule with comment period, this provision increased the amount of Medicare payment made under the PFS for certified nurse-midwife (CNM) services. There is no significant budgetary impact associated with this provision.

11. Section 3122: Extension of Medicare Reasonable Costs Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas

As discussed in section VI.K. of this final rule with comment period, this provision reinstitutes reasonable cost payment for clinical diagnostic laboratory tests performed by hospitals with fewer than 50 beds that are located in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010 through June 30, 2011. For some hospitals with cost reports that begin as late as June 30, 2011, this reinstitution of reasonable cost payment could affect services performed as late as June 29, 2012, because this is the date those cost reports will close.

12. Section 3134: Misvalued Codes Under the PFS

As discussed in section II.C. of this final rule with comment period, section 1848 (c)(2)(K) of the Act (as added by section 3134 of the ACA) requires the Secretary to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of those services identified as being potentially misvalued. The impacts of our CY 2011 policy changes under this provision are included in the discussion of RVU impacts in section XI.A. of this final rule and summarized by specialty in Table Q1 of this final rule with comment period.

13. Section 3135: Modification of Equipment Utilization Factor for Advanced Imaging Services

As discussed in section VI.M. of this final rule with comment period, for services furnished on or after July 1, 2010, section 1848(b)(4)(D) of the Act (as added by section 3135(b) of the ACA) adjusts the technical component MPPR for multiple imaging studies provided in a single imaging session on contiguous body parts within families of codes from 25 percent to 50 percent as of July 1, 2010. For services furnished on or after January 1, 2011, section 1848(b)(4)(C) of the Act (as added by section 3135(a) of the ACA) increases the equipment utilization rate to 75 percent for expensive diagnostic imaging equipment, changing the CY 2011 utilization rate adopted in the CY 2010 PFS final rule with comment period to the 75 percent rate. We estimate the impact on a fiscal year cash basis to be savings to the Medicare program of $160 million for FY 2011.

14. Section 3136: Revisions in Payments for Power Wheelchairs

As discussed in section VI.N. of this final rule with comment period, this provision requires the Secretary to revise the capped rental fee schedule amounts for all power wheelchairs effective for power wheelchairs furnished on or after January 1, 2011. Under the monthly capped rental payment structure, the fee schedule will pay 15 percent (instead of 10 percent) of the purchase price for the first 3 months and 6 percent (instead of 7.5 percent) for the remaining rental months not to exceed 13 months. In addition, the lump sum (up front) purchase payment will be eliminated for standard power-driven wheelchairs. For complex rehabilitative power-driven wheelchairs, the provision permits payment to be made on a lump sum purchase method or a monthly rental method. These changes are prescriptive in the statute and do not allow for alternatives.

We expect the changes mandated by section 3136 of the ACA as a whole to achieve program savings as a result of total payments per standard power wheelchair being less than 100 percent of the purchase fee schedule amount. This decrease in expenditures is expected for two reasons. Primarily, the provision will eliminate the lump sum payment method for standard power-driven wheelchairs and instead payment will be made under the monthly rental method resulting in lower aggregate payments because many beneficiaries who use standard power wheelchairs do not use them for as long

as 13 months. In addition, we note that currently a significantly lower volume of power-driven wheelchairs are paid under the monthly payment method. The payment impact of increasing monthly rental payments in the initial 3 months will be offset both by the savings achieved from eliminating the lump sum payment method for standard power-driven wheelchairs and by decreasing payments for the remaining months of rental from 7.5 percent to 6 percent of the purchase price for all power-driven wheelchairs. We compared the estimates of current payments for power-driven wheelchairs to estimates of payments resulting from the changes required by section 3136 of the ACA which showed an estimated payment impact of a decrease in expenditures of approximately $780 million over a 5-year period. The FY 2011 cash savings was $120 million.

15. Section 3139: Payment for Biosimilar Biological Products

In Section VI.O. of this rule we discussed the provisions of the ACA that establish the definition of biosimilar, and reference biological product as well as the payment methodology for these products under Section 1847A of the Act. We noted that while these provisions are effective July 1, 2010, per statute, we do not expect to make payment for biosimilar products until after such products are approved by the FDA. We do not expect this provision to have any impact on spending.

16. Section 3401: Revisions of Certain Market Basket Updates and Incorporation of Productivity Adjustments

As discussed in section VI.P. of this final rule with comment period, section 3401 of the ACA amends section 1881(b)(14)(F) of the Act so that in CY 2011, there is a full ESRD market basket update to the composite rate component of the blended payment amount under the new ESRD PPS. This provision is estimated to be a cost to the Medicare program of $40 million (does not include coinsurance).

Section 3401 of the ACA also incorporates a productivity adjustment into the update factors for certain payment systems. Specifically, section 3401 requires that in CY 2011 (and in subsequent years), update factors under the ASC payment system, the AFS, the CLFS, and the DMEPOS fee schedules be adjusted by the productivity adjustment. We estimate the impact to be savings to the Medicare program of $20 million, $30 million, $50 million, and $60 million for the ASC payment system, the AFS, the CLFS, and the DMEPOS fee schedules respectively, for FY 2011.

17. Section 4103: Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan

As discussed in section VI.Q. of this final rule with comment period, for services furnished on or after January 1, 2011, section 1861(s)(2)(FF) of the Act (as added by section 4103 of the ACA) provides Medicare coverage, with no coinsurance or deductible, for an annual wellness visit. The annual wellness visit entails the creation of a personalized prevention plan for an individual that ultimately will include a health risk assessment and also includes other elements, such as updating the family history, identifying providers that regularly provide medical care to the individual, body mass index measurement, development of a screening service schedule, and identification of risk factors. We estimate the impact on a fiscal year cash basis to be $110 million for FY 2011.

18. Section 4104: Removal of Barriers to Preventive Services in Medicare

As discussed in section VI.R. of this final rule with comment period, for services furnished on or after January 1, 2011, sections 1833(a)(1) and 1833(b) of the Act (as amended by section 4104 of the ACA) waive the deductible and coinsurance requirements for most preventive services, and waive the deductible for colorectal cancer screening tests that are reported with other codes. Services to which no coinsurance or deductible would be applied are the annual wellness visit, the initial preventive physical examination, and any covered preventive service if it is recommended with a grade of A or B by the United States Preventive Services Task Force. We estimate that this new benefit will result in an increase in Medicare payments. We estimate the impact on a fiscal year cash basis to be $110 million for FY 2011.

19. Section 5501: Expanding Access to Primary Care Services and General Surgery Services

As discussed in section VI.S. of this final rule with comment period, for services furnished on or after January 1, 2011 and before January 1, 2016, sections 1833(x) and (y) of the Act (as added by section 5501 of the ACA) provides for a 10 percent incentive payment applied to primary care services furnished by primary care practitioners, as well as a 10 percent incentive payment for major surgical procedures furnished by general surgeons practicing in geographic health professional shortage areas. Under the final CY 2011 policies, we estimate the impact on a fiscal year cash basis to be $240 million for section 1833(x) of the Act and $10 million for section 1833(y) of the Act for FY 2011.

20. Section 6003: Disclosure Requirements for In-office Ancillary Services Exception to the Prohibition of Physician Self-referral for Certain Imaging Services

In section VI.T of this final rule with comment period, we discuss our revisions to § 411.355(b)(2) to include a new disclosure requirement created by section 6003 of the ACA and related to the in-office ancillary services exception to the physician self-referral prohibition. We are finalizing this provision with some modification, including reducing the number of required suppliers on the disclosure from 10 to 5 and removing the requirement that a record of the signed disclosure notification be maintained as a part of the patient's medical record. Physicians are now able to document the disclosure without the patient's signature.

Comment: Two commenters disagreed with the estimated impact in the proposed rule related to section 6003 of the ACA. The commenter noted that requiring physicians to list 10 suppliers is excessive and places an unnecessary administrative burden on the referring physicians. The commenters also expressed concern that it will take longer to create and maintain the disclosure notice than we proposed. The commenters did not provide alternative values for calculating the impact of this provision.

Response: We have addressed the commenters' concerns regarding the administrative burden related to this new disclosure requirement in the final rule by reducing the number of suppliers that must be listed from 10 to 5. In addition, we have removed the requirement that the disclosure notice be signed by the patient and a copy of this maintained in the medical record. We believe that our previous economic estimates are appropriate taking into account the public comments received in response to the estimated values included in the proposed rule and the changes that have been finalized in this rule.

We believe that the provisions in section VI.T. of this final rule with comment period will have a minor economic impact on the affected physicians who self-refer for advanced imaging services under the in-office

ancillary services exception. We did not receive any public comments addressing the estimated number of physicians impacted by this provision. The burden associated for these physicians remains de minimis as we have reduced the number of suppliers to be listed and have reduced the requirements for effective disclosure by eliminating the patient signature maintained as part of the medical record. We still believe physicians will incur a one-time cost associated with developing the disclosure notice.

21. Section 6404: Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months

As discussed in section VI.U. of this final rule with comment period, section 6404 of the ACA reduces the maximum time period for filing Medicare claims to no more than 12 months after the date of service. Under the new law, claims for services furnished on or after January 1, 2010, must be filed within 1 calendar year after the date of service. In addition, section 6404 of the ACA provides that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010. Section 6404 of the ACA also permits the Secretary to make certain exceptions to the 1-year filing deadline. This final rule with comment period would create three new exceptions to the 1-year filing deadline.

The budgetary impact related to this provision is significant as future payment of claims for services incurred will now be made at an earlier date, relative to the 12-month submission expiration. This is reflected by the Part A and Part B payment amounts of $60 and $50 million for FY 2011. However, for purposes of the RIA, the economic impact of this provision is non-economically significant, as to the interest lost on money now required to pay claims prior to the 12-month submission expiration is minimal.

Providers and suppliers have established billing practices for the submission of claims for payment to the Medicare program. Although this final rule with comment period would require providers and suppliers to submit Medicare FFS claims within 12 months from the date of service, we believe providers and suppliers would easily revise their billing practices on a one-time basis, and suffer no economic impact. In fact, analysis of Medicare claims data shows that more than 99 percent of Part A and Part B claims are filed in 12 months or less. Lastly, providers, suppliers, or the small number of beneficiaries that occasionally submit claims may benefit from the availability of the three new exceptions to the timely filing rule. However, we believe the impact on program costs would be negligible.

We did not receive any comments on the RIA for this provision.

22. Section 6410 of Patient Accountability and Affordable Care Act and Section 154 of MIPPA: Adjustments to the Metropolitan Statistical Areas (MSA) for Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Acquisition Program

For the impact of this provision see section XI.E.7.c. of this final rule with comment period.

23. Section 10501(i)(3): Collection of HCPCS Data for the Development and Implementation of a Prospective Payment System for the Medicare FQHC Program

As discussed in section VI.W. of this final rule with comment period, section 10501(i)(3) of the ACA establishes a process by which we will collect claims level data, using HCPCS codes, from FQHCs. This data will be used to determine the time, scope, and intensity of services provided by FQHCs in anticipation of the establishment of a prospective payment system to be implemented beginning in 2014. We further noted that the proposed new data collection effort would be for informational and data gathering purposes only, and would not be utilized to determine Medicare payment to the FQHC. Because this provision does not affect payment to FQHCs, there is no impact.

E. Other Provisions of the Final Rule

1. Part B Drug Payment: ASP Issues

Application of our policies for "Carry Over ASP" and "Partial Quarter ASP Data," as discussed in section VII.A. of this final rule with comment period, are dependent on the status and quality of quarterly manufacturer data submissions, so we cannot quantify associated savings.

Furthermore, we do not expect that our policy for determining the payment amount for drugs and biologicals that include intentional overfill, as discussed in section VII.A of this final rule with comment period, will impact payments made by the Medicare program.

Finally, as discussed in section VII.A of this final rule with comment period, we are not finalizing our price substitution policy at this time and as a result there is no impact to the program as no changes to policy are being made.

2. Ambulance Fee Schedule: Policy for Reporting Units When Billing for Ambulance Fractional Mileage

As discussed in section VII.B. of this final rule with comment period, we are implementing fractional mileage billing for all providers and suppliers of ambulance services. Effective for dates of service on and after January 1, 2011, ambulance providers and suppliers (except for providers eligible to bill on the Form UB–04) will be required to report mileage rounded up to the nearest tenth of a mile, rather than the nearest whole mile, on all claims for mileage totaling up to 100 covered miles, and we will pay based on that amount. Implementation of the fractional mileage billing policy will be delayed until August 1, 2011 for ambulance providers submitting claims on the Form UB–04, unless updates to allow billing fractional units on the Form UB–04 are not completed by July 2011. In that case, implementation of the fractional mileage billing policy is delayed for ambulance providers eligible to bill on the Form UB–04 until January 1, 2012.

By requiring that providers and suppliers round up to the nearest tenth of a mile rather than the nearest whole mile, providers and suppliers will be submitting claims for anywhere between 0.1 and 0.9 of a mile less per claim and Medicare will pay based on that amount. In our analysis (using 2008 claim data) for the proposed rule, we indicated that Medicare could potentially save at least $45 million per year in payments for base mileage billed by suppliers, and perhaps as much as $80 million per year when considering other types of ambulance mileage payments such as those for rural mileage and those made to institutional providers. Further analysis has revealed that, once adjusted for other factors such as premium offsets and MA savings, the potential annual savings totals approximately $30 million for supplier-billed base mileage alone. We continue to anticipate that the total savings will likely increase when considering other ambulance mileage payments such as for rural mileage, institutional provider payments, etc. However, we were not able to further analyze the potential additional savings using available data. Although implementation of the fractional mileage billing policy for institutional providers billing on paper claims is delayed in the final rule with comment period, the volume of institutional paper billers is insignificant—less than 1 percent of all institutional billers submits claims on the Form UB–04—and therefore, will

not significantly impact any potential savings.

3. Chiropractic Services Demonstration

As discussed in section VII.D. of this final rule with comment period, we are continuing the recoupment of the $50 million in expenditures from this demonstration in order to satisfy the budget neutrality requirement in section 651(f)(1)(b) of the MMA. We initiated this recoupment in CY 2010 and this will be the second year. As discussed in the CY 2010 PFS final rule with comment period, we finalized a policy to recoup $10 million each year through adjustments to the PFS for all chiropractors in CYs 2010 through 2014. To implement this required budget neutrality adjustment, we are recouping $10 million in CY 2011 by reducing the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942) by approximately 2 percent.

4. Renal Dialysis Services Furnished by ESRD Facilities

The ESRD related provisions are discussed in sections VI.P.1. and VII.E. of this final rule with comment period. To understand the impact of the changes affecting payments to different categories of ESRD facilities, it is necessary to compare estimated payments under the current year (CY 2010 payments) to estimated payments under the revisions to the composite rate payment system (CY 2011 payments) as discussed in section VII.E. of this final rule with comment period. To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and estimates of proposed payments contain similar inputs. Therefore, we simulated payments only for those ESRD facilities for which we are able to calculate both current CY 2010 payments and proposed CY 2011 payments.

Also, as explained in the ESRD PPS final rule (74 FR 49162 through 49164), section 1881(b)(14)(E)(i) of the Act requires a 4-year transition (phase-in) from the current composite payment system to the ESRD PPS, and section 1881(b)(14)(E)(ii) allows ESRD facilities to make a one-time election to be excluded from the transition. As of January 1, 2011, ESRD facilities that elect to go through the transition would be paid a blended amount that will consist of 75 percent of the basic case-mix adjusted composite payment system and the remaining 25 percent would be based on the ESRD PPS payment. Therefore, these final rates listed in the impact table (Table Q3) reflect only the composite rate portion of the blended payment amounts for facilities going through the first year of the 4-year transition under the new ESRD PPS.

ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from the Healthcare Cost Report Information System (HCRIS). We also used the June 2010 update of CY 2009 National Claims History file as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. Since the December 2009 update of the CY 2009 National Claims History File is incomplete, we updated the data. The description of the updates for the separately billable drugs is described in section VII.E. of this final rule with comment period. To update the treatment counts we used the ratio of the June 2009 to the December 2008 updates of the CY 2008 National Claims History File figure for treatments. This was an increase of 12.4 percent. Due to data limitations, we are unable to estimate current and proposed payments for 32 of the 5431 ESRD facilities that bill for ESRD dialysis treatments.

Table 103 shows the impact of this year's changes to CY 2011 payments to hospital-based and independent ESRD facilities. The first column of Table 103 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments. The fourth column shows the effect of all changes to the ESRD wage index for CY 2011 as it affects the composite rate payments to ESRD facilities. The fourth column compares aggregate ESRD wage-adjusted composite rate payments in CY 2011 to aggregate ESRD wage-adjusted composite rate payments in CY 2010. In CY 2010, ESRD facilities receive 100 percent of the CBSA wage-adjusted composite rate. The overall effect to all ESRD providers in aggregate is zero because the CY 2011 ESRD wage index has been multiplied by a budget neutrality adjustment factor to comply with the statutory requirement that any wage index revisions be done in a manner that results in the same aggregate amount of expenditures as would have been made without any changes in the wage index. The fifth column shows the effect of changes to the ESRD wage index in CY 2011 and the effect of section 3401(h) of the ACA, which amends section 1881(b)(14)(F) of the Act to revise the ESRD market basket increase factor. Effective January 1, 2011, there is a full ESRD bundled market basket update to the composite rate component of the blended payment amount under the payment system. We apply an ESRD market basket increase factor of 2.5 percent for those facilities electing to go through the ESRD PPS transition. The sixth column shows the overall effect of the changes in composite rate payments to ESRD providers, including the drug add-on. The overall effect is measured as the difference between the CY 2011 payment with all changes in this rule and current CY 2010 payment. This payment amount is computed by multiplying the wage-adjusted composite rate with the drug add-on for each provider times the number of dialysis treatments from the CY 2009 claims. The CY 2011 payment is the composite rate for each provider (with the 14.7 percent drug add-on) times dialysis treatments from CY 2009 claims. The CY 2010 current payment is the composite rate for each provider (with the current 15.0 percent drug add-on) times dialysis treatments from CY 2009 claims.

The overall impact to ESRD providers in aggregate is 2.2 percent as shown in Table 103. Most ESRD facilities will see an increase in payments as a result of the ACA provision. While section 3401(h) of the ACA modifies the ESRD bundled market basket, which we will be a 2.5 percent increase to the ESRD composite rate portion of the blended payment amount, this 2.5 percent increase does not apply to the drug add-on to the composite rate. For this reason, the impact of all changes in this final rule with comment period is a 2.2 percent increase for all ESRD providers. Overall, payments to ineligible professional independent ESRD facilities will increase by 2.2 percent and payments to hospital-based ESRD facilities will increase by 2.1 percent.

TABLE 103—IMPACT OF CY 2011 CHANGES IN PAYMENTS TO HOSPITAL-BASED AND INDEPENDENT ESRD FACILITIES

[Percent change in composite rate payments to ESRD facilities]

1	2	3	4	5	6
	Number of facilities	Number of dialysis treatments (in millions)	Effect of changes in wage index [1] (percent)	Effect of changes in wage index and of afford-able Care Act provision [2] (percent)	Overall effect of wage index affordable Care Act & Drug Add-on [3] (percent)
All Providers:	5,399	38.6	0.0	2.5	2.2
Independent	4,821	34.9	0.0	2.5	2.2
Hospital Based	578	3.7	−0.1	2.4	2.1
By Facility Size:					
Less than 5000 treatments	2105	5.9	0.1	2.5	2.3
5000 to 9999 treatments	2,049	14.8	0.1	2.6	2.3
Greater than 9999 treatments	1,245	17.9	−0.1	2.4	2.2
Type of Ownership:					
Profit	4,423	31.8	0.0	2.5	2.3
Nonprofit	976	6.7	−0.1	2.4	2.1
By Geographic Location:					
Rural	1,178	6.2	0.1	2.6	2.4
Urban	4,221	32.4	0.0	2.5	2.2
By Region:					
New England	165	1.3	−0.6	1.8	1.6
Middle Atlantic	603	4.8	−0.4	2.1	1.8
East North Central	885	6.0	0.2	2.7	2.4
West North Central	403	2.1	−0.1	2.4	2.2
South Atlantic	1,211	8.8	0.0	2.5	2.2
East South Central	422	2.9	0.2	2.7	2.4
West South Central	729	5.6	0.4	2.9	2.6
Mountain	323	1.8	0.2	2.7	2.4
Pacific	619	5.0	0.1	2.6	2.4
Puerto Rico & Virgin Islands	39	0.4	−2.4	0.0	−0.2

Notes: Payments have been adjusted to reflect budget neutrality.
2010 includes the MIPPA 1% increase and site neutral rates.
2010 & 2011 are 100 percent new CBSA wage adjusted composite rate.

[1] This column shows the overall effect of wage index changes on ESRD providers. Composite rate payments are computed using the final CY 2011 wage indexes which are compared to composite rate payments using the current CY 2010 wage indexes.

[2] This column shows the effect of the changes in the Wage Indexes and the ACA provision which includes an ESRD Bundled Market Basket (2.5 percent) increase to the composite rate. This provision is effective January 1, 2011.

[3] This column shows the percent change between CY 2011 and CY 2010 composite rate payments to ESRD facilities. The CY 2011 payments include the CY 2011 wage adjusted composite rate, a 2.5% increase due to the ACA, effective January 1, 2011, and the drug add-on of 14.7%. The CY 2010 payments include the CY 2010 wage adjusted composite rate, a 1% increase and site neutral rates effective January 1, 2009 and the drug add-on of 15.0%. This column shows the effect of wage index, ACA, and drug add-on changes. While the ACA provision includes a 2.5% increase to the composite rate, this increase does not apply to the drug add-on to the composite rate. For this reason, the impact of all changes in this final rule with comment period is a 2.2% increase for all ESRD providers.

5. Section 131(b) of the MIPPA: Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting System

As discussed in section VII.F.1 of this final rule with comment period, we are finalizing several different reporting options for eligible professionals who wish to participate in the 2011 Physician Quality Reporting System. Although there may be some cost incurred in the Physician Quality Reporting System and their associated code sets, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and EHR-based reporting for the Physician Quality Reporting System, we do not anticipate a significant cost impact on the Medicare program.

Participation in the CY 2011 Physician Quality Reporting System by individual eligible professionals is voluntary and individual eligible professionals and group practices may have different processes for integrating the Physician Quality Reporting System into their practice's work flows. Given this variability and the multiple reporting options that we provide, it is difficult to accurately estimate the impact of the Physician Quality Reporting System on providers. Furthermore, we believe that costs for eligible professionals who are participating in the Physician Quality Reporting System for the first time in 2011 will be considerably higher than the cost for eligible professionals who participated in Physician Quality Reporting System in prior years. In addition, for many eligible professionals, the cost of participating in the Physician Quality Reporting System is offset by the incentive payment received.

With respect to the potential incentive payment that will be made for the 2011 Physician Quality Reporting System, we estimate this amount to be approximately $100 million. This estimate is derived from looking at our 2008 incentive payment of more than $95 million and then accounting for the fact that the 2008 incentive payment was 1.5 percent of an eligible professional's total estimated Medicare Part B PFS allowed charges for all covered professional services furnished during the 2008 reporting period. For 2011, the incentive payment is 1.0 percent of an eligible professional's total estimated Medicare Part B PFS allowed charges for all covered professional services furnished during the 2011 reporting period. Although we expect

that the lower incentive payment amount for 2011 would reduce the total outlay by approximately one-third, we also expect more eligible professionals to participate in the 2011 Physician Quality Reporting System as there are more methods of data submission and additional alternative reporting periods and that some eligible professionals would qualify for the additional 0.5 percent incentive authorized under section 1848(m)(7) of the Act ("Additional Incentive Payment").

One factor that influences the cost to individual eligible professionals is the time and effort associated with individual eligible professionals identifying applicable Physician Quality Reporting System quality measures and reviewing and selecting a reporting option. This burden will vary with each individual eligible professional by the number of applicable measures, the eligible professional's familiarity, and understanding of the Physician Quality Reporting System I, experience with Physician Quality Reporting System participation, and the method(s) selected by the eligible professional for reporting of the measures, and incorporating the reporting of the measures into the office work flows. Information obtained from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the Physician Quality Reporting System and was the first step for the reporting of physician quality of care through certain quality metrics, indicated an average labor cost per practice of approximately $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $58 per hour for our estimates, based on an assumption of an average annual increase of approximately 3 percent. Therefore, assuming that it takes an individual eligible professional approximately 5 hours to review the PQRI quality measures, review the various reporting options, select the most appropriate reporting option, identify the applicable measures for which they can report the necessary information, and incorporate reporting of the selected measures into their office work flows, we estimate that the cost to eligible professionals associated with preparing to report Physician Quality Reporting System quality measures would be approximately $290 per individual eligible professional ($58 per hour × 5 hours).

Another factor that influences the cost to individual eligible professionals is how they choose to report the Physician Quality Reporting System measures (that is, whether they select the claims-based, registry-based or EHR-based reporting mechanism). For claims-based reporting, estimates from the PVRP indicate the time needed to perform all the steps necessary to report quality data codes (QDCs) for 1 measure on a claim ranges from 15 seconds (0.25 minutes) to 12 minutes for complicated cases or measures. In previous years, when we required reporting on 80 percent of eligible cases for claims-based reporting, we found that on average, the median number of reporting instances for each of the PQRI measures was 9. Since we reduced the required reporting rate by over one-third to 50 percent, then for purposes of this impact analysis we will assume that an eligible professional will need to report each selected measure for 6 reporting instances, or 6 cases. Assuming that an eligible professional, on average, will report 3 measures and that an eligible professional reports on an average of 6 reporting instances per measure, we estimate that the cost to an individual eligible professional associated with claims-based reporting of Physician Quality Reporting System measures would range from approximately $4.35 (0.25 minutes per reporting instance × 6 reporting instances per measure × 3 measures × $58 per hour) to $208.80 (12 minutes per reporting instance × 6 reporting instances per measure × 3 measures × $58 per hour). If an eligible professional satisfactorily reports, these costs will more than likely be negated by the incentive earned. For the 2007 PQRI, which had a 1.5 percent incentive for a 6-month reporting period, the mean incentive amount was close to $700 for an individual eligible professional and the median incentive payment amount was over $300.

For registry-based reporting, individual eligible professionals must generally incur a cost to submit data to registries. Estimated fees for using a qualified registry range from no charge, or a nominal charge, for an individual eligible professional to use a registry to several thousand dollars, with a majority of registries charging fees ranging from $500 to $1,000. However, our impact analysis is limited to the incremental costs associated with Physician Quality Reporting System reporting, which we believe are minimal. Many eligible professionals who select registry-based reporting were already utilizing the registry for other purposes and would not need to report additional data to the registry specifically for Physician Quality Reporting System. The registries also often provide the eligible professional services above and beyond what is required for Physician Quality Reporting System.

For EHR-based reporting, an individual eligible professional generally will incur a cost associated with purchasing an EHR product. Although we do not believe that the majority of eligible professionals would purchase an EHR solely for the purpose of participating in Physician Quality Reporting System, cost estimates for EHR adoption by eligible professionals from the EHR Incentive Program final rule (75 FR 44549) show that an individual eligible professional who chooses to do so would have to spend anywhere from $25,000 to $54,000 to purchase and implement an EHR and up to $18,000 annually for ongoing maintenance.

Although we believe that the majority of eligible professionals attempting to qualify for the additional 0.5 percent incentive payment authorized by section 1848(m)(7) of the Act would be those who are already required by their Boards to participate in a Maintenance of Certification Program, individual eligible professionals who wish to qualify for the additional 0.5 percent incentive payment and are not currently participating in a Maintenance of Certification Program would also have to incur a cost for participating in a Maintenance of Certification Program. The manner in which fees are charged for participating in a Maintenance of Certification Program vary by specialty. Some Boards charge a single fee for participation in the full cycle of Maintenance of Certification Program. Such fees appear to range anywhere from over $1,100 to nearly $1,800 per cycle. Some Boards have annual fees that are paid by their diplomates. On average, ABMS diplomates pay approximately $200.00 per year for participating in Maintenance of Certification Program. Some Boards have an additional fee for the Maintenance of Certification Program Part III secure examination, but most Boards do not have additional charges for participation in the Part IV practice/quality improvement activities.

With respect to the process for group practices to be treated as satisfactorily submitting quality measures data for the CY 2011 Physician Quality Reporting System discussed in section VII.F.1 of this final rule with comment period, group practices interested in participating in the CY 2011 Physician Quality Reporting System through the group practice reporting option (GPRO) I or GPRO II may also incur a cost. However, for groups that satisfactorily report for 2011 Physician Quality Reporting System, we believe these

costs would be completely offset by the incentive payment earned since the group practice would be eligible for an incentive payment equal to 1 percent of the entire group's total estimated Medicare Part B PFS allowed charges for covered professional services furnished during the reporting period.

One factor in the cost to group practices would be the costs associated with the self-nomination process. Similar to our estimates for staff involved with the claims-based reporting option for individual eligible professionals, we also estimate that the group practice staff involved in the group practice self-nomination process has an average labor cost of $58 per hour. Therefore, assuming 2 hours for a group practice to decide whether to participate individually or as a group and 4 hours for the self-nomination process, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately $348 ($58 per hour × 6 hours per group practice).

For groups participating under the GPRO I process, another factor in the cost to the group would be the time and effort associated with the group practice completing and submitting the proposed data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011. Based on the Physician Group Practice (PGP) demonstration's estimate that it takes approximately 79 hours for a group practice to complete the data collection tool, which uses the same data submission methods as those we have finalized, we estimate the cost associated with a physician group completing the data collection tool would be approximately $4,582 ($58 per hour × 79 hours per group practice).

For group practices participating under the GPRO II process, the costs associated with submitting the Physician Quality Reporting System quality measures data will be the time associated with the group practice submitting the required data to CMS via claims or, if applicable, a registry. The costs for a group practice reporting to a registry is similar to the costs associated with registry reporting for an individual eligible professional, as the process is the same with the exception that more patients and more measures must be reported in GPRO II compared to an individual eligible professional. For similar reasons, the costs for a group practice reporting via claims should also be similar to the costs associated with claims-based reporting for an individual eligible professional. Overall, there is significantly less burden associated with a group practice participating in Physician Quality Reporting System via GPRO II than doing so as individual eligible professionals. Participation in GPRO II requires the group practice as a whole to report a fewer number of measures on a fewer number of people since eligible professionals within a group who share patients will not be required to separately report measures for those shared patients. Therefore, assuming that an average group practice will spend 20 hours for data submission, we estimate the cost of data submission under GPRO II would be approximately $1,160 (20 hours for data submission × $58 per hour). Smaller groups may need less time for data submission as they would be required to report fewer measures and presumably have a smaller patient population while larger groups may need more time for data submission since they would be required to report more measures and presumably have a larger patient population.

In addition to costs incurred by eligible professionals and group practices, registries and EHR vendors may also incur some costs related to the Physician Quality Reporting System. Registries interested in becoming "qualified" to submit on behalf of individual eligible professionals would also have to incur a cost associated with the vetting process and with calculating quality measures results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. We estimate the registry self-nomination process will cost approximately $500 per registry ($50 per hour × 10 hours per registry). This cost estimate includes the cost of submitting the self-nomination letter to CMS and completing the CMS vetting process. Our estimate of $50 per hour average labor cost for registries is based on the assumption that registry staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer. Because we are finalizing new requirements for 2011, the 2010 qualified registries will incur similar costs associated with the self-nomination process. We do not believe that there are any additional costs for registries associated with a registry calculating quality measures results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. We believe that the majority of registries already perform these functions for their participants.

An EHR vendor interested in having its product(s) be used by individual eligible professionals to submit Physician Quality Reporting System measures to CMS for 2012 will have to complete a vetting process during 2011 and program its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2012 quality measures in 2013 as well. We specified that previously qualified vendors will need to only update their electronic measure specifications and data transmission schema during 2011 to incorporate any new EHR measures to maintain their qualification for the 2012 Physician Quality Reporting System. Therefore, for EHR vendors that were not previously qualified, the cost associated with completing the self-nomination process, including the vetting process with CMS officials, is estimated to be $500 ($50 per hour × 10 hours per EHR vendor). Our estimate of a $50 per hour average labor cost for EHR vendors is based on the assumption that vendor staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer. We believe that the cost associated with the time and effort needed for an EHR vendor to review the quality measures and other information and program the EHR product to enable individual eligible professionals to submit Physician Quality Reporting System quality measures data to the CMS-designated clinical warehouse will be dependent on the EHR vendor's familiarity with the Physician Quality Reporting System, the vendor's system's capabilities, as well as the vendor's programming capabilities. Some vendors already have the necessary capabilities and for such vendors, we estimate the total cost to be approximately $2,000 ($50 per hour × 40 hours per vendor). However, given the variability in the capabilities of the vendors, we believe an estimate for those vendors with minimal experience would be approximately $10,000 per vendor ($50 per hour × 200 hours per EHR vendor).

6. Section 132 of the MIPPA: Incentives for Electronic Prescribing (eRx)—The eRx Incentive Program

Section VII.F.2. of this final rule with comment period describes the 2011

Electronic Prescribing (eRx) Incentive Program. To be considered a successful electronic prescriber in CY 2011, an individual eligible professional will need to meet the requirements described in section VII.F.2. of this final rule with comment period.

We estimate that the cost impact of the eRx Incentive Program on the Medicare program would be the cost incurred for maintaining the electronic prescribing measure and its associated code set, and for maintaining the existing clinical data warehouse to accommodate registry-based reporting and EHR-based reporting for the electronic prescribing measure. However, we do not believe that this provision has a significant cost impact on the Medicare program since much of this infrastructure has already been established for the Physician Quality Reporting System program.

Individual eligible professionals and group practices may have different processes for integrating the eRx Incentive Program into their practices' work flows. Given this variability and the multiple reporting options that we provide, it is difficult to accurately estimate the impact of the eRx Incentive Program on providers. Furthermore, we believe that costs for eligible professionals who are participating in the eRx Incentive Program for the first time in 2011 will be considerably higher than the cost for eligible professionals who participated in the eRx Incentive Program in prior years. In addition, for many eligible professionals (especially those who participated in the eRx Incentive Program in prior years), the cost of participating in the eRx Incentive Program for 2011 will be offset by the incentive payment received. As a result of the payment adjustment that begins in 2012, the cost of not participating in the eRx Incentive Program for 2011 could be higher than the cost of participating in the form of reduced Medicare payments.

For the 2009 eRx Incentive Program, approximately $148 million in total incentives were paid to eligible professionals with a median incentive amount of about $1,600. We estimate that the total incentive payments for the 2011 eRx Incentive Program (which will be paid in 2012) will be similar. We anticipate that despite a decrease in the incentive payment amount from 2 percent in 2010 to 1 percent of total estimated Medicare Part B allowed charges for covered professional services in 2011, more eligible professionals (and groups) will choose to participate in the 2011 eRx Incentive Program to avoid a prospective 1 percent payment penalty in 2012 for not demonstrating that they are successful electronic prescribers. Any eligible professional who wishes to participate in the eRx Incentive Program must have a qualified electronic prescribing system in order to participate. Therefore, a one-time potential cost to some individual eligible professionals would be the cost of purchasing and using an eRx system, which varies by the commercial software package selected, the level at which the professional currently employs information technology in his or her practice and the training needed. One study indicated that a midrange complete electronic medical record with electronic prescribing functionality costs $2,500 per license with an annual fee of $90 per license for quarterly updates of the drug database after setup costs while standalone prescribing, messaging, and problem list system may cost $1,200 per physician per year after setup costs. Hardware costs and setup fees substantially add to the final cost of any software package. (Corley, S.T. (2003). "Electronic prescribing: A review of costs and benefits." Topics in Health Information Management 24(1):29–38.). These are the estimates that we intend to use for our impact analysis.

Similar to the Physician Quality Reporting System, one factor in the cost to individual eligible professionals is the time and effort associated with individual eligible professionals reviewing the electronic prescribing measure to determine whether it is applicable to them, reviewing the available reporting options and selecting one, gathering the required information, and incorporating reporting of the measure into their office work flows. Since the eRx Incentive Program consists of only 1 quality measure, we estimate 2 hours as the amount of time needed for individual eligible professionals to prepare for participation in the eRx Incentive Program. Information obtained from the PVRP, which was a predecessor to the Physician Quality Reporting System and was the first step for the reporting of physician quality of care through certain quality metrics, indicated an average labor cost per practice of approximately $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $58 per hour for our estimates, based on an assumption of an average annual increase of approximately 3 percent. At an average cost of approximately $58 per hour, we estimate the total preparation costs to individual eligible professionals to be approximately $116 ($58 per hour × 2 hours).

Another factor that influences the cost to individual eligible professionals is how they choose to report the electronic prescribing measure (that is, whether they select the claims-based, registry-based or EHR-based reporting mechanism). For claims-based reporting, there would be a cost associated with reporting the appropriate QDC on the claims an individual eligible professional submits for payment. Based on the information from the PVRP described above for the amount of time it takes a median practice to report one measure one time (1.75 minutes) and the requirement to report 25 electronic prescribing events during 2011, we estimate the annual estimated cost per individual eligible professional to report the electronic prescribing measure via claims-submission to be $42.29 (1.75 minutes per case × 1 measure × 25 cases per measure × $58 per hour). We believe that for most successful electronic prescribers who earn an incentive, these costs would be negated by the incentive payment received given that the median incentive for eligible professionals who qualified for a 2009 eRx incentive was around $1,600.

For eligible professionals who select the registry-based reporting mechanism, we do not anticipate any additional cost for individual eligible professionals to report data to a registry, as individual eligible professionals opting for registry-based reporting are more than likely already reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the CY 2011 eRx Incentive Program. Individual eligible professionals using registries for Physician Quality Reporting System will likely experience minimal, if any, increased costs charged by the registry to report this 1 additional measure.

For EHR-based reporting, the eligible professional must extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Once the EHR is programmed by the vendor to allow data submission to CMS, the cost to the individual eligible professional associated with the time and effort to submit data on the electronic prescribing measure should be minimal.

With respect to the process for group practices to be treated as successful electronic prescribers under the CY 2011 eRx Incentive Program discussed in section VII.F.2 of this final rule with comment period, group practices have the same option as individual eligible professionals in terms of the form and manner for reporting the eRx measure (that is, group practices have the option of reporting the measure through claims,

a qualified registry, or a qualified EHR product). There are only 2 differences between the requirements for an individual eligible professional and a group practice: (1) The fact that a group practice would have to self-nominate; and (2) the number of times a group practice would be required to report the eRx measure. Overall, there could be less cost associated with a practice participating in the eRx Incentive Program as a group rather than the individual members of the group separately participating. We do not believe that there are any additional costs associated with the group practice self-nomination process since we are limiting the group practices to those selected to participate in the 2011 Physician Quality Reporting System GPRO I or Physician Quality Reporting System GPRO II. The practices only will need to indicate their desire to participate in the eRx GPRO at the time they self-nominate for either Physician Quality Reporting System GPRO I or Physician Quality Reporting System GPRO II.

The costs for a group practice reporting to an EHR or registry should be similar to the costs associated with registry and EHR reporting for an individual eligible professional, as the process is the same with the exception that more electronic prescribing events must be reported by the group. For similar reasons, the costs for a group practice reporting via claims should also be similar to the costs associated with claims-based reporting for an individual eligible professional. Therefore, we estimate that the costs for group practices who are selected to participate in the CY 2011 eRx Incentive Program as a group would range from $126.88 (1.75 minutes per case × 1 measure × 75 cases per measure × $58 per hour) for the smallest groups participating under GPRO II to $4,229.17 (1.75 minutes per case × 2,500 cases per measure × $58 per hour) for the groups participating under GPRO I.

We believe that the costs to individual eligible professionals and group practices associated with avoiding the eRx payment adjustment that goes into effect in 2012 would be similar to the costs of an eligible professional or group practice reporting the electronic prescribing measure for purposes of the 2011 eRx incentive. Specifically, we believe that the cost of reporting the eRx measure in one instance for purposes of the payment adjustment is identical to the cost of reporting the eRx measure for one instance on claims for purposes of the incentive payment. The only difference would be in the total costs for an individual eligible professional. Group practices are required to report the eRx measure for the same number of eRx events for both the 2011 incentive and the 2012 payment adjustment. Individual eligible professionals, however, are required to report the eRx measure only for 10 eRx events for purposes of the 2012 payment adjustment as opposed to 25 eRx events for purposes of the 2011 incentive.

Based on our decision to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2011 Physician Quality Reporting System to be qualified to submit results and numerator and denominator data on the eRx measure for the CY 2011 eRx Incentive Program, we do not estimate any cost to the registry associated with becoming a registry qualified to submit the eRx measure for CY 2011.

The cost for the registry would be the time and effort associated with the registry calculating results for the eRx measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the eRx quality measure to CMS on behalf of their participants. We believe such costs will be minimal as registries would already be required to perform these activities for the Physician Quality Reporting System.

Likewise, based on our decision to consider only EHR products qualified for the CY 2011 Physician Quality Reporting System to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the CY 2011 eRx Incentive Program, there would be no need for EHR vendors to undergo a separate self-nomination process for the eRx Incentive Program. Therefore, there will be no additional cost associated with the self-nomination process.

The cost to the EHR vendor associated with the EHR-based reporting requirements of this reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the individual eligible professional needs to submit to CMS for reporting the CY 2011 eRx measure. Since we determined that only EHR products qualified for the 2011 Physician Quality Reporting System will be qualified for the CY 2011 eRx Incentive Program, and the eRx Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable individual eligible professionals to submit data on the eRx measure to the CMS-designated clinical data warehouse will be minimal.

7. Durable Medical Equipment-Related Issues

a. Off-the-Shelf (OTS) Orthotics Exemption

In section VII.G. of this final rule with comment period, we are expanding the exemptions from the CBP for certain OTS orthotics to physicians, other practitioners (as defined by the Secretary), or by hospitals if furnished to their own patients as part of their professional service.

The exemption is a self-implementing mandate required by section 154(d) of MIPPA, which added section 1847(a)(7) of the Act. Section 1847(a)(7)(A) of the Act expanded the exemptions from the CBP for certain OTS orthotics to physicians, other practitioners (as defined by the Secretary), or hospitals if furnished to their own patients as part of their professional service. Section 1847(a)(7)(B) of the Act, as added by section 154(d) of MIPPA, also expanded the exemption from CBP for certain DME items (crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps) when furnished by hospitals to the hospital's own patients during an admission or on the date of discharge.

We believe this exemption will have a negligible impact on physicians, other practitioners, and hospitals. The exemption allows physicians, other practitioners, and hospitals to continue to provide these items to their own patients without submitting a bid and becoming a contract supplier. This exemption also allows continued access to these items for beneficiaries when these items are furnished by physicians, other practitioners, and hospitals to their own patients.

b. Changes to Payment for Oxygen Equipment

We are not finalizing our proposal pertaining to oxygen and oxygen equipment; and therefore, the impact analysis associated with this proposal is not being finalized.

c. Diabetic Testing Supplies

We are establishing requirements for conducting a national competition for furnishing diabetic testing supplies on a mail order basis. Specifically this final rule with comment period will establish 3 requirements: A new definition for what constitutes mail order; a rule that requires contract suppliers to provide at a minimum 50 percent of all of the different types of diabetic testing products on the market by brand and model name; and a prohibition against

influencing and incentivizing beneficiaries to switch their brand of monitor and testing supplies.

Currently, based on claims data from FY 2009, over 62 percent of beneficiaries receive their replacement diabetic testing supplies from mail order suppliers. The new mail order definition will not impact these beneficiaries because they can continue to obtain their items through mail order. The remaining 38 percent of beneficiaries may continue to obtain these items from a local pharmacy. We do not expect this rule to have any adverse effects on beneficiaries because the new definition of mail order item is reflective of the way that beneficiaries currently get their diabetic testing supplies. However, we believe that by clarifying this definition, we will protect beneficiaries from paying higher co-payment amounts and we anticipate program savings that would have been eroded by suppliers circumventing our definition to continue to provide items, even if not awarded a contract under competitive bidding and to obtain the higher fee schedule payment amount. This definition is also consistent with the way that suppliers currently do business by either providing items through mail order or at a local storefront. For these reasons we believe this new definition will have minimal impact.

Also, we considered the option to not bifurcate bidding based on delivery method and to bid for diabetic testing supplies regardless of how the items were obtained. We rejected this approach because it would force companies with different business models to compete against each other, by requiring local pharmacies to compete with national mail order suppliers in order to win a contract to be able to furnish diabetic testing supplies.

In order to implement a national mail order competition for diabetic supplies, we are also implementing the special "50 percent rule" mandated by MIPPA. This final rule with comment period requires a bidder to demonstrate that its bid covers types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, cover 50 percent (or such higher percentage as the Secretary may specify) of all such types of products. The 50 percent threshold would ensure that beneficiaries have access to mail order delivery of the top-selling diabetic test strip products from every contract supplier. We plan to use the information that bidding suppliers provide on their bidding Form B where suppliers list the products they plan to furnish. We believe this requirement will have a minimal impact on suppliers because most suppliers currently provide a wide range of the brands and models in order to gain market share. The statute states that suppliers are required to carry at least 50 percent of all brands on the market. However, the Secretary can establish suppliers to carry a higher percentage of brands. We have adopted the 50 percent criteria because we believe this is reflective of what suppliers are currently doing and ensures appropriate access for beneficiaries.

In addition to the 50 percent rule we are establishing an anti-switching requirement. This provision would prevent contract suppliers from influencing or incentivizing beneficiaries by persuading, pressuring, or advising them to switch from their current brand to a brand provided by the supplier. We believe this requirement will protect the beneficiary and physician choice of glucose monitoring systems. The decision concerning the type of monitor and testing supplies that a beneficiary chooses should not be made by the supplier but rather by the beneficiary and their physician. We believe that this provision will have a minimal impact on suppliers because suppliers currently offer a variety of products and generally do not require beneficiaries to switch from the brands they are familiar with and customarily use.

d. Metropolitan Statistical Areas

In section VII.V. of this final rule with comment period, we implement section 6410 of the ACA regarding adjustments to the DMEPOS CBP. We believe that the provisions pertaining to subdividing metropolitan statistical areas (MSAs) with populations of at least 8,000,000 for the purpose of establishing competitive bidding areas (CBAs) under Round 2 of the DMEPOS CBP will have a positive impact on most suppliers, particularly small suppliers. The authority provided by section 1847(a)(1)(D)(ii)(II) of the Act will be used to create CBAs that are smaller than the highly and densely populated MSAs of: Chicago-Naperville-Joliet, IL–IN–WI; Los Angeles-Long Beach-Santa Ana, CA; and New York-Northern New Jersey-Long Island, NY–NJ–PA. This results in more manageable service areas for suppliers to navigate when furnishing items. More importantly, it ensures more timely delivery of items and services to beneficiaries located throughout each of the MSAs. It also benefits small suppliers because they will have smaller geographic areas to cover as contract suppliers than the large MSAs, which in some cases, might prevent them from being considered for participation under the program. The larger suppliers will still have the opportunity to bid in all of the CBAs within each MSA. We expect that subdividing the large MSAs of Chicago, Los Angeles, and New York would not have a negative impact on program savings, as long as each CBA is large enough to be attractive to suppliers for bidding purposes.

Table 104 considers FY cash impact on the entire Medicare program, including Medicare Advantage for FYs 2011 thru 2015, of the provisions of this final rule with comment period related to the establishment of CBAs during Round 2 and prior to calendar year 2015. The FY–CY distinction is an important one when comparing savings. For example, the savings for the DMEPOS CBP will be for 9 months of FY 2013, but for 12 months of CY 2013. Table 104 considers the impact on program expenditures, and does not include beneficiary coinsurance. Finally, the estimates in Table 104 incorporate spillover effects from the competitive acquisition program onto the Medicare Advantage program. The expectation is that the 21 additional MSAs added to the DMEPOS CBP would lower prices for DME products in FFS and would lead to lower prices in the Medicare Advantage market. The table below considers FY cash impact of the above provisions on the entire Medicare program, including Medicare Advantage for the FY.

TABLE 104—IMPACT OF ADDING 21 MSAS TO ROUND 2 OF THE MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM

FY	Cost (in $ millions)
2011	0
2012	0
2013	−40
2014	−70
2015	−110

Subdividing the large MSAs of Chicago, Los Angeles, and New York is considered to have little to no fiscal impact. The exceptions to the DMEPOS CBP involving rural areas, MSAs with populations less than 250,000, and low population density areas in selected MSAs before 2015 are considered to have little to no impact because the baseline never considered these areas as subject to competitive bidding prices.

8. Air Ambulance

In section VII.H. of this final rule with comment period, we present our provision regarding air ambulance and provider and supplier enrollment. We note that this provision is an administrative initiative that may result in Medicare program savings but at this time those savings are inestimable. We believe the probable costs providers or suppliers will incur as a result of this rule to be negligible.

F. Alternatives Considered

This final rule with comment period contains a range of policies, including some provisions related to specific MIPPA and ACA provisions. The preceding preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, presents rationale for our final policies and, where relevant, alternatives that were considered.

G. Impact on Beneficiaries

There are a number of changes in this final rule with comment period that would have an effect on beneficiaries. In general, we believe that many of the proposed changes, including the refinements of the PQRI with its focus on measuring, submitting, and analyzing quality data, the expansion of the list of Medicare-approved telehealth services, the incentive payments for primary care services furnished by primary care practitioners in any location and major surgical procedures furnished by general surgeons in HPSAs, the waiver of beneficiary cost-sharing for most preventive services, and the annual wellness visit provisions, will have a positive impact and improve the quality and value of care provided to Medicare beneficiaries.

The regulatory provisions may affect beneficiary liability in some cases. For example, the waiver of the deductible and coinsurance for the annual wellness visit, the IPPE, and preventive services with a grade of A or B from the USPSTF would reduce beneficiary liability for these services. Most changes in aggregate beneficiary liability due to a particular provision would be a function of the coinsurance (20 percent if applicable for the particular provision after the beneficiary has met the deductible). To illustrate this point, as shown in Table 102, the CY 2010 national payment amount in the nonfacility setting for CPT code 99203 (Office/outpatient visit, new) is $76.93 which means that in CY 2010 a beneficiary would be responsible for 20 percent of this amount, or $15.39. Based on this final rule with comment period, the CY 2011 national payment amount in the nonfacility setting for CPT code 99203, as shown in Table 102, is $77.59, which means that, in CY 2011, the beneficiary coinsurance for this service would be $15.52

Additionally, beneficiary liability would also be impacted by the effect of the aggregate cost (savings) of the provisions on the standard calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings).

Most policies discussed in this final rule with comment period that impact payment rates, such as the expansion of the MPPR to therapy services and the increased discount on the TC of multiple imaging procedures from 25 percent to 50 percent, would similarly impact beneficiaries' coinsurance.

H. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 105, we have prepared an accounting statement showing the estimated expenditures associated with this final rule with comment period. This estimate includes the estimated FY 2011 cash benefit impact associated with certain ACA and MIPPA provisions, and the CY 2011 incurred benefit impact associated with the estimated CY 2011 PFS conversion factor update based on the Mid-Session Review of the FY 2011 President's Budget baseline.

TABLE 105—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES

Category	Transfers
CY 2011 Annualized Monetized Transfers.	Estimated decrease in expenditures of $17.6 billion for PFS conversion factor update.
From Whom To Whom?	Federal Government to physicians, other practitioners and providers and suppliers who receive payment under Medicare.
FY 2011 Annualized Monetized Transfers.	Estimated increase in expenditures of $1.97 billion for Affordable Care Act provisions.
From Whom To Whom?	Federal Government to providers.

In accordance with the provisions of Executive Order 12866, this final rule with comment period was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 405

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

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

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

42 CFR Part 411

Kidney diseases, Medicare, Physician Referral, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Part 414

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

42 CFR Part 415

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

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

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

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1886(k) of the Social Security Act (42 U.S.C. 1302, 1395x, 1395y(a), 1395hh, 1395kk, 1395rr and 1395ww(k)), and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

Subpart X—Rural Health Clinic and Federally Qualified Health Center Services

■ 2. A new § 405.2449 is added to read as follows

§ 405.2449 Preventive services.

For services furnished on or after January 1, 2011, preventive services covered under the Medicare Federally qualified health center benefit are those preventive services defined in section 1861(ddd)(3) of the Act, and § 410.2 of this chapter. Specifically, these include the following:

(a) The specific services currently listed in section 1861(ww)(2) of the Act, with the explicit exclusion of electrocardiograms.

(b) The Initial Preventive Physical Examination (IPPE) (as specified by section 1861(ww)(1) of the Act as added by section 611 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108–173) and § 410.16 of this chapter); and

(c) The Personalized Prevention Plan Services (PPPS), also known as the "Annual Wellness Visit" (as specified by section 1861(hhh) of the Act as added by section 4103 of the Affordable Care Act (Pub. L. 111–148) and § 410.15 of this chapter).

■ 3. Section 405.2470 is amended by adding a new paragraph (d) to read as follows:

§ 405.2470 Reports and maintenance of records.

* * * * *

(d) *Collection of additional claims data.* Beginning January 1, 2011, a Medicare FQHC must report on its Medicare claims such information as the Secretary determines is needed to develop and implement a prospective payment system for FQHCs including, but not limited to all pertinent HCPCS (Healthcare Common Procedure Coding System) code(s) corresponding to the service(s) provided for each Medicare FQHC visit (as defined in § 405.2463).

PART 409—HOSPITAL INSURANCE BENEFITS

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

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

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

§ 409.17 [Amended]

■ 5. Amend § 409.17(d) by removing the phrase "hospital policies and procedures." and adding in its place the phrase "the provider's policies and procedures.".

Subpart C—Posthospital SNF Care

■ 6. Section 409.20 is amended by revising paragraph (a)(3) to read as follows:

§ 409.20 Coverage of services.

(a) * * *

(3) Physical therapy, occupational therapy, and speech-language pathology services.

* * * * *

■ 7. Section 409.23 is revised to read as follows:

§ 409.23 Physical therapy, occupational therapy, and speech-language pathology services.

Medicare pays for physical therapy, occupational therapy, or speech-language pathology services as posthospital SNF care if they are furnished—

(a) By (or under arrangements made by) the facility and billed by (or through) the facility;

(b) By qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, or speech-language pathologists as defined in part 484 of this chapter; and

(c) In accordance with a plan that meets the requirements of § 409.17(b) through (d) of this part.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

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

Authority: Secs. 1102, 1834, 1871, and 1893 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395hh, and 1395ddd).

Subpart A—General Provisions

■ 9. Section 410.2 is amended by adding the definition of "Preventive services" in alphabetical order to read as follows:

§ 410.2 Definitions.

* * * * *

Preventive services means all of the following:

(1) The specific services listed in section 1861(ww)(2) of the Act, with the explicit exclusion of electrocardiograms;

(2) The Initial Preventive Physical Examination (IPPE) (as specified by section 1861(ww)(1) of the Act); and

(3) Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS) (as specified by section 1861(hhh)(1) of the Act).

§ 410.3 [Amended]

■ 10. Amend § 410.3(b)(2) by removing the reference "subpart E" and adding in its place the reference "subpart I."

Subpart B—Medical and Other Health Services

■ 11. Section 410.15 is added to read as follows:

§ 410.15 Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage.

(a) *Definitions.* For purposes of this section—

Detection of any cognitive impairment means assessment of an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers or others.

Eligible beneficiary means an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period and who has not received either an initial preventive physical examination or an annual wellness visit providing a personalized prevention plan within the past 12 months.

Establishment of, or an update to the individual's medical and family history means, at minimum, the collection and documentation of the following:

(i) Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries and treatments.

(ii) Use or exposure to medications and supplements, including calcium and vitamins.

(iii) Medical events in the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the individual at increased risk.

First annual wellness visit providing personalized prevention plan services means the following services furnished to an eligible beneficiary by a health professional as those terms are defined in this section:

(i) Establishment of an individual's medical and family history.

(ii) Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.

(iii) Measurement of an individual's height, weight, body-mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements as deemed appropriate, based on the beneficiary's medical and family history.

(iv) Detection of any cognitive impairment that the individual may have, as that term is defined in this section.

(v) Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.

(vi) Review of the individual's functional ability and level of safety, based on direct observation or the use of appropriate screening questions or a screening questionnaire, which the health professional as defined in this section may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

(vii) Establishment of the following:

(A) A written screening schedule for the individual such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.

(B) A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under § 410.16 of this subpart), and a list of treatment options and their associated risks and benefits.

(viii) Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

(ix) Voluntary advance care planning (as defined in this section) upon agreement with the individual.

(x) Any other element determined appropriate through the national coverage determination process.

Health professional means—

(i) A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act); or

(ii) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); or

(iii) A medical professional (including a health educator, a registered dietitian, or nutrition professional, or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in § 410.32(b)(3)(ii)) of a physician as defined in paragraph (i) of this definition.

Review of the individual's functional ability and level of safety means, at minimum, assessment of the following topics:

(i) Hearing impairment.

(ii) Ability to successfully perform activities of daily living.

(iii) Fall risk.

(iv) Home safety.

Subsequent annual wellness visit providing personalized prevention plan services means the following services furnished to an eligible beneficiary by a health professional as those terms are defined in this section:

(i) An update of the individual's medical and family history.

(ii) An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual as that list was developed for the first annual wellness visit providing personalized prevention plan services.

(iii) Measurement of an individual's weight (or waist circumference), blood pressure and other routine measurements as deemed appropriate, based on the individual's medical and family history.

(iv) Detection of any cognitive impairment that the individual may have, as that term is defined in this section.

(v) An update to the following:

(A) The written screening schedule for the individual as that schedule is defined in paragraph (a) of this section for the first annual wellness visit providing personalized prevention plan services.

(B) The list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual as that list was developed at the first annual wellness visit providing personalized prevention plan services.

(vi) Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs as that advice and related services are defined in paragraph (a) of this section.

(vii) Voluntary advance care planning (as defined in paragraph (a) of this section) upon agreement with the individual.

(viii) Any other element determined appropriate through the national coverage determination process.

Voluntary advance care planning means, for purposes of this section, verbal or written information regarding the following areas:

(i) An individual's ability to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions.

(ii) Whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

(b) *Conditions for coverage of annual wellness visits providing personalized prevention plan services.* Medicare Part B pays for first and subsequent annual wellness visits providing personalized prevention plan services that are furnished to an eligible beneficiary, as described in this section, if they are furnished by a health professional, as defined in this section.

(c) *Limitations on coverage of an annual wellness visit providing personalized prevention plan services.* Payment may not be made for either a first or a subsequent annual wellness visit providing personalized prevention plan services that is performed for an individual who is—

(1) Not an eligible beneficiary as described in this section.

(2) An eligible beneficiary as described in this section and who has had either an initial preventive physical examination as specified in § 410.16 of this subpart or either a first or a subsequent annual wellness visit providing personalized prevention plan services performed within the past 12 months.

(d) *Effective date.* Coverage for an annual wellness visit providing personalized prevention plan services is

effective for services furnished on or after January 1, 2011.

■ 12. Section 410.32 is amended by adding paragraph (b)(2)(vii) to read as follows:

§ 410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

* * * * *

(b) * * *

(2) * * *

(vii) Diagnostic tests performed by a certified nurse-midwife authorized to perform the tests under applicable State laws.

* * * * *

■ 13. Section 410.64 is amended by revising paragraph (a) introductory text to read as follows:

§ 410.64 Additional Preventive Services

(a) Medicare Part B pays for additional preventive services not described in paragraph (1) or (3) of the definition of "preventive services" under § 410.2, that identify medical conditions or risk factors for individuals if the Secretary determines through the national coverage determination process (as defined in section 1869(f)(1)(B) of the Act) that these services are all of the following:

* * * * *

■ 14. Section 410.78 is amended by revising paragraph (b) introductory text to read as follows:

§ 410.78 Telehealth services.

* * * * *

(b) *General rule.* Medicare Part B pays for office or other outpatient visits, subsequent hospital care services (with the limitation of one telehealth visit every 3 days), subsequent nursing facility care services (not including the Federally-mandated periodic visits under § 483.40(c) and with the limitation of one telehealth visit every 30 days), professional consultations, psychiatric diagnostic interview examination, neurobehavioral status exam, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one "hands on" visit per month to examine the access site), individual and group medical nutrition therapy services, individual and group kidney disease education services, individual and group diabetes self-management (DSMT) training services (except for one hour of in-person services to be furnished in the year following the initial DSMT service to ensure effective injection training), and individual and group health and behavior assessment and intervention services furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

Subpart I—Payment for SMI Benefits

■ 15. Section 410.150 is amended by adding paragraph (b)(20) to read as follows:

§ 410.150 To whom payment is made.

* * * * *

(b) * * *

(20) To a certified nurse-midwife for professional services furnished by the certified nurse-midwife in all settings and for services and supplies furnished incident to those services. Payment is made only if no facility or other provider charges or is paid any amount for the furnishing of the professional services of the certified nurse-midwife.

■ 16. Section 410.152 is amended by revising paragraph (l) to read as follows:

§ 410.152 Amount of payment.

* * * * *

(l) *Amount of payment: Preventive services.* Medicare Part B pays 100 percent of the Medicare payment amount established under the applicable payment methodology for the service setting for providers and suppliers for the following preventive services:

(1) Pneumococcal (as specified in paragraph (h) of this section), influenza, and hepatitis B vaccine and administration.

(2) Screening mammography.

(3) Screening pap tests and screening pelvic exam.

(4) Prostate cancer screening tests (excluding digital rectal examinations).

(5) Colorectal cancer screening tests (excluding barium enemas).

(6) Bone mass measurement.

(7) Medical nutrition therapy (MNT) services.

(8) Cardiovascular screening blood tests.

(9) Diabetes screening tests.

(10) Ultrasound screening for abdominal aortic aneurysm (AAA).

(11) Additional preventive services identified for coverage through the national coverage determination (NCD) process.

(12) Initial Preventive Physical Examination (IPPE).

(13) Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS).

■ 16. Section 410.160 is amended by—

■ A. Revising paragraph (b)(2).

■ B. Adding paragraphs (b)(10) through (13).

The revisions and additions read as follows:

§ 410.160 Part B annual deductible.

* * * * *

(b) * * *

(2) Pneumococcal, influenza, and hepatitis b vaccines and their administration.

* * * * *

(10) Bone mass measurement.

(11) Medical nutrition therapy (MNT) services.

(12) Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS).

(13) Additional preventive services identified for coverage through the national coverage determination (NCD) process.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

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

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w-101 through 1395w-152, 1395hh, and 1395nn).

Subpart A—General Exclusions and Exclusion of Particular Services

■ 18. Section 411.15 is amended by—

■ A. Revising paragraph (a)(1).

■ B. Adding new paragraph (k)(16).

The revision and addition read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(a) * * *

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, ultrasound screening for abdominal aortic aneurysms (AAA), cardiovascular disease screening tests, diabetes screening tests, a screening electrocardiogram, initial preventive physical examinations that meet the criteria specified in paragraphs (k)(6) through (k)(15) of this section, additional preventive services that meet the criteria in § 410.64 of this chapter, or annual wellness visits providing personalized prevention plan services.

* * * * *

(k) * * *

(16) In the case of an annual wellness visit providing a personalized

prevention plan, subject to the conditions and limitations specified in § 410.15 of this subpart.

* * * * *

Subpart J—Financial Relationships Between Physicians and Entities Furnishing Designated Health Services

■ 19. Section 411.355 is amended by adding paragraph (b)(7) to read as follows:

§ 411.355 General exceptions to the referral prohibition related to both ownership/investment and compensation.

* * * * *

(b) * * *

(7) *Disclosure requirement for certain imaging services.*

(i) With respect to magnetic resonance imaging, computed tomography, and positron emission tomography services identified as "radiology and certain other imaging services" on the List of CPT/HCPCS Codes, the referring physician must provide written notice to the patient at the time of the referral that the patient may receive the same services from a person other than one described in paragraph (b)(1) of this section. Except as set forth in paragraph (b)(7)(ii) of this section, the written notice must include a list of at least 5 other suppliers (as defined in § 400.202 of this chapter) that provide the services for which the individual is being referred and which are located within a 25-mile radius of the referring physician's office location at the time of the referral. The notice should be written in a manner sufficient to be reasonably understood by all patients and should include for each supplier on the list, at a minimum, the supplier's name, address, and telephone number.

(ii) If there are fewer than 5 other suppliers located within a 25-mile radius of the physician's office location at the time of the referral, the physician must list all of the other suppliers of the imaging service that are present within a 25-mile radius of the referring physician's office location. Provision of the written list of alternate suppliers will not be required if no other suppliers provide the services for which the individual is being referred within the 25-mile radius.

* * * * *

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

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

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Public Law 106–133 (113 Stat. 1501A–332).

Subpart E—Payments to Providers

■ 21. Section 413.70 is amended by adding a sentence at the end of paragraph (b)(3)(ii)(B) to read as follows:

§ 413.70 Payment for services of a CAH.

* * * * *

(b) * * *

(3) * * *

(ii) * * *

(B) * * * Effective for primary care services furnished by primary care practitioners (as defined in § 414.80(a)) and major surgical procedures furnished by general surgeons in health professional shortage areas (as defined in § 414.2) furnished on or after January 1, 2011 and before January 1, 2016, incentive payments specified under § 414.80 and § 414.67(b), respectively, of this title must not be included in determining payment made under this paragraph.

* * * * *

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

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

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

Subpart A—General Provisions

■ 23. Section 414.2 is amended by adding the definitions of "Health Professional Shortage Area" and "Major surgical procedure" in alphabetical order to read as follows:

§ 414.2 Definitions.

* * * * *

Health Professional Shortage Area (HPSA) means an area designated under section 332(a)(1)(A) of the Public Health Service Act as identified by the Secretary prior to the beginning of such year.

Major surgical procedure means a surgical procedure for which a 10-day or 90-day global period is used for payment under the physician fee schedule and section 1848(b) of the Act.

* * * * *

■ 24. Section 414.26 is amended by—

■ A. Redesignating paragraph (c) as paragraph (d).

■ B. Adding a new paragraph (c).

The addition reads as follows:

§ 414.26 Determining the GAF.

* * * * *

(c) *Adjusting the practice expense index to account for the Frontier State floor.*

(1) *General criteria.* Effective on or after January 1, 2011, CMS will adjust the practice expense index for physicians' services furnished in qualifying States to recognize the practice expense index floor established for Frontier States. A qualifying State must meet the following criteria:

(i) At least 50 percent of counties located within the State have a population density less than 6 persons per square mile.

(ii) The State does not receive a non-labor related share adjustment determined by the Secretary to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(2) *Amount of adjustment.* The practice expense value applied for physicians' services furnished in a qualifying State will be not less than 1.00.

(3) *Process for determining adjustment.* (i) CMS will use the most recent population estimate data published by the U.S. Census Bureau to determine county definitions and population density. This analysis will be periodically revised, such as for updates to the decennial census data.

(ii) CMS will publish annually a listing of qualifying Frontier States receiving a practice expense index floor attributable to this provision.

* * * * *

Subpart B—Physicians and Other Practitioners

■ 25. Section 414.54 is revised to read as follows:

§ 414.54 Payment for certified nurse-midwives' services.

(a) For services furnished after December 31, 1991, allowed amounts under the fee schedule established under section 1833(a)(1)(K) of the Act for the payment of certified nurse-midwife services may not exceed 65

percent of the physician fee schedule amount for the service.

(b) For certified nurse-midwife services furnished on or after January 1, 2011, allowed amounts may not exceed 100 percent of the physician fee schedule amount that would be paid to a physician for the services.

■ 26. Section 414.65 is amended by revising paragraph (a)(1) introductory text to read as follows:

§ 414.65 Payment for telehealth services.

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, subsequent hospital care services (with the limitation of one telehealth subsequent hospital care service every 3 days), subsequent nursing facility care services (not including the Federally-mandated periodic visits under § 483.40(c) and with the limitation of one telehealth nursing facility care service every 30 days), professional consultations, psychiatric diagnostic interview examination, neurobehavioral status exam, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one "hands on" visit per month to examine the access site), individual and group medical nutrition therapy services, individual and group kidney disease education services, individual and group diabetes self-management training (DSMT) services (except for 1 hour of in-person DSMT services to be furnished in the year following the initial DSMT service to ensure effective injection training), and individual and group health and behavior assessment and intervention furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

* * * * *

■ 27. Section 414.67 is revised to read as follows:

§ 414.67 Incentive payments for services furnished in Health Professional Shortage Areas.

(a) *Health Professional Shortage Area (HPSA) physician bonus program.* A HPSA physician incentive payment will be made subject to the following:

(1) HPSA bonuses are payable for services furnished by physicians as defined in section 1861(r) of the Act in areas designated as of December 31 of the prior year as geographic primary medical care HPSAs as defined in section 332(a)(1)(A) of the Public Health Service Act.

(2) HPSA bonuses are payable for services furnished by psychiatrists in areas designated as of December 31 of the prior year as geographic mental health HPSAs if the services are not already eligible for the bonus based on being in a geographic primary care HPSA.

(3) Physicians eligible for the HPSA physician bonus are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

(4) Physicians furnishing services in areas that are designated as geographic HPSAs prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA bonus payments are made must use the AQ modifier to receive the HPSA physician bonus payment.

(b) *HPSA surgical incentive payment program.* A HPSA surgical incentive payment will be made subject to the following:

(1) A major surgical procedure as defined in § 414.2 of this part is furnished by a general surgeon on or after January 1, 2011 and before January 1, 2016 in an area recognized for the HPSA physician bonus program under paragraph (a)(1) of this section.

(2) Payment will be made on a quarterly basis in an amount equal to 10 percent of the Part B payment amount for major surgical procedures furnished as described in paragraph (b)(1) of this section, in addition to the amount the physician would otherwise be paid.

(3) Physicians furnishing services in areas that are designated as geographic HPSAs eligible for the HPSA physician bonus program under paragraph (a)(1) of this section prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA surgical incentive payments are made should report HCPCS modifier -AQ to receive the HPSA surgical incentive payment.

(4) The payment described in paragraph (b)(2) of this section is made to the surgeon or, where the surgeon has reassigned his or her benefits to a critical access hospital (CAH) paid under the optional method, to the CAH based on an institutional claim.

■ 28. Section 414.80 is added to read as follows:

§ 414.80 Incentive payment for primary care services.

(a) *Definitions.* As defined in this section—

Eligible primary care practitioner means one of the following:

(i) A physician (as defined in section 1861(r)(1) of the Act) who meets all of the following criteria:

(A) Enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics.

(B) At least 60 percent of the physician's allowed charges under the physician fee schedule (excluding hospital inpatient care and emergency department visits) during a reference period specified by the Secretary are for primary care services.

(ii) A nurse practitioner, clinical nurse specialist, or physician assistant (as defined in section 1861(aa)(5) of the Act) who meets all of the following criteria:

(A) Enrolled in Medicare with a primary specialty designation of 50-nurse practitioner, 89-certified clinical nurse, or 97-physician assistant.

(B) At least 60 percent of the practitioner's allowed charges under the physician fee schedule (excluding hospital inpatient care and emergency department visits) during a reference period specified by the Secretary are for primary care services.

Primary care services means—

(i) New and established patient office or other outpatient evaluation and management (E/M) visits;

(ii) Initial, subsequent, discharge, and other nursing facility E/M services;

(iii) New and established patient domiciliary, rest home (for example, boarding home), or custodial care E/M services;

(iv) Domiciliary, rest home (for example, assisted living facility), or home care plan oversight services; and

(v) New and established patient home E/M visits.

(b) *Payment.*

(1) For primary care services furnished by an eligible primary care practitioner on or after January 1, 2011 and before January 1, 2016, payment is made on a quarterly basis in an amount equal to 10 percent of the payment amount for the primary care services under Part B, in addition to the amount the primary care practitioner would otherwise be paid for the primary care services under Part B.

(2) The payment described in paragraph (b)(1) of this section is made to the eligible primary care practitioner or, where the physician has reassigned his or her benefits to a critical access hospital (CAH) paid under the optional method, to the CAH based on an institutional claim.

■ 29. A new § 414.90 is added to read as follows:

§ 414.90 Physician Quality Reporting System.

(a) *Basis and scope.* This section implements the following provisions of the Act:

(1) 1848(a)—Payment Based on Fee Schedule.

(2) 1848(k)—Quality Reporting System.

(3) 1848(m)—Incentive Payments for Quality Reporting.

(b) *Definitions.* As used in this section, unless otherwise indicated—

Covered professional services means services for which payment is made under, or is based on, the Medicare physician fee schedule as provided under section 1848(k)(3) of the Act and which are furnished by an eligible professional.

Eligible professional means any of the following:

(i) A physician.

(ii) A practitioner described in section 1842(b)(18)(C) of the Act.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

Group practice means a single Taxpayer Identification Number (TIN) with two or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN.

Maintenance of Certification Program means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification Program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, and professionalism. Such a program must include the following:

(i) The program requires the physician to maintain a valid unrestricted license in the United States.

(ii) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(iii) The program requires a physician to demonstrate, through a formalized secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

(iv) The program requires successful completion of a qualified maintenance of certification program practice assessment.

Maintenance of Certification Program Practice Assessment means an assessment of a physician's practice that—

(i) Includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

(ii) Includes a survey of patient experience with care; and

(iii) Requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under paragraph (h) of this section and then to remeasure to assess performance improvement after such intervention.

Measures group means a subset of four or more Physician Quality Reporting System measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.

Physician Quality Reporting System means the physician reporting system under section 1848(k) of the Act for the reporting by eligible professionals of data on quality measures and the incentive payment associated with this physician reporting system.

Performance rate means the percentage of a defined population who receives a particular process of care or achieve a particular outcome for a particular quality measure.

Reporting rate means the percentage of patients that the eligible professional indicated a quality action was or was not performed divided by the total number of patients in the denominator of the measure.

Qualified registry means a medical registry or a maintenance of certification program operated by a specialty body of the American Board of Medical Specialties that, with respect to a particular program year, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate its compliance with the Physician Quality Reporting System qualification requirements specified by CMS for that program year. The registry may act as a data submission vendor, which has the requisite legal authority to provide Physician Quality Reporting System data (as specified by CMS) on behalf of an eligible professional to CMS.

Qualified electronic health record product means an electronic health record vendor's product and version that, with respect to a particular program year, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate the product's compliance with the Physician Quality Reporting System qualification requirements specified by CMS for a program year. The requirements and process for an electronic health record product to be qualified for the purpose of the Physician Quality Reporting System is separate from the standards, implementation specifications, and certification criteria established for the EHR Incentive Program specified in part 495.

(c) *Incentive payments.* With respect to covered professional services furnished during a reporting period by an eligible professional, if —

(1) There are any quality measures that have been established under the Physician Quality Reporting System that are applicable to any such services furnished by such professional (or in the case of a group practice under paragraph (g) of this section, such group practice) for such reporting period; and

(2) The eligible professional (or in the case of a group practice under paragraph (g) of this section, the group practice) satisfactorily submits (as determined under paragraph (f) of this section for eligible professionals and paragraph (g) of this section for group practices) to the Secretary data on such quality measures in accordance with the Physician Quality Reporting System for such reporting period, in addition to the amount otherwise paid under section 1848 of the Act, there also must be paid to the eligible professional (or to an employer or facility in the cases described in section 1842(b)(6)(A) of the Act or, in the case of a group practice) under paragraph (g) of this section, to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Act an amount equal to the applicable quality percent (as specified in paragraph (c)(3) of this section) of the eligible professional's (or, in the case of a group practice under paragraph (g) of this section, the group practice's) total estimated allowed charges for all covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (g) of this section, by the group practice) during the applicable reporting period. For purposes of this paragraph,

(i) The eligible professional's (or, in the case of a group practice under paragraph (g) of this section, the group practice's) total estimated allowed charges for covered professional services furnished during a reporting period are determined based on claims

processed in the National Claims History (NCH) no later than 2 months after the end of the applicable reporting period;

(ii) In the case of an eligible professional who furnishes covered professional services in more than one practice, incentive payments are separately determined for each practice based on claims submitted for the eligible professional for each practice;

(iii) Incentive payments earned by an eligible professional (or in the case of a group practice under paragraph (g) of this section, by a group practice) for a particular program year will be paid as a single consolidated payment to the TIN holder of record.

(3) *Applicable quality percent.* The applicable quality percent is as follows:

(i) For 2011, 1.0 percent; and

(ii) For 2012, 2013, and 2014, 0.5 percent;

(d) *Additional incentive payment.* (1) Through 2014, if an eligible professional meets the requirements described in paragraph (d)(2) of this section, the applicable percent for such year, as described in paragraphs (c)(3)(i) and (ii) of this section, must be increased by 0.5 percentage points.

(2) In order to qualify for the additional incentive payment described in paragraph (d)(1) of this section, an eligible professional must meet the following requirements:

(i) The eligible professional must—

(A) Satisfactorily submit data on quality measures for purposes of this section for a year; and

(B) Have such data submitted on their behalf through a Maintenance of Certification program (as defined in paragraph (b) of this section) that meets:

(*1*) The criteria for a registry (as specified by CMS); or

(*2*) An alternative form and manner determined appropriate by the Secretary.

(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

(A) Participates in a maintenance of certification program (as defined in paragraph (b) of this section) for a year; and

(B) Successfully completes a qualified maintenance of certification program practice assessment (as defined in paragraph (b) of this section) for such year.

(iii) A Maintenance of Certification Program submits to the Secretary, on behalf of the eligible professional, information—

(A) In a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of paragraph (d)(2)(ii) of this section, which may be in the form of a structural measure);

(B) If requested by the Secretary, on the survey of patient experience with care (as described in paragraph (b) of this section); and

(C) As the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

(e) *Use of consensus-based quality measures.* For each program year, CMS will publish the final list of measures and the final detailed measure specifications for all quality measures selected for inclusion in the Physician Quality Reporting System quality measure set for a given program year on a CMS Web site by no later than December 31 of the prior year.

(1) *General rule.* Subject to paragraph (e)(2) of this section, for purposes of reporting data on quality measures for covered professional services furnished during a year, subject to paragraph (f) of this section, the quality measures specified under this paragraph must be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) of the Act.

(2) *Exception.* In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance.

(3) *Opportunity to provide input on measures.* For each quality measure adopted by the Secretary under this paragraph, the Secretary ensures that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of quality measures applicable to services they furnish.

(f) *Requirements for individual eligible professionals to qualify to receive an incentive payment.* In order to qualify to earn a Physician Quality Reporting System incentive payment for a particular program year, an individual eligible professional, as identified by a unique TIN/NPI combination, must meet the criteria for satisfactory reporting specified by CMS for such year by reporting on either individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups identified by CMS during a reporting period specified in paragraph (f)(1) of this section and using one of the reporting mechanisms specified in paragraph (f)(2) of this section. Although an eligible professional may attempt to qualify for the Physician Quality Reporting System incentive payment by reporting on both individual Physician Quality Reporting System quality measures and measures groups, using more than one reporting mechanism (as specified in paragraph (f)(2) of this section), or reporting for more than one reporting period, he or she will receive only one Physician Quality Reporting System incentive payment per TIN/NPI combination for a program year.

(1) *Reporting periods.* For purposes of this paragraph, the reporting period with respect to program year 2011 is—

(i) The 12-month period from January 1 through December 31 of such program year; or

(ii) The 6-month period from July 1 through December 31 of such program year.

(2) *Exceptions.* In program year 2011, the 6-month reporting period is not available for EHR-based reporting of individual Physician Quality Reporting System quality measures or for reporting by group practices under the process described in paragraph (g) of this section.

(3) *Reporting mechanisms.* For program year 2011, an eligible professional who wishes to participate in the Physician Quality Reporting System must report information on the individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups identified by CMS in the following manner:

(i) Reporting the individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups to CMS, by no later than 2 months after the end of the applicable reporting period, on the eligible professional's Medicare Part B claims for covered professional services furnished during the applicable reporting period.

(ii) Reporting the individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups to a qualified registry (as specified in paragraph (b) of this section) in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected registry will submit information, as required by CMS, for covered professional services furnished

by the eligible professional during the applicable reporting period to CMS on the eligible professional's behalf; or

(iii) Reporting the individual Physician Quality Reporting System quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from a qualified EHR product (as defined in paragraph (b) of this section) by the deadline specified by CMS for covered professional services furnished by the eligible professional during the applicable reporting period. Prior to actual data submission for a given program year and by a date specified by CMS, the eligible professional must submit a test file containing real or dummy clinical quality data extracted from the qualified EHR product selected by the eligible professional using a secure data submission method, as required by CMS.

(g) *Requirements for group practices to qualify to receive an incentive payment.* A group practice (as defined in paragraph (b) of this section) will be treated as satisfactorily submitting data on quality measures under Physician Quality Reporting System for covered professional services for a reporting period, if, in lieu of reporting Physician Quality Reporting System measures, the group practice—

(1) Meets the participation requirements specified by CMS for the Physician Quality Reporting System group practice reporting option or is a group practice of any size (including solo practitioners) or comprised of multiple TINs participating in a Medicare approved demonstration project that is deemed to be participating in the Physician Quality Reporting System group practice reporting option;

(2) Is selected by CMS to participate in the Physician Quality Reporting System group practice reporting option;

(3) Reports measures specified by CMS in the form and manner, and at a time specified by CMS; and

(4) Meets other requirements for satisfactory reporting specified by CMS.

(5) No double payments. Payments to a group practice under this paragraph must be in lieu of the payments that would otherwise be made under the Physician Quality Reporting System to eligible professionals in the group practice for meeting the criteria for satisfactory reporting for individual eligible professionals.

(i) If an eligible professional, as identified by an individual NPI, has reassigned his or her Medicare billing rights to a TIN selected to participate in the Physician Quality Reporting System group practice reporting option for a program year, then for that program year the eligible professional must participate in the Physician Quality Reporting System via the group practice reporting option. For any program year in which the TIN is selected to participate in the Physician Quality Reporting System group practice reporting option, the eligible professional cannot individually qualify for a Physician Quality Reporting System incentive payment by meeting the requirements specified in paragraph (f) of this section.

(ii) If, for the program year, the eligible professional participates in the Physician Quality Reporting System under another TIN that is not selected to participate in the Physician Quality Reporting System group practice reporting option for that program year, then the eligible professional may individually qualify for a Physician Quality Reporting System incentive by meeting the requirements specified in paragraph (f) of this section under that TIN.

(h) *Limitations on review.* Except as specified in paragraph (i) of this section, there is no administrative or judicial review under section 1869 or 1879 of the Act, or otherwise of—

(1) The determination of measures applicable to services furnished by eligible professionals under the Physician Quality Reporting System;

(2) The determination of the payment limitation; and

(3) The determination of any Physician Quality Reporting System incentive payment and the Physician Quality Reporting System payment adjustment.

(i) *Informal review.* Eligible professionals (or in the case of reporting under paragraph (g) of this section, group practices) may seek an informal review of the determination that an eligible professional (or in the case of reporting under paragraph (g) of this section, group practices) did not satisfactorily submit data on quality measures under the Physician Quality Reporting System.

(1) To request an informal review, an eligible professional (or in the case of reporting under paragraph (g) of this section, group practices) must submit a request to CMS within 90 days of the release of the feedback reports. The request must be submitted in writing or via e-mail and summarize the concern(s) and reasons for requesting an informal review and may also include information to assist in the review.

(2) CMS will provide a written response within 60 days of the receipt of the original request.

(i) All decisions based on the informal review will be final.

(ii) There will be no further review or appeal.

(j) *Public reporting of an eligible professional's or group practice's Physician Quality Reporting System data.* For each program year, CMS will post on a public Web site, in an easily understandable format, a list of the names of eligible professionals (or in the case of reporting under paragraph (g) of this section, group practices) who satisfactorily submitted Physician Quality Reporting System quality measures.

■ 30. A new § 414.92 is added to read as follows:

§ 414.92 Electronic Prescribing Incentive Program.

(a) *Basis and scope.* This section implements the following provisions of the Act:

(1) Section 1848(a)—Payment Based on Fee Schedule.

(2) Section 1848(m)—Incentive Payments for Quality Reporting.

(b) *Definitions.* As used in this section, unless otherwise indicated—

Covered professional services means services for which payment is made under, or is based on, the Medicare physician fee schedule which are furnished by an eligible professional.

Electronic Prescribing Incentive Program means the incentive payment program established under section 1848(m) of the Act for the adoption and use of electronic prescribing technology by eligible professionals.

Eligible professional means any of the following healthcare professionals who have prescribing authority:

(i) A physician.

(ii) A practitioner described in section 1842(b)(18)(C) of the Act.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

Group practice means a group practice that is—

(i) Defined at § 414.90(b), that is participating in the Physician Quality Reporting System; or

(ii) (A) In a Medicare approved demonstration project that is deemed to be participating in the Physician Quality Reporting System group practice reporting option; and

(B) Has indicated its desire to participate in the electronic prescribing group practice option.

Qualified electronic health record product means an electronic health record product and version that, with

respect to a particular program year, is designated by CMS as a qualified electronic health record product for the purpose of the Physician Quality Reporting System (as described in § 414.90) and the product's vendor has indicated a desire to have the product qualified for purposes of the product's users to submit information related to the electronic prescribing measure.

Qualified registry means a medical registry or a Maintenance of Certification Program operated by a specialty body of the American Board of Medical Specialties that, with respect to a particular program year, is designated by CMS as a qualified registry for the purpose of the Physician Quality Reporting System (as described in § 414.90) and that has indicated its desire to be qualified to submit the electronic prescribing measure on behalf of eligible professionals for the purposes of the Electronic Prescribing Incentive Program.

(c) *Incentive payments and payment adjustments.* (1) *Incentive payments.* Subject to paragraph (c)(3) of this section, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting period, in addition to the amount otherwise paid under section 1848 of the Act, there also must be paid to the eligible professional (or to an employer or facility in the cases described in section 1842(b)(6)(A) of the Act) or, in the case of a group practice under paragraph (e) of this section, to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Act an amount equal to the applicable electronic prescribing percent (as specified in paragraph (c)(1)(ii) of this section) of the eligible professional's (or, in the case of a group practice under paragraph (e) of this section, the group practice's) total estimated allowed charges for all covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (e) of this section, by the group practice) during the applicable reporting period.

(i) For purposes of paragraph (c)(1) of this section,

(A) The eligible professional's (or, in the case of a group practice under paragraph (e) of this section, the group practice's) total estimated allowed charges for covered professional services furnished during a reporting period are determined based on claims processed in the National Claims History (NCH) no later than 2 months after the end of the applicable reporting period;

(B) In the case of an eligible professional who furnishes covered professional services in more than one practice, incentive payments are separately determined for each practice based on claims submitted for the eligible professional for each practice;

(C) Incentive payments earned by an eligible professional (or in the case of a group practice under paragraph (e) of this section, by a group practice) for a particular program year will be paid as a single consolidated payment to the TIN holder of record.

(ii) *Applicable electronic prescribing percent.* The applicable electronic prescribing percent is as follows:

(A) For the 2011 and 2012 program years, 1.0 percent.

(B) For the 2013 program year, 0.5 percent.

(iii) *Limitation with respect to electronic health record (EHR) incentive payments.* The provisions of this paragraph do not apply to an eligible professional (or, in the case of a group practice under paragraph (e) of this section, a group practice) if, for the electronic health record reporting period the eligible professional (or group practice) receives an incentive payment under section 1848(o)(1)(A) of the Act with respect to a certified electronic health record technology (as defined in section 1848(o)(4) of the Act) that has the capability of electronic prescribing.

(2) *Incentive payment adjustment.* Subject to paragraphs (c)(1)(ii) and (c)(3) of this section, with respect to covered professional services furnished by an eligible professional during 2012, 2013, or 2014, if the eligible professional (or in the case of a group practice under paragraph (e) of this section, the group practice) is not a successful electronic prescriber (as specified by CMS for purposes of the payment adjustment) for an applicable reporting period (as specified by CMS) the fee schedule amount for such services furnished by such professional (or group practice) during the program year (including the fee schedule amount for purposes of determining a payment based on such amount) is equal to the applicable percent (as specified in paragraph (c)(2)(i) of this section) of the fee schedule amount that would otherwise apply to such services under section 1848 of the Act.

(i) *Applicable percent.* The applicable percent is as follows:

(A) For 2012, 99 percent;

(B) For 2013, 98.5 percent; and

(C) For 2014, 98 percent.

(ii) *Significant hardship exception.* CMS may, on a case-by-case basis, exempt an eligible professional (or in the case of a group practice under paragraph (e) of this section, a group practice) from the application of the payment adjustment under paragraph (c)(2) of this section if, CMS determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship.

(3) *Limitation with respect to electronic prescribing quality measures.* The provisions of paragraphs (c)(1) and (c)(2) of this section do not apply to an eligible professional (or, in the case of a group practice under paragraph (e) of this section, a group practice) if for the reporting period the allowed charges under section 1848 of the Act for all covered professional services furnished by the eligible professional (or group, as applicable) for the codes to which the electronic prescribing measure applies are less than 10 percent of the total of the allowed charges under section 1848 of the Act for all such covered professional services furnished by the eligible professional (or the group practice, as applicable).

(d) *Requirements for individual eligible professionals to qualify to receive an incentive payment.* In order to be considered a successful electronic prescriber and qualify to earn an electronic prescribing incentive payment (subject to paragraph (c)(3) of this section), an individual eligible professional, as identified by a unique TIN/NPI combination, must meet the criteria for successful electronic prescriber under section 1848(m)(3)(B) of the Act and as specified by CMS during the reporting period specified in paragraph (d)(1) of this section and using one of the reporting mechanisms specified in paragraph (d)(2) of this section. Although an eligible professional may attempt to qualify for the electronic prescribing incentive payment using more than one reporting mechanism (as specified in paragraph (d)(2) of this section), the eligible professional will receive only one electronic prescribing incentive payment per TIN/NPI combination for a program year.

(1) *Reporting period.* For purposes of this paragraph in 2011, the reporting period with respect to a program year is the entire calendar year.

(2) *Reporting mechanisms.* For program year 2011, an eligible professional who wishes to participate in the Electronic Prescribing Incentive Program must report information on the electronic prescribing measure identified by CMS to—

(i) CMS, by no later than 2 months after the end of the applicable reporting period, on the eligible professional's Medicare Part B claims for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section;

(ii) A qualified registry (as defined in paragraph (b) of this section) in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected qualified registry will submit information, as required by CMS, for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section to CMS on the eligible professional's behalf; or

(iii) CMS by extracting clinical data using a secure data submission method, as required by CMS, from a qualified electronic health record product (as defined in paragraph (b) of this section) by the deadline specified by CMS for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section. Prior to actual data submission for a given program year and by a date specified by CMS, the eligible professional must submit a test file containing real or dummy clinical quality data extracted from the qualified electronic health record product selected by the eligible professional using a secure data submission method, as required by CMS.

(e) *Requirements for group practices to qualify to receive an incentive payment.* (1) A group practice (as defined in paragraph (b) of this section) will be treated as a successful electronic prescriber for covered professional services for a reporting period if the group practice meets the criteria for successful electronic prescriber specified by CMS in the form and manner and at the time specified by CMS.

(2) *No double payments.* Payments to a group practice under this paragraph must be in lieu of the payments that would otherwise be made under the Electronic Prescribing Incentive Program to eligible professionals in the group practice for being a successful electronic prescriber.

(i) If an eligible professional, as identified by an individual NPI, has reassigned his or her Medicare billing rights to a TIN selected to participate in the electronic prescribing group practice reporting option for a program year, then for that program year the eligible professional must participate in the Electronic Prescribing Incentive Program via the group practice reporting option. For any program year in which the TIN is selected to participate in the Electronic Prescribing Incentive Program group practice reporting option, the eligible professional cannot individually qualify for an electronic prescribing incentive payment by meeting the requirements specified in paragraph (d) of this section.

(ii) If, for the program year, the eligible professional participates in the Electronic Prescribing Incentive Program under another TIN that is not selected to participate in the Electronic Prescribing Incentive Program group practice reporting option for that program year, then the eligible professional may individually qualify for an electronic prescribing incentive by meeting the requirements specified in paragraph (d) of this section under that TIN.

(f) *Public reporting of an eligible professional's or group practice's Electronic Prescribing Incentive Program data.* For each program year, CMS will post on a public Web site, in an easily understandable format, a list of the names of eligible professionals (or in the case of reporting under paragraph (e) of this section, group practices) who are successful electronic prescribers.

Subpart D—Payment for Durable Medical Equipment and Prosthetic and Orthotic Devices

■ 31. Section 414.202 is amended by adding the definition of "Complex rehabilitative power-driven wheelchair.

§ 414.202 Definitions.

* * * * *

Complex rehabilitative power-driven wheelchair means a power-driven wheelchair that is classified as—

(1) Group 2 power wheelchair with power options that can accommodate rehabilitative features (for example, tilt in space); or

(2) Group 3 power wheelchair.

* * * * *

■ 32. Section 414.229 is amended by—

■ A. Revising paragraphs (a)(3), (d)(1), and (h).

■ B. Adding paragraphs (a)(4), (a)(5), and (b)(3).

The revisions and additions read as follows:

§ 414.229 Other durable medical equipment-capped rental items.

(a) * * *

(3) For power-driven wheelchairs furnished on or after January 1, 2006 through December 31, 2010, payment is made in accordance with the rules set forth in paragraphs (f) or (h) of this section.

(4) For power-driven wheelchairs that are not classified as complex rehabilitative power-driven wheelchairs, furnished on or after January 1, 2011, payment is made in accordance with the rules set forth in paragraph (f) of this section.

(5) For power-driven wheelchairs classified as complex rehabilitative power-driven wheelchairs, furnished on or after January 1, 2011, payment is made in accordance with the rules set forth in paragraphs (f) or (h) of this section.

(b) * * *

(3) For power-driven wheelchairs furnished on or after January 1, 2011, the monthly fee schedule amount for rental equipment equals 15 percent of the purchase price recognized as determined under paragraph (c) of this section for each of the first 3 months and 6 percent of the purchase price for each of the remaining months.

* * * * *

(d) * * *

(1) Suppliers must offer beneficiaries the option of purchasing power-driven wheelchairs at the time the supplier first furnishes the item. On or after January 1, 2011, this option is available only for complex rehabilitative power-driven wheelchairs. Payment must be on a lump-sum fee schedule purchase basis if the beneficiary chooses the purchase option. The purchase fee is the amount established in paragraph (c) of this section.

* * * * *

(h) *Purchase of power-driven wheelchairs furnished on or after January 1, 2006.* (1) Suppliers must offer beneficiaries the option to purchase power-driven wheelchairs at the time the equipment is initially furnished.

(2) Payment is made on a lump-sum purchase basis if the beneficiary chooses this option.

(3) On or after January 1, 2011, this option is available only for complex rehabilitative power-driven wheelchairs.

Subpart F—Competitive Bidding for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

■ 33. Section 414.402 is amended by adding the definitions of "Affected party," "Breach of contract," "Corrective action plan (CAP)," "Hearing officer," "Mail order item," "National mail order DMEPOS competitive bidding program," "Non-mail order item" and "Parties to the hearing" in alphabetical order to read as follows:

§ 414.402 Definitions.

Affected party means a contract supplier that has been notified that their DMEPOS CBP contract will be terminated for a breach of contract.

* * * * *

Breach of contract means any deviation from contract requirements, including a failure to comply with a governmental agency or licensing organization requirements, constitutes a breach of contract.

* * * * *

Corrective action plan (CAP) means a contract supplier's written document with supporting information that describes the actions the contract supplier will take within a specified timeframe to remedy a breach of contract.

* * * * *

Hearing officer (HO) means an individual, who was not involved with the CBIC recommendation to terminate a DMEPOS Competitive Bidding Program contract, who is designated by CMS to review and make an unbiased and independent recommendation when there is an appeal of CMS's initial determination to terminate a DMEPOS Competitive Bidding Program contract.

* * * * *

Mail order item means any item (for example, diabetic testing supplies) shipped or delivered to the beneficiary's home, regardless of the method of delivery.

* * * * *

National mail order DMEPOS competitive bidding program means a program whereby contracts are awarded to suppliers for the furnishing of mail order items across the nation.

* * * * *

Non-mail order item means any item (for example, diabetic testing supplies) that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront.

Parties to the hearing means the DMEPOS contract supplier and CMS.

* * * * *

■ 34. Section 414.404 is amended by revising paragraph (b)(1)(i) to read as follows:

§ 414.404 Scope and applicability.

* * * * *

(b) * * *

(1) * * *

(i) The items furnished are limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps that are DME, and off-the-shelf (OTS) orthotics.

* * * * *

■ 35. Section 414.408 is amended by—

■ A. Revising paragraph (f)(1).

■ B. Redesignating paragraph (h)(2) through (h)(7) as paragraphs (h)(3) through (h)(8), respectively.

■ C. Adding new paragraph (h)(2).

■ D. In newly designated paragraphs (h)(3)(i) and (ii), remove the phrase "(h)(2)" and insert in its place the phrase "(h)(3)."

The revision and addition reads as follows:

§ 414.408 Payment rules.

* * * * *

(f) * * *

(1) The single payment amounts for new purchased durable medical equipment, including power wheelchairs that are purchased when the equipment is initially furnished and enteral nutrition equipment are calculated based on the bids submitted and accepted for these items. For contracts entered into beginning on or after January 1, 2011, payment on a lump sum purchase basis is only available for power wheelchairs classified as complex rehabilitative power wheelchairs.

* * * * *

(h) * * *

(2) For contracts entered into beginning on or after January 1, 2011, the monthly fee schedule amount for rental of power wheelchairs equals 15 percent of the single payment amounts calculated for new durable medical equipment under paragraph (f)(1) of this section for each of the first 3 months, and 6 percent of the single payment amounts calculated for these items for each of the remaining months 4 through 13.

* * * * *

■ 36. Section 414.410 is amended as follows:

■ A. Revising paragraphs (a)(2) and (a)(3).

■ B. Adding a new paragraph (a)(4).

The revisions and addition read as follows:

§ 414.410 Phase-in implementation of competitive bidding programs.

(a) * * *

(2) In CY 2011, in an additional 91 MSAs (the additional 70 MSAs selected by CMS as of June 1, 2008, and the next 21 largest MSAs by total population based on 2009 population estimates, and not already phased in as of June 1, 2008). CMS may subdivide any of the 91 MSAs with a population of greater than 8,000,000 into separate CBAs, thereby resulting in more than 91 CBAs.

(3) After CY 2011, additional CBAs (or, in the case of national mail order for items and services, after CY 2010).

(4) For competitions (other than for national mail order items and services) after CY 2011 and prior to CY 2015, the following areas are excluded:

(i) Rural areas.

(ii) MSAs not selected under paragraphs (a)(1) or (a)(2) of this section with a population of less than 250,000.

(iii) An area with low population density within an MSA not selected under paragraphs (a)(1) or (a)(2) of this section.

* * * * *

■ 37. Section 414.411 is added to read as follows:

§ 414.411 Special rule in case of competitions for diabetic testing strips conducted on or after January 1, 2011.

(a) *National mail order competitions.* A supplier must demonstrate that their bid submitted as part of a national mail order competition for diabetic testing strips covers the furnishing of a sufficient number of different types of diabetic testing strip products that, in the aggregate, and taking into account volume for the different products, includes at least 50 percent of all the different types of products on the market. A type of diabetic testing strip means a specific brand and model of testing strips.

(b) *Other competitions.* CMS may apply this special rule to non-mail order or local competitions for diabetic testing strips.

■ 38. Section 414.422 is amended by adding paragraph (e)(3) to read as follows:

§ 414.422 Term of contracts.

* * * * *

(e) * * *

(3) Contract suppliers for diabetic testing supplies must furnish the brand of diabetic testing supplies that work with the home blood glucose monitor selected by the beneficiary. The contract supplier is prohibited from influencing or incentivizing the beneficiary by persuading, pressuring, or advising them to switch from their current brand or for new beneficiaries from their preferred brand of glucose monitor and testing supplies. The contract supplier may not furnish information about alternative brands to the beneficiary unless the beneficiary requests such information.

* * * * *

■ 39. Section 414.423 is added to read as follows:

§ 414.423 Appeals Process for Termination of Competitive Bidding Contract.

This section implements an appeals process for suppliers that CMS has determined are in breach of their

Medicare DMEPOS Competitive Bidding Program contracts and where CMS has taken action to terminate the supplier's contract. Except as specified in this regulation termination decisions made under this section are final and binding.

(a) *Terminations for breach of contract.* CMS may terminate a supplier's DMEPOS Competitive Bidding Program contract when it determines that the supplier has violated any of the terms of its contract.

(b) *Notice of termination.*

(1) *CMS notification.* If CMS determines a supplier to be in breach of its contract either in part or in whole, it will notify the Medicare DMEPOS supplier of the termination by certified mail.

(2) *Content of the notice.* The CMS notice will include the following:

(i) The reasons for the termination.

(ii) The right to request a hearing by a CBIC Hearing Officer, and depending on the nature of the breach, the supplier may also be allowed to submit a CAP in lieu of requesting a hearing by a CBIC Hearing Officer, as specified in paragraph (c)(1)(i) of this section.

(iii) The address to which the written request for a hearing must be mailed.

(iv) The address to which the CAP must be mailed, if applicable.

(v) Penalties that will accompany the termination, such as not being eligible to bid in future rounds of competitive bidding.

(vi) The effective date of termination is 45 days from the date of the notification letter unless a timely hearing request has been filed or a corrective action plan (CAP) has been submitted within 30 days of the date on the notification letter.

(c) *Corrective action plan (CAP).* (1) *Option for corrective action plan (CAP).*

(i) CMS has the option to allow a DMEPOS supplier to provide a written corrective action plan (CAP) to remedy the deficiencies identified in the notice, when CMS determines that the delay in the termination date caused by allowing a CAP will not cause harm to beneficiaries, for example, we would not allow a CAP if the supplier has been excluded from any Federal program, debarred by a Federal agency, or convicted of a healthcare-related crime.

(ii) If a supplier chooses not to submit a CAP or if CMS determines that a supplier's CAP is insufficient, the supplier may request a hearing on the termination.

(2) *Submission of a CAP.* (i) A corrective action plan must be submitted within 30 days from the date on the notification letter. If the supplier decides not to submit a corrective action plan the supplier may within 30 days of the date on the termination letter request a hearing by a CBIC hearing officer.

(ii) Suppliers will only have the opportunity to submit a CAP when they are first notified that they have been determined to be in breach of contract. If the CAP is not acceptable or properly implemented, suppliers will receive a subsequent termination notice.

(d) *The purpose of the corrective action plan.* (1) For the supplier to eliminate all of the deficiencies that were identified in the notice to terminate its contract to avoid contract termination.

(2) To identify the timeframes by which the supplier will implement each of the components of the CAP.

(e) *Review of the CAP.* (1) The CBIC will review the CAP. Suppliers may only revise their CAP one-time during the review process based on the deficiencies identified by the CBIC. The CBIC will submit a recommendation to CMS concerning whether the CAP includes the steps necessary to remedy the contract deficiencies as identified in the notice of termination.

(2) If CMS accepts the CAP, including supplier's designated timeframe for its completion; the supplier must provide a follow-up report within 5 days after the supplier has fully implemented the CAP that verifies that all of the deficiencies identified in the CAP have been corrected in accordance with the timeframes accepted by CMS.

(3) If the supplier does not implement an acceptable CAP the supplier will receive a subsequent notice that their contract will be terminated within 45 days of the date on that notice.

(f) *Right to request a hearing by the CBIC hearing officer (HO).* (1) A supplier who has received a notice that CMS considers the supplier in breach of contract or that the supplier's CAP is not acceptable has the right to request a hearing before an HO who was not involved with the original determination.

(2) A supplier who wishes to appeal the termination notice must submit a written request to the CBIC. The request for a hearing must be received by the CBIC within 30 days from the date of the notice to terminate.

(3) A request for hearing must be in writing and submitted by an authorized official of the supplier.

(4) The appeals process for the Medicare DMEPOS Competitive Bidding Program is not to be used in place of other existing appeals processes that apply to other parts of the Medicare.

(5) If the supplier is given the opportunity to submit a CAP and a CAP is not submitted and the supplier fails to timely request a hearing, this will result in the termination of the supplier's DMEPOS Competitive Bidding Program contract effective 45 days from the date on the notice to terminate received by the supplier.

(g) *The CBIC Hearing Officer schedules and conducts the hearing.* (1) Within 30 days from the receipt of the supplier's timely request for a hearing the hearing officer will contact the parties to schedule the hearing.

(2) The hearing may be held in person or by telephone at the supplier's request.

(3) The scheduling notice to the parties must indicate the time and place for the hearing and must be sent to the supplier 30 days before the date of the hearing.

(4) The HO may, on his or her own motion, or at the request of a party, change the time and place for the hearing, but must give the parties to the hearing 30 days notice of the change.

(5) The HO's scheduling notice must provide the parties to the hearing and the CBIC the following information:

(i) Description of the hearing procedure.

(ii) The general and specific issues to be resolved.

(iii) The supplier has the burden to prove it is not in violation of the contract.

(iv) The opportunity for parties to the hearing to submit additional evidence to support their positions, if requested by the HO.

(v) All evidence submitted, both from the supplier and CMS, in preparation for the hearing with all affected parties within 15 days prior to the scheduled date of the hearing.

(h) *Burden of proof.* (1) The burden of proof is on the Competitive Bidding Program contract supplier to demonstrate to the HO with convincing evidence that it has not breached its contract or that termination is not appropriate.

(2) The supplier's supporting evidence must be submitted with its request for a hearing.

(3) If the Medicare DMEPOS supplier fails to submit this evidence at the time of its submission, the Medicare DMEPOS supplier is precluded from introducing new evidence later during the hearing process, unless permitted by the hearing officer.

(4) CMS also has the opportunity to submit evidence to the HO within 10 days of receiving a notice announcing the hearing.

(5) The HO will share all evidence submitted by the supplier and/or CMS, with all parties to the hearing and the

CBIC within 15 days prior to the scheduled date of the hearing.

(i) *Role of the Hearing Officer.* The HO will conduct a thorough and independent review of the evidence including the information and documentation submitted for the hearing and other information that the HO considers pertinent for the hearing. The role of the HO includes, at a minimum, the following:

(1) Conducts the hearing and decides the order in which the evidence and the arguments of the parties are presented;

(2) Determines the rules on admissibility of the evidence;

(3) Examines the witnesses, in addition to the examinations conducted by CMS and the contract supplier;

(4) The CBIC may assist CMS in the appeals process including being present at the hearing, testifying as a witness, or performing other, related ministerial duties.

(5) Determines the rules for requesting documents and other evidence from other parties;

(6) Ensures a complete record of the hearing is made available to all parties to the hearing;

(7) Prepares a file of the record of the hearing which includes all evidence submitted as well as any relevant documents identified by the HO and considered as part of the hearing; and

(8) Complies with all applicable provisions of 42 USC Title 18 and related provisions of the Act, the applicable regulations issued by the Secretary, and manual instructions issued by CMS.

(j) *Hearing Officer recommendation.* (1) The HO will issue a written recommendation to CMS within 30 days of the close of the hearing unless an extension has been granted by CMS because the HO has demonstrated that an extension is needed due to the complexity of the matter or heavy workload.

(2) The recommendation will explain the basis and the rationale for the HO's recommendation.

(3) The hearing officer must include the record of the hearing, along with all evidence and documents produced during the hearing along with its recommendation.

(k) *CMS' final determination.* (1) CMS' review of the HO recommendation will not allow the supplier to submit new information.

(2) After reviewing the HO recommendation, CMS' decision will be made within 30 days from the date of receipt of the HO's recommendation.

(3) A CMS decision to terminate will indicate the effective date of the termination.

(4) This decision is final and binding.

(l) *Effect of contract termination.* A contract supplier whose contract has been terminated—

(1) All locations included in the contract can no longer furnish competitive bid items to beneficiaries within a CBA and the supplier cannot be reimbursed by Medicare for these items after the effective date of the termination.

(2) Must notify all beneficiaries who are receiving rented competitive bid items or competitive bid items received on a recurring basis, of the termination of their contract.

(i) The notice to the beneficiary from the supplier whose contract was terminated must be provided within 15 days of receipt of the final notice of termination.

(ii) The notification to the beneficiaries must inform the beneficiaries that they are going to have to select a new contract supplier to furnish these items in order for Medicare to pay these items.

(m) *Effective date of the contract termination.* (1) A supplier's DMEPOS CBP contract is terminated effective on the termination date specified in the notice to the supplier, unless the supplier timely requests a hearing with the HO or the supplier has submitted a CAP under paragraph (c) of this section.

(2) If a supplier requests an HO review of the CMS decision to terminate its contract, and CMS based upon the HO's recommendation terminates the supplier's contract, the effective date of the termination will be the date specified in the post-hearing notice to the supplier indicating CMS's final determination to terminate the contract.

(3) For violations of the terms of the supplier's DMEPOS CBP contract that may harm beneficiaries, such as a supplier providing an inferior product that causes harm to the beneficiary, no delays of the effective date of the termination will be allowed.

Subpart H —Fee Schedule for Ambulance Services

■ 39. Section 414.610 is amended as follows:

■ A. Revising paragraph (c)(1)(i).

■ B. Redesignating (c)(1)(ii) as (c)(1)(iii).

■ C. Adding a new paragraph (c)(1)(ii).

■ D. Revising paragraphs (c)(5)(ii), (f), and (h).

The revisions and addition read as follows:

§ 414.610 Basis of payments.

* * * * *

(c) * * *

(1) * * *

(i) For services furnished during the period July 1, 2004 through December 31, 2006, ambulance services originating in—

(A) Urban areas (both base rate and mileage) are paid based on a rate that is 1 percent higher than otherwise is applicable under this section; and

(B) Rural areas (both base rate and mileage) are paid based on a rate that is 2 percent higher than otherwise is applicable under this section.

(ii) For services furnished during the period July 1, 2008 through December 31, 2010, ambulance services originating in—

(A) Urban areas (both base rate and mileage) are paid based on a rate that is 2 percent higher than otherwise is applicable under this section;

(B) Rural areas (both base rate and mileage) are paid based on a rate that is 3 percent higher than otherwise is applicable under this section.

* * * * *

(5) * * *

(ii) For services furnished during the period July 1, 2004 through December 31, 2010, the payment amount for the ground ambulance base rate is increased by 22.6 percent where the point of pickup is in a rural area determined to be in the lowest 25 percent of rural population arrayed by population density. The amount of this increase is based on CMS's estimate of the ratio of the average cost per trip for the rural areas in the lowest quartile of population compared to the average cost per trip for the rural areas in the highest quartile of population. In making this estimate, CMS may use data provided by the GAO.

* * * * *

(f) *Updates.* The CF, the air ambulance base rates, and the mileage rates are updated annually by an inflation factor established by law. The inflation factor is based on the consumer price index for all urban consumers (CPI–U) (U.S. city average) for the 12-month period ending with June of the previous year and, for 2011 and each subsequent year, is reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

* * * * *

(h) *Treatment of certain areas for payment for air ambulance services.* Any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished on December 31, 2006, must be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services

furnished during the period July 1, 2008 through December 31, 2010.

■ 40. Section 414.620 is revised to read as follows:

§ 414.620 Publication of the ambulance fee schedule.

(a) Changes in payment rates resulting from incorporation of the annual inflation factor and the productivity adjustment as described in § 414.610(f) will be announced by CMS by instruction and on the CMS Web site.

(b) CMS will follow applicable rulemaking procedures in publishing revisions to the fee schedule for ambulance services that result from any factors other than those described in § 414.610(f).

Subpart J—Submission of Manufacturer's Average Sales Price Data

■ 41. Section 414.804 is amended by—
■ A. Redesignating paragraph (a)(6) as (a)(7).
■ B. Adding new paragraph (a)(6).
■ C. Reserving paragraph (b).
■ The addition reads as follows:

§ 414.804 Basis of payment.

(a) * * *

(6) The manufacturer's average sales price must be calculated based on the amount of product in a vial or other container as conspicuously reflected on the FDA approved label as defined by section 201(k) of the Food, Drug, and Cosmetic Act.

(b) [Reserved]

Subpart K—Payment for Drugs and Biologicals Under Part B

■ 42. Section 414.902 is amended by adding the definitions of "Biosimilar biological product" and "Reference biological product" in alphabetical order to read as follows:

§ 414.902 Definitions.

* * * * *

Biosimilar biological product means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act (PHSA) as defined at section 1847A(c)(6)(H) of the Act.

* * * * *

Reference biological product means the biological product licensed under such section 351 of the PHSA that is referred to in the application of the biosimilar biological product as defined at section 1847A(c)(6)(I) of the Act.

* * * * *

■ 43. Section 414.904 is amended by—
■ A. Adding paragraphs (a)(3), (i), and (j).
■ B. Revising paragraph (d)(3).

The revisions and additions read as follows:

§ 414.904 Average sales price as the basis for payment.

(a) * * *

(3) For purposes of this paragraph—

(i) CMS calculates an average sales price payment limit based on the amount of product included in a vial or other container as reflected on the FDA-approved label.

(ii) Additional product contained in the vial or other container does not represent a cost to providers and is not incorporated into the ASP payment limit.

(iii) No payment is made for amounts of product in excess of that reflected on the FDA-approved label.

* * * * *

(d) * * *

(3) *Widely available market price and average manufacturer price.* If the Inspector General finds that the average sales price exceeds the widely available market price or the average manufacturer price by 5 percent or more in CYs 2005 through 2011 the payment limit in the quarter following the transmittal of this information to the Secretary is the lesser of the widely available market price or 103 percent of the average manufacturer price.

* * * * *

(i) If manufacturer ASP data is not available prior to the publication deadline for quarterly payment limits and the unavailability of manufacturer ASP data significantly changes the quarterly payment limit for the billing code when compared to the prior quarter's billing code payment limit, the payment limit is calculated by carrying over the most recent available manufacturer ASP price from a previous quarter for an NDC in the billing code, adjusted by the weighted average of the change in the manufacturer ASPs for the NDCs that were reported for both the most recently available previous quarter and the current quarter.

(j) *Biosimilar biological products.* Effective July 1, 2010, the payment amount for a biosimilar biological drug product (as defined in § 414.902 of this subpart) is the sum of the average sales price of all NDCs assigned to the biosimilar biological product as determined under section 1847A(b)(6) of the Act and 6 percent of the amount determined under section 1847A(b)(4) of the Act for the reference drug product (as defined in § 414.902 of this subpart).

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

■ 44. The authority citation for part 415 continues to read as follows:

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

Subpart C—Part B Carrier Payments for Physician Services to Beneficiaries in Providers

■ 45. Section 415.130 is amended by revising paragraph (d) to read as follows:

§ 415.130 Conditions for payment: Physician pathology services.

* * * * *

(d) *Physician pathology services furnished by an independent laboratory.*

(1) The technical component of physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient on or before December 31, 2010, may be paid to the laboratory by the contractor under the physician fee schedule if the Medicare beneficiary is a patient of a covered hospital as defined in paragraph (a)(1) of this section.

(2) For services furnished after December 31, 2010, an independent laboratory may not bill the Medicare contractor for the technical component of physician pathology services furnished to a hospital inpatient or outpatient.

(3) For services furnished on or after January 1, 2008, the date of service policy in § 414.510 of this chapter applies to the TC of specimens for physician pathology services.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

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

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

Subpart B—Certification and Plan of Treatment Requirements

■ 47. Section 424.20 is amended by revising paragraph (e)(2) to read as follows:

§ 424.20 Requirements for posthospital SNF care.

* * * * *

(e) * * *

(2) A physician extender (that is, a nurse practitioner, a clinical nurse

specialist, or a physician assistant as those terms are defined in section 1861(aa)(5) of the Act) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with a physician. For purposes of this section—

(i) *Collaboration.* (A) Collaboration means a process whereby a physician extender works with a doctor of medicine or osteopathy to deliver health care services.

(B) The services are delivered within the scope of the physician extender's professional expertise, with medical direction and appropriate supervision as provided for in guidelines jointly developed by the physician extender and the physician or other mechanisms defined by Federal regulations and the law of the State in which the services are performed.

(ii) *Types of employment relationships.* (A) *Direct employment relationship.* A direct employment relationship with the facility is one in which the physician extender meets the common law definition of the facility's "employee," as specified in § 404.1005, § 404.1007, and § 404.1009 of title 20 of the regulations. When a physician extender meets this definition with respect to an entity other than the facility itself, and that entity has an agreement with the facility for the provision of nursing services under § 409.21 of this subchapter, the facility is considered to have an indirect employment relationship with the physician extender.

(B) *Indirect employment relationship.* (*1*) When a physician extender meets the definition of a direct employment relationship in paragraph (e)(2)(ii)(A) of this section with respect to an entity other than the facility itself, and that entity has an agreement with the facility for the provision of nursing services under § 409.21 of this subchapter, the facility is considered to have an indirect employment relationship with the physician extender.

(*2*) An indirect employment relationship does not exist if the agreement between the entity and the facility involves only the performance of delegated physician tasks under § 483.40(e) of this chapter.

* * * * *

Subpart C—Claims for Payment

■ 48. Section 424.44 is amended by revising paragraphs (a), (b), and (e) to read as follows:

§ 424.44 Time limits for filing claims.

(a) *Time limits.* (1) Except as provided in paragraphs (b) and (e) of this section, for services furnished on or after January 1, 2010, the claim must be filed no later than the close of the period ending 1 calendar year after the date of service.

(2) Except as provided in paragraphs (b) and (e) of this section and except for services furnished during the last 3 months of 2009, for services furnished before January 1, 2010, the claim must be filed—

(i) On or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year; and

(ii) On or before December 31st of the second following year for services that were furnished during the last 3 months of the calendar year.

(3) For services furnished during the last 3 months of CY 2009 all claims must be filed no later than December 31, 2010.

(b) *Exceptions to time limits.* Exceptions to the time limits for filing claims include the following:

(1) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of HHS that was performing Medicare functions and acting within the scope of its authority.

(2) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was not entitled to Medicare.

(ii) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(3) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was not entitled to Medicare.

(ii) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(iii) A State Medicaid agency recovered the Medicaid payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.

(4) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was enrolled in a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization.

(ii) The beneficiary was subsequently disenrolled from the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization effective retroactively to or before the date of the furnished service.

(iii) The Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.

(5) *Extension of time.* (i) If CMS or one of its contractors determines that a failure to meet the deadline specified in paragraph (a) of this section was caused by error or misrepresentation of an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of HHS that was performing Medicare functions and acting within the scope of its authority, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which either the beneficiary or the provider or supplier received notification that the error or misrepresentation referenced in paragraph (b)(1) of this section was corrected. No extension of time will be granted for paragraph (b)(1) when the request for that exception is made to CMS or one of its contractors more than 4 years after the date of service.

(ii) If CMS or one of its contractors determines that both of the conditions are met in paragraph (b)(2) of this section but that all of the conditions in paragraph (b)(3) are not satisfied, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which either the beneficiary or the provider or supplier received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(iii) If CMS or one of its contractors determines that all of the conditions are met in paragraph (b)(3) of this section, the time to file a claim will be extended through the last day of the sixth

calendar month following the month in which the State Medicaid agency recovered the Medicaid payment for the furnished service from the provider or supplier.

(iv) If CMS or one of its contractors determines that all of the conditions are met in paragraph (b)(4) of this section, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from the provider or supplier.

* * * * *

(e) As specified in § 424.520 and § 424.521 of this subpart, there are restrictions on the ability of the following newly-enrolled suppliers to submit claims for items or services furnished prior to the effective date of their Medicare billing privileges:

(1) Physician or nonphysician practitioner organizations.

(2) Physicians.

(3) Nonphysician practitioners.

(4) Independent diagnostic testing facilities.

* * * * *

Subpart P—Requirements for Establishing and Maintaining Medicare Billing Privileges

■ 49. Section 424.502 is amended by adding a definition of "Voluntary termination" to read as follows:

§ 424.502 Definitions.

* * * * *

Voluntary termination means that a provider or supplier, including an individual physician or nonphysician practitioner, submits written confirmation to CMS of its decision to discontinue enrollment in the Medicare program.

■ 50. Section 424.510 is amended by revising paragraph (d)(2)(iii) to read as follows:

§ 424.510 Requirements for enrolling in the Medicare program.

(d) * * *

(2) * * *

(iii) Submission of all documentation, including—

(A) All applicable Federal and State licenses, certifications including, but not limited to Federal Aviation Administration; and

(B) Documentation associated with regulatory and statutory requirements necessary to establish a provider's or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program.

■ 51. Section 424.516 is amended by adding a new paragraph (e)(3) to read as follows:

§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.

(e) * * *

(3) Within 30 days of any revocation or suspension of a Federal or State license or certification including Federal Aviation Administration certifications, an air ambulance supplier must report a revocation or suspension of its license or certification to the applicable Medicare contractor. The following FAA certifications must be reported:

(i) Specific pilot certifications including but not limited to instrument and medical certifications.

(ii) Airworthiness certification.

* * * * *

Authority: Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program.

Dated: October 26, 2010.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: October 29, 2010.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

Addendum A: Explanation and Use of Addenda B and C

The Addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in CY 2011. Addendum B contains the RVUs for work, nonfacility PE, facility PE, and malpractice expense, and other information for all services included in the PFS. Addendum C contains the list of HCPCS codes that have interim work, PE, and/or malpractice expense RVUs for CY 2011 and are open for comment on this final rule with comment period.

(1) Addendum B, CY 2011 Relative Value Units and Related Information Used in Determining Medicare Payments

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes or the alpha-numeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B.

Addendum B contains the following information for each CPT code and alpha-numeric HCPCS code, except for: alpha-numeric codes beginning with B (enteral and parenteral therapy); E (durable medical equipment); K (temporary codes for nonphysicians' services or items); or L (orthotics); and codes for anesthesiology. Please also note the following:

- An "NA" in the "Nonfacility PE RVUs" column of Addendum B means that CMS has not developed a PE RVU in the nonfacility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office). If there is an "NA" in the nonfacility PE RVU column, and the contractor determines that this service can be performed in the nonfacility setting, the service will be paid at the facility PE RVU rate.
- Services that have an "NA" in the "Facility PE RVUs" column of Addendum B are typically not paid under the PFS when provided in a facility setting. These services (which include "incident to" services and the technical portion of diagnostic tests) are generally paid under either the hospital outpatient prospective payment system or bundled into the hospital inpatient prospective payment system payment. In some cases, these services may be paid in a facility setting at the PFS rate (for example, therapy services), but there would be no payment made to the practitioner under the PFS in these situations.

1. *CPT/HCPCS code.* This is the CPT or alpha-numeric HCPCS number for the service. Alpha-numeric HCPCS codes are included at the end of this Addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier-26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code. A code for: the global values (both professional and technical); modifier-26 (PC); and modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service. Modifier-53 is shown for a discontinued procedure, for example, a colonoscopy that is not completed. There will be RVUs for a code with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is included in the PFS and whether it is separately payable if the service is covered. An explanation of types of status indicators follows:

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

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

C = Contractors price the code. Contractors establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation, such as an operative report.

E = Excluded from the PFS by regulation. These codes are for items and services that

CMS chose to exclude from the PFS by regulation. No RVUs are shown, and no payment may be made under the PFS for these codes. Payment for them, when covered, continues under reasonable charge procedures.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Codes not subject to a 90 day grace period.)

M = Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. CMS uses them to aid with performance measurement. No separate payment is made. These codes should be billed with a zero (($0.00) charge and are denied) on the MPFSDB.

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

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

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

X = Statutory exclusion. These codes represent an item or service that is not within the statutory definition of "physicians' services" for PFS payment purposes. No RVUs are shown for these codes, and no payment may be made under the PFS, (for example, ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is the code's short descriptor, which is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work in CY 2011.

6. *Fully implemented nonfacility PE RVUs.* These are the fully implemented resource-based PE RVUs for nonfacility settings.

7. *CY 2011 transitional nonfacility PE RVUs.* These are the CY 2011 resource-based PE RVUs for nonfacility settings.

8. *Fully implemented facility PE RVUs.* These are the fully implemented resource-based PE RVUs for facility settings.

9. *CY 2011 Transitional facility PE RVUs.* These are the CY 2011 resource-based PE RVUs for facility settings.

10. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for CY 2011.

Note: The BN reduction resulting from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

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

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

XXX = The global concept does not apply.

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

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and PE are associated with intra-service time and, in some instances, with the post-service time.)

(2) Addendum C, Codes with Interim RVUs

Addendum C, Codes with Interim RVUs, includes the columns and indicators described above for Addendum B, plus an additional column to indicate which component, or components, of each code's RVUs are interim final for CY 2011 and, therefore, open for public comment: work, PE, and/or malpractice expense. This column, headed "RVUs Open for Comment" and located between the columns for the "Description" and "Physician Work RVUs," displays the indicators below.

W = Physician work RVUs are interim for CY 2011 and open for comment.

PE = Nonfacility and facility PE RVUs are interim for CY 2011 and open for comment.

MP = Malpractice expense RVUs are interim for CY 2011 and open for comment.

BILLING CODE 4120–01–P

ADDENDUM B: CY 2011—RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
0001F		I	Heart failure composite	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0005F		I	Osteoarthritis composite	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0012F		I	Cap bacterial assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0014F		I	Comp preop assess cat surg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0015F		I	Melan follow-up complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T		C	Extracorp shock wv tx ms nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0030T		C	Antiprothrombin antibody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0042T		C	Ct perfusion w/contrast cbf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0048T		C	Implant ventricular device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0050T		C	Removal circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0051T		C	Implant total heart system	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0052T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0053T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0054T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0055T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0058T		C	Cryopreservation ovary tiss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0059T		C	Cryopreservation oocyte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0073T		A	Delivery comp imrt	0.00	13.38	15.38	NA	NA	0.01	XXX
0075T		C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0075T	TC	C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0075T	26	C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0076T		C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0076T	TC	C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0076T	26	C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0080T		C	Endovasc aort repr rad s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0081T		C	Endovasc visc extnsn s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0085T		N	Breath test heart reject	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0092T		C	Artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0095T		C	Artific diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0098T		C	Rev artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0099T		C	Implant corneal ring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0100T		C	Prosth retina receive&gen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0101T		C	Extracorp shockwv tx hi enrg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0102T		C	Extracorp shockwv tx anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0103T		C	Holotranscobalamin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0106T		C	Touch quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0107T		C	Vibrate quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0108T		C	Cool quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0109T		C	Heat quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0110T		C	Nos quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0111T		C	Rbc membranes fatty acids	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0123T		C	Scleral fistulization	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0124T		C	Conjunctival drug placement	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0126T		C	Chd risk imt study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0141T		I	Perq islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0142T		I	Open islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0143T		I	Laparoscopic islet transplnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0155T		C	Lap impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0156T		C	Lap remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
0157T		C	Open impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0158T		C	Open remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0159T		C	Cad breast mri	0.00	0.00	0.00	NA	NA	0.00	ZZZ
0159T	TC	C	Cad breast mri	0.00	0.00	0.00	NA	NA	0.00	ZZZ
0159T	26	C	Cad breast mri	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0163T		C	Lumb artif diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0164T		C	Remove lumb artif disc addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0165T		C	Revise lumb artif disc addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0166T		C	Tcath vsd close w/o bypass	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0167T		C	Tcath vsd close w/bypass	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0168T		C	Rhinophototx light app bilat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0169T		C	Place stereo cath brain	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0171T		C	Lumbar spine proces distract	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0172T		C	Lumbar spine process addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0173T		C	Iop monit io pressure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0174T		C	Cad cxr with interp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0175T		C	Cad cxr remote	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0178T		C	64 lead ecg w/i&r	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0179T		C	64 lead ecg w/tracing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0180T		C	64 lead ecg w/i&r only	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0181T		C	Corneal hysteresis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0182T		C	Hdr elect brachytherapy	0.00	0.00	0.00	NA	NA	0.00	XXX
0182T	TC	C	Hdr elect brachytherapy	0.00	0.00	0.00	NA	NA	0.00	XXX
0182T	26	C	Hdr elect brachytherapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0183T		C	Wound ultrasound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0184T		C	Exc rectal tumor endoscopic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0185T		C	Comptr probability analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0186T		C	Suprachoroidal drug delivery	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
0188T		N	Videoconf crit care 74 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0189T		N	Videoconf crit care addl 30	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0190T		C	Place intraoc radiation src	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0191T		C	Insert ant segment drain int	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0192T		C	Insert ant segment drain ext	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0195T		C	Arthrod presac interbody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0196T		C	Arthrod presac interbody eac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0197T		C	Intrafraction track motion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0198T		C	Ocular blood flow measure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0199T		C	Physiologic tremor record	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0200T		C	Perq sacral augmt unilat inj	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0201T		C	Perq sacral augmt bilat inj	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0202T		C	Post vert arthrplst 1 lumbar	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0205T		C	Inirs each vessel add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0206T		C	Remote algorithm analys ecg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0207T		C	Clear eyelid gland w/heat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0208T		C	Audiometry air only	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0209T		C	Audiometry air & bone	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0210T		C	Speech audiometry threshold	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0211T		C	Speech audiom thresh & recog	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0212T		C	Compre audiometry evaluation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0213T		C	Njx paravert w/us cer/thor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0214T		C	Njx paravert w/us cer/thor	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0215T		C	Njx paravert w/us cer/thor	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0216T		C	Njx paravert w/us lumb/sac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0217T		C	Njx paravert w/us lumb/sac	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0218T		C	Njx paravert w/us lumb/sac	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0219T		C	Plmt post facet implt cerv	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
0220T		C	Plmt post facet implt thor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0221T		C	Plmt post facet implt lumb	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0222T		C	Plmt post facet implt addl	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0223T		C	Acoustic ecg w/i&r	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0224T		C	Acoustic ecg 1+ analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0225T		C	Acoustic ecg analy & reprog	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0226T		C	Anoscopy hra w/spec collect	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0227T		C	Anoscopy hra w/biopsy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0228T		C	Njx tfrml eprl w/us cer/thor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0229T		C	Njx tfrml eprl w/us cer/thor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0230T		C	Njx tfrml eprl w/us lumb/sac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0231T		C	Njx tfrml eprl w/us lumb/sac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0232T		C	Njx platelet plasma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0233T		C	Skin glycation spectroscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0234T		C	Trluml perip athrc renal art	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0235T		C	Trluml perip athrc visceral	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0236T		C	Trluml perip athrc abd aorta	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0237T		C	Trluml perip athrc brchiocph	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0238T		C	Trluml perip athrc iliac art	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0239T		C	Bioimpedance spectroscopy	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0240T		C	Esoph motility 3d topography	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0240T	TC	C	Esoph motility 3d topography	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0240T	26	C	Esoph motility 3d topography	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0241T		C	Esoph motility w/stim/perf	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0241T	TC	C	Esoph motility w/stim/perf	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0241T	26	C	Esoph motility w/stim/perf	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0242T		C	Gi tract transit & pres meas	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0242T	TC	C	Gi tract transit & pres meas	0.00	0.00	0.00	0.00	0.00	0.00	YYY

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
0242T	26	C	Gi tract transit & pres meas	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0243T		C	Intm msr bronchodil wheeze	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0243T	TC	C	Intm msr bronchodil wheeze	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0243T	26	C	Intm msr bronchodil wheeze	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0244T		C	Cont msr bronchodil wheeze	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0244T	TC	C	Cont msr bronchodil wheeze	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0244T	26	C	Cont msr bronchodil wheeze	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0245T		C	Opn tx rib fx 1-2 ribs	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0246T		C	Opn tx rib fx 3-4 ribs	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0247T		C	Opn tx rib fx 5-6 ribs	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0248T		C	Opn tx rib fx 7+ ribs	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0249T		C	Ligation hemorrhoid w/us	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0250T		C	Insert bronchial valve	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0251T		C	Remov bronchial valve addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0252T		C	Bronchscpc rmvl bronch valve	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0253T		C	Insert aqueous drain device	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0254T		C	Evasc rpr iliac art bifur	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0255T		C	Evasc rpr iliac art bifr s&i	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0255T	TC	C	Evasc rpr iliac art bifr s&i	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0255T	26	C	Evasc rpr iliac art bifr s&i	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0256T		C	Evasc aortic hrt valve	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0257T		C	Opn tthrc aortic hrt valve	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0258T		C	Aortic hrt valv w/o card byp	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0259T		C	Aortic hrt valve w/card byp	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0260T		C	Hypthrm bdy neonate 28d/<	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0261T		C	Hypthrm head neonate 28d/<	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0501F		I	Prenatal flow sheet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0502F		I	Subsequent prenatal care	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
0503F		I	Postpartum care visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0516F		I	Anemia plan of care docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0519F		I	Pland chemo docd b/4 txmnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0525F		I	Initial visit for episode	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0528F		I	Rcmnd flw-up 10 yrs docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0535F		I	Dyspnea mngmnt plan docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0545F		I	Follow up care plan mdd docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1000F		I	Tobacco use assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10021		A	Fna w/o image	1.27	2.78	2.71	0.64	0.59	0.22	XXX
10022		A	Fna w/image	1.27	2.47	2.62	0.52	0.52	0.14	XXX
1003F		I	Level of activity assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10040		A	Acne surgery	1.21	1.65	1.60	1.29	1.23	0.18	010
1004F		I	Clin symp vol ovrld assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10060		A	Drainage of skin abscess	1.22	2.00	1.87	1.46	1.37	0.12	010
10061		A	Drainage of skin abscess	2.45	2.75	2.60	2.04	1.94	0.30	010
10080		A	Drainage of pilonidal cyst	1.22	3.62	3.49	1.58	1.47	0.20	010
10081		A	Drainage of pilonidal cyst	2.50	4.78	4.63	2.14	1.98	0.45	010
1008F		I	Gi/renal risk assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10120		A	Remove foreign body	1.25	2.66	2.55	1.34	1.26	0.16	010
10121		A	Remove foreign body	2.74	4.81	4.54	2.37	2.22	0.41	010
10140		A	Drainage of hematoma/fluid	1.58	2.93	2.76	1.69	1.64	0.20	010
1015F		I	Copd symptoms assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10160		A	Puncture drainage of lesion	1.25	2.36	2.27	1.41	1.36	0.16	010
10180		A	Complex drainage wound	2.30	4.35	4.13	2.50	2.39	0.48	010
1018F		I	Assess dyspnea not present	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1019F		I	Assess dyspnea present	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1022F		I	Pneumo imm status assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1026F		I	Co-morbid condition assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
1030F		I	Influenza imm status assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1034F		I	Current tobacco smoker	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1035F		I	Smokeless tobacco user	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1050F		I	History of mole changes	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1055F		I	Visual funct status assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1060F		I	Doc perm/cont/parox atr fib	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1061F		I	Doc lack perm+cont+parox fib	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1065F		I	Ischm stroke symp lt3 hrsb/4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1066F		I	Ischm stroke symp ge3 hrsb/4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1070F		I	Alarm symp assessed-absent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1071F		I	Alarm symp assessed-1+ prsnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11000		A	Debride infected skin	0.60	0.92	0.88	0.21	0.22	0.05	000
11001		A	Debride infected skin add-on	0.30	0.29	0.29	0.10	0.11	0.03	ZZZ
11004		A	Debride genitalia & perineum	10.80	NA	NA	4.73	4.55	1.89	000
11005		A	Debride abdom wall	14.24	NA	NA	6.32	5.89	2.96	000
11006		A	Debride genit/per/abdom wall	13.10	NA	NA	5.84	5.59	2.34	000
11008		A	Remove mesh from abd wall	5.00	NA	NA	2.21	2.07	1.05	ZZZ
11010		A	Debride skin at fx site	4.19	9.45	8.94	3.49	3.28	0.76	010
11011		A	Debride skin musc at fx site	4.94	9.62	9.33	3.11	2.92	0.98	000
11012		A	Deb skin bone at fx site	6.87	12.49	12.28	4.68	4.46	1.30	000
11042		A	Deb subq tissue 20 sq cm/<	0.80	2.13	1.66	0.62	0.50	0.10	000
11043		A	Deb musc/fascia 20 sq cm/<	2.00	3.30	3.30	1.28	1.28	0.33	000
11044		A	Deb bone 20 sq cm/<	3.60	4.34	4.34	2.03	2.03	0.62	000
11045		A	Deb subq tissue add-on	0.33	0.51	0.51	0.13	0.13	0.07	ZZZ
11046		A	Deb musc/fascia add-on	0.70	0.77	0.77	0.31	0.31	0.12	ZZZ
11047		A	Deb bone add-on	1.20	1.19	1.19	0.54	0.54	0.22	ZZZ
11055		R	Trim skin lesion	0.43	1.01	0.95	0.13	0.14	0.03	000
11056		R	Trim skin lesions 2 to 4	0.61	1.09	1.04	0.18	0.20	0.04	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
11057		R	Trim skin lesions over 4	0.79	1.23	1.17	0.24	0.26	0.05	000
11100		A	Biopsy skin lesion	0.81	2.10	2.10	0.59	0.54	0.11	000
11101		A	Biopsy skin add-on	0.41	0.51	0.50	0.30	0.28	0.05	ZZZ
1118F		I	Gerd symps assessed 12 month	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11200		A	Removal of skin tags	0.82	1.61	1.53	1.22	1.15	0.11	010
11201		A	Remove skin tags add-on	0.29	0.24	0.22	0.18	0.17	0.04	ZZZ
11300		A	Shave skin lesion	0.51	1.45	1.42	0.33	0.30	0.07	000
11301		A	Shave skin lesion	0.85	1.78	1.75	0.59	0.54	0.11	000
11302		A	Shave skin lesion	1.05	2.08	2.05	0.75	0.68	0.14	000
11303		A	Shave skin lesion	1.24	2.45	2.40	0.87	0.79	0.18	000
11305		A	Shave skin lesion	0.67	1.32	1.27	0.26	0.27	0.05	000
11306		A	Shave skin lesion	0.99	1.71	1.67	0.52	0.51	0.11	000
11307		A	Shave skin lesion	1.14	2.04	2.00	0.68	0.65	0.14	000
11308		A	Shave skin lesion	1.41	2.15	2.08	0.70	0.68	0.14	000
11310		A	Shave skin lesion	0.73	1.66	1.64	0.49	0.45	0.10	000
11311		A	Shave skin lesion	1.05	1.95	1.92	0.74	0.69	0.14	000
11312		A	Shave skin lesion	1.20	2.27	2.23	0.86	0.79	0.18	000
11313		A	Shave skin lesion	1.62	2.69	2.64	1.14	1.04	0.24	000
1134F		I	Epsd bk pain for =< 6 wks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1135F		I	Epsd bk pain for > 6 wks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1136F		I	Epsd bk pain for <= 12 wks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1137F		I	Epsd bk pain for > 12 wks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.90	2.50	2.43	1.32	1.23	0.12	010
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.28	2.83	2.74	1.61	1.50	0.20	010
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.45	3.11	3.01	1.71	1.59	0.24	010
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.84	3.40	3.25	2.20	2.04	0.31	010
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.11	3.83	3.66	2.33	2.16	0.37	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	3.52	4.90	4.57	3.10	2.81	0.67	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	1.03	2.38	2.29	1.26	1.20	0.12	010
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.47	2.89	2.78	1.62	1.52	0.22	010
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.68	3.16	3.04	2.09	1.96	0.26	010
11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.06	3.51	3.38	2.30	2.15	0.33	010
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.48	3.90	3.75	2.46	2.30	0.41	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	4.09	4.95	4.69	3.38	3.11	0.71	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.05	2.66	2.59	1.82	1.72	0.16	010
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.53	3.12	3.02	2.14	2.02	0.24	010
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.77	3.45	3.33	2.29	2.16	0.29	010
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.34	3.86	3.71	2.63	2.46	0.38	010
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.19	4.57	4.37	3.12	2.90	0.52	010
11446		A	Exc face-mm b9+marg > 4 cm	4.80	5.95	5.52	4.21	3.82	0.80	010
11450		A	Removal sweat gland lesion	3.22	7.05	6.66	3.53	3.21	0.65	090
11451		A	Removal sweat gland lesion	4.43	8.44	8.13	4.18	3.84	0.90	090
11462		A	Removal sweat gland lesion	3.00	7.05	6.74	3.49	3.20	0.60	090
11463		A	Removal sweat gland lesion	4.43	8.65	8.42	4.33	4.00	0.88	090
11470		A	Removal sweat gland lesion	3.74	7.54	7.06	3.91	3.54	0.71	090
11471		A	Removal sweat gland lesion	4.89	8.92	8.44	4.51	4.09	0.91	090
1150F		I	Doc pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1151F		I	Doc no pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1152F		I	Doc advncd dis comfort 1st	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1153F		I	Doc advncd dis cmfrt not 1st	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1157F		I	Advnc care plan in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1158F		I	Advnc care plan tlk docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1159F		I	Med list docd in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.63	3.66	3.49	1.68	1.53	0.26	010
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	2.07	4.29	4.15	2.12	1.97	0.31	010
11602		A	Exc tr-ext mlg+marg 1.1-2 cm	2.27	4.66	4.54	2.35	2.18	0.34	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.82	5.07	4.88	2.68	2.45	0.42	010
11604		A	Exc tr-ext mlg+marg 3.1-4 cm	3.17	5.54	5.31	2.83	2.57	0.52	010
11606		A	Exc tr-ext mlg+marg > 4 cm	5.02	7.32	6.85	3.77	3.35	0.88	010
1160F		I	Rvw meds by rx/dr in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.64	3.72	3.57	1.73	1.58	0.26	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	2.08	4.34	4.20	2.15	2.00	0.31	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.41	4.76	4.64	2.44	2.28	0.37	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	3.11	5.27	5.07	2.86	2.62	0.49	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.62	5.77	5.52	3.09	2.82	0.60	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.61	6.67	6.36	3.55	3.27	0.80	010
11640		A	Exc face-mm malig+marg 0.5 <	1.67	3.89	3.76	1.84	1.70	0.26	010
11641		A	Exc face-mm malig+marg 0.6-1	2.17	4.48	4.38	2.26	2.13	0.33	010
11642		A	Exc face-mm malig+marg 1.1-2	2.62	4.98	4.87	2.60	2.44	0.39	010
11643		A	Exc face-mm malig+marg 2.1-3	3.42	5.51	5.32	3.08	2.85	0.54	010
11644		A	Exc face-mm malig+marg 3.1-4	4.34	6.65	6.39	3.67	3.40	0.71	010
11646		A	Exc face-mm mlg+marg > 4 cm	6.26	8.06	7.67	4.82	4.46	1.05	010
11719		R	Trim nail(s)	0.17	0.47	0.44	0.05	0.06	0.01	000
11720		A	Debride nail 1-5	0.32	0.58	0.55	0.10	0.10	0.03	000
11721		A	Debride nail 6 or more	0.54	0.67	0.65	0.16	0.18	0.04	000
11730		A	Removal of nail plate	1.10	1.66	1.59	0.34	0.36	0.08	000
11732		A	Remove nail plate add-on	0.57	0.68	0.65	0.17	0.19	0.04	ZZZ
11740		A	Drain blood from under nail	0.37	1.00	0.94	0.54	0.52	0.03	000
11750		A	Removal of nail bed	2.50	3.75	3.54	2.38	2.31	0.22	010
11752		A	Remove nail bed/finger tip	3.63	5.39	5.00	3.71	3.59	0.39	010
11755		A	Biopsy nail unit	1.31	2.49	2.40	0.94	0.94	0.11	000
11760		A	Repair of nail bed	1.63	4.71	4.32	2.03	1.95	0.26	010
11762		A	Reconstruction of nail bed	2.94	4.88	4.56	2.23	2.25	0.31	010
11765		A	Excision of nail fold toe	0.74	3.37	3.15	1.27	1.20	0.05	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
11770		A	Removal of pilonidal lesion	2.66	4.77	4.51	2.26	2.07	0.52	010
11771		A	Removal of pilonidal lesion	6.09	9.28	8.61	5.47	5.00	1.24	090
11772		A	Removal of pilonidal lesion	7.35	10.92	10.30	7.83	7.27	1.47	090
1180F		I	Thromboemb risk assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11900		A	Injection into skin lesions	0.52	1.04	1.04	0.38	0.34	0.07	000
11901		A	Added skin lesions injection	0.80	1.18	1.16	0.59	0.54	0.11	000
11920		R	Correct skin color defects	1.61	3.13	3.21	1.59	1.48	0.31	000
11921		R	Correct skin color defects	1.93	3.60	3.62	1.85	1.71	0.37	000
11922		R	Correct skin color defects	0.49	1.23	1.20	0.35	0.32	0.08	ZZZ
11950		R	Therapy for contour defects	0.84	1.05	1.13	0.49	0.49	0.10	000
11951		R	Therapy for contour defects	1.19	1.51	1.50	0.75	0.69	0.24	000
11952		R	Therapy for contour defects	1.69	1.62	1.85	0.81	0.88	0.24	000
11954		R	Therapy for contour defects	1.85	2.57	2.50	1.39	1.24	0.35	000
11960		A	Insert tissue expander(s)	11.49	NA	NA	13.05	13.07	1.83	090
11970		A	Replace tissue expander	8.01	NA	NA	9.04	8.36	1.56	090
11971		A	Remove tissue expander(s)	3.41	9.50	9.48	5.37	5.10	0.64	090
11975		N	Insert contraceptive cap	1.48	2.14	2.12	0.65	0.65	0.10	XXX
11976		R	Removal of contraceptive cap	1.78	2.14	2.17	0.83	0.75	0.30	000
11977		N	Removal/reinsert contra cap	3.30	2.97	2.97	1.45	1.43	0.24	XXX
11980		A	Implant hormone pellet(s)	1.48	1.37	1.34	0.73	0.68	0.23	000
11981		A	Insert drug implant device	1.48	2.18	2.22	0.71	0.74	0.24	XXX
11982		A	Remove drug implant device	1.78	2.24	2.37	0.84	0.90	0.24	XXX
11983		A	Remove/insert drug implant	3.30	2.55	2.87	1.36	1.56	0.35	XXX
12001		A	Repair superficial wound(s)	0.84	1.52	1.84	0.38	0.64	0.14	000
12002		A	Repair superficial wound(s)	1.14	1.72	1.98	0.46	0.75	0.19	000
12004		A	Repair superficial wound(s)	1.44	1.92	2.25	0.55	0.85	0.24	000
12005		A	Repair superficial wound(s)	1.97	2.39	2.76	0.73	1.03	0.33	000
12006		A	Repair superficial wound(s)	2.39	2.87	3.31	0.91	1.27	0.41	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
12007		A	Repair superficial wound(s)	2.90	3.20	3.72	1.07	1.50	0.50	000
1200F		I	Seizure type& frequ docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
12011		A	Repair superficial wound(s)	1.07	1.87	2.12	0.43	0.68	0.19	000
12013		A	Repair superficial wound(s)	1.22	1.88	2.21	0.46	0.77	0.20	000
12014		A	Repair superficial wound(s)	1.57	2.08	2.47	0.57	0.89	0.26	000
12015		A	Repair superficial wound(s)	1.98	2.46	2.96	0.67	1.03	0.33	000
12016		A	Repair superficial wound(s)	2.68	2.92	3.45	0.91	1.29	0.46	000
12017		A	Repair superficial wound(s)	3.18	NA	NA	0.76	1.34	0.56	000
12018		A	Repair superficial wound(s)	3.61	NA	NA	0.85	1.78	0.64	000
12020		A	Closure of split wound	2.67	4.93	4.73	2.47	2.34	0.42	010
12021		A	Closure of split wound	1.89	2.63	2.45	1.94	1.80	0.31	010
12031		A	Intmd wnd repair s/tr/ext	2.20	4.76	4.53	2.41	2.20	0.35	010
12032		A	Intmd wnd repair s/tr/ext	2.52	6.07	6.01	2.98	2.84	0.38	010
12034		A	Intmd wnd repair s/tr/ext	2.97	5.65	5.42	2.72	2.52	0.50	010
12035		A	Intmd wnd repair s/tr/ext	3.47	6.90	6.68	2.98	2.82	0.64	010
12036		A	Intmd wnd repair s/tr/ext	4.09	7.24	6.92	3.26	3.06	0.77	010
12037		A	Intmd wnd repair s/tr/ext	4.71	7.90	7.60	3.78	3.59	0.90	010
12041		A	Intmd wnd repair n-hf/genit	2.42	4.86	4.60	2.47	2.25	0.37	010
12042		A	Intmd wnd repair n-hg/genit	2.79	5.38	5.26	2.86	2.67	0.41	010
12044		A	Intmd wnd repair n-hg/genit	3.19	6.72	6.32	2.71	2.53	0.52	010
12045		A	Intmd wnd repair n-hg/genit	3.68	6.61	6.44	2.92	2.79	0.62	010
12046		A	Intmd wnd repair n-hg/genit	4.29	7.79	7.62	3.46	3.30	0.84	010
12047		A	Intmd wnd repair n-hg/genit	4.69	8.60	8.24	3.52	3.48	0.91	010
12051		A	Intmd wnd repair face/mm	2.52	5.04	4.91	2.63	2.45	0.39	010
12052		A	Intmd wnd repair face/mm	2.87	5.79	5.63	3.36	3.11	0.42	010
12053		A	Intmd wnd repair face/mm	3.17	6.45	6.19	2.89	2.69	0.50	010
12054		A	Intmd wnd repair face/mm	3.50	6.70	6.37	2.77	2.60	0.58	010
12055		A	Intmd wnd repair face/mm	4.47	7.83	7.35	2.98	2.80	0.73	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
12056		A	Intmd wnd repair face/mm	5.28	9.98	9.02	4.87	4.14	0.67	010
12057		A	Intmd wnd repair face/mm	6.00	11.66	10.32	4.79	4.41	0.76	010
1205F		I	Epi etiol synd rvwd and docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1220F		I	Pt screened for depression	0.00	0.00	0.00	0.00	0.00	0.00	XXX
13100		A	Repair of wound or lesion	3.17	5.52	5.47	3.38	3.24	0.50	010
13101		A	Repair of wound or lesion	3.96	7.14	7.04	4.05	3.86	0.61	010
13102		A	Repair wound/lesion add-on	1.24	1.77	1.69	0.84	0.76	0.23	ZZZ
13120		A	Repair of wound or lesion	3.35	5.70	5.63	3.54	3.37	0.52	010
13121		A	Repair of wound or lesion	4.42	8.00	7.85	4.83	4.58	0.67	010
13122		A	Repair wound/lesion add-on	1.44	1.85	1.79	0.94	0.85	0.26	ZZZ
13131		A	Repair of wound or lesion	3.83	6.17	6.08	3.91	3.74	0.58	010
13132		A	Repair of wound or lesion	6.58	9.71	9.44	6.71	6.37	0.98	010
13133		A	Repair wound/lesion add-on	2.19	2.51	2.40	1.53	1.41	0.34	ZZZ
13150		A	Repair of wound or lesion	3.85	6.09	5.97	3.86	3.65	0.61	010
13151		A	Repair of wound or lesion	4.49	6.85	6.73	4.44	4.25	0.67	010
13152		A	Repair of wound or lesion	6.37	9.35	9.11	5.58	5.31	0.95	010
13153		A	Repair wound/lesion add-on	2.38	2.79	2.65	1.63	1.49	0.38	ZZZ
13160		A	Late closure of wound	12.04	NA	NA	10.04	9.45	2.23	090
14000		A	Skin tissue rearrangement	6.37	11.00	10.69	7.75	7.41	1.13	090
14001		A	Skin tissue rearrangement	8.78	13.56	13.17	9.63	9.26	1.53	090
1400F		I	Prkns diag rviewed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
14020		A	Skin tissue rearrangement	7.22	12.33	11.99	8.86	8.53	1.21	090
14021		A	Skin tissue rearrangement	9.72	14.81	14.39	10.73	10.39	1.55	090
14040		A	Skin tissue rearrangement	8.60	12.97	12.59	9.49	9.16	1.32	090
14041		A	Skin tissue rearrangement	10.83	15.86	15.46	11.44	11.06	1.62	090
14060		A	Skin tissue rearrangement	9.23	12.69	12.23	9.97	9.54	1.41	090
14061		A	Skin tissue rearrangement	11.48	17.19	16.76	12.31	11.91	1.71	090
14301		A	Skin tissue rearrangement	12.65	17.55	17.55	12.30	12.30	2.13	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
14302		A	Skin tissue rearrange add-on	3.73	2.55	2.55	2.55	2.55	0.62	ZZZ
14350		A	Skin tissue rearrangement	11.05	NA	NA	8.71	8.61	1.55	090
15002		A	Wound prep trk/arm/leg	3.65	5.85	5.50	2.60	2.37	0.65	000
15003		A	Wound prep addl 100 cm	0.80	1.23	1.17	0.42	0.38	0.16	ZZZ
15004		A	Wound prep f/n/hf/g	4.58	6.51	6.27	3.00	2.82	0.67	000
15005		A	Wnd prep f/n/hf/g addl cm	1.60	1.74	1.63	0.86	0.76	0.31	ZZZ
15040		A	Harvest cultured skin graft	2.00	5.05	5.01	1.46	1.38	0.37	000
15050		A	Skin pinch graft	5.57	10.51	9.81	7.12	6.67	0.90	090
15100		A	Skin splt grft trnk/arm/leg	9.90	13.66	13.30	9.80	9.26	1.94	090
15101		A	Skin splt grft t/a/l add-on	1.72	3.34	3.37	1.28	1.23	0.34	ZZZ
15110		A	Epidrm autogrft trnk/arm/leg	10.97	12.19	11.67	9.12	8.51	2.15	090
15111		A	Epidrm autogrft t/a/l add-on	1.85	1.22	1.23	0.90	0.88	0.38	ZZZ
15115		A	Epidrm a-grft face/nck/hf/g	11.28	12.90	12.06	9.87	9.17	1.85	090
15116		A	Epidrm a-grft f/n/hf/g addl	2.50	2.24	1.98	1.81	1.55	0.49	ZZZ
15120		A	Skn splt a-grft fac/nck/hf/g	11.16	15.60	14.69	10.93	10.17	1.93	090
15121		A	Skn splt a-grft f/n/hf/g add	2.67	4.71	4.60	2.02	1.88	0.50	ZZZ
15130		A	Derm autograft trnk/arm/leg	7.53	11.04	10.66	8.03	7.56	1.48	090
15131		A	Derm autograft t/a/l add-on	1.50	1.31	1.17	1.08	0.91	0.31	ZZZ
15135		A	Derm autograft face/nck/hf/g	11.03	13.33	12.46	10.31	9.62	1.87	090
15136		A	Derm autograft f/n/hf/g add	1.50	1.18	0.99	1.00	0.80	0.10	ZZZ
15150		A	Cult epiderm grft t/arm/leg	9.39	8.97	8.84	7.32	7.17	1.98	090
15151		A	Cult epiderm grft t/a/l addl	2.00	1.67	1.46	1.41	1.17	0.42	ZZZ
15152		A	Cult epiderm graft t/a/l +%	2.50	1.38	1.56	1.12	1.27	0.49	ZZZ
15155		A	Cult epiderm graft f/n/hf/g	10.14	6.92	7.93	5.57	6.55	0.76	090
15156		A	Cult epidrm grft f/n/hfg add	2.75	1.47	1.62	1.20	1.35	0.58	ZZZ
15157		A	Cult epiderm grft f/n/hfg +%	3.00	1.20	1.60	0.90	1.25	0.22	ZZZ
15170		A	Acell graft trunk/arms/legs	5.99	6.09	5.58	4.27	3.81	1.09	090
15171		A	Acell graft t/arm/leg add-on	1.55	0.98	0.90	0.81	0.75	0.31	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
15175		A	Acellular graft f/n/hf/g	7.99	6.23	6.05	4.53	4.39	1.05	090
15176		A	Acell graft f/n/hf/g add-on	2.45	1.58	1.47	1.27	1.19	0.39	ZZZ
15200		A	Skin full graft trunk	9.15	13.90	13.10	9.61	8.85	1.64	090
15201		A	Skin full graft trunk add-on	1.32	2.81	2.75	0.90	0.80	0.26	ZZZ
15220		A	Skin full graft sclp/arm/leg	8.09	13.52	13.01	9.29	8.83	1.39	090
15221		A	Skin full graft add-on	1.19	2.62	2.59	0.80	0.74	0.23	ZZZ
15240		A	Skin full grft face/genit/hf	10.41	15.82	15.08	12.31	11.57	1.70	090
15241		A	Skin full graft add-on	1.86	3.34	3.21	1.30	1.19	0.33	ZZZ
15260		A	Skin full graft een & lips	11.64	16.83	16.07	12.89	12.20	1.77	090
15261		A	Skin full graft add-on	2.23	3.85	3.70	1.78	1.67	0.37	ZZZ
15300		A	Apply skinallogrft t/arm/lg	4.65	5.06	4.64	3.37	3.07	0.86	090
15301		A	Apply sknallogrft t/a/l addl	1.00	0.68	0.64	0.51	0.48	0.20	ZZZ
15320		A	Apply skin allogrft f/n/hf/g	5.36	4.98	4.79	3.18	3.08	0.73	090
15321		A	Aply sknallogrft f/n/hfg add	1.50	1.04	0.96	0.81	0.75	0.30	ZZZ
15330		A	Aply acell alogrft t/arm/leg	3.99	5.11	4.69	3.37	3.07	0.76	090
15331		A	Aply acell grft t/a/l add-on	1.00	0.75	0.68	0.59	0.53	0.20	ZZZ
15335		A	Apply acell graft f/n/hf/g	4.50	4.45	4.27	2.80	2.71	0.50	090
15336		A	Aply acell grft f/n/hf/g add	1.43	1.33	1.07	1.03	0.80	0.10	ZZZ
15340		A	Apply cult skin substitute	3.82	4.92	4.77	3.57	3.43	0.52	010
15341		A	Apply cult skin sub add-on	0.50	0.82	0.79	0.20	0.20	0.07	ZZZ
15360		A	Apply cult derm sub t/a/l	4.02	5.87	5.77	4.35	4.23	0.60	090
15361		A	Aply cult derm sub t/a/l add	1.15	0.50	0.58	0.35	0.40	0.20	ZZZ
15365		A	Apply cult derm sub f/n/hf/g	4.30	5.33	5.22	3.92	3.82	0.41	090
15366		A	Apply cult derm f/hf/g add	1.45	0.76	0.76	0.53	0.54	0.16	ZZZ
15400		A	Apply skin xenograft t/a/l	4.47	7.12	6.62	5.53	5.24	0.69	090
15401		A	Apply skn xenogrft t/a/l add	1.00	1.37	1.43	0.51	0.48	0.22	ZZZ
15420		A	Apply skin xgraft f/n/hf/g	4.98	7.32	7.14	5.81	5.63	0.67	090
15421		A	Apply skn xgrft f/n/hf/g add	1.50	1.69	1.59	0.83	0.74	0.30	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
15430		A	Apply acellular xenograft	6.20	9.05	8.50	8.33	7.86	1.05	090
15431		C	Apply acellular xgraft add	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
15570		A	Form skin pedicle flap	10.21	14.44	13.78	9.67	9.00	2.06	090
15572		A	Form skin pedicle flap	10.12	14.40	13.46	10.64	9.73	1.82	090
15574		A	Form skin pedicle flap	10.70	14.86	14.04	10.89	10.11	1.82	090
15576		A	Form skin pedicle flap	9.37	13.32	12.68	9.67	9.01	1.53	090
15600		A	Skin graft	2.01	6.99	7.07	3.78	3.63	0.38	090
15610		A	Skin graft	2.52	7.38	6.96	4.25	4.07	0.45	090
15620		A	Skin graft	3.75	8.51	8.41	5.41	5.11	0.61	090
15630		A	Skin graft	4.08	8.89	8.77	5.78	5.54	0.65	090
15650		A	Transfer skin pedicle flap	4.77	9.41	9.37	6.08	5.89	0.77	090
15731		A	Forehead flap w/vasc pedicle	14.38	17.64	16.69	14.44	13.49	2.40	090
15732		A	Muscle-skin graft head/neck	19.90	21.93	20.64	17.57	15.98	3.53	090
15734		A	Muscle-skin graft trunk	19.86	21.72	20.94	16.90	15.95	3.98	090
15736		A	Muscle-skin graft arm	17.04	19.70	19.02	14.92	13.87	3.35	090
15738		A	Muscle-skin graft leg	19.04	19.76	19.11	15.25	14.31	3.80	090
15740		A	Island pedicle flap graft	11.80	17.12	16.48	12.82	12.17	1.77	090
15750		A	Neurovascular pedicle graft	12.96	NA	NA	12.53	11.76	2.28	090
15756		A	Free myo/skin flap microvasc	36.94	NA	NA	29.02	26.64	6.34	090
15757		A	Free skin flap microvasc	37.15	NA	NA	28.48	26.16	5.91	090
15758		A	Free fascial flap microvasc	36.90	NA	NA	28.29	26.11	5.91	090
15760		A	Composite skin graft	9.86	14.22	13.50	10.30	9.61	1.58	090
15770		A	Derma-fat-fascia graft	8.96	NA	NA	9.82	9.09	1.63	090
15775		R	Hair transplant punch grafts	3.95	3.84	4.18	2.00	1.98	0.29	000
15776		R	Hair transplant punch grafts	5.53	6.64	6.42	3.38	3.17	0.38	000
15780		A	Abrasion treatment of skin	8.73	14.19	14.09	8.63	8.65	1.20	090
15781		A	Abrasion treatment of skin	5.02	10.46	10.10	7.20	6.93	0.76	090
15782		A	Abrasion treatment of skin	4.44	10.83	11.08	6.40	6.61	0.62	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
15783		A	Abrasion treatment of skin	4.41	9.33	9.19	6.32	6.00	0.62	090
15786		A	Abrasion lesion single	2.08	4.72	4.64	1.75	1.68	0.33	010
15787		A	Abrasion lesions add-on	0.33	1.01	1.02	0.16	0.15	0.04	ZZZ
15788		R	Chemical peel face epiderm	2.09	11.13	10.62	5.07	4.79	0.35	090
15789		R	Chemical peel face dermal	4.91	10.76	10.79	7.14	6.94	0.68	090
15792		R	Chemical peel nonfacial	1.86	10.60	10.39	5.64	5.56	0.30	090
15793		A	Chemical peel nonfacial	3.96	9.99	9.66	6.51	6.20	0.56	090
15819		A	Plastic surgery neck	10.65	NA	NA	7.61	8.17	2.09	090
15820		A	Revision of lower eyelid	6.27	9.47	8.85	8.01	7.36	1.24	090
15821		A	Revision of lower eyelid	6.84	10.06	9.28	8.41	7.62	1.33	090
15822		A	Revision of upper eyelid	4.62	7.76	7.24	6.32	5.79	0.81	090
15823		A	Revision of upper eyelid	6.81	10.15	9.79	8.49	8.16	1.26	090
15824		R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15825		R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15826		R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15828		R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15830		R	Exc skin abd	17.11	NA	NA	15.13	13.81	3.38	090
15832		A	Excise excessive skin tissue	12.85	NA	NA	13.28	11.75	2.57	090
15833		A	Excise excessive skin tissue	11.90	NA	NA	12.59	11.29	2.32	090
15834		A	Excise excessive skin tissue	12.17	NA	NA	12.79	11.12	2.39	090
15835		A	Excise excessive skin tissue	12.99	NA	NA	13.35	11.63	2.55	090
15836		A	Excise excessive skin tissue	10.61	NA	NA	8.54	8.53	2.08	090
15837		A	Excise excessive skin tissue	9.55	14.51	12.66	10.04	8.94	2.01	090
15838		A	Excise excessive skin tissue	8.25	NA	NA	8.21	7.66	1.06	090
15839		A	Excise excessive skin tissue	10.50	13.50	12.77	9.54	8.92	1.93	090
15840		A	Graft for face nerve palsy	14.99	NA	NA	13.88	12.75	2.39	090
15841		A	Graft for face nerve palsy	25.99	NA	NA	22.89	20.42	3.35	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
15842		A	Flap for face nerve palsy	41.01	NA	NA	29.43	28.39	5.27	090
15845		A	Skin and muscle repair face	14.32	NA	NA	14.23	12.63	1.83	090
15847		C	Exc skin abd add-on	0.00	0.00	0.00	0.00	0.00	0.00	YYY
15850		B	Removal of sutures	0.78	1.61	1.68	0.34	0.34	0.05	XXX
15851		A	Removal of sutures	0.86	1.85	1.78	0.42	0.37	0.12	000
15852		A	Dressing change not for burn	0.86	NA	NA	0.42	0.39	0.14	000
15860		A	Test for blood flow in graft	1.95	NA	NA	0.91	0.90	0.38	000
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15920		A	Removal of tail bone ulcer	8.29	NA	NA	8.22	7.57	1.71	090
15922		A	Removal of tail bone ulcer	10.38	NA	NA	11.56	10.22	2.02	090
15931		A	Remove sacrum pressure sore	10.07	NA	NA	8.08	7.52	2.06	090
15933		A	Remove sacrum pressure sore	11.77	NA	NA	10.93	10.18	2.40	090
15934		A	Remove sacrum pressure sore	13.68	NA	NA	11.55	10.61	2.77	090
15935		A	Remove sacrum pressure sore	15.78	NA	NA	13.98	13.09	3.18	090
15936		A	Remove sacrum pressure sore	13.16	NA	NA	11.15	10.30	2.66	090
15937		A	Remove sacrum pressure sore	15.14	NA	NA	13.40	12.38	3.06	090
15940		A	Remove hip pressure sore	10.20	NA	NA	8.67	7.99	2.06	090
15941		A	Remove hip pressure sore	12.41	NA	NA	12.12	11.39	2.47	090
15944		A	Remove hip pressure sore	12.44	NA	NA	12.18	11.20	2.50	090
15945		A	Remove hip pressure sore	13.75	NA	NA	13.62	12.52	2.73	090
15946		A	Remove hip pressure sore	24.12	NA	NA	20.95	19.29	4.81	090
15950		A	Remove thigh pressure sore	8.03	NA	NA	7.41	7.04	1.59	090
15951		A	Remove thigh pressure sore	11.58	NA	NA	13.10	11.24	2.27	090
15952		A	Remove thigh pressure sore	12.31	NA	NA	9.56	9.58	2.62	090
15953		A	Remove thigh pressure sore	13.57	NA	NA	10.50	10.67	2.66	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
15956		A	Remove thigh pressure sore	16.79	NA	NA	14.93	13.69	3.41	090
15958		A	Remove thigh pressure sore	16.75	NA	NA	15.71	14.45	3.38	090
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	YYY
16000		A	Initial treatment of burn(s)	0.89	1.03	0.98	0.39	0.34	0.12	000
16020		A	Dress/debrid p-thick burn s	0.80	1.57	1.48	0.82	0.76	0.11	000
16025		A	Dress/debrid p-thick burn m	1.85	2.27	2.14	1.34	1.23	0.31	000
16030		A	Dress/debrid p-thick burn l	2.08	2.87	2.72	1.53	1.41	0.37	000
16035		A	Incision of burn scab initi	3.74	NA	NA	1.58	1.62	0.62	000
16036		A	Escharotomy addl incision	1.50	NA	NA	0.67	0.65	0.27	ZZZ
17000		A	Destruct premalg lesion	0.65	1.64	1.61	0.94	0.90	0.08	010
17003		A	Destruct premalg les 2-14	0.07	0.12	0.13	0.05	0.05	0.01	ZZZ
17004		A	Destroy premlg lesions 15+	1.85	2.93	2.95	1.86	1.83	0.27	010
17106		A	Destruction of skin lesions	3.69	5.87	5.78	4.04	3.93	0.53	090
17107		A	Destruction of skin lesions	4.79	7.40	7.47	4.96	5.00	0.73	090
17108		A	Destruction of skin lesions	7.49	10.10	9.74	6.88	6.68	1.30	090
17110		A	Destruct b9 lesion 1-14	0.70	2.41	2.42	1.28	1.24	0.08	010
17111		A	Destruct lesion 15 or more	0.97	2.73	2.72	1.47	1.42	0.12	010
17250		A	Chemical cautery tissue	0.50	1.69	1.63	0.51	0.49	0.07	000
17260		A	Destruction of skin lesions	0.96	1.70	1.69	0.97	0.92	0.12	010
17261		A	Destruction of skin lesions	1.22	2.80	2.79	1.39	1.33	0.18	010
17262		A	Destruction of skin lesions	1.63	3.24	3.21	1.69	1.61	0.23	010
17263		A	Destruction of skin lesions	1.84	3.52	3.49	1.84	1.74	0.26	010
17264		A	Destruction of skin lesions	1.99	3.74	3.70	1.92	1.82	0.29	010
17266		A	Destruction of skin lesions	2.39	4.11	4.05	2.18	2.04	0.34	010
17270		A	Destruction of skin lesions	1.37	2.84	2.79	1.47	1.39	0.20	010
17271		A	Destruction of skin lesions	1.54	3.06	3.02	1.62	1.54	0.23	010
17272		A	Destruction of skin lesions	1.82	3.42	3.38	1.83	1.74	0.26	010
17273		A	Destruction of skin lesions	2.10	3.73	3.69	2.02	1.91	0.30	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
17274		A	Destruction of skin lesions	2.64	4.22	4.17	2.37	2.25	0.37	010
17276		A	Destruction of skin lesions	3.25	4.68	4.58	2.73	2.57	0.48	010
17280		A	Destruction of skin lesions	1.22	2.72	2.69	1.36	1.29	0.18	010
17281		A	Destruction of skin lesions	1.77	3.19	3.15	1.79	1.70	0.26	010
17282		A	Destruction of skin lesions	2.09	3.67	3.61	2.03	1.92	0.30	010
17283		A	Destruction of skin lesions	2.69	4.23	4.15	2.44	2.30	0.38	010
17284		A	Destruction of skin lesions	3.26	4.75	4.66	2.81	2.66	0.45	010
17286		A	Destruction of skin lesions	4.48	5.62	5.44	3.58	3.38	0.67	010
17311		A	Mohs 1 stage h/n/hf/g	6.20	12.21	12.64	4.67	4.34	0.87	000
17312		A	Mohs addl stage	3.30	7.67	8.01	2.48	2.31	0.45	ZZZ
17313		A	Mohs 1 stage t/a/l	5.56	11.23	11.64	4.19	3.90	0.77	000
17314		A	Mohs addl stage t/a/l	3.06	7.11	7.43	2.30	2.14	0.42	ZZZ
17315		A	Mohs surg addl block	0.87	1.36	1.38	0.66	0.61	0.11	ZZZ
17340		A	Cryotherapy of skin	0.77	0.65	0.58	0.59	0.52	0.10	010
17360		A	Skin peel therapy	1.46	2.21	2.19	1.38	1.31	0.22	010
17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	000
17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
19000		A	Drainage of breast lesion	0.84	2.15	2.26	0.33	0.35	0.11	000
19001		A	Drain breast lesion add-on	0.42	0.29	0.31	0.16	0.17	0.05	ZZZ
19020		A	Incision of breast lesion	3.83	8.89	8.45	4.32	3.98	0.77	090
19030		A	Injection for breast x-ray	1.53	2.83	3.09	0.57	0.64	0.14	000
19100		A	Bx breast percut w/o image	1.27	2.77	2.66	0.55	0.50	0.26	000
19101		A	Biopsy of breast open	3.23	5.90	5.65	2.62	2.44	0.67	010
19102		A	Bx breast percut w/image	2.00	3.73	4.06	0.76	0.83	0.22	000
19103		A	Bx breast percut w/device	3.69	11.15	11.97	1.44	1.51	0.48	000
19105		A	Cryosurg ablate fa each	3.69	49.38	56.05	1.62	1.61	0.39	000
19110		A	Nipple exploration	4.44	8.74	8.19	4.69	4.30	0.92	090
19112		A	Excise breast duct fistula	3.81	8.61	8.12	4.52	4.15	0.80	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
19120		A	Removal of breast lesion	5.92	7.17	6.65	4.98	4.55	1.25	090
19125		A	Excision breast lesion	6.69	7.83	7.23	5.41	4.93	1.41	090
19126		A	Excision addl breast lesion	2.93	NA	NA	1.27	1.16	0.62	ZZZ
19260		A	Removal of chest wall lesion	17.78	NA	NA	14.21	13.62	3.95	090
19271		A	Revision of chest wall	22.19	NA	NA	20.98	20.72	5.04	090
19272		A	Extensive chest wall surgery	25.17	NA	NA	22.11	21.98	5.95	090
19290		A	Place needle wire breast	1.27	3.08	3.31	0.48	0.53	0.12	000
19291		A	Place needle wire breast	0.63	1.22	1.32	0.24	0.26	0.05	ZZZ
19295		A	Place breast clip percut	0.00	2.45	2.67	NA	NA	0.01	ZZZ
19296		A	Place po breast cath for rad	3.63	108.67	112.34	1.89	1.76	0.73	000
19297		A	Place breast cath for rad	1.72	NA	NA	0.75	0.69	0.35	ZZZ
19298		A	Place breast rad tube/caths	6.00	24.98	29.07	2.87	2.83	0.76	000
19300		A	Removal of breast tissue	5.31	8.56	8.23	5.55	5.09	1.13	090
19301		A	Partical mastectomy	10.13	NA	NA	7.04	6.26	2.15	090
19302		A	P-mastectomy w/ln removal	13.99	NA	NA	9.36	8.60	2.97	090
19303		A	Mast simple complete	15.85	NA	NA	10.70	9.47	3.37	090
19304		A	Mast subq	7.95	NA	NA	7.34	6.71	1.67	090
19305		A	Mast radical	17.46	NA	NA	12.34	11.23	3.72	090
19306		A	Mast rad urban type	18.13	NA	NA	13.47	12.16	3.86	090
19307		A	Mast mod rad	18.23	NA	NA	13.27	12.07	3.86	090
19316		A	Suspension of breast	11.09	NA	NA	10.21	9.50	2.19	090
19318		A	Reduction of large breast	16.03	NA	NA	14.90	13.87	3.15	090
19324		A	Enlarge breast	6.80	NA	NA	6.17	5.86	1.45	090
19325		A	Enlarge breast with implant	8.64	NA	NA	9.45	8.75	1.68	090
19328		A	Removal of breast implant	6.48	NA	NA	7.34	6.79	1.28	090
19330		A	Removal of implant material	8.54	NA	NA	9.09	8.38	1.66	090
19340		A	Immediate breast prosthesis	13.99	NA	NA	14.10	8.97	2.74	090
19342		A	Delayed breast prosthesis	12.63	NA	NA	13.28	12.25	2.43	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
19350		A	Breast reconstruction	9.11	13.85	13.60	9.72	9.06	1.78	090
19355		A	Correct inverted nipple(s)	8.52	10.13	10.14	6.52	6.24	1.82	090
19357		A	Breast reconstruction	18.50	NA	NA	23.79	21.54	3.61	090
19361		A	Breast reconstr w/lat flap	23.36	NA	NA	24.43	22.01	4.59	090
19364		A	Breast reconstruction	42.58	NA	NA	34.56	31.69	8.23	090
19366		A	Breast reconstruction	21.84	NA	NA	15.73	14.41	4.45	090
19367		A	Breast reconstruction	26.80	NA	NA	23.29	21.48	5.26	090
19368		A	Breast reconstruction	33.90	NA	NA	28.12	25.63	6.65	090
19369		A	Breast reconstruction	31.31	NA	NA	26.25	23.66	6.14	090
19370		A	Surgery of breast capsule	9.17	NA	NA	10.04	9.27	1.79	090
19371		A	Removal of breast capsule	10.62	NA	NA	11.38	10.51	2.06	090
19380		A	Revise breast reconstruction	10.41	NA	NA	11.22	10.37	2.02	090
19396		A	Design custom breast implant	2.17	5.14	4.44	1.59	1.40	0.45	000
19499		C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
20005		A	I&d abscess subfascial	3.58	4.64	4.54	2.66	2.62	0.58	010
2001F		I	Weight record	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2002F		I	Clin sign vol ovrld assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2004F		I	Initial exam involved joints	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20100		A	Explore wound neck	10.38	NA	NA	5.76	5.15	1.96	010
20101		A	Explore wound chest	3.23	7.91	7.74	2.04	1.98	0.69	010
20102		A	Explore wound abdomen	3.98	9.29	8.97	2.80	2.58	0.80	010
20103		A	Explore wound extremity	5.34	10.62	10.21	4.15	3.93	0.99	010
20150		A	Excise epiphyseal bar	14.75	NA	NA	12.58	11.30	2.92	090
2018F		I	Hydration status assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20200		A	Muscle biopsy	1.46	4.12	3.96	1.03	0.97	0.33	000
20205		A	Deep muscle biopsy	2.35	5.28	5.00	1.68	1.55	0.56	000
20206		A	Needle biopsy muscle	0.99	5.66	6.21	0.63	0.69	0.10	000
2020F		I	Dilated fundus eval done	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
20220		A	Bone biopsy trocar/needle	1.27	2.95	3.42	0.74	0.82	0.11	000
20225		A	Bone biopsy trocar/needle	1.87	13.33	15.89	1.14	1.25	0.23	000
20240		A	Bone biopsy excisional	3.28	NA	NA	2.85	2.77	0.52	010
20245		A	Bone biopsy excisional	8.95	NA	NA	8.34	7.87	1.64	010
20250		A	Open bone biopsy	5.19	NA	NA	4.98	4.69	1.22	010
20251		A	Open bone biopsy	5.72	NA	NA	5.28	5.10	1.32	010
2029F		I	Complete phys skin exam done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2030F		I	H2o stat docd normal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2031F		I	H2o stat docd dehydrated	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2044F		I	Doc mntl tst b/4 bk trxmnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20500		A	Injection of sinus tract	1.28	1.67	1.80	1.10	1.20	0.12	010
20501		A	Inject sinus tract for x-ray	0.76	2.53	2.80	0.28	0.32	0.07	000
2050F		I	Wound char size etc docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20520		A	Removal of foreign body	1.90	3.62	3.45	2.10	1.99	0.30	010
20525		A	Removal of foreign body	3.54	9.68	9.50	3.25	3.07	0.64	010
20526		A	Ther injection carp tunnel	0.94	1.13	1.10	0.63	0.59	0.14	000
20550		A	Inj tendon sheath/ligament	0.75	0.85	0.83	0.40	0.37	0.08	000
20551		A	Inj tendon origin/insertion	0.75	0.91	0.85	0.45	0.41	0.08	000
20552		A	Inj trigger point 1/2 muscl	0.66	0.86	0.81	0.40	0.35	0.07	000
20553		A	Inject trigger points =/> 3	0.75	1.00	0.93	0.45	0.39	0.07	000
20555		A	Place ndl musc/tis for rt	6.00	NA	NA	2.83	2.85	0.86	000
20600		A	Drain/inject joint/bursa	0.66	0.86	0.84	0.42	0.41	0.07	000
20605		A	Drain/inject joint/bursa	0.68	0.98	0.94	0.46	0.44	0.08	000
2060F		I	Pt talk eval hlthwkr re mdd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20610		A	Drain/inject joint/bursa	0.79	1.43	1.36	0.58	0.55	0.12	000
20612		A	Aspirate/inj ganglion cyst	0.70	0.97	0.91	0.46	0.44	0.08	000
20615		A	Treatment of bone cyst	2.33	3.78	3.69	2.08	2.00	0.29	010
20650		A	Insert and remove bone pin	2.28	3.31	3.15	1.96	1.89	0.29	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
20660		A	Apply rem fixation device	4.00	NA	NA	2.22	2.10	1.10	000
20661		A	Application of head brace	5.26	NA	NA	7.77	7.36	1.64	090
20662		A	Application of pelvis brace	6.38	NA	NA	4.74	5.62	0.61	090
20663		A	Application of thigh brace	5.74	NA	NA	6.98	6.46	1.14	090
20664		A	Application of halo	10.06	NA	NA	10.63	10.16	3.60	090
20665		A	Removal of fixation device	1.36	1.57	1.75	1.17	1.25	0.11	010
20670		A	Removal of support implant	1.79	8.81	9.16	2.30	2.24	0.30	010
20680		A	Removal of support implant	5.96	11.16	10.67	5.75	5.36	1.06	090
20690		A	Apply bone fixation device	8.78	NA	NA	7.27	6.41	1.62	090
20692		A	Apply bone fixation device	16.27	NA	NA	14.38	12.53	2.80	090
20693		A	Adjust bone fixation device	6.06	NA	NA	6.39	6.17	1.07	090
20694		A	Remove bone fixation device	4.28	7.41	7.26	5.01	4.78	0.76	090
20696		A	Comp multiplane ext fixation	17.56	NA	NA	15.51	12.69	1.25	090
20697		A	Comp ext fixate strut change	0.00	58.00	49.48	NA	NA	0.01	000
20802		A	Replantation arm complete	42.62	NA	NA	23.11	22.13	3.04	090
20805		A	Replant forearm complete	51.46	NA	NA	18.05	22.27	10.12	090
20808		A	Replantation hand complete	63.09	NA	NA	50.32	47.23	12.40	090
20816		A	Replantation digit complete	31.95	NA	NA	26.94	27.23	3.98	090
20822		A	Replantation digit complete	26.66	NA	NA	24.09	23.89	5.26	090
20824		A	Replantation thumb complete	31.95	NA	NA	24.13	25.62	6.27	090
20827		A	Replantation thumb complete	27.48	NA	NA	24.69	25.07	5.40	090
20838		A	Replantation foot complete	42.88	NA	NA	23.52	23.67	3.06	090
20900		A	Removal of bone for graft	3.00	8.62	8.50	2.77	3.25	0.56	000
20902		A	Removal of bone for graft	4.58	NA	NA	3.75	4.17	0.87	000
20910		A	Remove cartilage for graft	5.53	NA	NA	6.31	6.16	0.71	090
20912		A	Remove cartilage for graft	6.54	NA	NA	7.25	6.83	0.99	090
20920		A	Removal of fascia for graft	5.51	NA	NA	5.89	5.61	0.69	090
20922		A	Removal of fascia for graft	6.93	9.01	9.28	6.22	6.28	1.28	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
20924		A	Removal of tendon for graft	6.68	NA	NA	7.21	6.88	1.20	090
20926		A	Removal of tissue for graft	5.79	NA	NA	5.98	5.82	1.17	090
20930		B	Sp bone algrft morsel add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931		A	Sp bone algrft struct add-on	1.81	NA	NA	1.03	0.99	0.56	ZZZ
20936		B	Sp bone agrft local add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20937		A	Sp bone agrft morsel add-on	2.79	NA	NA	1.62	1.57	0.68	ZZZ
20938		A	Sp bone agrft struct add-on	3.02	NA	NA	1.74	1.68	0.83	ZZZ
20950		A	Fluid pressure muscle	1.26	5.61	5.68	1.22	1.16	0.23	000
20955		A	Fibula bone graft microvasc	40.26	NA	NA	30.96	28.58	6.65	090
20956		A	Iliac bone graft microvasc	41.18	NA	NA	30.65	28.73	8.11	090
20957		A	Mt bone graft microvasc	42.61	NA	NA	28.63	24.93	8.39	090
20962		A	Other bone graft microvasc	39.21	NA	NA	33.18	30.44	7.71	090
20969		A	Bone/skin graft microvasc	45.43	NA	NA	33.82	31.18	6.65	090
20970		A	Bone/skin graft iliac crest	44.58	NA	NA	31.43	29.98	8.79	090
20972		A	Bone/skin graft metatarsal	44.51	NA	NA	17.74	19.73	3.42	090
20973		A	Bone/skin graft great toe	47.27	NA	NA	34.61	28.49	3.37	090
20974		A	Electrical bone stimulation	0.62	1.43	1.29	0.72	0.68	0.12	000
20975		A	Electrical bone stimulation	2.60	NA	NA	2.09	2.01	0.58	000
20979		A	Us bone stimulation	0.62	0.84	0.82	0.29	0.29	0.08	000
20982		A	Ablate bone tumor(s) perq	7.27	88.94	97.51	3.06	3.31	0.80	000
20985		A	Cptr-asst dir ms px	2.50	NA	NA	1.50	1.40	0.49	ZZZ
20999		C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21010		A	Incision of jaw joint	11.04	NA	NA	9.56	8.81	1.41	090
21011		A	Exc face les sc < 2 cm	2.99	6.26	6.26	3.95	3.95	0.45	090
21012		A	Exc face les sbq 2+ cm	4.45	NA	NA	5.04	5.04	0.72	090
21013		A	Exc face tum deep < 2 cm	5.42	8.74	8.74	5.65	5.65	0.81	090
21014		A	Exc face tum deep 2+ cm	7.13	NA	NA	7.46	7.46	1.15	090
21015		A	Resect face tum < 2 cm	9.89	NA	NA	9.50	7.59	1.86	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
21016		A	Resect face tum + cm	15.26	NA	NA	13.07	13.07	2.91	090
21025		A	Excision of bone lower jaw	10.03	15.17	14.42	11.30	10.50	1.44	090
21026		A	Excision of facial bone(s)	5.70	11.75	11.13	8.41	7.93	0.83	090
21029		A	Contour of face bone lesion	8.39	13.21	12.48	9.56	8.92	1.64	090
21030		A	Excise max/zygoma b9 tumor	4.91	9.71	9.14	6.87	6.39	0.76	090
21031		A	Remove exostosis mandible	3.30	7.80	7.44	5.06	4.72	0.41	090
21032		A	Remove exostosis maxilla	3.34	7.96	7.59	4.94	4.59	0.42	090
21034		A	Excise max/zygoma mlg tumor	17.38	20.61	19.31	16.06	14.81	2.43	090
21040		A	Excise mandible lesion	4.91	9.84	9.26	6.95	6.40	0.75	090
21044		A	Removal of jaw bone lesion	12.80	NA	NA	12.37	11.48	1.78	090
21045		A	Extensive jaw surgery	18.37	NA	NA	16.73	15.41	2.51	090
21046		A	Remove mandible cyst complex	14.21	NA	NA	17.41	16.03	1.82	090
21047		A	Excise lwr jaw cyst w/repair	20.07	NA	NA	17.23	15.66	2.58	090
21048		A	Remove maxilla cyst complex	14.71	NA	NA	17.81	16.18	1.89	090
21049		A	Excis uppr jaw cyst w/repair	19.32	NA	NA	15.84	14.98	2.46	090
21050		A	Removal of jaw joint	11.76	NA	NA	12.47	11.80	2.30	090
21060		A	Remove jaw joint cartilage	11.07	NA	NA	11.70	10.69	2.34	090
21070		A	Remove coronoid process	8.62	NA	NA	9.13	8.67	1.10	090
21073		A	Mnpj of tmj w/anesth	3.45	7.65	7.15	3.70	3.29	0.68	090
21076		A	Prepare face/oral prosthesis	13.40	15.05	13.32	10.49	9.15	1.70	010
21077		A	Prepare face/oral prosthesis	33.70	37.54	32.77	26.53	23.45	4.32	090
21079		A	Prepare face/oral prosthesis	22.31	25.78	22.91	17.72	15.55	2.87	090
21080		A	Prepare face/oral prosthesis	25.06	29.04	26.00	19.63	17.28	3.22	090
21081		A	Prepare face/oral prosthesis	22.85	26.89	24.03	17.87	15.79	2.95	090
21082		A	Prepare face/oral prosthesis	20.84	26.31	23.23	17.57	15.30	2.66	090
21083		A	Prepare face/oral prosthesis	19.27	25.66	22.76	16.40	14.24	1.37	090
21084		A	Prepare face/oral prosthesis	22.48	28.80	25.82	18.79	16.52	2.89	090
21085		A	Prepare face/oral prosthesis	8.99	12.65	10.86	7.23	6.38	3.34	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
21086		A	Prepare face/oral prosthesis	24.88	28.05	23.92	19.38	16.89	3.19	090
21087		A	Prepare face/oral prosthesis	24.88	27.83	23.82	19.03	16.73	3.19	090
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21100		A	Maxillofacial fixation	4.73	11.85	13.68	4.71	5.47	0.64	090
21110		A	Interdental fixation	5.99	16.72	15.79	13.08	12.29	0.76	090
21116		A	Injection jaw joint x-ray	0.81	3.33	3.42	0.38	0.35	0.05	000
21120		A	Reconstruction of chin	5.10	13.03	12.58	9.48	8.97	1.00	090
21121		A	Reconstruction of chin	7.81	15.07	14.11	11.23	10.49	0.54	090
21122		A	Reconstruction of chin	8.71	NA	NA	11.79	11.17	0.61	090
21123		A	Reconstruction of chin	11.34	NA	NA	15.56	13.47	0.80	090
21125		A	Augmentation lower jaw bone	10.80	74.31	76.24	11.48	10.33	2.13	090
21127		A	Augmentation lower jaw bone	12.44	96.47	94.88	13.23	11.88	1.59	090
21137		A	Reduction of forehead	10.24	NA	NA	9.26	8.91	2.00	090
21138		A	Reduction of forehead	12.87	NA	NA	12.35	11.43	1.82	090
21139		A	Reduction of forehead	15.02	NA	NA	14.19	12.93	1.06	090
21141		A	Reconstruct midface lefort	19.57	NA	NA	18.24	17.08	3.84	090
21142		A	Reconstruct midface lefort	20.28	NA	NA	18.59	16.55	3.99	090
21143		A	Reconstruct midface lefort	21.05	NA	NA	19.75	17.73	4.48	090
21145		A	Reconstruct midface lefort	23.94	NA	NA	20.42	18.35	1.68	090
21146		A	Reconstruct midface lefort	24.87	NA	NA	23.22	20.73	4.89	090
21147		A	Reconstruct midface lefort	26.47	NA	NA	21.01	19.86	1.87	090
21150		A	Reconstruct midface lefort	25.96	NA	NA	22.77	20.50	1.83	090
21151		A	Reconstruct midface lefort	29.02	NA	NA	24.56	25.08	3.73	090
21154		A	Reconstruct midface lefort	31.29	NA	NA	31.32	27.36	4.01	090
21155		A	Reconstruct midface lefort	35.22	NA	NA	28.65	26.13	2.50	090
21159		A	Reconstruct midface lefort	43.14	NA	NA	39.89	33.83	5.51	090
21160		A	Reconstruct midface lefort	47.19	NA	NA	28.85	28.59	3.35	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
21172		A	Reconstruct orbit/forehead	28.20	NA	NA	23.96	20.84	3.61	090
21175		A	Reconstruct orbit/forehead	33.56	NA	NA	28.82	25.18	12.00	090
21179		A	Reconstruct entire forehead	22.65	NA	NA	20.18	17.92	4.45	090
21180		A	Reconstruct entire forehead	25.58	NA	NA	22.40	20.14	3.29	090
21181		A	Contour cranial bone lesion	10.28	NA	NA	10.58	9.39	1.30	090
21182		A	Reconstruct cranial bone	32.58	NA	NA	22.72	21.85	4.17	090
21183		A	Reconstruct cranial bone	35.70	NA	NA	24.56	23.92	7.01	090
21184		A	Reconstruct cranial bone	38.62	NA	NA	30.61	27.12	7.60	090
21188		A	Reconstruction of midface	23.15	NA	NA	22.24	21.42	2.97	090
21193		A	Reconst lwr jaw w/o graft	18.90	NA	NA	17.94	15.76	4.03	090
21194		A	Reconst lwr jaw w/graft	21.82	NA	NA	17.60	16.59	2.80	090
21195		A	Reconst lwr jaw w/o fixation	19.16	NA	NA	19.43	18.03	2.44	090
21196		A	Reconst lwr jaw w/fixation	20.83	NA	NA	21.81	19.87	2.66	090
21198		A	Reconstr lwr jaw segment	15.71	NA	NA	17.62	16.37	2.17	090
21199		A	Reconstr lwr jaw w/advance	16.73	NA	NA	12.33	11.30	2.15	090
21206		A	Reconstruct upper jaw bone	15.59	NA	NA	19.51	17.19	3.08	090
21208		A	Augmentation of facial bones	11.42	41.16	39.37	11.50	11.10	2.24	090
21209		A	Reduction of facial bones	7.82	15.72	15.17	10.70	10.07	1.53	090
21210		A	Face bone graft	11.69	53.00	50.23	12.87	11.54	1.51	090
21215		A	Lower jaw bone graft	12.23	101.33	96.04	13.13	11.79	2.39	090
21230		A	Rib cartilage graft	11.17	NA	NA	10.25	9.58	2.19	090
21235		A	Ear cartilage graft	7.50	13.33	12.87	8.79	8.30	1.10	090
21240		A	Reconstruction of jaw joint	16.07	NA	NA	15.62	14.24	2.04	090
21242		A	Reconstruction of jaw joint	14.59	NA	NA	14.26	13.21	1.87	090
21243		A	Reconstruction of jaw joint	24.53	NA	NA	23.27	21.16	3.15	090
21244		A	Reconstruction of lower jaw	13.62	NA	NA	16.81	15.69	1.93	090
21245		A	Reconstruction of jaw	13.12	19.10	18.42	12.55	11.93	1.67	090
21246		A	Reconstruction of jaw	12.92	NA	NA	10.80	10.11	1.64	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
21247		A	Reconstruct lower jaw bone	24.37	NA	NA	19.78	18.85	4.81	090
21248		A	Reconstruction of jaw	12.74	18.63	17.23	12.91	11.61	1.63	090
21249		A	Reconstruction of jaw	18.77	24.40	22.30	17.91	15.67	2.39	090
21255		A	Reconstruct lower jaw bone	18.46	NA	NA	19.82	19.88	2.35	090
21256		A	Reconstruction of orbit	17.66	NA	NA	16.57	14.97	2.25	090
21260		A	Revise eye sockets	17.90	NA	NA	21.79	19.95	1.26	090
21261		A	Revise eye sockets	34.07	NA	NA	23.67	24.31	6.71	090
21263		A	Revise eye sockets	31.01	NA	NA	22.32	22.38	2.20	090
21267		A	Revise eye sockets	20.69	NA	NA	24.13	22.54	4.07	090
21268		A	Revise eye sockets	27.07	NA	NA	20.59	21.74	5.32	090
21270		A	Augmentation cheek bone	10.63	17.28	15.69	10.62	9.30	1.51	090
21275		A	Revision orbitofacial bones	11.76	NA	NA	11.84	10.62	2.30	090
21280		A	Revision of eyelid	7.13	NA	NA	8.90	8.04	1.40	090
21282		A	Revision of eyelid	4.27	NA	NA	6.36	5.85	0.77	090
21295		A	Revision of jaw muscle/bone	1.90	NA	NA	2.90	2.92	0.37	090
21296		A	Revision of jaw muscle/bone	4.78	NA	NA	5.93	6.39	0.61	090
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21310		A	Treatment of nose fracture	0.58	2.74	2.60	0.16	0.16	0.10	000
21315		A	Treatment of nose fracture	1.83	6.04	5.80	2.45	2.33	0.29	010
21320		A	Treatment of nose fracture	1.88	5.52	5.32	2.00	1.89	0.27	010
21325		A	Treatment of nose fracture	4.18	NA	NA	9.16	9.06	0.67	090
21330		A	Treatment of nose fracture	5.79	NA	NA	10.54	10.27	0.73	090
21335		A	Treatment of nose fracture	9.02	NA	NA	11.88	11.40	1.22	090
21336		A	Treat nasal septal fracture	6.77	NA	NA	11.93	11.44	0.91	090
21337		A	Treat nasal septal fracture	3.39	8.12	7.81	5.01	4.71	0.52	090
21338		A	Treat nasoethmoid fracture	6.87	NA	NA	14.27	13.80	1.36	090
21339		A	Treat nasoethmoid fracture	8.50	NA	NA	13.43	13.57	1.66	090
21340		A	Treatment of nose fracture	11.49	NA	NA	10.16	9.98	1.48	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
21343		A	Treatment of sinus fracture	14.32	NA	NA	17.14	16.85	2.82	090
21344		A	Treatment of sinus fracture	21.57	NA	NA	22.09	19.96	7.73	090
21345		A	Treat nose/jaw fracture	9.06	13.11	12.87	8.77	8.57	1.17	090
21346		A	Treat nose/jaw fracture	11.45	NA	NA	14.83	14.53	1.48	090
21347		A	Treat nose/jaw fracture	13.53	NA	NA	18.47	17.29	1.71	090
21348		A	Treat nose/jaw fracture	17.52	NA	NA	16.57	14.45	2.24	090
21355		A	Treat cheek bone fracture	4.45	8.48	8.04	5.16	4.73	0.56	010
21356		A	Treat cheek bone fracture	4.83	9.31	8.96	5.85	5.53	0.71	010
21360		A	Treat cheek bone fracture	7.19	NA	NA	8.15	7.54	0.91	090
21365		A	Treat cheek bone fracture	16.77	NA	NA	14.67	13.40	2.80	090
21366		A	Treat cheek bone fracture	18.60	NA	NA	17.36	15.13	3.67	090
21385		A	Treat eye socket fracture	9.57	NA	NA	10.20	9.79	1.22	090
21386		A	Treat eye socket fracture	9.57	NA	NA	8.49	8.19	1.87	090
21387		A	Treat eye socket fracture	10.11	NA	NA	10.50	10.03	1.97	090
21390		A	Treat eye socket fracture	11.23	NA	NA	11.31	10.25	1.89	090
21395		A	Treat eye socket fracture	14.70	NA	NA	13.74	12.13	1.87	090
21400		A	Treat eye socket fracture	1.50	3.80	3.61	2.79	2.63	0.27	090
21401		A	Treat eye socket fracture	3.68	9.57	9.52	4.62	4.43	0.72	090
21406		A	Treat eye socket fracture	7.42	NA	NA	8.73	7.82	0.95	090
21407		A	Treat eye socket fracture	9.02	NA	NA	9.22	8.51	1.59	090
21408		A	Treat eye socket fracture	12.78	NA	NA	12.60	11.34	2.51	090
21421		A	Treat mouth roof fracture	6.02	15.28	14.72	11.98	11.48	1.18	090
21422		A	Treat mouth roof fracture	8.73	NA	NA	10.30	9.67	1.13	090
21423		A	Treat mouth roof fracture	10.85	NA	NA	12.40	11.25	2.13	090
21431		A	Treat craniofacial fracture	7.90	NA	NA	12.54	12.41	1.55	090
21432		A	Treat craniofacial fracture	8.82	NA	NA	11.34	10.16	1.71	090
21433		A	Treat craniofacial fracture	26.29	NA	NA	18.97	18.40	5.17	090
21435		A	Treat craniofacial fracture	20.26	NA	NA	16.23	15.61	2.59	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
21436		A	Treat craniofacial fracture	30.30	NA	NA	27.36	24.32	5.96	090
21440		A	Treat dental ridge fracture	3.44	12.58	12.09	9.59	9.25	0.67	090
21445		A	Treat dental ridge fracture	6.26	15.57	15.05	11.53	11.07	0.80	090
21450		A	Treat lower jaw fracture	3.71	13.28	12.63	9.94	9.59	0.65	090
21451		A	Treat lower jaw fracture	5.65	16.64	15.66	12.74	12.08	0.72	090
21452		A	Treat lower jaw fracture	2.40	13.41	14.19	7.23	7.11	0.48	090
21453		A	Treat lower jaw fracture	6.64	19.17	18.03	15.51	14.77	1.05	090
21454		A	Treat lower jaw fracture	7.36	NA	NA	8.76	8.06	0.92	090
21461		A	Treat lower jaw fracture	9.31	51.81	48.72	17.56	16.70	1.40	090
21462		A	Treat lower jaw fracture	11.01	53.30	50.61	18.76	17.63	1.41	090
21465		A	Treat lower jaw fracture	13.12	NA	NA	13.76	12.31	2.58	090
21470		A	Treat lower jaw fracture	17.54	NA	NA	16.70	15.15	2.89	090
21480		A	Reset dislocated jaw	0.61	2.02	1.97	0.26	0.24	0.10	000
21485		A	Reset dislocated jaw	4.77	15.28	14.42	11.96	11.32	0.61	090
21490		A	Repair dislocated jaw	12.95	NA	NA	12.89	11.97	2.55	090
21495		A	Treat hyoid bone fracture	6.79	NA	NA	13.84	13.04	0.86	090
21497		A	Interdental wiring	4.64	14.72	14.31	11.71	11.37	0.90	090
21499		C	Head surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21501		A	Drain neck/chest lesion	3.98	8.63	8.31	4.88	4.67	0.75	090
21502		A	Drain chest lesion	7.55	NA	NA	5.73	5.87	1.60	090
21510		A	Drainage of bone lesion	6.20	NA	NA	6.35	6.18	1.45	090
21550		A	Biopsy of neck/chest	2.11	5.21	5.11	2.30	2.24	0.30	010
21552		A	Exc neck les sc 3+ cm	6.49	NA	NA	5.64	5.64	1.28	090
21554		A	Exc neck tum deep 5+ cm	11.13	NA	NA	8.79	8.79	2.08	090
21555		A	Exc neck les sc < 3 cm	3.96	7.45	7.25	4.38	4.29	0.77	090
21556		A	Exc neck tum deep < 5 cm	7.66	NA	NA	6.93	6.05	1.44	090
21557		A	Resect neck tum < 5 cm	14.75	NA	NA	11.40	8.73	2.78	090
21558		A	Resect neck tum 5+ cm	21.58	NA	NA	15.25	15.25	4.07	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
21600		A	Partial removal of rib	7.26	NA	NA	8.12	7.70	1.56	090
21610		A	Partial removal of rib	15.91	NA	NA	14.07	12.49	5.70	090
21615		A	Removal of rib	10.45	NA	NA	6.52	6.67	2.46	090
21616		A	Removal of rib and nerves	12.69	NA	NA	6.95	8.19	3.03	090
21620		A	Partial removal of sternum	7.28	NA	NA	6.74	6.58	1.62	090
21627		A	Sternal debridement	7.30	NA	NA	7.36	7.27	1.64	090
21630		A	Extensive sternum surgery	19.18	NA	NA	14.91	14.29	4.03	090
21632		A	Extensive sternum surgery	19.68	NA	NA	12.86	12.70	4.93	090
21685		A	Hyoid myotomy & suspension	15.26	NA	NA	13.55	12.49	1.96	090
21700		A	Revision of neck muscle	6.31	NA	NA	4.71	4.88	1.49	090
21705		A	Revision of neck muscle/rib	9.92	NA	NA	4.73	5.69	2.34	090
21720		A	Revision of neck muscle	5.80	NA	NA	5.87	5.33	2.06	090
21725		A	Revision of neck muscle	7.19	NA	NA	7.45	7.02	1.41	090
21740		A	Reconstruction of sternum	17.57	NA	NA	9.36	9.80	3.46	090
21742		C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21743		C	Repair sternum/nuss w/scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21750		A	Repair of sternum separation	11.40	NA	NA	6.68	6.86	2.70	090
21800		A	Treatment of rib fracture	1.01	1.91	1.78	2.00	1.85	0.18	090
21805		A	Treatment of rib fracture	2.88	NA	NA	4.22	4.15	0.67	090
21810		A	Treatment of rib fracture(s)	7.03	NA	NA	7.26	6.65	1.63	090
21820		A	Treat sternum fracture	1.36	2.50	2.33	2.59	2.40	0.26	090
21825		A	Treat sternum fracture	7.76	NA	NA	7.13	7.10	1.82	090
21899		C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21920		A	Biopsy soft tissue of back	2.11	5.14	5.08	2.42	2.30	0.34	010
21925		A	Biopsy soft tissue of back	4.63	7.37	6.97	4.84	4.50	0.92	090
21930		A	Exc back les sc < 3 cm	4.94	7.79	7.56	4.78	4.68	1.02	090
21931		A	Exc back les sc 3+ cm	6.88	NA	NA	5.70	5.70	1.41	090
21932		A	Exc back tum deep < 5 cm	9.82	NA	NA	8.08	8.08	2.08	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
21933		A	Exc back tum deep 5+ cm	11.13	NA	NA	8.53	8.53	2.35	090
21935		A	Resect back tum < 5 cm	15.72	NA	NA	11.71	11.41	3.20	090
21936		A	Resect back tum 5+ cm	22.55	NA	NA	15.50	15.50	4.59	090
22010		A	I&d p-spine c/t/cerv-thor	12.75	NA	NA	12.01	11.36	3.29	090
22015		A	I&d p-spine l/s/ls	12.64	NA	NA	11.79	11.25	3.07	090
22100		A	Remove part of neck vertebra	11.00	NA	NA	11.33	10.61	3.95	090
22101		A	Remove part thorax vertebra	11.08	NA	NA	10.06	9.98	3.97	090
22102		A	Remove part lumbar vertebra	11.08	NA	NA	10.76	10.30	2.66	090
22103		A	Remove extra spine segment	2.34	NA	NA	1.36	1.32	0.64	ZZZ
22110		A	Remove part of neck vertebra	14.00	NA	NA	13.10	12.41	5.02	090
22112		A	Remove part thorax vertebra	14.07	NA	NA	12.93	11.88	5.04	090
22114		A	Remove part lumbar vertebra	14.07	NA	NA	12.80	12.16	2.77	090
22116		A	Remove extra spine segment	2.32	NA	NA	1.33	1.27	0.60	ZZZ
22206		A	Cut spine 3 col thor	37.18	NA	NA	26.43	24.70	7.31	090
22207		A	Cut spine 3 col lumb	36.68	NA	NA	26.12	24.44	9.18	090
22208		A	Cut spine 3 col addl seg	9.66	NA	NA	5.63	5.27	2.58	ZZZ
22210		A	Revision of neck spine	25.38	NA	NA	20.74	19.73	6.74	090
22212		A	Revision of thorax spine	20.99	NA	NA	18.01	17.03	4.96	090
22214		A	Revision of lumbar spine	21.02	NA	NA	17.97	17.13	5.11	090
22216		A	Revise extra spine segment	6.03	NA	NA	3.51	3.39	1.51	ZZZ
22220		A	Revision of neck spine	22.94	NA	NA	19.04	17.84	6.41	090
22222		A	Revision of thorax spine	23.09	NA	NA	19.34	16.16	4.54	090
22224		A	Revision of lumbar spine	23.09	NA	NA	18.88	17.79	5.36	090
22226		A	Revise extra spine segment	6.03	NA	NA	3.48	3.35	1.58	ZZZ
22305		A	Treat spine process fracture	2.13	3.07	2.89	2.60	2.44	0.41	090
22310		A	Treat spine fracture	3.89	4.37	4.03	3.72	3.41	0.77	090
22315		A	Treat spine fracture	10.11	13.56	12.81	10.46	9.83	2.54	090
22318		A	Treat odontoid fx w/o graft	22.72	NA	NA	18.27	17.43	7.66	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
22319		A	Treat odontoid fx w/graft	25.33	NA	NA	20.11	18.84	9.09	090
22325		A	Treat spine fracture	19.87	NA	NA	17.16	16.24	5.68	090
22326		A	Treat neck spine fracture	20.84	NA	NA	17.16	16.29	6.29	090
22327		A	Treat thorax spine fracture	20.77	NA	NA	17.89	16.74	5.61	090
22328		A	Treat each add spine fx	4.60	NA	NA	2.62	2.52	1.36	ZZZ
22505		A	Manipulation of spine	1.87	NA	NA	1.43	1.31	0.29	010
22520		A	Percut vertebroplasty thor	9.22	53.30	55.57	4.80	5.15	1.06	010
22521		A	Percut vertebroplasty lumb	8.65	53.07	54.94	4.60	4.93	1.00	010
22522		A	Percut vertebroplasty addl	4.30	NA	NA	1.89	1.97	0.54	ZZZ
22523		A	Percut kyphoplasty thor	9.26	NA	NA	6.13	6.22	1.82	010
22524		A	Percut kyphoplasty lumbar	8.86	NA	NA	5.97	6.04	1.74	010
22525		A	Percut kyphoplasty add-on	4.47	NA	NA	2.33	2.35	0.95	ZZZ
22526		N	Idet single level	6.10	59.00	55.12	3.49	2.93	0.54	010
22527		N	Idet 1 or more levels	3.03	50.65	46.41	1.33	1.02	0.24	ZZZ
22532		A	Lat thorax spine fusion	25.99	NA	NA	19.90	18.82	7.55	090
22533		A	Lat lumbar spine fusion	24.79	NA	NA	19.23	18.19	6.37	090
22534		A	Lat thor/lumb addl seg	5.99	NA	NA	3.43	3.31	1.59	ZZZ
22548		A	Neck spine fusion	27.06	NA	NA	21.81	20.34	9.70	090
22551		A	Neck spine fuse&remove addl	25.00	NA	NA	18.65	18.65	7.55	090
22552		A	Addl neck spine fusion	6.50	NA	NA	3.65	3.65	1.78	ZZZ
22554		A	Neck spine fusion	17.69	NA	NA	14.70	14.28	5.46	090
22556		A	Thorax spine fusion	24.70	NA	NA	18.63	17.77	6.61	090
22558		A	Lumbar spine fusion	23.53	NA	NA	17.15	16.19	5.65	090
22585		A	Additional spinal fusion	5.52	NA	NA	3.10	3.00	1.59	ZZZ
22590		A	Spine & skull spinal fusion	21.76	NA	NA	18.25	17.38	7.03	090
22595		A	Neck spinal fusion	20.64	NA	NA	17.55	16.69	6.56	090
22600		A	Neck spine fusion	17.40	NA	NA	15.53	14.77	5.31	090
22610		A	Thorax spine fusion	17.28	NA	NA	15.34	14.59	4.85	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
22612		A	Lumbar spine fusion	23.53	NA	NA	18.04	17.22	6.22	090
22614		A	Spine fusion extra segment	6.43	NA	NA	3.69	3.57	1.77	ZZZ
22630		A	Lumbar spine fusion	22.09	NA	NA	17.67	16.91	6.26	090
22632		A	Spine fusion extra segment	5.22	NA	NA	2.99	2.88	1.49	ZZZ
22800		A	Fusion of spine	19.50	NA	NA	16.06	15.37	4.89	090
22802		A	Fusion of spine	32.11	NA	NA	23.65	22.65	7.50	090
22804		A	Fusion of spine	37.50	NA	NA	26.91	25.73	8.51	090
22808		A	Fusion of spine	27.51	NA	NA	20.21	19.34	7.25	090
22810		A	Fusion of spine	31.50	NA	NA	21.71	20.78	7.92	090
22812		A	Fusion of spine	34.25	NA	NA	25.84	24.09	6.74	090
22818		A	Kyphectomy 1-2 segments	34.33	NA	NA	24.84	23.27	6.75	090
22819		A	Kyphectomy 3 or more	39.38	NA	NA	28.70	26.88	14.12	090
22830		A	Exploration of spinal fusion	11.22	NA	NA	9.99	9.58	2.89	090
22840		A	Insert spine fixation device	12.52	NA	NA	7.16	6.94	3.48	ZZZ
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
22842		A	Insert spine fixation device	12.56	NA	NA	7.21	6.98	3.44	ZZZ
22843		A	Insert spine fixation device	13.44	NA	NA	7.77	7.46	3.49	ZZZ
22844		A	Insert spine fixation device	16.42	NA	NA	9.62	9.35	3.68	ZZZ
22845		A	Insert spine fixation device	11.94	NA	NA	6.76	6.53	3.65	ZZZ
22846		A	Insert spine fixation device	12.40	NA	NA	7.02	6.79	3.76	ZZZ
22847		A	Insert spine fixation device	13.78	NA	NA	7.71	7.51	4.94	ZZZ
22848		A	Insert pelv fixation device	5.99	NA	NA	3.52	3.41	1.39	ZZZ
22849		A	Reinsert spinal fixation	19.17	NA	NA	14.65	14.05	5.13	090
22850		A	Remove spine fixation device	9.82	NA	NA	8.99	8.61	2.61	090
22851		A	Apply spine prosth device	6.70	NA	NA	3.82	3.68	1.89	ZZZ
22852		A	Remove spine fixation device	9.37	NA	NA	8.72	8.34	2.40	090
22855		A	Remove spine fixation device	15.86	NA	NA	12.79	12.24	4.74	090
22856		A	Cerv artific diskectomy	24.05	NA	NA	18.16	17.47	7.27	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
22857		R	Lumbar artif diskectomy	27.13	NA	NA	16.18	16.54	5.77	090
22861		A	Revise cerv artific disc	33.36	NA	NA	17.43	17.05	9.10	090
22862		R	Revise lumbar artif disc	32.63	NA	NA	17.61	17.24	6.41	090
22864		A	Remove cerv artif disc	29.40	NA	NA	21.76	18.45	8.03	090
22865		R	Remove lumb artif disc	31.75	NA	NA	21.16	21.76	6.23	090
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
22900		A	Exc back tum deep < 5 cm	8.32	NA	NA	6.61	5.49	1.71	090
22901		A	Exc back tum deep 5+ cm	10.11	NA	NA	7.39	7.39	2.09	090
22902		A	Exc abd les sc < 3 cm	4.42	7.75	7.75	4.95	4.95	0.71	090
22903		A	Exc abd les sc > 3 cm	6.39	NA	NA	5.57	5.57	1.21	090
22904		A	Resect abd tum < 5 cm	16.69	NA	NA	10.40	10.40	3.54	090
22905		A	Resect abd tum > 5 cm	21.58	NA	NA	13.67	13.67	4.59	090
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23000		A	Removal of calcium deposits	4.48	11.36	10.67	5.58	5.25	0.86	090
23020		A	Release shoulder joint	9.36	NA	NA	9.25	8.87	1.79	090
23030		A	Drain shoulder lesion	3.47	8.59	8.30	3.47	3.31	0.68	010
23031		A	Drain shoulder bursa	2.79	8.70	8.27	3.12	2.93	0.53	010
23035		A	Drain shoulder bone lesion	9.16	NA	NA	9.21	8.92	1.79	090
23040		A	Exploratory shoulder surgery	9.75	NA	NA	9.74	9.29	1.90	090
23044		A	Exploratory shoulder surgery	7.59	NA	NA	7.82	7.52	1.49	090
23065		A	Biopsy shoulder tissues	2.30	3.71	3.59	2.36	2.24	0.38	010
23066		A	Biopsy shoulder tissues	4.30	10.50	9.98	5.15	4.87	0.84	090
23071		A	Exc shoulder les sc > 3 cm	5.91	NA	NA	5.36	5.36	1.21	090
23073		A	Exc shoulder tum deep > 5 cm	10.13	NA	NA	8.51	8.51	2.04	090
23075		A	Exc shoulder les sc < 3 cm	4.21	8.49	6.53	4.53	3.37	0.86	090
23076		A	Exc shoulder tum deep < 5 cm	7.41	NA	NA	7.02	6.85	1.51	090
23077		A	Resect shoulder tum < 5 cm	17.66	NA	NA	13.15	12.71	3.59	090
23078		A	Resect shoulder tum > 5 cm	22.55	NA	NA	14.10	14.10	4.81	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
23100		A	Biopsy of shoulder joint	6.20	NA	NA	7.37	6.94	1.22	090
23101		A	Shoulder joint surgery	5.72	NA	NA	6.45	6.19	1.13	090
23105		A	Remove shoulder joint lining	8.48	NA	NA	8.77	8.39	1.66	090
23106		A	Incision of collarbone joint	6.13	NA	NA	7.33	6.80	1.21	090
23107		A	Explore treat shoulder joint	8.87	NA	NA	9.02	8.62	1.71	090
23120		A	Partial removal collar bone	7.39	NA	NA	8.45	8.02	1.45	090
23125		A	Removal of collar bone	9.64	NA	NA	9.57	9.02	1.89	090
23130		A	Remove shoulder bone part	7.77	NA	NA	8.76	8.35	1.52	090
23140		A	Removal of bone lesion	7.12	NA	NA	7.01	6.58	1.41	090
23145		A	Removal of bone lesion	9.40	NA	NA	9.43	8.95	1.85	090
23146		A	Removal of bone lesion	8.08	NA	NA	8.75	8.10	1.59	090
23150		A	Removal of humerus lesion	8.91	NA	NA	8.91	8.49	1.71	090
23155		A	Removal of humerus lesion	10.86	NA	NA	10.63	10.08	2.13	090
23156		A	Removal of humerus lesion	9.11	NA	NA	9.25	8.77	1.79	090
23170		A	Remove collar bone lesion	7.21	NA	NA	7.97	7.24	1.41	090
23172		A	Remove shoulder blade lesion	7.31	NA	NA	8.03	7.46	1.45	090
23174		A	Remove humerus lesion	10.05	NA	NA	10.51	9.99	1.97	090
23180		A	Remove collar bone lesion	8.99	NA	NA	9.13	8.98	1.81	090
23182		A	Remove shoulder blade lesion	8.61	NA	NA	9.39	9.02	1.68	090
23184		A	Remove humerus lesion	9.90	NA	NA	9.99	9.72	1.90	090
23190		A	Partial removal of scapula	7.47	NA	NA	8.02	7.49	1.48	090
23195		A	Removal of head of humerus	10.36	NA	NA	10.11	9.57	2.02	090
23200		A	Resect clavicle tumor	22.71	NA	NA	18.41	14.25	4.47	090
23210		A	Resect scapula tumor	27.21	NA	NA	21.11	15.92	5.35	090
23220		A	Resect prox humerus tumor	30.21	NA	NA	22.58	17.36	5.95	090
23330		A	Remove shoulder foreign body	1.90	4.54	4.38	2.18	2.10	0.35	010
23331		A	Remove shoulder foreign body	7.63	NA	NA	8.40	8.02	1.49	090
23332		A	Remove shoulder foreign body	12.37	NA	NA	11.52	11.01	2.39	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
23350		A	Injection for shoulder x-ray	1.00	2.98	3.27	0.40	0.43	0.10	000
23395		A	Muscle transfer shoulder/arm	18.54	NA	NA	16.30	15.51	3.59	090
23397		A	Muscle transfers	16.76	NA	NA	14.16	13.48	3.30	090
23400		A	Fixation of shoulder blade	13.87	NA	NA	12.43	11.87	2.73	090
23405		A	Incision of tendon & muscle	8.54	NA	NA	8.41	8.09	1.66	090
23406		A	Incise tendon(s) & muscle(s)	11.01	NA	NA	10.02	9.62	2.16	090
23410		A	Repair rotator cuff acute	11.39	NA	NA	10.86	10.46	2.21	090
23412		A	Repair rotator cuff chronic	11.93	NA	NA	11.18	10.80	2.31	090
23415		A	Release of shoulder ligament	9.23	NA	NA	9.64	9.21	1.81	090
23420		A	Repair of shoulder	13.54	NA	NA	12.73	12.23	2.65	090
23430		A	Repair biceps tendon	10.17	NA	NA	10.07	9.51	1.97	090
23440		A	Remove/transplant tendon	10.64	NA	NA	9.79	9.39	2.06	090
23450		A	Repair shoulder capsule	13.70	NA	NA	11.92	11.37	2.70	090
23455		A	Repair shoulder capsule	14.67	NA	NA	12.52	11.98	2.85	090
23460		A	Repair shoulder capsule	15.82	NA	NA	13.71	13.10	3.12	090
23462		A	Repair shoulder capsule	15.72	NA	NA	13.32	12.66	3.11	090
23465		A	Repair shoulder capsule	16.30	NA	NA	13.92	13.27	3.20	090
23466		A	Repair shoulder capsule	15.80	NA	NA	14.51	13.82	3.11	090
23470		A	Reconstruct shoulder joint	17.89	NA	NA	14.81	14.18	3.50	090
23472		A	Reconstruct shoulder joint	22.65	NA	NA	17.83	17.01	4.41	090
23480		A	Revision of collar bone	11.54	NA	NA	10.71	10.18	2.25	090
23485		A	Revision of collar bone	13.91	NA	NA	12.05	11.52	2.72	090
23490		A	Reinforce clavicle	12.16	NA	NA	12.13	10.97	2.39	090
23491		A	Reinforce shoulder bones	14.54	NA	NA	12.89	12.30	2.87	090
23500		A	Treat clavicle fracture	2.21	3.67	3.49	3.77	3.52	0.41	090
23505		A	Treat clavicle fracture	3.83	5.67	5.38	5.14	4.85	0.72	090
23515		A	Treat clavicle fracture	9.69	NA	NA	10.10	9.40	1.89	090
23520		A	Treat clavicle dislocation	2.29	3.98	3.70	4.08	3.77	0.43	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
23525		A	Treat clavicle dislocation	3.79	6.92	6.01	5.85	5.15	0.73	090
23530		A	Treat clavicle dislocation	7.48	NA	NA	8.02	7.22	1.48	090
23532		A	Treat clavicle dislocation	8.20	NA	NA	8.71	8.28	1.60	090
23540		A	Treat clavicle dislocation	2.36	3.63	3.46	3.72	3.46	0.42	090
23545		A	Treat clavicle dislocation	3.43	5.42	5.10	4.60	4.33	0.60	090
23550		A	Treat clavicle dislocation	7.59	NA	NA	7.88	7.55	1.47	090
23552		A	Treat clavicle dislocation	8.82	NA	NA	9.04	8.62	1.70	090
23570		A	Treat shoulder blade fx	2.36	3.91	3.71	4.10	3.85	0.43	090
23575		A	Treat shoulder blade fx	4.23	6.64	6.19	5.95	5.53	0.83	090
23585		A	Treat scapula fracture	14.23	NA	NA	12.40	11.48	2.76	090
23600		A	Treat humerus fracture	3.11	5.68	5.42	5.11	4.79	0.60	090
23605		A	Treat humerus fracture	5.06	7.57	7.23	6.51	6.19	0.98	090
23615		A	Treat humerus fracture	12.30	NA	NA	11.71	11.07	2.39	090
23616		A	Treat humerus fracture	18.37	NA	NA	15.31	14.87	3.57	090
23620		A	Treat humerus fracture	2.55	4.76	4.51	4.40	4.12	0.49	090
23625		A	Treat humerus fracture	4.10	6.22	5.92	5.50	5.23	0.77	090
23630		A	Treat humerus fracture	10.57	NA	NA	10.67	9.88	2.06	090
23650		A	Treat shoulder dislocation	3.53	4.58	4.35	3.93	3.67	0.61	090
23655		A	Treat shoulder dislocation	4.76	NA	NA	6.01	5.59	0.88	090
23660		A	Treat shoulder dislocation	7.66	NA	NA	8.16	7.75	1.49	090
23665		A	Treat dislocation/fracture	4.66	6.83	6.49	6.04	5.74	0.88	090
23670		A	Treat dislocation/fracture	12.28	NA	NA	11.45	10.57	2.39	090
23675		A	Treat dislocation/fracture	6.27	8.67	8.20	7.33	6.94	1.20	090
23680		A	Treat dislocation/fracture	13.15	NA	NA	12.00	11.22	2.57	090
23700		A	Fixation of shoulder	2.57	NA	NA	2.70	2.58	0.49	010
23800		A	Fusion of shoulder joint	14.73	NA	NA	13.06	12.41	2.92	090
23802		A	Fusion of shoulder joint	18.42	NA	NA	16.40	15.14	3.61	090
23900		A	Amputation of arm & girdle	20.72	NA	NA	16.89	15.02	4.09	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
23920		A	Amputation at shoulder joint	16.23	NA	NA	14.33	12.92	3.19	090
23921		A	Amputation follow-up surgery	5.72	NA	NA	6.97	5.75	1.36	090
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23930		A	Drainage of arm lesion	2.99	6.69	6.62	2.83	2.71	0.61	010
23931		A	Drainage of arm bursa	1.84	6.03	5.90	2.52	2.41	0.34	010
23935		A	Drain arm/elbow bone lesion	6.38	NA	NA	7.43	6.97	1.24	090
24000		A	Exploratory elbow surgery	6.08	NA	NA	6.91	6.55	1.17	090
24006		A	Release elbow joint	9.74	NA	NA	9.66	9.16	1.82	090
24065		A	Biopsy arm/elbow soft tissue	2.13	5.05	4.93	2.57	2.45	0.34	010
24066		A	Biopsy arm/elbow soft tissue	5.35	11.45	10.91	5.74	5.35	1.07	090
24071		A	Exc arm/elbow les sc 3+ cm	5.70	NA	NA	5.31	5.31	1.15	090
24073		A	Ex arm/elbow tum deep > 5 cm	10.13	NA	NA	8.60	8.60	2.01	090
24075		A	Exc arm/elbow les sc < 3 cm	4.24	9.14	8.99	4.66	4.39	0.84	090
24076		A	Ex arm/elbow tum deep < 5 cm	7.41	NA	NA	7.17	6.50	1.48	090
24077		A	Resect arm/elbow tum < 5 cm	15.72	NA	NA	12.15	10.51	3.18	090
24079		A	Resect arm/elbow tum > 5 cm	20.61	NA	NA	13.25	13.25	4.37	090
24100		A	Biopsy elbow joint lining	5.07	NA	NA	6.25	5.84	1.00	090
24101		A	Explore/treat elbow joint	6.30	NA	NA	7.31	6.97	1.21	090
24102		A	Remove elbow joint lining	8.26	NA	NA	8.48	8.04	1.55	090
24105		A	Removal of elbow bursa	3.78	NA	NA	5.76	5.44	0.72	090
24110		A	Remove humerus lesion	7.58	NA	NA	8.34	7.91	1.49	090
24115		A	Remove/graft bone lesion	10.12	NA	NA	9.86	9.28	1.98	090
24116		A	Remove/graft bone lesion	12.23	NA	NA	11.12	10.55	2.40	090
24120		A	Remove elbow lesion	6.82	NA	NA	7.56	7.13	1.29	090
24125		A	Remove/graft bone lesion	8.14	NA	NA	8.67	8.13	1.59	090
24126		A	Remove/graft bone lesion	8.62	NA	NA	8.96	8.50	1.68	090
24130		A	Removal of head of radius	6.42	NA	NA	7.39	7.05	1.20	090
24134		A	Removal of arm bone lesion	10.22	NA	NA	10.03	9.64	2.00	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
24136		A	Remove radius bone lesion	8.40	NA	NA	8.69	7.79	1.64	090
24138		A	Remove elbow bone lesion	8.50	NA	NA	9.80	9.29	1.66	090
24140		A	Partial removal of arm bone	9.55	NA	NA	9.63	9.36	1.78	090
24145		A	Partial removal of radius	7.81	NA	NA	8.22	8.05	1.53	090
24147		A	Partial removal of elbow	7.84	NA	NA	9.12	8.85	1.51	090
24149		A	Radical resection of elbow	16.22	NA	NA	15.93	14.90	2.97	090
24150		A	Resect distal humerus tumor	23.46	NA	NA	18.75	15.03	4.62	090
24152		A	Resect radius tumor	19.99	NA	NA	16.67	12.76	3.92	090
24155		A	Removal of elbow joint	12.09	NA	NA	11.03	10.41	2.38	090
24160		A	Remove elbow joint implant	8.00	NA	NA	8.55	8.11	1.49	090
24164		A	Remove radius head implant	6.43	NA	NA	7.05	6.73	1.26	090
24200		A	Removal of arm foreign body	1.81	3.86	3.69	2.03	1.89	0.31	010
24201		A	Removal of arm foreign body	4.70	10.54	10.34	5.21	4.98	0.92	090
24220		A	Injection for elbow x-ray	1.31	3.00	3.32	0.58	0.59	0.12	000
24300		A	Manipulate elbow w/anesth	4.04	NA	NA	7.23	6.87	0.72	090
24301		A	Muscle/tendon transfer	10.38	NA	NA	9.94	9.51	2.02	090
24305		A	Arm tendon lengthening	7.62	NA	NA	8.26	7.85	1.36	090
24310		A	Revision of arm tendon	6.12	NA	NA	6.84	6.52	1.18	090
24320		A	Repair of arm tendon	10.86	NA	NA	10.29	9.71	2.13	090
24330		A	Revision of arm muscles	9.79	NA	NA	9.65	9.19	1.91	090
24331		A	Revision of arm muscles	10.95	NA	NA	11.25	10.37	2.16	090
24332		A	Tenolysis triceps	7.91	NA	NA	8.69	8.25	1.55	090
24340		A	Repair of biceps tendon	8.08	NA	NA	8.56	8.17	1.58	090
24341		A	Repair arm tendon/muscle	9.49	NA	NA	10.82	10.17	1.85	090
24342		A	Repair of ruptured tendon	10.86	NA	NA	10.28	9.83	2.06	090
24343		A	Repr elbow lat ligmnt w/tiss	9.16	NA	NA	10.09	9.62	1.67	090
24344		A	Reconstruct elbow lat ligmnt	15.21	NA	NA	14.56	13.79	3.00	090
24345		A	Repr elbw med ligmnt w/tissu	9.16	NA	NA	9.99	9.49	1.67	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
24346		A	Reconstruct elbow med ligmnt	15.21	NA	NA	14.56	13.83	3.00	090
24357		A	Repair elbow perc	5.44	NA	NA	6.71	6.42	1.03	090
24358		A	Repair elbow w/deb open	6.66	NA	NA	7.65	7.27	1.25	090
24359		A	Repair elbow deb/attch open	8.98	NA	NA	9.04	8.45	1.67	090
24360		A	Reconstruct elbow joint	12.67	NA	NA	11.69	11.15	2.47	090
24361		A	Reconstruct elbow joint	14.41	NA	NA	12.84	12.29	2.84	090
24362		A	Reconstruct elbow joint	15.32	NA	NA	13.39	12.73	3.03	090
24363		A	Replace elbow joint	22.65	NA	NA	18.19	17.10	4.20	090
24365		A	Reconstruct head of radius	8.62	NA	NA	8.69	8.31	1.68	090
24366		A	Reconstruct head of radius	9.36	NA	NA	9.20	8.76	1.77	090
24400		A	Revision of humerus	11.33	NA	NA	10.88	10.41	2.19	090
24410		A	Revision of humerus	15.11	NA	NA	13.53	12.67	2.99	090
24420		A	Revision of humerus	13.73	NA	NA	13.13	12.50	2.70	090
24430		A	Repair of humerus	15.25	NA	NA	13.52	12.71	2.95	090
24435		A	Repair humerus with graft	14.99	NA	NA	14.32	13.52	2.92	090
24470		A	Revision of elbow joint	8.93	NA	NA	9.25	8.24	1.77	090
24495		A	Decompression of forearm	8.41	NA	NA	9.07	8.98	1.79	090
24498		A	Reinforce humerus	12.28	NA	NA	11.20	10.71	2.40	090
24500		A	Treat humerus fracture	3.41	6.23	5.92	5.36	5.02	0.64	090
24505		A	Treat humerus fracture	5.39	8.18	7.81	6.88	6.54	1.05	090
24515		A	Treat humerus fracture	12.12	NA	NA	11.67	11.11	2.34	090
24516		A	Treat humerus fracture	12.19	NA	NA	11.12	10.63	2.38	090
24530		A	Treat humerus fracture	3.69	6.63	6.30	5.65	5.31	0.69	090
24535		A	Treat humerus fracture	7.11	9.62	9.20	8.33	7.94	1.37	090
24538		A	Treat humerus fracture	9.77	NA	NA	10.39	9.96	1.91	090
24545		A	Treat humerus fracture	13.15	NA	NA	12.09	11.32	2.55	090
24546		A	Treat humerus fracture	14.91	NA	NA	13.33	12.77	2.89	090
24560		A	Treat humerus fracture	2.98	5.68	5.41	4.78	4.46	0.56	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
24565		A	Treat humerus fracture	5.78	8.68	8.02	7.47	6.86	1.14	090
24566		A	Treat humerus fracture	9.06	NA	NA	10.39	9.85	1.79	090
24575		A	Treat humerus fracture	9.71	NA	NA	10.19	9.74	1.87	090
24576		A	Treat humerus fracture	3.06	6.18	5.85	5.24	4.90	0.58	090
24577		A	Treat humerus fracture	6.01	8.88	8.27	7.61	7.04	1.18	090
24579		A	Treat humerus fracture	11.44	NA	NA	11.25	10.68	2.20	090
24582		A	Treat humerus fracture	10.14	NA	NA	11.79	11.08	1.98	090
24586		A	Treat elbow fracture	15.78	NA	NA	13.70	13.08	3.04	090
24587		A	Treat elbow fracture	15.79	NA	NA	13.84	13.12	2.92	090
24600		A	Treat elbow dislocation	4.37	5.26	5.10	4.48	4.24	0.76	090
24605		A	Treat elbow dislocation	5.64	NA	NA	7.05	6.66	1.09	090
24615		A	Treat elbow dislocation	9.83	NA	NA	9.54	9.10	1.83	090
24620		A	Treat elbow fracture	7.22	NA	NA	7.79	7.42	1.36	090
24635		A	Treat elbow fracture	8.80	NA	NA	9.51	10.02	1.67	090
24640		A	Treat elbow dislocation	1.25	2.36	2.14	1.18	1.08	0.23	010
24650		A	Treat radius fracture	2.31	4.78	4.55	4.20	3.91	0.42	090
24655		A	Treat radius fracture	4.62	7.12	6.86	6.10	5.83	0.86	090
24665		A	Treat radius fracture	8.36	NA	NA	9.40	8.94	1.59	090
24666		A	Treat radius fracture	9.86	NA	NA	10.08	9.60	1.86	090
24670		A	Treat ulnar fracture	2.69	5.19	4.95	4.42	4.15	0.50	090
24675		A	Treat ulnar fracture	4.91	7.48	7.16	6.41	6.11	0.92	090
24685		A	Treat ulnar fracture	8.37	NA	NA	9.39	8.94	1.62	090
24800		A	Fusion of elbow joint	11.41	NA	NA	11.06	10.11	2.24	090
24802		A	Fusion/graft of elbow joint	14.32	NA	NA	12.80	12.13	2.82	090
24900		A	Amputation of upper arm	10.18	NA	NA	9.63	9.01	2.01	090
24920		A	Amputation of upper arm	10.13	NA	NA	9.71	8.96	1.98	090
24925		A	Amputation follow-up surgery	7.30	NA	NA	8.02	7.60	1.44	090
24930		A	Amputation follow-up surgery	10.83	NA	NA	10.13	9.38	2.13	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
24931		A	Amputate upper arm & implant	13.44	NA	NA	8.42	8.18	0.95	090
24935		A	Revision of amputation	16.45	NA	NA	7.58	8.56	3.23	090
24940		C	Revision of upper arm	0.00	0.00	0.00	0.00	0.00	0.00	090
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
25000		A	Incision of tendon sheath	3.55	NA	NA	5.68	5.75	0.64	090
25001		A	Incise flexor carpi radialis	3.79	NA	NA	5.69	5.33	0.67	090
25020		A	Decompress forearm 1 space	6.06	NA	NA	9.89	9.60	1.06	090
25023		A	Decompress forearm 1 space	13.83	NA	NA	16.21	15.61	2.73	090
25024		A	Decompress forearm 2 spaces	10.79	NA	NA	10.27	9.76	2.12	090
25025		A	Decompress forearm 2 spaces	17.94	NA	NA	15.28	14.03	3.53	090
25028		A	Drainage of forearm lesion	5.39	NA	NA	8.82	8.57	1.03	090
25031		A	Drainage of forearm bursa	4.26	NA	NA	5.14	5.44	0.83	090
25035		A	Treat forearm bone lesion	7.65	NA	NA	8.19	8.80	1.48	090
25040		A	Explore/treat wrist joint	7.50	NA	NA	7.85	7.61	1.36	090
25065		A	Biopsy forearm soft tissues	2.04	5.12	5.00	2.58	2.49	0.33	010
25066		A	Biopsy forearm soft tissues	4.27	NA	NA	5.48	5.62	0.80	090
25071		A	Exc forearm les sc > 3 cm	5.91	NA	NA	5.71	5.71	1.17	090
25073		A	Exc forearm tum deep 3+ cm	7.13	NA	NA	7.50	7.50	1.36	090
25075		A	Exc forearm les sc < 3 cm	3.96	9.20	9.20	4.66	4.77	0.76	090
25076		A	Exc forearm tum deep < 3 cm	6.74	NA	NA	7.27	7.03	1.28	090
25077		A	Resect forearm/wrist tum<3cm	12.93	NA	NA	10.93	10.24	2.61	090
25078		A	Resect forearm/wrist tum3+cm	17.69	NA	NA	11.98	11.98	3.78	090
25085		A	Incision of wrist capsule	5.64	NA	NA	6.62	6.57	1.10	090
25100		A	Biopsy of wrist joint	4.02	NA	NA	5.36	5.23	0.77	090
25101		A	Explore/treat wrist joint	4.83	NA	NA	6.20	6.03	0.90	090
25105		A	Remove wrist joint lining	6.02	NA	NA	7.18	7.05	1.10	090
25107		A	Remove wrist joint cartilage	7.70	NA	NA	9.26	8.91	1.36	090
25109		A	Excise tendon forearm/wrist	6.94	NA	NA	7.84	7.28	1.24	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
25110		A	Remove wrist tendon lesion	4.04	NA	NA	5.22	5.39	0.75	090
25111		A	Remove wrist tendon lesion	3.53	NA	NA	5.19	5.01	0.67	090
25112		A	Reremove wrist tendon lesion	4.67	NA	NA	5.87	5.63	0.87	090
25115		A	Remove wrist/forearm lesion	10.09	NA	NA	10.83	11.04	1.79	090
25116		A	Remove wrist/forearm lesion	7.56	NA	NA	8.95	9.38	1.33	090
25118		A	Excise wrist tendon sheath	4.51	NA	NA	5.97	5.80	0.80	090
25119		A	Partial removal of ulna	6.21	NA	NA	7.29	7.20	1.22	090
25120		A	Removal of forearm lesion	6.27	NA	NA	7.32	7.91	1.17	090
25125		A	Remove/graft forearm lesion	7.67	NA	NA	8.39	8.95	1.51	090
25126		A	Remove/graft forearm lesion	7.74	NA	NA	8.43	8.94	1.52	090
25130		A	Removal of wrist lesion	5.43	NA	NA	6.88	6.66	0.99	090
25135		A	Remove & graft wrist lesion	7.08	NA	NA	8.03	7.84	1.39	090
25136		A	Remove & graft wrist lesion	6.14	NA	NA	7.21	7.01	1.21	090
25145		A	Remove forearm bone lesion	6.54	NA	NA	7.46	8.04	1.28	090
25150		A	Partial removal of ulna	7.38	NA	NA	8.04	7.91	1.36	090
25151		A	Partial removal of radius	7.68	NA	NA	8.18	8.71	1.51	090
25170		A	Resect radius/ulnar tumor	22.21	NA	NA	17.89	14.89	4.36	090
25210		A	Removal of wrist bone	6.12	NA	NA	7.32	7.08	1.07	090
25215		A	Removal of wrist bones	8.14	NA	NA	8.86	8.64	1.40	090
25230		A	Partial removal of radius	5.37	NA	NA	6.52	6.31	0.90	090
25240		A	Partial removal of ulna	5.31	NA	NA	6.45	6.40	0.91	090
25246		A	Injection for wrist x-ray	1.45	2.94	3.24	0.59	0.63	0.14	000
25248		A	Remove forearm foreign body	5.31	NA	NA	5.82	6.09	1.05	090
25250		A	Removal of wrist prosthesis	6.77	NA	NA	7.58	7.23	1.32	090
25251		A	Removal of wrist prosthesis	9.82	NA	NA	9.66	9.21	1.93	090
25259		A	Manipulate wrist w/anesthes	4.04	NA	NA	7.31	6.94	0.72	090
25260		A	Repair forearm tendon/muscle	8.04	NA	NA	9.25	9.65	1.48	090
25263		A	Repair forearm tendon/muscle	8.04	NA	NA	8.95	9.48	1.58	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
25265		A	Repair forearm tendon/muscle	10.10	NA	NA	10.18	10.64	1.97	090
25270		A	Repair forearm tendon/muscle	6.17	NA	NA	7.29	7.85	1.15	090
25272		A	Repair forearm tendon/muscle	7.21	NA	NA	7.94	8.51	1.32	090
25274		A	Repair forearm tendon/muscle	8.94	NA	NA	9.15	9.69	1.77	090
25275		A	Repair forearm tendon sheath	8.96	NA	NA	9.32	8.93	1.77	090
25280		A	Revise wrist/forearm tendon	7.39	NA	NA	8.09	8.61	1.28	090
25290		A	Incise wrist/forearm tendon	5.43	NA	NA	6.53	7.68	0.98	090
25295		A	Release wrist/forearm tendon	6.72	NA	NA	7.65	8.18	1.18	090
25300		A	Fusion of tendons at wrist	9.02	NA	NA	9.52	9.20	1.78	090
25301		A	Fusion of tendons at wrist	8.59	NA	NA	9.01	8.69	1.56	090
25310		A	Transplant forearm tendon	8.08	NA	NA	8.94	9.36	1.39	090
25312		A	Transplant forearm tendon	9.82	NA	NA	9.84	10.26	1.78	090
25315		A	Revise palsy hand tendon(s)	10.68	NA	NA	10.19	10.69	2.09	090
25316		A	Revise palsy hand tendon(s)	12.90	NA	NA	11.84	12.10	1.60	090
25320		A	Repair/revise wrist joint	12.75	NA	NA	14.46	13.64	2.25	090
25332		A	Revise wrist joint	11.74	NA	NA	11.35	10.74	2.17	090
25335		A	Realignment of hand	13.39	NA	NA	8.62	10.04	0.95	090
25337		A	Reconstruct ulna/radioulnar	11.73	NA	NA	12.81	12.22	2.01	090
25350		A	Revision of radius	9.09	NA	NA	9.35	9.86	1.60	090
25355		A	Revision of radius	10.53	NA	NA	10.21	10.70	2.06	090
25360		A	Revision of ulna	8.74	NA	NA	9.04	9.61	1.64	090
25365		A	Revise radius & ulna	12.91	NA	NA	11.86	12.13	2.54	090
25370		A	Revise radius or ulna	14.10	NA	NA	13.15	13.35	2.77	090
25375		A	Revise radius & ulna	13.55	NA	NA	12.24	12.65	0.95	090
25390		A	Shorten radius or ulna	10.70	NA	NA	10.41	10.81	1.87	090
25391		A	Lengthen radius or ulna	14.28	NA	NA	12.68	12.98	2.82	090
25392		A	Shorten radius & ulna	14.58	NA	NA	12.86	13.18	2.89	090
25393		A	Lengthen radius & ulna	16.56	NA	NA	15.48	15.06	3.27	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
25394		A	Repair carpal bone shorten	10.85	NA	NA	10.36	9.84	2.13	090
25400		A	Repair radius or ulna	11.28	NA	NA	10.65	11.13	2.06	090
25405		A	Repair/graft radius or ulna	15.01	NA	NA	13.26	13.58	2.73	090
25415		A	Repair radius & ulna	13.80	NA	NA	12.89	13.18	2.72	090
25420		A	Repair/graft radius & ulna	17.04	NA	NA	14.58	14.90	3.37	090
25425		A	Repair/graft radius or ulna	13.72	NA	NA	12.34	13.45	2.70	090
25426		A	Repair/graft radius & ulna	16.45	NA	NA	13.98	13.18	3.23	090
25430		A	Vasc graft into carpal bone	9.71	NA	NA	10.10	9.50	1.21	090
25431		A	Repair nonunion carpal bone	10.89	NA	NA	10.47	9.86	2.15	090
25440		A	Repair/graft wrist bone	10.68	NA	NA	10.30	9.93	1.89	090
25441		A	Reconstruct wrist joint	13.29	NA	NA	13.19	12.14	1.64	090
25442		A	Reconstruct wrist joint	11.12	NA	NA	11.08	10.50	1.39	090
25443		A	Reconstruct wrist joint	10.66	NA	NA	10.49	10.05	2.09	090
25444		A	Reconstruct wrist joint	11.42	NA	NA	11.87	10.92	0.80	090
25445		A	Reconstruct wrist joint	9.88	NA	NA	9.82	9.32	1.79	090
25446		A	Wrist replacement	17.30	NA	NA	14.94	14.10	2.95	090
25447		A	Repair wrist joint(s)	11.14	NA	NA	11.59	10.88	1.96	090
25449		A	Remove wrist joint implant	14.94	NA	NA	13.51	12.69	2.95	090
25450		A	Revision of wrist joint	8.06	NA	NA	6.05	6.83	1.58	090
25455		A	Revision of wrist joint	9.71	NA	NA	7.00	7.75	0.68	090
25490		A	Reinforce radius	9.73	NA	NA	8.85	9.56	1.25	090
25491		A	Reinforce ulna	10.15	NA	NA	9.88	10.39	1.98	090
25492		A	Reinforce radius and ulna	12.66	NA	NA	11.82	12.13	2.47	090
25500		A	Treat fracture of radius	2.60	4.75	4.45	4.14	3.82	0.45	090
25505		A	Treat fracture of radius	5.45	8.14	7.79	7.01	6.67	1.03	090
25515		A	Treat fracture of radius	8.80	NA	NA	9.37	8.91	1.67	090
25520		A	Treat fracture of radius	6.50	8.88	8.20	8.08	7.42	1.28	090
25525		A	Treat fracture of radius	10.55	NA	NA	10.76	10.45	2.01	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
25526		A	Treat fracture of radius	13.15	NA	NA	12.72	12.60	2.59	090
25530		A	Treat fracture of ulna	2.24	4.86	4.62	4.19	3.91	0.41	090
25535		A	Treat fracture of ulna	5.36	7.92	7.51	6.94	6.57	1.02	090
25545		A	Treat fracture of ulna	7.94	NA	NA	8.99	8.63	1.51	090
25560		A	Treat fracture radius & ulna	2.59	4.83	4.55	4.13	3.80	0.48	090
25565		A	Treat fracture radius & ulna	5.85	8.30	7.95	6.97	6.64	1.10	090
25574		A	Treat fracture radius & ulna	8.80	NA	NA	9.44	8.94	1.70	090
25575		A	Treat fracture radius/ulna	12.29	NA	NA	12.13	11.52	2.34	090
25600		A	Treat fracture radius/ulna	2.78	5.14	4.90	4.46	4.16	0.52	090
25605		A	Treat fracture radius/ulna	7.25	9.66	9.14	8.68	8.17	1.39	090
25606		A	Treat fx distal radial	8.31	NA	NA	9.70	9.39	1.60	090
25607		A	Treat fx rad extra-articul	9.56	NA	NA	10.45	9.77	1.82	090
25608		A	Treat fx rad intra-articul	11.07	NA	NA	11.37	10.63	2.06	090
25609		A	Treat fx radial 3+ frag	14.38	NA	NA	14.20	13.24	2.69	090
25622		A	Treat wrist bone fracture	2.79	5.46	5.18	4.73	4.39	0.52	090
25624		A	Treat wrist bone fracture	4.77	7.73	7.45	6.60	6.31	0.88	090
25628		A	Treat wrist bone fracture	9.67	NA	NA	10.03	9.50	1.74	090
25630		A	Treat wrist bone fracture	3.03	5.25	5.00	4.58	4.24	0.56	090
25635		A	Treat wrist bone fracture	4.61	7.75	7.20	6.66	5.98	0.90	090
25645		A	Treat wrist bone fracture	7.42	NA	NA	7.98	7.60	1.47	090
25650		A	Treat wrist bone fracture	3.23	5.46	5.18	4.93	4.55	0.60	090
25651		A	Pin ulnar styloid fracture	5.82	NA	NA	7.45	7.00	1.10	090
25652		A	Treat fracture ulnar styloid	8.06	NA	NA	8.97	8.49	1.47	090
25660		A	Treat wrist dislocation	4.98	NA	NA	5.93	5.69	0.90	090
25670		A	Treat wrist dislocation	8.09	NA	NA	8.33	8.01	1.49	090
25671		A	Pin radioulnar dislocation	6.46	NA	NA	8.00	7.54	1.26	090
25675		A	Treat wrist dislocation	4.89	6.85	6.53	5.84	5.54	0.87	090
25676		A	Treat wrist dislocation	8.29	NA	NA	8.94	8.50	1.53	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
25680		A	Treat wrist fracture	6.23	NA	NA	6.36	5.99	1.07	090
25685		A	Treat wrist fracture	10.09	NA	NA	9.83	9.30	1.97	090
25690		A	Treat wrist dislocation	5.72	NA	NA	7.30	6.80	1.14	090
25695		A	Treat wrist dislocation	8.51	NA	NA	8.63	8.24	1.66	090
25800		A	Fusion of wrist joint	10.07	NA	NA	9.95	9.61	1.81	090
25805		A	Fusion/graft of wrist joint	11.73	NA	NA	11.14	10.84	2.30	090
25810		A	Fusion/graft of wrist joint	11.95	NA	NA	11.87	11.28	2.12	090
25820		A	Fusion of hand bones	7.64	NA	NA	9.20	8.80	1.37	090
25825		A	Fuse hand bones with graft	9.69	NA	NA	11.12	10.60	1.68	090
25830		A	Fusion radioulnar jnt/ulna	10.88	NA	NA	15.00	14.66	2.15	090
25900		A	Amputation of forearm	9.61	NA	NA	9.76	9.96	1.82	090
25905		A	Amputation of forearm	9.59	NA	NA	9.40	9.60	1.89	090
25907		A	Amputation follow-up surgery	8.09	NA	NA	8.50	8.76	1.59	090
25909		A	Amputation follow-up surgery	9.31	NA	NA	9.23	9.48	1.83	090
25915		A	Amputation of forearm	17.52	NA	NA	10.17	12.60	3.10	090
25920		A	Amputate hand at wrist	9.03	NA	NA	9.84	9.34	1.78	090
25922		A	Amputate hand at wrist	7.65	NA	NA	6.22	6.84	0.53	090
25924		A	Amputation follow-up surgery	8.81	NA	NA	7.66	8.14	1.71	090
25927		A	Amputation of hand	9.09	NA	NA	12.92	12.30	1.79	090
25929		A	Amputation follow-up surgery	7.82	NA	NA	8.94	7.82	1.53	090
25931		A	Amputation follow-up surgery	8.04	NA	NA	10.00	10.47	1.70	090
25999		C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26010		A	Drainage of finger abscess	1.59	5.52	5.47	2.16	2.04	0.27	010
26011		A	Drainage of finger abscess	2.24	8.50	8.46	2.84	2.70	0.39	010
26020		A	Drain hand tendon sheath	5.08	NA	NA	6.84	6.47	0.92	090
26025		A	Drainage of palm bursa	5.08	NA	NA	6.48	6.11	0.91	090
26030		A	Drainage of palm bursa(s)	6.25	NA	NA	7.25	6.85	1.15	090
26034		A	Treat hand bone lesion	6.63	NA	NA	8.06	7.64	1.22	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
26035		A	Decompress fingers/hand	11.37	NA	NA	11.87	10.97	2.23	090
26037		A	Decompress fingers/hand	7.57	NA	NA	8.03	7.58	1.44	090
26040		A	Release palm contracture	3.46	NA	NA	5.16	4.88	0.56	090
26045		A	Release palm contracture	5.73	NA	NA	7.00	6.67	1.09	090
26055		A	Incise finger tendon sheath	3.11	12.31	12.47	5.42	5.09	0.56	090
26060		A	Incision of finger tendon	2.91	NA	NA	4.45	4.22	0.54	090
26070		A	Explore/treat hand joint	3.81	NA	NA	4.68	4.33	0.65	090
26075		A	Explore/treat finger joint	3.91	NA	NA	4.95	4.65	0.67	090
26080		A	Explore/treat finger joint	4.47	NA	NA	6.24	5.89	0.77	090
26100		A	Biopsy hand joint lining	3.79	NA	NA	5.29	4.95	0.73	090
26105		A	Biopsy finger joint lining	3.83	NA	NA	5.31	5.03	0.75	090
26110		A	Biopsy finger joint lining	3.65	NA	NA	5.21	4.91	0.64	090
26111		A	Exc hand les sc > 1.5 cm	5.42	NA	NA	6.09	6.09	0.99	090
26113		A	Exc hand tum deep > 1.5 cm	7.13	NA	NA	8.00	8.00	1.25	090
26115		A	Exc hand les sc < 1.5 cm	3.96	9.92	11.43	5.17	5.28	0.71	090
26116		A	Exc hand tum deep < 1.5 cm	6.74	NA	NA	7.75	7.29	1.20	090
26117		A	Exc hand tum ra < 3 cm	10.13	NA	NA	10.52	9.29	1.85	090
26118		A	Exc hand tum ra > 3 cm	14.81	NA	NA	14.28	14.28	2.93	090
26121		A	Release palm contracture	7.73	NA	NA	8.66	8.21	1.40	090
26123		A	Release palm contracture	10.88	NA	NA	12.07	11.29	1.91	090
26125		A	Release palm contracture	4.60	NA	NA	2.95	2.78	0.81	ZZZ
26130		A	Remove wrist joint lining	5.59	NA	NA	7.05	6.62	1.06	090
26135		A	Revise finger joint each	7.13	NA	NA	8.00	7.58	1.26	090
26140		A	Revise finger joint each	6.34	NA	NA	7.52	7.13	1.14	090
26145		A	Tendon excision palm/finger	6.49	NA	NA	7.55	7.16	1.18	090
26160		A	Remove tendon sheath lesion	3.57	12.27	12.16	5.61	5.27	0.65	090
26170		A	Removal of palm tendon each	4.91	NA	NA	6.27	5.94	0.86	090
26180		A	Removal of finger tendon	5.35	NA	NA	6.77	6.47	0.90	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
26185		A	Remove finger bone	6.52	NA	NA	8.41	7.90	1.28	090
26200		A	Remove hand bone lesion	5.65	NA	NA	6.68	6.36	1.03	090
26205		A	Remove/graft bone lesion	7.93	NA	NA	8.36	8.01	1.56	090
26210		A	Removal of finger lesion	5.32	NA	NA	6.83	6.47	0.95	090
26215		A	Remove/graft finger lesion	7.27	NA	NA	7.96	7.55	1.44	090
26230		A	Partial removal of hand bone	6.47	NA	NA	7.22	6.88	1.13	090
26235		A	Partial removal finger bone	6.33	NA	NA	7.29	6.89	1.10	090
26236		A	Partial removal finger bone	5.46	NA	NA	6.64	6.31	0.98	090
26250		A	Extensive hand surgery	15.21	NA	NA	13.81	10.66	3.00	090
26260		A	Resect prox finger tumor	11.16	NA	NA	11.54	9.29	2.19	090
26262		A	Resect distal finger tumor	8.29	NA	NA	8.90	7.49	1.62	090
26320		A	Removal of implant from hand	4.10	NA	NA	5.48	5.18	0.71	090
26340		A	Manipulate finger w/anesth	2.80	NA	NA	6.43	6.08	0.52	090
26350		A	Repair finger/hand tendon	6.21	NA	NA	13.12	13.17	1.13	090
26352		A	Repair/graft hand tendon	7.87	NA	NA	14.08	14.00	1.55	090
26356		A	Repair finger/hand tendon	10.62	NA	NA	19.20	18.76	1.91	090
26357		A	Repair finger/hand tendon	8.77	NA	NA	14.61	14.54	1.71	090
26358		A	Repair/graft hand tendon	9.36	NA	NA	15.80	15.51	1.85	090
26370		A	Repair finger/hand tendon	7.28	NA	NA	13.41	13.44	1.36	090
26372		A	Repair/graft hand tendon	9.01	NA	NA	14.76	14.80	1.78	090
26373		A	Repair finger/hand tendon	8.41	NA	NA	14.40	14.39	1.64	090
26390		A	Revise hand/finger tendon	9.43	NA	NA	13.01	12.76	1.86	090
26392		A	Repair/graft hand tendon	10.50	NA	NA	15.65	15.48	2.06	090
26410		A	Repair hand tendon	4.77	NA	NA	10.57	10.64	0.87	090
26412		A	Repair/graft hand tendon	6.48	NA	NA	12.12	12.10	1.15	090
26415		A	Excision hand/finger tendon	8.51	NA	NA	10.28	10.45	1.17	090
26416		A	Graft hand or finger tendon	9.56	NA	NA	14.37	12.74	1.87	090
26418		A	Repair finger tendon	4.47	NA	NA	11.21	11.24	0.81	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
26420		A	Repair/graft finger tendon	6.94	NA	NA	12.09	12.17	1.37	090
26426		A	Repair finger/hand tendon	6.32	NA	NA	7.42	8.15	1.14	090
26428		A	Repair/graft finger tendon	7.40	NA	NA	12.92	12.85	1.47	090
26432		A	Repair finger tendon	4.16	NA	NA	9.40	9.40	0.73	090
26433		A	Repair finger tendon	4.70	NA	NA	9.71	9.73	0.86	090
26434		A	Repair/graft finger tendon	6.26	NA	NA	11.11	11.00	1.24	090
26437		A	Realignment of tendons	5.99	NA	NA	10.96	10.86	1.03	090
26440		A	Release palm/finger tendon	5.16	NA	NA	11.73	11.84	0.90	090
26442		A	Release palm & finger tendon	9.75	NA	NA	16.56	16.19	1.74	090
26445		A	Release hand/finger tendon	4.45	NA	NA	11.29	11.43	0.77	090
26449		A	Release forearm/hand tendon	8.59	NA	NA	10.68	11.19	1.51	090
26450		A	Incision of palm tendon	3.79	NA	NA	7.22	7.13	0.68	090
26455		A	Incision of finger tendon	3.76	NA	NA	7.23	7.11	0.69	090
26460		A	Incise hand/finger tendon	3.58	NA	NA	7.17	7.04	0.62	090
26471		A	Fusion of finger tendons	5.90	NA	NA	10.87	10.74	1.03	090
26474		A	Fusion of finger tendons	5.49	NA	NA	10.88	10.67	1.07	090
26476		A	Tendon lengthening	5.35	NA	NA	10.78	10.46	1.06	090
26477		A	Tendon shortening	5.32	NA	NA	10.50	10.40	1.02	090
26478		A	Lengthening of hand tendon	5.97	NA	NA	10.90	10.91	1.09	090
26479		A	Shortening of hand tendon	5.91	NA	NA	10.90	10.84	1.17	090
26480		A	Transplant hand tendon	6.90	NA	NA	13.58	13.56	1.21	090
26483		A	Transplant/graft hand tendon	8.48	NA	NA	14.33	14.32	1.56	090
26485		A	Transplant palm tendon	7.89	NA	NA	14.04	14.05	1.40	090
26489		A	Transplant/graft palm tendon	9.86	NA	NA	15.27	14.41	1.93	090
26490		A	Revise thumb tendon	8.60	NA	NA	12.91	12.61	1.68	090
26492		A	Tendon transfer with graft	9.84	NA	NA	13.84	13.60	1.93	090
26494		A	Hand tendon/muscle transfer	8.66	NA	NA	12.80	12.63	1.68	090
26496		A	Revise thumb tendon	9.78	NA	NA	13.57	13.27	1.64	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
26497		A	Finger tendon transfer	9.76	NA	NA	13.46	13.25	1.91	090
26498		A	Finger tendon transfer	14.21	NA	NA	16.45	16.12	2.80	090
26499		A	Revision of finger	9.17	NA	NA	13.11	12.89	1.81	090
26500		A	Hand tendon reconstruction	6.13	NA	NA	10.91	10.80	1.14	090
26502		A	Hand tendon reconstruction	7.31	NA	NA	12.14	11.81	1.45	090
26508		A	Release thumb contracture	6.18	NA	NA	11.06	10.86	1.10	090
26510		A	Thumb tendon transfer	5.60	NA	NA	10.58	10.56	0.98	090
26516		A	Fusion of knuckle joint	7.32	NA	NA	11.69	11.56	1.29	090
26517		A	Fusion of knuckle joints	9.08	NA	NA	13.05	12.91	1.79	090
26518		A	Fusion of knuckle joints	9.27	NA	NA	13.39	13.11	1.82	090
26520		A	Release knuckle contracture	5.47	NA	NA	12.27	12.34	0.99	090
26525		A	Release finger contracture	5.50	NA	NA	12.27	12.36	0.95	090
26530		A	Revise knuckle joint	6.88	NA	NA	7.85	7.42	1.22	090
26531		A	Revise knuckle with implant	8.13	NA	NA	9.05	8.54	1.39	090
26535		A	Revise finger joint	5.41	NA	NA	6.08	5.55	0.83	090
26536		A	Revise/implant finger joint	6.56	NA	NA	12.93	12.23	1.13	090
26540		A	Repair hand joint	6.60	NA	NA	11.28	11.19	1.18	090
26541		A	Repair hand joint with graft	8.81	NA	NA	12.82	12.70	1.52	090
26542		A	Repair hand joint with graft	6.95	NA	NA	11.55	11.44	1.25	090
26545		A	Reconstruct finger joint	7.11	NA	NA	11.87	11.68	1.26	090
26546		A	Repair nonunion hand	10.83	NA	NA	16.17	15.73	1.85	090
26548		A	Reconstruct finger joint	8.22	NA	NA	12.53	12.32	1.49	090
26550		A	Construct thumb replacement	21.68	NA	NA	22.52	19.73	4.25	090
26551		A	Great toe-hand transfer	48.48	NA	NA	28.89	30.88	9.53	090
26553		A	Single transfer toe-hand	48.17	NA	NA	44.78	35.27	3.42	090
26554		A	Double transfer toe-hand	57.01	NA	NA	32.96	34.22	4.05	090
26555		A	Positional change of finger	17.08	NA	NA	19.76	19.31	3.37	090
26556		A	Toe joint transfer	49.75	NA	NA	32.53	29.48	3.95	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
26560		A	Repair of web finger	5.52	NA	NA	10.58	10.18	1.09	090
26561		A	Repair of web finger	11.10	NA	NA	15.02	13.92	2.35	090
26562		A	Repair of web finger	16.68	NA	NA	19.39	18.69	1.18	090
26565		A	Correct metacarpal flaw	6.91	NA	NA	11.40	11.30	1.36	090
26567		A	Correct finger deformity	6.99	NA	NA	11.43	11.35	1.24	090
26568		A	Lengthen metacarpal/finger	9.27	NA	NA	14.91	14.77	1.82	090
26580		A	Repair hand deformity	19.75	NA	NA	15.21	15.89	3.88	090
26587		A	Reconstruct extra finger	14.50	NA	NA	14.82	12.52	3.10	090
26590		A	Repair finger deformity	18.67	NA	NA	15.18	14.40	3.69	090
26591		A	Repair muscles of hand	3.38	NA	NA	8.49	8.58	0.61	090
26593		A	Release muscles of hand	5.50	NA	NA	10.87	10.76	0.92	090
26596		A	Excision constricting tissue	9.14	NA	NA	11.34	10.64	1.81	090
26600		A	Treat metacarpal fracture	2.60	5.37	5.01	4.91	4.48	0.48	090
26605		A	Treat metacarpal fracture	3.03	5.73	5.45	4.95	4.66	0.56	090
26607		A	Treat metacarpal fracture	5.48	NA	NA	6.96	6.38	1.06	090
26608		A	Treat metacarpal fracture	5.55	NA	NA	7.51	7.17	1.03	090
26615		A	Treat metacarpal fracture	7.07	NA	NA	8.75	8.03	1.29	090
26641		A	Treat thumb dislocation	4.13	5.44	5.35	4.66	4.52	0.72	090
26645		A	Treat thumb fracture	4.58	7.01	6.49	6.05	5.55	0.88	090
26650		A	Treat thumb fracture	5.35	NA	NA	7.71	7.40	1.02	090
26665		A	Treat thumb fracture	7.94	NA	NA	9.19	8.61	1.47	090
26670		A	Treat hand dislocation	3.83	5.06	4.82	4.27	3.96	0.67	090
26675		A	Treat hand dislocation	4.83	7.49	6.95	6.48	5.97	0.95	090
26676		A	Pin hand dislocation	5.74	NA	NA	7.92	7.61	1.06	090
26685		A	Treat hand dislocation	7.07	NA	NA	8.66	8.11	1.39	090
26686		A	Treat hand dislocation	8.17	NA	NA	8.71	8.28	1.60	090
26700		A	Treat knuckle dislocation	3.83	4.68	4.43	4.19	3.87	0.65	090
26705		A	Treat knuckle dislocation	4.38	7.05	6.52	6.07	5.56	0.81	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
26706		A	Pin knuckle dislocation	5.31	NA	NA	6.80	6.34	0.95	090
26715		A	Treat knuckle dislocation	7.03	NA	NA	8.62	7.99	1.30	090
26720		A	Treat finger fracture each	1.76	3.57	3.39	3.20	2.98	0.33	090
26725		A	Treat finger fracture each	3.48	5.70	5.46	4.81	4.52	0.64	090
26727		A	Treat finger fracture each	5.42	NA	NA	7.46	7.12	0.99	090
26735		A	Treat finger fracture each	7.42	NA	NA	8.94	8.23	1.37	090
26740		A	Treat finger fracture each	2.07	4.21	3.96	3.82	3.57	0.35	090
26742		A	Treat finger fracture each	3.99	5.92	5.71	5.01	4.77	0.72	090
26746		A	Treat finger fracture each	9.80	NA	NA	10.54	9.55	1.78	090
26750		A	Treat finger fracture each	1.80	3.12	2.97	3.14	2.91	0.33	090
26755		A	Treat finger fracture each	3.23	5.20	5.00	4.12	3.89	0.58	090
26756		A	Pin finger fracture each	4.58	NA	NA	6.89	6.58	0.83	090
26765		A	Treat finger fracture each	5.86	NA	NA	7.91	7.19	1.09	090
26770		A	Treat finger dislocation	3.15	4.10	3.90	3.59	3.32	0.54	090
26775		A	Treat finger dislocation	3.90	6.48	6.18	5.50	5.14	0.69	090
26776		A	Pin finger dislocation	4.99	NA	NA	7.13	6.82	0.91	090
26785		A	Treat finger dislocation	6.60	NA	NA	8.41	7.61	1.21	090
26820		A	Thumb fusion with graft	8.45	NA	NA	12.68	12.57	1.66	090
26841		A	Fusion of thumb	7.35	NA	NA	12.37	12.27	1.39	090
26842		A	Thumb fusion with graft	8.49	NA	NA	12.73	12.63	1.66	090
26843		A	Fusion of hand joint	7.78	NA	NA	12.02	11.89	1.53	090
26844		A	Fusion/graft of hand joint	8.98	NA	NA	12.99	12.85	1.78	090
26850		A	Fusion of knuckle	7.14	NA	NA	11.69	11.58	1.24	090
26852		A	Fusion of knuckle with graft	8.71	NA	NA	12.96	12.72	1.47	090
26860		A	Fusion of finger joint	4.88	NA	NA	10.49	10.43	0.84	090
26861		A	Fusion of finger jnt add-on	1.74	NA	NA	1.10	1.04	0.31	ZZZ
26862		A	Fusion/graft of finger joint	7.56	NA	NA	12.20	12.01	1.30	090
26863		A	Fuse/graft added joint	3.89	NA	NA	2.33	2.26	0.75	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
26910		A	Amputate metacarpal bone	7.79	NA	NA	11.59	11.37	1.49	090
26951		A	Amputation of finger/thumb	6.04	NA	NA	11.67	11.26	1.14	090
26952		A	Amputation of finger/thumb	6.48	NA	NA	11.08	10.99	1.21	090
26989		C	Hand/finger surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26990		A	Drainage of pelvis lesion	7.95	NA	NA	8.95	8.53	1.58	090
26991		A	Drainage of pelvis bursa	7.06	12.23	11.86	7.18	6.76	1.39	090
26992		A	Drainage of bone lesion	13.48	NA	NA	12.53	11.93	2.66	090
27000		A	Incision of hip tendon	5.74	NA	NA	6.07	5.96	1.07	090
27001		A	Incision of hip tendon	7.14	NA	NA	7.50	7.16	1.40	090
27003		A	Incision of hip tendon	7.81	NA	NA	8.33	7.84	1.53	090
27005		A	Incision of hip tendon	10.07	NA	NA	9.61	9.17	1.97	090
27006		A	Incision of hip tendons	10.11	NA	NA	9.90	9.42	1.96	090
27025		A	Incision of hip/thigh fascia	12.89	NA	NA	11.82	11.07	2.57	090
27027		A	Buttock fasciotomy	13.04	NA	NA	11.45	10.40	0.91	090
27030		A	Drainage of hip joint	13.65	NA	NA	11.57	11.14	2.66	090
27033		A	Exploration of hip joint	14.11	NA	NA	12.24	11.69	2.77	090
27035		A	Denervation of hip joint	17.37	NA	NA	14.53	12.73	3.42	090
27036		A	Excision of hip joint/muscle	14.38	NA	NA	12.91	12.27	2.78	090
27040		A	Biopsy of soft tissues	2.92	6.38	6.41	2.45	2.44	0.48	010
27041		A	Biopsy of soft tissues	10.18	NA	NA	8.00	7.82	1.81	090
27043		A	Exc hip pelvis les sc > 3 cm	6.88	NA	NA	5.70	5.70	1.41	090
27045		A	Exc hip/pelv tum deep > 5 cm	11.13	NA	NA	8.82	8.82	2.25	090
27047		A	Exc hip/pelvis les sc < 3 cm	4.94	7.74	8.19	4.78	5.22	1.02	090
27048		A	Exc hip/pelv tum deep < 5 cm	8.85	NA	NA	7.53	6.69	1.81	090
27049		A	Resect hip/pelv tum < 5 cm	21.55	NA	NA	14.95	12.68	4.32	090
27050		A	Biopsy of sacroiliac joint	4.74	NA	NA	6.17	5.29	0.92	090
27052		A	Biopsy of hip joint	7.42	NA	NA	8.18	7.65	1.47	090
27054		A	Removal of hip joint lining	9.21	NA	NA	9.34	8.88	1.81	090
27057		A	Buttock fasciotomy w/dbrdmt	14.91	NA	NA	12.57	11.42	1.06	090
27059		A	Resect hip/pelv tum > 5 cm	29.35	NA	NA	19.25	19.25	5.77	090
27060		A	Removal of ischial bursa	5.87	NA	NA	6.73	6.03	1.17	090
27062		A	Remove femur lesion/bursa	5.75	NA	NA	6.64	6.30	1.13	090
27065		A	Remove hip bone les super	6.55	NA	NA	7.14	6.82	1.28	090
27066		A	Remove hip bone les deep	11.20	NA	NA	10.81	10.26	2.20	090
27067		A	Remove/graft hip bone lesion	14.72	NA	NA	13.30	12.66	2.91	090
27070		A	Part remove hip bone super	11.56	NA	NA	11.52	10.99	2.27	090
27071		A	Part removal hip bone deep	12.39	NA	NA	12.28	11.76	2.43	090
27075		A	Resect hip tumor	32.71	NA	NA	23.28	22.60	6.42	090
27076		A	Resect hip tum incl acetabul	40.21	NA	NA	28.22	22.53	7.92	090
27077		A	Resect hip tum w/innom bone	45.21	NA	NA	31.77	28.73	8.89	090
27078		A	Rsect hip tum incl femur	32.21	NA	NA	23.99	17.89	6.33	090
27080		A	Removal of tail bone	6.89	NA	NA	6.86	6.39	1.41	090
27086		A	Remove hip foreign body	1.92	4.91	4.86	2.12	2.05	0.31	010
27087		A	Remove hip foreign body	8.83	NA	NA	8.14	7.83	1.70	090
27090		A	Removal of hip prosthesis	11.69	NA	NA	10.79	10.30	2.28	090
27091		A	Removal of hip prosthesis	24.35	NA	NA	18.96	17.88	4.79	090
27093		A	Injection for hip x-ray	1.30	4.03	4.15	0.66	0.64	0.14	000
27095		A	Injection for hip x-ray	1.50	5.07	5.16	0.78	0.73	0.18	000
27096		A	Inject sacroiliac joint	1.40	4.15	3.92	0.68	0.56	0.12	000
27097		A	Revision of hip tendon	9.27	NA	NA	9.20	8.54	1.82	090
27098		A	Transfer tendon to pelvis	9.32	NA	NA	9.48	8.24	1.83	090
27100		A	Transfer of abdominal muscle	11.35	NA	NA	11.03	10.46	2.23	090
27105		A	Transfer of spinal muscle	12.04	NA	NA	11.44	10.89	2.35	090
27110		A	Transfer of iliopsoas muscle	13.77	NA	NA	12.47	11.70	2.72	090
27111		A	Transfer of iliopsoas muscle	12.60	NA	NA	11.77	10.58	2.46	090
27120		A	Reconstruction of hip socket	19.25	NA	NA	15.99	14.97	3.79	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27122		A	Reconstruction of hip socket	16.09	NA	NA	13.76	13.11	3.15	090
27125		A	Partial hip replacement	16.64	NA	NA	14.08	13.30	3.27	090
27130		A	Total hip arthroplasty	21.79	NA	NA	17.26	16.38	4.28	090
27132		A	Total hip arthroplasty	25.69	NA	NA	19.77	18.81	5.05	090
27134		A	Revise hip joint replacement	30.28	NA	NA	21.71	20.77	5.95	090
27137		A	Revise hip joint replacement	22.70	NA	NA	17.27	16.48	4.45	090
27138		A	Revise hip joint replacement	23.70	NA	NA	17.87	17.04	4.66	090
27140		A	Transplant femur ridge	12.78	NA	NA	11.40	10.93	2.51	090
27146		A	Incision of hip bone	18.92	NA	NA	15.93	14.83	3.73	090
27147		A	Revision of hip bone	22.07	NA	NA	17.81	16.82	4.33	090
27151		A	Incision of hip bones	24.12	NA	NA	19.04	17.00	4.75	090
27156		A	Revision of hip bones	26.23	NA	NA	20.30	19.05	5.15	090
27158		A	Revision of pelvis	21.04	NA	NA	16.97	15.75	4.14	090
27161		A	Incision of neck of femur	17.89	NA	NA	15.00	14.33	3.50	090
27165		A	Incision/fixation of femur	20.29	NA	NA	16.99	16.05	3.98	090
27170		A	Repair/graft femur head/neck	17.61	NA	NA	14.28	13.58	3.46	090
27175		A	Treat slipped epiphysis	9.38	NA	NA	8.69	8.23	1.85	090
27176		A	Treat slipped epiphysis	12.92	NA	NA	11.97	11.30	2.55	090
27177		A	Treat slipped epiphysis	16.09	NA	NA	14.12	13.37	3.16	090
27178		A	Treat slipped epiphysis	12.92	NA	NA	11.97	11.21	2.55	090
27179		A	Revise head/neck of femur	13.97	NA	NA	12.48	11.83	2.74	090
27181		A	Treat slipped epiphysis	16.18	NA	NA	14.29	13.40	3.19	090
27185		A	Revision of femur epiphysis	9.79	NA	NA	6.81	7.08	0.69	090
27187		A	Reinforce hip bones	14.23	NA	NA	12.61	12.06	2.80	090
27193		A	Treat pelvic ring fracture	6.09	6.67	6.31	6.84	6.46	1.20	090
27194		A	Treat pelvic ring fracture	10.20	NA	NA	8.55	8.38	1.66	090
27200		A	Treat tail bone fracture	1.92	2.97	2.78	3.17	2.94	0.35	090
27202		A	Treat tail bone fracture	7.31	NA	NA	7.86	8.79	1.45	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27215		I	Treat pelvic fracture(s)	10.45	NA	NA	6.58	7.40	0.73	090
27216		I	Treat pelvic ring fracture	15.73	NA	NA	9.53	10.60	1.13	090
27217		I	Treat pelvic ring fracture	14.65	NA	NA	9.05	10.23	1.05	090
27218		I	Treat pelvic ring fracture	20.93	NA	NA	11.82	13.06	1.49	090
27220		A	Treat hip socket fracture	6.83	7.55	7.14	7.42	7.02	1.33	090
27222		A	Treat hip socket fracture	14.11	NA	NA	12.27	11.73	2.76	090
27226		A	Treat hip wall fracture	15.57	NA	NA	13.18	12.13	3.07	090
27227		A	Treat hip fracture(s)	25.41	NA	NA	19.72	18.71	5.00	090
27228		A	Treat hip fracture(s)	29.33	NA	NA	22.01	20.97	5.77	090
27230		A	Treat thigh fracture	5.81	7.03	6.69	6.94	6.55	1.14	090
27232		A	Treat thigh fracture	11.72	NA	NA	8.89	8.49	2.24	090
27235		A	Treat thigh fracture	13.00	NA	NA	11.68	11.13	2.55	090
27236		A	Treat thigh fracture	17.61	NA	NA	14.84	14.01	3.46	090
27238		A	Treat thigh fracture	5.75	NA	NA	6.66	6.33	1.13	090
27240		A	Treat thigh fracture	13.81	NA	NA	12.05	11.46	2.69	090
27244		A	Treat thigh fracture	18.18	NA	NA	15.21	14.35	3.56	090
27245		A	Treat thigh fracture	18.18	NA	NA	15.24	14.74	3.56	090
27246		A	Treat thigh fracture	4.83	5.60	5.33	5.65	5.37	0.92	090
27248		A	Treat thigh fracture	10.78	NA	NA	9.34	9.01	2.12	090
27250		A	Treat hip dislocation	3.82	NA	NA	0.98	1.54	0.67	000
27252		A	Treat hip dislocation	11.03	NA	NA	9.37	8.92	2.13	090
27253		A	Treat hip dislocation	13.58	NA	NA	11.92	11.39	2.66	090
27254		A	Treat hip dislocation	18.94	NA	NA	15.32	14.58	3.72	090
27256		A	Treat hip dislocation	4.28	3.54	3.43	1.79	1.86	0.75	010
27257		A	Treat hip dislocation	5.38	NA	NA	3.59	3.41	0.98	010
27258		A	Treat hip dislocation	16.18	NA	NA	13.92	13.17	3.19	090
27259		A	Treat hip dislocation	23.26	NA	NA	18.86	17.80	4.56	090
27265		A	Treat hip dislocation	5.24	NA	NA	5.31	5.16	0.92	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27266		A	Treat hip dislocation	7.78	NA	NA	7.99	7.59	1.52	090
27267		A	Cltx thigh fx	5.50	NA	NA	6.26	5.77	1.09	090
27268		A	Cltx thigh fx w/mnpj	7.12	NA	NA	7.47	6.78	1.40	090
27269		A	Optx thigh fx	18.89	NA	NA	14.59	13.39	3.69	090
27275		A	Manipulation of hip joint	2.32	NA	NA	2.54	2.45	0.39	010
27280		A	Fusion of sacroiliac joint	14.64	NA	NA	13.11	12.48	3.03	090
27282		A	Fusion of pubic bones	11.85	NA	NA	11.33	10.15	2.31	090
27284		A	Fusion of hip joint	25.06	NA	NA	18.84	16.67	4.94	090
27286		A	Fusion of hip joint	25.17	NA	NA	19.67	18.72	4.96	090
27290		A	Amputation of leg at hip	24.55	NA	NA	19.51	17.74	4.83	090
27295		A	Amputation of leg at hip	19.66	NA	NA	14.48	13.70	4.01	090
27299		C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27301		A	Drain thigh/knee lesion	6.78	11.42	11.08	6.74	6.38	1.37	090
27303		A	Drainage of bone lesion	8.63	NA	NA	8.69	8.28	1.68	090
27305		A	Incise thigh tendon & fascia	6.18	NA	NA	6.80	6.36	1.22	090
27306		A	Incision of thigh tendon	4.74	NA	NA	5.37	5.22	0.92	090
27307		A	Incision of thigh tendons	6.06	NA	NA	6.95	6.47	1.20	090
27310		A	Exploration of knee joint	10.00	NA	NA	9.82	9.31	1.96	090
27323		A	Biopsy thigh soft tissues	2.33	5.23	5.08	2.60	2.50	0.41	010
27324		A	Biopsy thigh soft tissues	5.04	NA	NA	5.54	5.22	1.05	090
27325		A	Neurectomy hamstring	7.20	NA	NA	7.89	7.18	1.41	090
27326		A	Neurectomy popliteal	6.47	NA	NA	7.46	6.80	1.26	090
27327		A	Exc thigh/knee les sc < 3 cm	3.96	8.48	7.95	4.44	4.47	0.80	090
27328		A	Exc thigh/knee tum deep <5cm	8.85	NA	NA	7.79	6.50	1.81	090
27329		A	Resect thigh/knee tum < 5 cm	15.72	NA	NA	12.32	11.60	3.18	090
27330		A	Biopsy knee joint lining	5.11	NA	NA	6.13	5.70	0.95	090
27331		A	Explore/treat knee joint	6.02	NA	NA	6.88	6.56	1.18	090
27332		A	Removal of knee cartilage	8.46	NA	NA	8.91	8.49	1.64	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27333		A	Removal of knee cartilage	7.55	NA	NA	8.32	7.90	1.49	090
27334		A	Remove knee joint lining	9.19	NA	NA	9.34	8.85	1.81	090
27335		A	Remove knee joint lining	10.55	NA	NA	10.12	9.67	2.06	090
27337		A	Exc thigh/knee les sc 3+ cm	5.91	NA	NA	5.40	5.40	1.21	090
27339		A	Exc thigh/knee tum deep 5+cm	11.13	NA	NA	9.13	9.13	2.25	090
27340		A	Removal of kneecap bursa	4.32	NA	NA	5.79	5.49	0.84	090
27345		A	Removal of knee cyst	6.09	NA	NA	6.94	6.65	1.20	090
27347		A	Remove knee cyst	6.73	NA	NA	7.60	7.15	1.32	090
27350		A	Removal of kneecap	8.66	NA	NA	9.01	8.59	1.68	090
27355		A	Remove femur lesion	8.00	NA	NA	8.31	7.96	1.58	090
27356		A	Remove femur lesion/graft	10.09	NA	NA	9.85	9.40	1.97	090
27357		A	Remove femur lesion/graft	11.16	NA	NA	10.90	10.38	2.20	090
27358		A	Remove femur lesion/fixation	4.73	NA	NA	2.83	2.73	0.91	ZZZ
27360		A	Partial removal leg bone(s)	11.46	NA	NA	11.60	11.09	2.25	090
27364		A	Resect thigh/knee tum 5+ cm	24.49	NA	NA	17.30	17.30	4.96	090
27365		A	Resect femur/knee tumor	32.21	NA	NA	23.83	18.80	6.34	090
27370		A	Injection for knee x-ray	0.96	3.85	3.85	0.51	0.48	0.12	000
27372		A	Removal of foreign body	5.21	11.41	11.10	5.79	5.53	1.03	090
27380		A	Repair of kneecap tendon	7.45	NA	NA	8.61	8.28	1.47	090
27381		A	Repair/graft kneecap tendon	10.76	NA	NA	10.84	10.42	2.12	090
27385		A	Repair of thigh muscle	8.11	NA	NA	9.04	8.68	1.59	090
27386		A	Repair/graft of thigh muscle	11.13	NA	NA	11.38	10.91	2.19	090
27390		A	Incision of thigh tendon	5.53	NA	NA	6.63	6.27	1.09	090
27391		A	Incision of thigh tendons	7.49	NA	NA	8.13	7.72	1.48	090
27392		A	Incision of thigh tendons	9.63	NA	NA	9.67	9.07	1.89	090
27393		A	Lengthening of thigh tendon	6.59	NA	NA	7.09	6.81	1.29	090
27394		A	Lengthening of thigh tendons	8.79	NA	NA	8.77	8.42	1.70	090
27395		A	Lengthening of thigh tendons	12.24	NA	NA	11.56	11.01	2.40	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27396		A	Transplant of thigh tendon	8.15	NA	NA	8.53	8.14	1.60	090
27397		A	Transplants of thigh tendons	12.66	NA	NA	12.18	11.49	2.47	090
27400		A	Revise thigh muscles/tendons	9.33	NA	NA	9.49	8.99	1.83	090
27403		A	Repair of knee cartilage	8.62	NA	NA	8.74	8.36	1.67	090
27405		A	Repair of knee ligament	9.08	NA	NA	9.25	8.83	1.79	090
27407		A	Repair of knee ligament	10.85	NA	NA	10.62	9.81	2.13	090
27409		A	Repair of knee ligaments	13.71	NA	NA	12.44	11.82	2.70	090
27412		A	Autochondrocyte implant knee	24.74	NA	NA	19.95	18.86	4.88	090
27415		A	Osteochondral knee allograft	20.00	NA	NA	17.29	16.25	3.92	090
27416		A	Osteochondral knee autograft	14.16	NA	NA	12.41	11.55	2.78	090
27418		A	Repair degenerated kneecap	11.60	NA	NA	10.91	10.45	2.25	090
27420		A	Revision of unstable kneecap	10.26	NA	NA	9.95	9.51	2.00	090
27422		A	Revision of unstable kneecap	10.21	NA	NA	9.92	9.48	1.98	090
27424		A	Revision/removal of kneecap	10.24	NA	NA	9.86	9.47	2.00	090
27425		A	Lat retinacular release open	5.39	NA	NA	6.77	6.44	1.06	090
27427		A	Reconstruction knee	9.79	NA	NA	9.64	9.21	1.91	090
27428		A	Reconstruction knee	15.58	NA	NA	14.59	13.83	3.08	090
27429		A	Reconstruction knee	17.54	NA	NA	16.13	15.34	3.46	090
27430		A	Revision of thigh muscles	10.16	NA	NA	9.88	9.43	1.98	090
27435		A	Incision of knee joint	10.88	NA	NA	10.96	10.40	2.15	090
27437		A	Revise kneecap	8.93	NA	NA	8.98	8.55	1.77	090
27438		A	Revise kneecap with implant	11.89	NA	NA	10.88	10.35	2.32	090
27440		A	Revision of knee joint	11.09	NA	NA	10.53	9.61	2.17	090
27441		A	Revision of knee joint	11.54	NA	NA	10.80	9.82	2.25	090
27442		A	Revision of knee joint	12.37	NA	NA	11.19	10.62	2.42	090
27443		A	Revision of knee joint	11.41	NA	NA	10.72	10.19	2.24	090
27445		A	Revision of knee joint	18.66	NA	NA	15.25	14.55	3.69	090
27446		A	Revision of knee joint	16.38	NA	NA	13.54	12.98	3.22	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27447		A	Total knee arthroplasty	23.25	NA	NA	18.45	17.56	4.56	090
27448		A	Incision of thigh	11.60	NA	NA	10.55	10.07	2.28	090
27450		A	Incision of thigh	14.61	NA	NA	12.81	12.28	2.89	090
27454		A	Realignment of thigh bone	19.17	NA	NA	16.08	15.00	3.78	090
27455		A	Realignment of knee	13.36	NA	NA	12.18	11.59	2.62	090
27457		A	Realignment of knee	14.03	NA	NA	12.05	11.51	2.76	090
27465		A	Shortening of thigh bone	18.60	NA	NA	15.39	14.25	3.68	090
27466		A	Lengthening of thigh bone	17.28	NA	NA	14.53	13.93	3.41	090
27468		A	Shorten/lengthen thighs	19.97	NA	NA	16.44	15.46	3.92	090
27470		A	Repair of thigh	17.14	NA	NA	14.81	14.11	3.38	090
27472		A	Repair/graft of thigh	18.72	NA	NA	15.52	14.85	3.69	090
27475		A	Surgery to stop leg growth	8.93	NA	NA	6.34	7.21	1.77	090
27477		A	Surgery to stop leg growth	10.14	NA	NA	9.72	9.24	1.98	090
27479		A	Surgery to stop leg growth	13.16	NA	NA	11.78	11.24	0.92	090
27485		A	Surgery to stop leg growth	9.13	NA	NA	9.04	8.63	1.81	090
27486		A	Revise/replace knee joint	21.12	NA	NA	17.04	16.23	4.14	090
27487		A	Revise/replace knee joint	27.11	NA	NA	20.59	19.64	5.32	090
27488		A	Removal of knee prosthesis	17.60	NA	NA	14.97	14.22	3.46	090
27495		A	Reinforce thigh	16.54	NA	NA	14.02	13.39	3.25	090
27496		A	Decompression of thigh/knee	6.78	NA	NA	7.96	7.15	1.33	090
27497		A	Decompression of thigh/knee	7.79	NA	NA	7.98	7.12	1.53	090
27498		A	Decompression of thigh/knee	8.66	NA	NA	9.09	7.87	1.68	090
27499		A	Decompression of thigh/knee	9.43	NA	NA	9.55	8.52	1.86	090
27500		A	Treatment of thigh fracture	6.30	7.76	7.36	6.70	6.30	1.22	090
27501		A	Treatment of thigh fracture	6.45	7.21	6.87	7.09	6.70	1.26	090
27502		A	Treatment of thigh fracture	11.36	NA	NA	9.69	9.31	2.19	090
27503		A	Treatment of thigh fracture	11.27	NA	NA	10.53	9.99	2.20	090
27506		A	Treatment of thigh fracture	19.65	NA	NA	16.66	15.78	3.86	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27507		A	Treatment of thigh fracture	14.48	NA	NA	11.90	11.39	2.85	090
27508		A	Treatment of thigh fracture	6.20	8.02	7.65	7.17	6.80	1.20	090
27509		A	Treatment of thigh fracture	8.14	NA	NA	9.41	9.03	1.59	090
27510		A	Treatment of thigh fracture	9.80	NA	NA	8.84	8.54	1.87	090
27511		A	Treatment of thigh fracture	15.11	NA	NA	11.95	11.62	2.97	090
27513		A	Treatment of thigh fracture	19.25	NA	NA	14.41	14.08	3.79	090
27514		A	Treatment of thigh fracture	14.60	NA	NA	11.63	11.68	2.87	090
27516		A	Treat thigh fx growth plate	5.59	8.22	7.71	7.35	6.87	1.10	090
27517		A	Treat thigh fx growth plate	9.12	NA	NA	9.47	8.98	1.79	090
27519		A	Treat thigh fx growth plate	13.25	NA	NA	10.91	10.81	2.61	090
27520		A	Treat kneecap fracture	3.04	5.73	5.46	4.96	4.64	0.58	090
27524		A	Treat kneecap fracture	10.37	NA	NA	10.04	9.59	2.02	090
27530		A	Treat knee fracture	4.09	6.75	6.43	6.00	5.66	0.77	090
27532		A	Treat knee fracture	7.55	9.20	8.75	8.16	7.74	1.48	090
27535		A	Treat knee fracture	13.41	NA	NA	10.93	10.61	2.62	090
27536		A	Treat knee fracture	17.39	NA	NA	14.94	14.16	3.42	090
27538		A	Treat knee fracture(s)	5.09	7.77	7.39	6.94	6.55	0.99	090
27540		A	Treat knee fracture	11.30	NA	NA	10.76	10.40	2.21	090
27550		A	Treat knee dislocation	5.98	7.47	7.13	6.48	6.14	1.10	090
27552		A	Treat knee dislocation	8.18	NA	NA	8.83	8.37	1.60	090
27556		A	Treat knee dislocation	13.00	NA	NA	10.76	10.67	2.57	090
27557		A	Treat knee dislocation	15.90	NA	NA	12.50	12.36	3.14	090
27558		A	Treat knee dislocation	18.39	NA	NA	13.99	13.61	3.61	090
27560		A	Treat kneecap dislocation	3.99	6.36	5.97	5.64	5.12	0.76	090
27562		A	Treat kneecap dislocation	5.98	NA	NA	7.13	6.55	1.18	090
27566		A	Treat kneecap dislocation	12.71	NA	NA	11.40	10.90	2.50	090
27570		A	Fixation of knee joint	1.79	NA	NA	2.31	2.19	0.34	010
27580		A	Fusion of knee	21.10	NA	NA	17.90	17.11	4.14	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27590		A	Amputate leg at thigh	13.47	NA	NA	8.44	8.11	2.95	090
27591		A	Amputate leg at thigh	13.94	NA	NA	10.17	9.95	2.91	090
27592		A	Amputate leg at thigh	10.98	NA	NA	7.82	7.51	2.34	090
27594		A	Amputation follow-up surgery	7.29	NA	NA	6.45	6.26	1.55	090
27596		A	Amputation follow-up surgery	11.29	NA	NA	8.37	8.07	2.39	090
27598		A	Amputate lower leg at knee	11.22	NA	NA	8.85	8.51	2.32	090
27599		C	Leg surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27600		A	Decompression of lower leg	6.03	NA	NA	5.14	5.09	1.26	090
27601		A	Decompression of lower leg	6.05	NA	NA	6.00	5.79	1.26	090
27602		A	Decompression of lower leg	7.82	NA	NA	5.68	5.65	1.74	090
27603		A	Drain lower leg lesion	5.23	9.64	9.21	5.54	5.23	1.00	090
27604		A	Drain lower leg bursa	4.59	8.63	8.14	4.70	4.50	0.77	090
27605		A	Incision of achilles tendon	2.92	6.55	6.81	2.20	2.27	0.34	010
27606		A	Incision of achilles tendon	4.18	NA	NA	3.68	3.59	0.72	010
27607		A	Treat lower leg bone lesion	8.62	NA	NA	8.14	7.75	1.58	090
27610		A	Explore/treat ankle joint	9.13	NA	NA	8.75	8.35	1.63	090
27612		A	Exploration of ankle joint	8.15	NA	NA	7.37	7.10	1.15	090
27613		A	Biopsy lower leg soft tissue	2.22	4.92	4.77	2.39	2.31	0.31	010
27614		A	Biopsy lower leg soft tissue	5.80	10.13	9.66	5.30	5.14	1.03	090
27615		A	Resect leg/ankle tum < 5 cm	15.72	NA	NA	12.26	11.03	3.14	090
27616		A	Resect leg/ankle tum 5+ cm	19.63	NA	NA	14.66	14.66	3.90	090
27618		A	Exc leg/ankle tum < 3 cm	3.96	8.36	8.07	4.39	4.59	0.73	090
27619		A	Exc leg/ankle tum deep <5 cm	6.91	NA	NA	6.34	6.52	1.22	090
27620		A	Explore/treat ankle joint	6.15	NA	NA	6.44	6.21	1.05	090
27625		A	Remove ankle joint lining	8.49	NA	NA	7.34	7.18	1.26	090
27626		A	Remove ankle joint lining	9.10	NA	NA	8.13	7.85	1.52	090
27630		A	Removal of tendon lesion	4.94	10.64	10.09	5.18	5.01	0.77	090
27632		A	Exc leg/ankle les sc 3+ cm	5.91	NA	NA	5.36	5.36	1.13	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27634		A	Exc leg/ankle tum deep 5+ cm	10.13	NA	NA	8.16	8.16	1.79	090
27635		A	Remove lower leg bone lesion	8.03	NA	NA	8.16	7.81	1.49	090
27637		A	Remove/graft leg bone lesion	10.31	NA	NA	10.41	9.86	2.01	090
27638		A	Remove/graft leg bone lesion	10.99	NA	NA	9.93	9.59	2.16	090
27640		A	Partial removal of tibia	12.24	NA	NA	10.74	10.52	2.20	090
27641		A	Partial removal of fibula	9.84	NA	NA	8.49	8.37	1.67	090
27645		A	Resect tibia tumor	27.21	NA	NA	21.11	16.76	5.35	090
27646		A	Resect fibula tumor	23.21	NA	NA	18.71	14.80	4.56	090
27647		A	Resect talus/calcaneus tum	20.26	NA	NA	10.89	9.53	2.02	090
27648		A	Injection for ankle x-ray	0.96	3.63	3.65	0.49	0.46	0.12	000
27650		A	Repair achilles tendon	9.21	NA	NA	9.18	8.84	1.51	090
27652		A	Repair/graft achilles tendon	10.78	NA	NA	8.61	8.54	1.51	090
27654		A	Repair of achilles tendon	10.53	NA	NA	9.18	8.81	1.51	090
27656		A	Repair leg fascia defect	4.71	12.67	11.33	6.06	5.31	0.91	090
27658		A	Repair of leg tendon each	5.12	NA	NA	5.30	5.15	0.77	090
27659		A	Repair of leg tendon each	7.10	NA	NA	6.45	6.25	0.99	090
27664		A	Repair of leg tendon each	4.73	NA	NA	5.39	5.17	0.75	090
27665		A	Repair of leg tendon each	5.57	NA	NA	5.73	5.60	0.88	090
27675		A	Repair lower leg tendons	7.35	NA	NA	6.18	6.11	1.02	090
27676		A	Repair lower leg tendons	8.73	NA	NA	8.13	7.83	1.70	090
27680		A	Release of lower leg tendon	5.88	NA	NA	6.07	5.80	0.98	090
27681		A	Release of lower leg tendons	7.05	NA	NA	7.77	7.14	1.39	090
27685		A	Revision of lower leg tendon	6.69	11.87	11.06	6.25	6.09	0.91	090
27686		A	Revise lower leg tendons	7.75	NA	NA	7.49	7.26	1.29	090
27687		A	Revision of calf tendon	6.41	NA	NA	6.22	6.00	0.99	090
27690		A	Revise lower leg tendon	9.17	NA	NA	8.56	8.11	1.32	090
27691		A	Revise lower leg tendon	10.49	NA	NA	10.19	9.70	1.82	090
27692		A	Revise additional leg tendon	1.87	NA	NA	1.06	1.01	0.34	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27695		A	Repair of ankle ligament	6.70	NA	NA	6.51	6.42	1.07	090
27696		A	Repair of ankle ligaments	8.58	NA	NA	7.03	6.91	1.15	090
27698		A	Repair of ankle ligament	9.61	NA	NA	8.12	7.87	1.51	090
27700		A	Revision of ankle joint	9.66	NA	NA	6.81	6.70	1.20	090
27702		A	Reconstruct ankle joint	14.42	NA	NA	12.18	11.82	2.65	090
27703		A	Reconstruction ankle joint	16.94	NA	NA	13.78	13.35	3.18	090
27704		A	Removal of ankle implant	7.81	NA	NA	8.00	7.52	1.41	090
27705		A	Incision of tibia	10.86	NA	NA	9.95	9.51	2.01	090
27707		A	Incision of fibula	4.78	NA	NA	6.36	6.03	0.90	090
27709		A	Incision of tibia & fibula	17.48	NA	NA	14.66	13.32	3.37	090
27712		A	Realignment of lower leg	15.87	NA	NA	14.11	13.35	3.14	090
27715		A	Revision of lower leg	15.50	NA	NA	13.03	12.59	3.07	090
27720		A	Repair of tibia	12.36	NA	NA	11.42	10.95	2.39	090
27722		A	Repair/graft of tibia	12.45	NA	NA	11.69	11.00	2.43	090
27724		A	Repair/graft of tibia	19.31	NA	NA	15.12	14.45	3.79	090
27725		A	Repair of lower leg	17.41	NA	NA	15.70	14.78	3.44	090
27726		A	Repair fibula nonunion	14.34	NA	NA	12.13	10.92	2.77	090
27727		A	Repair of lower leg	14.84	NA	NA	13.27	11.71	2.93	090
27730		A	Repair of tibia epiphysis	7.70	NA	NA	8.19	7.77	1.52	090
27732		A	Repair of fibula epiphysis	5.46	NA	NA	6.68	5.88	1.07	090
27734		A	Repair lower leg epiphyses	8.83	NA	NA	8.94	7.79	0.62	090
27740		A	Repair of leg epiphyses	9.61	NA	NA	6.76	7.11	1.89	090
27742		A	Repair of leg epiphyses	10.63	NA	NA	9.01	8.11	2.08	090
27745		A	Reinforce tibia	10.49	NA	NA	9.93	9.53	2.04	090
27750		A	Treatment of tibia fracture	3.37	6.03	5.74	5.25	4.95	0.64	090
27752		A	Treatment of tibia fracture	6.27	8.38	7.99	7.25	6.89	1.21	090
27756		A	Treatment of tibia fracture	7.45	NA	NA	8.15	7.77	1.45	090
27758		A	Treatment of tibia fracture	12.54	NA	NA	11.66	11.08	2.44	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27759		A	Treatment of tibia fracture	14.45	NA	NA	12.65	12.08	2.84	090
27760		A	Cltx medial ankle fx	3.21	5.89	5.63	5.09	4.79	0.58	090
27762		A	Cltx med ankle fx w/mnpj	5.47	7.60	7.33	6.47	6.23	1.00	090
27766		A	Optx medial ankle fx	7.89	NA	NA	8.77	8.38	1.51	090
27767		A	Cltx post ankle fx	2.64	5.07	4.67	5.12	4.71	0.50	090
27768		A	Cltx post ankle fx w/mnpj	5.14	NA	NA	6.81	6.13	1.02	090
27769		A	Optx post ankle fx	10.14	NA	NA	9.85	8.84	1.98	090
27780		A	Treatment of fibula fracture	2.83	5.47	5.17	4.72	4.40	0.53	090
27781		A	Treatment of fibula fracture	4.59	6.98	6.64	6.13	5.80	0.87	090
27784		A	Treatment of fibula fracture	9.67	NA	NA	9.88	9.19	1.87	090
27786		A	Treatment of ankle fracture	3.02	5.61	5.36	4.79	4.49	0.54	090
27788		A	Treatment of ankle fracture	4.64	6.89	6.61	5.90	5.63	0.84	090
27792		A	Treatment of ankle fracture	9.71	NA	NA	9.79	9.19	1.83	090
27808		A	Treatment of ankle fracture	3.03	6.07	5.79	5.14	4.85	0.56	090
27810		A	Treatment of ankle fracture	5.32	7.44	7.19	6.29	6.06	1.00	090
27814		A	Treatment of ankle fracture	10.62	NA	NA	10.44	9.98	2.04	090
27816		A	Treatment of ankle fracture	3.07	5.62	5.30	4.72	4.41	0.54	090
27818		A	Treatment of ankle fracture	5.69	7.33	7.12	6.02	5.84	1.05	090
27822		A	Treatment of ankle fracture	11.21	NA	NA	11.75	11.40	2.16	090
27823		A	Treatment of ankle fracture	13.16	NA	NA	12.91	12.47	2.54	090
27824		A	Treat lower leg fracture	3.31	5.20	4.95	4.95	4.66	0.61	090
27825		A	Treat lower leg fracture	6.69	8.17	7.83	6.77	6.48	1.28	090
27826		A	Treat lower leg fracture	11.10	NA	NA	11.77	11.13	2.13	090
27827		A	Treat lower leg fracture	14.79	NA	NA	14.74	14.17	2.89	090
27828		A	Treat lower leg fracture	18.43	NA	NA	16.87	16.12	3.59	090
27829		A	Treat lower leg joint	8.80	NA	NA	9.88	9.28	1.68	090
27830		A	Treat lower leg dislocation	3.96	6.40	5.85	5.67	5.16	0.76	090
27831		A	Treat lower leg dislocation	4.73	NA	NA	6.13	5.65	0.91	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27832		A	Treat lower leg dislocation	10.17	NA	NA	10.35	9.41	1.98	090
27840		A	Treat ankle dislocation	4.77	NA	NA	4.96	4.70	0.83	090
27842		A	Treat ankle dislocation	6.46	NA	NA	7.07	6.61	1.21	090
27846		A	Treat ankle dislocation	10.28	NA	NA	9.67	9.30	1.94	090
27848		A	Treat ankle dislocation	11.68	NA	NA	10.54	10.28	2.24	090
27860		A	Fixation of ankle joint	2.39	NA	NA	2.37	2.33	0.39	010
27870		A	Fusion of ankle joint open	15.41	NA	NA	12.97	12.45	2.80	090
27871		A	Fusion of tibiofibular joint	9.54	NA	NA	9.30	8.90	1.85	090
27880		A	Amputation of lower leg	15.37	NA	NA	9.54	9.07	3.31	090
27881		A	Amputation of lower leg	13.47	NA	NA	10.28	10.01	2.80	090
27882		A	Amputation of lower leg	9.79	NA	NA	6.71	6.66	2.15	090
27884		A	Amputation follow-up surgery	8.76	NA	NA	7.03	6.80	1.86	090
27886		A	Amputation follow-up surgery	10.02	NA	NA	7.93	7.69	2.13	090
27888		A	Amputation of foot at ankle	10.37	NA	NA	8.18	8.15	1.93	090
27889		A	Amputation of foot at ankle	10.86	NA	NA	7.07	7.05	2.40	090
27892		A	Decompression of leg	7.94	NA	NA	7.03	6.67	1.63	090
27893		A	Decompression of leg	7.90	NA	NA	8.63	7.62	1.67	090
27894		A	Decompression of leg	12.67	NA	NA	10.48	10.01	2.66	090
27899		C	Leg/ankle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
28001		A	Drainage of bursa of foot	2.78	5.00	4.75	1.98	2.02	0.23	010
28002		A	Treatment of foot infection	5.93	8.56	8.08	4.59	4.52	0.67	010
28003		A	Treatment of foot infection	9.06	9.83	9.42	5.77	5.81	1.06	090
28005		A	Treat foot bone lesion	9.44	NA	NA	7.14	7.06	1.02	090
28008		A	Incision of foot fascia	4.59	7.65	7.27	3.68	3.68	0.41	090
28010		A	Incision of toe tendon	2.97	3.65	3.48	2.99	2.92	0.27	090
28011		A	Incision of toe tendons	4.28	5.07	4.79	4.05	3.93	0.49	090
28020		A	Exploration of foot joint	5.15	9.89	9.19	4.85	4.70	0.67	090
28022		A	Exploration of foot joint	4.81	8.76	8.28	4.19	4.20	0.49	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
28024		A	Exploration of toe joint	4.52	8.29	7.89	3.93	3.99	0.42	090
28035		A	Decompression of tibia nerve	5.23	9.50	9.00	4.65	4.61	0.65	090
28039		A	Exc foot/toe tum sc > 1.5 cm	5.42	8.38	8.38	4.05	4.05	0.54	090
28041		A	Exc foot/toe tum deep 1.5cm+	7.13	NA	NA	5.30	5.30	0.73	090
28043		A	Exc foot/toe tum sc < 1.5 cm	3.96	7.53	6.52	3.53	3.49	0.39	090
28045		A	Exc foot/toe tum deep <1.5cm	5.45	8.90	8.45	4.55	4.32	0.56	090
28046		A	Resect foot/toe tumor < 3 cm	12.38	NA	NA	8.56	7.94	1.66	090
28047		A	Resect foot/toe tumor > 3 cm	17.45	NA	NA	8.56	8.56	1.33	090
28050		A	Biopsy of foot joint lining	4.39	7.72	7.73	3.56	3.83	0.39	090
28052		A	Biopsy of foot joint lining	4.06	8.07	7.61	3.67	3.67	0.49	090
28054		A	Biopsy of toe joint lining	3.57	7.14	7.08	3.12	3.32	0.27	090
28055		A	Neurectomy foot	6.29	NA	NA	4.42	4.38	0.53	090
28060		A	Partial removal foot fascia	5.40	9.20	8.65	4.60	4.52	0.54	090
28062		A	Removal of foot fascia	6.69	9.96	9.52	4.82	4.78	0.60	090
28070		A	Removal of foot joint lining	5.24	9.92	9.02	4.79	4.57	0.56	090
28072		A	Removal of foot joint lining	4.72	9.81	9.20	4.69	4.67	0.64	090
28080		A	Removal of foot lesion	4.86	9.87	9.16	5.40	5.16	0.48	090
28086		A	Excise foot tendon sheath	4.92	10.27	9.81	5.03	4.93	0.72	090
28088		A	Excise foot tendon sheath	3.98	9.85	9.04	4.58	4.39	0.54	090
28090		A	Removal of foot lesion	4.55	8.74	8.21	4.10	4.03	0.48	090
28092		A	Removal of toe lesions	3.78	8.34	7.86	3.86	3.82	0.39	090
28100		A	Removal of ankle/heel lesion	5.83	10.84	10.36	5.43	5.31	0.76	090
28102		A	Remove/graft foot lesion	7.92	NA	NA	8.53	7.81	0.61	090
28103		A	Remove/graft foot lesion	6.67	NA	NA	4.46	4.92	0.50	090
28104		A	Removal of foot lesion	5.26	9.23	8.70	4.41	4.38	0.54	090
28106		A	Remove/graft foot lesion	7.35	NA	NA	4.83	5.07	0.56	090
28107		A	Remove/graft foot lesion	5.73	9.00	9.11	4.18	4.48	0.42	090
28108		A	Removal of toe lesions	4.30	8.12	7.61	3.80	3.75	0.38	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
28110		A	Part removal of metatarsal	4.22	8.87	8.34	3.90	3.84	0.41	090
28111		A	Part removal of metatarsal	5.15	9.22	8.82	4.20	4.15	0.60	090
28112		A	Part removal of metatarsal	4.63	9.33	8.81	4.22	4.15	0.52	090
28113		A	Part removal of metatarsal	6.11	10.80	10.12	5.96	5.75	0.62	090
28114		A	Removal of metatarsal heads	12.00	18.04	16.92	11.29	10.78	1.64	090
28116		A	Revision of foot	9.14	12.22	11.36	6.89	6.64	0.95	090
28118		A	Removal of heel bone	6.13	10.48	9.85	5.35	5.23	0.75	090
28119		A	Removal of heel spur	5.56	9.29	8.72	4.58	4.49	0.53	090
28120		A	Part removal of ankle/heel	8.27	12.11	10.84	6.97	6.00	1.14	090
28122		A	Partial removal of foot bone	7.72	10.72	10.25	6.16	6.09	0.81	090
28124		A	Partial removal of toe	5.00	8.57	8.10	4.34	4.31	0.42	090
28126		A	Partial removal of toe	3.64	7.58	7.12	3.36	3.35	0.34	090
28130		A	Removal of ankle bone	9.50	NA	NA	10.29	8.95	1.86	090
28140		A	Removal of metatarsal	7.14	9.89	9.60	5.24	5.25	0.90	090
28150		A	Removal of toe	4.23	8.12	7.66	3.80	3.76	0.42	090
28153		A	Partial removal of toe	3.80	7.99	7.45	3.70	3.58	0.37	090
28160		A	Partial removal of toe	3.88	8.14	7.62	3.76	3.73	0.38	090
28171		A	Resect tarsal tumor	16.41	NA	NA	7.71	7.08	1.25	090
28173		A	Resect metatarsal tumor	14.16	NA	NA	7.48	6.68	1.56	090
28175		A	Resect phalanx of toe tumor	8.29	NA	NA	5.58	5.02	0.80	090
28190		A	Removal of foot foreign body	2.01	5.22	4.94	1.76	1.72	0.20	010
28192		A	Removal of foot foreign body	4.78	8.62	8.16	4.10	4.05	0.49	090
28193		A	Removal of foot foreign body	5.90	9.22	8.76	4.55	4.52	0.56	090
28200		A	Repair of foot tendon	4.74	8.80	8.28	4.11	4.07	0.45	090
28202		A	Repair/graft of foot tendon	7.07	9.52	9.38	4.75	4.87	0.64	090
28208		A	Repair of foot tendon	4.51	8.76	8.15	4.17	4.05	0.49	090
28210		A	Repair/graft of foot tendon	6.52	9.64	9.20	4.93	4.88	0.64	090
28220		A	Release of foot tendon	4.67	8.08	7.63	3.84	3.84	0.41	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
28222		A	Release of foot tendons	5.76	8.78	8.29	4.19	4.24	0.50	090
28225		A	Release of foot tendon	3.78	7.57	7.09	3.39	3.35	0.35	090
28226		A	Release of foot tendons	4.67	8.93	8.35	4.21	4.19	0.35	090
28230		A	Incision of foot tendon(s)	4.36	7.89	7.47	3.59	3.66	0.39	090
28232		A	Incision of toe tendon	3.51	7.63	7.18	3.43	3.44	0.34	090
28234		A	Incision of foot tendon	3.54	8.21	7.69	3.99	3.91	0.35	090
28238		A	Revision of foot tendon	7.96	11.13	10.49	5.81	5.68	0.86	090
28240		A	Release of big toe	4.48	7.98	7.61	3.67	3.74	0.43	090
28250		A	Revision of foot fascia	6.06	10.12	9.40	5.15	5.01	0.76	090
28260		A	Release of midfoot joint	8.19	11.52	10.53	6.35	6.05	1.03	090
28261		A	Revision of foot tendon	13.11	14.13	13.28	8.39	8.26	1.28	090
28262		A	Revision of foot and ankle	17.21	21.08	19.70	13.53	12.97	3.00	090
28264		A	Release of midfoot joint	10.65	16.99	14.65	10.21	9.16	0.81	090
28270		A	Release of foot contracture	4.93	9.08	8.42	4.51	4.41	0.50	090
28272		A	Release of toe joint each	3.92	7.30	6.90	3.28	3.28	0.31	090
28280		A	Fusion of toes	5.33	9.34	8.94	4.52	4.58	0.60	090
28285		A	Repair of hammertoe	4.76	8.68	8.12	4.32	4.21	0.45	090
28286		A	Repair of hammertoe	4.70	8.31	7.81	3.86	3.81	0.39	090
28288		A	Partial removal of foot bone	6.02	11.34	10.45	6.21	5.99	0.67	090
28289		A	Repair hallux rigidus	8.31	12.46	11.71	7.09	6.87	1.00	090
28290		A	Correction of bunion	5.83	10.81	10.05	5.25	5.16	0.69	090
28292		A	Correction of bunion	9.05	13.40	12.54	7.97	7.66	0.87	090
28293		A	Correction of bunion	11.48	18.25	17.27	8.66	8.42	0.95	090
28294		A	Correction of bunion	8.75	11.65	11.24	5.80	5.82	0.92	090
28296		A	Correction of bunion	8.35	11.92	11.42	6.38	6.31	0.76	090
28297		A	Correction of bunion	9.43	13.65	12.95	6.97	6.91	1.18	090
28298		A	Correction of bunion	8.13	12.26	11.47	6.06	5.93	0.87	090
28299		A	Correction of bunion	11.57	13.75	13.05	7.45	7.32	1.14	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
28300		A	Incision of heel bone	9.73	NA	NA	8.45	8.15	1.60	090
28302		A	Incision of ankle bone	9.74	NA	NA	9.67	8.71	1.91	090
28304		A	Incision of midfoot bones	9.41	13.28	12.29	7.16	6.87	1.21	090
28305		A	Incise/graft midfoot bones	10.77	NA	NA	7.67	7.72	0.81	090
28306		A	Incision of metatarsal	6.00	11.41	10.63	5.33	5.14	0.83	090
28307		A	Incision of metatarsal	6.50	12.54	12.46	5.94	5.95	1.28	090
28308		A	Incision of metatarsal	5.48	10.44	9.71	5.05	4.86	0.61	090
28309		A	Incision of metatarsals	14.16	NA	NA	10.60	10.00	2.09	090
28310		A	Revision of big toe	5.57	9.82	9.20	4.44	4.33	0.54	090
28312		A	Revision of toe	4.69	9.61	8.99	4.20	4.16	0.50	090
28313		A	Repair deformity of toe	5.15	9.81	9.14	4.90	4.93	0.69	090
28315		A	Removal of sesamoid bone	5.00	8.51	7.99	4.08	4.01	0.49	090
28320		A	Repair of foot bones	9.37	NA	NA	7.50	7.37	1.39	090
28322		A	Repair of metatarsals	8.53	13.41	12.56	7.43	7.16	1.30	090
28340		A	Resect enlarged toe tissue	7.15	9.38	9.21	4.60	4.74	0.54	090
28341		A	Resect enlarged toe	8.72	10.45	10.12	5.27	5.36	0.67	090
28344		A	Repair extra toe(s)	4.40	7.85	8.12	3.64	3.95	0.34	090
28345		A	Repair webbed toe(s)	6.09	8.83	8.93	4.28	4.66	0.45	090
28360		A	Reconstruct cleft foot	14.92	NA	NA	14.52	12.56	3.18	090
28400		A	Treatment of heel fracture	2.31	4.55	4.36	3.96	3.78	0.37	090
28405		A	Treatment of heel fracture	4.74	6.22	5.84	5.20	4.96	0.65	090
28406		A	Treatment of heel fracture	6.56	NA	NA	7.85	7.57	1.17	090
28415		A	Treat heel fracture	16.19	NA	NA	14.43	14.04	2.82	090
28420		A	Treat/graft heel fracture	17.52	NA	NA	16.53	15.16	3.45	090
28430		A	Treatment of ankle fracture	2.22	4.27	4.06	3.54	3.33	0.35	090
28435		A	Treatment of ankle fracture	3.54	6.29	5.56	5.23	4.68	0.69	090
28436		A	Treatment of ankle fracture	4.90	NA	NA	7.33	6.86	0.98	090
28445		A	Treat ankle fracture	15.76	NA	NA	13.13	12.68	2.77	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
28446		A	Osteochondral talus autogrft	17.71	NA	NA	15.51	14.32	3.49	090
28450		A	Treat midfoot fracture each	2.03	3.94	3.77	3.28	3.12	0.30	090
28455		A	Treat midfoot fracture each	3.24	4.99	4.70	4.15	3.99	0.43	090
28456		A	Treat midfoot fracture	2.86	NA	NA	6.10	5.34	0.56	090
28465		A	Treat midfoot fracture each	8.80	NA	NA	8.07	7.78	1.26	090
28470		A	Treat metatarsal fracture	2.03	3.82	3.67	3.23	3.08	0.33	090
28475		A	Treat metatarsal fracture	3.01	4.14	4.01	3.33	3.30	0.38	090
28476		A	Treat metatarsal fracture	3.60	NA	NA	6.07	5.82	0.53	090
28485		A	Treat metatarsal fracture	7.44	NA	NA	7.43	7.11	0.95	090
28490		A	Treat big toe fracture	1.17	2.83	2.67	2.27	2.15	0.16	090
28495		A	Treat big toe fracture	1.68	3.32	3.11	2.52	2.43	0.20	090
28496		A	Treat big toe fracture	2.48	9.87	9.46	4.03	3.84	0.35	090
28505		A	Treat big toe fracture	7.44	11.39	10.79	6.54	6.10	0.92	090
28510		A	Treatment of toe fracture	1.17	2.26	2.12	2.16	2.04	0.14	090
28515		A	Treatment of toe fracture	1.56	2.93	2.76	2.40	2.32	0.18	090
28525		A	Treat toe fracture	5.62	10.47	9.94	5.59	5.24	0.71	090
28530		A	Treat sesamoid bone fracture	1.11	2.18	2.04	1.80	1.73	0.11	090
28531		A	Treat sesamoid bone fracture	2.57	7.23	7.35	2.61	2.59	0.50	090
28540		A	Treat foot dislocation	2.19	3.53	3.34	2.96	2.87	0.22	090
28545		A	Treat foot dislocation	2.60	5.50	4.72	4.55	3.97	0.50	090
28546		A	Treat foot dislocation	3.40	12.58	10.98	5.87	5.27	0.67	090
28555		A	Repair foot dislocation	9.65	14.66	13.90	8.69	8.22	1.60	090
28570		A	Treat foot dislocation	1.76	2.86	2.85	2.20	2.27	0.12	090
28575		A	Treat foot dislocation	3.49	6.48	5.86	5.50	5.05	0.68	090
28576		A	Treat foot dislocation	4.60	NA	NA	6.17	5.46	0.90	090
28585		A	Repair foot dislocation	11.13	14.52	13.71	8.76	8.55	1.64	090
28600		A	Treat foot dislocation	2.02	4.13	3.86	3.25	3.12	0.29	090
28605		A	Treat foot dislocation	2.89	4.98	4.63	4.21	3.98	0.56	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
28606		A	Treat foot dislocation	5.09	NA	NA	5.72	5.45	0.84	090
28615		A	Repair foot dislocation	10.70	NA	NA	11.07	10.55	1.77	090
28630		A	Treat toe dislocation	1.75	2.54	2.34	1.26	1.21	0.23	010
28635		A	Treat toe dislocation	1.96	3.11	2.90	1.83	1.76	0.22	010
28636		A	Treat toe dislocation	2.77	4.44	4.69	1.99	2.29	0.39	010
28645		A	Repair toe dislocation	7.44	10.85	10.00	6.01	5.65	0.80	090
28660		A	Treat toe dislocation	1.28	1.84	1.71	1.11	1.04	0.20	010
28665		A	Treat toe dislocation	1.97	2.39	2.25	1.74	1.70	0.24	010
28666		A	Treat toe dislocation	2.66	NA	NA	3.10	2.78	0.52	010
28675		A	Repair of toe dislocation	5.62	10.69	10.25	5.79	5.50	0.75	090
28705		A	Fusion of foot bones	20.33	NA	NA	14.96	14.46	3.45	090
28715		A	Fusion of foot bones	14.60	NA	NA	12.01	11.53	2.47	090
28725		A	Fusion of foot bones	12.18	NA	NA	9.61	9.24	1.87	090
28730		A	Fusion of foot bones	12.42	NA	NA	10.91	10.39	1.91	090
28735		A	Fusion of foot bones	12.23	NA	NA	9.74	9.35	1.78	090
28737		A	Revision of foot bones	11.03	NA	NA	7.78	7.77	1.28	090
28740		A	Fusion of foot bones	9.29	14.68	13.95	8.20	7.87	1.36	090
28750		A	Fusion of big toe joint	8.57	14.57	14.04	8.08	7.81	1.30	090
28755		A	Fusion of big toe joint	4.88	9.40	8.94	4.33	4.29	0.52	090
28760		A	Fusion of big toe joint	9.14	13.41	12.48	7.21	6.92	1.05	090
28800		A	Amputation of midfoot	8.79	NA	NA	6.57	6.50	1.30	090
28805		A	Amputation thru metatarsal	12.71	NA	NA	7.83	7.56	2.13	090
28810		A	Amputation toe & metatarsal	6.64	NA	NA	5.38	5.26	1.18	090
28820		A	Amputation of toe	5.00	9.68	9.46	4.58	4.50	0.73	090
28825		A	Partial amputation of toe	6.01	10.33	9.90	5.35	5.11	0.84	090
28890		A	High energy eswt plantar f	3.45	6.24	6.06	3.03	2.85	0.35	090
28899		C	Foot/toes surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29000		A	Application of body cast	2.25	7.00	5.96	2.77	2.47	0.18	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
29010		A	Application of body cast	2.06	6.89	5.66	2.66	2.31	0.39	000
29015		A	Application of body cast	2.41	4.13	4.01	1.92	1.85	0.41	000
29020		A	Application of body cast	2.11	3.90	3.92	1.53	1.59	0.08	000
29025		A	Application of body cast	2.40	4.27	4.32	1.99	2.06	0.48	000
29035		A	Application of body cast	1.77	5.24	4.98	2.16	2.03	0.34	000
29040		A	Application of body cast	2.22	4.45	4.15	1.99	1.89	0.42	000
29044		A	Application of body cast	2.12	5.74	5.29	2.47	2.30	0.41	000
29046		A	Application of body cast	2.41	4.55	4.83	2.06	2.25	0.48	000
29049		A	Application of figure eight	0.89	1.81	1.59	1.02	0.85	0.18	000
29055		A	Application of shoulder cast	1.78	4.30	3.99	1.99	1.85	0.35	000
29058		A	Application of shoulder cast	1.31	1.23	1.39	0.79	0.80	0.23	000
29065		A	Application of long arm cast	0.87	1.75	1.67	1.00	0.94	0.16	000
29075		A	Application of forearm cast	0.77	1.69	1.61	0.94	0.88	0.14	000
29085		A	Apply hand/wrist cast	0.87	1.74	1.65	0.99	0.91	0.14	000
29086		A	Apply finger cast	0.62	1.56	1.42	0.81	0.74	0.08	000
29105		A	Apply long arm splint	0.87	1.49	1.44	0.75	0.70	0.14	000
29125		A	Apply forearm splint	0.59	1.33	1.26	0.61	0.56	0.10	000
29126		A	Apply forearm splint	0.77	1.42	1.35	0.70	0.65	0.11	000
29130		A	Application of finger splint	0.50	0.61	0.58	0.28	0.26	0.07	000
29131		A	Application of finger splint	0.55	0.88	0.83	0.37	0.34	0.08	000
29200		A	Strapping of chest	0.65	0.86	0.81	0.49	0.46	0.05	000
29240		A	Strapping of shoulder	0.71	0.88	0.87	0.52	0.49	0.05	000
29260		A	Strapping of elbow or wrist	0.55	0.90	0.86	0.51	0.47	0.05	000
29280		A	Strapping of hand or finger	0.51	0.92	0.88	0.52	0.48	0.04	000
29305		A	Application of hip cast	2.03	4.73	4.43	2.31	2.19	0.39	000
29325		A	Application of hip casts	2.32	5.16	4.84	2.55	2.42	0.45	000
29345		A	Application of long leg cast	1.40	2.30	2.19	1.34	1.28	0.27	000
29355		A	Application of long leg cast	1.53	2.33	2.19	1.39	1.32	0.29	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
29358		A	Apply long leg cast brace	1.43	2.95	2.75	1.40	1.31	0.29	000
29365		A	Application of long leg cast	1.18	2.18	2.07	1.22	1.16	0.23	000
29405		A	Apply short leg cast	0.86	1.61	1.54	0.90	0.86	0.12	000
29425		A	Apply short leg cast	1.01	1.63	1.56	0.88	0.86	0.12	000
29435		A	Apply short leg cast	1.18	2.05	1.97	1.11	1.08	0.23	000
29440		A	Addition of walker to cast	0.57	0.66	0.73	0.25	0.28	0.08	000
29445		A	Apply rigid leg cast	1.78	2.08	2.03	1.20	1.16	0.24	000
29450		A	Application of leg cast	2.08	1.92	1.89	1.07	1.10	0.22	000
29505		A	Application long leg splint	0.69	1.46	1.40	0.64	0.60	0.11	000
29515		A	Application lower leg splint	0.73	1.29	1.21	0.63	0.60	0.10	000
29520		A	Strapping of hip	0.54	0.86	0.84	0.47	0.47	0.04	000
29530		A	Strapping of knee	0.57	0.90	0.86	0.50	0.46	0.05	000
29540		A	Strapping of ankle and/or ft	0.32	0.63	0.62	0.32	0.35	0.03	000
29550		A	Strapping of toes	0.15	0.62	0.62	0.27	0.31	0.01	000
29580		A	Application of paste boot	0.55	0.92	0.89	0.44	0.43	0.07	000
29581		A	Apply multlay comprs lwr leg	0.60	2.04	2.04	0.27	0.27	0.07	000
29590		A	Application of foot splint	0.76	0.74	0.71	0.31	0.32	0.05	000
29700		A	Removal/revision of cast	0.57	1.25	1.20	0.36	0.35	0.10	000
29705		A	Removal/revision of cast	0.76	1.07	1.02	0.53	0.50	0.12	000
29710		A	Removal/revision of cast	1.34	2.02	1.87	0.93	0.85	0.27	000
29715		A	Removal/revision of cast	0.94	1.32	1.38	0.53	0.54	0.12	000
29720		A	Repair of body cast	0.68	1.61	1.52	0.51	0.48	0.12	000
29730		A	Windowing of cast	0.75	1.03	0.98	0.49	0.46	0.11	000
29740		A	Wedging of cast	1.12	1.30	1.29	0.60	0.59	0.18	000
29750		A	Wedging of clubfoot cast	1.26	1.47	1.40	0.78	0.74	0.26	000
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29800		A	Jaw arthroscopy/surgery	6.84	NA	NA	7.48	7.12	1.33	090
29804		A	Jaw arthroscopy/surgery	8.87	NA	NA	9.17	8.51	1.74	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
29805		A	Shoulder arthroscopy dx	6.03	NA	NA	6.80	6.50	1.18	090
29806		A	Shoulder arthroscopy/surgery	15.14	NA	NA	13.60	13.01	2.97	090
29807		A	Shoulder arthroscopy/surgery	14.67	NA	NA	13.47	12.84	2.87	090
29819		A	Shoulder arthroscopy/surgery	7.79	NA	NA	8.16	7.81	1.52	090
29820		A	Shoulder arthroscopy/surgery	7.21	NA	NA	7.45	7.15	1.40	090
29821		A	Shoulder arthroscopy/surgery	7.89	NA	NA	8.15	7.81	1.55	090
29822		A	Shoulder arthroscopy/surgery	7.60	NA	NA	7.99	7.67	1.49	090
29823		A	Shoulder arthroscopy/surgery	8.36	NA	NA	8.66	8.32	1.63	090
29824		A	Shoulder arthroscopy/surgery	8.98	NA	NA	9.35	8.93	1.77	090
29825		A	Shoulder arthroscopy/surgery	7.79	NA	NA	8.11	7.77	1.52	090
29826		A	Shoulder arthroscopy/surgery	9.16	NA	NA	8.91	8.56	1.79	090
29827		A	Arthroscop rotator cuff repr	15.59	NA	NA	13.56	13.03	3.07	090
29828		A	Arthroscopy biceps tenodesis	13.16	NA	NA	11.86	11.14	2.58	090
29830		A	Elbow arthroscopy	5.88	NA	NA	6.47	6.18	1.17	090
29834		A	Elbow arthroscopy/surgery	6.42	NA	NA	7.01	6.71	1.22	090
29835		A	Elbow arthroscopy/surgery	6.62	NA	NA	7.17	6.85	1.29	090
29836		A	Elbow arthroscopy/surgery	7.72	NA	NA	8.12	7.78	1.52	090
29837		A	Elbow arthroscopy/surgery	7.01	NA	NA	7.39	7.07	1.36	090
29838		A	Elbow arthroscopy/surgery	7.88	NA	NA	8.26	7.89	1.49	090
29840		A	Wrist arthroscopy	5.68	NA	NA	6.60	6.31	1.13	090
29843		A	Wrist arthroscopy/surgery	6.15	NA	NA	7.00	6.69	1.21	090
29844		A	Wrist arthroscopy/surgery	6.51	NA	NA	7.20	6.80	1.18	090
29845		A	Wrist arthroscopy/surgery	7.69	NA	NA	8.18	7.67	1.37	090
29846		A	Wrist arthroscopy/surgery	6.89	NA	NA	7.47	7.09	1.22	090
29847		A	Wrist arthroscopy/surgery	7.22	NA	NA	7.52	7.21	1.41	090
29848		A	Wrist endoscopy/surgery	6.39	NA	NA	7.67	7.19	1.17	090
29850		A	Knee arthroscopy/surgery	8.27	NA	NA	8.68	7.58	1.62	090
29851		A	Knee arthroscopy/surgery	13.26	NA	NA	12.04	11.47	2.61	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
29855		A	Tibial arthroscopy/surgery	10.76	NA	NA	10.59	10.12	2.12	090
29856		A	Tibial arthroscopy/surgery	14.28	NA	NA	12.76	12.20	2.82	090
29860		A	Hip arthroscopy dx	9.00	NA	NA	9.11	8.52	1.78	090
29861		A	Hip arthro w/fb removal	10.10	NA	NA	9.77	9.17	1.97	090
29862		A	Hip arthr0 w/debridement	11.17	NA	NA	11.08	10.48	2.19	090
29863		A	Hip arthr0 w/synovectomy	11.17	NA	NA	11.03	10.40	2.20	090
29866		A	Autgrft implnt knee w/scope	14.67	NA	NA	13.82	13.13	2.91	090
29867		A	Allgrft implnt knee w/scope	18.39	NA	NA	16.33	15.37	3.61	090
29868		A	Meniscal trnspl knee w/scpe	25.10	NA	NA	20.34	19.20	4.94	090
29870		A	Knee arthroscopy dx	5.19	10.83	10.83	6.04	5.75	1.02	090
29871		A	Knee arthroscopy/drainage	6.69	NA	NA	7.30	6.95	1.30	090
29873		A	Knee arthroscopy/surgery	6.24	NA	NA	8.05	7.67	1.22	090
29874		A	Knee arthroscopy/surgery	7.19	NA	NA	7.48	7.13	1.40	090
29875		A	Knee arthroscopy/surgery	6.45	NA	NA	7.04	6.73	1.26	090
29876		A	Knee arthroscopy/surgery	8.87	NA	NA	9.00	8.53	1.74	090
29877		A	Knee arthroscopy/surgery	8.30	NA	NA	8.66	8.21	1.62	090
29879		A	Knee arthroscopy/surgery	8.99	NA	NA	9.05	8.60	1.77	090
29880		A	Knee arthroscopy/surgery	9.45	NA	NA	9.35	8.87	1.85	090
29881		A	Knee arthroscopy/surgery	8.71	NA	NA	8.91	8.45	1.70	090
29882		A	Knee arthroscopy/surgery	9.60	NA	NA	9.41	8.90	1.89	090
29883		A	Knee arthroscopy/surgery	11.77	NA	NA	11.01	10.54	2.30	090
29884		A	Knee arthroscopy/surgery	8.28	NA	NA	8.63	8.18	1.62	090
29885		A	Knee arthroscopy/surgery	10.21	NA	NA	10.24	9.70	2.00	090
29886		A	Knee arthroscopy/surgery	8.49	NA	NA	8.81	8.34	1.66	090
29887		A	Knee arthroscopy/surgery	10.16	NA	NA	10.15	9.62	1.98	090
29888		A	Knee arthroscopy/surgery	14.30	NA	NA	12.53	11.95	2.80	090
29889		A	Knee arthroscopy/surgery	17.41	NA	NA	15.67	14.92	3.41	090
29891		A	Ankle arthroscopy/surgery	9.67	NA	NA	9.26	8.91	1.64	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
29892		A	Ankle arthroscopy/surgery	10.27	NA	NA	6.18	7.21	2.01	090
29893		A	Scope plantar fasciotomy	6.32	11.04	10.44	5.79	5.61	0.50	090
29894		A	Ankle arthroscopy/surgery	7.35	NA	NA	6.89	6.52	1.22	090
29895		A	Ankle arthroscopy/surgery	7.13	NA	NA	6.41	6.17	1.13	090
29897		A	Ankle arthroscopy/surgery	7.32	NA	NA	6.75	6.57	1.24	090
29898		A	Ankle arthroscopy/surgery	8.49	NA	NA	7.27	7.03	1.29	090
29899		A	Ankle arthroscopy/surgery	15.41	NA	NA	12.98	12.47	2.87	090
29900		A	Mcp joint arthroscopy dx	5.88	NA	NA	7.59	6.86	0.41	090
29901		A	Mcp joint arthroscopy surg	6.59	NA	NA	7.90	7.20	1.29	090
29902		A	Mcp joint arthroscopy surg	7.16	NA	NA	5.76	6.27	2.57	090
29904		A	Subtalar arthro w/fb rmvl	8.65	NA	NA	8.68	8.09	1.68	090
29905		A	Subtalar arthro w/exc	9.18	NA	NA	9.58	8.92	1.81	090
29906		A	Subtalar arthro w/deb	9.65	NA	NA	10.10	9.42	1.89	090
29907		A	Subtalar arthro w/fusion	12.18	NA	NA	11.62	10.83	2.39	090
29914		A	Hip arthro w/femoroplasty	14.67	NA	NA	12.79	12.79	2.91	090
29915		A	Hip arthro acetabuloplasty	15.00	NA	NA	12.99	12.99	2.95	090
29916		A	Hip arthro w/labral repair	15.00	NA	NA	12.99	12.99	2.95	090
29999		C	Arthroscopy of joint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
30000		A	Drainage of nose lesion	1.48	5.16	5.06	1.91	1.80	0.22	010
30020		A	Drainage of nose lesion	1.48	5.27	5.01	1.95	1.84	0.20	010
3006F		I	Cxr doc rev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3008F		I	Body mass index docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30100		A	Intranasal biopsy	0.94	3.18	3.07	1.03	0.99	0.11	000
30110		A	Removal of nose polyp(s)	1.68	5.00	4.78	2.07	1.96	0.23	010
30115		A	Removal of nose polyp(s)	4.44	NA	NA	8.01	7.66	0.56	090
30117		A	Removal of intranasal lesion	3.26	22.18	21.35	6.49	6.22	0.41	090
30118		A	Removal of intranasal lesion	9.92	NA	NA	12.05	11.43	1.30	090
3011F		I	Lipid panel doc rev	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
30120		A	Revision of nose	5.39	9.32	9.01	7.02	6.88	0.84	090
30124		A	Removal of nose lesion	3.20	NA	NA	4.68	4.43	0.41	090
30125		A	Removal of nose lesion	7.30	NA	NA	10.23	9.80	0.92	090
30130		A	Excise inferior turbinate	3.47	NA	NA	7.49	7.21	0.43	090
30140		A	Resect inferior turbinate	3.57	NA	NA	9.17	8.80	0.45	090
30150		A	Partial removal of nose	9.55	NA	NA	12.37	12.03	1.41	090
3015F		I	Cerv cancer screen docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30160		A	Removal of nose	9.99	NA	NA	12.29	11.81	1.28	090
3018F		I	Pre-prxd rsk et al docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30200		A	Injection treatment of nose	0.78	2.53	2.43	0.95	0.90	0.10	000
30210		A	Nasal sinus therapy	1.13	3.23	3.09	1.75	1.67	0.14	010
30220		A	Insert nasal septal button	1.59	7.24	6.92	2.02	1.92	0.22	010
30300		A	Remove nasal foreign body	1.09	5.54	5.43	2.53	2.41	0.14	010
30310		A	Remove nasal foreign body	2.01	NA	NA	3.91	3.77	0.26	010
30320		A	Remove nasal foreign body	4.64	NA	NA	8.40	8.07	0.60	090
3035F		I	O2 saturation<=88% /pao<=55	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3037F		I	O2 saturation> 88% /pao>55	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30400		R	Reconstruction of nose	10.86	NA	NA	18.23	17.92	1.39	090
3040F		I	Fev<40% predicted value	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30410		R	Reconstruction of nose	14.00	NA	NA	20.08	19.68	1.79	090
30420		R	Reconstruction of nose	16.90	NA	NA	22.28	21.30	2.39	090
3042F		I	Fev>=40% predicted value	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30430		R	Revision of nose	8.24	NA	NA	16.68	16.89	1.62	090
30435		R	Revision of nose	12.73	NA	NA	22.28	21.16	1.63	090
30450		R	Revision of nose	19.66	NA	NA	23.42	23.11	2.51	090
30460		A	Revision of nose	10.32	NA	NA	10.65	10.28	2.01	090
30462		A	Revision of nose	20.28	NA	NA	23.50	21.85	3.99	090
30465		A	Repair nasal stenosis	12.36	NA	NA	15.74	14.90	1.74	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
30520		A	Repair of nasal septum	7.01	NA	NA	11.00	10.26	0.90	090
30540		A	Repair nasal defect	7.92	NA	NA	11.90	11.10	1.02	090
30545		A	Repair nasal defect	11.62	NA	NA	12.29	13.12	0.81	090
30560		A	Release of nasal adhesions	1.31	6.57	6.42	2.68	2.60	0.18	010
30580		A	Repair upper jaw fistula	6.88	11.45	10.74	7.58	6.93	0.87	090
30600		A	Repair mouth/nose fistula	6.16	10.36	9.93	6.18	5.87	0.77	090
30620		A	Intranasal reconstruction	6.16	NA	NA	11.65	11.22	0.88	090
30630		A	Repair nasal septum defect	7.29	NA	NA	10.68	10.16	0.99	090
3073F		I	Pre-surg eye measures docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30801		A	Ablate inf turbinate superf	1.14	5.46	5.35	2.81	2.68	0.14	010
30802		A	Ablate inf turbinate submuc	2.08	6.33	6.15	3.41	3.23	0.27	010
3088F		I	Mdd mild	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3089F		I	Mdd moderate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30901		A	Control of nosebleed	1.10	1.55	1.57	0.47	0.43	0.16	000
30903		A	Control of nosebleed	1.54	4.23	4.02	0.70	0.63	0.23	000
30905		A	Control of nosebleed	1.97	5.16	4.91	0.84	0.79	0.30	000
30906		A	Repeat control of nosebleed	2.45	5.58	5.36	1.30	1.22	0.33	000
3090F		I	Mdd severe w/o psych	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30915		A	Ligation nasal sinus artery	7.44	NA	NA	9.12	8.61	0.99	090
3091F		I	Mdd severe w/psych	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30920		A	Ligation upper jaw artery	11.14	NA	NA	12.82	11.98	1.45	090
30930		A	Ther fx nasal inf turbinate	1.31	NA	NA	2.25	2.13	0.18	010
3093F		I	Doc new diag 1st/addl mdd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31000		A	Irrigation maxillary sinus	1.20	4.05	3.93	1.82	1.75	0.14	010
31002		A	Irrigation sphenoid sinus	1.96	NA	NA	3.78	3.68	0.26	010
31020		A	Exploration maxillary sinus	3.07	10.83	10.65	7.21	6.95	0.39	090
31030		A	Exploration maxillary sinus	6.01	13.74	13.45	9.00	8.55	0.75	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
31032		A	Explore sinus remove polyps	6.69	NA	NA	9.74	9.25	0.87	090
31040		A	Exploration behind upper jaw	9.77	NA	NA	11.56	10.92	1.39	090
31050		A	Exploration sphenoid sinus	5.37	NA	NA	8.60	8.33	0.68	090
31051		A	Sphenoid sinus surgery	7.25	NA	NA	11.35	10.81	0.91	090
31070		A	Exploration of frontal sinus	4.40	NA	NA	8.25	7.90	0.58	090
31075		A	Exploration of frontal sinus	9.51	NA	NA	12.98	12.37	1.22	090
31080		A	Removal of frontal sinus	12.74	NA	NA	16.92	15.70	1.63	090
31081		A	Removal of frontal sinus	14.19	NA	NA	24.18	21.39	5.08	090
31084		A	Removal of frontal sinus	14.95	NA	NA	18.22	17.59	1.91	090
31085		A	Removal of frontal sinus	15.64	NA	NA	18.63	18.18	5.61	090
31086		A	Removal of frontal sinus	14.36	NA	NA	17.87	16.87	1.85	090
31087		A	Removal of frontal sinus	14.57	NA	NA	16.51	15.74	1.86	090
31090		A	Exploration of sinuses	11.17	NA	NA	18.29	17.28	1.47	090
31200		A	Removal of ethmoid sinus	5.14	NA	NA	10.62	10.20	0.73	090
31201		A	Removal of ethmoid sinus	8.60	NA	NA	12.55	11.87	1.14	090
31205		A	Removal of ethmoid sinus	10.58	NA	NA	14.61	13.67	1.59	090
31225		A	Removal of upper jaw	26.70	NA	NA	26.80	24.67	3.54	090
31230		A	Removal of upper jaw	30.82	NA	NA	28.87	26.50	3.95	090
31231		A	Nasal endoscopy dx	1.10	4.48	4.39	1.13	1.06	0.12	000
31233		A	Nasal/sinus endoscopy dx	2.18	5.50	5.36	1.76	1.65	0.29	000
31235		A	Nasal/sinus endoscopy dx	2.64	6.00	5.91	2.00	1.88	0.33	000
31237		A	Nasal/sinus endoscopy surg	2.98	6.40	6.25	2.24	2.08	0.38	000
31238		A	Nasal/sinus endoscopy surg	3.26	6.37	6.22	2.40	2.24	0.41	000
31239		A	Nasal/sinus endoscopy surg	9.33	NA	NA	10.11	9.37	1.24	010
31240		A	Nasal/sinus endoscopy surg	2.61	NA	NA	2.02	1.89	0.34	000
31254		A	Revision of ethmoid sinus	4.64	NA	NA	3.23	3.00	0.60	000
31255		A	Removal of ethmoid sinus	6.95	NA	NA	4.58	4.25	0.88	000
31256		A	Exploration maxillary sinus	3.29	NA	NA	2.42	2.26	0.41	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
31267		A	Endoscopy maxillary sinus	5.45	NA	NA	3.70	3.43	0.69	000
31276		A	Sinus endoscopy surgical	8.84	NA	NA	5.69	5.27	1.14	000
31287		A	Nasal/sinus endoscopy surg	3.91	NA	NA	2.79	2.59	0.50	000
31288		A	Nasal/sinus endoscopy surg	4.57	NA	NA	3.18	2.96	0.60	000
31290		A	Nasal/sinus endoscopy surg	18.61	NA	NA	14.46	13.47	2.63	010
31291		A	Nasal/sinus endoscopy surg	19.56	NA	NA	15.18	14.11	3.14	010
31292		A	Nasal/sinus endoscopy surg	15.90	NA	NA	12.81	11.94	2.04	010
31293		A	Nasal/sinus endoscopy surg	17.47	NA	NA	13.81	12.85	2.23	010
31294		A	Nasal/sinus endoscopy surg	20.31	NA	NA	15.48	14.38	2.61	010
31295		A	Sinus endo w/balloon dil	2.70	57.07	57.07	2.12	2.12	0.35	000
31296		A	Sinus endo w/balloon dil	3.29	108.70	108.70	2.47	2.47	0.42	000
31297		A	Sinus endo w/balloon dil	2.64	108.37	108.37	2.08	2.08	0.34	000
31299		C	Sinus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31300		A	Removal of larynx lesion	15.91	NA	NA	20.57	19.46	2.02	090
3130F		I	Upper gi endoscopy performed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
31320		A	Diagnostic incision larynx	5.73	NA	NA	13.28	12.83	0.72	090
3132F		I	Doc ref upper gi endoscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
31360		A	Removal of larynx	29.91	NA	NA	29.89	27.04	3.91	090
31365		A	Removal of larynx	38.81	NA	NA	35.10	31.68	5.07	090
31367		A	Partial removal of larynx	30.57	NA	NA	32.90	30.46	3.97	090
31368		A	Partial removal of larynx	34.19	NA	NA	36.20	33.61	4.37	090
31370		A	Partial removal of larynx	27.57	NA	NA	32.12	29.95	3.53	090
31375		A	Partial removal of larynx	26.07	NA	NA	30.60	28.46	3.35	090
31380		A	Partial removal of larynx	25.57	NA	NA	30.30	28.16	3.29	090
31382		A	Partial removal of larynx	28.57	NA	NA	32.71	30.32	3.68	090
31390		A	Removal of larynx & pharynx	42.51	NA	NA	38.98	35.65	5.83	090
31395		A	Reconstruct larynx & pharynx	43.80	NA	NA	42.76	39.26	5.62	090
31400		A	Revision of larynx	11.60	NA	NA	17.19	16.55	1.49	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
3140F		I	Upper gi endo shows barrtts	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3141F		I	Upper gi endo not barrtts	0.00	0.00	0.00	0.00	0.00	0.00	XXX
31420		A	Removal of epiglottis	11.43	NA	NA	12.64	11.90	1.47	090
3142F		I	Barium swallow test ordered	0.00	0.00	0.00	0.00	0.00	0.00	XXX
31500		A	Insert emergency airway	2.33	NA	NA	0.64	0.60	0.31	000
31502		A	Change of windpipe airway	0.65	NA	NA	0.34	0.32	0.07	000
31505		A	Diagnostic laryngoscopy	0.61	1.79	1.77	0.81	0.77	0.07	000
3150F		I	Forceps esoph biopsy done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
31510		A	Laryngoscopy with biopsy	1.92	4.15	4.07	1.55	1.45	0.26	000
31511		A	Remove foreign body larynx	2.16	3.85	3.76	1.42	1.37	0.31	000
31512		A	Removal of larynx lesion	2.07	3.95	3.84	1.70	1.58	0.27	000
31513		A	Injection into vocal cord	2.10	NA	NA	1.72	1.61	0.27	000
31515		A	Laryngoscopy for aspiration	1.80	4.16	4.12	1.32	1.25	0.24	000
31520		A	Dx laryngoscopy newborn	2.56	NA	NA	1.99	1.80	0.33	000
31525		A	Dx laryngoscopy excl nb	2.63	4.62	4.46	1.95	1.83	0.34	000
31526		A	Dx laryngoscopy w/oper scope	2.57	NA	NA	1.99	1.86	0.33	000
31527		A	Laryngoscopy for treatment	3.27	NA	NA	2.41	2.19	0.41	000
31528		A	Laryngoscopy and dilation	2.37	NA	NA	1.82	1.69	0.31	000
31529		A	Laryngoscopy and dilation	2.68	NA	NA	2.00	1.87	0.34	000
31530		A	Laryngoscopy w/fb removal	3.38	NA	NA	2.33	2.16	0.43	000
31531		A	Laryngoscopy w/fb & op scope	3.58	NA	NA	2.57	2.40	0.45	000
31535		A	Laryngoscopy w/biopsy	3.16	NA	NA	2.33	2.17	0.41	000
31536		A	Laryngoscopy w/bx & op scope	3.55	NA	NA	2.58	2.40	0.45	000
31540		A	Laryngoscopy w/exc of tumor	4.12	NA	NA	2.90	2.70	0.53	000
31541		A	Larynscop w/tumr exc + scope	4.52	NA	NA	3.14	2.93	0.58	000
31545		A	Remove vc lesion w/scope	6.30	NA	NA	4.22	3.89	0.80	000
31546		A	Remove vc lesion scope/graft	9.73	NA	NA	6.27	5.67	1.25	000
31560		A	Laryngoscop w/arytenoidectom	5.45	NA	NA	3.66	3.38	0.69	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
31561		A	Larynscop remve cart + scop	5.99	NA	NA	3.97	3.66	0.76	000
31570		A	Laryngoscope w/vc inj	3.86	5.90	5.81	2.72	2.53	0.53	000
31571		A	Laryngoscop w/vc inj + scope	4.26	NA	NA	2.98	2.77	0.54	000
31575		A	Diagnostic laryngoscopy	1.10	2.21	2.18	1.11	1.06	0.12	000
31576		A	Laryngoscopy with biopsy	1.97	4.52	4.45	1.60	1.50	0.24	000
31577		A	Remove foreign body larynx	2.47	4.52	4.39	1.78	1.68	0.33	000
31578		A	Removal of larynx lesion	2.84	5.30	5.16	2.16	1.96	0.35	000
31579		A	Diagnostic laryngoscopy	2.26	3.85	3.83	1.81	1.69	0.30	XXX
31580		A	Revision of larynx	14.66	NA	NA	20.63	19.45	1.87	090
31582		A	Revision of larynx	23.22	NA	NA	31.48	30.26	2.99	090
31584		A	Treat larynx fracture	20.47	NA	NA	23.03	21.75	2.62	090
31587		A	Revision of larynx	15.27	NA	NA	13.62	12.44	1.94	090
31588		A	Revision of larynx	14.99	NA	NA	17.96	16.94	1.93	090
31590		A	Reinnervate larynx	7.85	NA	NA	17.94	17.54	1.02	090
31595		A	Larynx nerve surgery	8.84	NA	NA	13.23	12.71	1.14	090
31599		C	Larynx surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31600		A	Incision of windpipe	7.17	NA	NA	3.66	3.44	1.26	000
31601		A	Incision of windpipe	4.44	NA	NA	3.06	2.84	0.56	000
31603		A	Incision of windpipe	4.14	NA	NA	2.02	1.87	0.69	000
31605		A	Incision of windpipe	3.57	NA	NA	1.34	1.26	0.62	000
31610		A	Incision of windpipe	9.38	NA	NA	10.99	10.38	1.32	090
31611		A	Surgery/speech prosthesis	6.00	NA	NA	9.60	9.16	0.76	090
31612		A	Puncture/clear windpipe	0.91	1.44	1.38	0.44	0.40	0.11	000
31613		A	Repair windpipe opening	4.71	NA	NA	8.16	7.84	0.72	090
31614		A	Repair windpipe opening	8.63	NA	NA	13.10	12.35	1.18	090
31615		A	Visualization of windpipe	2.09	3.12	3.05	1.58	1.48	0.26	000
31620		A	Endobronchial us add-on	1.40	6.28	6.69	0.50	0.50	0.12	ZZZ
31622		A	Dx bronchoscope/wash	2.78	5.84	6.14	1.27	1.23	0.34	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
31623		A	Dx bronchoscope/brush	2.88	6.29	6.80	1.25	1.20	0.26	000
31624		A	Dx bronchoscope/lavage	2.88	5.75	6.14	1.27	1.22	0.26	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	5.91	6.30	1.43	1.38	0.31	000
31626		A	Bronchoscopy w/markers	4.16	8.59	8.59	1.73	1.73	0.31	000
31627		A	Navigational bronchoscopy	2.00	35.43	35.43	0.88	0.88	0.14	ZZZ
31628		A	Bronchoscopy/lung bx each	3.80	6.80	7.58	1.57	1.50	0.30	000
31629		A	Bronchoscopy/needle bx each	4.09	12.45	13.74	1.69	1.61	0.34	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	NA	1.76	1.75	0.49	000
31631		A	Bronchoscopy dilate w/stent	4.36	NA	NA	1.98	1.94	0.60	000
31632		A	Bronchoscopy/lung bx addl	1.03	0.99	1.00	0.37	0.35	0.07	ZZZ
31633		A	Bronchoscopy/needle bx addl	1.32	1.14	1.16	0.47	0.45	0.10	ZZZ
31634		A	Bronch w/balloon occlusion	4.00	48.98	48.98	1.76	1.76	0.33	000
31635		A	Bronchoscopy w/fb removal	3.67	5.79	6.18	1.59	1.55	0.39	000
31636		A	Bronchoscopy bronch stents	4.30	NA	NA	1.82	1.83	0.56	000
31637		A	Bronchoscopy stent add-on	1.58	NA	NA	0.61	0.59	0.11	ZZZ
31638		A	Bronchoscopy revise stent	4.88	NA	NA	2.15	2.12	0.65	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	NA	2.17	2.15	0.64	000
31641		A	Bronchoscopy treat blockage	5.02	NA	NA	2.18	2.09	0.58	000
31643		A	Diag bronchoscope/catheter	3.49	NA	NA	1.45	1.40	0.29	000
31645		A	Bronchoscopy clear airways	3.16	5.17	5.49	1.36	1.31	0.29	000
31646		A	Bronchoscopy reclear airway	2.72	4.87	5.17	1.20	1.15	0.26	000
31656		A	Bronchoscopy inj for x-ray	2.17	6.07	6.74	0.93	0.92	0.16	000
31715		A	Injection for bronchus x-ray	1.11	NA	NA	0.37	0.39	0.08	000
31717		A	Bronchial brush biopsy	2.12	5.43	6.14	1.03	0.97	0.16	000
31720		A	Clearance of airways	1.06	NA	NA	0.41	0.38	0.08	000
31725		A	Clearance of airways	1.96	NA	NA	0.73	0.65	0.20	000
31730		A	Intro windpipe wire/tube	2.85	29.77	26.77	1.20	1.13	0.45	000
31750		A	Repair of windpipe	15.39	NA	NA	23.74	22.68	2.27	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
31755		A	Repair of windpipe	17.54	NA	NA	32.42	31.20	2.24	090
31760		A	Repair of windpipe	23.48	NA	NA	12.37	12.79	5.47	090
31766		A	Reconstruction of windpipe	31.67	NA	NA	14.67	15.01	7.39	090
31770		A	Repair/graft of bronchus	23.54	NA	NA	11.19	11.44	5.49	090
31775		A	Reconstruct bronchus	24.59	NA	NA	10.49	11.10	5.74	090
31780		A	Reconstruct windpipe	19.84	NA	NA	13.54	12.75	3.22	090
31781		A	Reconstruct windpipe	24.85	NA	NA	11.21	12.17	5.80	090
31785		A	Remove windpipe lesion	18.35	NA	NA	12.19	11.38	2.61	090
31786		A	Remove windpipe lesion	25.42	NA	NA	12.19	13.04	5.95	090
31800		A	Repair of windpipe injury	8.18	NA	NA	12.03	11.49	1.05	090
31805		A	Repair of windpipe injury	13.42	NA	NA	7.95	8.19	3.15	090
31820		A	Closure of windpipe lesion	4.64	7.89	7.53	4.77	4.48	0.67	090
31825		A	Repair of windpipe defect	7.07	10.28	9.80	6.73	6.33	0.99	090
31830		A	Revise windpipe scar	4.62	8.00	7.63	5.13	4.85	0.71	090
31899		C	Airways surgical procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
3200F		I	Barium swallow test not req	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32035		A	Exploration of chest	11.29	NA	NA	8.00	7.81	2.57	090
32036		A	Exploration of chest	12.30	NA	NA	8.28	8.21	2.89	090
32095		A	Biopsy through chest wall	10.14	NA	NA	6.60	6.59	2.34	090
32100		A	Exploration/biopsy of chest	16.16	NA	NA	8.95	9.09	3.79	090
32110		A	Explore/repair chest	25.28	NA	NA	13.30	13.10	5.73	090
32120		A	Re-exploration of chest	14.39	NA	NA	8.65	8.70	3.40	090
32124		A	Explore chest free adhesions	15.45	NA	NA	9.03	9.01	3.67	090
32140		A	Removal of lung lesion(s)	16.66	NA	NA	9.38	9.43	3.88	090
32141		A	Remove/treat lung lesions	27.18	NA	NA	13.02	12.76	6.38	090
32150		A	Removal of lung lesion(s)	16.82	NA	NA	9.60	9.55	3.92	090
32151		A	Remove lung foreign body	16.94	NA	NA	9.43	9.74	3.97	090
32160		A	Open chest heart massage	13.10	NA	NA	7.53	7.39	2.99	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
32200		A	Drain open lung lesion	18.68	NA	NA	11.45	11.27	4.28	090
32201		A	Drain percut lung lesion	3.99	21.28	22.93	1.49	1.66	0.38	000
32215		A	Treat chest lining	13.05	NA	NA	8.07	8.15	3.04	090
32220		A	Release of lung	26.65	NA	NA	15.22	15.41	6.29	090
32225		A	Partial release of lung	16.75	NA	NA	9.52	9.54	3.91	090
3230F		I	Note hring tst w/in 6 mon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32310		A	Removal of chest lining	15.28	NA	NA	8.82	8.90	3.61	090
32320		A	Free/remove chest lining	27.25	NA	NA	14.95	14.96	6.31	090
32400		A	Needle biopsy chest lining	1.76	2.31	2.49	0.65	0.69	0.18	000
32402		A	Open biopsy chest lining	8.97	NA	NA	6.06	6.11	2.02	090
32405		A	Biopsy lung or mediastinum	1.93	0.71	0.81	0.71	0.80	0.18	000
32420		A	Puncture/clear lung	2.18	NA	NA	0.82	0.88	0.24	000
32421		A	Thoracentesis for aspiration	1.54	2.66	2.90	0.59	0.60	0.14	000
32422		A	Thoracentesis w/tube insert	2.19	3.14	3.40	1.20	1.27	0.22	000
32440		A	Removal of lung	27.28	NA	NA	13.89	14.26	6.34	090
32442		A	Sleeve pneumonectomy	56.47	NA	NA	23.22	22.80	4.24	090
32445		A	Removal of lung	63.84	NA	NA	28.23	27.39	14.91	090
32480		A	Partial removal of lung	25.82	NA	NA	13.16	13.44	6.04	090
32482		A	Bilobectomy	27.44	NA	NA	14.32	14.59	6.41	090
32484		A	Segmentectomy	25.38	NA	NA	12.39	12.64	5.89	090
32486		A	Sleeve lobectomy	42.88	NA	NA	18.67	18.64	10.12	090
32488		A	Completion pneumonectomy	42.99	NA	NA	19.86	19.60	10.09	090
32491		R	Lung volume reduction	25.24	NA	NA	13.53	14.05	5.87	090
32500		A	Partial removal of lung	24.64	NA	NA	13.18	13.50	5.79	090
32501		A	Repair bronchus add-on	4.68	NA	NA	1.70	1.77	1.09	ZZZ
32503		A	Resect apical lung tumor	31.74	NA	NA	15.61	15.99	7.48	090
32504		A	Resect apical lung tum/chest	36.54	NA	NA	16.88	17.75	8.50	090
32540		A	Removal of lung lesion	30.35	NA	NA	14.85	14.72	7.09	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
32550		A	Insert pleural cath	4.17	17.51	18.65	1.86	1.94	0.69	000
32551		A	Insertion of chest tube	3.29	NA	NA	1.30	1.34	0.52	000
32552		A	Remove lung catheter	2.53	2.43	2.43	1.76	1.76	0.60	010
32553		A	Ins mark thor for rt perq	3.80	13.63	13.63	1.54	1.54	0.88	000
32560		A	Treat pleurodesis w/agent	1.54	5.21	5.89	0.57	0.68	0.27	000
32561		A	Lyse chest fibrin init day	1.39	1.21	1.21	0.51	0.51	0.24	000
32562		A	Lyse chest fibrin subq day	1.24	1.08	1.08	0.46	0.46	0.23	000
32601		A	Thoracoscopy diagnostic	5.45	NA	NA	2.64	2.70	1.26	000
32602		A	Thoracoscopy diagnostic	5.95	NA	NA	2.83	2.89	1.36	000
32603		A	Thoracoscopy diagnostic	7.80	NA	NA	3.43	3.56	1.94	000
32604		A	Thoracoscopy diagnostic	8.77	NA	NA	3.77	3.97	2.04	000
32605		A	Thoracoscopy diagnostic	6.92	NA	NA	3.12	3.20	1.62	000
32606		A	Thoracoscopy diagnostic	8.39	NA	NA	3.72	3.83	1.93	000
32650		A	Thoracoscopy surgical	10.83	NA	NA	6.81	6.97	2.47	090
32651		A	Thoracoscopy surgical	18.78	NA	NA	10.11	9.89	4.30	090
32652		A	Thoracoscopy surgical	29.13	NA	NA	14.43	14.23	6.71	090
32653		A	Thoracoscopy surgical	18.17	NA	NA	9.63	9.49	4.11	090
32654		A	Thoracoscopy surgical	20.52	NA	NA	10.46	10.31	4.64	090
32655		A	Thoracoscopy surgical	16.17	NA	NA	9.03	8.98	3.76	090
32656		A	Thoracoscopy surgical	13.26	NA	NA	7.83	8.00	3.00	090
32657		A	Thoracoscopy surgical	12.93	NA	NA	7.81	7.98	3.03	090
32658		A	Thoracoscopy surgical	11.71	NA	NA	7.02	7.35	2.74	090
32659		A	Thoracoscopy surgical	11.94	NA	NA	7.37	7.61	2.80	090
32660		A	Thoracoscopy surgical	17.77	NA	NA	9.35	9.71	4.44	090
32661		A	Thoracoscopy surgical	13.33	NA	NA	7.59	7.91	3.12	090
32662		A	Thoracoscopy surgical	14.99	NA	NA	8.52	8.82	3.49	090
32663		A	Thoracoscopy surgical	24.64	NA	NA	12.02	12.29	5.73	090
32664		A	Thoracoscopy surgical	14.28	NA	NA	7.93	8.16	3.35	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
32665		A	Thoracoscopy surgical	21.53	NA	NA	10.68	10.75	4.59	090
3268F		I	Psa/t/glsc docd b/4 txmnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32800		A	Repair lung hernia	15.71	NA	NA	9.02	9.05	3.68	090
32810		A	Close chest after drainage	14.95	NA	NA	8.69	8.88	3.50	090
32815		A	Close bronchial fistula	50.03	NA	NA	23.31	22.44	11.87	090
32820		A	Reconstruct injured chest	22.51	NA	NA	12.33	12.92	5.27	090
32850		X	Donor pneumonectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32851		A	Lung transplant single	41.61	NA	NA	26.31	27.34	9.78	090
32852		A	Lung transplant with bypass	45.48	NA	NA	29.61	30.99	10.63	090
32853		A	Lung transplant double	50.78	NA	NA	29.61	30.85	11.99	090
32854		A	Lung transplant with bypass	54.74	NA	NA	33.44	34.83	12.87	090
32855		C	Prepare donor lung single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32856		C	Prepare donor lung double	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32900		A	Removal of rib(s)	23.81	NA	NA	13.12	12.75	5.47	090
32905		A	Revise & repair chest wall	23.29	NA	NA	11.64	11.94	5.43	090
32906		A	Revise & repair chest wall	29.30	NA	NA	13.76	14.20	6.86	090
3290F		I	Pt=d(rh)- and unsensitized	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3291F		I	Pt=d(rh)+ or sensitized	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3292F		I	Hiv tstng asked/docd/revwd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3293F		I	Abo rh blood typing docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32940		A	Revision of lung	21.34	NA	NA	11.04	11.13	5.00	090
3294F		I	Grp b strep screening docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32960		A	Therapeutic pneumothorax	1.84	1.76	1.92	0.83	0.86	0.42	000
32997		A	Total lung lavage	7.31	NA	NA	2.43	2.36	0.91	000
32998		A	Perq rf ablate tx pul tumor	5.68	74.39	79.04	2.22	2.55	0.60	000
32999		C	Chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
33010		A	Drainage of heart sac	2.24	NA	NA	0.84	1.03	0.45	000
33011		A	Repeat drainage of heart sac	2.24	NA	NA	0.87	1.00	0.49	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33015		A	Incision of heart sac	8.52	NA	NA	4.80	5.64	1.67	090
33020		A	Incision of heart sac	14.95	NA	NA	8.21	8.28	3.50	090
33025		A	Incision of heart sac	13.70	NA	NA	7.36	7.52	3.25	090
33030		A	Partial removal of heart sac	22.39	NA	NA	11.60	11.71	5.31	090
33031		A	Partial removal of heart sac	25.38	NA	NA	12.13	12.40	6.10	090
33050		A	Removal of heart sac lesion	16.97	NA	NA	9.66	9.64	3.97	090
33120		A	Removal of heart lesion	27.45	NA	NA	13.32	13.68	6.56	090
33130		A	Removal of heart lesion	24.17	NA	NA	11.95	12.27	6.03	090
33140		A	Heart revascularize (tmr)	28.34	NA	NA	13.06	13.45	7.06	090
33141		A	Heart tmr w/other procedure	2.54	NA	NA	0.93	1.09	0.61	ZZZ
3317F		I	Path rpt malig cancer docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3318F		I	Path rpt malig cancer docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33202		A	Insert epicard eltrd open	13.20	NA	NA	7.11	7.43	3.15	090
33203		A	Insert epicard eltrd endo	13.97	NA	NA	6.99	7.71	3.27	090
33206		A	Insertion of heart pacemaker	7.39	NA	NA	4.36	5.22	1.62	090
33207		A	Insertion of heart pacemaker	8.05	NA	NA	4.41	5.34	1.77	090
33208		A	Insertion of heart pacemaker	8.77	NA	NA	4.68	5.69	1.91	090
33210		A	Insertion of heart electrode	3.30	NA	NA	1.28	1.61	0.71	000
33211		A	Insertion of heart electrode	3.39	NA	NA	1.30	1.56	0.75	000
33212		A	Insertion of pulse generator	5.52	NA	NA	3.17	3.81	1.21	090
33213		A	Insertion of pulse generator	6.37	NA	NA	3.49	4.26	1.40	090
33214		A	Upgrade of pacemaker system	7.84	NA	NA	4.60	5.48	1.70	090
33215		A	Reposition pacing-defib lead	4.92	NA	NA	2.89	3.52	1.07	090
33216		A	Insert 1 electrode pm-defib	5.87	NA	NA	3.75	4.61	1.28	090
33217		A	Insert 2 electrode pm-defib	5.84	NA	NA	3.77	4.57	1.28	090
33218		A	Repair lead pace-defib one	6.07	NA	NA	4.05	4.87	1.32	090
33220		A	Repair lead pace-defib dual	6.15	NA	NA	4.04	4.88	1.33	090
33222		A	Revise pocket pacemaker	5.10	NA	NA	3.85	4.55	1.14	090
33223		A	Revise pocket for defib	6.55	NA	NA	4.02	4.94	1.45	090
33224		A	Insert pacing lead & connect	9.04	NA	NA	3.88	4.83	1.98	000
33225		A	L ventric pacing lead add-on	8.33	NA	NA	3.27	4.14	1.82	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	NA	3.77	4.68	1.90	000
33233		A	Removal of pacemaker system	3.39	NA	NA	2.73	3.34	0.73	090
33234		A	Removal of pacemaker system	7.91	NA	NA	4.55	5.54	1.74	090
33235		A	Removal pacemaker electrode	10.15	NA	NA	6.15	7.43	2.24	090
33236		A	Remove electrode/thoracotomy	12.73	NA	NA	7.89	8.19	3.18	090
33237		A	Remove electrode/thoracotomy	13.84	NA	NA	7.61	8.73	3.23	090
33238		A	Remove electrode/thoracotomy	15.40	NA	NA	9.37	9.61	3.68	090
33240		A	Insert pulse generator	7.64	NA	NA	4.13	5.17	1.66	090
33241		A	Remove pulse generator	3.29	NA	NA	2.43	3.03	0.71	090
33243		A	Remove eltrd/thoracotomy	23.57	NA	NA	12.12	13.06	5.55	090
33244		A	Remove eltrd transven	13.99	NA	NA	7.80	9.61	3.10	090
33249		A	Eltrd/insert pace-defib	15.17	NA	NA	7.94	9.88	3.31	090
3324F		I	Mri ct scan ord rvwd rqstd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33250		A	Ablate heart dysrhythm focus	25.90	NA	NA	12.56	12.97	6.45	090
33251		A	Ablate heart dysrhythm focus	28.92	NA	NA	14.16	14.33	6.99	090
33254		A	Ablate atria lmtd	23.71	NA	NA	12.26	12.50	5.91	090
33255		A	Ablate atria w/o bypass ext	29.04	NA	NA	14.03	14.83	7.24	090
33256		A	Ablate atria w/bypass exten	34.90	NA	NA	16.15	17.11	8.73	090
33257		A	Ablate atria lmtd add-on	9.63	NA	NA	5.85	6.02	2.31	ZZZ
33258		A	Ablate atria x10sv add-on	11.00	NA	NA	6.37	6.57	2.62	ZZZ
33259		A	Ablate atria w/bypass add-on	14.14	NA	NA	8.24	8.53	3.42	ZZZ
3325F		I	Preop asses 4 cataract surg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33261		A	Ablate heart dysrhythm focus	28.92	NA	NA	13.48	13.91	7.21	090
33265		A	Ablate atria lmtd endo	23.71	NA	NA	11.88	12.27	5.64	090
33266		A	Ablate atria x10sv endo	33.04	NA	NA	15.29	15.89	7.96	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33282		A	Implant pat-active ht record	4.80	NA	NA	3.45	4.26	1.05	090
33284		A	Remove pat-active ht record	3.14	NA	NA	2.81	3.46	0.68	090
33300		A	Repair of heart wound	44.97	NA	NA	19.25	18.60	10.71	090
33305		A	Repair of heart wound	76.93	NA	NA	30.61	29.61	18.39	090
3330F		I	Imaging study ordered (bkp)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33310		A	Exploratory heart surgery	20.34	NA	NA	10.49	10.77	4.48	090
33315		A	Exploratory heart surgery	26.17	NA	NA	12.74	13.19	6.27	090
3331F		I	Bk imaging tst not ordered	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33320		A	Repair major blood vessel(s)	18.54	NA	NA	9.56	9.82	4.29	090
33321		A	Repair major vessel	20.81	NA	NA	10.60	10.82	4.86	090
33322		A	Repair major blood vessel(s)	24.42	NA	NA	12.31	12.62	5.85	090
33330		A	Insert major vessel graft	25.29	NA	NA	12.22	12.27	6.31	090
33332		A	Insert major vessel graft	24.56	NA	NA	11.80	12.38	6.11	090
33335		A	Insert major vessel graft	33.91	NA	NA	15.64	16.03	8.16	090
33400		A	Repair of aortic valve	41.50	NA	NA	18.58	19.20	9.87	090
33401		A	Valvuloplasty open	24.63	NA	NA	12.38	14.20	5.36	090
33403		A	Valvuloplasty w/cp bypass	25.61	NA	NA	13.29	14.19	6.38	090
33404		A	Prepare heart-aorta conduit	31.37	NA	NA	14.75	15.54	7.32	090
33405		A	Replacement of aortic valve	41.32	NA	NA	18.91	19.74	9.90	090
33406		A	Replacement of aortic valve	52.68	NA	NA	22.74	23.45	12.74	090
33410		A	Replacement of aortic valve	46.41	NA	NA	20.72	21.13	11.12	090
33411		A	Replacement of aortic valve	62.07	NA	NA	26.37	26.58	14.90	090
33412		A	Replacement of aortic valve	43.94	NA	NA	20.21	21.36	10.97	090
33413		A	Replacement of aortic valve	59.87	NA	NA	25.08	26.09	13.99	090
33414		A	Repair of aortic valve	39.37	NA	NA	17.00	17.87	9.82	090
33415		A	Revision subvalvular tissue	37.27	NA	NA	16.36	16.43	8.50	090
33416		A	Revise ventricle muscle	36.56	NA	NA	17.14	17.27	8.79	090
33417		A	Repair of aortic valve	29.33	NA	NA	14.62	15.19	7.02	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33420		A	Revision of mitral valve	25.79	NA	NA	15.77	13.70	3.53	090
33422		A	Revision of mitral valve	29.73	NA	NA	14.45	15.01	7.40	090
33425		A	Repair of mitral valve	49.96	NA	NA	22.02	21.72	11.96	090
33426		A	Repair of mitral valve	43.28	NA	NA	19.69	20.29	10.39	090
33427		A	Repair of mitral valve	44.83	NA	NA	19.58	20.54	10.76	090
33430		A	Replacement of mitral valve	50.93	NA	NA	23.15	23.44	12.24	090
33460		A	Revision of tricuspid valve	44.70	NA	NA	18.40	18.62	11.15	090
33463		A	Valvuloplasty tricuspid	57.08	NA	NA	24.26	23.89	13.76	090
33464		A	Valvuloplasty tricuspid	44.62	NA	NA	20.07	19.94	10.71	090
33465		A	Replace tricuspid valve	50.72	NA	NA	21.85	21.63	12.26	090
33468		A	Revision of tricuspid valve	32.94	NA	NA	15.09	16.45	8.23	090
33470		A	Revision of pulmonary valve	21.54	NA	NA	12.51	12.16	5.04	090
33471		A	Valvotomy pulmonary valve	22.96	NA	NA	13.09	12.80	1.62	090
33472		A	Revision of pulmonary valve	23.06	NA	NA	11.09	11.89	1.63	090
33474		A	Revision of pulmonary valve	39.40	NA	NA	17.32	16.77	9.21	090
33475		A	Replacement pulmonary valve	42.40	NA	NA	18.78	19.19	10.58	090
33476		A	Revision of heart chamber	26.57	NA	NA	13.33	13.37	6.63	090
33478		A	Revision of heart chamber	27.54	NA	NA	13.53	14.08	6.87	090
33496		A	Repair prosth valve clot	29.84	NA	NA	14.21	14.68	6.97	090
33500		A	Repair heart vessel fistula	27.94	NA	NA	13.28	13.78	6.97	090
33501		A	Repair heart vessel fistula	19.51	NA	NA	9.91	10.16	4.88	090
33502		A	Coronary artery correction	21.85	NA	NA	11.54	11.93	5.45	090
33503		A	Coronary artery graft	22.51	NA	NA	11.57	13.55	4.92	090
33504		A	Coronary artery graft	25.46	NA	NA	12.85	13.15	6.34	090
33505		A	Repair artery w/tunnel	38.40	NA	NA	15.38	15.72	9.57	090
33506		A	Repair artery translocation	37.85	NA	NA	22.95	20.09	8.85	090
33507		A	Repair art intramural	31.40	NA	NA	13.48	14.32	7.33	090
33508		A	Endoscopic vein harvest	0.31	NA	NA	0.11	0.12	0.07	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33510		A	Cabg vein single	34.98	NA	NA	16.30	17.04	8.39	090
33511		A	Cabg vein two	38.45	NA	NA	17.75	18.51	9.23	090
33512		A	Cabg vein three	43.98	NA	NA	19.81	20.52	10.58	090
33513		A	Cabg vein four	45.37	NA	NA	20.18	20.61	10.95	090
33514		A	Cabg vein five	48.08	NA	NA	21.07	21.84	11.52	090
33516		A	Cabg vein six or more	49.76	NA	NA	21.77	22.71	12.40	090
33517		A	Cabg artery-vein single	3.61	NA	NA	1.32	1.34	0.86	ZZZ
33518		A	Cabg artery-vein two	7.93	NA	NA	2.90	2.89	1.90	ZZZ
33519		A	Cabg artery-vein three	10.49	NA	NA	3.84	3.87	2.51	ZZZ
3351F		I	Neg scrn dep symp by deptool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33521		A	Cabg artery-vein four	12.59	NA	NA	4.62	4.69	3.04	ZZZ
33522		A	Cabg artery-vein five	14.14	NA	NA	5.19	5.32	3.42	ZZZ
33523		A	Cabg art-vein six or more	16.08	NA	NA	5.86	6.04	3.86	ZZZ
3352F		I	No sig dep symp by dep tool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33530		A	Coronary artery bypass/reop	10.13	NA	NA	3.69	3.66	2.42	ZZZ
33533		A	Cabg arterial single	33.75	NA	NA	15.67	16.59	8.11	090
33534		A	Cabg arterial two	39.88	NA	NA	18.26	19.14	9.56	090
33535		A	Cabg arterial three	44.75	NA	NA	20.04	20.91	10.73	090
33536		A	Cabg arterial four or more	48.43	NA	NA	21.42	22.05	11.68	090
3353F		I	Mild-mod dep symp by deptool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33542		A	Removal of heart lesion	48.21	NA	NA	21.14	20.91	11.61	090
33545		A	Repair of heart damage	57.06	NA	NA	24.26	24.18	13.65	090
33548		A	Restore/remodel ventricle	54.14	NA	NA	24.05	24.86	13.08	090
3354F		I	Clin sig dep sym by dep tool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33572		A	Open coronary endarterectomy	4.44	NA	NA	1.62	1.69	1.07	ZZZ
33600		A	Closure of valve	30.31	NA	NA	14.70	15.02	7.06	090
33602		A	Closure of valve	29.34	NA	NA	14.35	14.37	6.23	090
33606		A	Anastomosis/artery-aorta	31.53	NA	NA	17.05	16.53	6.71	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33608		A	Repair anomaly w/conduit	31.88	NA	NA	15.25	16.04	7.44	090
33610		A	Repair by enlargement	31.40	NA	NA	14.92	15.52	7.33	090
33611		A	Repair double ventricle	35.57	NA	NA	15.42	16.11	8.88	090
33612		A	Repair double ventricle	36.57	NA	NA	15.60	16.25	7.96	090
33615		A	Repair modified fontan	35.89	NA	NA	16.28	17.33	8.39	090
33617		A	Repair single ventricle	39.09	NA	NA	17.45	17.80	9.14	090
33619		A	Repair single ventricle	48.76	NA	NA	25.83	23.73	11.39	090
33620		A	Apply r&l pulm art bands	30.00	NA	NA	13.45	13.45	7.48	090
33621		A	Transthor cath for stent	16.18	NA	NA	7.42	7.42	3.75	090
33622		A	Redo compl cardiac anomaly	64.00	NA	NA	28.32	28.32	14.94	090
33641		A	Repair heart septum defect	29.58	NA	NA	13.82	13.76	7.10	090
33645		A	Revision of heart veins	28.10	NA	NA	13.24	13.79	7.01	090
33647		A	Repair heart septum defects	29.53	NA	NA	14.42	15.37	7.36	090
33660		A	Repair of heart defects	31.83	NA	NA	20.12	17.63	7.94	090
33665		A	Repair of heart defects	34.85	NA	NA	15.17	15.81	8.72	090
33670		A	Repair of heart chambers	36.63	NA	NA	14.84	15.51	9.15	090
33675		A	Close mult vsd	35.95	NA	NA	15.43	16.06	8.96	090
33676		A	Close mult vsd w/resection	36.95	NA	NA	18.64	18.20	2.62	090
33677		A	Cl mult vsd w/rem pul band	38.45	NA	NA	13.42	15.85	2.73	090
33681		A	Repair heart septum defect	32.34	NA	NA	16.22	16.53	7.78	090
33684		A	Repair heart septum defect	34.37	NA	NA	15.00	15.64	8.58	090
33688		A	Repair heart septum defect	34.75	NA	NA	14.27	14.62	8.68	090
33690		A	Reinforce pulmonary artery	20.36	NA	NA	13.26	12.34	4.75	090
33692		A	Repair of heart defects	31.54	NA	NA	16.34	15.97	2.23	090
33694		A	Repair of heart defects	35.57	NA	NA	15.26	16.25	8.88	090
33697		A	Repair of heart defects	37.57	NA	NA	16.42	18.60	8.18	090
33702		A	Repair of heart defects	27.24	NA	NA	13.26	13.58	6.79	090
33710		A	Repair of heart defects	30.41	NA	NA	14.23	17.10	7.10	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33720		A	Repair of heart defect	27.26	NA	NA	13.13	13.77	6.37	090
33722		A	Repair of heart defect	29.21	NA	NA	15.31	14.59	7.28	090
33724		A	Repair venous anomaly	27.63	NA	NA	12.59	13.55	6.44	090
33726		A	Repair pul venous stenosis	37.12	NA	NA	19.38	18.61	9.26	090
33730		A	Repair heart-vein defect(s)	36.14	NA	NA	16.11	16.00	9.03	090
33732		A	Repair heart-vein defect	28.96	NA	NA	14.22	14.75	7.22	090
33735		A	Revision of heart chamber	22.20	NA	NA	11.71	11.97	5.55	090
33736		A	Revision of heart chamber	24.32	NA	NA	12.45	12.92	6.06	090
33737		A	Revision of heart chamber	22.47	NA	NA	11.46	11.94	5.26	090
33750		A	Major vessel shunt	22.22	NA	NA	9.54	12.15	7.96	090
33755		A	Major vessel shunt	22.60	NA	NA	11.97	12.01	4.93	090
33762		A	Major vessel shunt	22.60	NA	NA	12.40	12.24	1.60	090
33764		A	Major vessel shunt & graft	22.60	NA	NA	13.22	12.40	4.82	090
33766		A	Major vessel shunt	23.57	NA	NA	11.20	12.60	5.12	090
33767		A	Major vessel shunt	25.30	NA	NA	11.93	12.10	6.31	090
33768		A	Cavopulmonary shunting	8.00	NA	NA	3.52	3.41	0.56	ZZZ
33770		A	Repair great vessels defect	39.07	NA	NA	16.01	16.85	9.14	090
33771		A	Repair great vessels defect	40.63	NA	NA	19.37	18.49	2.89	090
33774		A	Repair great vessels defect	31.73	NA	NA	15.24	15.95	7.92	090
33775		A	Repair great vessels defect	32.99	NA	NA	17.69	17.53	2.32	090
33776		A	Repair great vessels defect	34.75	NA	NA	18.80	18.61	2.44	090
33777		A	Repair great vessels defect	34.17	NA	NA	12.35	14.86	2.42	090
33778		A	Repair great vessels defect	42.75	NA	NA	21.70	21.23	3.04	090
33779		A	Repair great vessels defect	43.23	NA	NA	20.79	20.17	3.08	090
33780		A	Repair great vessels defect	43.90	NA	NA	21.28	21.16	3.12	090
33781		A	Repair great vessels defect	43.21	NA	NA	20.50	19.60	3.08	090
33782		A	Nikaidoh proc	60.08	NA	NA	24.13	24.13	14.04	090
33783		A	Nikaidoh proc w/ostia implt	65.08	NA	NA	25.90	25.90	15.21	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33786		A	Repair arterial trunk	41.87	NA	NA	17.34	18.35	2.97	090
33788		A	Revision of pulmonary artery	27.42	NA	NA	12.54	13.31	1.93	090
33800		A	Aortic suspension	17.28	NA	NA	8.52	8.63	4.30	090
33802		A	Repair vessel defect	18.37	NA	NA	12.01	11.06	4.59	090
33803		A	Repair vessel defect	20.31	NA	NA	9.72	9.82	5.07	090
33813		A	Repair septal defect	21.36	NA	NA	12.39	13.08	5.00	090
33814		A	Repair septal defect	26.57	NA	NA	13.24	13.78	6.63	090
33820		A	Revise major vessel	16.69	NA	NA	8.75	9.20	4.17	090
33822		A	Revise major vessel	17.71	NA	NA	10.14	10.13	1.25	090
33824		A	Revise major vessel	20.23	NA	NA	11.86	11.60	4.73	090
33840		A	Remove aorta constriction	21.34	NA	NA	13.30	12.15	5.32	090
33845		A	Remove aorta constriction	22.93	NA	NA	11.96	13.07	5.72	090
33851		A	Remove aorta constriction	21.98	NA	NA	18.50	15.17	5.47	090
33852		A	Repair septal defect	24.41	NA	NA	11.82	12.46	6.08	090
33853		A	Repair septal defect	32.51	NA	NA	15.31	16.78	8.12	090
33860		A	Ascending aortic graft	59.46	NA	NA	25.09	25.17	14.22	090
33863		A	Ascending aortic graft	58.79	NA	NA	24.02	24.63	14.04	090
33864		A	Ascending aortic graft	60.08	NA	NA	24.42	25.40	14.29	090
33870		A	Transverse aortic arch graft	46.06	NA	NA	20.09	20.96	10.97	090
33875		A	Thoracic aortic graft	35.78	NA	NA	17.19	17.15	8.53	090
33877		A	Thoracoabdominal graft	69.03	NA	NA	26.65	26.29	16.31	090
33880		A	Endovasc taa repr incl subcl	34.58	NA	NA	13.65	14.38	7.70	090
33881		A	Endovasc taa repr w/o subcl	29.58	NA	NA	12.01	12.58	6.59	090
33883		A	Insert endovasc prosth taa	21.09	NA	NA	9.15	9.55	4.69	090
33884		A	Endovasc prosth taa add-on	8.20	NA	NA	2.77	2.84	1.83	ZZZ
33886		A	Endovasc prosth delayed	18.09	NA	NA	7.98	8.30	4.29	090
33889		A	Artery transpose/endovas taa	15.92	NA	NA	5.48	5.51	3.78	000
33891		A	Car-car bp grft/endovas taa	20.00	NA	NA	5.96	6.38	4.74	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33910		A	Remove lung artery emboli	29.71	NA	NA	14.31	14.65	7.40	090
33915		A	Remove lung artery emboli	24.95	NA	NA	11.15	11.45	5.43	090
33916		A	Surgery of great vessel	28.42	NA	NA	13.31	14.99	7.09	090
33917		A	Repair pulmonary artery	25.30	NA	NA	12.92	14.15	5.91	090
33920		A	Repair pulmonary atresia	32.74	NA	NA	14.56	15.21	8.16	090
33922		A	Transect pulmonary artery	24.22	NA	NA	12.07	12.47	6.04	090
33924		A	Remove pulmonary shunt	5.49	NA	NA	1.92	2.00	1.28	ZZZ
33925		A	Rpr pul art unifocal w/o cpb	31.30	NA	NA	13.59	14.66	7.31	090
33926		A	Repr pul art unifocal w/cpb	44.73	NA	NA	26.84	22.00	11.15	090
33930		X	Removal of donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33933		C	Prepare donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33935		R	Transplantation heart/lung	62.01	NA	NA	28.00	29.37	15.47	090
33940		X	Removal of donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33944		C	Prepare donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33945		R	Transplantation of heart	89.50	NA	NA	37.49	37.17	21.29	090
33960		A	External circulation assist	19.33	NA	NA	7.13	7.11	3.82	000
33961		A	External circulation assist	10.91	NA	NA	4.01	4.14	1.66	ZZZ
33967		A	Insert ia percut device	4.84	NA	NA	1.88	2.35	1.07	000
33968		A	Remove aortic assist device	0.64	NA	NA	0.25	0.29	0.14	000
33970		A	Aortic circulation assist	6.74	NA	NA	2.50	2.85	1.56	000
33971		A	Aortic circulation assist	11.99	NA	NA	6.73	7.23	2.80	090
33973		A	Insert balloon device	9.75	NA	NA	3.67	4.19	2.25	000
33974		A	Remove intra-aortic balloon	15.03	NA	NA	7.93	8.98	3.76	090
33975		A	Implant ventricular device	20.97	NA	NA	7.65	8.02	4.98	XXX
33976		A	Implant ventricular device	22.97	NA	NA	8.15	9.00	5.73	XXX
33977		A	Remove ventricular device	20.28	NA	NA	11.42	11.98	4.81	090
33978		A	Remove ventricular device	22.72	NA	NA	12.48	12.80	5.68	090
33979		A	Insert intracorporeal device	45.93	NA	NA	16.48	17.38	10.97	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33980		A	Remove intracorporeal device	65.20	NA	NA	29.84	30.70	15.70	090
33981		C	Replace vad pump ext	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33982		C	Replace vad intra w/o bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33983		C	Replace vad intra w/bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33999		C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
34001		A	Removal of artery clot	17.88	NA	NA	8.85	8.63	4.06	090
34051		A	Removal of artery clot	16.99	NA	NA	9.11	9.20	4.24	090
34101		A	Removal of artery clot	10.93	NA	NA	5.68	5.71	2.46	090
34111		A	Removal of arm artery clot	10.93	NA	NA	5.69	5.72	2.43	090
34151		A	Removal of artery clot	26.52	NA	NA	11.80	11.63	5.96	090
34201		A	Removal of artery clot	19.48	NA	NA	8.80	8.40	4.47	090
34203		A	Removal of leg artery clot	17.86	NA	NA	8.46	8.55	4.10	090
34401		A	Removal of vein clot	26.52	NA	NA	14.59	13.96	5.65	090
34421		A	Removal of vein clot	13.37	NA	NA	6.86	6.89	2.96	090
34451		A	Removal of vein clot	28.52	NA	NA	10.36	11.42	6.76	090
34471		A	Removal of vein clot	21.11	NA	NA	12.23	10.45	4.49	090
34490		A	Removal of vein clot	10.91	NA	NA	6.05	5.97	2.42	090
34501		A	Repair valve femoral vein	16.85	NA	NA	7.51	8.27	3.99	090
34502		A	Reconstruct vena cava	28.07	NA	NA	13.17	13.50	5.88	090
3450F		I	Dyspnea scrnd no-mild dysp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34510		A	Transposition of vein valve	19.91	NA	NA	11.72	10.67	4.22	090
3451F		I	Dyspnea scrnd mod-high dysp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34520		A	Cross-over vein graft	19.18	NA	NA	7.69	8.38	4.54	090
3452F		I	Dyspnea not screened	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34530		A	Leg vein fusion	17.93	NA	NA	7.62	8.33	3.82	090
34800		A	Endovas aaa repr w/sm tube	21.54	NA	NA	9.05	9.56	4.56	090
34802		A	Endovas aaa repr w/2-p part	23.79	NA	NA	10.13	10.54	5.08	090
34803		A	Endovas aaa repr w/3-p part	24.82	NA	NA	10.22	10.57	5.32	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
34804		A	Endovas aaa repr w/1-p part	23.79	NA	NA	10.12	10.53	5.13	090
34805		A	Endovas aaa repr w/long tube	22.67	NA	NA	9.62	9.81	5.02	090
34806		A	Aneurysm press sensor add-on	2.06	NA	NA	0.70	0.74	0.45	ZZZ
34808		A	Endovas iliac a device addon	4.12	NA	NA	1.42	1.44	0.90	ZZZ
34812		A	Xpose for endoprosth femorl	6.74	NA	NA	2.34	2.34	1.55	000
34813		A	Femoral endovas graft add-on	4.79	NA	NA	1.61	1.62	1.10	ZZZ
34820		A	Xpose for endoprosth iliac	9.74	NA	NA	3.35	3.40	2.17	000
34825		A	Endovasc extend prosth init	12.80	NA	NA	6.28	6.56	2.74	090
34826		A	Endovasc exten prosth addl	4.12	NA	NA	1.44	1.49	0.88	ZZZ
34830		A	Open aortic tube prosth repr	35.23	NA	NA	12.45	13.50	8.34	090
34831		A	Open aortoiliac prosth repr	37.98	NA	NA	13.27	13.91	9.00	090
34832		A	Open aortofemor prosth repr	37.98	NA	NA	13.27	14.39	9.00	090
34833		A	Xpose for endoprosth iliac	11.98	NA	NA	4.39	4.50	2.78	000
34834		A	Xpose endoprosth brachial	5.34	NA	NA	2.05	2.13	1.24	000
34900		A	Endovasc iliac repr w/graft	16.85	NA	NA	7.63	7.96	3.57	090
3491F		I	Hiv unsure baby of hiv+moms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3497F		I	Cd4+ cell percentage <15%	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3498F		I	Cd4+ cell % >=15% (hiv)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35001		A	Repair defect of artery	20.81	NA	NA	9.72	10.04	4.81	090
35002		A	Repair artery rupture neck	22.23	NA	NA	8.56	9.56	4.74	090
35005		A	Repair defect of artery	19.29	NA	NA	11.57	10.79	4.56	090
35011		A	Repair defect of artery	18.58	NA	NA	8.69	8.66	4.21	090
35013		A	Repair artery rupture arm	23.23	NA	NA	11.14	10.86	5.27	090
35021		A	Repair defect of artery	22.17	NA	NA	8.77	9.97	5.19	090
35022		A	Repair artery rupture chest	25.70	NA	NA	12.15	12.04	6.00	090
35045		A	Repair defect of arm artery	18.01	NA	NA	9.18	8.83	3.99	090
35081		A	Repair defect of artery	33.53	NA	NA	14.43	14.20	7.75	090
35082		A	Repair artery rupture aorta	42.09	NA	NA	17.73	17.46	9.64	090
35091		A	Repair defect of artery	35.35	NA	NA	13.38	13.67	8.18	090
35092		A	Repair artery rupture aorta	50.97	NA	NA	19.71	19.70	11.76	090
35102		A	Repair defect of artery	36.53	NA	NA	15.07	14.96	8.43	090
35103		A	Repair artery rupture groin	43.62	NA	NA	17.35	17.39	9.97	090
3510F		I	Doc tb scrng-rslts interpd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35111		A	Repair defect of artery	26.28	NA	NA	14.49	13.07	5.59	090
35112		A	Repair artery rupture spleen	32.57	NA	NA	17.39	15.66	6.93	090
35121		A	Repair defect of artery	31.52	NA	NA	13.64	13.42	7.24	090
35122		A	Repair artery rupture belly	37.89	NA	NA	13.25	14.56	8.07	090
35131		A	Repair defect of artery	26.40	NA	NA	11.59	11.67	6.08	090
35132		A	Repair artery rupture groin	32.57	NA	NA	11.66	12.62	7.43	090
3513F		I	Hep b scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35141		A	Repair defect of artery	20.91	NA	NA	9.33	9.39	4.82	090
35142		A	Repair artery rupture thigh	25.16	NA	NA	11.01	11.13	5.77	090
3514F		I	Hep c scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35151		A	Repair defect of artery	23.72	NA	NA	10.39	10.46	5.46	090
35152		A	Repair artery rupture knee	27.66	NA	NA	10.19	11.19	6.56	090
3515F		I	Pt has docd immun to hep c	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35180		A	Repair blood vessel lesion	15.10	NA	NA	11.40	10.13	3.57	090
35182		A	Repair blood vessel lesion	31.71	NA	NA	14.79	15.02	6.75	090
35184		A	Repair blood vessel lesion	18.82	NA	NA	9.32	9.10	4.01	090
35188		A	Repair blood vessel lesion	15.16	NA	NA	6.46	7.33	3.23	090
35189		A	Repair blood vessel lesion	29.98	NA	NA	16.26	14.75	7.48	090
35190		A	Repair blood vessel lesion	13.42	NA	NA	7.14	7.08	3.06	090
35201		A	Repair blood vessel lesion	16.93	NA	NA	8.80	8.70	3.75	090
35206		A	Repair blood vessel lesion	13.84	NA	NA	7.40	7.23	3.06	090
35207		A	Repair blood vessel lesion	10.94	NA	NA	9.89	9.23	1.93	090
35211		A	Repair blood vessel lesion	24.58	NA	NA	12.05	12.31	5.89	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
35216		A	Repair blood vessel lesion	36.61	NA	NA	17.94	16.99	8.62	090
35221		A	Repair blood vessel lesion	26.62	NA	NA	12.27	11.77	5.81	090
35226		A	Repair blood vessel lesion	15.30	NA	NA	7.39	7.59	3.52	090
35231		A	Repair blood vessel lesion	21.16	NA	NA	11.52	11.19	4.16	090
35236		A	Repair blood vessel lesion	18.02	NA	NA	8.72	8.65	3.98	090
35241		A	Repair blood vessel lesion	25.58	NA	NA	13.28	13.19	6.29	090
35246		A	Repair blood vessel lesion	28.23	NA	NA	10.48	12.05	6.68	090
35251		A	Repair blood vessel lesion	31.91	NA	NA	13.98	13.46	6.98	090
35256		A	Repair blood vessel lesion	19.06	NA	NA	8.63	8.72	4.35	090
35261		A	Repair blood vessel lesion	18.96	NA	NA	9.55	9.44	4.63	090
35266		A	Repair blood vessel lesion	15.83	NA	NA	7.75	7.71	3.61	090
35271		A	Repair blood vessel lesion	24.58	NA	NA	12.06	12.29	6.12	090
35276		A	Repair blood vessel lesion	25.83	NA	NA	12.60	12.81	6.03	090
35281		A	Repair blood vessel lesion	30.06	NA	NA	13.73	13.35	6.78	090
35286		A	Repair blood vessel lesion	17.19	NA	NA	8.42	8.50	3.95	090
35301		A	Rechanneling of artery	19.61	NA	NA	9.07	9.08	4.55	090
35302		A	Rechanneling of artery	21.35	NA	NA	9.42	9.19	4.92	090
35303		A	Rechanneling of artery	23.60	NA	NA	10.44	10.09	5.42	090
35304		A	Rechanneling of artery	24.60	NA	NA	10.51	10.27	5.64	090
35305		A	Rechanneling of artery	23.60	NA	NA	10.31	10.00	5.42	090
35306		A	Rechanneling of artery	9.25	NA	NA	4.04	3.51	2.19	ZZZ
35311		A	Rechanneling of artery	28.60	NA	NA	12.27	12.50	6.68	090
35321		A	Rechanneling of artery	16.59	NA	NA	7.86	7.87	3.76	090
35331		A	Rechanneling of artery	27.72	NA	NA	12.17	12.32	6.42	090
35341		A	Rechanneling of artery	26.21	NA	NA	10.93	11.19	6.04	090
35351		A	Rechanneling of artery	24.61	NA	NA	10.53	10.49	5.64	090
35355		A	Rechanneling of artery	19.86	NA	NA	8.57	8.64	4.55	090
35361		A	Rechanneling of artery	30.24	NA	NA	10.97	11.94	7.17	090
35363		A	Rechanneling of artery	32.35	NA	NA	14.32	14.63	7.55	090
35371		A	Rechanneling of artery	15.31	NA	NA	7.27	7.27	3.52	090
35372		A	Rechanneling of artery	18.58	NA	NA	8.30	8.35	4.25	090
35390		A	Reoperation carotid add-on	3.19	NA	NA	1.11	1.13	0.73	ZZZ
35400		A	Angioscopy	3.00	NA	NA	1.01	1.06	0.68	ZZZ
35450		A	Repair arterial blockage	10.05	NA	NA	3.82	3.93	2.24	000
35452		A	Repair arterial blockage	6.90	NA	NA	2.79	2.82	1.58	000
35458		A	Repair arterial blockage	9.48	NA	NA	3.80	3.79	2.13	000
35460		A	Repair venous blockage	6.03	NA	NA	2.54	2.48	1.32	000
35471		A	Repair arterial blockage	10.05	61.23	75.23	3.99	4.80	1.98	000
35472		A	Repair arterial blockage	6.90	47.73	54.85	2.80	3.11	1.44	000
35475		R	Repair arterial blockage	9.48	54.18	57.58	3.77	4.09	1.52	000
35476		A	Repair venous blockage	6.03	42.38	44.97	2.52	2.71	0.83	000
35500		A	Harvest vein for bypass	6.44	NA	NA	2.22	2.22	1.49	ZZZ
35501		A	Artery bypass graft	29.09	NA	NA	14.28	13.94	6.68	090
35506		A	Artery bypass graft	25.33	NA	NA	10.73	11.04	6.00	090
35508		A	Artery bypass graft	26.09	NA	NA	12.33	12.16	6.50	090
35509		A	Artery bypass graft	28.09	NA	NA	12.03	12.47	6.65	090
3550F		I	Low rsk thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35510		A	Artery bypass graft	24.39	NA	NA	8.96	9.86	5.77	090
35511		A	Artery bypass graft	22.20	NA	NA	12.98	11.67	5.27	090
35512		A	Artery bypass graft	23.89	NA	NA	8.81	9.57	5.66	090
35515		A	Artery bypass graft	26.09	NA	NA	9.97	10.17	6.18	090
35516		A	Artery bypass graft	24.21	NA	NA	8.86	9.07	5.73	090
35518		A	Artery bypass graft	22.65	NA	NA	8.30	9.33	5.36	090
3551F		I	Intrmed rsk thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35521		A	Artery bypass graft	24.13	NA	NA	13.70	12.21	5.72	090
35522		A	Artery bypass graft	23.15	NA	NA	10.18	10.25	5.47	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
35523		A	Artery bypass graft	24.13	NA	NA	10.87	11.19	5.47	090
35525		A	Artery bypass graft	21.69	NA	NA	9.80	9.71	4.82	090
35526		A	Artery bypass graft	31.55	NA	NA	11.39	12.81	7.88	090
3552F		I	Hgh risk for thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35531		A	Artery bypass graft	39.11	NA	NA	16.23	16.14	8.89	090
35533		A	Artery bypass graft	29.92	NA	NA	16.23	14.66	7.09	090
35535		A	Artery bypass graft	38.13	NA	NA	13.36	15.00	2.70	090
35536		A	Artery bypass graft	33.73	NA	NA	12.01	12.85	8.00	090
35537		A	Artery bypass graft	41.88	NA	NA	21.58	19.29	9.91	090
35538		A	Artery bypass graft	47.03	NA	NA	23.88	21.52	11.14	090
35539		A	Artery bypass graft	44.11	NA	NA	15.18	16.03	10.46	090
35540		A	Artery bypass graft	49.33	NA	NA	20.98	20.01	11.33	090
35548		A	Artery bypass graft	22.68	NA	NA	8.70	9.51	5.38	090
35549		A	Artery bypass graft	24.45	NA	NA	16.12	13.81	5.20	090
35551		A	Artery bypass graft	27.83	NA	NA	15.30	14.19	5.93	090
35556		A	Artery bypass graft	26.75	NA	NA	11.67	11.51	6.12	090
35558		A	Artery bypass graft	23.13	NA	NA	10.84	10.70	5.32	090
3555F		I	Pt inr measurement performed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35560		A	Artery bypass graft	34.03	NA	NA	12.09	13.27	8.07	090
35563		A	Artery bypass graft	26.12	NA	NA	9.74	10.46	6.18	090
35565		A	Artery bypass graft	25.13	NA	NA	11.05	11.11	5.73	090
35566		A	Artery bypass graft	32.35	NA	NA	13.52	13.35	7.48	090
35570		A	Artery bypass graft	29.15	NA	NA	10.78	12.10	2.06	090
35571		A	Artery bypass graft	25.52	NA	NA	10.97	11.09	5.88	090
35572		A	Harvest femoropopliteal vein	6.81	NA	NA	2.48	2.55	1.59	ZZZ
35583		A	Vein bypass graft	27.75	NA	NA	12.03	11.81	6.34	090
35585		A	Vein bypass graft	32.35	NA	NA	13.82	13.64	7.39	090
35587		A	Vein bypass graft	26.21	NA	NA	11.71	11.71	6.03	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
35600		A	Harvest art for cabg add-on	4.94	NA	NA	1.85	1.93	1.20	ZZZ
35601		A	Artery bypass graft	27.09	NA	NA	13.27	12.83	6.33	090
35606		A	Artery bypass graft	22.46	NA	NA	9.63	9.74	5.24	090
35612		A	Artery bypass graft	16.82	NA	NA	6.95	7.82	3.99	090
35616		A	Artery bypass graft	21.82	NA	NA	12.05	10.71	4.64	090
35621		A	Artery bypass graft	21.03	NA	NA	9.11	9.17	4.86	090
35623		A	Bypass graft not vein	25.92	NA	NA	14.48	12.93	6.12	090
35626		A	Artery bypass graft	29.14	NA	NA	12.90	13.25	6.97	090
35631		A	Artery bypass graft	36.03	NA	NA	14.15	14.35	8.41	090
35632		A	Artery bypass graft	36.13	NA	NA	12.77	14.33	2.57	090
35633		A	Artery bypass graft	39.11	NA	NA	15.07	16.05	2.77	090
35634		A	Artery bypass graft	35.33	NA	NA	13.58	14.60	2.50	090
35636		A	Artery bypass graft	31.75	NA	NA	17.03	15.29	7.52	090
35637		A	Artery bypass graft	33.05	NA	NA	14.03	13.78	7.63	090
35638		A	Artery bypass graft	33.60	NA	NA	14.49	14.27	7.81	090
35642		A	Artery bypass graft	18.94	NA	NA	11.94	10.93	4.48	090
35645		A	Artery bypass graft	18.43	NA	NA	10.91	9.72	4.60	090
35646		A	Artery bypass graft	32.98	NA	NA	13.93	14.04	7.58	090
35647		A	Artery bypass graft	29.73	NA	NA	12.96	12.96	6.89	090
35650		A	Artery bypass graft	20.16	NA	NA	9.29	9.20	4.59	090
35651		A	Artery bypass graft	26.08	NA	NA	9.72	10.81	5.57	090
35654		A	Artery bypass graft	26.28	NA	NA	11.35	11.38	6.06	090
35656		A	Artery bypass graft	20.47	NA	NA	9.27	9.27	4.70	090
35661		A	Artery bypass graft	20.35	NA	NA	9.51	9.55	4.69	090
35663		A	Artery bypass graft	23.93	NA	NA	10.28	10.49	5.46	090
35665		A	Artery bypass graft	22.35	NA	NA	9.86	9.95	5.11	090
35666		A	Artery bypass graft	23.66	NA	NA	11.29	11.36	5.43	090
35671		A	Artery bypass graft	20.77	NA	NA	10.00	10.10	4.77	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
35681		A	Composite bypass graft	1.60	NA	NA	0.56	0.56	0.37	ZZZ
35682		A	Composite bypass graft	7.19	NA	NA	2.38	2.42	1.66	ZZZ
35683		A	Composite bypass graft	8.49	NA	NA	2.53	2.71	2.00	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	NA	1.38	1.38	0.92	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	NA	1.13	1.17	0.75	ZZZ
35691		A	Arterial transposition	18.41	NA	NA	7.25	7.97	4.36	090
35693		A	Arterial transposition	15.73	NA	NA	7.04	7.78	3.73	090
35694		A	Arterial transposition	19.28	NA	NA	8.56	8.62	4.56	090
35695		A	Arterial transposition	20.06	NA	NA	7.75	8.42	4.75	090
35697		A	Reimplant artery each	3.00	NA	NA	1.02	1.04	0.69	ZZZ
35700		A	Reoperation bypass graft	3.08	NA	NA	1.07	1.08	0.71	ZZZ
35701		A	Exploration carotid artery	9.19	NA	NA	6.57	6.18	1.79	090
35721		A	Exploration femoral artery	7.72	NA	NA	4.74	4.84	1.74	090
3572F		I	Pt consid poss risk fx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3573F		I	Pt not consid poss risk fx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35741		A	Exploration popliteal artery	8.69	NA	NA	5.32	5.23	1.93	090
35761		A	Exploration of artery/vein	5.93	NA	NA	4.83	4.67	1.29	090
35800		A	Explore neck vessels	8.07	NA	NA	5.59	5.40	1.70	090
35820		A	Explore chest vessels	36.89	NA	NA	16.03	15.52	8.81	090
35840		A	Explore abdominal vessels	10.96	NA	NA	6.77	6.49	2.35	090
35860		A	Explore limb vessels	6.80	NA	NA	4.44	4.45	1.55	090
35870		A	Repair vessel graft defect	24.50	NA	NA	13.85	12.32	5.80	090
35875		A	Removal of clot in graft	10.72	NA	NA	5.73	5.71	2.43	090
35876		A	Removal of clot in graft	17.82	NA	NA	8.14	8.12	4.07	090
35879		A	Revise graft w/vein	17.41	NA	NA	8.07	8.08	4.01	090
35881		A	Revise graft w/vein	19.35	NA	NA	8.69	8.82	4.48	090
35883		A	Revise graft w/nonauto graft	23.15	NA	NA	10.03	9.75	5.32	090
35884		A	Revise graft w/vein	24.65	NA	NA	8.97	9.30	5.83	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
35901		A	Excision graft neck	8.38	NA	NA	5.61	5.62	1.90	090
35903		A	Excision graft extremity	9.53	NA	NA	6.17	6.20	2.15	090
35905		A	Excision graft thorax	33.52	NA	NA	11.94	12.98	7.94	090
35907		A	Excision graft abdomen	37.27	NA	NA	15.24	15.13	8.57	090
36000		A	Place needle in vein	0.18	0.49	0.54	0.08	0.08	0.03	XXX
36002		A	Pseudoaneurysm injection trt	1.96	2.45	2.71	0.95	1.04	0.30	000
36005		A	Injection ext venography	0.95	8.58	9.23	0.35	0.40	0.14	000
36010		A	Place catheter in vein	2.43	12.00	13.98	0.88	0.96	0.35	XXX
36011		A	Place catheter in vein	3.14	21.61	23.92	1.18	1.25	0.43	XXX
36012		A	Place catheter in vein	3.51	21.25	22.64	1.30	1.45	0.52	XXX
36013		A	Place catheter in artery	2.52	19.58	21.31	0.95	1.01	0.45	XXX
36014		A	Place catheter in artery	3.02	20.58	22.10	1.12	1.28	0.33	XXX
36015		A	Place catheter in artery	3.51	21.91	23.78	1.30	1.47	0.37	XXX
36100		A	Establish access to artery	3.02	10.84	12.19	1.14	1.29	0.67	XXX
36120		A	Establish access to artery	2.01	10.43	11.15	0.72	0.76	0.33	XXX
36140		A	Establish access to artery	2.01	10.65	12.00	0.73	0.81	0.39	XXX
36147		A	Access av dial grft for eval	3.72	20.20	20.20	1.43	1.43	0.50	XXX
36148		A	Access av dial grft for proc	1.00	6.57	6.57	0.37	0.37	0.12	ZZZ
36160		A	Establish access to aorta	2.52	11.15	12.70	0.90	1.06	0.38	XXX
36200		A	Place catheter in aorta	3.02	14.31	15.87	1.07	1.18	0.60	XXX
36215		A	Place catheter in artery	4.67	26.62	29.12	1.81	2.06	0.81	XXX
36216		A	Place catheter in artery	5.27	29.41	31.88	2.09	2.34	0.92	XXX
36217		A	Place catheter in artery	6.29	50.83	54.84	2.54	2.80	1.06	XXX
36218		A	Place catheter in artery	1.01	4.18	4.59	0.41	0.44	0.16	ZZZ
36245		A	Place catheter in artery	4.67	26.55	30.98	1.79	2.15	0.87	XXX
36246		A	Place catheter in artery	5.27	27.34	30.63	1.93	2.22	0.98	XXX
36247		A	Place catheter in artery	6.29	45.26	50.53	2.29	2.62	1.18	XXX
36248		A	Place catheter in artery	1.01	3.21	3.66	0.36	0.42	0.16	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
36260		A	Insertion of infusion pump	9.91	NA	NA	7.20	6.55	2.12	090
36261		A	Revision of infusion pump	5.63	NA	NA	5.01	4.61	1.33	090
36262		A	Removal of infusion pump	4.11	NA	NA	4.07	3.74	0.87	090
36299		C	Vessel injection procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
36400		A	Bl draw < 3 yrs fem/jugular	0.38	0.52	0.43	0.08	0.09	0.05	XXX
36405		A	Bl draw < 3 yrs scalp vein	0.31	0.35	0.36	0.13	0.12	0.05	XXX
36406		A	Bl draw < 3 yrs other vein	0.18	0.28	0.30	0.07	0.07	0.03	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.27	0.33	0.08	0.07	0.03	XXX
36415		X	Routine venipuncture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36416		B	Capillary blood draw	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36420		A	Vein access cutdown < 1 yr	1.01	NA	NA	0.24	0.27	0.12	XXX
36425		A	Vein access cutdown > 1 yr	0.76	NA	NA	0.34	0.31	0.11	XXX
36430		A	Blood transfusion service	0.00	0.90	1.03	NA	NA	0.01	XXX
36440		A	Bl push transfuse 2 yr or <	1.03	NA	NA	0.50	0.43	0.24	XXX
36450		A	Bl exchange/transfuse nb	2.23	NA	NA	1.09	1.04	0.11	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	NA	0.85	0.99	0.14	XXX
36460		A	Transfusion service fetal	6.58	NA	NA	3.07	2.72	1.40	XXX
36468		R	Injection(s) spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36469		R	Injection(s) spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36470		A	Injection therapy of vein	1.10	2.92	2.95	0.85	0.83	0.22	010
36471		A	Injection therapy of veins	1.65	3.23	3.28	1.10	1.08	0.33	010
36475		A	Endovenous rf 1st vein	6.72	43.94	46.52	2.78	2.74	1.41	000
36476		A	Endovenous rf vein add-on	3.38	7.60	7.83	1.24	1.22	0.72	ZZZ
36478		A	Endovenous laser 1st vein	6.72	31.43	35.16	2.73	2.77	1.32	000
36479		A	Endovenous laser vein addon	3.38	7.81	8.25	1.29	1.26	0.65	ZZZ
36481		A	Insertion of catheter vein	6.98	53.67	29.60	3.01	3.01	0.88	000
36500		A	Insertion of catheter vein	3.51	NA	NA	1.36	1.49	0.53	000
3650F		I	Eeg ordered rvwd reqstd	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
36510		A	Insertion of catheter vein	1.09	1.52	1.82	0.53	0.50	0.24	000
36511		A	Apheresis wbc	1.74	NA	NA	0.89	0.83	0.27	000
36512		A	Apheresis rbc	1.74	NA	NA	0.88	0.84	0.16	000
36513		A	Apheresis platelets	1.74	NA	NA	0.98	0.91	0.34	000
36514		A	Apheresis plasma	1.74	12.18	13.39	0.80	0.77	0.27	000
36515		A	Apheresis adsorp/reinfuse	1.74	50.32	55.40	0.88	0.78	0.24	000
36516		A	Apheresis selective	1.22	54.37	61.86	0.56	0.53	0.35	000
36522		A	Photopheresis	1.67	34.95	38.52	1.20	1.20	0.16	000
36555		A	Insert non-tunnel cv cath	2.68	4.68	5.09	0.67	0.74	0.22	000
36556		A	Insert non-tunnel cv cath	2.50	3.93	4.14	0.85	0.81	0.31	000
36557		A	Insert tunneled cv cath	5.14	22.72	21.68	3.60	3.38	1.09	010
36558		A	Insert tunneled cv cath	4.84	16.89	18.46	2.81	2.95	0.72	010
36560		A	Insert tunneled cv cath	6.29	32.00	30.73	4.11	3.83	0.58	010
36561		A	Insert tunneled cv cath	6.04	26.85	28.07	3.60	3.54	1.10	010
36563		A	Insert tunneled cv cath	6.24	30.48	29.88	3.88	3.66	1.30	010
36565		A	Insert tunneled cv cath	6.04	21.59	22.57	3.35	3.32	1.29	010
36566		A	Insert tunneled cv cath	6.54	141.04	125.28	3.72	3.59	1.26	010
36568		A	Insert picc cath	1.92	5.88	6.76	0.75	0.77	0.18	000
36569		A	Insert picc cath	1.82	4.97	5.68	0.74	0.79	0.18	000
36570		A	Insert picvad cath	5.36	24.28	27.68	3.00	3.22	0.49	010
36571		A	Insert picvad cath	5.34	30.41	31.51	3.35	3.26	1.02	010
36575		A	Repair tunneled cv cath	0.67	3.86	4.06	0.30	0.30	0.10	000
36576		A	Repair tunneled cv cath	3.24	7.14	7.35	2.06	2.06	0.56	010
36578		A	Replace tunneled cv cath	3.54	10.52	11.18	2.38	2.48	0.53	010
36580		A	Replace cvad cath	1.31	4.59	5.18	0.54	0.55	0.16	000
36581		A	Replace tunneled cv cath	3.48	17.59	18.90	1.97	2.13	0.43	010
36582		A	Replace tunneled cv cath	5.24	25.57	26.68	3.12	3.18	0.88	010
36583		A	Replace tunneled cv cath	5.29	32.42	30.14	3.68	3.44	1.14	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
36584		A	Replace picc cath	1.20	4.36	5.08	0.66	0.72	0.11	000
36585		A	Replace picvad cath	4.84	25.72	27.46	2.87	3.01	0.67	010
36589		A	Removal tunneled cv cath	2.28	2.28	2.36	1.55	1.58	0.37	010
36590		A	Removal tunneled cv cath	3.35	4.67	4.54	2.22	2.15	0.62	010
36591		T	Draw blood off venous device	0.00	0.61	0.67	NA	NA	0.01	XXX
36592		T	Collect blood from picc	0.00	0.69	0.75	NA	NA	0.01	XXX
36593		A	Declot vascular device	0.00	0.82	0.85	NA	NA	0.01	XXX
36595		A	Mech remov tunneled cv cath	3.59	11.92	13.58	1.53	1.69	0.39	000
36596		A	Mech remov tunneled cv cath	0.75	2.89	3.19	0.48	0.52	0.10	000
36597		A	Reposition venous catheter	1.21	2.21	2.42	0.49	0.54	0.11	000
36598		T	Inj w/fluor eval cv device	0.74	2.32	2.56	0.27	0.67	0.07	000
36600		A	Withdrawal of arterial blood	0.32	0.53	0.56	0.11	0.11	0.03	XXX
36620		A	Insertion catheter artery	1.15	NA	NA	0.29	0.25	0.10	000
36625		A	Insertion catheter artery	2.11	NA	NA	0.71	0.70	0.42	000
36640		A	Insertion catheter artery	2.10	NA	NA	1.40	1.29	0.42	000
36660		A	Insertion catheter artery	1.40	NA	NA	0.68	0.54	0.34	000
36680		A	Insert needle bone cavity	1.20	NA	NA	0.35	0.37	0.22	000
36800		A	Insertion of cannula	2.43	NA	NA	2.02	2.01	0.42	000
36810		A	Insertion of cannula	3.96	NA	NA	1.80	1.75	0.73	000
36815		A	Insertion of cannula	2.62	NA	NA	1.46	1.43	0.56	000
36818		A	Av fuse uppr arm cephalic	11.89	NA	NA	6.37	6.28	2.65	090
36819		A	Av fuse uppr arm basilic	14.47	NA	NA	7.23	7.08	3.25	090
36820		A	Av fusion/forearm vein	14.47	NA	NA	7.52	7.27	3.23	090
36821		A	Av fusion direct any site	12.11	NA	NA	6.79	6.45	2.70	090
36822		A	Insertion of cannula(s)	5.57	NA	NA	4.71	4.81	1.29	090
36823		A	Insertion of cannula(s)	22.98	NA	NA	12.46	11.96	5.00	090
36825		A	Artery-vein autograft	15.13	NA	NA	7.83	6.73	3.37	090
36830		A	Artery-vein nonautograft	12.03	NA	NA	5.80	5.70	2.70	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
36831		A	Open thrombect av fistula	8.04	NA	NA	4.45	4.36	1.79	090
36832		A	Av fistula revision open	10.53	NA	NA	5.28	5.17	2.34	090
36833		A	Av fistula revision	11.98	NA	NA	5.85	5.72	2.69	090
36835		A	Artery to vein shunt	7.51	NA	NA	5.94	5.53	1.78	090
36838		A	Dist revas ligation hemo	21.69	NA	NA	9.47	9.55	4.93	090
36860		A	External cannula declotting	2.01	3.80	3.73	1.05	0.94	0.26	000
36861		A	Cannula declotting	2.52	NA	NA	1.62	1.63	0.48	000
36870		A	Percut thrombect av fistula	5.20	46.44	49.97	3.12	3.36	0.68	090
3700F		I	Psych disorders assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
37140		A	Revision of circulation	25.23	NA	NA	14.17	12.93	5.36	090
37145		A	Revision of circulation	26.24	NA	NA	14.51	13.73	5.70	090
37160		A	Revision of circulation	23.24	NA	NA	13.30	12.04	4.96	090
37180		A	Revision of circulation	26.24	NA	NA	14.61	13.12	5.59	090
37181		A	Splice spleen/kidney veins	28.37	NA	NA	15.54	14.14	6.03	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	NA	6.34	7.34	1.62	000
37183		A	Remove hepatic shunt (tips)	7.99	152.24	152.24	3.01	3.53	0.73	000
37184		A	Prim art mech thrombectomy	8.66	54.65	61.25	3.56	3.91	1.51	000
37185		A	Prim art m-thrombect add-on	3.28	17.49	19.69	1.20	1.32	0.61	ZZZ
37186		A	Sec art m-thrombect add-on	4.92	34.36	40.61	1.81	2.09	0.95	ZZZ
37187		A	Venous mech thrombectomy	8.03	52.29	58.83	3.19	3.58	1.13	000
37188		A	Venous m-thrombectomy add-on	5.71	44.92	50.94	2.39	2.70	0.69	000
37195		C	Thrombolytic therapy stroke	0.00	0.00	0.00	0.00	0.00	0.00	XXX
37200		A	Transcatheter biopsy	4.55	NA	NA	1.64	1.90	0.42	000
37201		A	Transcatheter therapy infuse	4.99	NA	NA	2.49	2.76	0.76	000
37202		A	Transcatheter therapy infuse	5.67	NA	NA	2.97	3.50	1.18	000
37203		A	Transcatheter retrieval	5.02	31.63	34.51	2.08	2.37	0.68	000
37204		A	Transcatheter occlusion	18.11	NA	NA	6.52	7.35	2.21	000
37205		A	Transcath iv stent percut	8.27	108.43	118.66	3.05	3.64	1.56	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
37206		A	Transcath iv stent/perc addl	4.12	65.91	72.34	1.49	1.71	0.81	ZZZ
37207		A	Transcath iv stent open	8.27	NA	NA	3.23	3.27	1.86	000
37208		A	Transcath iv stent/open addl	4.12	NA	NA	1.42	1.43	0.92	ZZZ
37209		A	Change iv cath at thromb tx	2.27	NA	NA	0.80	0.90	0.33	000
3720F		I	Cognit impairment assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
37210		A	Embolization uterine fibroid	10.60	88.63	95.23	4.00	4.68	1.02	000
37215		R	Transcath stent cca w/eps	19.68	NA	NA	8.94	10.51	4.18	090
37216		N	Transcath stent cca w/o eps	18.95	NA	NA	10.10	10.04	1.33	090
37220		A	Iliac revasc	8.15	83.88	83.88	3.03	3.03	1.67	000
37221		A	Iliac revasc w/stent	10.00	126.56	126.56	3.75	3.75	1.89	000
37222		A	Iliac revasc add-on	3.73	22.52	22.52	1.34	1.34	0.76	ZZZ
37223		A	Iliac revasc w/stent add-on	4.25	132.39	132.39	1.53	1.53	0.84	ZZZ
37224		A	Fem/popl revas w/tla	9.00	101.76	101.76	3.34	3.34	1.81	000
37225		A	Fem/popl revas w/ather	12.00	303.34	303.34	4.55	4.55	2.51	000
37226		A	Fem/popl revasc w/stent	10.49	254.28	254.28	3.93	3.93	1.29	000
37227		A	Fem/popl revasc stnt & ather	14.50	412.19	412.19	5.48	5.48	3.04	000
37228		A	Tib/per revasc w/tla	11.00	146.98	146.98	4.04	4.04	2.25	000
37229		A	Tib/per revasc w/ather	14.05	298.12	298.12	5.30	5.30	2.97	000
37230		A	Tib/per revasc w/stent	13.80	231.18	231.18	5.13	5.13	2.61	000
37231		A	Tib/per revasc stent & ather	15.00	379.46	379.46	5.57	5.57	2.84	000
37232		A	Tib/per revasc add-on	4.00	31.17	31.17	1.43	1.43	0.81	ZZZ
37233		A	Tibper revasc w/ather add-on	6.50	36.11	36.11	2.41	2.41	1.37	ZZZ
37234		A	Revsc opn/prq tib/pero stent	5.50	108.02	108.02	1.98	1.98	1.09	ZZZ
37235		A	Tib/per revasc stnt & ather	7.80	113.10	113.10	2.81	2.81	1.55	ZZZ
37250		A	Iv us first vessel add-on	2.10	NA	NA	0.74	0.85	0.45	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	NA	0.53	0.58	0.35	ZZZ
37500		A	Endoscopy ligate perf veins	11.67	NA	NA	7.15	7.18	2.62	090
37501		C	Vascular endoscopy procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
37565		A	Ligation of neck vein	12.05	NA	NA	7.67	7.19	2.57	090
37600		A	Ligation of neck artery	12.42	NA	NA	7.14	6.91	2.54	090
37605		A	Ligation of neck artery	14.28	NA	NA	7.54	7.39	3.38	090
37606		A	Ligation of neck artery	8.81	NA	NA	4.33	4.88	1.87	090
37607		A	Ligation of a-v fistula	6.25	NA	NA	4.10	4.03	1.37	090
37609		A	Temporal artery procedure	3.05	5.62	5.44	2.67	2.50	0.64	010
37615		A	Ligation of neck artery	7.80	NA	NA	6.99	6.09	1.64	090
37616		A	Ligation of chest artery	18.97	NA	NA	10.40	10.30	4.05	090
37617		A	Ligation of abdomen artery	23.79	NA	NA	11.75	11.10	5.01	090
37618		A	Ligation of extremity artery	6.03	NA	NA	4.52	4.40	1.32	090
37620		A	Revision of major vein	11.57	NA	NA	6.01	6.55	1.70	090
37650		A	Revision of major vein	8.49	NA	NA	4.08	4.74	1.87	090
37660		A	Revision of major vein	22.28	NA	NA	12.25	11.15	4.74	090
37700		A	Revise leg vein	3.82	NA	NA	3.16	3.13	0.84	090
37718		A	Ligate/strip short leg vein	7.13	NA	NA	4.86	4.75	1.56	090
37722		A	Ligate/strip long leg vein	8.16	NA	NA	5.13	5.00	1.81	090
37735		A	Removal of leg veins/lesion	10.90	NA	NA	6.16	6.14	2.39	090
37760		A	Ligate leg veins radical	10.78	NA	NA	7.47	6.74	2.28	090
37761		A	Ligate leg veins open	9.13	NA	NA	6.21	6.21	1.96	090
37765		A	Stab phleb veins xtr 10-20	7.71	10.69	10.69	4.68	4.75	1.56	090
37766		A	Phleb veins - extrem 20+	9.66	12.11	12.11	5.44	5.51	2.01	090
37780		A	Revision of leg vein	3.93	NA	NA	3.25	3.24	0.86	090
37785		A	Ligate/divide/excise vein	3.93	5.98	6.04	3.27	3.25	0.86	090
37788		A	Revascularization penis	23.33	NA	NA	12.86	13.74	4.97	090
37790		A	Penile venous occlusion	8.43	NA	NA	5.02	5.28	0.81	090
37799		C	Vascular surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38100		A	Removal of spleen total	19.55	NA	NA	10.78	9.67	4.07	090
38101		A	Removal of spleen partial	19.55	NA	NA	11.07	9.85	4.16	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
38102		A	Removal of spleen total	4.79	NA	NA	2.09	1.91	0.99	ZZZ
38115		A	Repair of ruptured spleen	21.88	NA	NA	11.83	10.60	4.28	090
38120		A	Laparoscopy splenectomy	17.07	NA	NA	10.74	9.82	3.60	090
38129		C	Laparoscope proc spleen	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38200		A	Injection for spleen x-ray	2.64	NA	NA	1.15	1.18	0.62	000
38204		B	Bl donor search management	2.00	NA	NA	0.88	0.85	0.14	XXX
38205		R	Harvest allogenic stem cells	1.50	NA	NA	0.81	0.77	0.08	000
38206		R	Harvest auto stem cells	1.50	NA	NA	0.82	0.78	0.11	000
38207		I	Cryopreserve stem cells	0.89	NA	NA	0.39	0.47	0.05	XXX
38208		I	Thaw preserved stem cells	0.56	NA	NA	0.25	0.29	0.04	XXX
38209		I	Wash harvest stem cells	0.24	NA	NA	0.11	0.13	0.01	XXX
38210		I	T-cell depletion of harvest	1.57	NA	NA	0.69	0.82	0.10	XXX
38211		I	Tumor cell deplete of harvst	1.42	NA	NA	0.63	0.75	0.10	XXX
38212		I	Rbc depletion of harvest	0.94	NA	NA	0.41	0.49	0.05	XXX
38213		I	Platelet deplete of harvest	0.24	NA	NA	0.11	0.13	0.01	XXX
38214		I	Volume deplete of harvest	0.81	NA	NA	0.36	0.42	0.05	XXX
38215		I	Harvest stem cell concentrte	0.94	NA	NA	0.41	0.49	0.05	XXX
38220		A	Bone marrow aspiration	1.08	2.94	3.28	0.63	0.62	0.11	XXX
38221		A	Bone marrow biopsy	1.37	2.96	3.37	0.79	0.78	0.08	XXX
38230		R	Bone marrow collection	4.85	NA	NA	4.45	4.17	1.10	010
38240		R	Bone marrow/stem transplant	2.24	NA	NA	1.35	1.30	0.16	XXX
38241		R	Bone marrow/stem transplant	2.24	NA	NA	1.34	1.30	0.14	XXX
38242		A	Lymphocyte infuse transplant	1.71	NA	NA	1.06	1.00	0.10	000
38300		A	Drainage lymph node lesion	2.36	5.30	5.26	2.70	2.62	0.41	010
38305		A	Drainage lymph node lesion	6.68	NA	NA	5.71	5.49	1.33	090
38308		A	Incision of lymph channels	6.81	NA	NA	5.17	4.83	1.45	090
38380		A	Thoracic duct procedure	8.46	NA	NA	8.09	7.30	1.09	090
38381		A	Thoracic duct procedure	13.38	NA	NA	7.66	7.80	3.14	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
38382		A	Thoracic duct procedure	10.65	NA	NA	7.08	6.96	2.25	090
38500		A	Biopsy/removal lymph nodes	3.79	5.15	4.88	2.98	2.77	0.77	010
38505		A	Needle biopsy lymph nodes	1.14	2.33	2.45	0.84	0.89	0.12	000
38510		A	Biopsy/removal lymph nodes	6.74	7.63	7.19	4.80	4.42	1.21	010
38520		A	Biopsy/removal lymph nodes	7.03	NA	NA	5.53	5.19	1.41	090
38525		A	Biopsy/removal lymph nodes	6.43	NA	NA	5.13	4.71	1.36	090
38530		A	Biopsy/removal lymph nodes	8.34	NA	NA	6.27	5.80	1.82	090
38542		A	Explore deep node(s) neck	7.95	NA	NA	6.52	6.03	1.33	090
38550		A	Removal neck/armpit lesion	7.11	NA	NA	6.39	5.80	1.52	090
38555		A	Removal neck/armpit lesion	15.59	NA	NA	11.12	10.46	3.34	090
38562		A	Removal pelvic lymph nodes	11.06	NA	NA	7.67	7.48	1.96	090
38564		A	Removal abdomen lymph nodes	11.38	NA	NA	7.35	6.95	2.24	090
38570		A	Laparoscopy lymph node biop	9.34	NA	NA	5.15	5.17	1.37	010
38571		A	Laparoscopy lymphadenectomy	14.76	NA	NA	7.08	7.81	1.48	010
38572		A	Laparoscopy lymphadenectomy	16.94	NA	NA	8.92	8.46	2.39	010
38589		C	Laparoscope proc lymphatic	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38700		A	Removal of lymph nodes neck	12.81	NA	NA	10.18	9.18	1.77	090
38720		A	Removal of lymph nodes neck	21.95	NA	NA	15.95	14.35	3.38	090
38724		A	Removal of lymph nodes neck	23.95	NA	NA	17.66	15.66	3.34	090
38740		A	Remove armpit lymph nodes	10.70	NA	NA	7.55	6.93	2.25	090
38745		A	Remove armpit lymph nodes	13.87	NA	NA	9.25	8.46	2.95	090
38746		A	Remove thoracic lymph nodes	4.88	NA	NA	1.80	1.86	1.14	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	NA	2.10	1.94	1.03	ZZZ
38760		A	Remove groin lymph nodes	13.62	NA	NA	8.73	8.16	2.78	090
38765		A	Remove groin lymph nodes	21.91	NA	NA	12.34	11.64	4.22	090
38770		A	Remove pelvis lymph nodes	14.06	NA	NA	7.87	8.10	1.77	090
38780		A	Remove abdomen lymph nodes	17.70	NA	NA	10.27	10.36	2.55	090
38790		A	Inject for lymphatic x-ray	1.29	NA	NA	0.96	0.95	0.24	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
38792		A	Identify sentinel node	0.52	NA	NA	0.59	0.59	0.08	000
38794		A	Access thoracic lymph duct	4.62	NA	NA	3.43	3.80	0.42	090
38900		A	Io map of sent lymph node	2.50	1.02	1.02	1.02	1.02	0.53	ZZZ
38999		C	Blood/lymph system procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39000		A	Exploration of chest	7.57	NA	NA	5.80	5.70	1.67	090
39010		A	Exploration of chest	13.19	NA	NA	7.62	7.89	3.12	090
39200		A	Removal chest lesion	15.09	NA	NA	8.03	8.18	3.53	090
39220		A	Removal chest lesion	19.55	NA	NA	10.49	10.61	4.43	090
39400		A	Visualization of chest	8.05	NA	NA	5.34	5.41	1.87	010
39499		C	Chest procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39501		A	Repair diaphragm laceration	13.98	NA	NA	8.48	8.03	2.95	090
39503		A	Repair of diaphragm hernia	108.91	NA	NA	52.18	46.00	23.18	090
39540		A	Repair of diaphragm hernia	14.57	NA	NA	8.44	7.90	3.11	090
39541		A	Repair of diaphragm hernia	15.75	NA	NA	9.23	8.59	3.40	090
39545		A	Revision of diaphragm	14.67	NA	NA	8.78	8.86	3.41	090
39560		A	Resect diaphragm simple	13.06	NA	NA	7.88	7.57	2.78	090
39561		A	Resect diaphragm complex	19.99	NA	NA	13.04	12.44	4.37	090
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4014F		I	Written discharge instr prvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4016F		I	Anti-inflm/anlgsc agent rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4017F		I	Gi prophylaxis for nsaid rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4018F		I	Therapy exercise joint rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4019F		I	Doc recpt counsl vit d/calc+	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4030F		I	Oxygen therapy rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4033F		I	Pulmonary rehab rec	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4035F		I	Influenza imm rec	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40490		A	Biopsy of lip	1.22	2.40	2.41	0.89	0.83	0.18	000
40500		A	Partial excision of lip	4.47	10.04	9.69	5.99	5.68	0.67	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
40510		A	Partial excision of lip	4.82	9.02	8.66	5.40	5.04	0.71	090
40520		A	Partial excision of lip	4.79	9.22	8.96	5.49	5.15	0.75	090
40525		A	Reconstruct lip with flap	7.72	NA	NA	7.99	7.54	1.26	090
40527		A	Reconstruct lip with flap	9.32	NA	NA	8.66	8.39	1.20	090
4052F		I	Hemodialysis via av fistula	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40530		A	Partial removal of lip	5.54	9.90	9.60	6.02	5.69	0.86	090
4053F		I	Hemodialysis via av graft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4054F		I	Hemodialysis via catheter	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4055F		I	Pt rcvng periton dialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4056F		I	Approp oral rehyd recommd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4058F		I	Ped gastro ed given caregvr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4060F		I	Psych svcs provided	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4062F		I	Pt referral psych docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4063F		I	Antidepres rxthxpy not rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4064F		I	Antidepressant rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40650		A	Repair lip	3.78	8.04	7.79	4.33	4.13	0.65	090
40652		A	Repair lip	4.43	9.28	9.06	5.52	5.25	0.76	090
40654		A	Repair lip	5.48	10.62	10.36	6.55	6.24	0.92	090
4065F		I	Antipsychotic rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4066F		I	Ect provided	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4067F		I	Pt referral for ect docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40700		A	Repair cleft lip/nasal	14.17	NA	NA	14.38	12.56	1.82	090
40701		A	Repair cleft lip/nasal	17.23	NA	NA	13.91	13.59	2.20	090
40702		A	Repair cleft lip/nasal	14.27	NA	NA	9.14	9.18	1.02	090
40720		A	Repair cleft lip/nasal	14.72	NA	NA	12.13	11.61	2.91	090
40761		A	Repair cleft lip/nasal	15.84	NA	NA	14.92	13.52	3.12	090
4077F		I	Doc t-pa admin considered	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
40800		A	Drainage of mouth lesion	1.23	4.79	4.61	2.54	2.41	0.18	010
40801		A	Drainage of mouth lesion	2.63	6.39	6.09	3.75	3.52	0.37	010
40804		A	Removal foreign body mouth	1.30	4.95	4.71	2.51	2.39	0.16	010
40805		A	Removal foreign body mouth	2.79	6.57	6.29	3.73	3.53	0.35	010
40806		A	Incision of lip fold	0.31	2.72	2.74	0.52	0.57	0.04	000
40808		A	Biopsy of mouth lesion	1.01	4.41	4.26	2.14	2.05	0.12	010
40810		A	Excision of mouth lesion	1.36	4.63	4.44	2.36	2.23	0.18	010
40812		A	Excise/repair mouth lesion	2.37	5.91	5.63	3.34	3.11	0.31	010
40814		A	Excise/repair mouth lesion	3.52	7.58	7.18	5.31	4.98	0.48	090
40816		A	Excision of mouth lesion	3.77	7.87	7.47	5.42	5.10	0.52	090
40818		A	Excise oral mucosa for graft	2.83	7.27	7.14	4.88	4.82	0.37	090
40819		A	Excise lip or cheek fold	2.51	6.32	6.05	4.28	4.06	0.33	090
40820		A	Treatment of mouth lesion	1.34	6.33	6.23	3.66	3.58	0.18	010
40830		A	Repair mouth laceration	1.82	5.29	5.08	2.72	2.60	0.31	010
40831		A	Repair mouth laceration	2.57	6.95	6.60	3.78	3.63	0.42	010
40840		R	Reconstruction of mouth	9.15	15.74	14.13	9.91	8.74	1.18	090
40842		R	Reconstruction of mouth	9.15	14.12	13.11	9.46	8.31	1.18	090
40843		R	Reconstruction of mouth	12.79	17.26	16.01	10.06	9.12	2.51	090
40844		R	Reconstruction of mouth	16.80	22.39	21.03	16.06	14.41	3.31	090
40845		R	Reconstruction of mouth	19.36	22.64	21.40	15.94	14.84	2.47	090
40899		C	Mouth surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41000		A	Drainage of mouth lesion	1.35	3.33	3.19	1.89	1.78	0.18	010
41005		A	Drainage of mouth lesion	1.31	5.10	5.07	2.41	2.31	0.16	010
41006		A	Drainage of mouth lesion	3.34	7.09	6.76	4.33	3.97	0.42	090
41007		A	Drainage of mouth lesion	3.20	7.14	6.90	3.97	3.78	0.41	090
41008		A	Drainage of mouth lesion	3.46	7.38	6.98	4.32	4.01	0.43	090
41009		A	Drainage of mouth lesion	3.71	7.83	7.39	4.73	4.41	0.48	090
41010		A	Incision of tongue fold	1.11	4.91	4.77	2.10	2.02	0.14	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
41015		A	Drainage of mouth lesion	4.08	8.80	8.10	5.93	5.44	0.52	090
41016		A	Drainage of mouth lesion	4.19	8.43	7.99	5.95	5.55	0.53	090
41017		A	Drainage of mouth lesion	4.19	8.55	8.09	5.98	5.59	0.53	090
41018		A	Drainage of mouth lesion	5.22	9.04	8.60	6.35	5.99	0.67	090
41019		A	Place needles h&n for rt	8.84	NA	NA	4.28	4.31	0.72	000
41100		A	Biopsy of tongue	1.42	3.46	3.33	1.71	1.63	0.20	010
41105		A	Biopsy of tongue	1.47	3.48	3.33	1.78	1.66	0.20	010
41108		A	Biopsy of floor of mouth	1.10	3.21	3.08	1.54	1.45	0.14	010
41110		A	Excision of tongue lesion	1.56	4.65	4.45	2.29	2.16	0.22	010
41112		A	Excision of tongue lesion	2.83	6.86	6.54	4.53	4.27	0.37	090
41113		A	Excision of tongue lesion	3.29	7.27	6.91	4.84	4.54	0.42	090
41114		A	Excision of tongue lesion	8.82	NA	NA	9.65	8.94	1.17	090
41115		A	Excision of tongue fold	1.79	5.28	5.12	2.61	2.42	0.23	010
41116		A	Excision of mouth lesion	2.52	7.11	6.77	3.89	3.68	0.34	090
41120		A	Partial removal of tongue	11.14	NA	NA	19.34	18.69	1.48	090
41130		A	Partial removal of tongue	15.74	NA	NA	22.06	20.92	2.08	090
41135		A	Tongue and neck surgery	30.14	NA	NA	32.02	29.90	4.03	090
41140		A	Removal of tongue	29.15	NA	NA	34.19	32.40	3.75	090
41145		A	Tongue removal neck surgery	37.93	NA	NA	42.14	39.43	4.86	090
41150		A	Tongue mouth jaw surgery	29.86	NA	NA	33.20	31.27	3.95	090
41153		A	Tongue mouth neck surgery	33.59	NA	NA	35.13	32.74	4.40	090
41155		A	Tongue jaw & neck surgery	44.30	NA	NA	41.68	38.17	5.91	090
41250		A	Repair tongue laceration	1.96	5.23	4.76	2.26	2.04	0.33	010
41251		A	Repair tongue laceration	2.32	5.46	4.75	2.53	2.29	0.30	010
41252		A	Repair tongue laceration	3.02	5.99	5.65	3.01	2.81	0.48	010
4133F		I	Antihist/decong rx/recom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4134F		I	No antihist/decong rx/recom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4135F		I	Systemic corticosteroids rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
4136F		I	Syst corticosteroids not rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41500		A	Fixation of tongue	3.80	NA	NA	9.40	9.08	0.49	090
41510		A	Tongue to lip surgery	3.51	NA	NA	6.61	7.33	0.43	090
41512		A	Tongue suspension	6.86	NA	NA	11.76	11.09	0.49	090
41520		A	Reconstruction tongue fold	2.83	7.28	6.98	4.59	4.35	0.35	090
41530		A	Tongue base vol reduction	4.51	91.00	90.45	7.62	7.24	0.31	010
4155F		I	Hep a vac series prev recvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4157F		I	Hep b vac series prev recvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41599		C	Tongue and mouth surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4163F		I	Pt couns 4 txmnt opt prost	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4167F		I	Hd bed tilted 1st day vent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4168F		I	Pt care icu&vent w/in 24hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4169F		I	No pt care icu/vent in 24hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4174F		I	Couns potent glauc impct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4176F		I	Talk re uv light pt/crgvr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4178F		I	Antid glbln rcvd w/in 26wks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41800		A	Drainage of gum lesion	1.27	6.19	5.69	2.81	2.57	0.22	010
41805		A	Removal foreign body gum	1.34	5.73	5.51	3.58	3.44	0.18	010
41806		A	Removal foreign body jawbone	2.79	7.70	7.12	4.80	4.45	0.54	010
4181F		I	Conformal radn thxpy rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41820		R	Excision gum each quadrant	0.00	0.00	0.00	0.00	0.00	0.00	000
41821		R	Excision of gum flap	0.00	0.00	0.00	0.00	0.00	0.00	000
41822		R	Excision of gum lesion	2.41	5.93	5.67	2.89	2.56	0.31	010
41823		R	Excision of gum lesion	3.77	8.51	8.20	5.59	5.23	0.48	090
41825		A	Excision of gum lesion	1.41	4.64	4.49	2.11	2.09	0.20	010
41826		A	Excision of gum lesion	2.41	6.59	6.03	3.73	3.40	0.31	010
41827		A	Excision of gum lesion	3.83	8.79	8.34	5.08	4.71	0.49	090
41828		R	Excision of gum lesion	3.14	5.66	5.29	3.04	2.76	0.39	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
4182F		I	No conformal radn thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41830		R	Removal of gum tissue	3.45	7.82	7.41	4.76	4.38	0.43	010
41850		R	Treatment of gum lesion	0.00	0.00	0.00	0.00	0.00	0.00	000
4185F		I	Continuous ppi or h2ra rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4186F		I	No cont ppi or h2ra rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41870		R	Gum graft	0.00	0.00	0.00	0.00	0.00	0.00	000
41872		R	Repair gum	3.01	7.40	7.19	4.52	4.32	0.60	090
41874		R	Repair tooth socket	3.19	7.50	7.13	4.19	3.88	0.39	090
4188F		I	Approp ace/arb tstng done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
41899		C	Dental surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4189F		I	Approp digoxin tstng done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4190F		I	Approp diuretic tstng done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4191F		I	Approp anticonvuls tstng	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42000		A	Drainage mouth roof lesion	1.28	3.26	3.17	1.76	1.64	0.16	010
42100		A	Biopsy roof of mouth	1.36	2.99	2.86	1.82	1.71	0.18	010
42104		A	Excision lesion mouth roof	1.69	4.60	4.33	2.37	2.20	0.23	010
42106		A	Excision lesion mouth roof	2.15	5.73	5.42	3.02	2.86	0.29	010
42107		A	Excision lesion mouth roof	4.56	8.78	8.32	5.48	5.11	0.58	090
4210F		I	Ace/arb thxpy for >= 6 mons	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42120		A	Remove palate/lesion	11.86	NA	NA	17.06	16.05	1.56	090
42140		A	Excision of uvula	1.70	5.78	5.55	2.86	2.73	0.23	090
42145		A	Repair palate pharynx/uvula	9.78	NA	NA	10.79	10.05	1.25	090
42160		A	Treatment mouth roof lesion	1.85	4.93	4.88	2.44	2.38	0.24	010
42180		A	Repair palate	2.55	4.01	4.02	2.39	2.40	0.33	010
42182		A	Repair palate	3.87	5.51	5.23	3.61	3.43	0.49	010
42200		A	Reconstruct cleft palate	12.53	NA	NA	12.28	11.72	1.60	090
42205		A	Reconstruct cleft palate	13.66	NA	NA	14.46	12.89	1.77	090
4220F		I	Digoxin thxpy for >= 6 mons	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
42210		A	Reconstruct cleft palate	15.03	NA	NA	13.77	13.35	2.96	090
42215		A	Reconstruct cleft palate	8.99	NA	NA	11.52	10.62	1.78	090
4221F		I	Diuretic thxpy for >= 6 mons	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42220		A	Reconstruct cleft palate	7.16	NA	NA	8.37	7.97	0.50	090
42225		A	Reconstruct cleft palate	9.77	NA	NA	15.96	16.18	1.25	090
42226		A	Lengthening of palate	10.35	NA	NA	15.81	15.59	1.32	090
42227		A	Lengthening of palate	9.90	NA	NA	14.63	14.87	1.26	090
42235		A	Repair palate	8.01	NA	NA	13.51	13.03	1.03	090
42260		A	Repair nose to lip fistula	10.22	13.50	12.77	9.01	8.38	1.30	090
42280		A	Preparation palate mold	1.59	3.09	2.88	1.58	1.36	0.34	010
42281		A	Insertion palate prosthesis	1.98	4.03	3.81	2.44	2.30	0.26	010
42299		C	Palate/uvula surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42300		A	Drainage of salivary gland	1.98	4.14	3.94	2.47	2.32	0.27	010
42305		A	Drainage of salivary gland	6.31	NA	NA	6.10	5.71	0.86	090
4230F		I	Anticonv thxpy for >= 6 mons	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42310		A	Drainage of salivary gland	1.61	3.14	2.98	2.04	1.91	0.22	010
42320		A	Drainage of salivary gland	2.40	4.95	4.70	2.75	2.58	0.31	010
42330		A	Removal of salivary stone	2.26	4.52	4.32	2.55	2.38	0.30	010
42335		A	Removal of salivary stone	3.41	7.55	7.19	4.13	3.89	0.42	090
42340		A	Removal of salivary stone	4.72	8.81	8.40	5.08	4.78	0.61	090
42400		A	Biopsy of salivary gland	0.78	2.33	2.32	0.82	0.82	0.08	000
42405		A	Biopsy of salivary gland	3.34	5.27	5.10	3.18	2.99	0.42	010
42408		A	Excision of salivary cyst	4.66	8.68	8.21	4.94	4.57	0.60	090
42409		A	Drainage of salivary cyst	2.91	6.91	6.57	3.61	3.41	0.37	090
4240F		I	Instr xrcz 4bk pn >12 weeks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42410		A	Excise parotid gland/lesion	9.57	NA	NA	8.21	7.62	1.44	090
42415		A	Excise parotid gland/lesion	18.12	NA	NA	13.86	12.79	2.42	090
42420		A	Excise parotid gland/lesion	21.00	NA	NA	15.59	14.35	2.82	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
42425		A	Excise parotid gland/lesion	13.42	NA	NA	10.67	9.93	1.83	090
42426		A	Excise parotid gland/lesion	22.66	NA	NA	16.19	14.96	3.11	090
4242F		I	Sprvsd xrcz bk pn >12 weeks	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42440		A	Excise submaxillary gland	7.13	NA	NA	6.37	5.91	0.95	090
42450		A	Excise sublingual gland	4.74	8.44	8.05	5.71	5.38	0.64	090
42500		A	Repair salivary duct	4.42	8.19	7.81	5.54	5.23	0.60	090
42505		A	Repair salivary duct	6.32	9.85	9.36	6.88	6.47	0.80	090
42507		A	Parotid duct diversion	6.25	NA	NA	8.79	8.37	0.80	090
42508		A	Parotid duct diversion	9.33	NA	NA	10.74	10.60	1.20	090
42509		A	Parotid duct diversion	11.76	NA	NA	10.17	10.49	2.30	090
42510		A	Parotid duct diversion	8.35	NA	NA	10.03	9.47	1.07	090
42550		A	Injection for salivary x-ray	1.25	2.43	2.76	0.47	0.53	0.11	000
42600		A	Closure of salivary fistula	4.94	9.13	8.76	5.24	4.97	0.64	090
4260F		I	Wound srfc culturetech used	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4261F		I	Tech other than surfc cultr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42650		A	Dilation of salivary duct	0.77	1.68	1.60	0.94	0.89	0.10	000
4265F		I	Wet-dry dressings rx recmd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42660		A	Dilation of salivary duct	1.13	1.97	1.87	1.13	1.06	0.14	000
42665		A	Ligation of salivary duct	2.63	6.62	6.30	3.44	3.25	0.34	090
4266F		I	No wet-dry drssings rx recmd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4268F		I	Pt ed re comp thxpy rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4269F		I	Appropos mthd offloading rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42700		A	Drainage of tonsil abscess	1.67	3.86	3.70	2.28	2.18	0.23	010
42720		A	Drainage of throat abscess	6.31	6.88	6.43	5.07	4.67	0.83	010
42725		A	Drainage of throat abscess	12.41	NA	NA	11.14	10.30	1.59	090
4275F		I	Hep b vac inj admin/rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4279F		I	Pcp prophylaxis rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
42800		A	Biopsy of throat	1.44	3.22	3.07	1.84	1.74	0.20	010
42802		A	Biopsy of throat	1.59	5.22	5.23	2.31	2.25	0.22	010
42804		A	Biopsy of upper nose/throat	1.29	4.53	4.48	2.05	1.99	0.16	010
42806		A	Biopsy of upper nose/throat	1.63	4.87	4.82	2.24	2.17	0.22	010
42808		A	Excise pharynx lesion	2.35	4.31	4.12	2.39	2.25	0.30	010
42809		A	Remove pharynx foreign body	1.86	3.06	2.92	1.91	1.78	0.27	010
42810		A	Excision of neck cyst	3.38	8.06	7.73	5.13	4.82	0.42	090
42815		A	Excision of neck cyst	7.31	NA	NA	8.87	8.35	1.00	090
42820		A	Remove tonsils and adenoids	4.22	NA	NA	4.25	3.98	0.53	090
42821		A	Remove tonsils and adenoids	4.36	NA	NA	4.44	4.17	0.56	090
42825		A	Removal of tonsils	3.51	NA	NA	4.16	3.93	0.43	090
42826		A	Removal of tonsils	3.45	NA	NA	3.90	3.68	0.43	090
42830		A	Removal of adenoids	2.65	NA	NA	3.42	3.24	0.34	090
42831		A	Removal of adenoids	2.81	NA	NA	3.74	3.55	0.35	090
42835		A	Removal of adenoids	2.38	NA	NA	2.59	2.67	0.30	090
42836		A	Removal of adenoids	3.26	NA	NA	3.78	3.59	0.41	090
42842		A	Extensive surgery of throat	12.23	NA	NA	16.84	15.73	1.58	090
42844		A	Extensive surgery of throat	17.78	NA	NA	22.09	20.83	2.27	090
42845		A	Extensive surgery of throat	32.56	NA	NA	31.94	29.68	4.17	090
42860		A	Excision of tonsil tags	2.30	NA	NA	3.22	3.06	0.30	090
42870		A	Excision of lingual tonsil	5.52	NA	NA	11.47	11.07	0.71	090
42890		A	Partial removal of pharynx	19.13	NA	NA	21.96	20.34	2.51	090
42892		A	Revision of pharyngeal walls	26.03	NA	NA	28.45	25.95	3.41	090
42894		A	Revision of pharyngeal walls	33.92	NA	NA	34.69	31.90	4.41	090
42900		A	Repair throat wound	5.29	NA	NA	4.58	4.26	0.68	010
42950		A	Reconstruction of throat	8.27	NA	NA	14.81	14.34	1.14	090
42953		A	Repair throat esophagus	9.45	NA	NA	18.27	18.11	1.30	090
42955		A	Surgical opening of throat	8.01	NA	NA	14.03	13.36	1.03	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
42960		A	Control throat bleeding	2.38	NA	NA	2.54	2.39	0.31	010
42961		A	Control throat bleeding	5.77	NA	NA	6.52	6.13	0.73	090
42962		A	Control throat bleeding	7.40	NA	NA	7.69	7.22	0.95	090
42970		A	Control nose/throat bleeding	5.82	NA	NA	5.58	5.15	0.84	090
42971		A	Control nose/throat bleeding	6.60	NA	NA	6.76	6.30	0.84	090
42972		A	Control nose/throat bleeding	7.59	NA	NA	7.34	6.82	0.98	090
42999		C	Throat surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4300F		I	Pt rcvng warf thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4301F		I	Pt not rcvng warf thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43020		A	Incision of esophagus	8.23	NA	NA	7.49	6.64	1.06	090
43030		A	Throat muscle surgery	7.99	NA	NA	6.90	6.47	1.17	090
43045		A	Incision of esophagus	21.88	NA	NA	12.24	12.41	5.11	090
4305F		I	Pt ed re ft care inspct rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4306F		I	Pt tlk psych & rx opd addic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43100		A	Excision of esophagus lesion	9.66	NA	NA	8.60	7.82	1.24	090
43101		A	Excision of esophagus lesion	17.07	NA	NA	9.29	9.41	3.99	090
43107		A	Removal of esophagus	44.18	NA	NA	22.77	22.18	9.85	090
43108		A	Removal of esophagus	82.87	NA	NA	40.35	34.99	17.63	090
43112		A	Removal of esophagus	47.48	NA	NA	22.69	22.61	10.74	090
43113		A	Removal of esophagus	80.06	NA	NA	40.50	36.60	17.04	090
43116		A	Partial removal of esophagus	92.99	NA	NA	58.63	47.62	11.91	090
43117		A	Partial removal of esophagus	43.65	NA	NA	20.91	20.64	9.85	090
43118		A	Partial removal of esophagus	67.07	NA	NA	33.45	29.34	14.27	090
43121		A	Partial removal of esophagus	51.43	NA	NA	23.19	22.50	12.00	090
43122		A	Partial removal of esophagus	44.18	NA	NA	22.75	21.64	9.61	090
43123		A	Partial removal of esophagus	83.12	NA	NA	41.83	35.91	17.67	090
43124		A	Removal of esophagus	69.09	NA	NA	36.58	32.29	16.15	090
43130		A	Removal of esophagus pouch	12.53	NA	NA	9.67	9.09	1.98	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
43135		A	Removal of esophagus pouch	26.17	NA	NA	13.21	12.68	5.96	090
43200		A	Esophagus endoscopy	1.59	4.55	4.59	1.39	1.32	0.23	000
43201		A	Esoph scope w/submucous inj	2.09	6.22	6.37	1.50	1.49	0.30	000
43202		A	Esophagus endoscopy biopsy	1.89	6.07	6.21	1.33	1.28	0.29	000
43204		A	Esoph scope w/sclerosis inj	3.76	NA	NA	2.29	2.33	0.58	000
43205		A	Esophagus endoscopy/ligation	3.78	NA	NA	2.41	2.40	0.56	000
4320F		I	Pt talk psychsoc&rx oh dpnd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43215		A	Esophagus endoscopy	2.60	NA	NA	1.68	1.63	0.41	000
43216		A	Esophagus endoscopy/lesion	2.40	3.66	3.39	1.59	1.55	0.35	000
43217		A	Esophagus endoscopy	2.90	7.67	7.83	1.81	1.74	0.49	000
43219		A	Esophagus endoscopy	2.80	NA	NA	1.87	1.88	0.48	000
43220		A	Esoph endoscopy dilation	2.10	NA	NA	1.45	1.41	0.31	000
43226		A	Esoph endoscopy dilation	2.34	NA	NA	1.56	1.54	0.37	000
43227		A	Esoph endoscopy repair	3.59	NA	NA	2.23	2.19	0.54	000
43228		A	Esoph endoscopy ablation	3.76	NA	NA	2.39	2.36	0.58	000
43231		A	Esoph endoscopy w/us exam	3.19	NA	NA	2.07	2.06	0.48	000
43232		A	Esoph endoscopy w/us fn bx	4.47	NA	NA	2.74	2.73	0.69	000
43234		A	Upper gi endoscopy exam	2.01	5.79	5.96	1.33	1.28	0.34	000
43235		A	Uppr gi endoscopy diagnosis	2.39	5.74	6.03	1.62	1.61	0.37	000
43236		A	Uppr gi scope w/submuc inj	2.92	7.14	7.56	1.93	1.93	0.42	000
43237		A	Endoscopic us exam esoph	3.98	NA	NA	2.50	2.51	0.60	000
43238		A	Uppr gi endoscopy w/us fn bx	5.02	NA	NA	3.04	3.07	0.75	000
43239		A	Upper gi endoscopy biopsy	2.87	6.60	6.90	1.88	1.86	0.42	000
43240		A	Esoph endoscope w/drain cyst	6.85	NA	NA	4.08	4.06	1.03	000
43241		A	Upper gi endoscopy with tube	2.59	NA	NA	1.72	1.70	0.39	000
43242		A	Uppr gi endoscopy w/us fn bx	7.30	NA	NA	4.38	4.37	1.07	000
43243		A	Upper gi endoscopy & inject	4.56	NA	NA	2.81	2.81	0.68	000
43244		A	Upper gi endoscopy/ligation	5.04	NA	NA	3.12	3.12	0.73	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
43245		A	Uppr gi scope dilate strictr	3.18	NA	NA	2.01	1.97	0.50	000
43246		A	Place gastrostomy tube	4.32	NA	NA	2.59	2.56	0.69	000
43247		A	Operative upper gi endoscopy	3.38	NA	NA	2.15	2.13	0.52	000
43248		A	Uppr gi endoscopy/guide wire	3.15	NA	NA	2.06	2.07	0.45	000
43249		A	Esoph endoscopy dilation	2.90	NA	NA	1.91	1.91	0.42	000
4324F		I	Pt queried prkns complic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43250		A	Upper gi endoscopy/tumor	3.20	NA	NA	2.00	1.96	0.52	000
43251		A	Operative upper gi endoscopy	3.69	NA	NA	2.33	2.31	0.56	000
43255		A	Operative upper gi endoscopy	4.81	NA	NA	2.99	2.99	0.71	000
43256		A	Uppr gi endoscopy w/stent	4.34	NA	NA	2.65	2.65	0.68	000
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	NA	3.47	3.27	0.80	000
43258		A	Operative upper gi endoscopy	4.54	NA	NA	2.82	2.81	0.68	000
43259		A	Endoscopic ultrasound exam	5.19	NA	NA	3.20	3.20	0.75	000
4325F		I	Med txmnt options rvwd w/pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43260		A	Endo cholangiopancreatograph	5.95	NA	NA	3.61	3.62	0.87	000
43261		A	Endo cholangiopancreatograph	6.26	NA	NA	3.80	3.80	0.91	000
43262		A	Endo cholangiopancreatograph	7.38	NA	NA	4.42	4.42	1.09	000
43263		A	Endo cholangiopancreatograph	7.28	NA	NA	4.29	4.35	1.07	000
43264		A	Endo cholangiopancreatograph	8.89	NA	NA	5.26	5.27	1.30	000
43265		A	Endo cholangiopancreatograph	10.00	NA	NA	5.87	5.88	1.48	000
43267		A	Endo cholangiopancreatograph	7.38	NA	NA	4.37	4.37	1.09	000
43268		A	Endo cholangiopancreatograph	7.38	NA	NA	4.58	4.59	1.09	000
43269		A	Endo cholangiopancreatograph	8.20	NA	NA	4.87	4.87	1.21	000
4326F		I	Pt asked re symp auto dysfxn	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43271		A	Endo cholangiopancreatograph	7.38	NA	NA	4.41	4.41	1.09	000
43272		A	Endo cholangiopancreatograph	7.38	NA	NA	4.45	4.42	1.09	000
43273		A	Endoscopic pancreatoscopy	2.24	NA	NA	1.25	1.29	0.33	ZZZ
43279		A	Lap myotomy heller	22.10	NA	NA	12.06	11.01	4.70	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
43280		A	Laparoscopy fundoplasty	18.10	NA	NA	10.44	9.56	3.84	090
43281		A	Lap paraesophag hern repair	26.60	NA	NA	14.16	14.16	5.65	090
43282		A	Lap paraesoph her rpr w/mesh	30.10	NA	NA	15.67	15.67	6.37	090
43283		A	Lap esoph lengthening	2.95	NA	NA	1.29	1.29	0.60	ZZZ
43289		C	Laparoscope proc esoph	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4328F		I	Pt asked re sleep disturb	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43300		A	Repair of esophagus	9.33	NA	NA	8.60	7.88	1.20	090
43305		A	Repair esophagus and fistula	18.10	NA	NA	13.62	12.49	2.31	090
4330F		I	Cnslng epi spec sfty issues	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43310		A	Repair of esophagus	26.26	NA	NA	12.49	12.83	6.12	090
43312		A	Repair esophagus and fistula	29.25	NA	NA	12.35	13.23	6.84	090
43313		A	Esophagoplasty congenital	48.45	NA	NA	26.11	23.68	11.33	090
43314		A	Tracheo-esophagoplasty cong	53.43	NA	NA	23.24	24.88	6.86	090
43320		A	Fuse esophagus & stomach	23.31	NA	NA	13.41	12.58	4.97	090
43325		A	Revise esophagus & stomach	22.60	NA	NA	12.41	11.59	4.82	090
43327		A	Esoph fundoplasty lap	13.35	NA	NA	8.16	8.16	2.84	090
43328		A	Esoph fundoplasty thor	19.91	NA	NA	10.87	10.87	4.97	090
43330		A	Esophagomyotomy abdominal	22.19	NA	NA	12.46	11.48	4.77	090
43331		A	Esophagomyotomy thoracic	23.06	NA	NA	12.31	12.41	5.39	090
43332		A	Transab esoph hiat hern rpr	19.62	NA	NA	11.07	11.07	4.17	090
43333		A	Transab esoph hiat hern rpr	21.46	NA	NA	11.85	11.85	4.54	090
43334		A	Transthor diaphrag hern rpr	22.12	NA	NA	11.44	11.44	4.70	090
43335		A	Transthor diaphrag hern rpr	23.97	NA	NA	12.18	12.18	5.07	090
43336		A	Thorabd diaphr hern repair	25.81	NA	NA	13.52	13.52	5.84	090
43337		A	Thorabd diaphr hern repair	27.65	NA	NA	15.40	15.40	6.26	090
43338		A	Esoph lengthening	2.21	NA	NA	1.30	1.30	0.50	ZZZ
43340		A	Fuse esophagus & intestine	22.99	NA	NA	13.27	12.22	4.89	090
43341		A	Fuse esophagus & intestine	24.23	NA	NA	14.86	14.17	5.66	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
43350		A	Surgical opening esophagus	19.49	NA	NA	14.48	12.43	4.14	090
43351		A	Surgical opening esophagus	22.05	NA	NA	12.01	12.23	5.15	090
43352		A	Surgical opening esophagus	17.81	NA	NA	10.20	10.31	4.16	090
43360		A	Gastrointestinal repair	40.11	NA	NA	18.79	19.03	9.38	090
43361		A	Gastrointestinal repair	45.68	NA	NA	20.62	20.91	9.72	090
43400		A	Ligate esophagus veins	25.60	NA	NA	14.41	15.67	3.76	090
43401		A	Esophagus surgery for veins	26.49	NA	NA	12.55	12.38	5.64	090
43405		A	Ligate/staple esophagus	24.73	NA	NA	15.95	14.58	5.27	090
4340F		I	Cnslng chldbrng women epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43410		A	Repair esophagus wound	16.41	NA	NA	11.43	10.66	3.83	090
43415		A	Repair esophagus wound	28.91	NA	NA	16.36	15.72	6.59	090
43420		A	Repair esophagus opening	16.78	NA	NA	12.81	11.26	2.15	090
43425		A	Repair esophagus opening	25.04	NA	NA	15.22	14.46	5.34	090
43450		A	Dilate esophagus	1.38	2.90	3.06	1.08	1.08	0.22	000
43453		A	Dilate esophagus	1.51	6.58	7.02	1.15	1.16	0.23	000
43456		A	Dilate esophagus	2.57	13.84	14.78	1.73	1.71	0.38	000
43458		A	Dilate esophagus	3.06	7.68	7.97	1.98	1.94	0.45	000
43460		A	Pressure treatment esophagus	3.79	NA	NA	2.44	2.32	0.54	000
43496		C	Free jejunum flap microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
43499		C	Esophagus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43500		A	Surgical opening of stomach	12.79	NA	NA	7.94	7.25	2.70	090
43501		A	Surgical repair of stomach	22.60	NA	NA	12.81	11.60	4.77	090
43502		A	Surgical repair of stomach	25.69	NA	NA	14.40	12.97	5.46	090
43510		A	Surgical opening of stomach	15.14	NA	NA	11.40	10.33	2.21	090
43520		A	Incision of pyloric muscle	11.29	NA	NA	6.83	6.54	2.50	090
43605		A	Biopsy of stomach	13.72	NA	NA	8.67	7.71	2.87	090
43610		A	Excision of stomach lesion	16.34	NA	NA	9.52	8.62	3.45	090
43611		A	Excision of stomach lesion	20.38	NA	NA	11.79	10.72	4.29	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
43620		A	Removal of stomach	34.04	NA	NA	17.62	16.04	7.24	090
43621		A	Removal of stomach	39.53	NA	NA	19.95	17.90	8.39	090
43622		A	Removal of stomach	40.03	NA	NA	20.37	18.20	8.53	090
43631		A	Removal of stomach partial	24.51	NA	NA	13.66	12.41	5.19	090
43632		A	Removal of stomach partial	35.14	NA	NA	18.22	16.03	7.40	090
43633		A	Removal of stomach partial	33.14	NA	NA	17.38	15.38	6.98	090
43634		A	Removal of stomach partial	36.64	NA	NA	19.18	16.96	7.79	090
43635		A	Removal of stomach partial	2.06	NA	NA	0.89	0.81	0.42	ZZZ
43640		A	Vagotomy & pylorus repair	19.56	NA	NA	11.57	10.44	4.11	090
43641		A	Vagotomy & pylorus repair	19.81	NA	NA	11.83	10.57	4.21	090
43644		A	Lap gastric bypass/roux-en-y	29.40	NA	NA	16.19	14.75	6.21	090
43645		A	Lap gastr bypass incl smll i	31.53	NA	NA	17.14	15.57	6.72	090
43647		C	Lap impl electrode antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43648		C	Lap revise/remv eltrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43651		A	Laparoscopy vagus nerve	10.13	NA	NA	7.17	6.56	2.16	090
43652		A	Laparoscopy vagus nerve	12.13	NA	NA	8.04	7.33	2.58	090
43653		A	Laparoscopy gastrostomy	8.48	NA	NA	6.66	6.09	1.81	090
43659		C	Laparoscope proc stom	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43752		A	Nasal/orogastric w/stent	0.81	NA	NA	0.32	0.33	0.08	000
43753		A	Tx gastro intub w/asp	0.45	NA	NA	0.13	0.13	0.03	000
43754		A	Dx gastr intub w/asp spec	0.45	1.84	1.84	0.44	0.44	0.04	000
43755		A	Dx gastr intub w/asp specs	0.94	2.53	2.53	0.68	0.68	0.08	000
43756		A	Dx duod intub w/asp spec	0.77	5.62	5.62	0.71	0.71	0.05	000
43757		A	Dx duod intub w/asp specs	1.26	6.95	6.95	0.87	0.87	0.08	000
43760		A	Change gastrostomy tube	0.90	12.32	10.90	0.42	0.43	0.14	000
43761		A	Reposition gastrostomy tube	2.01	1.22	1.30	0.83	0.88	0.24	000
43770		A	Lap place gastr adj device	18.00	NA	NA	11.55	10.54	3.80	090
43771		A	Lap revise gastr adj device	20.79	NA	NA	12.80	11.63	4.43	090
43772		A	Lap rmvl gastr adj device	15.70	NA	NA	9.51	8.70	3.35	090
43773		A	Lap replace gastr adj device	20.79	NA	NA	12.77	11.63	4.43	090
43774		A	Lap rmvl gastr adj all parts	15.76	NA	NA	9.52	8.73	3.35	090
43775		N	Lap sleeve gastrectomy	21.56	NA	NA	12.14	12.14	4.59	XXX
43800		A	Reconstruction of pylorus	15.43	NA	NA	9.01	8.23	3.30	090
43810		A	Fusion of stomach and bowel	16.88	NA	NA	9.88	8.89	3.59	090
43820		A	Fusion of stomach and bowel	22.53	NA	NA	12.79	11.31	4.75	090
43825		A	Fusion of stomach and bowel	21.76	NA	NA	12.72	11.41	4.63	090
43830		A	Place gastrostomy tube	10.85	NA	NA	7.71	7.07	2.23	090
43831		A	Place gastrostomy tube	8.49	NA	NA	7.32	6.74	1.81	090
43832		A	Place gastrostomy tube	17.34	NA	NA	10.41	9.67	3.57	090
43840		A	Repair of stomach lesion	22.83	NA	NA	12.95	11.47	4.81	090
43842		N	V-band gastroplasty	21.03	NA	NA	11.67	11.26	1.49	090
43843		A	Gastroplasty w/o v-band	21.21	NA	NA	12.49	11.18	4.51	090
43845		A	Gastroplasty duodenal switch	33.30	NA	NA	18.37	16.42	7.05	090
43846		A	Gastric bypass for obesity	27.41	NA	NA	15.57	14.12	5.79	090
43847		A	Gastric bypass incl small i	30.28	NA	NA	17.12	15.23	6.44	090
43848		A	Revision gastroplasty	32.75	NA	NA	18.09	16.34	6.93	090
43850		A	Revise stomach-bowel fusion	27.58	NA	NA	15.22	13.59	5.87	090
43855		A	Revise stomach-bowel fusion	28.69	NA	NA	15.71	14.17	6.10	090
43860		A	Revise stomach-bowel fusion	27.89	NA	NA	15.08	13.69	5.87	090
43865		A	Revise stomach-bowel fusion	29.05	NA	NA	15.86	14.28	6.18	090
43870		A	Repair stomach opening	11.44	NA	NA	7.43	6.75	2.35	090
43880		A	Repair stomach-bowel fistula	27.18	NA	NA	14.84	13.46	5.69	090
43881		C	Impl/redo electrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43882		C	Revise/remove electrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43886		A	Revise gastric port open	4.64	NA	NA	5.06	4.63	0.99	090
43887		A	Remove gastric port open	4.32	NA	NA	4.41	4.07	0.91	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
43888		A	Change gastric port open	6.44	NA	NA	5.81	5.33	1.37	090
43999		C	Stomach surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44005		A	Freeing of bowel adhesion	18.46	NA	NA	10.40	9.43	3.83	090
4400F		I	Rehab thxpy options w/pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44010		A	Incision of small bowel	14.26	NA	NA	8.62	7.82	3.00	090
44015		A	Insert needle cath bowel	2.62	NA	NA	1.10	1.03	0.56	ZZZ
44020		A	Explore small intestine	16.22	NA	NA	9.47	8.56	3.40	090
44021		A	Decompress small bowel	16.31	NA	NA	9.59	8.72	3.44	090
44025		A	Incision of large bowel	16.51	NA	NA	9.60	8.69	3.42	090
44050		A	Reduce bowel obstruction	15.52	NA	NA	9.16	8.31	3.23	090
44055		A	Correct malrotation of bowel	25.63	NA	NA	13.69	12.34	5.40	090
44100		A	Biopsy of bowel	2.01	NA	NA	1.09	1.10	0.31	000
44110		A	Excise intestine lesion(s)	14.04	NA	NA	8.42	7.65	2.89	090
44111		A	Excision of bowel lesion(s)	16.52	NA	NA	9.49	8.60	3.44	090
44120		A	Removal of small intestine	20.82	NA	NA	11.44	10.29	4.32	090
44121		A	Removal of small intestine	4.44	NA	NA	1.93	1.76	0.90	ZZZ
44125		A	Removal of small intestine	20.03	NA	NA	11.25	10.16	4.06	090
44126		A	Enterectomy w/o taper cong	42.23	NA	NA	22.56	20.09	8.98	090
44127		A	Enterectomy w/taper cong	49.30	NA	NA	25.55	22.80	10.48	090
44128		A	Enterectomy cong add-on	4.44	NA	NA	1.94	1.77	0.92	ZZZ
44130		A	Bowel to bowel fusion	22.11	NA	NA	12.62	11.13	4.55	090
44132		R	Enterectomy cadaver donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44133		R	Enterectomy live donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44135		R	Intestine transplnt cadaver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44136		R	Intestine transplant live	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44139		A	Mobilization of colon	2.23	NA	NA	0.97	0.88	0.43	ZZZ
44140		A	Partial removal of colon	22.59	NA	NA	12.89	11.69	4.63	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
44141		A	Partial removal of colon	29.91	NA	NA	18.48	16.48	6.17	090
44143		A	Partial removal of colon	27.79	NA	NA	16.30	14.76	5.73	090
44144		A	Partial removal of colon	29.91	NA	NA	16.93	15.10	6.17	090
44145		A	Partial removal of colon	28.58	NA	NA	15.51	14.03	5.65	090
44146		A	Partial removal of colon	35.30	NA	NA	21.23	19.04	6.86	090
44147		A	Partial removal of colon	33.69	NA	NA	17.78	15.51	6.76	090
44150		A	Removal of colon	30.18	NA	NA	19.64	17.71	6.11	090
44151		A	Removal of colon/ileostomy	34.92	NA	NA	21.70	19.58	7.43	090
44155		A	Removal of colon/ileostomy	34.42	NA	NA	21.44	19.21	6.45	090
44156		A	Removal of colon/ileostomy	37.42	NA	NA	23.63	21.25	7.97	090
44157		A	Colectomy w/ileoanal anast	35.70	NA	NA	21.80	19.70	7.60	090
44158		A	Colectomy w/neo-rectum pouch	36.70	NA	NA	22.08	19.98	7.81	090
44160		A	Removal of colon	20.89	NA	NA	12.03	10.85	4.25	090
44180		A	Lap enterolysis	15.27	NA	NA	9.05	8.28	3.16	090
44186		A	Lap jejunostomy	10.38	NA	NA	6.85	6.35	2.21	090
44187		A	Lap ileo/jejuno-stomy	17.40	NA	NA	12.29	11.21	3.30	090
44188		A	Lap colostomy	19.35	NA	NA	13.42	12.23	3.83	090
44202		A	Lap enterectomy	23.39	NA	NA	13.28	12.04	4.83	090
44203		A	Lap resect s/intestine addl	4.44	NA	NA	1.92	1.74	0.92	ZZZ
44204		A	Laparo partial colectomy	26.42	NA	NA	14.55	13.13	5.21	090
44205		A	Lap colectomy part w/ileum	22.95	NA	NA	12.77	11.54	4.49	090
44206		A	Lap part colectomy w/stoma	29.79	NA	NA	16.86	15.23	6.04	090
44207		A	L colectomy/coloproctostomy	31.92	NA	NA	16.86	15.14	6.17	090
44208		A	L colectomy/coloproctostomy	33.99	NA	NA	19.35	17.46	6.38	090
44210		A	Laparo total proctocolectomy	30.09	NA	NA	17.95	16.20	5.80	090
44211		A	Lap colectomy w/proctectomy	37.08	NA	NA	22.46	20.00	7.90	090
44212		A	Laparo total proctocolectomy	34.58	NA	NA	20.78	18.80	6.36	090
44213		A	Lap mobil splenic fl add-on	3.50	NA	NA	1.52	1.38	0.67	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
44227		A	Lap close enterostomy	28.62	NA	NA	15.65	14.14	5.83	090
44238		C	Laparoscope proc intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44300		A	Open bowel to skin	13.75	NA	NA	8.52	7.77	2.91	090
44310		A	Ileostomy/jejunostomy	17.59	NA	NA	10.20	9.24	3.45	090
44312		A	Revision of ileostomy	9.43	NA	NA	6.47	6.06	1.71	090
44314		A	Revision of ileostomy	16.74	NA	NA	10.22	9.39	3.15	090
44316		A	Devise bowel pouch	23.59	NA	NA	13.61	12.22	5.02	090
44320		A	Colostomy	19.91	NA	NA	11.96	10.82	4.06	090
44322		A	Colostomy with biopsies	13.32	NA	NA	13.43	12.28	2.84	090
44340		A	Revision of colostomy	9.28	NA	NA	7.38	6.68	1.87	090
44345		A	Revision of colostomy	17.22	NA	NA	10.84	9.81	3.44	090
44346		A	Revision of colostomy	19.63	NA	NA	11.91	10.72	3.87	090
44360		A	Small bowel endoscopy	2.59	NA	NA	1.76	1.77	0.38	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	NA	1.92	1.92	0.41	000
44363		A	Small bowel endoscopy	3.49	NA	NA	2.24	2.20	0.52	000
44364		A	Small bowel endoscopy	3.73	NA	NA	2.38	2.38	0.54	000
44365		A	Small bowel endoscopy	3.31	NA	NA	2.15	2.14	0.49	000
44366		A	Small bowel endoscopy	4.40	NA	NA	2.78	2.78	0.64	000
44369		A	Small bowel endoscopy	4.51	NA	NA	2.84	2.83	0.65	000
44370		A	Small bowel endoscopy/stent	4.79	NA	NA	3.18	3.15	0.69	000
44372		A	Small bowel endoscopy	4.40	NA	NA	2.64	2.59	0.69	000
44373		A	Small bowel endoscopy	3.49	NA	NA	2.16	2.16	0.53	000
44376		A	Small bowel endoscopy	5.25	NA	NA	3.10	3.08	0.81	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	NA	3.33	3.33	0.81	000
44378		A	Small bowel endoscopy	7.12	NA	NA	4.27	4.25	1.05	000
44379		A	S bowel endoscope w/stent	7.46	NA	NA	4.69	4.61	1.09	000
44380		A	Small bowel endoscopy	1.05	NA	NA	0.84	0.86	0.14	000
44382		A	Small bowel endoscopy	1.27	NA	NA	1.01	1.01	0.20	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
44383		A	Ileoscopy w/stent	2.94	NA	NA	1.62	1.79	0.33	000
44385		A	Endoscopy of bowel pouch	1.82	5.37	5.39	1.11	1.08	0.26	000
44386		A	Endoscopy bowel pouch/biop	2.12	7.66	7.85	1.38	1.31	0.33	000
44388		A	Colonoscopy	2.82	6.97	7.03	1.75	1.70	0.45	000
44389		A	Colonoscopy with biopsy	3.13	7.93	8.17	1.97	1.93	0.49	000
44390		A	Colonoscopy for foreign body	3.82	9.19	9.33	2.45	2.32	0.56	000
44391		A	Colonoscopy for bleeding	4.31	9.55	10.06	2.62	2.59	0.65	000
44392		A	Colonoscopy & polypectomy	3.81	8.41	8.49	2.21	2.13	0.62	000
44393		A	Colonoscopy lesion removal	4.83	9.32	9.39	2.85	2.76	0.76	000
44394		A	Colonoscopy w/snare	4.42	9.53	9.81	2.63	2.58	0.69	000
44397		A	Colonoscopy w/stent	4.70	NA	NA	2.94	2.89	0.68	000
44500		A	Intro gastrointestinal tube	0.49	NA	NA	0.19	0.21	0.04	000
44602		A	Suture small intestine	24.72	NA	NA	12.45	10.90	5.09	090
44603		A	Suture small intestine	28.16	NA	NA	14.59	12.79	5.74	090
44604		A	Suture large intestine	18.16	NA	NA	9.77	8.83	3.71	090
44605		A	Repair of bowel lesion	22.08	NA	NA	12.54	11.34	4.55	090
44615		A	Intestinal stricturoplasty	18.16	NA	NA	10.36	9.39	3.72	090
44620		A	Repair bowel opening	14.43	NA	NA	8.72	7.83	2.82	090
44625		A	Repair bowel opening	17.28	NA	NA	9.95	8.93	3.35	090
44626		A	Repair bowel opening	27.90	NA	NA	14.56	13.15	5.69	090
44640		A	Repair bowel-skin fistula	24.20	NA	NA	12.97	11.73	4.88	090
44650		A	Repair bowel fistula	25.12	NA	NA	13.23	12.08	5.05	090
44660		A	Repair bowel-bladder fistula	23.91	NA	NA	12.16	11.93	3.84	090
44661		A	Repair bowel-bladder fistula	27.35	NA	NA	13.99	13.04	5.09	090
44680		A	Surgical revision intestine	17.96	NA	NA	10.27	9.29	3.83	090
44700		A	Suspend bowel w/prosthesis	17.48	NA	NA	9.98	9.00	3.03	090
44701		A	Intraop colon lavage add-on	3.10	NA	NA	1.34	1.21	0.58	ZZZ
44715		C	Prepare donor intestine	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
44720		A	Prep donor intestine/venous	5.00	NA	NA	2.18	2.13	0.35	XXX
44721		A	Prep donor intestine/artery	7.00	NA	NA	3.08	2.82	1.49	XXX
44799		C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44800		A	Excision of bowel pouch	12.05	NA	NA	8.24	7.56	2.43	090
44820		A	Excision of mesentery lesion	13.73	NA	NA	8.49	7.78	2.82	090
44850		A	Repair of mesentery	12.11	NA	NA	7.76	7.00	2.51	090
44899		C	Bowel surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44900		A	Drain app abscess open	12.57	NA	NA	7.90	7.12	2.63	090
44901		A	Drain app abscess percut	3.37	21.51	24.14	1.26	1.39	0.35	000
44950		A	Appendectomy	10.60	NA	NA	6.34	5.79	2.23	090
44955		A	Appendectomy add-on	1.53	NA	NA	0.68	0.62	0.31	ZZZ
44960		A	Appendectomy	14.50	NA	NA	8.54	7.71	3.07	090
44970		A	Laparoscopy appendectomy	9.45	NA	NA	6.44	5.86	1.97	090
44979		C	Laparoscope proc app	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45000		A	Drainage of pelvic abscess	6.30	NA	NA	5.15	4.74	1.09	090
45005		A	Drainage of rectal abscess	2.02	5.31	5.08	2.25	2.10	0.38	010
45020		A	Drainage of rectal abscess	8.56	NA	NA	6.70	6.02	1.62	090
45100		A	Biopsy of rectum	4.04	NA	NA	4.07	3.73	0.72	090
45108		A	Removal of anorectal lesion	5.12	NA	NA	4.70	4.25	1.09	090
45110		A	Removal of rectum	30.76	NA	NA	18.89	17.06	5.81	090
45111		A	Partial removal of rectum	18.01	NA	NA	11.10	10.03	3.54	090
45112		A	Removal of rectum	33.18	NA	NA	17.42	15.61	6.07	090
45113		A	Partial proctectomy	33.22	NA	NA	18.99	17.08	7.06	090
45114		A	Partial removal of rectum	30.79	NA	NA	16.98	15.09	6.56	090
45116		A	Partial removal of rectum	27.72	NA	NA	15.62	13.78	3.95	090
45119		A	Remove rectum w/reservoir	33.48	NA	NA	19.30	17.17	5.85	090
45120		A	Removal of rectum	26.40	NA	NA	15.47	13.91	5.62	090
45121		A	Removal of rectum and colon	29.08	NA	NA	16.64	14.91	6.18	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
45123		A	Partial proctectomy	18.86	NA	NA	11.50	10.16	3.16	090
45126		A	Pelvic exenteration	49.10	NA	NA	26.72	24.96	10.44	090
45130		A	Excision of rectal prolapse	18.50	NA	NA	11.07	9.81	3.12	090
45135		A	Excision of rectal prolapse	22.36	NA	NA	13.95	12.35	4.75	090
45136		A	Excise ileoanal reservior	30.82	NA	NA	19.04	17.17	4.40	090
45150		A	Excision of rectal stricture	5.85	NA	NA	5.16	4.74	0.83	090
45160		A	Excision of rectal lesion	16.33	NA	NA	10.30	9.36	3.48	090
45171		A	Exc rect tum transanal part	8.13	NA	NA	8.06	8.06	1.51	090
45172		A	Exc rect tum transanal full	12.13	NA	NA	9.80	9.80	2.23	090
45190		A	Destruction rectal tumor	10.42	NA	NA	8.26	7.45	1.86	090
45300		A	Proctosigmoidoscopy dx	0.80	2.59	2.43	0.68	0.60	0.12	000
45303		A	Proctosigmoidoscopy dilate	1.50	24.73	24.19	1.00	0.86	0.26	000
45305		A	Proctosigmoidoscopy w/bx	1.25	4.08	3.90	0.90	0.81	0.23	000
45307		A	Proctosigmoidoscopy fb	1.70	4.24	4.01	1.07	0.93	0.33	000
45308		A	Proctosigmoidoscopy removal	1.40	4.37	4.01	0.98	0.85	0.26	000
45309		A	Proctosigmoidoscopy removal	1.50	4.45	4.28	1.03	0.97	0.27	000
45315		A	Proctosigmoidoscopy removal	1.80	4.86	4.57	1.14	1.07	0.33	000
45317		A	Proctosigmoidoscopy bleed	2.00	4.44	4.13	1.23	1.08	0.33	000
45320		A	Proctosigmoidoscopy ablate	1.78	4.26	4.19	1.15	1.08	0.31	000
45321		A	Proctosigmoidoscopy volvul	1.75	NA	NA	1.17	1.07	0.33	000
45327		A	Proctosigmoidoscopy w/stent	2.00	NA	NA	1.45	1.32	0.42	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.93	2.96	0.80	0.77	0.14	000
45331		A	Sigmoidoscopy and biopsy	1.15	3.57	3.73	0.94	0.93	0.18	000
45332		A	Sigmoidoscopy w/fb removal	1.79	6.25	6.38	1.27	1.23	0.29	000
45333		A	Sigmoidoscopy & polypectomy	1.79	6.37	6.47	1.24	1.21	0.29	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	NA	1.80	1.80	0.39	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	5.81	5.77	1.09	1.07	0.23	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	NA	1.56	1.52	0.38	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
45338		A	Sigmoidoscopy w/tumr remove	2.34	6.47	6.68	1.56	1.54	0.35	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	6.28	6.25	2.00	1.98	0.48	000
45340		A	Sig w/balloon dilation	1.89	11.33	11.23	1.31	1.27	0.30	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	NA	1.74	1.73	0.38	000
45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	NA	2.57	2.55	0.60	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	NA	1.90	1.88	0.43	000
45355		A	Surgical colonoscopy	3.51	NA	NA	2.10	1.99	0.58	000
45378		A	Diagnostic colonoscopy	3.69	7.15	7.41	2.27	2.23	0.58	000
45378	53	A	Diagnostic colonoscopy	0.96	2.93	2.96	0.80	0.77	0.14	000
45379		A	Colonoscopy w/fb removal	4.68	9.27	9.50	2.83	2.74	0.72	000
45380		A	Colonoscopy and biopsy	4.43	8.51	8.86	2.73	2.70	0.67	000
45381		A	Colonoscopy submucous inj	4.19	8.39	8.76	2.60	2.58	0.62	000
45382		A	Colonoscopy/control bleeding	5.68	11.16	11.76	3.44	3.43	0.84	000
45383		A	Lesion removal colonoscopy	5.86	9.79	9.99	3.39	3.29	0.91	000
45384		A	Lesion remove colonoscopy	4.69	8.19	8.39	2.77	2.71	0.73	000
45385		A	Lesion removal colonoscopy	5.30	9.27	9.63	3.19	3.15	0.80	000
45386		A	Colonoscopy dilate stricture	4.57	13.60	14.23	2.74	2.69	0.72	000
45387		A	Colonoscopy w/stent	5.90	NA	NA	3.64	3.58	0.88	000
45391		A	Colonoscopy w/endoscope us	5.09	NA	NA	3.10	3.08	0.73	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	NA	3.90	3.86	1.02	000
45395		A	Lap removal of rectum	33.00	NA	NA	20.67	18.73	5.98	090
45397		A	Lap remove rectum w/pouch	36.50	NA	NA	22.03	19.73	6.00	090
45400		A	Laparoscopic proc	19.44	NA	NA	11.55	10.40	3.56	090
45402		A	Lap proctopexy w/sig resect	26.51	NA	NA	14.64	13.12	4.81	090
45499		C	Laparoscope proc rectum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45500		A	Repair of rectum	7.73	NA	NA	6.62	5.95	1.21	090
45505		A	Repair of rectum	8.36	NA	NA	7.63	6.81	1.51	090
45520		A	Treatment of rectal prolapse	0.55	3.75	3.43	0.57	0.52	0.07	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
45540		A	Correct rectal prolapse	18.12	NA	NA	10.43	9.37	3.11	090
45541		A	Correct rectal prolapse	14.85	NA	NA	10.31	9.23	2.58	090
45550		A	Repair rectum/remove sigmoid	24.80	NA	NA	14.66	13.09	4.47	090
45560		A	Repair of rectocele	11.50	NA	NA	7.56	7.18	1.79	090
45562		A	Exploration/repair of rectum	17.98	NA	NA	11.89	10.92	3.37	090
45563		A	Exploration/repair of rectum	26.38	NA	NA	17.05	15.30	5.62	090
45800		A	Repair rect/bladder fistula	20.31	NA	NA	11.96	11.54	3.38	090
45805		A	Repair fistula w/colostomy	23.32	NA	NA	15.22	13.69	4.97	090
45820		A	Repair rectourethral fistula	20.37	NA	NA	12.48	11.75	1.96	090
45825		A	Repair fistula w/colostomy	24.17	NA	NA	15.55	14.46	3.45	090
45900		A	Reduction of rectal prolapse	2.99	NA	NA	2.44	2.23	0.56	010
45905		A	Dilation of anal sphincter	2.35	NA	NA	2.23	2.09	0.41	010
45910		A	Dilation of rectal narrowing	2.85	NA	NA	2.45	2.34	0.48	010
45915		A	Remove rectal obstruction	3.19	5.73	5.45	2.94	2.73	0.52	010
45990		A	Surg dx exam anorectal	1.80	NA	NA	1.10	1.02	0.31	000
45999		C	Rectum surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
46020		A	Placement of seton	3.00	4.52	4.09	3.37	3.04	0.54	010
46030		A	Removal of rectal marker	1.26	2.56	2.35	1.19	1.08	0.23	010
46040		A	Incision of rectal abscess	5.37	9.00	8.35	5.73	5.28	1.05	090
46045		A	Incision of rectal abscess	5.87	NA	NA	5.72	5.15	1.17	090
46050		A	Incision of anal abscess	1.24	4.24	3.96	1.40	1.28	0.24	010
46060		A	Incision of rectal abscess	6.37	NA	NA	6.46	5.80	1.18	090
46070		A	Incision of anal septum	2.79	NA	NA	3.83	3.50	0.20	090
46080		A	Incision of anal sphincter	2.52	4.22	3.89	1.74	1.58	0.49	010
46083		A	Incise external hemorrhoid	1.45	3.33	3.33	1.45	1.38	0.24	010
46200		A	Removal of anal fissure	3.59	8.49	7.72	5.24	4.79	0.62	090
46220		A	Excise anal ext tag/papilla	1.61	4.05	3.76	1.61	1.47	0.30	010
46221		A	Ligation of hemorrhoid(s)	2.36	5.00	4.62	2.84	2.62	0.41	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
46230		A	Removal of anal tags	2.62	4.83	4.50	2.04	1.85	0.48	010
46250		A	Remove ext hem groups 2+	4.25	8.25	7.70	4.19	3.84	0.81	090
46255		A	Remove int/ext hem 1 group	4.96	8.64	8.15	4.50	4.13	0.95	090
46257		A	Remove in/ex hem grp & fiss	5.76	NA	NA	5.61	5.04	1.07	090
46258		A	Remove in/ex hem grp w/fistu	6.41	NA	NA	6.09	5.46	1.37	090
46260		A	Remove in/ex hem groups 2+	6.73	NA	NA	6.02	5.41	1.26	090
46261		A	Remove in/ex hem grps & fiss	7.76	NA	NA	6.51	5.84	1.39	090
46262		A	Remove in/ex hem grps w/fist	7.91	NA	NA	7.01	6.31	1.44	090
46270		A	Remove anal fist subq	4.92	8.77	8.09	5.61	5.07	0.98	090
46275		A	Remove anal fist inter	5.42	9.13	8.33	5.77	5.20	0.98	090
46280		A	Remove anal fist complex	6.39	NA	NA	6.29	5.64	1.13	090
46285		A	Remove anal fist 2 stage	5.42	9.09	8.14	5.80	5.17	0.91	090
46288		A	Repair anal fistula	7.81	NA	NA	7.04	6.31	1.33	090
46320		A	Removal of hemorrhoid clot	1.64	3.35	3.11	1.35	1.23	0.30	010
46500		A	Injection into hemorrhoid(s)	1.69	4.81	4.39	1.84	1.68	0.29	010
46505		A	Chemodenervation anal musc	3.18	4.60	4.29	3.33	3.04	0.58	010
46600		A	Diagnostic anoscopy	0.55	1.86	1.80	0.57	0.51	0.08	000
46604		A	Anoscopy and dilation	1.03	15.93	14.94	0.77	0.72	0.16	000
46606		A	Anoscopy and biopsy	1.20	4.95	4.84	0.87	0.78	0.23	000
46608		A	Anoscopy remove for body	1.30	5.11	4.93	0.86	0.80	0.24	000
46610		A	Anoscopy remove lesion	1.28	4.97	4.84	0.91	0.83	0.24	000
46611		A	Anoscopy	1.30	3.57	3.43	0.93	0.85	0.23	000
46612		A	Anoscopy remove lesions	1.50	5.78	5.69	1.01	0.97	0.31	000
46614		A	Anoscopy control bleeding	1.00	2.50	2.49	0.78	0.76	0.14	000
46615		A	Anoscopy	1.50	2.40	2.37	1.01	0.97	0.29	000
46700		A	Repair of anal stricture	9.81	NA	NA	7.96	7.08	1.63	090
46705		A	Repair of anal stricture	7.43	NA	NA	6.23	6.02	0.52	090
46706		A	Repr of anal fistula w/glue	2.44	NA	NA	2.09	1.95	0.42	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
46707		A	Repair anorectal fist w/plug	6.39	NA	NA	6.52	6.52	0.90	090
46710		A	Repr per/vag pouch sngl proc	17.14	NA	NA	11.59	10.81	3.67	090
46712		A	Repr per/vag pouch dbl proc	36.45	NA	NA	22.21	19.99	2.58	090
46715		A	Rep perf anoper fistu	7.62	NA	NA	6.38	5.87	0.53	090
46716		A	Rep perf anoper/vestib fistu	17.54	NA	NA	13.80	14.51	1.24	090
46730		A	Construction of absent anus	30.65	NA	NA	19.25	18.50	2.17	090
46735		A	Construction of absent anus	36.14	NA	NA	21.67	20.80	2.57	090
46740		A	Construction of absent anus	33.90	NA	NA	22.59	20.28	7.21	090
46742		A	Repair of imperforated anus	40.14	NA	NA	25.22	22.99	8.54	090
46744		A	Repair of cloacal anomaly	58.94	NA	NA	35.38	30.59	8.41	090
46746		A	Repair of cloacal anomaly	65.44	NA	NA	34.70	33.69	4.63	090
46748		A	Repair of cloacal anomaly	71.42	NA	NA	33.57	33.79	5.07	090
46750		A	Repair of anal sphincter	12.15	NA	NA	8.64	7.87	1.97	090
46751		A	Repair of anal sphincter	9.30	NA	NA	6.98	6.92	1.56	090
46753		A	Reconstruction of anus	8.89	NA	NA	7.00	6.31	1.51	090
46754		A	Removal of suture from anus	3.01	5.22	4.88	3.40	3.02	0.42	010
46760		A	Repair of anal sphincter	17.45	NA	NA	12.54	11.16	2.47	090
46761		A	Repair of anal sphincter	15.29	NA	NA	10.19	9.13	2.42	090
46762		A	Implant artificial sphincter	14.82	NA	NA	10.48	9.46	2.12	090
46900		A	Destruction anal lesion(s)	1.91	4.76	4.47	1.90	1.77	0.30	010
46910		A	Destruction anal lesion(s)	1.91	4.90	4.70	1.71	1.59	0.34	010
46916		A	Cryosurgery anal lesion(s)	1.91	4.56	4.53	2.16	2.05	0.27	010
46917		A	Laser surgery anal lesions	1.91	10.96	10.89	1.74	1.62	0.33	010
46922		A	Excision of anal lesion(s)	1.91	5.39	5.08	1.75	1.60	0.35	010
46924		A	Destruction anal lesion(s)	2.81	12.04	11.73	2.25	2.06	0.45	010
46930		A	Destroy internal hemorrhoids	1.61	3.94	4.14	2.41	2.49	0.26	090
46940		A	Treatment of anal fissure	2.35	3.94	3.59	1.65	1.49	0.37	010
46942		A	Treatment of anal fissure	2.07	3.85	3.50	1.52	1.37	0.33	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
46945		A	Remove by ligat int hem grp	2.21	6.17	5.76	3.93	3.70	0.38	090
46946		A	Remove by ligat int hem grps	2.63	5.87	5.62	3.49	3.33	0.43	090
46947		A	Hemorrhoidopexy by stapling	5.57	NA	NA	4.68	4.23	1.09	090
46999		C	Anus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47000		A	Needle biopsy of liver	1.90	8.20	8.09	0.74	0.82	0.20	000
47001		A	Needle biopsy liver add-on	1.90	NA	NA	0.82	0.75	0.38	ZZZ
47010		A	Open drainage liver lesion	19.40	NA	NA	12.19	11.36	3.95	090
47011		A	Percut drain liver lesion	3.69	NA	NA	1.36	1.54	0.35	000
47015		A	Inject/aspirate liver cyst	18.50	NA	NA	12.17	10.98	3.92	090
47100		A	Wedge biopsy of liver	12.91	NA	NA	9.48	8.67	2.69	090
47120		A	Partial removal of liver	39.01	NA	NA	22.18	20.23	8.24	090
47122		A	Extensive removal of liver	59.48	NA	NA	30.30	27.65	12.62	090
47125		A	Partial removal of liver	53.04	NA	NA	27.49	25.09	11.18	090
47130		A	Partial removal of liver	57.19	NA	NA	29.16	26.67	12.02	090
47133		X	Removal of donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47135		R	Transplantation of liver	83.64	NA	NA	44.88	40.79	17.67	090
47136		R	Transplantation of liver	70.74	NA	NA	37.60	34.87	15.06	090
47140		A	Partial removal donor liver	59.40	NA	NA	34.45	31.12	12.64	090
47141		A	Partial removal donor liver	71.50	NA	NA	38.50	35.66	5.07	090
47142		A	Partial removal donor liver	79.44	NA	NA	44.07	39.87	16.89	090
47143		C	Prep donor liver whole	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47144		C	Prep donor liver 3-segment	0.00	0.00	0.00	0.00	0.00	0.00	090
47145		C	Prep donor liver lobe split	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47146		A	Prep donor liver/venous	6.00	NA	NA	2.62	2.38	1.28	XXX
47147		A	Prep donor liver/arterial	7.00	NA	NA	3.06	2.78	1.48	XXX
47300		A	Surgery for liver lesion	18.14	NA	NA	11.86	10.71	3.83	090
47350		A	Repair liver wound	22.49	NA	NA	13.72	12.50	4.69	090
47360		A	Repair liver wound	31.31	NA	NA	18.05	16.30	6.65	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
47361		A	Repair liver wound	52.60	NA	NA	26.72	24.42	10.67	090
47362		A	Repair liver wound	23.54	NA	NA	14.66	13.13	4.93	090
47370		A	Laparo ablate liver tumor rf	20.80	NA	NA	11.93	10.91	4.21	090
47371		A	Laparo ablate liver cryosurg	20.80	NA	NA	12.25	11.39	4.43	090
47379		C	Laparoscope procedure liver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47380		A	Open ablate liver tumor rf	24.56	NA	NA	13.38	12.35	4.94	090
47381		A	Open ablate liver tumor cryo	24.88	NA	NA	11.36	11.58	5.30	090
47382		A	Percut ablate liver rf	15.22	120.12	120.12	6.22	7.17	1.48	010
47399		C	Liver surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47400		A	Incision of liver duct	36.36	NA	NA	20.26	18.33	7.73	090
47420		A	Incision of bile duct	22.03	NA	NA	13.34	12.14	4.66	090
47425		A	Incision of bile duct	22.31	NA	NA	13.69	12.35	4.75	090
47460		A	Incise bile duct sphincter	20.52	NA	NA	12.91	12.10	4.36	090
47480		A	Incision of gallbladder	13.25	NA	NA	9.90	9.03	2.74	090
47490		A	Incision of gallbladder	4.76	NA	NA	4.32	5.57	0.43	010
47500		A	Injection for liver x-rays	1.96	NA	NA	0.71	0.82	0.20	000
47505		A	Injection for liver x-rays	0.76	NA	NA	0.28	0.32	0.07	000
47510		A	Insert catheter bile duct	8.03	NA	NA	4.88	5.46	0.80	090
47511		A	Insert bile duct drain	10.77	NA	NA	5.16	5.89	1.02	090
47525		A	Change bile duct catheter	1.54	12.36	13.52	0.81	1.23	0.14	000
47530		A	Revise/reinsert bile tube	6.05	33.64	36.11	3.65	4.09	0.61	090
47550		A	Bile duct endoscopy add-on	3.02	NA	NA	1.32	1.21	0.62	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	NA	2.60	2.94	0.62	000
47553		A	Biliary endoscopy thru skin	6.34	NA	NA	2.34	2.63	0.62	000
47554		A	Biliary endoscopy thru skin	9.05	NA	NA	4.07	4.16	1.51	000
47555		A	Biliary endoscopy thru skin	7.55	NA	NA	2.72	3.14	0.71	000
47556		A	Biliary endoscopy thru skin	8.55	NA	NA	3.10	3.57	0.80	000
47560		A	Laparoscopy w/cholangio	4.88	NA	NA	2.13	1.96	1.05	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
47561		A	Laparo w/cholangio/biopsy	5.17	NA	NA	2.55	2.34	1.10	000
47562		A	Laparoscopic cholecystectomy	11.76	NA	NA	8.08	7.32	2.47	090
47563		A	Laparo cholecystectomy/graph	12.11	NA	NA	7.86	7.17	2.57	090
47564		A	Laparo cholecystectomy/explr	14.24	NA	NA	8.49	7.77	3.03	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	NA	7.86	7.18	2.66	090
47579		C	Laparoscope proc biliary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47600		A	Removal of gallbladder	17.48	NA	NA	11.15	9.98	3.69	090
47605		A	Removal of gallbladder	15.98	NA	NA	9.92	9.02	3.40	090
47610		A	Removal of gallbladder	20.92	NA	NA	12.08	10.96	4.44	090
47612		A	Removal of gallbladder	21.21	NA	NA	12.15	11.02	4.49	090
47620		A	Removal of gallbladder	23.07	NA	NA	13.18	11.90	4.93	090
47630		A	Remove bile duct stone	9.65	NA	NA	5.27	5.71	1.21	090
47700		A	Exploration of bile ducts	16.50	NA	NA	11.28	10.34	3.52	090
47701		A	Bile duct revision	28.73	NA	NA	16.91	16.21	6.10	090
47711		A	Excision of bile duct tumor	25.90	NA	NA	15.17	13.78	5.47	090
47712		A	Excision of bile duct tumor	33.72	NA	NA	18.82	16.96	7.18	090
47715		A	Excision of bile duct cyst	21.55	NA	NA	13.50	12.14	4.59	090
47720		A	Fuse gallbladder & bowel	18.34	NA	NA	11.91	10.81	3.87	090
47721		A	Fuse upper gi structures	21.99	NA	NA	13.70	12.33	4.69	090
47740		A	Fuse gallbladder & bowel	21.23	NA	NA	13.36	12.00	4.51	090
47741		A	Fuse gallbladder & bowel	24.21	NA	NA	14.67	13.22	5.15	090
47760		A	Fuse bile ducts and bowel	38.32	NA	NA	21.00	18.53	8.09	090
47765		A	Fuse liver ducts & bowel	52.19	NA	NA	27.60	23.85	11.11	090
47780		A	Fuse bile ducts and bowel	42.32	NA	NA	22.63	19.92	8.96	090
47785		A	Fuse bile ducts and bowel	56.19	NA	NA	28.92	25.19	11.96	090
47800		A	Reconstruction of bile ducts	26.17	NA	NA	15.49	13.99	5.58	090
47801		A	Placement bile duct support	17.60	NA	NA	10.00	10.40	2.43	090
47802		A	Fuse liver duct & intestine	24.93	NA	NA	15.27	13.79	5.31	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
47900		A	Suture bile duct injury	22.44	NA	NA	13.49	12.29	4.71	090
47999		C	Bile tract surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
48000		A	Drainage of abdomen	31.95	NA	NA	16.98	15.69	6.17	090
48001		A	Placement of drain pancreas	39.69	NA	NA	20.93	18.88	8.46	090
48020		A	Removal of pancreatic stone	19.09	NA	NA	11.93	10.83	4.07	090
48100		A	Biopsy of pancreas open	14.46	NA	NA	9.00	8.20	2.99	090
48102		A	Needle biopsy pancreas	4.70	10.25	10.82	1.98	2.25	0.43	010
48105		A	Resect/debride pancreas	49.26	NA	NA	25.85	23.20	10.28	090
48120		A	Removal of pancreas lesion	18.41	NA	NA	10.73	9.73	3.90	090
48140		A	Partial removal of pancreas	26.32	NA	NA	14.77	13.39	5.57	090
48145		A	Partial removal of pancreas	27.39	NA	NA	15.56	13.96	5.81	090
48146		A	Pancreatectomy	30.60	NA	NA	18.92	17.00	6.50	090
48148		A	Removal of pancreatic duct	20.39	NA	NA	12.50	11.23	4.33	090
48150		A	Partial removal of pancreas	52.84	NA	NA	28.53	26.02	11.20	090
48152		A	Pancreatectomy	48.65	NA	NA	27.23	24.63	10.36	090
48153		A	Pancreatectomy	52.79	NA	NA	28.51	25.96	11.19	090
48154		A	Pancreatectomy	48.88	NA	NA	27.33	24.63	10.40	090
48155		A	Removal of pancreas	29.45	NA	NA	18.34	16.69	6.26	090
48160		N	Pancreas removal/transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48400		A	Injection intraop add-on	1.95	NA	NA	0.85	0.86	0.29	ZZZ
48500		A	Surgery of pancreatic cyst	18.16	NA	NA	12.23	11.03	3.86	090
48510		A	Drain pancreatic pseudocyst	17.19	NA	NA	11.56	10.53	3.59	090
48511		A	Drain pancreatic pseudocyst	3.99	21.85	23.46	1.48	1.68	0.38	000
48520		A	Fuse pancreas cyst and bowel	18.15	NA	NA	10.64	9.67	3.83	090
48540		A	Fuse pancreas cyst and bowel	21.94	NA	NA	11.97	10.95	4.66	090
48545		A	Pancreatorrhaphy	22.23	NA	NA	13.18	11.76	4.74	090
48547		A	Duodenal exclusion	30.38	NA	NA	16.74	14.98	6.45	090
48548		A	Fuse pancreas and bowel	28.09	NA	NA	15.64	14.21	5.96	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
48550		X	Donor pancreatectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48551		C	Prep donor pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	NA	1.88	1.73	0.90	XXX
48554		R	Transpl allograft pancreas	37.80	NA	NA	30.15	27.65	7.88	090
48556		A	Removal allograft pancreas	19.47	NA	NA	14.12	12.84	4.14	090
48999		C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49000		A	Exploration of abdomen	12.54	NA	NA	7.85	7.26	2.57	090
49002		A	Reopening of abdomen	17.63	NA	NA	9.96	8.85	3.65	090
49010		A	Exploration behind abdomen	16.06	NA	NA	8.90	8.38	3.19	090
49020		A	Drain abdominal abscess	26.67	NA	NA	15.41	14.06	5.40	090
49021		A	Drain abdominal abscess	3.37	21.10	22.81	1.24	1.41	0.31	000
49040		A	Drain open abdom abscess	16.52	NA	NA	9.99	9.12	3.38	090
49041		A	Drain percut abdom abscess	3.99	21.53	22.93	1.46	1.66	0.38	000
49060		A	Drain open retrop abscess	18.53	NA	NA	10.59	9.94	3.68	090
49061		A	Drain percut retroper absc	3.69	21.18	22.69	1.36	1.54	0.34	000
49062		A	Drain to peritoneal cavity	12.22	NA	NA	7.50	7.08	2.46	090
49080		A	Puncture peritoneal cavity	1.35	2.97	3.35	0.53	0.58	0.12	000
49081		A	Removal of abdominal fluid	1.26	3.32	3.40	0.57	0.58	0.16	000
49180		A	Biopsy abdominal mass	1.73	2.64	2.96	0.64	0.72	0.16	000
49203		A	Exc abd tum 5 cm or less	20.13	NA	NA	11.59	10.74	3.92	090
49204		A	Exc abd tum over 5 cm	26.13	NA	NA	14.20	13.12	5.07	090
49205		A	Exc abd tum over 10 cm	30.13	NA	NA	15.97	14.72	6.02	090
49215		A	Excise sacral spine tumor	37.81	NA	NA	20.79	18.77	7.52	090
49220		A	Multiple surgery abdomen	15.79	NA	NA	9.77	8.96	3.38	090
49250		A	Excision of umbilicus	9.01	NA	NA	6.52	6.00	1.83	090
49255		A	Removal of omentum	12.56	NA	NA	8.38	7.74	2.54	090
49320		A	Diag laparo separate proc	5.14	NA	NA	3.57	3.35	1.03	010
49321		A	Laparoscopy biopsy	5.44	NA	NA	3.77	3.51	1.13	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
49322		A	Laparoscopy aspiration	6.01	NA	NA	3.89	3.67	1.15	010
49323		A	Laparo drain lymphocele	10.23	NA	NA	6.91	6.38	2.13	090
49324		A	Lap insert tunnel ip cath	6.32	NA	NA	4.13	3.82	1.33	010
49325		A	Lap revision perm ip cath	6.82	NA	NA	4.32	3.99	1.47	010
49326		A	Lap w/omentopexy add-on	3.50	NA	NA	1.47	1.32	0.73	ZZZ
49327		A	Lap ins device for rt	2.38	NA	NA	1.04	1.04	0.48	ZZZ
49329		C	Laparo proc abdm/per/oment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49400		A	Air injection into abdomen	1.88	1.81	2.53	0.70	0.77	0.24	000
49402		A	Remove foreign body adbomen	14.09	NA	NA	8.57	7.81	2.89	090
49411		A	Ins mark abd/pel for rt perq	3.82	11.25	11.25	1.66	1.66	0.35	000
49412		A	Ins device for rt guide open	1.50	NA	NA	0.63	0.63	0.30	ZZZ
49418		A	Insert tun ip cath perc	4.21	40.03	40.03	2.07	2.07	0.62	000
49419		A	Insert tun ip cath w/port	7.08	NA	NA	4.81	4.61	1.22	090
49421		A	Ins tun ip cath for dial opn	4.21	NA	NA	1.91	2.90	0.83	000
49422		A	Remove tunneled ip cath	6.29	NA	NA	3.84	3.63	1.29	010
49423		A	Exchange drainage catheter	1.46	14.18	15.28	0.56	0.65	0.12	000
49424		A	Assess cyst contrast inject	0.76	3.34	3.66	0.31	0.35	0.07	000
49425		A	Insert abdomen-venous drain	12.22	NA	NA	7.57	7.21	2.66	090
49426		A	Revise abdomen-venous shunt	10.41	NA	NA	6.47	6.16	2.06	090
49427		A	Injection abdominal shunt	0.89	NA	NA	0.34	0.38	0.10	000
49428		A	Ligation of shunt	6.87	NA	NA	4.52	4.36	1.47	010
49429		A	Removal of shunt	7.44	NA	NA	4.65	4.32	1.59	010
49435		A	Insert subq exten to ip cath	2.25	NA	NA	0.89	0.81	0.45	ZZZ
49436		A	Embedded ip cath exit-site	2.72	NA	NA	2.22	2.10	0.58	010
49440		A	Place gastrostomy tube perc	4.18	25.13	27.53	2.01	2.17	0.48	010
49441		A	Place duod/jej tube perc	4.77	28.30	30.37	2.29	2.45	0.54	010
49442		A	Place cecostomy tube perc	4.00	21.78	25.57	2.02	2.05	0.37	010
49446		A	Change g-tube to g-j perc	3.31	24.26	26.15	1.22	1.39	0.31	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
49450		A	Replace g/c tube perc	1.36	17.15	19.76	0.52	0.55	0.12	000
49451		A	Replace duod/jej tube perc	1.84	18.30	19.47	0.69	0.78	0.20	000
49452		A	Replace g-j tube perc	2.86	21.94	23.61	1.06	1.21	0.27	000
49460		A	Fix g/colon tube w/device	0.96	19.55	22.38	0.38	0.40	0.10	000
49465		A	Fluoro exam of g/colon tube	0.62	4.14	4.44	0.23	0.26	0.05	000
49491		A	Rpr hern preemie reduc	12.53	NA	NA	8.39	7.57	2.66	090
49492		A	Rpr ing hern premie blocked	15.43	NA	NA	9.75	8.86	3.29	090
49495		A	Rpr ing hernia baby reduc	6.20	NA	NA	4.64	4.13	1.32	090
49496		A	Rpr ing hernia baby blocked	9.42	NA	NA	6.80	6.17	2.20	090
49500		A	Rpr ing hernia init reduce	5.84	NA	NA	3.96	4.01	1.24	090
49501		A	Rpr ing hernia init blocked	9.36	NA	NA	6.62	6.02	1.98	090
49505		A	Prp i/hern init reduc >5 yr	7.96	NA	NA	5.82	5.33	1.66	090
49507		A	Prp i/hern init block >5 yr	10.05	NA	NA	6.80	6.21	2.12	090
49520		A	Rerepair ing hernia reduce	9.99	NA	NA	6.70	6.13	2.09	090
49521		A	Rerepair ing hernia blocked	12.44	NA	NA	7.73	7.07	2.61	090
49525		A	Repair ing hernia sliding	8.93	NA	NA	6.23	5.70	1.86	090
49540		A	Repair lumbar hernia	10.74	NA	NA	7.17	6.51	2.25	090
49550		A	Rpr rem hernia init reduce	8.99	NA	NA	6.24	5.71	1.89	090
49553		A	Rpr fem hernia init blocked	9.92	NA	NA	6.76	6.16	2.09	090
49555		A	Rerepair fem hernia reduce	9.39	NA	NA	6.40	5.87	1.97	090
49557		A	Rerepair fem hernia blocked	11.62	NA	NA	7.49	6.84	2.44	090
49560		A	Rpr ventral hern init reduc	11.92	NA	NA	7.56	6.91	2.47	090
49561		A	Rpr ventral hern init block	15.38	NA	NA	9.13	8.29	3.23	090
49565		A	Rerepair ventrl hern reduce	12.37	NA	NA	7.93	7.22	2.59	090
49566		A	Rerepair ventrl hern block	15.53	NA	NA	9.24	8.39	3.29	090
49568		A	Hernia repair w/mesh	4.88	NA	NA	2.13	1.94	1.03	ZZZ
49570		A	Rpr epigastric hern reduce	6.05	NA	NA	4.98	4.57	1.28	090
49572		A	Rpr epigastric hern blocked	7.87	NA	NA	5.78	5.24	1.64	090
49580		A	Rpr umbil hern reduc < 5 yr	4.47	NA	NA	4.39	3.99	0.95	090
49582		A	Rpr umbil hern block < 5 yr	7.13	NA	NA	5.64	5.13	1.52	090
49585		A	Rpr umbil hern reduc > 5 yr	6.59	NA	NA	5.20	4.77	1.37	090
49587		A	Rpr umbil hern block > 5 yr	8.04	NA	NA	5.83	5.33	1.68	090
49590		A	Repair spigelian hernia	8.90	NA	NA	6.24	5.70	1.87	090
49600		A	Repair umbilical lesion	11.55	NA	NA	7.71	7.18	2.44	090
49605		A	Repair umbilical lesion	87.09	NA	NA	42.20	39.18	18.54	090
49606		A	Repair umbilical lesion	19.00	NA	NA	10.75	9.80	4.05	090
49610		A	Repair umbilical lesion	10.91	NA	NA	7.21	6.66	2.31	090
49611		A	Repair umbilical lesion	9.34	NA	NA	6.03	6.15	0.65	090
49650		A	Lap ing hernia repair init	6.36	NA	NA	4.99	4.58	1.33	090
49651		A	Lap ing hernia repair recur	8.38	NA	NA	6.38	5.81	1.78	090
49652		A	Lap vent/abd hernia repair	12.88	NA	NA	8.14	7.42	0.90	090
49653		A	Lap vent/abd hern proc comp	16.21	NA	NA	10.12	9.20	1.15	090
49654		A	Lap inc hernia repair	15.03	NA	NA	9.11	8.27	1.06	090
49655		A	Lap inc hern repair comp	18.11	NA	NA	10.93	9.93	1.28	090
49656		A	Lap inc hernia repair recur	15.08	NA	NA	9.15	8.30	1.07	090
49657		A	Lap inc hern recur comp	22.11	NA	NA	12.70	11.48	1.56	090
49659		C	Laparo proc hernia repair	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49900		A	Repair of abdominal wall	12.41	NA	NA	9.30	8.60	2.54	090
49904		A	Omental flap extra-abdom	22.35	NA	NA	15.87	15.84	4.74	090
49905		A	Omental flap intra-abdom	6.54	NA	NA	2.81	2.60	1.24	ZZZ
49906		C	Free omental flap microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
49999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50010		A	Exploration of kidney	12.28	NA	NA	7.79	7.94	1.79	090
50020		A	Renal abscess open drain	18.08	NA	NA	10.81	10.81	2.40	090
50021		A	Renal abscess percut drain	3.37	22.57	24.30	1.23	1.40	0.31	000
50040		A	Drainage of kidney	16.68	NA	NA	8.81	9.81	1.68	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
50045		A	Exploration of kidney	16.82	NA	NA	8.93	9.83	1.62	090
5005F		I	Pt counsld on exam for moles	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50060		A	Removal of kidney stone	20.95	NA	NA	10.55	11.78	2.01	090
50065		A	Incision of kidney	22.32	NA	NA	11.09	12.12	2.16	090
50070		A	Incision of kidney	21.85	NA	NA	10.91	12.26	2.12	090
50075		A	Removal of kidney stone	27.09	NA	NA	13.19	14.80	2.62	090
50080		A	Removal of kidney stone	15.74	NA	NA	8.27	9.27	1.55	090
50081		A	Removal of kidney stone	23.50	NA	NA	11.79	13.19	2.31	090
50100		A	Revise kidney blood vessels	17.45	NA	NA	7.25	8.35	3.72	090
50120		A	Exploration of kidney	17.21	NA	NA	9.01	9.95	1.66	090
50125		A	Explore and drain kidney	17.82	NA	NA	11.11	11.11	1.71	090
50130		A	Removal of kidney stone	18.82	NA	NA	9.76	10.89	1.82	090
50135		A	Exploration of kidney	20.59	NA	NA	10.41	11.56	1.98	090
50200		A	Renal biopsy perq	2.63	14.16	14.16	1.29	1.42	0.31	000
50205		A	Renal biopsy open	12.29	NA	NA	7.64	7.23	2.39	090
5020F		I	Txmnts 2 main dr by 1 mon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50220		A	Remove kidney open	18.68	NA	NA	9.89	10.70	2.24	090
50225		A	Removal kidney open complex	21.88	NA	NA	11.07	12.06	2.38	090
50230		A	Removal kidney open radical	23.81	NA	NA	11.52	12.79	2.44	090
50234		A	Removal of kidney & ureter	24.05	NA	NA	11.88	13.16	2.43	090
50236		A	Removal of kidney & ureter	26.94	NA	NA	13.55	15.15	2.63	090
50240		A	Partial removal of kidney	24.21	NA	NA	12.35	13.72	2.42	090
50250		A	Cryoablate renal mass open	22.22	NA	NA	11.40	12.86	2.17	090
50280		A	Removal of kidney lesion	17.09	NA	NA	9.24	10.08	1.86	090
50290		A	Removal of kidney lesion	16.15	NA	NA	10.38	9.89	1.56	090
50300		X	Remove cadaver donor kidney	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50320		A	Remove kidney living donor	22.43	NA	NA	15.49	15.40	3.87	090
50323		C	Prep cadaver renal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
50325		C	Prep donor renal graft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50327		A	Prep renal graft/venous	4.00	NA	NA	1.70	1.61	0.77	XXX
50328		A	Prep renal graft/arterial	3.50	NA	NA	1.48	1.41	0.67	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	NA	1.37	1.42	0.48	XXX
50340		A	Removal of kidney	14.04	NA	NA	11.05	10.10	3.00	090
50360		A	Transplantation of kidney	40.90	NA	NA	27.22	24.92	8.28	090
50365		A	Transplantation of kidney	46.13	NA	NA	29.82	27.52	9.82	090
50370		A	Remove transplanted kidney	18.88	NA	NA	13.01	11.98	3.75	090
50380		A	Reimplantation of kidney	30.11	NA	NA	22.85	22.02	6.40	090
50382		A	Change ureter stent percut	5.50	28.06	31.83	2.07	2.38	0.52	000
50384		A	Remove ureter stent percut	5.00	22.03	26.14	1.86	2.15	0.48	000
50385		A	Change stent via transureth	4.44	28.19	32.12	1.98	2.31	0.42	000
50386		A	Remove stent via transureth	3.30	18.15	20.49	1.56	1.81	0.31	000
50387		A	Change ext/int ureter stent	2.00	13.51	15.35	0.73	0.85	0.20	000
50389		A	Remove renal tube w/fluoro	1.10	7.09	8.56	0.41	0.47	0.10	000
50390		A	Drainage of kidney lesion	1.96	NA	NA	0.72	0.82	0.18	000
50391		A	Instll rx agnt into rnal tub	1.96	1.43	1.66	0.79	0.88	0.20	000
50392		A	Insert kidney drain	3.37	NA	NA	1.56	1.77	0.31	000
50393		A	Insert ureteral tube	4.15	NA	NA	1.84	2.10	0.38	000
50394		A	Injection for kidney x-ray	0.76	1.99	2.27	0.61	0.68	0.07	000
50395		A	Create passage to kidney	3.37	NA	NA	1.59	1.80	0.33	000
50396		A	Measure kidney pressure	2.09	NA	NA	1.10	1.26	0.20	000
50398		A	Change kidney tube	1.46	12.74	14.30	0.57	0.65	0.12	000
50400		A	Revision of kidney/ureter	21.27	NA	NA	10.73	11.86	2.09	090
50405		A	Revision of kidney/ureter	25.86	NA	NA	12.71	14.14	2.50	090
50500		A	Repair of kidney wound	21.22	NA	NA	12.04	11.66	4.51	090
50520		A	Close kidney-skin fistula	18.88	NA	NA	9.74	10.72	1.83	090
50525		A	Repair renal-abdomen fistula	24.39	NA	NA	14.20	13.94	5.19	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
50526		A	Repair renal-abdomen fistula	26.31	NA	NA	14.24	13.77	1.86	090
50540		A	Revision of horseshoe kidney	21.10	NA	NA	10.61	11.50	2.02	090
50541		A	Laparo ablate renal cyst	16.86	NA	NA	8.56	9.51	1.70	090
50542		A	Laparo ablate renal mass	21.36	NA	NA	10.92	12.17	2.09	090
50543		A	Laparo partial nephrectomy	27.41	NA	NA	13.74	15.32	2.72	090
50544		A	Laparoscopy pyeloplasty	23.37	NA	NA	11.10	12.42	2.31	090
50545		A	Laparo radical nephrectomy	25.06	NA	NA	12.00	13.40	2.54	090
50546		A	Laparoscopic nephrectomy	21.87	NA	NA	11.24	12.42	2.30	090
50547		A	Laparo removal donor kidney	26.34	NA	NA	16.40	15.91	4.82	090
50548		A	Laparo remove w/ureter	25.36	NA	NA	11.91	13.34	2.50	090
50549		C	Laparoscope proc renal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50551		A	Kidney endoscopy	5.59	4.28	4.95	2.58	2.89	0.54	000
50553		A	Kidney endoscopy	5.98	4.56	5.14	2.69	3.01	0.65	000
50555		A	Kidney endoscopy & biopsy	6.52	4.79	5.50	2.94	3.30	0.62	000
50557		A	Kidney endoscopy & treatment	6.61	4.88	5.63	2.97	3.34	0.64	000
50561		A	Kidney endoscopy & treatment	7.58	5.48	6.30	3.36	3.78	0.75	000
50562		A	Renal scope w/tumor resect	10.90	NA	NA	5.18	5.87	1.06	090
50570		A	Kidney endoscopy	9.53	NA	NA	4.09	4.62	0.91	000
50572		A	Kidney endoscopy	10.33	NA	NA	4.40	4.99	1.00	000
50574		A	Kidney endoscopy & biopsy	11.00	NA	NA	4.67	5.27	1.07	000
50575		A	Kidney endoscopy	13.96	NA	NA	5.83	6.60	1.36	000
50576		A	Kidney endoscopy & treatment	10.97	NA	NA	4.66	5.27	1.06	000
50580		A	Kidney endoscopy & treatment	11.84	NA	NA	5.00	5.59	1.15	000
50590		A	Fragmenting of kidney stone	9.77	11.28	15.39	5.83	6.50	0.95	090
50592		A	Perc rf ablate renal tumor	6.80	76.66	94.45	3.17	3.57	0.64	010
50593		A	Perc cryo ablate renal tum	9.13	115.70	130.21	4.23	4.32	0.86	010
50600		A	Exploration of ureter	17.17	NA	NA	8.77	9.69	1.66	090
50605		A	Insert ureteral support	16.79	NA	NA	9.42	9.53	2.65	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
5060F		I	Fndngs mammo 2pt w/in 3 days	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50610		A	Removal of ureter stone	17.25	NA	NA	8.87	9.90	1.66	090
50620		A	Removal of ureter stone	16.43	NA	NA	8.55	9.54	1.59	090
5062F		I	Mammo result com to pt 5 day	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50630		A	Removal of ureter stone	16.21	NA	NA	8.46	9.23	1.56	090
50650		A	Removal of ureter	18.82	NA	NA	9.78	10.83	1.89	090
50660		A	Removal of ureter	21.02	NA	NA	10.58	11.71	2.02	090
50684		A	Injection for ureter x-ray	0.76	2.15	3.63	0.62	0.68	0.07	000
50686		A	Measure ureter pressure	1.51	2.63	2.63	1.03	1.12	0.22	000
50688		A	Change of ureter tube/stent	1.20	NA	NA	0.99	1.12	0.11	010
50690		A	Injection for ureter x-ray	1.16	1.48	1.71	0.76	0.85	0.10	000
50700		A	Revision of ureter	16.69	NA	NA	8.88	9.81	1.62	090
50715		A	Release of ureter	20.64	NA	NA	11.64	11.32	3.00	090
50722		A	Release of ureter	17.95	NA	NA	10.55	10.06	3.04	090
50725		A	Release/revise ureter	20.20	NA	NA	12.15	12.01	1.94	090
50727		A	Revise ureter	8.28	NA	NA	5.68	6.24	0.84	090
50728		A	Revise ureter	12.18	NA	NA	7.10	7.70	1.18	090
50740		A	Fusion of ureter & kidney	20.07	NA	NA	11.45	11.25	4.28	090
50750		A	Fusion of ureter & kidney	21.22	NA	NA	10.66	11.98	2.04	090
50760		A	Fusion of ureters	20.07	NA	NA	10.62	11.24	2.66	090
50770		A	Splicing of ureters	21.22	NA	NA	10.66	11.30	2.04	090
50780		A	Reimplant ureter in bladder	19.95	NA	NA	10.38	11.26	2.31	090
50782		A	Reimplant ureter in bladder	19.66	NA	NA	10.04	10.89	4.18	090
50783		A	Reimplant ureter in bladder	20.70	NA	NA	12.37	11.98	2.00	090
50785		A	Reimplant ureter in bladder	22.23	NA	NA	11.20	12.37	2.24	090
50800		A	Implant ureter in bowel	16.41	NA	NA	9.12	10.00	1.74	090
50810		A	Fusion of ureter & bowel	22.61	NA	NA	11.88	12.15	4.82	090
50815		A	Urine shunt to intestine	22.26	NA	NA	11.52	12.77	2.16	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
50820		A	Construct bowel bladder	24.07	NA	NA	12.25	13.24	2.65	090
50825		A	Construct bowel bladder	30.68	NA	NA	15.05	16.59	3.16	090
50830		A	Revise urine flow	33.77	NA	NA	16.05	17.51	3.29	090
50840		A	Replace ureter by bowel	22.39	NA	NA	11.57	12.88	2.17	090
50845		A	Appendico-vesicostomy	22.46	NA	NA	12.04	13.38	2.17	090
50860		A	Transplant ureter to skin	17.08	NA	NA	9.03	9.98	1.64	090
50900		A	Repair of ureter	15.04	NA	NA	8.52	9.08	1.47	090
50920		A	Closure ureter/skin fistula	15.81	NA	NA	8.53	9.48	1.53	090
50930		A	Closure ureter/bowel fistula	20.19	NA	NA	10.25	10.75	4.29	090
50940		A	Release of ureter	15.93	NA	NA	8.58	9.42	1.55	090
50945		A	Laparoscopy ureterolithotomy	17.97	NA	NA	8.93	9.95	1.74	090
50947		A	Laparo new ureter/bladder	25.78	NA	NA	12.45	13.73	2.50	090
50948		A	Laparo new ureter/bladder	23.82	NA	NA	11.43	12.86	2.30	090
50949		C	Laparoscope proc ureter	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50951		A	Endoscopy of ureter	5.83	4.48	5.18	2.68	3.02	0.56	000
50953		A	Endoscopy of ureter	6.23	4.69	5.41	3.16	3.55	0.61	000
50955		A	Ureter endoscopy & biopsy	6.74	4.94	5.94	3.37	3.81	0.65	000
50957		A	Ureter endoscopy & treatment	6.78	4.99	5.73	3.04	3.42	0.65	000
50961		A	Ureter endoscopy & treatment	6.04	4.56	5.26	2.75	3.10	0.58	000
50970		A	Ureter endoscopy	7.13	NA	NA	3.14	3.55	0.68	000
50972		A	Ureter endoscopy & catheter	6.88	NA	NA	3.05	3.42	0.67	000
50974		A	Ureter endoscopy & biopsy	9.16	NA	NA	3.94	4.46	0.88	000
50976		A	Ureter endoscopy & treatment	9.03	NA	NA	3.89	4.38	0.87	000
50980		A	Ureter endoscopy & treatment	6.84	NA	NA	3.03	3.43	0.65	000
5100F		I	Rsk fx ref w/n 24 hrs xray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
51020		A	Incise & treat bladder	7.69	NA	NA	5.22	5.81	0.77	090
51030		A	Incise & treat bladder	7.81	NA	NA	5.17	5.59	0.75	090
51040		A	Incise & drain bladder	4.49	NA	NA	3.48	3.92	0.43	090
51045		A	Incise bladder/drain ureter	7.81	NA	NA	5.59	5.88	1.06	090
51050		A	Removal of bladder stone	7.97	NA	NA	5.07	5.65	0.77	090
51060		A	Removal of ureter stone	9.95	NA	NA	6.08	6.80	0.98	090
51065		A	Remove ureter calculus	9.95	NA	NA	6.00	6.68	0.98	090
51080		A	Drainage of bladder abscess	6.71	NA	NA	4.56	5.03	0.65	090
51100		A	Drain bladder by needle	0.78	0.95	1.02	0.31	0.33	0.08	000
51101		A	Drain bladder by trocar/cath	1.02	2.46	2.71	0.45	0.46	0.12	000
51102		A	Drain bl w/cath insertion	2.70	3.51	4.03	1.31	1.50	0.29	000
51500		A	Removal of bladder cyst	11.05	NA	NA	7.95	7.59	1.07	090
51520		A	Removal of bladder lesion	10.21	NA	NA	6.19	6.73	0.99	090
51525		A	Removal of bladder lesion	15.42	NA	NA	8.28	9.21	1.56	090
51530		A	Removal of bladder lesion	13.71	NA	NA	8.01	8.49	1.64	090
51535		A	Repair of ureter lesion	13.90	NA	NA	7.62	8.31	1.33	090
51550		A	Partial removal of bladder	17.23	NA	NA	9.23	9.92	2.13	090
51555		A	Partial removal of bladder	23.18	NA	NA	11.75	12.77	2.59	090
51565		A	Revise bladder & ureter(s)	23.68	NA	NA	12.12	13.19	2.42	090
51570		A	Removal of bladder	27.46	NA	NA	13.55	14.67	2.80	090
51575		A	Removal of bladder & nodes	34.18	NA	NA	16.17	18.04	3.34	090
51580		A	Remove bladder/revise tract	35.37	NA	NA	17.03	19.07	3.44	090
51585		A	Removal of bladder & nodes	39.64	NA	NA	18.71	20.95	3.84	090
51590		A	Remove bladder/revise tract	36.33	NA	NA	17.03	18.92	3.67	090
51595		A	Remove bladder/revise tract	41.32	NA	NA	19.20	21.40	4.10	090
51596		A	Remove bladder/create pouch	44.26	NA	NA	20.79	23.20	4.33	090
51597		A	Removal of pelvic structures	42.86	NA	NA	20.45	22.42	4.52	090
51600		A	Injection for bladder x-ray	0.88	4.23	4.83	0.34	0.38	0.08	000
51605		A	Preparation for bladder xray	0.64	NA	NA	0.42	0.47	0.05	000
51610		A	Injection for bladder x-ray	1.05	1.88	2.17	0.71	0.78	0.10	000
51700		A	Irrigation of bladder	0.88	1.40	1.63	0.36	0.39	0.08	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
51701		A	Insert bladder catheter	0.50	1.00	1.21	0.26	0.28	0.05	000
51702		A	Insert temp bladder cath	0.50	1.43	1.73	0.33	0.36	0.05	000
51703		A	Insert bladder cath complex	1.47	2.08	2.51	0.79	0.87	0.14	000
51705		A	Change of bladder tube	1.05	1.85	2.20	0.81	0.90	0.10	010
51710		A	Change of bladder tube	1.52	2.48	3.01	1.11	1.24	0.14	010
51715		A	Endoscopic injection/implant	3.73	4.18	4.74	1.80	1.95	0.39	000
51720		A	Treatment of bladder lesion	1.50	1.49	1.77	0.72	0.83	0.14	000
51725		A	Simple cystometrogram	1.51	3.64	4.59	NA	NA	0.13	000
51725	TC	A	Simple cystometrogram	0.00	3.01	3.93	NA	NA	0.01	000
51725	26	A	Simple cystometrogram	1.51	0.63	0.66	0.63	0.66	0.12	000
51726		A	Complex cystometrogram	1.71	5.72	7.22	NA	NA	0.17	000
51726	TC	A	Complex cystometrogram	0.00	5.01	6.46	NA	NA	0.03	000
51726	26	A	Complex cystometrogram	1.71	0.71	0.76	0.71	0.76	0.14	000
51727		A	Cystometrogram w/up	2.11	6.71	6.71	NA	NA	0.23	000
51727	TC	A	Cystometrogram w/up	0.00	5.81	5.81	NA	NA	0.01	000
51727	26	A	Cystometrogram w/up	2.11	0.90	0.90	0.90	0.90	0.22	000
51728		A	Cystometrogram w/vp	2.11	6.66	6.66	NA	NA	0.19	000
51728	TC	A	Cystometrogram w/vp	0.00	5.79	5.79	NA	NA	0.01	000
51728	26	A	Cystometrogram w/vp	2.11	0.87	0.87	0.87	0.87	0.18	000
51729		A	Cystometrogram w/vp&up	2.51	7.06	7.06	NA	NA	0.25	000
51729	TC	A	Cystometrogram w/vp&up	0.00	5.99	5.99	NA	NA	0.01	000
51729	26	A	Cystometrogram w/vp&up	2.51	1.07	1.07	1.07	1.07	0.24	000
51736		A	Urine flow measurement	0.17	0.66	0.85	NA	NA	0.02	XXX
51736	TC	A	Urine flow measurement	0.00	0.59	0.67	NA	NA	0.01	XXX
51736	26	A	Urine flow measurement	0.17	0.07	0.18	0.07	0.18	0.01	XXX
51741		A	Electro-uroflowmetry first	0.17	0.76	1.09	NA	NA	0.02	XXX
51741	TC	A	Electro-uroflowmetry first	0.00	0.69	0.78	NA	NA	0.01	XXX
51741	26	A	Electro-uroflowmetry first	0.17	0.07	0.31	0.07	0.31	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
51784		A	Anal/urinary muscle study	1.53	3.92	4.42	NA	NA	0.13	000
51784	TC	A	Anal/urinary muscle study	0.00	3.28	3.75	NA	NA	0.01	000
51784	26	A	Anal/urinary muscle study	1.53	0.64	0.67	0.64	0.67	0.12	000
51785		A	Anal/urinary muscle study	1.53	4.52	5.02	NA	NA	0.13	000
51785	TC	A	Anal/urinary muscle study	0.00	3.87	4.34	NA	NA	0.01	000
51785	26	A	Anal/urinary muscle study	1.53	0.65	0.68	0.65	0.68	0.12	000
51792		A	Urinary reflex study	1.10	4.99	5.68	NA	NA	0.11	000
51792	TC	A	Urinary reflex study	0.00	4.51	5.18	NA	NA	0.01	000
51792	26	A	Urinary reflex study	1.10	0.48	0.50	0.48	0.50	0.10	000
51797		A	Intraabdominal pressure test	0.80	2.28	3.13	NA	NA	0.06	ZZZ
51797	TC	A	Intraabdominal pressure test	0.00	1.95	2.74	NA	NA	0.01	ZZZ
51797	26	A	Intraabdominal pressure test	0.80	0.33	0.39	0.33	0.39	0.05	ZZZ
51798		A	Us urine capacity measure	0.00	0.51	0.57	NA	NA	0.01	XXX
51800		A	Revision of bladder/urethra	18.89	NA	NA	9.95	10.99	1.94	090
51820		A	Revision of urinary tract	19.59	NA	NA	10.33	10.94	1.89	090
51840		A	Attach bladder/urethra	11.36	NA	NA	6.82	7.05	1.49	090
51841		A	Attach bladder/urethra	13.68	NA	NA	7.96	8.17	1.83	090
51845		A	Repair bladder neck	10.15	NA	NA	6.08	6.56	1.20	090
51860		A	Repair of bladder wound	12.60	NA	NA	7.72	7.97	1.85	090
51865		A	Repair of bladder wound	15.80	NA	NA	8.76	9.42	1.91	090
51880		A	Repair of bladder opening	7.87	NA	NA	5.00	5.36	0.99	090
51900		A	Repair bladder/vagina lesion	14.63	NA	NA	8.38	8.89	1.41	090
51920		A	Close bladder-uterus fistula	13.41	NA	NA	7.66	8.22	1.29	090
51925		A	Hysterectomy/bladder repair	17.53	NA	NA	11.70	11.34	2.96	090
51940		A	Correction of bladder defect	30.66	NA	NA	14.71	15.56	2.97	090
51960		A	Revision of bladder & bowel	25.40	NA	NA	12.91	14.32	2.65	090
51980		A	Construct bladder opening	12.57	NA	NA	7.12	7.87	1.22	090
51990		A	Laparo urethral suspension	13.36	NA	NA	7.48	7.67	1.77	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
51992		A	Laparo sling operation	14.87	NA	NA	8.55	8.43	2.23	090
51999		C	Laparoscope proc bla	0.00	0.00	0.00	0.00	0.00	0.00	YYY
52000		A	Cystoscopy	2.23	3.31	3.85	1.25	1.38	0.23	000
52001		A	Cystoscopy removal of clots	5.44	4.71	5.52	2.52	2.82	0.53	000
52005		A	Cystoscopy & ureter catheter	2.37	5.11	6.03	1.31	1.46	0.24	000
52007		A	Cystoscopy and biopsy	3.02	9.57	12.19	1.56	1.75	0.30	000
5200F		I	Eval appros surg thxpy epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
52010		A	Cystoscopy & duct catheter	3.02	7.22	8.64	1.56	1.66	0.30	000
52204		A	Cystoscopy w/biopsy(s)	2.59	7.39	9.69	1.33	1.47	0.26	000
52214		A	Cystoscopy and treatment	3.70	13.91	14.67	1.76	2.32	0.35	000
52224		A	Cystoscopy and treatment	3.14	13.20	18.93	1.54	1.73	0.31	000
52234		A	Cystoscopy and treatment	4.62	NA	NA	2.19	2.47	0.43	000
52235		A	Cystoscopy and treatment	5.44	NA	NA	2.55	2.87	0.53	000
52240		A	Cystoscopy and treatment	9.71	NA	NA	4.23	4.77	0.95	000
52250		A	Cystoscopy and radiotracer	4.49	NA	NA	2.24	2.50	0.45	000
52260		A	Cystoscopy and treatment	3.91	NA	NA	1.91	2.12	0.39	000
52265		A	Cystoscopy and treatment	2.94	7.02	8.94	1.58	1.67	0.35	000
52270		A	Cystoscopy & revise urethra	3.36	6.27	8.04	1.67	1.88	0.33	000
52275		A	Cystoscopy & revise urethra	4.69	8.32	10.81	2.19	2.47	0.45	000
52276		A	Cystoscopy and treatment	4.99	NA	NA	2.36	2.66	0.49	000
52277		A	Cystoscopy and treatment	6.16	NA	NA	2.88	3.20	0.60	000
52281		A	Cystoscopy and treatment	2.60	4.57	5.80	1.40	1.61	0.27	000
52282		A	Cystoscopy implant stent	6.39	NA	NA	2.93	3.26	0.65	000
52283		A	Cystoscopy and treatment	3.73	3.85	4.43	1.87	2.06	0.37	000
52285		A	Cystoscopy and treatment	3.60	4.01	4.63	1.82	2.01	0.37	000
52290		A	Cystoscopy and treatment	4.58	NA	NA	2.19	2.46	0.43	000
52300		A	Cystoscopy and treatment	5.30	NA	NA	2.56	2.82	0.56	000
52301		A	Cystoscopy and treatment	5.50	NA	NA	2.60	2.94	0.53	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
52305		A	Cystoscopy and treatment	5.30	NA	NA	2.42	2.72	0.52	000
52310		A	Cystoscopy and treatment	2.81	3.64	4.39	1.38	1.55	0.29	000
52315		A	Cystoscopy and treatment	5.20	6.02	7.42	2.40	2.70	0.50	000
52317		A	Remove bladder stone	6.71	15.18	19.81	2.91	3.29	0.65	000
52318		A	Remove bladder stone	9.18	NA	NA	3.94	4.45	0.88	000
52320		A	Cystoscopy and treatment	4.69	NA	NA	2.14	2.41	0.45	000
52325		A	Cystoscopy stone removal	6.15	NA	NA	2.73	3.07	0.60	000
52327		A	Cystoscopy inject material	5.18	NA	NA	2.06	2.33	0.52	000
52330		A	Cystoscopy and treatment	5.03	8.37	14.37	2.27	2.56	0.49	000
52332		A	Cystoscopy and treatment	1.47	10.39	11.72	0.95	1.39	0.15	000
52334		A	Create passage to kidney	4.82	NA	NA	2.28	2.56	0.48	000
52341		A	Cysto w/ureter stricture tx	5.35	NA	NA	2.64	3.01	0.52	000
52342		A	Cysto w/up stricture tx	5.85	NA	NA	2.84	3.23	0.56	000
52343		A	Cysto w/renal stricture tx	6.55	NA	NA	3.12	3.55	0.64	000
52344		A	Cysto/uretero stricture tx	7.05	NA	NA	3.46	3.92	0.68	000
52345		A	Cysto/uretero w/up stricture	7.55	NA	NA	3.66	4.15	0.72	000
52346		A	Cystouretero w/renal strict	8.58	NA	NA	4.05	4.61	0.83	000
52351		A	Cystouretero & or pyeloscope	5.85	NA	NA	2.85	3.20	0.56	000
52352		A	Cystouretero w/stone remove	6.87	NA	NA	3.34	3.75	0.67	000
52353		A	Cystouretero w/lithotripsy	7.96	NA	NA	3.76	4.24	0.76	000
52354		A	Cystouretero w/biopsy	7.33	NA	NA	3.52	3.96	0.71	000
52355		A	Cystouretero w/excise tumor	8.81	NA	NA	4.10	4.62	0.86	000
52400		A	Cystouretero w/congen repr	8.69	NA	NA	4.52	5.13	0.84	090
52402		A	Cystourethro cut ejacul duct	5.27	NA	NA	2.12	2.40	0.50	000
52450		A	Incision of prostate	7.78	NA	NA	5.19	5.77	0.75	090
52500		A	Revision of bladder neck	8.14	NA	NA	5.33	5.96	0.77	090
52601		A	Prostatectomy (turp)	15.26	NA	NA	8.09	8.72	1.49	090
52630		A	Remove prostate regrowth	7.73	NA	NA	4.56	5.05	0.75	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
52640		A	Relieve bladder contracture	4.79	NA	NA	3.33	3.82	0.45	090
52647		A	Laser surgery of prostate	11.30	37.09	48.90	6.57	7.31	1.10	090
52648		A	Laser surgery of prostate	12.15	37.66	49.44	6.91	7.68	1.20	090
52649		A	Prostate laser enucleation	17.29	NA	NA	8.96	10.52	1.67	090
52700		A	Drainage of prostate abscess	7.49	NA	NA	4.68	5.10	0.72	090
53000		A	Incision of urethra	2.33	NA	NA	1.75	1.97	0.24	010
53010		A	Incision of urethra	4.45	NA	NA	3.67	4.10	0.42	090
53020		A	Incision of urethra	1.77	NA	NA	0.91	1.02	0.18	000
53025		A	Incision of urethra	1.13	NA	NA	0.84	0.81	0.07	000
53040		A	Drainage of urethra abscess	6.55	NA	NA	4.28	4.75	0.64	090
53060		A	Drainage of urethra abscess	2.68	2.41	2.45	1.90	1.86	0.43	010
53080		A	Drainage of urinary leakage	6.92	NA	NA	4.67	5.45	0.67	090
53085		A	Drainage of urinary leakage	11.18	NA	NA	6.73	6.85	1.45	090
53200		A	Biopsy of urethra	2.59	1.69	1.86	1.33	1.44	0.27	000
53210		A	Removal of urethra	13.72	NA	NA	7.72	8.47	1.32	090
53215		A	Removal of urethra	16.85	NA	NA	8.80	9.86	1.63	090
53220		A	Treatment of urethra lesion	7.63	NA	NA	4.96	5.44	0.73	090
53230		A	Removal of urethra lesion	10.44	NA	NA	6.31	6.90	1.17	090
53235		A	Removal of urethra lesion	10.99	NA	NA	6.47	7.31	1.06	090
53240		A	Surgery for urethra pouch	7.08	NA	NA	4.63	5.23	0.68	090
53250		A	Removal of urethra gland	6.52	NA	NA	4.85	5.16	1.41	090
53260		A	Treatment of urethra lesion	3.03	2.51	2.74	1.95	2.06	0.35	010
53265		A	Treatment of urethra lesion	3.17	2.81	3.19	1.97	2.14	0.34	010
53270		A	Removal of urethra gland	3.14	2.66	2.79	2.12	2.15	0.53	010
53275		A	Repair of urethra defect	4.57	NA	NA	2.67	3.01	0.45	010
53400		A	Revise urethra stage 1	14.13	NA	NA	8.03	8.89	1.41	090
53405		A	Revise urethra stage 2	15.66	NA	NA	8.46	9.52	1.52	090
53410		A	Reconstruction of urethra	17.68	NA	NA	9.40	10.49	1.71	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
53415		A	Reconstruction of urethra	20.70	NA	NA	10.50	11.71	2.04	090
53420		A	Reconstruct urethra stage 1	15.17	NA	NA	8.06	8.36	1.48	090
53425		A	Reconstruct urethra stage 2	17.07	NA	NA	8.81	9.94	1.64	090
53430		A	Reconstruction of urethra	17.43	NA	NA	9.24	9.89	1.97	090
53431		A	Reconstruct urethra/bladder	21.18	NA	NA	10.71	11.94	2.04	090
53440		A	Male sling procedure	15.54	NA	NA	8.88	9.82	1.52	090
53442		A	Remove/revise male sling	13.49	NA	NA	8.13	8.96	1.30	090
53444		A	Insert tandem cuff	14.19	NA	NA	7.72	8.66	1.37	090
53445		A	Insert uro/ves nck sphincter	15.39	NA	NA	8.82	9.93	1.51	090
53446		A	Remove uro sphincter	11.02	NA	NA	6.71	7.53	1.09	090
53447		A	Remove/replace ur sphincter	14.28	NA	NA	8.05	9.06	1.40	090
53448		A	Remov/replc ur sphinctr comp	23.44	NA	NA	11.93	13.37	2.25	090
53449		A	Repair uro sphincter	10.56	NA	NA	6.32	7.09	1.05	090
53450		A	Revision of urethra	6.77	NA	NA	4.50	5.04	0.65	090
53460		A	Revision of urethra	7.75	NA	NA	4.88	5.47	0.73	090
53500		A	Urethrlys transvag w/ scope	13.00	NA	NA	7.63	8.29	1.49	090
53502		A	Repair of urethra injury	8.26	NA	NA	5.17	5.70	0.80	090
53505		A	Repair of urethra injury	8.26	NA	NA	5.15	5.77	0.80	090
53510		A	Repair of urethra injury	10.96	NA	NA	6.46	7.24	1.06	090
53515		A	Repair of urethra injury	14.22	NA	NA	7.75	8.61	1.37	090
53520		A	Repair of urethra defect	9.48	NA	NA	5.88	6.57	0.91	090
53600		A	Dilate urethra stricture	1.21	1.07	1.25	0.56	0.63	0.11	000
53601		A	Dilate urethra stricture	0.98	1.24	1.45	0.50	0.56	0.08	000
53605		A	Dilate urethra stricture	1.28	NA	NA	0.51	0.57	0.12	000
53620		A	Dilate urethra stricture	1.62	1.56	1.88	0.80	0.89	0.16	000
53621		A	Dilate urethra stricture	1.35	1.64	1.98	0.65	0.73	0.12	000
53660		A	Dilation of urethra	0.71	1.21	1.42	0.44	0.48	0.07	000
53661		A	Dilation of urethra	0.72	1.17	1.38	0.40	0.44	0.07	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
53665		A	Dilation of urethra	0.76	NA	NA	0.31	0.33	0.08	000
53850		A	Prostatic microwave thermotx	10.08	43.43	58.37	5.61	6.25	0.99	090
53852		A	Prostatic rf thermotx	10.83	40.95	55.07	6.35	7.06	1.06	090
53855		A	Insert prost urethral stent	1.64	19.37	19.37	0.65	0.65	0.16	000
53860		A	Transurethral rf treatment	3.97	38.52	38.52	2.24	2.24	0.68	090
53899		C	Urology surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54000		A	Slitting of prepuce	1.59	2.45	2.93	1.39	1.54	0.14	010
54001		A	Slitting of prepuce	2.24	2.81	3.31	1.59	1.76	0.23	010
54015		A	Drain penis lesion	5.36	NA	NA	3.10	3.49	0.56	010
54050		A	Destruction penis lesion(s)	1.29	2.40	2.44	1.67	1.65	0.16	010
54055		A	Destruction penis lesion(s)	1.25	2.01	2.16	1.32	1.36	0.14	010
54056		A	Cryosurgery penis lesion(s)	1.29	2.72	2.69	1.87	1.81	0.18	010
54057		A	Laser surg penis lesion(s)	1.29	2.47	2.76	1.33	1.42	0.12	010
54060		A	Excision of penis lesion(s)	1.98	2.94	3.38	1.62	1.75	0.22	010
54065		A	Destruction penis lesion(s)	2.47	3.65	3.74	2.38	2.32	0.31	010
54100		A	Biopsy of penis	1.90	3.62	3.79	1.69	1.62	0.24	000
54105		A	Biopsy of penis	3.54	3.70	4.37	2.34	2.64	0.35	010
54110		A	Treatment of penis lesion	10.92	NA	NA	6.31	7.03	1.06	090
54111		A	Treat penis lesion graft	14.42	NA	NA	7.69	8.63	1.40	090
54112		A	Treat penis lesion graft	16.98	NA	NA	8.92	10.05	1.63	090
54115		A	Treatment of penis lesion	6.95	5.47	6.15	4.75	5.28	0.67	090
54120		A	Partial removal of penis	11.01	NA	NA	6.43	7.18	1.09	090
54125		A	Removal of penis	14.56	NA	NA	7.88	8.77	1.48	090
54130		A	Remove penis & nodes	21.84	NA	NA	11.13	12.47	2.12	090
54135		A	Remove penis & nodes	28.17	NA	NA	13.62	15.29	2.73	090
54150		A	Circumcision w/regionl block	1.90	2.34	2.84	0.80	0.86	0.23	000
54160		A	Circumcision neonate	2.53	3.46	4.14	1.44	1.62	0.24	010
54161		A	Circum 28 days or older	3.32	NA	NA	2.11	2.35	0.34	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
54162		A	Lysis penil circumic lesion	3.32	3.73	4.44	2.18	2.39	0.33	010
54163		A	Repair of circumcision	3.32	NA	NA	2.72	3.03	0.33	010
54164		A	Frenulotomy of penis	2.82	NA	NA	2.50	2.79	0.29	010
54200		A	Treatment of penis lesion	1.11	1.83	2.12	1.21	1.36	0.10	010
54205		A	Treatment of penis lesion	8.97	NA	NA	5.72	6.49	0.86	090
54220		A	Treatment of penis lesion	2.42	3.07	3.66	1.29	1.44	0.26	000
54230		A	Prepare penis study	1.34	1.30	1.48	0.86	0.96	0.12	000
54231		A	Dynamic cavernosometry	2.04	1.80	2.04	1.17	1.32	0.20	000
54235		A	Penile injection	1.19	1.29	1.45	0.85	0.94	0.11	000
54240		A	Penis study	1.31	1.43	1.60	NA	NA	0.09	000
54240	TC	A	Penis study	0.00	0.92	1.03	NA	NA	0.01	000
54240	26	A	Penis study	1.31	0.51	0.57	0.51	0.57	0.08	000
54250		A	Penis study	2.22	1.17	1.33	NA	NA	0.15	000
54250	TC	A	Penis study	0.00	0.29	0.34	NA	NA	0.01	000
54250	26	A	Penis study	2.22	0.88	0.99	0.88	0.99	0.14	000
54300		A	Revision of penis	11.20	NA	NA	6.53	7.41	1.09	090
54304		A	Revision of penis	13.28	NA	NA	7.43	8.46	1.28	090
54308		A	Reconstruction of urethra	12.62	NA	NA	7.89	8.49	1.22	090
54312		A	Reconstruction of urethra	14.51	NA	NA	8.96	9.67	1.40	090
54316		A	Reconstruction of urethra	18.05	NA	NA	10.56	11.34	1.74	090
54318		A	Reconstruction of urethra	12.43	NA	NA	7.97	8.53	0.87	090
54322		A	Reconstruction of urethra	13.98	NA	NA	7.59	8.64	1.36	090
54324		A	Reconstruction of urethra	17.55	NA	NA	9.22	10.51	1.68	090
54326		A	Reconstruction of urethra	17.02	NA	NA	9.11	9.77	1.64	090
54328		A	Revise penis/urethra	16.89	NA	NA	9.06	10.11	1.63	090
54332		A	Revise penis/urethra	18.37	NA	NA	9.65	10.91	1.78	090
54336		A	Revise penis/urethra	21.62	NA	NA	12.48	12.34	2.09	090
54340		A	Secondary urethral surgery	9.71	NA	NA	6.02	6.64	0.92	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
54344		A	Secondary urethral surgery	17.06	NA	NA	10.12	10.89	1.64	090
54348		A	Secondary urethral surgery	18.32	NA	NA	16.82	14.68	1.29	090
54352		A	Reconstruct urethra/penis	26.13	NA	NA	22.83	19.83	2.54	090
54360		A	Penis plastic surgery	12.78	NA	NA	7.12	8.10	1.24	090
54380		A	Repair penis	14.18	NA	NA	7.89	8.97	1.37	090
54385		A	Repair penis	16.56	NA	NA	9.07	11.07	2.42	090
54390		A	Repair penis and bladder	22.77	NA	NA	12.79	12.46	2.20	090
54400		A	Insert semi-rigid prosthesis	9.17	NA	NA	5.45	6.15	0.88	090
54401		A	Insert self-contd prosthesis	10.44	NA	NA	7.63	8.56	1.03	090
54405		A	Insert multi-comp penis pros	14.52	NA	NA	7.84	8.78	1.41	090
54406		A	Remove muti-comp penis pros	12.89	NA	NA	7.28	8.15	1.25	090
54408		A	Repair multi-comp penis pros	13.91	NA	NA	7.93	8.83	1.37	090
54410		A	Remove/replace penis prosth	15.18	NA	NA	8.57	9.62	1.48	090
54411		A	Remov/replc penis pros comp	18.35	NA	NA	10.02	11.16	1.78	090
54415		A	Remove self-contd penis pros	8.88	NA	NA	5.70	6.37	0.86	090
54416		A	Remv/repl penis contain pros	12.08	NA	NA	7.54	8.39	1.18	090
54417		A	Remv/replc penis pros compl	16.10	NA	NA	8.72	9.73	1.56	090
54420		A	Revision of penis	12.39	NA	NA	7.07	7.98	1.21	090
54430		A	Revision of penis	11.06	NA	NA	6.61	7.45	1.07	090
54435		A	Revision of penis	6.81	NA	NA	4.69	5.27	0.65	090
54440		C	Repair of penis	0.00	0.00	0.00	0.00	0.00	0.00	090
54450		A	Preputial stretching	1.12	0.80	0.95	0.47	0.54	0.10	000
54500		A	Biopsy of testis	1.31	NA	NA	0.75	0.85	0.12	000
54505		A	Biopsy of testis	3.50	NA	NA	2.29	2.60	0.34	010
54512		A	Excise lesion testis	9.33	NA	NA	5.52	6.10	0.92	090
54520		A	Removal of testis	5.30	NA	NA	3.68	4.04	0.61	090
54522		A	Orchiectomy partial	10.25	NA	NA	6.04	6.50	1.00	090
54530		A	Removal of testis	8.46	NA	NA	5.47	6.11	0.87	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
54535		A	Extensive testis surgery	13.19	NA	NA	7.36	8.01	1.28	090
54550		A	Exploration for testis	8.41	NA	NA	5.17	5.71	0.81	090
54560		A	Exploration for testis	12.10	NA	NA	6.86	7.25	1.18	090
54600		A	Reduce testis torsion	7.64	NA	NA	4.86	5.42	0.73	090
54620		A	Suspension of testis	5.21	NA	NA	3.07	3.47	0.50	010
54640		A	Suspension of testis	7.73	NA	NA	5.48	5.88	0.87	090
54650		A	Orchiopexy (fowler-stephens)	12.39	NA	NA	7.26	7.95	1.21	090
54660		A	Revision of testis	5.74	NA	NA	4.12	4.56	0.54	090
54670		A	Repair testis injury	6.65	NA	NA	4.53	5.03	0.64	090
54680		A	Relocation of testis(es)	14.04	NA	NA	7.70	8.42	1.36	090
54690		A	Laparoscopy orchiectomy	11.70	NA	NA	6.46	6.66	2.47	090
54692		A	Laparoscopy orchiopexy	13.74	NA	NA	7.23	8.13	1.32	090
54699		C	Laparoscope proc testis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54700		A	Drainage of scrotum	3.47	NA	NA	2.40	2.62	0.39	010
54800		A	Biopsy of epididymis	2.33	NA	NA	2.07	1.82	0.33	000
54830		A	Remove epididymis lesion	6.01	NA	NA	4.26	4.71	0.62	090
54840		A	Remove epididymis lesion	5.27	NA	NA	3.59	4.03	0.52	090
54860		A	Removal of epididymis	6.95	NA	NA	4.61	5.13	0.68	090
54861		A	Removal of epididymis	9.70	NA	NA	5.92	6.59	0.92	090
54865		A	Explore epididymis	5.77	NA	NA	4.13	4.57	0.56	090
54900		A	Fusion of spermatic ducts	14.20	NA	NA	7.90	8.03	1.02	090
54901		A	Fusion of spermatic ducts	19.10	NA	NA	11.17	11.87	1.36	090
55000		A	Drainage of hydrocele	1.43	1.79	2.07	0.92	1.00	0.14	000
55040		A	Removal of hydrocele	5.45	NA	NA	3.86	4.26	0.61	090
55041		A	Removal of hydroceles	8.54	NA	NA	5.52	6.09	0.90	090
55060		A	Repair of hydrocele	6.15	NA	NA	4.33	4.76	0.67	090
55100		A	Drainage of scrotum abscess	2.45	3.42	3.88	2.12	2.28	0.30	010
55110		A	Explore scrotum	6.33	NA	NA	4.39	4.81	0.68	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
55120		A	Removal of scrotum lesion	5.72	NA	NA	4.10	4.51	0.61	090
55150		A	Removal of scrotum	8.14	NA	NA	5.41	5.94	0.86	090
55175		A	Revision of scrotum	5.87	NA	NA	4.19	4.63	0.60	090
55180		A	Revision of scrotum	11.78	NA	NA	7.32	7.98	1.29	090
55200		A	Incision of sperm duct	4.55	7.35	9.22	3.13	3.43	0.43	090
55250		A	Removal of sperm duct(s)	3.37	7.32	8.98	2.96	3.25	0.33	090
55300		A	Prepare sperm duct x-ray	3.50	NA	NA	1.68	1.73	0.34	000
55400		A	Repair of sperm duct	8.61	NA	NA	5.15	5.81	0.83	090
55450		A	Ligation of sperm duct	4.43	5.38	6.47	2.68	2.94	0.42	010
55500		A	Removal of hydrocele	6.22	NA	NA	4.67	4.80	0.88	090
55520		A	Removal of sperm cord lesion	6.66	NA	NA	5.38	5.00	1.36	090
55530		A	Revise spermatic cord veins	5.75	NA	NA	3.98	4.41	0.62	090
55535		A	Revise spermatic cord veins	7.19	NA	NA	4.69	5.17	0.69	090
55540		A	Revise hernia & sperm veins	8.30	NA	NA	6.11	5.68	1.64	090
55550		A	Laparo ligate spermatic vein	7.20	NA	NA	4.62	5.02	0.69	090
55559		C	Laparo proc spermatic cord	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55600		A	Incise sperm duct pouch	7.01	NA	NA	4.62	5.17	0.68	090
55605		A	Incise sperm duct pouch	8.76	NA	NA	6.21	6.24	0.84	090
55650		A	Remove sperm duct pouch	12.65	NA	NA	7.16	7.88	1.22	090
55680		A	Remove sperm pouch lesion	5.67	NA	NA	3.88	4.17	0.54	090
55700		A	Biopsy of prostate	2.58	3.37	4.04	1.28	1.39	0.26	000
55705		A	Biopsy of prostate	4.61	NA	NA	2.75	3.11	0.45	010
55706		A	Prostate saturation sampling	6.28	NA	NA	4.01	4.69	0.43	010
55720		A	Drainage of prostate abscess	7.73	NA	NA	4.75	5.29	0.73	090
55725		A	Drainage of prostate abscess	10.05	NA	NA	6.33	6.96	0.98	090
55801		A	Removal of prostate	19.80	NA	NA	10.41	11.49	1.91	090
55810		A	Extensive prostate surgery	24.29	NA	NA	12.08	13.39	2.47	090
55812		A	Extensive prostate surgery	29.89	NA	NA	14.59	16.28	2.91	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
55815		A	Extensive prostate surgery	32.95	NA	NA	15.80	17.67	3.19	090
55821		A	Removal of prostate	15.76	NA	NA	8.40	9.37	1.55	090
55831		A	Removal of prostate	17.19	NA	NA	8.95	10.01	1.66	090
55840		A	Extensive prostate surgery	24.63	NA	NA	12.35	13.80	2.40	090
55842		A	Extensive prostate surgery	26.49	NA	NA	13.08	14.65	2.59	090
55845		A	Extensive prostate surgery	30.67	NA	NA	14.54	16.26	3.03	090
55860		A	Surgical exposure prostate	15.84	NA	NA	8.32	9.33	1.52	090
55862		A	Extensive prostate surgery	20.04	NA	NA	10.27	11.56	1.93	090
55865		A	Extensive prostate surgery	24.57	NA	NA	12.31	13.83	2.38	090
55866		A	Laparo radical prostatectomy	32.06	NA	NA	16.00	17.65	3.18	090
55870		A	Electroejaculation	2.58	2.24	2.51	1.35	1.54	0.26	000
55873		A	Cryoablate prostate	13.60	172.34	172.34	7.50	10.58	1.36	090
55875		A	Transperi needle place pros	13.46	NA	NA	7.62	8.50	1.29	090
55876		A	Place rt device/marker pros	1.73	1.98	2.27	1.05	1.20	0.16	000
55899		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55920		A	Place needles pelvic for rt	8.31	NA	NA	4.10	4.15	0.80	000
55970		N	Sex transformation m to f	0.00	0.00	0.00	0.00	0.00	0.00	XXX
55980		N	Sex transformation f to m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
56405		A	I & d of vulva/perineum	1.49	1.50	1.50	1.48	1.45	0.26	010
56420		A	Drainage of gland abscess	1.44	1.88	1.99	1.05	1.05	0.24	010
56440		A	Surgery for vulva lesion	2.89	NA	NA	2.12	2.06	0.49	010
56441		A	Lysis of labial lesion(s)	2.02	1.93	2.04	1.78	1.84	0.29	010
56442		A	Hymenotomy	0.68	NA	NA	0.64	0.64	0.11	000
56501		A	Destroy vulva lesions sim	1.58	2.00	2.03	1.57	1.55	0.27	010
56515		A	Destroy vulva lesion/s compl	3.08	3.10	3.06	2.43	2.32	0.50	010
56605		A	Biopsy of vulva/perineum	1.10	1.15	1.17	0.56	0.52	0.18	000
56606		A	Biopsy of vulva/perineum	0.55	0.47	0.48	0.26	0.24	0.08	ZZZ
56620		A	Partial removal of vulva	7.53	NA	NA	6.29	6.06	1.26	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
56625		A	Complete removal of vulva	9.68	NA	NA	6.86	6.53	1.62	090
56630		A	Extensive vulva surgery	14.80	NA	NA	9.47	8.83	2.55	090
56631		A	Extensive vulva surgery	18.99	NA	NA	11.79	10.98	3.20	090
56632		A	Extensive vulva surgery	21.86	NA	NA	14.10	13.01	3.69	090
56633		A	Extensive vulva surgery	19.62	NA	NA	11.96	11.10	3.31	090
56634		A	Extensive vulva surgery	20.66	NA	NA	12.79	11.83	3.49	090
56637		A	Extensive vulva surgery	24.75	NA	NA	14.49	13.42	4.17	090
56640		A	Extensive vulva surgery	24.78	NA	NA	13.71	12.80	4.17	090
56700		A	Partial removal of hymen	2.84	NA	NA	2.29	2.25	0.48	010
56740		A	Remove vagina gland lesion	4.88	NA	NA	3.28	3.13	0.83	010
56800		A	Repair of vagina	3.93	NA	NA	2.67	2.62	0.64	010
56805		A	Repair clitoris	19.88	NA	NA	11.34	10.84	3.37	090
56810		A	Repair of perineum	4.29	NA	NA	2.85	2.75	0.69	010
56820		A	Exam of vulva w/scope	1.50	1.52	1.52	0.83	0.77	0.26	000
56821		A	Exam/biopsy of vulva w/scope	2.05	1.95	1.97	1.08	1.02	0.34	000
57000		A	Exploration of vagina	3.02	NA	NA	2.17	2.14	0.50	010
57010		A	Drainage of pelvic abscess	6.84	NA	NA	5.08	4.90	1.15	090
57020		A	Drainage of pelvic fluid	1.50	1.05	1.03	0.73	0.67	0.26	000
57022		A	I & d vaginal hematoma pp	2.73	NA	NA	1.88	1.81	0.45	010
57023		A	I & d vag hematoma non-ob	5.18	NA	NA	3.35	3.22	0.87	010
57061		A	Destroy vag lesions simple	1.30	1.80	1.85	1.39	1.38	0.22	010
57065		A	Destroy vag lesions complex	2.66	2.58	2.58	2.03	1.98	0.43	010
57100		A	Biopsy of vagina	1.20	1.20	1.21	0.60	0.55	0.20	000
57105		A	Biopsy of vagina	1.74	1.93	1.98	1.67	1.68	0.29	010
57106		A	Remove vagina wall partial	7.50	NA	NA	5.74	5.54	1.21	090
57107		A	Remove vagina tissue part	24.56	NA	NA	13.92	13.00	4.14	090
57109		A	Vaginectomy partial w/nodes	28.40	NA	NA	15.62	14.47	4.79	090
57110		A	Remove vagina wall complete	15.48	NA	NA	9.12	8.67	2.58	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
57111		A	Remove vagina tissue compl	28.40	NA	NA	15.62	14.75	4.79	090
57112		A	Vaginectomy w/nodes compl	30.52	NA	NA	9.63	12.01	2.42	090
57120		A	Closure of vagina	8.28	NA	NA	5.73	5.57	1.36	090
57130		A	Remove vagina lesion	2.46	2.40	2.44	1.91	1.89	0.41	010
57135		A	Remove vagina lesion	2.70	2.53	2.56	2.02	1.99	0.43	010
57150		A	Treat vagina infection	0.55	0.69	0.79	0.25	0.24	0.08	000
57155		A	Insert uteri tandems/ovoids	3.37	6.05	6.05	1.69	1.69	0.30	000
57156		A	Ins vag brachytx device	1.87	2.41	2.41	1.01	1.01	0.16	000
57160		A	Insert pessary/other device	0.89	1.21	1.24	0.41	0.38	0.14	000
57170		A	Fitting of diaphragm/cap	0.91	0.75	0.87	0.41	0.38	0.14	000
57180		A	Treat vaginal bleeding	1.63	2.20	2.29	1.25	1.26	0.27	010
57200		A	Repair of vagina	4.42	NA	NA	3.77	3.72	0.71	090
57210		A	Repair vagina/perineum	5.71	NA	NA	4.33	4.26	0.91	090
57220		A	Revision of urethra	4.85	NA	NA	3.92	3.87	0.80	090
57230		A	Repair of urethral lesion	6.30	NA	NA	4.55	4.55	1.06	090
57240		A	Repair bladder & vagina	11.50	NA	NA	6.91	6.69	1.63	090
57250		A	Repair rectum & vagina	11.50	NA	NA	7.08	6.53	1.86	090
57260		A	Repair of vagina	14.44	NA	NA	8.43	7.79	2.34	090
57265		A	Extensive repair of vagina	15.94	NA	NA	9.10	8.56	2.57	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	NA	2.18	2.14	0.72	ZZZ
57268		A	Repair of bowel bulge	7.57	NA	NA	5.67	5.53	1.22	090
57270		A	Repair of bowel pouch	13.67	NA	NA	8.21	7.83	2.24	090
57280		A	Suspension of vagina	16.72	NA	NA	9.45	9.19	2.59	090
57282		A	Colpopexy extraperitoneal	7.97	NA	NA	5.80	5.74	1.24	090
57283		A	Colpopexy intraperitoneal	11.66	NA	NA	7.26	7.00	1.91	090
57284		A	Repair paravag defect open	14.33	NA	NA	8.07	8.02	2.16	090
57285		A	Repair paravag defect vag	11.60	NA	NA	6.97	6.78	1.79	090
57287		A	Revise/remove sling repair	11.15	NA	NA	7.53	7.85	1.47	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
57288		A	Repair bladder defect	12.13	NA	NA	7.19	7.53	1.59	090
57289		A	Repair bladder & vagina	12.80	NA	NA	7.32	7.73	1.24	090
57291		A	Construction of vagina	8.64	NA	NA	9.10	7.54	1.47	090
57292		A	Construct vagina with graft	14.01	NA	NA	8.41	8.16	2.34	090
57295		A	Revise vag graft via vagina	7.82	NA	NA	5.32	5.35	1.20	090
57296		A	Revise vag graft open abd	16.56	NA	NA	9.49	8.98	2.78	090
57300		A	Repair rectum-vagina fistula	8.71	NA	NA	6.50	6.03	1.52	090
57305		A	Repair rectum-vagina fistula	15.35	NA	NA	9.64	8.78	2.96	090
57307		A	Fistula repair & colostomy	17.17	NA	NA	11.04	9.94	3.67	090
57308		A	Fistula repair transperine	10.59	NA	NA	7.43	6.84	1.79	090
57310		A	Repair urethrovaginal lesion	7.65	NA	NA	5.05	5.50	0.73	090
57311		A	Repair urethrovaginal lesion	8.91	NA	NA	5.55	6.04	0.86	090
57320		A	Repair bladder-vagina lesion	8.88	NA	NA	5.79	6.13	1.05	090
57330		A	Repair bladder-vagina lesion	13.21	NA	NA	7.20	7.76	1.28	090
57335		A	Repair vagina	20.02	NA	NA	11.72	11.32	3.38	090
57400		A	Dilation of vagina	2.27	NA	NA	1.37	1.34	0.38	000
57410		A	Pelvic examination	1.75	NA	NA	1.19	1.14	0.29	000
57415		A	Remove vaginal foreign body	2.49	NA	NA	1.90	1.89	0.37	010
57420		A	Exam of vagina w/scope	1.60	1.56	1.57	0.87	0.81	0.26	000
57421		A	Exam/biopsy of vag w/scope	2.20	2.05	2.05	1.16	1.08	0.37	000
57423		A	Repair paravag defect lap	16.08	NA	NA	8.96	8.67	2.72	090
57425		A	Laparoscopy surg colpopexy	17.03	NA	NA	9.66	9.21	2.66	090
57426		A	Revise prosth vag graft lap	14.30	NA	NA	8.42	8.42	2.40	090
57452		A	Exam of cervix w/scope	1.50	1.47	1.48	1.02	0.98	0.24	000
57454		A	Bx/curett of cervix w/scope	2.33	1.87	1.84	1.41	1.34	0.38	000
57455		A	Biopsy of cervix w/scope	1.99	1.92	1.92	1.05	0.98	0.33	000
57456		A	Endocerv curettage w/scope	1.85	1.84	1.85	0.98	0.92	0.31	000
57460		A	Bx of cervix w/scope leep	2.83	4.91	5.32	1.64	1.56	0.48	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
57461		A	Conz of cervix w/scope leep	3.43	5.30	5.69	1.72	1.60	0.58	000
57500		A	Biopsy of cervix	1.20	2.29	2.46	0.88	0.84	0.20	000
57505		A	Endocervical curettage	1.19	1.59	1.63	1.33	1.33	0.20	010
57510		A	Cauterization of cervix	1.90	1.69	1.69	1.27	1.22	0.31	010
57511		A	Cryocautery of cervix	1.95	2.03	2.04	1.68	1.65	0.33	010
57513		A	Laser surgery of cervix	1.95	1.98	1.98	1.68	1.66	0.33	010
57520		A	Conization of cervix	4.11	4.23	4.29	3.35	3.30	0.68	090
57522		A	Conization of cervix	3.67	3.52	3.53	2.99	2.93	0.62	090
57530		A	Removal of cervix	5.27	NA	NA	4.17	4.09	0.87	090
57531		A	Removal of cervix radical	29.95	NA	NA	17.28	15.89	5.05	090
57540		A	Removal of residual cervix	13.29	NA	NA	8.09	7.65	2.23	090
57545		A	Remove cervix/repair pelvis	14.10	NA	NA	8.46	8.01	2.35	090
57550		A	Removal of residual cervix	6.34	NA	NA	4.84	4.73	1.07	090
57555		A	Remove cervix/repair vagina	9.94	NA	NA	6.55	6.26	1.66	090
57556		A	Remove cervix repair bowel	9.36	NA	NA	6.15	6.05	1.45	090
57558		A	D&c of cervical stump	1.72	1.70	1.71	1.40	1.37	0.29	010
57700		A	Revision of cervix	4.35	NA	NA	4.18	4.16	0.72	090
57720		A	Revision of cervix	4.61	NA	NA	3.83	3.77	0.76	090
57800		A	Dilation of cervical canal	0.77	0.88	0.89	0.56	0.55	0.12	000
58100		A	Biopsy of uterus lining	1.53	1.46	1.47	0.88	0.83	0.26	000
58110		A	Bx done w/colposcopy add-on	0.77	0.55	0.54	0.36	0.33	0.12	ZZZ
58120		A	Dilation and curettage	3.59	3.44	3.34	2.37	2.26	0.61	010
58140		A	Myomectomy abdom method	15.79	NA	NA	9.28	8.70	2.80	090
58145		A	Myomectomy vag method	8.91	NA	NA	6.00	5.76	1.49	090
58146		A	Myomectomy abdom complex	20.34	NA	NA	11.30	10.66	3.44	090
58150		A	Total hysterectomy	17.31	NA	NA	9.97	9.31	2.93	090
58152		A	Total hysterectomy	21.86	NA	NA	12.25	11.51	3.73	090
58180		A	Partial hysterectomy	16.60	NA	NA	9.60	9.02	2.80	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
58200		A	Extensive hysterectomy	23.10	NA	NA	12.91	11.97	3.88	090
58210		A	Extensive hysterectomy	30.91	NA	NA	17.23	15.89	5.26	090
58240		A	Removal of pelvis contents	49.33	NA	NA	26.97	24.96	8.31	090
58260		A	Vaginal hysterectomy	14.15	NA	NA	8.53	8.08	2.38	090
58262		A	Vag hyst including t/o	15.94	NA	NA	9.34	8.83	2.69	090
58263		A	Vag hyst w/t/o & vag repair	17.23	NA	NA	9.94	9.40	2.91	090
58267		A	Vag hyst w/urinary repair	18.36	NA	NA	10.54	9.94	3.11	090
58270		A	Vag hyst w/enterocele repair	15.30	NA	NA	8.86	8.38	2.57	090
58275		A	Hysterectomy/revise vagina	17.03	NA	NA	9.90	9.36	2.89	090
58280		A	Hysterectomy/revise vagina	18.33	NA	NA	10.54	9.92	3.07	090
58285		A	Extensive hysterectomy	23.38	NA	NA	12.58	11.78	3.92	090
58290		A	Vag hyst complex	20.27	NA	NA	11.27	10.61	3.42	090
58291		A	Vag hyst incl t/o complex	22.06	NA	NA	12.11	11.43	3.72	090
58292		A	Vag hyst t/o & repair compl	23.35	NA	NA	12.70	11.94	3.92	090
58293		A	Vag hyst w/uro repair compl	24.33	NA	NA	13.16	12.32	4.10	090
58294		A	Vag hyst w/enterocele compl	21.55	NA	NA	11.86	11.11	3.65	090
58300		N	Insert intrauterine device	1.01	0.94	1.05	0.44	0.44	0.07	XXX
58301		A	Remove intrauterine device	1.27	1.33	1.35	0.59	0.54	0.22	000
58321		A	Artificial insemination	0.92	1.18	1.24	0.42	0.40	0.05	000
58322		A	Artificial insemination	1.10	1.25	1.29	0.51	0.47	0.18	000
58323		A	Sperm washing	0.23	0.19	0.25	0.11	0.10	0.04	000
58340		A	Catheter for hysterography	0.88	2.34	2.63	0.72	0.73	0.12	000
58345		A	Reopen fallopian tube	4.70	NA	NA	2.96	2.86	0.77	010
58346		A	Insert heyman uteri capsule	7.56	NA	NA	4.77	4.77	0.62	090
58350		A	Reopen fallopian tube	1.06	1.58	1.64	1.10	1.10	0.18	010
58353		A	Endometr ablate thermal	3.60	23.90	27.71	2.41	2.34	0.61	010
58356		A	Endometrial cryoablation	6.41	45.31	51.65	3.07	2.87	1.07	010
58400		A	Suspension of uterus	7.14	NA	NA	4.95	4.92	1.07	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
58410		A	Suspension of uterus	13.80	NA	NA	8.26	7.80	2.31	090
58520		A	Repair of ruptured uterus	13.48	NA	NA	8.11	7.62	2.89	090
58540		A	Revision of uterus	15.71	NA	NA	9.21	8.66	2.65	090
58541		A	Lsh uterus 250 g or less	14.70	NA	NA	9.01	8.43	2.46	090
58542		A	Lsh w/t/o ut 250 g or less	16.56	NA	NA	9.88	9.22	2.80	090
58543		A	Lsh uterus above 250 g	16.87	NA	NA	10.04	9.34	2.85	090
58544		A	Lsh w/t/o uterus above 250 g	18.37	NA	NA	10.73	9.93	3.11	090
58545		A	Laparoscopic myomectomy	15.55	NA	NA	8.93	8.40	2.66	090
58546		A	Laparo-myomectomy complex	19.94	NA	NA	10.93	10.27	3.38	090
58548		A	Lap radical hyst	31.63	NA	NA	17.88	16.16	5.31	090
58550		A	Laparo-asst vag hysterectomy	15.10	NA	NA	9.09	8.62	2.55	090
58552		A	Laparo-vag hyst incl t/o	16.91	NA	NA	9.92	9.37	2.87	090
58553		A	Laparo-vag hyst complex	20.06	NA	NA	11.04	10.34	3.40	090
58554		A	Laparo-vag hyst w/t/o compl	23.11	NA	NA	12.90	12.06	3.92	090
58555		A	Hysteroscopy dx sep proc	3.33	4.97	4.12	1.88	1.77	0.56	000
58558		A	Hysteroscopy biopsy	4.74	6.09	5.08	2.56	2.42	0.80	000
58559		A	Hysteroscopy lysis	6.16	NA	NA	3.22	3.03	1.05	000
58560		A	Hysteroscopy resect septum	6.99	NA	NA	3.61	3.40	1.18	000
58561		A	Hysteroscopy remove myoma	9.99	NA	NA	5.01	4.69	1.67	000
58562		A	Hysteroscopy remove fb	5.20	6.02	5.04	2.74	2.59	0.87	000
58563		A	Hysteroscopy ablation	6.16	39.21	45.03	3.22	3.04	1.05	000
58565		A	Hysteroscopy sterilization	7.12	43.93	48.55	4.77	4.60	1.20	090
58570		A	Tlh uterus 250 g or less	15.88	NA	NA	9.60	8.94	2.69	090
58571		A	Tlh w/t/o 250 g or less	17.69	NA	NA	10.61	9.77	3.00	090
58572		A	Tlh uterus over 250 g	20.09	NA	NA	11.60	10.69	3.40	090
58573		A	Tlh w/t/o uterus over 250 g	23.11	NA	NA	13.16	12.02	3.88	090
58578		C	Laparo proc uterus	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58579		C	Hysteroscope procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
58600		A	Division of fallopian tube	5.91	NA	NA	4.09	3.92	1.00	090
58605		A	Division of fallopian tube	5.28	NA	NA	3.75	3.63	0.88	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	NA	0.68	0.62	0.24	ZZZ
58615		A	Occlude fallopian tube(s)	3.94	NA	NA	2.75	2.73	0.67	010
58660		A	Laparoscopy lysis	11.59	NA	NA	6.76	6.36	2.04	090
58661		A	Laparoscopy remove adnexa	11.35	NA	NA	6.23	5.85	1.93	010
58662		A	Laparoscopy excise lesions	12.15	NA	NA	7.13	6.75	2.06	090
58670		A	Laparoscopy tubal cautery	5.91	NA	NA	4.11	3.96	1.00	090
58671		A	Laparoscopy tubal block	5.91	NA	NA	4.10	3.95	1.00	090
58672		A	Laparoscopy fimbrioplasty	12.91	NA	NA	7.26	6.84	2.17	090
58673		A	Laparoscopy salpingostomy	14.04	NA	NA	7.89	7.46	2.35	090
58679		C	Laparo proc oviduct-ovary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58700		A	Removal of fallopian tube	12.95	NA	NA	8.13	7.61	2.40	090
58720		A	Removal of ovary/tube(s)	12.16	NA	NA	7.53	7.11	2.15	090
58740		A	Adhesiolysis tube ovary	14.90	NA	NA	8.94	8.49	2.63	090
58750		A	Repair oviduct	15.64	NA	NA	9.08	8.60	2.63	090
58752		A	Revise ovarian tube(s)	15.64	NA	NA	8.85	8.60	1.10	090
58760		A	Fimbrioplasty	13.93	NA	NA	8.28	7.91	2.34	090
58770		A	Create new tubal opening	14.77	NA	NA	8.61	7.91	2.47	090
58800		A	Drainage of ovarian cyst(s)	4.62	4.09	4.14	3.57	3.52	0.76	090
58805		A	Drainage of ovarian cyst(s)	6.42	NA	NA	4.54	4.48	1.09	090
58820		A	Drain ovary abscess open	4.70	NA	NA	4.62	4.21	0.77	090
58822		A	Drain ovary abscess percut	11.81	NA	NA	7.39	7.17	2.51	090
58823		A	Drain pelvic abscess percut	3.37	21.62	23.22	1.27	1.40	0.38	000
58825		A	Transposition ovary(s)	11.78	NA	NA	7.59	7.08	1.97	090
58900		A	Biopsy of ovary(s)	6.59	NA	NA	5.45	4.97	1.40	090
58920		A	Partial removal of ovary(s)	11.95	NA	NA	7.26	6.84	2.00	090
58925		A	Removal of ovarian cyst(s)	12.43	NA	NA	7.74	7.28	2.23	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
58940		A	Removal of ovary(s)	8.22	NA	NA	5.87	5.49	1.53	090
58943		A	Removal of ovary(s)	19.52	NA	NA	11.24	10.44	3.52	090
58950		A	Resect ovarian malignancy	18.37	NA	NA	11.13	10.37	3.25	090
58951		A	Resect ovarian malignancy	24.26	NA	NA	13.70	12.66	4.17	090
58952		A	Resect ovarian malignancy	27.29	NA	NA	15.53	14.35	4.73	090
58953		A	Tah rad dissect for debulk	34.13	NA	NA	18.85	17.38	5.87	090
58954		A	Tah rad debulk/lymph remove	37.13	NA	NA	20.28	18.71	6.34	090
58956		A	Bso omentectomy w/tah	22.80	NA	NA	13.35	12.43	3.98	090
58957		A	Resect recurrent gyn mal	26.22	NA	NA	15.06	13.71	4.79	090
58958		A	Resect recur gyn mal w/lym	29.22	NA	NA	16.42	15.01	4.93	090
58960		A	Exploration of abdomen	15.79	NA	NA	9.54	8.96	2.76	090
58970		A	Retrieval of oocyte	3.52	2.58	2.52	1.99	1.84	0.26	000
58974		C	Transfer of embryo	0.00	0.00	0.00	0.00	0.00	0.00	000
58976		A	Transfer of embryo	3.82	3.01	3.05	2.08	2.07	0.27	000
58999		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59000		A	Amniocentesis diagnostic	1.30	2.01	2.13	0.79	0.76	0.37	000
59001		A	Amniocentesis therapeutic	3.00	NA	NA	1.64	1.63	0.86	000
59012		A	Fetal cord puncture prenatal	3.44	NA	NA	1.80	1.69	0.99	000
59015		A	Chorion biopsy	2.20	1.86	1.84	1.22	1.16	0.62	000
59020		A	Fetal contract stress test	0.66	1.23	1.22	NA	NA	0.17	000
59020	TC	A	Fetal contract stress test	0.00	0.92	0.94	NA	NA	0.01	000
59020	26	A	Fetal contract stress test	0.66	0.31	0.28	0.31	0.28	0.16	000
59025		A	Fetal non-stress test	0.53	0.75	0.73	NA	NA	0.13	000
59025	TC	A	Fetal non-stress test	0.00	0.50	0.50	NA	NA	0.01	000
59025	26	A	Fetal non-stress test	0.53	0.25	0.23	0.25	0.23	0.12	000
59030		A	Fetal scalp blood sample	1.99	NA	NA	0.88	0.83	0.12	000
59050		A	Fetal monitor w/report	0.89	NA	NA	0.42	0.38	0.26	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	NA	0.35	0.31	0.22	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
59070		A	Transabdom amnioinfus w/us	5.24	5.75	5.82	2.71	2.65	1.51	000
59072		A	Umbilical cord occlud w/us	8.99	NA	NA	4.36	4.22	2.58	000
59074		A	Fetal fluid drainage w/us	5.24	5.92	5.58	3.01	2.76	1.51	000
59076		A	Fetal shunt placement w/us	8.99	NA	NA	4.36	4.05	2.58	000
59100		A	Remove uterus lesion	13.37	NA	NA	8.21	7.73	3.83	090
59120		A	Treat ectopic pregnancy	12.67	NA	NA	7.89	7.51	3.65	090
59121		A	Treat ectopic pregnancy	12.74	NA	NA	7.83	7.46	3.67	090
59130		A	Treat ectopic pregnancy	15.08	NA	NA	8.92	8.40	1.07	090
59135		A	Treat ectopic pregnancy	14.92	NA	NA	8.65	8.58	1.06	090
59136		A	Treat ectopic pregnancy	14.25	NA	NA	8.47	8.00	4.09	090
59140		A	Treat ectopic pregnancy	5.94	NA	NA	4.48	4.28	0.41	090
59150		A	Treat ectopic pregnancy	12.29	NA	NA	7.62	7.24	3.53	090
59151		A	Treat ectopic pregnancy	12.11	NA	NA	7.25	6.90	3.48	090
59160		A	D & c after delivery	2.76	2.57	2.72	1.73	1.76	0.77	010
59200		A	Insert cervical dilator	0.79	1.11	1.17	0.37	0.34	0.23	000
59300		A	Episiotomy or vaginal repair	2.41	2.65	2.65	1.44	1.33	0.68	000
59320		A	Revision of cervix	2.48	NA	NA	1.48	1.41	0.69	000
59325		A	Revision of cervix	4.06	NA	NA	2.21	2.09	0.29	000
59350		A	Repair of uterus	4.94	NA	NA	2.31	2.05	1.41	000
59400		A	Obstetrical care	28.69	NA	NA	20.68	19.40	7.97	MMM
59409		A	Obstetrical care	12.82	NA	NA	6.02	5.65	3.54	MMM
59410		A	Obstetrical care	16.07	NA	NA	8.03	7.40	4.44	MMM
59412		A	Antepartum manipulation	1.53	NA	NA	0.88	0.87	0.43	MMM
59414		A	Deliver placenta	1.44	NA	NA	0.67	0.65	0.45	MMM
59425		A	Antepartum care only	5.63	5.34	5.31	2.62	2.43	1.55	MMM
59426		A	Antepartum care only	9.96	9.73	9.67	4.64	4.30	2.69	MMM
59430		A	Care after delivery	2.20	2.27	1.84	1.03	1.00	0.60	MMM
59510		A	Cesarean delivery	31.80	NA	NA	22.68	21.59	9.04	MMM

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
59514		A	Cesarean delivery only	14.39	NA	NA	6.77	6.53	4.07	MMM
59515		A	Cesarean delivery	19.15	NA	NA	10.07	9.25	5.42	MMM
59525		A	Remove uterus after cesarean	8.53	NA	NA	3.98	3.67	2.43	ZZZ
59610		A	Vbac delivery	30.22	NA	NA	21.32	20.17	8.68	MMM
59612		A	Vbac delivery only	14.35	NA	NA	6.70	6.35	4.11	MMM
59614		A	Vbac care after delivery	17.60	NA	NA	8.66	7.92	5.04	MMM
59618		A	Attempted vbac delivery	32.26	NA	NA	22.83	22.08	9.26	MMM
59620		A	Attempted vbac delivery only	14.86	NA	NA	6.93	6.92	4.26	MMM
59622		A	Attempted vbac after care	19.63	NA	NA	10.32	9.78	5.64	MMM
59812		A	Treatment of miscarriage	4.44	3.86	3.78	3.25	3.13	1.25	090
59820		A	Care of miscarriage	4.84	5.08	5.12	4.47	4.40	1.39	090
59821		A	Treatment of miscarriage	5.09	4.88	4.89	4.21	4.12	1.47	090
59830		A	Treat uterus infection	6.59	NA	NA	4.74	4.61	1.89	090
59840		R	Abortion	3.01	2.67	2.61	2.42	2.38	0.80	010
59841		R	Abortion	5.65	4.28	4.15	3.69	3.52	1.62	010
59850		R	Abortion	5.90	NA	NA	3.96	3.95	0.41	090
59851		R	Abortion	5.92	NA	NA	4.44	4.34	1.68	090
59852		R	Abortion	8.23	NA	NA	6.02	6.03	0.58	090
59855		R	Abortion	6.43	NA	NA	4.33	4.18	1.85	090
59856		R	Abortion	7.79	NA	NA	4.83	4.63	2.23	090
59857		R	Abortion	9.33	NA	NA	5.44	5.40	0.65	090
59866		R	Abortion (mpr)	3.99	NA	NA	2.16	2.08	0.29	000
59870		A	Evacuate mole of uterus	6.57	NA	NA	5.73	5.71	1.89	090
59871		A	Remove cerclage suture	2.13	NA	NA	1.34	1.29	0.61	000
59897		C	Fetal invas px w/us	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59898		C	Laparo proc ob care/deliver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59899		C	Maternity care procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60000		A	Drain thyroid/tongue cyst	1.81	2.86	2.74	2.37	2.28	0.24	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
6005F		I	Care level rationale doc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
60100		A	Biopsy of thyroid	1.56	1.48	1.58	0.61	0.65	0.16	000
60200		A	Remove thyroid lesion	10.02	NA	NA	8.26	7.67	1.70	090
60210		A	Partial thyroid excision	11.23	NA	NA	8.14	7.45	2.06	090
60212		A	Partial thyroid excision	16.43	NA	NA	11.42	10.31	3.06	090
60220		A	Partial removal of thyroid	12.37	NA	NA	8.91	8.14	2.15	090
60225		A	Partial removal of thyroid	14.79	NA	NA	10.72	9.83	2.63	090
60240		A	Removal of thyroid	16.22	NA	NA	10.32	9.44	2.95	090
60252		A	Removal of thyroid	22.01	NA	NA	14.15	12.92	3.87	090
60254		A	Extensive thyroid surgery	28.42	NA	NA	18.44	16.84	4.52	090
60260		A	Repeat thyroid surgery	18.26	NA	NA	11.93	10.89	3.12	090
60270		A	Removal of thyroid	23.20	NA	NA	14.04	13.17	4.37	090
60271		A	Removal of thyroid	17.62	NA	NA	11.44	10.55	3.00	090
60280		A	Remove thyroid duct lesion	6.16	NA	NA	6.53	6.09	0.84	090
60281		A	Remove thyroid duct lesion	8.82	NA	NA	8.22	7.49	1.14	090
60300		A	Aspir/inj thyroid cyst	0.97	2.18	2.19	0.38	0.39	0.11	000
6040F		I	Appro rad ds dvcs techs docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
60500		A	Explore parathyroid glands	16.78	NA	NA	10.83	9.87	3.23	090
60502		A	Re-explore parathyroids	21.15	NA	NA	13.42	12.25	4.14	090
60505		A	Explore parathyroid glands	23.06	NA	NA	14.75	13.62	4.32	090
60512		A	Autotransplant parathyroid	4.44	NA	NA	2.10	1.90	0.83	ZZZ
60520		A	Removal of thymus gland	17.16	NA	NA	10.54	9.88	3.46	090
60521		A	Removal of thymus gland	19.18	NA	NA	10.41	10.66	4.52	090
60522		A	Removal of thymus gland	23.48	NA	NA	12.52	12.70	5.45	090
60540		A	Explore adrenal gland	18.02	NA	NA	10.23	10.26	3.03	090
60545		A	Explore adrenal gland	20.93	NA	NA	11.61	11.35	3.68	090
60600		A	Remove carotid body lesion	25.09	NA	NA	12.93	12.50	5.30	090
60605		A	Remove carotid body lesion	31.96	NA	NA	18.79	16.84	4.10	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
60650		A	Laparoscopy adrenalectomy	20.73	NA	NA	11.14	10.74	3.73	090
60659		C	Laparo proc endocrine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60699		C	Endocrine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
6070F		I	Pt asked/cnsld aed effects	0.00	0.00	0.00	0.00	0.00	0.00	XXX
6080F		I	Pt/caregiver queried falls	0.00	0.00	0.00	0.00	0.00	0.00	XXX
6090F		I	Pt/caregiver counsel safety	0.00	0.00	0.00	0.00	0.00	0.00	XXX
61000		A	Remove cranial cavity fluid	1.58	NA	NA	1.53	1.46	0.14	000
61001		A	Remove cranial cavity fluid	1.49	NA	NA	1.32	1.36	0.53	000
61020		A	Remove brain cavity fluid	1.51	NA	NA	2.09	1.99	0.50	000
61026		A	Injection into brain canal	1.69	NA	NA	1.70	1.68	0.38	000
61050		A	Remove brain canal fluid	1.51	NA	NA	1.38	1.43	0.12	000
61055		A	Injection into brain canal	2.10	NA	NA	1.55	1.62	0.29	000
61070		A	Brain canal shunt procedure	0.89	NA	NA	1.39	1.36	0.20	000
61105		A	Twist drill hole	5.45	NA	NA	6.33	5.91	1.91	090
61107		A	Drill skull for implantation	4.99	NA	NA	2.77	2.67	1.78	000
61108		A	Drill skull for drainage	11.64	NA	NA	11.22	10.56	4.13	090
61120		A	Burr hole for puncture	9.60	NA	NA	9.20	8.63	3.45	090
61140		A	Pierce skull for biopsy	17.23	NA	NA	14.22	13.53	6.10	090
61150		A	Pierce skull for drainage	18.90	NA	NA	14.88	14.04	6.76	090
61151		A	Pierce skull for drainage	13.49	NA	NA	11.38	10.64	4.83	090
61154		A	Pierce skull & remove clot	17.07	NA	NA	14.64	13.86	6.08	090
61156		A	Pierce skull for drainage	17.45	NA	NA	13.49	12.93	6.25	090
61210		A	Pierce skull implant device	5.83	NA	NA	3.23	3.12	2.08	000
61215		A	Insert brain-fluid device	5.85	NA	NA	7.00	6.62	2.06	090
61250		A	Pierce skull & explore	11.49	NA	NA	10.26	9.55	4.11	090
61253		A	Pierce skull & explore	13.49	NA	NA	10.18	9.60	1.71	090
61304		A	Open skull for exploration	23.41	NA	NA	17.59	16.70	8.13	090
61305		A	Open skull for exploration	28.64	NA	NA	21.34	20.23	10.25	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
61312		A	Open skull for drainage	30.17	NA	NA	21.35	20.27	10.77	090
61313		A	Open skull for drainage	28.09	NA	NA	21.22	20.13	10.01	090
61314		A	Open skull for drainage	25.90	NA	NA	19.54	18.51	9.25	090
61315		A	Open skull for drainage	29.65	NA	NA	21.63	20.64	10.63	090
61316		A	Implt cran bone flap to abdo	1.39	NA	NA	0.77	0.73	0.49	ZZZ
61320		A	Open skull for drainage	27.42	NA	NA	19.80	18.97	9.67	090
61321		A	Open skull for drainage	30.53	NA	NA	22.39	20.91	10.95	090
61322		A	Decompressive craniotomy	34.26	NA	NA	24.65	23.03	12.21	090
61323		A	Decompressive lobectomy	35.06	NA	NA	24.33	22.78	12.43	090
61330		A	Decompress eye socket	25.30	NA	NA	19.41	17.55	9.07	090
61332		A	Explore/biopsy eye socket	28.60	NA	NA	20.69	18.96	10.24	090
61333		A	Explore orbit/remove lesion	29.27	NA	NA	23.27	20.52	10.48	090
61334		A	Explore orbit/remove object	19.60	NA	NA	14.29	12.88	7.01	090
61340		A	Subtemporal decompression	20.11	NA	NA	15.95	14.98	7.21	090
61343		A	Incise skull (press relief)	31.86	NA	NA	22.61	21.56	11.33	090
61345		A	Relieve cranial pressure	29.23	NA	NA	21.46	20.40	10.47	090
61440		A	Incise skull for surgery	28.66	NA	NA	21.14	20.01	10.25	090
61450		A	Incise skull for surgery	27.69	NA	NA	20.06	18.93	9.91	090
61458		A	Incise skull for brain wound	28.84	NA	NA	21.05	20.09	10.23	090
61460		A	Incise skull for surgery	30.24	NA	NA	22.03	20.54	10.82	090
61470		A	Incise skull for surgery	27.62	NA	NA	20.03	18.99	9.89	090
61480		A	Incise skull for surgery	28.05	NA	NA	14.48	14.77	1.97	090
61490		A	Incise skull for surgery	27.22	NA	NA	19.80	18.88	9.76	090
61500		A	Removal of skull lesion	19.18	NA	NA	15.33	14.41	5.77	090
61501		A	Remove infected skull bone	16.35	NA	NA	13.71	12.84	4.66	090
61510		A	Removal of brain lesion	30.83	NA	NA	23.45	22.35	10.99	090
61512		A	Remove brain lining lesion	37.14	NA	NA	26.01	24.86	13.25	090
61514		A	Removal of brain abscess	27.23	NA	NA	19.88	19.05	9.70	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
61516		A	Removal of brain lesion	26.58	NA	NA	19.64	18.71	9.21	090
61517		A	Implt brain chemotx add-on	1.38	NA	NA	0.76	0.73	0.49	ZZZ
61518		A	Removal of brain lesion	39.89	NA	NA	28.45	27.10	14.27	090
61519		A	Remove brain lining lesion	43.43	NA	NA	29.60	28.23	15.45	090
61520		A	Removal of brain lesion	57.09	NA	NA	37.88	36.12	17.93	090
61521		A	Removal of brain lesion	46.99	NA	NA	31.85	30.17	16.83	090
61522		A	Removal of brain abscess	31.54	NA	NA	22.76	21.68	11.30	090
61524		A	Removal of brain lesion	29.89	NA	NA	21.83	20.59	10.71	090
61526		A	Removal of brain lesion	54.08	NA	NA	36.25	33.64	19.37	090
61530		A	Removal of brain lesion	45.56	NA	NA	30.60	28.63	16.34	090
61531		A	Implant brain electrodes	16.41	NA	NA	14.19	13.46	5.88	090
61533		A	Implant brain electrodes	21.46	NA	NA	16.49	15.64	7.67	090
61534		A	Removal of brain lesion	23.01	NA	NA	17.98	17.07	8.24	090
61535		A	Remove brain electrodes	13.15	NA	NA	11.93	11.30	4.71	090
61536		A	Removal of brain lesion	37.72	NA	NA	26.21	25.05	13.51	090
61537		A	Removal of brain tissue	36.45	NA	NA	24.62	22.89	12.98	090
61538		A	Removal of brain tissue	39.45	NA	NA	26.64	24.63	14.15	090
61539		A	Removal of brain tissue	34.28	NA	NA	24.29	22.90	12.28	090
61540		A	Removal of brain tissue	31.43	NA	NA	22.79	21.73	11.26	090
61541		A	Incision of brain tissue	30.94	NA	NA	22.42	21.23	11.08	090
61542		A	Removal of brain tissue	33.16	NA	NA	20.48	20.97	11.87	090
61543		A	Removal of brain tissue	31.31	NA	NA	22.63	21.14	11.20	090
61544		A	Remove & treat brain lesion	27.36	NA	NA	19.88	17.23	9.80	090
61545		A	Excision of brain tumor	46.43	NA	NA	32.54	30.77	16.62	090
61546		A	Removal of pituitary gland	33.44	NA	NA	23.82	22.55	11.96	090
61548		A	Removal of pituitary gland	23.37	NA	NA	16.88	15.98	6.65	090
61550		A	Release of skull seams	15.59	NA	NA	10.56	10.62	1.10	090
61552		A	Release of skull seams	20.40	NA	NA	11.44	12.81	1.45	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
61556		A	Incise skull/sutures	24.09	NA	NA	15.89	15.71	8.64	090
61557		A	Incise skull/sutures	23.31	NA	NA	18.61	17.84	8.35	090
61558		A	Excision of skull/sutures	26.50	NA	NA	14.27	16.24	9.49	090
61559		A	Excision of skull/sutures	34.02	NA	NA	25.45	24.42	2.40	090
61563		A	Excision of skull tumor	28.44	NA	NA	20.74	19.75	10.19	090
61564		A	Excision of skull tumor	34.74	NA	NA	25.00	23.86	12.43	090
61566		A	Removal of brain tissue	32.45	NA	NA	23.36	22.39	11.61	090
61567		A	Incision of brain tissue	37.00	NA	NA	26.63	25.59	13.27	090
61570		A	Remove foreign body brain	26.51	NA	NA	19.94	18.70	9.49	090
61571		A	Incise skull for brain wound	28.42	NA	NA	21.01	20.04	10.17	090
61575		A	Skull base/brainstem surgery	36.56	NA	NA	25.56	23.60	13.09	090
61576		A	Skull base/brainstem surgery	55.31	NA	NA	43.73	42.30	7.09	090
61580		A	Craniofacial approach skull	34.51	NA	NA	34.41	31.96	5.88	090
61581		A	Craniofacial approach skull	39.13	NA	NA	38.59	35.60	5.02	090
61582		A	Craniofacial approach skull	35.14	NA	NA	42.59	39.77	12.59	090
61583		A	Craniofacial approach skull	38.50	NA	NA	34.95	33.43	12.91	090
61584		A	Orbitocranial approach/skull	37.70	NA	NA	34.64	33.06	12.67	090
61585		A	Orbitocranial approach/skull	42.57	NA	NA	38.81	35.18	15.25	090
61586		A	Resect nasopharynx skull	27.48	NA	NA	35.11	31.28	9.85	090
61590		A	Infratemporal approach/skull	47.04	NA	NA	38.58	35.68	8.43	090
61591		A	Infratemporal approach/skull	47.02	NA	NA	38.23	35.69	9.57	090
61592		A	Orbitocranial approach/skull	43.08	NA	NA	36.93	35.42	14.48	090
61595		A	Transtemporal approach/skull	33.74	NA	NA	30.77	28.97	7.13	090
61596		A	Transcochlear approach/skull	39.43	NA	NA	31.60	29.64	5.05	090
61597		A	Transcondylar approach/skull	40.82	NA	NA	31.25	30.02	14.63	090
61598		A	Transpetrosal approach/skull	36.53	NA	NA	34.82	30.95	13.08	090
61600		A	Resect/excise cranial lesion	30.01	NA	NA	28.86	26.82	6.21	090
61601		A	Resect/excise cranial lesion	31.14	NA	NA	29.86	28.39	10.14	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
61605		A	Resect/excise cranial lesion	32.57	NA	NA	29.75	27.60	4.94	090
61606		A	Resect/excise cranial lesion	42.05	NA	NA	33.80	32.64	13.65	090
61607		A	Resect/excise cranial lesion	40.93	NA	NA	31.97	29.99	14.65	090
61608		A	Resect/excise cranial lesion	45.54	NA	NA	36.04	34.42	15.35	090
61609		A	Transect artery sinus	9.88	NA	NA	4.35	4.45	3.54	ZZZ
61610		A	Transect artery sinus	29.63	NA	NA	16.57	15.74	10.62	ZZZ
61611		A	Transect artery sinus	7.41	NA	NA	3.26	3.57	0.52	ZZZ
61612		A	Transect artery sinus	27.84	NA	NA	12.25	12.84	1.96	ZZZ
61613		A	Remove aneurysm sinus	45.03	NA	NA	36.99	34.81	16.13	090
61615		A	Resect/excise lesion skull	35.77	NA	NA	29.59	28.45	4.59	090
61616		A	Resect/excise lesion skull	46.74	NA	NA	38.32	36.35	14.38	090
61618		A	Repair dura	18.69	NA	NA	14.72	13.86	5.74	090
61619		A	Repair dura	22.10	NA	NA	16.62	15.58	6.31	090
61623		A	Endovasc tempory vessel occl	9.95	NA	NA	4.48	4.70	1.85	000
61624		A	Transcath occlusion cns	20.12	NA	NA	8.79	9.14	3.76	000
61626		A	Transcath occlusion non-cns	16.60	NA	NA	6.44	7.10	2.13	000
61630		R	Intracranial angioplasty	22.07	NA	NA	11.23	11.64	4.17	XXX
61635		R	Intracran angioplsty w/stent	24.28	NA	NA	12.14	12.60	4.06	XXX
61640		N	Dilate ic vasospasm init	12.32	NA	NA	5.42	5.25	0.87	000
61641		N	Dilate ic vasospasm add-on	4.33	NA	NA	1.91	1.85	0.31	ZZZ
61642		N	Dilate ic vasospasm add-on	8.66	NA	NA	3.81	3.69	0.61	ZZZ
61680		A	Intracranial vessel surgery	32.55	NA	NA	23.52	22.49	11.65	090
61682		A	Intracranial vessel surgery	63.41	NA	NA	39.78	38.15	22.71	090
61684		A	Intracranial vessel surgery	41.64	NA	NA	28.86	27.12	14.91	090
61686		A	Intracranial vessel surgery	67.50	NA	NA	43.76	41.84	24.19	090
61690		A	Intracranial vessel surgery	31.34	NA	NA	22.97	21.74	11.23	090
61692		A	Intracranial vessel surgery	54.59	NA	NA	35.98	34.11	19.56	090
61697		A	Brain aneurysm repr complx	63.40	NA	NA	41.17	38.76	22.47	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
61698		A	Brain aneurysm repr complx	69.63	NA	NA	44.95	41.70	24.93	090
61700		A	Brain aneurysm repr simple	50.62	NA	NA	34.03	32.74	18.02	090
61702		A	Inner skull vessel surgery	60.04	NA	NA	39.59	36.93	21.50	090
61703		A	Clamp neck artery	18.80	NA	NA	15.09	14.39	6.74	090
61705		A	Revise circulation to head	38.10	NA	NA	26.42	24.59	13.65	090
61708		A	Revise circulation to head	37.20	NA	NA	22.58	20.67	3.07	090
61710		A	Revise circulation to head	31.29	NA	NA	16.13	17.18	6.50	090
61711		A	Fusion of skull arteries	38.23	NA	NA	26.42	25.01	13.69	090
61720		A	Incise skull/brain surgery	17.62	NA	NA	14.05	12.58	6.31	090
61735		A	Incise skull/brain surgery	22.35	NA	NA	15.01	14.16	8.00	090
61750		A	Incise skull/brain biopsy	19.83	NA	NA	15.20	14.44	7.05	090
61751		A	Brain biopsy w/ct/mr guide	18.79	NA	NA	15.57	14.84	6.68	090
61760		A	Implant brain electrodes	22.39	NA	NA	16.93	15.59	8.01	090
61770		A	Incise skull for treatment	23.19	NA	NA	17.17	15.66	8.18	090
61781		A	Scan proc cranial intra	3.75	NA	NA	2.14	2.14	1.25	ZZZ
61782		A	Scan proc cranial extra	3.18	NA	NA	1.81	1.81	0.87	ZZZ
61783		A	Scan proc spinal	3.75	NA	NA	2.14	2.14	0.15	ZZZ
61790		A	Treat trigeminal nerve	11.60	NA	NA	10.44	9.66	4.06	090
61791		A	Treat trigeminal tract	15.41	NA	NA	12.67	11.93	5.19	090
61796		A	Srs cranial lesion simple	13.93	NA	NA	11.40	9.94	4.62	090
61797		A	Srs cran les simple addl	3.48	NA	NA	1.94	1.80	1.15	ZZZ
61798		A	Srs cranial lesion complex	19.85	NA	NA	14.69	11.61	6.59	090
61799		A	Srs cran les complex addl	4.81	NA	NA	2.68	2.48	1.59	ZZZ
61800		A	Apply srs headframe add-on	2.25	NA	NA	1.58	1.48	0.73	ZZZ
61850		A	Implant neuroelectrodes	13.34	NA	NA	8.23	9.17	4.79	090
61860		A	Implant neuroelectrodes	22.26	NA	NA	16.65	15.86	7.97	090
61863		A	Implant neuroelectrode	20.71	NA	NA	16.69	15.98	7.39	090
61864		A	Implant neuroelectrde addl	4.49	NA	NA	2.51	2.42	1.60	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
61867		A	Implant neuroelectrode	33.03	NA	NA	23.62	22.54	11.80	090
61868		A	Implant neuroelectrde addl	7.91	NA	NA	4.41	4.26	2.84	ZZZ
61870		A	Implant neuroelectrodes	16.34	NA	NA	13.19	12.66	5.85	090
61875		A	Implant neuroelectrodes	16.46	NA	NA	13.25	12.54	1.17	090
61880		A	Revise/remove neuroelectrode	6.95	NA	NA	7.44	6.95	2.46	090
61885		A	Insrt/redo neurostim 1 array	6.05	NA	NA	7.22	7.82	2.06	090
61886		A	Implant neurostim arrays	9.93	NA	NA	11.59	10.88	3.52	090
61888		A	Revise/remove neuroreceiver	5.23	NA	NA	4.68	4.54	1.71	010
62000		A	Treat skull fracture	13.93	NA	NA	11.84	10.10	5.00	090
62005		A	Treat skull fracture	17.63	NA	NA	14.06	13.14	6.31	090
62010		A	Treatment of head injury	21.43	NA	NA	16.72	15.72	7.67	090
62100		A	Repair brain fluid leakage	23.53	NA	NA	17.22	16.25	7.50	090
62115		A	Reduction of skull defect	22.91	NA	NA	12.99	11.62	1.62	090
62116		A	Reduction of skull defect	25.02	NA	NA	19.12	18.20	8.96	090
62117		A	Reduction of skull defect	28.35	NA	NA	20.36	19.50	3.65	090
62120		A	Repair skull cavity lesion	24.59	NA	NA	23.74	22.83	3.16	090
62121		A	Incise skull repair	23.03	NA	NA	19.61	18.80	8.26	090
62140		A	Repair of skull defect	14.55	NA	NA	11.93	11.28	4.74	090
62141		A	Repair of skull defect	16.07	NA	NA	12.85	12.22	5.30	090
62142		A	Remove skull plate/flap	11.83	NA	NA	10.57	10.03	4.07	090
62143		A	Replace skull plate/flap	14.15	NA	NA	11.84	11.21	5.00	090
62145		A	Repair of skull & brain	20.09	NA	NA	15.01	14.35	7.20	090
62146		A	Repair of skull with graft	17.28	NA	NA	13.86	12.89	6.19	090
62147		A	Repair of skull with graft	20.67	NA	NA	15.76	14.84	7.39	090
62148		A	Retr bone flap to fix skull	2.00	NA	NA	1.12	1.05	0.71	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	NA	1.66	1.61	1.07	ZZZ
62161		A	Dissect brain w/scope	21.23	NA	NA	16.55	15.74	7.60	090
62162		A	Remove colloid cyst w/scope	26.80	NA	NA	20.22	19.34	9.59	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
62163		A	Neuroendoscopy w/fb removal	16.53	NA	NA	14.10	13.49	5.91	090
62164		A	Remove brain tumor w/scope	29.43	NA	NA	22.59	21.01	10.55	090
62165		A	Remove pituit tumor w/scope	23.23	NA	NA	17.35	16.45	6.36	090
62180		A	Establish brain cavity shunt	22.58	NA	NA	17.26	16.43	8.09	090
62190		A	Establish brain cavity shunt	12.17	NA	NA	11.01	10.39	4.36	090
62192		A	Establish brain cavity shunt	13.35	NA	NA	11.18	10.55	4.62	090
62194		A	Replace/irrigate catheter	5.78	NA	NA	6.56	5.28	0.45	010
62200		A	Establish brain cavity shunt	19.29	NA	NA	14.99	14.24	6.91	090
62201		A	Brain cavity shunt w/scope	16.04	NA	NA	14.13	13.35	5.72	090
62220		A	Establish brain cavity shunt	14.10	NA	NA	11.50	10.84	4.82	090
62223		A	Establish brain cavity shunt	14.05	NA	NA	12.49	11.88	4.83	090
62225		A	Replace/irrigate catheter	6.19	NA	NA	7.03	6.58	2.20	090
62230		A	Replace/revise brain shunt	11.43	NA	NA	9.69	9.21	3.97	090
62252		A	Csf shunt reprogram	0.74	1.43	1.72	NA	NA	0.25	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.02	1.33	NA	NA	0.01	XXX
62252	26	A	Csf shunt reprogram	0.74	0.41	0.39	0.41	0.39	0.24	XXX
62256		A	Remove brain cavity shunt	7.38	NA	NA	7.78	7.35	2.62	090
62258		A	Replace brain cavity shunt	15.64	NA	NA	12.43	11.87	5.42	090
62263		A	Epidural lysis mult sessions	6.54	15.67	13.85	5.76	4.72	0.52	010
62264		A	Epidural lysis on single day	4.42	8.07	7.40	2.54	2.07	0.35	010
62267		A	Interdiscal perq aspir dx	3.00	3.81	3.98	1.37	1.39	0.30	000
62268		A	Drain spinal cord cyst	4.73	2.04	5.21	2.53	2.46	0.45	000
62269		A	Needle biopsy spinal cord	5.01	1.92	5.61	2.31	2.27	0.56	000
62270		A	Spinal fluid tap diagnostic	1.37	2.86	2.98	0.71	0.72	0.23	000
62272		A	Drain cerebro spinal fluid	1.35	4.08	4.00	0.84	0.83	0.33	000
62273		A	Inject epidural patch	2.15	2.76	2.59	1.08	0.93	0.20	000
62280		A	Treat spinal cord lesion	2.63	6.74	6.41	1.92	1.64	0.50	010
62281		A	Treat spinal cord lesion	2.66	4.03	4.71	1.73	1.48	0.27	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
62282		A	Treat spinal canal lesion	2.33	5.90	6.03	1.70	1.50	0.29	010
62284		A	Injection for myelogram	1.54	4.18	4.58	0.81	0.86	0.18	000
62287		A	Percutaneous diskectomy	9.03	NA	NA	6.89	6.35	0.81	090
62290		A	Inject for spine disk x-ray	3.00	6.65	6.49	1.92	1.73	0.30	000
62291		A	Inject for spine disk x-ray	2.91	6.34	6.06	1.88	1.67	0.27	000
62292		A	Injection into disk lesion	9.24	NA	NA	8.48	6.05	0.75	090
62294		A	Injection into spinal artery	12.87	NA	NA	4.63	6.34	1.02	090
62310		A	Inject spine c/t	1.91	5.15	4.73	1.20	0.98	0.16	000
62311		A	Inject spine l/s (cd)	1.54	4.37	4.18	0.99	0.84	0.12	000
62318		A	Inject spine w/cath c/t	2.04	4.98	4.79	0.84	0.72	0.16	000
62319		A	Inject spine w/cath l/s (cd)	1.87	2.98	3.54	0.87	0.74	0.16	000
62350		A	Implant spinal canal cath	6.05	NA	NA	4.95	4.38	1.05	010
62351		A	Implant spinal canal cath	11.66	NA	NA	10.89	10.10	3.38	090
62355		A	Remove spinal canal catheter	4.35	NA	NA	4.02	3.59	0.73	010
62360		A	Insert spine infusion device	4.33	NA	NA	4.18	3.66	0.87	010
62361		A	Implant spine infusion pump	5.65	NA	NA	4.95	4.69	1.10	010
62362		A	Implant spine infusion pump	6.10	NA	NA	5.10	4.67	1.22	010
62365		A	Remove spine infusion device	4.65	NA	NA	4.43	4.03	0.88	010
62367		A	Analyze spine infusion pump	0.48	0.72	0.66	0.23	0.19	0.05	XXX
62368		A	Analyze spine infusion pump	0.75	1.01	0.88	0.37	0.30	0.07	XXX
63001		A	Removal of spinal lamina	17.61	NA	NA	13.71	12.96	5.68	090
63003		A	Removal of spinal lamina	17.74	NA	NA	13.78	13.05	5.62	090
63005		A	Removal of spinal lamina	16.43	NA	NA	13.71	13.08	5.07	090
63011		A	Removal of spinal lamina	15.91	NA	NA	12.76	11.93	4.01	090
63012		A	Removal of spinal lamina	16.85	NA	NA	13.53	12.96	5.09	090
63015		A	Removal of spinal lamina	20.85	NA	NA	16.47	15.69	6.99	090
63016		A	Removal of spinal lamina	22.03	NA	NA	16.65	15.73	6.76	090
63017		A	Removal of spinal lamina	17.33	NA	NA	14.40	13.71	5.55	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
63020		A	Neck spine disk surgery	16.20	NA	NA	13.61	12.98	5.05	090
63030		A	Low back disk surgery	13.18	NA	NA	11.89	11.30	3.86	090
63035		A	Spinal disk surgery add-on	3.15	NA	NA	1.80	1.74	0.88	ZZZ
63040		A	Laminotomy single cervical	20.31	NA	NA	15.47	14.73	6.26	090
63042		A	Laminotomy single lumbar	18.76	NA	NA	14.97	14.27	5.19	090
63043		C	Laminotomy addl cervical	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63044		C	Laminotomy addl lumbar	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63045		A	Removal of spinal lamina	17.95	NA	NA	14.34	13.65	5.72	090
63046		A	Removal of spinal lamina	17.25	NA	NA	13.83	13.16	5.13	090
63047		A	Removal of spinal lamina	15.37	NA	NA	13.09	12.50	4.40	090
63048		A	Remove spinal lamina add-on	3.47	NA	NA	1.98	1.90	1.00	ZZZ
63050		A	Cervical laminoplasty	22.01	NA	NA	17.41	16.26	7.89	090
63051		A	C-laminoplasty w/graft/plate	25.51	NA	NA	18.77	17.76	7.22	090
63055		A	Decompress spinal cord	23.55	NA	NA	17.54	16.74	7.65	090
63056		A	Decompress spinal cord	21.86	NA	NA	16.34	15.52	6.18	090
63057		A	Decompress spine cord add-on	5.25	NA	NA	3.00	2.88	1.51	ZZZ
63064		A	Decompress spinal cord	26.22	NA	NA	18.93	17.92	7.93	090
63066		A	Decompress spine cord add-on	3.26	NA	NA	1.82	1.77	1.17	ZZZ
63075		A	Neck spine disk surgery	19.60	NA	NA	15.40	14.78	6.10	090
63076		A	Neck spine disk surgery	4.04	NA	NA	2.29	2.21	1.25	ZZZ
63077		A	Spine disk surgery thorax	22.88	NA	NA	16.29	15.50	5.85	090
63078		A	Spine disk surgery thorax	3.28	NA	NA	1.87	1.78	0.75	ZZZ
63081		A	Removal of vertebral body	26.10	NA	NA	19.18	18.25	7.88	090
63082		A	Remove vertebral body add-on	4.36	NA	NA	2.48	2.39	1.30	ZZZ
63085		A	Removal of vertebral body	29.47	NA	NA	19.52	18.64	7.92	090
63086		A	Remove vertebral body add-on	3.19	NA	NA	1.72	1.68	0.87	ZZZ
63087		A	Removal of vertebral body	37.53	NA	NA	24.49	23.44	9.71	090
63088		A	Remove vertebral body add-on	4.32	NA	NA	2.48	2.38	1.06	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
63090		A	Removal of vertebral body	30.93	NA	NA	21.10	19.96	7.18	090
63091		A	Remove vertebral body add-on	3.03	NA	NA	1.70	1.63	0.68	ZZZ
63101		A	Removal of vertebral body	34.10	NA	NA	24.98	23.73	10.61	090
63102		A	Removal of vertebral body	34.10	NA	NA	24.62	23.40	8.58	090
63103		A	Remove vertebral body add-on	4.82	NA	NA	2.75	2.67	1.29	ZZZ
63170		A	Incise spinal cord tract(s)	22.21	NA	NA	17.49	16.25	7.96	090
63172		A	Drainage of spinal cyst	19.76	NA	NA	15.32	14.50	7.06	090
63173		A	Drainage of spinal cyst	24.31	NA	NA	18.66	17.73	8.73	090
63180		A	Revise spinal cord ligaments	20.53	NA	NA	16.55	14.99	7.35	090
63182		A	Revise spinal cord ligaments	22.82	NA	NA	17.83	15.15	8.18	090
63185		A	Incise spinal column/nerves	16.49	NA	NA	13.34	12.46	5.91	090
63190		A	Incise spinal column/nerves	18.89	NA	NA	14.90	14.11	4.28	090
63191		A	Incise spinal column/nerves	18.92	NA	NA	15.50	12.23	3.73	090
63194		A	Incise spinal column & cord	22.10	NA	NA	16.17	15.43	2.84	090
63195		A	Incise spinal column & cord	21.64	NA	NA	16.63	15.54	7.75	090
63196		A	Incise spinal column & cord	25.27	NA	NA	13.49	15.30	1.79	090
63197		A	Incise spinal column & cord	24.08	NA	NA	18.53	17.53	8.64	090
63198		A	Incise spinal column & cord	29.90	NA	NA	15.75	14.84	2.12	090
63199		A	Incise spinal column & cord	31.47	NA	NA	16.44	17.96	2.23	090
63200		A	Release of spinal cord	21.44	NA	NA	16.60	15.70	7.56	090
63250		A	Revise spinal cord vessels	43.86	NA	NA	29.65	27.92	15.71	090
63251		A	Revise spinal cord vessels	44.64	NA	NA	30.54	28.98	16.00	090
63252		A	Revise spinal cord vessels	44.63	NA	NA	30.54	28.93	16.00	090
63265		A	Excise intraspinal lesion	23.82	NA	NA	18.05	17.18	8.07	090
63266		A	Excise intraspinal lesion	24.68	NA	NA	18.41	17.48	8.38	090
63267		A	Excise intraspinal lesion	19.45	NA	NA	15.42	14.70	6.25	090
63268		A	Excise intraspinal lesion	20.02	NA	NA	16.31	15.16	7.17	090
63270		A	Excise intraspinal lesion	29.80	NA	NA	21.78	20.55	10.69	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
63271		A	Excise intraspinal lesion	29.92	NA	NA	21.58	20.53	10.55	090
63272		A	Excise intraspinal lesion	27.50	NA	NA	20.03	19.10	9.45	090
63273		A	Excise intraspinal lesion	26.47	NA	NA	19.92	18.29	9.48	090
63275		A	Biopsy/excise spinal tumor	25.86	NA	NA	19.12	18.15	8.80	090
63276		A	Biopsy/excise spinal tumor	25.69	NA	NA	19.09	18.13	8.69	090
63277		A	Biopsy/excise spinal tumor	22.39	NA	NA	17.12	16.25	6.98	090
63278		A	Biopsy/excise spinal tumor	22.12	NA	NA	17.49	16.31	7.93	090
63280		A	Biopsy/excise spinal tumor	30.29	NA	NA	22.13	21.23	10.81	090
63281		A	Biopsy/excise spinal tumor	29.99	NA	NA	22.09	21.07	10.65	090
63282		A	Biopsy/excise spinal tumor	28.15	NA	NA	20.96	20.05	9.93	090
63283		A	Biopsy/excise spinal tumor	26.76	NA	NA	20.54	19.35	9.57	090
63285		A	Biopsy/excise spinal tumor	38.05	NA	NA	26.58	25.09	13.63	090
63286		A	Biopsy/excise spinal tumor	37.62	NA	NA	26.26	25.05	13.17	090
63287		A	Biopsy/excise spinal tumor	40.08	NA	NA	27.99	26.46	14.37	090
63290		A	Biopsy/excise spinal tumor	40.82	NA	NA	28.00	26.64	14.63	090
63295		A	Repair of laminectomy defect	5.25	NA	NA	2.94	2.74	1.87	ZZZ
63300		A	Removal of vertebral body	26.80	NA	NA	19.47	18.51	8.66	090
63301		A	Removal of vertebral body	31.57	NA	NA	23.23	21.07	11.31	090
63302		A	Removal of vertebral body	31.15	NA	NA	23.00	20.96	11.15	090
63303		A	Removal of vertebral body	33.55	NA	NA	23.88	21.66	12.00	090
63304		A	Removal of vertebral body	33.85	NA	NA	24.51	23.07	12.11	090
63305		A	Removal of vertebral body	36.24	NA	NA	25.75	23.21	12.98	090
63306		A	Removal of vertebral body	35.55	NA	NA	15.91	19.30	12.74	090
63307		A	Removal of vertebral body	34.96	NA	NA	24.75	23.07	12.53	090
63308		A	Remove vertebral body add-on	5.24	NA	NA	2.91	2.82	1.56	ZZZ
63600		A	Remove spinal cord lesion	15.12	NA	NA	10.46	8.20	1.58	090
63610		A	Stimulation of spinal cord	8.72	2.03	15.94	2.41	2.33	0.68	000
63615		A	Remove lesion of spinal cord	17.32	NA	NA	13.50	12.25	6.19	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
63620		A	Srs spinal lesion	15.60	NA	NA	12.19	10.34	5.17	090
63621		A	Srs spinal lesion addl	4.00	NA	NA	2.24	2.07	1.32	ZZZ
63650		A	Implant neuroelectrodes	7.20	NA	NA	5.26	4.39	0.64	010
63655		A	Implant neuroelectrodes	11.56	NA	NA	10.74	10.04	3.61	090
63661		A	Remove spine eltrd perq aray	5.08	11.83	11.83	3.94	3.94	0.71	010
63662		A	Remove spine eltrd plate	11.00	NA	NA	8.57	8.57	1.55	090
63663		A	Revise spine eltrd perq aray	7.75	16.34	16.34	5.29	5.29	1.09	010
63664		A	Revise spine eltrd plate	11.52	NA	NA	8.83	8.83	1.60	090
63685		A	Insrt/redo spine n generator	6.05	NA	NA	5.10	4.54	1.10	010
63688		A	Revise/remove neuroreceiver	5.30	NA	NA	4.74	4.25	1.00	010
63700		A	Repair of spinal herniation	17.47	NA	NA	15.02	13.85	6.25	090
63702		A	Repair of spinal herniation	19.41	NA	NA	16.10	15.25	6.95	090
63704		A	Repair of spinal herniation	22.43	NA	NA	18.79	16.95	8.03	090
63706		A	Repair of spinal herniation	25.35	NA	NA	20.42	19.10	9.10	090
63707		A	Repair spinal fluid leakage	12.65	NA	NA	11.06	10.42	3.49	090
63709		A	Repair spinal fluid leakage	15.65	NA	NA	12.73	12.10	4.49	090
63710		A	Graft repair of spine defect	15.40	NA	NA	12.78	12.13	4.85	090
63740		A	Install spinal shunt	12.63	NA	NA	11.01	10.64	4.25	090
63741		A	Install spinal shunt	9.12	NA	NA	7.60	6.69	2.19	090
63744		A	Revision of spinal shunt	8.94	NA	NA	8.09	7.40	3.06	090
63746		A	Removal of spinal shunt	7.33	NA	NA	7.84	7.20	2.62	090
64400		A	N block inj trigeminal	1.11	2.18	2.04	0.78	0.67	0.18	000
64402		A	N block inj facial	1.25	1.99	1.89	0.79	0.71	0.18	000
64405		A	N block inj occipital	1.32	1.95	1.73	0.90	0.76	0.26	000
64408		A	N block inj vagus	1.41	2.21	2.05	1.24	1.11	0.16	000
64410		A	N block inj phrenic	1.43	2.75	2.61	0.76	0.70	0.33	000
64412		A	N block inj spinal accessor	1.18	3.26	3.02	0.92	0.81	0.20	000
64413		A	N block inj cervical plexus	1.40	2.01	1.89	0.83	0.73	0.20	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
64415		A	N block inj brachial plexus	1.48	1.90	2.02	0.36	0.40	0.11	000
64416		A	N block cont infuse b plex	1.81	NA	NA	0.43	0.44	0.14	000
64417		A	N block inj axillary	1.44	2.25	2.24	0.56	0.50	0.11	000
64418		A	N block inj suprascapular	1.32	2.70	2.60	0.83	0.73	0.12	000
64420		A	N block inj intercost sng	1.18	2.01	2.71	0.77	0.66	0.12	000
64421		A	N block inj intercost mlt	1.68	2.64	3.88	0.97	0.82	0.20	000
64425		A	N block inj ilio-ing/hypogi	1.75	2.08	1.90	0.96	0.82	0.20	000
64430		A	N block inj pudendal	1.46	2.26	2.62	0.79	0.85	0.14	000
64435		A	N block inj paracervical	1.45	2.36	2.47	0.79	0.77	0.24	000
64445		A	N block inj sciatic sng	1.48	2.30	2.30	0.54	0.58	0.16	000
64446		A	N blk inj sciatic cont inf	1.81	NA	NA	0.44	0.48	0.14	000
64447		A	N block inj fem single	1.50	1.89	1.89	0.36	0.33	0.11	000
64448		A	N block inj fem cont inf	1.63	NA	NA	0.39	0.41	0.12	000
64449		A	N block inj lumbar plexus	1.81	NA	NA	0.51	0.53	0.14	000
64450		A	N block other peripheral	1.27	1.73	1.63	0.68	0.64	0.11	000
64455		A	N block inj plantar digit	0.75	0.59	0.61	0.24	0.27	0.08	000
64479		A	Inj foramen epidural c/t	2.29	4.76	5.27	1.54	1.30	0.27	000
64480		A	Inj foramen epidural add-on	1.20	2.36	2.35	0.64	0.59	0.18	ZZZ
64483		A	Inj foramen epidural l/s	1.90	4.55	5.23	1.35	1.16	0.16	000
64484		A	Inj foramen epidural add-on	1.00	1.61	2.06	0.52	0.48	0.08	ZZZ
64490		A	Inj paravert f jnt c/t 1 lev	1.82	3.78	3.78	1.26	1.26	0.20	000
64491		A	Inj paravert f jnt c/t 2 lev	1.16	1.59	1.59	0.58	0.58	0.11	ZZZ
64492		A	Inj paravert f jnt c/t 3 lev	1.16	1.63	1.63	0.61	0.61	0.11	ZZZ
64493		A	Inj paravert f jnt l/s 1 lev	1.52	3.50	3.50	1.10	1.10	0.14	000
64494		A	Inj paravert f jnt l/s 2 lev	1.00	1.51	1.51	0.49	0.49	0.08	ZZZ
64495		A	Inj paravert f jnt l/s 3 lev	1.00	1.54	1.54	0.52	0.52	0.08	ZZZ
64505		A	N block spenopalatine gangl	1.36	1.45	1.43	1.02	0.95	0.10	000
64508		A	N block carotid sinus s/p	1.12	0.50	1.72	0.94	0.85	0.24	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
64510		A	N block stellate ganglion	1.22	2.49	2.65	0.90	0.74	0.10	000
64517		A	N block inj hypogas plxs	2.20	2.99	2.73	1.35	1.15	0.18	000
64520		A	N block lumbar/thoracic	1.35	4.33	4.18	1.01	0.85	0.11	000
64530		A	N block inj celiac pelus	1.58	4.06	3.99	1.06	0.94	0.14	000
64550		A	Apply neurostimulator	0.18	0.29	0.27	0.08	0.07	0.01	000
64553		A	Implant neuroelectrodes	2.36	3.39	3.33	2.01	1.97	0.38	010
64555		A	Implant neuroelectrodes	2.32	3.02	3.35	1.72	1.80	0.26	010
64560		A	Implant neuroelectrodes	2.41	4.85	4.19	2.50	2.20	0.16	010
64561		A	Implant neuroelectrodes	7.15	14.88	20.88	3.88	4.17	0.77	010
64565		A	Implant neuroelectrodes	1.81	3.31	3.15	1.81	1.61	0.24	010
64566		A	Neuroeltrd stim post tibial	0.60	3.17	3.17	0.23	0.23	0.05	000
64568		A	Inc for vagus n elect impl	9.00	NA	NA	8.67	8.67	1.25	090
64569		A	Revise/repl vagus n eltrd	11.00	NA	NA	4.50	4.50	3.15	090
64570		A	Remove vagus n eltrd	9.10	NA	NA	4.06	4.06	3.26	090
64575		A	Implant neuroelectrodes	4.42	NA	NA	4.21	3.58	0.43	090
64577		A	Implant neuroelectrodes	4.69	NA	NA	2.75	3.54	1.67	090
64580		A	Implant neuroelectrodes	4.19	NA	NA	3.92	3.82	0.88	090
64581		A	Implant neuroelectrodes	12.20	NA	NA	6.04	7.05	1.58	090
64585		A	Revise/remove neuroelectrode	2.11	4.75	6.22	1.89	2.10	0.27	010
64590		A	Insrt/redo pn/gastr stimul	2.45	4.76	5.71	1.96	2.22	0.29	010
64595		A	Revise/rmv pn/gastr stimul	1.78	4.97	6.38	1.70	1.92	0.22	010
64600		A	Injection treatment of nerve	3.49	8.24	8.08	2.81	2.46	0.53	010
64605		A	Injection treatment of nerve	5.65	15.95	13.00	4.84	3.93	0.43	010
64610		A	Injection treatment of nerve	7.20	13.02	12.12	5.26	5.00	2.15	010
64611		A	Chemodenerv saliv glands	1.03	1.64	1.64	1.35	1.35	0.29	010
64612		A	Destroy nerve face muscle	2.01	2.52	2.39	2.19	1.93	0.65	010
64613		A	Destroy nerve neck muscle	2.01	2.29	2.24	1.93	1.69	0.58	010
64614		A	Destroy nerve extrem musc	2.20	2.59	2.54	2.09	1.86	0.42	010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
64620		A	Injection treatment of nerve	2.89	3.06	3.87	2.12	1.82	0.29	010
64622		A	Destr paravertebrl nerve l/s	3.05	6.96	6.57	2.51	2.08	0.26	010
64623		A	Destr paravertebral n add-on	0.99	2.76	2.61	0.51	0.40	0.08	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.92	8.15	7.49	3.66	3.04	0.34	010
64627		A	Destr paravertebral n add-on	1.16	3.96	3.78	0.60	0.47	0.10	ZZZ
64630		A	Injection treatment of nerve	3.05	3.16	3.26	2.16	2.15	0.34	010
64632		A	N block inj common digit	1.23	1.17	1.17	0.72	0.75	0.10	010
64640		A	Injection treatment of nerve	2.81	3.27	3.37	1.94	1.90	0.24	010
64650		A	Chemodenerv eccrine glands	0.70	2.60	1.90	0.42	0.38	0.11	000
64653		A	Chemodenerv eccrine glands	0.88	2.94	2.11	0.48	0.44	0.24	000
64680		A	Injection treatment of nerve	2.67	6.47	6.29	2.03	1.84	0.30	010
64681		A	Injection treatment of nerve	3.78	6.51	6.93	1.70	1.79	0.30	010
64702		A	Revise finger/toe nerve	6.26	NA	NA	7.53	6.80	1.06	090
64704		A	Revise hand/foot nerve	4.69	NA	NA	4.33	4.25	0.54	090
64708		A	Revise arm/leg nerve	6.36	NA	NA	7.09	6.63	1.15	090
64712		A	Revision of sciatic nerve	8.07	NA	NA	7.25	6.71	1.33	090
64713		A	Revision of arm nerve(s)	11.40	NA	NA	9.05	8.55	2.34	090
64714		A	Revise low back nerve(s)	10.55	NA	NA	8.66	7.44	1.71	090
64716		A	Revision of cranial nerve	6.99	NA	NA	7.97	7.49	1.13	090
64718		A	Revise ulnar nerve at elbow	7.26	NA	NA	8.90	8.29	1.48	090
64719		A	Revise ulnar nerve at wrist	4.97	NA	NA	5.98	5.64	0.92	090
64721		A	Carpal tunnel surgery	4.97	6.74	6.40	6.66	6.34	0.98	090
64722		A	Relieve pressure on nerve(s)	4.82	NA	NA	4.82	4.41	0.84	090
64726		A	Release foot/toe nerve	4.27	NA	NA	3.57	3.47	0.39	090
64727		A	Internal nerve revision	3.10	NA	NA	1.89	1.77	0.60	ZZZ
64732		A	Incision of brow nerve	4.89	NA	NA	6.32	5.65	1.77	090
64734		A	Incision of cheek nerve	5.55	NA	NA	7.15	6.18	0.71	090
64736		A	Incision of chin nerve	5.23	NA	NA	5.97	5.58	1.87	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
64738		A	Incision of jaw nerve	6.36	NA	NA	7.60	6.56	2.27	090
64740		A	Incision of tongue nerve	6.22	NA	NA	7.01	6.49	0.80	090
64742		A	Incision of facial nerve	6.85	NA	NA	7.10	6.29	0.87	090
64744		A	Incise nerve back of head	5.72	NA	NA	6.79	5.77	2.04	090
64746		A	Incise diaphragm nerve	6.56	NA	NA	4.78	4.88	1.53	090
64752		A	Incision of vagus nerve	7.69	NA	NA	6.06	5.68	1.81	090
64755		A	Incision of stomach nerves	15.05	NA	NA	9.12	8.28	3.20	090
64760		A	Incision of vagus nerve	7.59	NA	NA	6.01	5.34	1.60	090
64761		A	Incision of pelvis nerve	7.04	NA	NA	5.43	5.11	1.00	090
64763		A	Incise hip/thigh nerve	7.56	NA	NA	5.90	6.31	1.60	090
64766		A	Incise hip/thigh nerve	9.47	NA	NA	7.08	6.96	0.91	090
64771		A	Sever cranial nerve	8.15	NA	NA	7.55	7.36	1.05	090
64772		A	Incision of spinal nerve	7.84	NA	NA	7.68	7.18	1.81	090
64774		A	Remove skin nerve lesion	5.80	NA	NA	5.64	5.27	1.05	090
64776		A	Remove digit nerve lesion	5.60	NA	NA	5.30	4.96	0.84	090
64778		A	Digit nerve surgery add-on	3.11	NA	NA	2.25	1.93	0.61	ZZZ
64782		A	Remove limb nerve lesion	6.86	NA	NA	5.76	5.45	0.91	090
64783		A	Limb nerve surgery add-on	3.71	NA	NA	2.58	2.28	0.45	ZZZ
64784		A	Remove nerve lesion	10.62	NA	NA	9.49	8.76	2.00	090
64786		A	Remove sciatic nerve lesion	16.25	NA	NA	13.07	12.10	3.20	090
64787		A	Implant nerve end	4.29	NA	NA	2.28	2.26	0.68	ZZZ
64788		A	Remove skin nerve lesion	5.24	NA	NA	5.68	5.26	1.07	090
64790		A	Removal of nerve lesion	12.10	NA	NA	10.32	9.55	2.74	090
64792		A	Removal of nerve lesion	15.86	NA	NA	12.21	11.77	5.68	090
64795		A	Biopsy of nerve	3.01	NA	NA	2.15	2.00	0.81	000
64802		A	Remove sympathetic nerves	10.37	NA	NA	8.86	6.90	0.81	090
64804		A	Remove sympathetic nerves	15.91	NA	NA	6.62	6.83	1.26	090
64809		A	Remove sympathetic nerves	14.71	NA	NA	10.82	9.09	1.17	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
64818		A	Remove sympathetic nerves	11.34	NA	NA	6.76	6.22	2.06	090
64820		A	Remove sympathetic nerves	10.74	NA	NA	10.51	9.66	1.90	090
64821		A	Remove sympathetic nerves	9.33	NA	NA	9.45	8.99	1.83	090
64822		A	Remove sympathetic nerves	9.33	NA	NA	9.45	8.84	1.83	090
64823		A	Remove sympathetic nerves	10.94	NA	NA	10.42	9.62	2.15	090
64831		A	Repair of digit nerve	9.16	NA	NA	9.80	9.13	1.63	090
64832		A	Repair nerve add-on	5.65	NA	NA	3.72	3.44	1.00	ZZZ
64834		A	Repair of hand or foot nerve	10.81	NA	NA	9.80	9.11	1.85	090
64835		A	Repair of hand or foot nerve	11.73	NA	NA	10.36	9.72	2.30	090
64836		A	Repair of hand or foot nerve	11.73	NA	NA	10.36	9.74	2.30	090
64837		A	Repair nerve add-on	6.25	NA	NA	3.74	3.63	0.76	ZZZ
64840		A	Repair of leg nerve	14.02	NA	NA	11.22	10.60	1.07	090
64856		A	Repair/transpose nerve	15.07	NA	NA	12.79	11.91	2.84	090
64857		A	Repair arm/leg nerve	15.82	NA	NA	13.16	12.31	2.91	090
64858		A	Repair sciatic nerve	17.82	NA	NA	15.92	14.50	3.50	090
64859		A	Nerve surgery	4.25	NA	NA	3.07	2.72	0.83	ZZZ
64861		A	Repair of arm nerves	20.89	NA	NA	12.46	12.94	4.11	090
64862		A	Repair of low back nerves	21.09	NA	NA	16.84	14.53	7.55	090
64864		A	Repair of facial nerve	13.41	NA	NA	11.13	10.36	1.70	090
64865		A	Repair of facial nerve	16.09	NA	NA	16.12	15.50	2.04	090
64866		A	Fusion of facial/other nerve	16.83	NA	NA	14.71	14.80	2.16	090
64868		A	Fusion of facial/other nerve	14.90	NA	NA	14.59	13.85	1.90	090
64870		A	Fusion of facial/other nerve	17.08	NA	NA	12.19	10.98	3.99	090
64872		A	Subsequent repair of nerve	1.99	NA	NA	1.19	1.16	0.26	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	NA	2.07	1.84	0.37	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	NA	1.88	1.74	0.65	ZZZ
64885		A	Nerve graft head or neck	17.60	NA	NA	13.91	13.10	2.24	090
64886		A	Nerve graft head or neck	20.82	NA	NA	15.86	15.17	2.66	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
64890		A	Nerve graft hand or foot	16.24	NA	NA	13.06	12.45	3.19	090
64891		A	Nerve graft hand or foot	17.35	NA	NA	15.58	13.85	3.42	090
64892		A	Nerve graft arm or leg	15.74	NA	NA	12.76	12.08	3.11	090
64893		A	Nerve graft arm or leg	16.87	NA	NA	14.17	12.90	3.34	090
64895		A	Nerve graft hand or foot	20.39	NA	NA	17.77	15.53	4.01	090
64896		A	Nerve graft hand or foot	21.96	NA	NA	15.97	15.49	7.88	090
64897		A	Nerve graft arm or leg	19.38	NA	NA	15.58	14.41	3.82	090
64898		A	Nerve graft arm or leg	20.97	NA	NA	16.34	15.49	4.13	090
64901		A	Nerve graft add-on	10.20	NA	NA	7.38	6.41	2.00	ZZZ
64902		A	Nerve graft add-on	11.81	NA	NA	8.54	7.35	2.31	ZZZ
64905		A	Nerve pedicle transfer	15.11	NA	NA	13.04	12.09	2.97	090
64907		A	Nerve pedicle transfer	20.03	NA	NA	11.02	12.44	1.41	090
64910		A	Nerve repair w/allograft	11.39	NA	NA	11.50	10.70	1.97	090
64911		A	Neurorraphy w/vein autograft	14.39	NA	NA	14.30	12.79	2.84	090
64999		C	Nervous system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
65091		A	Revise eye	7.26	NA	NA	10.44	9.69	1.44	090
65093		A	Revise eye with implant	7.04	NA	NA	10.43	9.79	1.39	090
65101		A	Removal of eye	8.30	NA	NA	12.26	11.37	1.63	090
65103		A	Remove eye/insert implant	8.84	NA	NA	12.64	11.68	1.74	090
65105		A	Remove eye/attach implant	9.93	NA	NA	13.77	12.68	1.94	090
65110		A	Removal of eye	15.70	NA	NA	18.37	16.77	2.00	090
65112		A	Remove eye/revise socket	18.51	NA	NA	21.25	19.40	2.35	090
65114		A	Remove eye/revise socket	19.65	NA	NA	22.05	20.02	2.51	090
65125		A	Revise ocular implant	3.27	9.18	9.02	4.84	4.46	0.64	090
65130		A	Insert ocular implant	8.42	NA	NA	11.99	11.05	1.64	090
65135		A	Insert ocular implant	8.60	NA	NA	12.12	11.19	1.67	090
65140		A	Attach ocular implant	9.46	NA	NA	13.08	12.08	1.22	090
65150		A	Revise ocular implant	6.43	NA	NA	9.65	9.06	0.45	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
65155		A	Reinsert ocular implant	10.10	NA	NA	13.53	12.49	1.97	090
65175		A	Removal of ocular implant	7.40	NA	NA	10.94	10.14	0.95	090
65205		A	Remove foreign body from eye	0.71	0.82	0.77	0.51	0.45	0.10	000
65210		A	Remove foreign body from eye	0.84	1.09	1.01	0.67	0.58	0.12	000
65220		A	Remove foreign body from eye	0.71	0.87	0.81	0.46	0.41	0.11	000
65222		A	Remove foreign body from eye	0.93	1.18	1.10	0.71	0.62	0.14	000
65235		A	Remove foreign body from eye	9.01	NA	NA	10.96	9.78	1.24	090
65260		A	Remove foreign body from eye	12.54	NA	NA	14.38	12.90	0.88	090
65265		A	Remove foreign body from eye	14.34	NA	NA	15.98	14.29	3.07	090
65270		A	Repair of eye wound	1.95	5.32	5.23	1.99	1.79	0.27	010
65272		A	Repair of eye wound	4.62	9.27	8.79	5.26	4.68	0.33	090
65273		A	Repair of eye wound	5.16	NA	NA	5.57	4.97	0.37	090
65275		A	Repair of eye wound	6.29	9.82	8.87	6.74	5.87	0.86	090
65280		A	Repair of eye wound	9.10	NA	NA	9.66	8.63	1.79	090
65285		A	Repair of eye wound	14.71	NA	NA	14.50	12.79	2.59	090
65286		A	Repair of eye wound	6.63	12.85	12.24	7.32	6.50	0.90	090
65290		A	Repair of eye socket wound	6.53	NA	NA	7.28	6.52	1.28	090
65400		A	Removal of eye lesion	7.50	11.46	10.54	9.42	8.46	1.03	090
65410		A	Biopsy of cornea	1.47	2.49	2.36	1.47	1.30	0.31	000
65420		A	Removal of eye lesion	4.36	9.87	9.50	6.19	5.66	0.56	090
65426		A	Removal of eye lesion	6.05	12.00	11.41	7.39	6.65	0.83	090
65430		A	Corneal smear	1.47	1.73	1.59	1.44	1.29	0.22	000
65435		A	Curette/treat cornea	0.92	1.31	1.22	1.04	0.94	0.16	000
65436		A	Curette/treat cornea	4.82	6.04	5.46	5.62	5.03	0.84	090
65450		A	Treatment of corneal lesion	3.47	5.59	5.16	5.50	5.06	0.48	090
65600		A	Revision of cornea	4.20	6.80	6.28	5.47	4.88	0.60	090
65710		A	Corneal transplant	14.45	NA	NA	16.70	14.98	1.97	090
65730		A	Corneal transplant	16.35	NA	NA	18.22	16.28	2.23	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
65750		A	Corneal transplant	16.90	NA	NA	17.89	15.96	2.16	090
65755		A	Corneal transplant	16.79	NA	NA	17.81	15.89	2.28	090
65756		A	Corneal trnspl endothelial	16.84	NA	NA	16.58	14.56	1.20	090
65757		C	Prep corneal endo allograft	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
65760		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65765		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65767		N	Corneal tissue transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65770		A	Revise cornea with implant	19.74	NA	NA	19.87	17.68	7.06	090
65771		N	Radial keratotomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65772		A	Correction of astigmatism	5.09	7.51	6.91	6.32	5.68	0.65	090
65775		A	Correction of astigmatism	6.91	NA	NA	8.58	7.77	0.49	090
65778		A	Cover eye w/membrane	1.19	35.71	35.71	0.84	0.84	0.18	010
65779		A	Cover eye w/membrane stent	3.92	29.05	29.05	4.09	4.09	0.56	010
65780		A	Ocular reconst transplant	10.73	NA	NA	14.18	12.94	1.39	090
65781		A	Ocular reconst transplant	18.14	NA	NA	19.44	17.46	1.28	090
65782		A	Ocular reconst transplant	15.43	NA	NA	16.99	15.29	3.06	090
65800		A	Drainage of eye	1.91	2.25	2.07	1.77	1.57	0.27	000
65805		A	Drainage of eye	1.91	2.64	2.47	1.78	1.58	0.34	000
65810		A	Drainage of eye	5.82	NA	NA	7.46	6.70	0.84	090
65815		A	Drainage of eye	6.00	11.65	11.08	7.40	6.65	1.06	090
65820		A	Relieve inner eye pressure	8.91	NA	NA	12.03	11.04	0.62	090
65850		A	Incision of eye	11.39	NA	NA	12.25	10.99	1.98	090
65855		A	Laser surgery of eye	3.99	5.48	5.07	4.38	3.95	0.62	010
65860		A	Incise inner eye adhesions	3.59	5.06	4.70	3.55	3.18	1.32	090
65865		A	Incise inner eye adhesions	5.77	NA	NA	7.47	6.85	0.39	090
65870		A	Incise inner eye adhesions	7.39	NA	NA	9.19	8.32	1.29	090
65875		A	Incise inner eye adhesions	7.81	NA	NA	9.86	8.93	1.07	090
65880		A	Incise inner eye adhesions	8.36	NA	NA	10.25	9.24	0.60	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
65900		A	Remove eye lesion	12.51	NA	NA	14.58	13.14	0.88	090
65920		A	Remove implant of eye	9.99	NA	NA	12.14	10.93	1.29	090
65930		A	Remove blood clot from eye	8.39	NA	NA	9.52	8.60	1.48	090
66020		A	Injection treatment of eye	1.64	3.51	3.37	2.05	1.86	0.11	010
66030		A	Injection treatment of eye	1.30	3.27	3.16	1.81	1.65	0.18	010
66130		A	Remove eye lesion	7.83	11.58	10.85	8.20	7.34	1.66	090
66150		A	Glaucoma surgery	10.53	NA	NA	14.03	12.69	0.73	090
66155		A	Glaucoma surgery	10.52	NA	NA	14.02	12.67	0.73	090
66160		A	Glaucoma surgery	12.39	NA	NA	15.34	13.81	0.87	090
66165		A	Glaucoma surgery	10.24	NA	NA	13.83	12.50	0.72	090
66170		A	Glaucoma surgery	15.02	NA	NA	18.68	16.78	1.91	090
66172		A	Incision of eye	18.86	NA	NA	23.66	21.22	2.40	090
66174		A	Translum dil eye canal	12.85	NA	NA	13.84	13.84	2.27	090
66175		A	Trnslum dil eye canal w/stnt	13.60	NA	NA	14.37	14.37	4.86	090
66180		A	Implant eye shunt	16.30	NA	NA	16.55	14.67	2.12	090
66185		A	Revise eye shunt	9.58	NA	NA	11.48	10.28	1.67	090
66220		A	Repair eye lesion	9.21	NA	NA	11.66	10.36	1.26	090
66225		A	Repair/graft eye lesion	12.63	NA	NA	13.59	12.09	2.47	090
66250		A	Follow-up surgery of eye	7.10	13.63	12.96	8.55	7.65	1.40	090
66500		A	Incision of iris	3.83	NA	NA	6.03	5.60	0.27	090
66505		A	Incision of iris	4.22	NA	NA	6.58	6.10	0.30	090
66600		A	Remove iris and lesion	10.12	NA	NA	13.19	11.84	0.76	090
66605		A	Removal of iris	14.22	NA	NA	15.54	13.78	1.02	090
66625		A	Removal of iris	5.30	NA	NA	6.74	6.11	0.72	090
66630		A	Removal of iris	7.28	NA	NA	8.72	7.82	1.22	090
66635		A	Removal of iris	7.37	NA	NA	8.78	7.87	0.52	090
66680		A	Repair iris & ciliary body	6.39	NA	NA	8.10	7.29	1.36	090
66682		A	Repair iris & ciliary body	7.33	NA	NA	10.47	9.45	1.45	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
66700		A	Destruction ciliary body	5.14	7.44	6.82	5.92	5.30	0.49	090
66710		A	Ciliary transsleral therapy	5.14	7.19	6.59	5.91	5.29	1.02	090
66711		A	Ciliary endoscopic ablation	7.93	NA	NA	10.12	9.09	0.56	090
66720		A	Destruction ciliary body	5.00	8.16	7.49	6.80	6.17	0.68	090
66740		A	Destruction ciliary body	5.14	7.09	6.49	5.92	5.32	0.35	090
66761		A	Revision of iris	3.00	5.25	5.85	3.63	4.46	0.45	010
66762		A	Revision of iris	5.38	7.91	7.25	6.59	5.91	0.68	090
66770		A	Removal of inner eye lesion	6.13	8.63	7.89	7.43	6.67	0.42	090
66820		A	Incision secondary cataract	4.01	NA	NA	6.91	6.54	0.67	090
66821		A	After cataract laser surgery	3.42	5.77	5.33	5.26	4.81	0.53	090
66825		A	Reposition intraocular lens	9.01	NA	NA	12.23	11.23	1.17	090
66830		A	Removal of lens lesion	9.47	NA	NA	10.60	9.46	0.67	090
66840		A	Removal of lens material	9.18	NA	NA	10.41	9.28	1.81	090
66850		A	Removal of lens material	10.55	NA	NA	11.75	10.48	1.45	090
66852		A	Removal of lens material	11.41	NA	NA	12.37	11.03	2.00	090
66920		A	Extraction of lens	10.13	NA	NA	11.10	9.90	0.71	090
66930		A	Extraction of lens	11.61	NA	NA	12.52	11.15	0.81	090
66940		A	Extraction of lens	10.37	NA	NA	11.62	10.38	1.74	090
66982		A	Cataract surgery complex	15.02	NA	NA	14.70	13.07	2.32	090
66983		A	Cataract surg w/iol 1 stage	10.43	NA	NA	10.41	9.28	0.83	090
66984		A	Cataract surg w/iol 1 stage	10.52	NA	NA	10.85	9.72	1.64	090
66985		A	Insert lens prosthesis	9.98	NA	NA	11.68	10.43	1.29	090
66986		A	Exchange lens prosthesis	12.26	NA	NA	13.32	11.99	1.56	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	NA	1.06	0.91	0.10	ZZZ
66999		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67005		A	Partial removal of eye fluid	5.89	NA	NA	7.36	6.63	1.25	090
67010		A	Partial removal of eye fluid	7.06	NA	NA	8.18	7.34	0.98	090
67015		A	Release of eye fluid	7.14	NA	NA	9.11	8.28	0.99	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
67025		A	Replace eye fluid	8.11	12.14	11.23	9.66	8.64	1.44	090
67027		A	Implant eye drug system	11.62	NA	NA	12.31	10.97	2.02	090
67028		A	Injection eye drug	1.44	1.43	2.15	1.38	1.52	0.20	000
67030		A	Incise inner eye strands	6.11	NA	NA	8.77	7.96	0.42	090
67031		A	Laser surgery eye strands	4.47	6.39	5.86	5.55	4.98	0.58	090
67036		A	Removal of inner eye fluid	13.32	NA	NA	13.71	12.20	1.82	090
67039		A	Laser treatment of retina	16.74	NA	NA	17.98	16.08	2.96	090
67040		A	Laser treatment of retina	19.61	NA	NA	20.40	18.17	2.69	090
67041		A	Vit for macular pucker	19.25	NA	NA	18.16	15.87	2.63	090
67042		A	Vit for macular hole	22.38	NA	NA	20.37	17.73	3.08	090
67043		A	Vit for membrane dissect	23.24	NA	NA	21.69	18.94	4.09	090
67101		A	Repair detached retina	8.80	13.11	12.00	10.16	9.07	1.55	090
67105		A	Repair detached retina	8.53	11.66	10.62	9.59	8.55	1.17	090
67107		A	Repair detached retina	16.71	NA	NA	17.54	15.56	2.95	090
67108		A	Repair detached retina	22.89	NA	NA	22.40	19.77	3.14	090
67110		A	Repair detached retina	10.25	14.05	12.87	11.55	10.29	1.30	090
67112		A	Rerepair detached retina	18.75	NA	NA	18.65	16.47	2.57	090
67113		A	Repair retinal detach cplx	25.35	NA	NA	23.92	20.91	3.48	090
67115		A	Release encircling material	6.11	NA	NA	7.89	7.10	0.77	090
67120		A	Remove eye implant material	7.10	11.23	10.42	8.59	7.70	1.40	090
67121		A	Remove eye implant material	12.25	NA	NA	13.34	11.85	2.16	090
67141		A	Treatment of retina	6.15	8.51	7.74	7.54	6.76	1.09	090
67145		A	Treatment of retina	6.32	8.46	7.67	7.66	6.86	0.86	090
67208		A	Treatment of retinal lesion	7.65	9.18	8.26	8.61	7.68	0.53	090
67210		A	Treatment of retinal lesion	9.45	9.96	8.87	9.34	8.24	1.40	090
67218		A	Treatment of retinal lesion	20.36	NA	NA	18.72	16.48	1.45	090
67220		A	Treatment of choroid lesion	14.39	15.45	13.82	14.10	12.44	2.54	090
67221		R	Ocular photodynamic ther	3.45	4.58	4.35	2.62	2.29	0.48	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
67225		A	Eye photodynamic ther add-on	0.47	0.38	0.33	0.33	0.28	0.03	ZZZ
67227		A	Treatment of retinal lesion	7.53	9.59	8.69	8.53	7.61	0.53	090
67228		A	Treatment of retinal lesion	13.82	18.53	17.49	16.01	14.24	2.09	090
67229		A	Tr retinal les preterm inf	16.30	NA	NA	15.61	13.98	1.17	090
67250		A	Reinforce eye wall	9.61	NA	NA	12.25	11.22	1.62	090
67255		A	Reinforce/graft eye wall	10.17	NA	NA	13.37	12.25	1.98	090
67299		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67311		A	Revise eye muscle	7.77	NA	NA	9.04	8.11	1.30	090
67312		A	Revise two eye muscles	9.66	NA	NA	10.36	9.23	1.90	090
67314		A	Revise eye muscle	8.79	NA	NA	10.12	9.05	1.48	090
67316		A	Revise two eye muscles	10.93	NA	NA	11.59	10.29	2.15	090
67318		A	Revise eye muscle(s)	9.12	NA	NA	10.71	9.57	0.64	090
67320		A	Revise eye muscle(s) add-on	5.40	NA	NA	3.78	3.18	0.38	ZZZ
67331		A	Eye surgery follow-up add-on	5.13	NA	NA	3.56	2.99	0.86	ZZZ
67332		A	Rerevise eye muscles add-on	5.56	NA	NA	3.90	3.28	0.92	ZZZ
67334		A	Revise eye muscle w/suture	5.05	NA	NA	3.56	2.98	0.35	ZZZ
67335		A	Eye suture during surgery	2.49	NA	NA	1.74	1.50	0.41	ZZZ
67340		A	Revise eye muscle add-on	6.00	NA	NA	4.23	3.55	0.42	ZZZ
67343		A	Release eye tissue	8.47	NA	NA	9.88	8.86	1.66	090
67345		A	Destroy nerve of eye muscle	3.01	3.57	3.22	2.93	2.60	0.80	010
67346		A	Biopsy eye muscle	2.87	NA	NA	2.79	2.48	0.61	000
67399		C	Eye muscle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67400		A	Explore/biopsy eye socket	11.20	NA	NA	14.82	13.64	2.06	090
67405		A	Explore/drain eye socket	9.20	NA	NA	12.95	12.00	1.18	090
67412		A	Explore/treat eye socket	10.30	NA	NA	13.50	12.52	1.86	090
67413		A	Explore/treat eye socket	10.24	NA	NA	13.65	12.65	2.00	090
67414		A	Explr/decompress eye socket	17.94	NA	NA	19.33	17.20	2.28	090
67415		A	Aspiration orbital contents	1.76	NA	NA	1.24	1.05	0.24	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
67420		A	Explore/treat eye socket	21.87	NA	NA	23.61	21.38	4.30	090
67430		A	Explore/treat eye socket	15.29	NA	NA	19.61	17.99	1.09	090
67440		A	Explore/drain eye socket	14.84	NA	NA	18.92	17.33	1.90	090
67445		A	Explr/decompress eye socket	19.12	NA	NA	20.30	18.22	3.76	090
67450		A	Explore/biopsy eye socket	15.41	NA	NA	19.69	18.04	1.97	090
67500		A	Inject/treat eye socket	1.44	0.89	0.83	0.71	0.62	0.11	000
67505		A	Inject/treat eye socket	1.27	1.25	1.09	1.04	0.86	0.26	000
67515		A	Inject/treat eye socket	1.40	1.34	1.14	1.13	0.93	0.26	000
67550		A	Insert eye socket implant	11.77	NA	NA	15.24	14.01	2.30	090
67560		A	Revise eye socket implant	12.18	NA	NA	15.56	14.21	1.56	090
67570		A	Decompress optic nerve	14.40	NA	NA	17.46	16.18	5.15	090
67599		C	Orbit surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67700		A	Drainage of eyelid abscess	1.40	5.86	5.85	1.85	1.68	0.23	010
67710		A	Incision of eyelid	1.07	4.99	5.03	1.65	1.52	0.22	010
67715		A	Incision of eyelid fold	1.27	5.16	5.16	1.78	1.63	0.26	010
67800		A	Remove eyelid lesion	1.41	2.13	1.98	1.50	1.35	0.24	010
67801		A	Remove eyelid lesions	1.91	2.62	2.41	1.86	1.65	0.37	010
67805		A	Remove eyelid lesions	2.27	3.36	3.11	2.38	2.13	0.43	010
67808		A	Remove eyelid lesion(s)	4.60	NA	NA	5.74	5.17	0.90	090
67810		A	Biopsy of eyelid	1.48	4.53	4.58	1.08	0.98	0.22	000
67820		A	Revise eyelashes	0.71	0.70	0.65	0.79	0.72	0.11	000
67825		A	Revise eyelashes	1.43	2.15	2.00	1.97	1.81	0.27	010
67830		A	Revise eyelashes	1.75	5.53	5.46	2.13	1.93	0.34	010
67835		A	Revise eyelashes	5.70	NA	NA	6.63	5.99	1.13	090
67840		A	Remove eyelid lesion	2.09	5.47	5.39	2.37	2.14	0.34	010
67850		A	Treat eyelid lesion	1.74	4.25	4.24	2.11	2.00	0.24	010
67875		A	Closure of eyelid by suture	1.35	3.36	3.30	1.39	1.24	0.24	000
67880		A	Revision of eyelid	4.60	8.12	7.64	5.74	5.17	0.81	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
67882		A	Revision of eyelid	6.02	9.67	9.02	7.25	6.52	1.18	090
67900		A	Repair brow defect	6.82	11.01	10.37	7.51	6.79	1.22	090
67901		A	Repair eyelid defect	7.59	13.34	11.74	8.60	7.68	1.49	090
67902		A	Repair eyelid defect	9.82	NA	NA	10.59	9.24	1.93	090
67903		A	Repair eyelid defect	6.51	10.03	9.61	7.12	6.50	1.26	090
67904		A	Repair eyelid defect	7.97	12.41	11.55	8.85	7.83	1.52	090
67906		A	Repair eyelid defect	6.93	NA	NA	7.39	6.63	0.49	090
67908		A	Repair eyelid defect	5.30	8.45	7.88	6.62	6.12	1.05	090
67909		A	Revise eyelid defect	5.57	9.29	8.80	6.72	6.13	1.10	090
67911		A	Revise eyelid defect	7.50	NA	NA	8.32	7.34	1.40	090
67912		A	Correction eyelid w/implant	6.36	18.05	18.00	7.48	6.85	0.92	090
67914		A	Repair eyelid defect	3.75	6.98	6.70	4.35	3.94	0.68	090
67915		A	Repair eyelid defect	3.26	6.28	6.08	3.86	3.53	0.45	090
67916		A	Repair eyelid defect	5.48	9.47	8.97	6.65	6.05	0.95	090
67917		A	Repair eyelid defect	6.19	10.10	9.53	7.16	6.49	1.15	090
67921		A	Repair eyelid defect	3.47	6.77	6.50	4.14	3.75	0.68	090
67922		A	Repair eyelid defect	3.14	6.09	5.91	3.71	3.40	0.42	090
67923		A	Repair eyelid defect	6.05	9.74	9.16	7.05	6.38	1.13	090
67924		A	Repair eyelid defect	5.93	10.32	9.80	6.69	6.03	1.13	090
67930		A	Repair eyelid wound	3.65	6.47	6.18	3.16	2.80	0.71	010
67935		A	Repair eyelid wound	6.36	10.18	9.59	6.14	5.50	1.25	090
67938		A	Remove eyelid foreign body	1.38	5.25	5.23	1.87	1.71	0.22	010
67950		A	Revision of eyelid	5.99	9.94	9.43	7.04	6.42	1.10	090
67961		A	Revision of eyelid	5.86	10.12	9.60	6.93	6.31	1.10	090
67966		A	Revision of eyelid	8.97	12.50	11.49	9.56	8.43	1.70	090
67971		A	Reconstruction of eyelid	10.01	NA	NA	10.40	9.33	1.96	090
67973		A	Reconstruction of eyelid	13.13	NA	NA	13.16	11.80	2.58	090
67974		A	Reconstruction of eyelid	13.10	NA	NA	13.13	11.75	2.58	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
67975		A	Reconstruction of eyelid	9.35	NA	NA	9.96	8.95	1.83	090
67999		C	Revision of eyelid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68020		A	Incise/drain eyelid lining	1.42	1.92	1.77	1.69	1.53	0.20	010
68040		A	Treatment of eyelid lesions	0.85	0.97	0.89	0.65	0.57	0.16	000
68100		A	Biopsy of eyelid lining	1.35	3.30	3.25	1.41	1.27	0.20	000
68110		A	Remove eyelid lining lesion	1.82	4.38	4.25	2.35	2.14	0.35	010
68115		A	Remove eyelid lining lesion	2.41	6.13	5.99	2.76	2.49	0.31	010
68130		A	Remove eyelid lining lesion	5.10	9.81	9.37	6.47	5.88	0.35	090
68135		A	Remove eyelid lining lesion	1.89	2.49	2.28	2.34	2.13	0.26	010
68200		A	Treat eyelid by injection	0.49	0.69	0.64	0.49	0.44	0.08	000
68320		A	Revise/graft eyelid lining	6.64	13.42	12.75	8.50	7.65	1.29	090
68325		A	Revise/graft eyelid lining	8.63	NA	NA	9.91	8.88	1.68	090
68326		A	Revise/graft eyelid lining	8.42	NA	NA	9.75	8.72	1.64	090
68328		A	Revise/graft eyelid lining	9.45	NA	NA	10.57	9.48	1.86	090
68330		A	Revise eyelid lining	5.78	10.95	10.40	7.17	6.45	1.14	090
68335		A	Revise/graft eyelid lining	8.46	NA	NA	9.74	8.72	1.66	090
68340		A	Separate eyelid adhesions	4.97	10.07	9.62	6.23	5.60	0.99	090
68360		A	Revise eyelid lining	5.17	9.49	9.01	6.34	5.72	1.02	090
68362		A	Revise eyelid lining	8.61	NA	NA	9.86	8.81	1.68	090
68371		A	Harvest eye tissue alograft	5.09	NA	NA	6.50	5.93	0.35	010
68399		C	Eyelid lining surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68400		A	Incise/drain tear gland	1.74	5.97	5.90	1.96	1.83	0.34	010
68420		A	Incise/drain tear sac	2.35	6.43	6.30	2.39	2.21	0.30	010
68440		A	Incise tear duct opening	0.99	1.85	1.83	1.77	1.64	0.20	010
68500		A	Removal of tear gland	12.77	NA	NA	14.66	13.13	2.99	090
68505		A	Partial removal tear gland	12.69	NA	NA	14.60	13.23	2.47	090
68510		A	Biopsy of tear gland	4.60	7.76	7.46	3.70	3.19	0.90	000
68520		A	Removal of tear sac	8.78	NA	NA	10.49	9.52	1.14	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
68525		A	Biopsy of tear sac	4.42	NA	NA	3.11	2.66	0.86	000
68530		A	Clearance of tear duct	3.70	8.05	7.90	3.56	3.21	0.72	010
68540		A	Remove tear gland lesion	12.18	NA	NA	13.95	12.53	1.56	090
68550		A	Remove tear gland lesion	15.16	NA	NA	16.89	15.09	1.93	090
68700		A	Repair tear ducts	7.87	NA	NA	9.12	8.17	1.53	090
68705		A	Revise tear duct opening	2.11	4.40	4.26	2.56	2.31	0.41	010
68720		A	Create tear sac drain	9.96	NA	NA	11.32	10.20	1.66	090
68745		A	Create tear duct drain	9.90	NA	NA	11.47	10.34	1.94	090
68750		A	Create tear duct drain	10.10	NA	NA	12.02	10.85	1.97	090
68760		A	Close tear duct opening	1.78	3.75	3.63	2.31	2.10	0.34	010
68761		A	Close tear duct opening	1.41	2.68	2.55	1.92	1.76	0.22	010
68770		A	Close tear system fistula	8.29	NA	NA	9.41	7.96	1.62	090
68801		A	Dilate tear duct opening	1.00	2.45	2.35	2.00	1.88	0.16	010
68810		A	Probe nasolacrimal duct	2.15	4.54	4.30	3.09	2.90	0.39	010
68811		A	Probe nasolacrimal duct	2.45	NA	NA	3.34	3.06	0.48	010
68815		A	Probe nasolacrimal duct	3.30	9.01	8.76	3.93	3.57	0.58	010
68816		A	Probe nl duct w/balloon	3.06	17.09	16.34	4.00	3.60	0.60	010
68840		A	Explore/irrigate tear ducts	1.30	2.26	2.08	1.96	1.76	0.24	010
68850		A	Injection for tear sac x-ray	0.80	0.84	0.90	0.70	0.75	0.07	000
68899		C	Tear duct system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69000		A	Drain external ear lesion	1.50	3.80	3.67	1.89	1.78	0.22	010
69005		A	Drain external ear lesion	2.16	4.00	3.84	2.35	2.22	0.29	010
69020		A	Drain outer ear canal lesion	1.53	5.25	5.12	2.61	2.51	0.20	010
69090		N	Pierce earlobes	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69100		A	Biopsy of external ear	0.81	2.03	2.12	0.60	0.55	0.11	000
69105		A	Biopsy of external ear canal	0.85	3.26	3.20	1.00	0.95	0.10	000
69110		A	Remove external ear partial	3.53	9.61	9.45	5.80	5.66	0.53	090
69120		A	Removal of external ear	4.14	NA	NA	7.53	7.21	0.60	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
69140		A	Remove ear canal lesion(s)	8.14	NA	NA	17.35	16.82	1.05	090
69145		A	Remove ear canal lesion(s)	2.70	8.89	8.54	4.57	4.35	0.35	090
69150		A	Extensive ear canal surgery	13.61	NA	NA	16.24	15.60	1.94	090
69155		A	Extensive ear/neck surgery	23.35	NA	NA	24.99	23.64	3.00	090
69200		A	Clear outer ear canal	0.77	2.80	2.75	0.88	0.81	0.10	000
69205		A	Clear outer ear canal	1.21	NA	NA	1.72	1.64	0.16	010
69210		A	Remove impacted ear wax	0.61	0.85	0.79	0.32	0.28	0.07	000
69220		A	Clean out mastoid cavity	0.83	3.21	3.14	0.97	0.92	0.10	000
69222		A	Clean out mastoid cavity	1.45	4.99	4.89	2.54	2.47	0.18	010
69300		R	Revise external ear	6.69	13.43	12.23	7.10	6.60	0.86	YYY
69310		A	Rebuild outer ear canal	10.97	NA	NA	20.58	19.93	1.44	090
69320		A	Rebuild outer ear canal	17.18	NA	NA	27.24	26.32	2.20	090
69399		C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69400		A	Inflate middle ear canal	0.83	3.49	3.36	0.97	0.91	0.10	000
69401		A	Inflate middle ear canal	0.63	1.90	1.80	0.80	0.76	0.07	000
69405		A	Catheterize middle ear canal	2.68	4.93	4.69	2.90	2.74	0.34	010
69420		A	Incision of eardrum	1.38	4.22	4.11	2.13	2.03	0.18	010
69421		A	Incision of eardrum	1.78	NA	NA	2.57	2.48	0.23	010
69424		A	Remove ventilating tube	0.85	2.90	2.85	0.95	0.90	0.10	000
69433		A	Create eardrum opening	1.57	4.26	4.12	2.21	2.10	0.22	010
69436		A	Create eardrum opening	2.01	NA	NA	2.66	2.57	0.26	010
69440		A	Exploration of middle ear	7.71	NA	NA	12.39	11.76	0.99	090
69450		A	Eardrum revision	5.69	NA	NA	10.21	9.72	0.72	090
69501		A	Mastoidectomy	9.21	NA	NA	12.08	11.41	1.18	090
69502		A	Mastoidectomy	12.56	NA	NA	15.60	14.73	1.68	090
69505		A	Remove mastoid structures	13.17	NA	NA	21.83	21.00	1.70	090
69511		A	Extensive mastoid surgery	13.70	NA	NA	22.15	21.34	1.77	090
69530		A	Extensive mastoid surgery	20.38	NA	NA	27.62	26.40	2.61	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
69535		A	Remove part of temporal bone	37.42	NA	NA	39.58	37.37	5.21	090
69540		A	Remove ear lesion	1.25	4.88	4.78	2.47	2.39	0.16	010
69550		A	Remove ear lesion	11.15	NA	NA	19.14	18.44	1.44	090
69552		A	Remove ear lesion	19.81	NA	NA	25.75	24.56	2.54	090
69554		A	Remove ear lesion	35.97	NA	NA	37.14	34.18	4.60	090
69601		A	Mastoid surgery revision	13.45	NA	NA	16.99	16.04	1.71	090
69602		A	Mastoid surgery revision	13.76	NA	NA	17.91	16.94	1.77	090
69603		A	Mastoid surgery revision	14.20	NA	NA	22.44	21.70	1.82	090
69604		A	Mastoid surgery revision	14.20	NA	NA	18.17	17.31	1.82	090
69605		A	Mastoid surgery revision	18.69	NA	NA	26.62	25.52	2.39	090
69610		A	Repair of eardrum	4.47	6.71	6.49	3.96	3.72	0.58	010
69620		A	Repair of eardrum	6.03	14.14	13.78	8.13	7.76	0.76	090
69631		A	Repair eardrum structures	10.05	NA	NA	15.72	14.94	1.29	090
69632		A	Rebuild eardrum structures	12.96	NA	NA	18.44	17.50	1.66	090
69633		A	Rebuild eardrum structures	12.31	NA	NA	18.00	17.10	1.59	090
69635		A	Repair eardrum structures	13.51	NA	NA	22.05	21.15	1.74	090
69636		A	Rebuild eardrum structures	15.43	NA	NA	24.70	23.75	1.97	090
69637		A	Rebuild eardrum structures	15.32	NA	NA	24.67	23.71	2.00	090
69641		A	Revise middle ear & mastoid	12.89	NA	NA	17.36	16.47	1.67	090
69642		A	Revise middle ear & mastoid	17.06	NA	NA	21.83	20.68	2.19	090
69643		A	Revise middle ear & mastoid	15.59	NA	NA	19.97	18.90	2.00	090
69644		A	Revise middle ear & mastoid	17.23	NA	NA	25.68	24.70	2.21	090
69645		A	Revise middle ear & mastoid	16.71	NA	NA	25.46	24.46	2.17	090
69646		A	Revise middle ear & mastoid	18.37	NA	NA	26.38	25.26	2.35	090
69650		A	Release middle ear bone	9.80	NA	NA	13.61	12.75	1.25	090
69660		A	Revise middle ear bone	12.03	NA	NA	14.92	14.11	1.55	090
69661		A	Revise middle ear bone	15.92	NA	NA	19.19	18.17	2.00	090
69662		A	Revise middle ear bone	15.60	NA	NA	17.96	16.97	2.00	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
69666		A	Repair middle ear structures	9.89	NA	NA	13.65	12.89	1.28	090
69667		A	Repair middle ear structures	9.90	NA	NA	13.63	12.92	1.28	090
69670		A	Remove mastoid air cells	11.73	NA	NA	15.74	14.87	1.51	090
69676		A	Remove middle ear nerve	9.69	NA	NA	14.54	13.86	1.24	090
69700		A	Close mastoid fistula	8.37	NA	NA	11.59	11.11	1.07	090
69710		N	Implant/replace hearing aid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69711		A	Remove/repair hearing aid	10.62	NA	NA	14.49	13.81	1.36	090
69714		A	Implant temple bone w/stimul	14.45	NA	NA	16.78	15.84	1.86	090
69715		A	Temple bne implnt w/stimulat	18.96	NA	NA	19.63	18.44	2.42	090
69717		A	Temple bone implant revision	15.43	NA	NA	17.40	16.58	1.97	090
69718		A	Revise temple bone implant	19.21	NA	NA	19.78	18.59	2.44	090
69720		A	Release facial nerve	14.71	NA	NA	19.47	18.44	1.89	090
69725		A	Release facial nerve	27.64	NA	NA	26.95	25.14	3.54	090
69740		A	Repair facial nerve	16.27	NA	NA	17.65	16.61	2.08	090
69745		A	Repair facial nerve	17.02	NA	NA	19.08	18.06	2.17	090
69799		C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69801		A	Incise inner ear	2.06	3.63	3.63	1.58	6.61	0.27	000
69802		A	Incise inner ear	13.50	NA	NA	16.79	15.85	1.71	090
69805		A	Explore inner ear	14.71	NA	NA	15.93	14.91	1.89	090
69806		A	Explore inner ear	12.63	NA	NA	14.81	13.98	1.63	090
69820		A	Establish inner ear window	10.52	NA	NA	14.43	13.78	1.36	090
69840		A	Revise inner ear window	10.44	NA	NA	12.74	13.68	0.73	090
69905		A	Remove inner ear	11.26	NA	NA	15.46	14.71	1.45	090
69910		A	Remove inner ear & mastoid	13.91	NA	NA	15.65	14.78	1.79	090
69915		A	Incise inner ear nerve	22.77	NA	NA	21.88	20.36	2.96	090
69930		A	Implant cochlear device	17.73	NA	NA	17.74	16.81	2.27	090
69949		C	Inner ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69950		A	Incise inner ear nerve	27.63	NA	NA	28.86	25.12	3.54	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
69955		A	Release facial nerve	29.42	NA	NA	28.02	26.17	3.78	090
69960		A	Release inner ear canal	29.42	NA	NA	26.42	24.54	3.78	090
69970		A	Remove inner ear lesion	32.41	NA	NA	29.77	27.80	4.16	090
69979		C	Temporal bone surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69990		R	Microsurgery add-on	3.46	NA	NA	1.94	1.87	1.15	ZZZ
70010		A	Contrast x-ray of brain	1.19	0.80	2.39	0.80	2.39	0.16	XXX
70015		A	Contrast x-ray of brain	1.19	3.02	3.10	NA	NA	0.08	XXX
70015	TC	A	Contrast x-ray of brain	0.00	2.57	2.60	NA	NA	0.01	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.45	0.50	0.45	0.50	0.07	XXX
70030		A	X-ray eye for foreign body	0.17	0.63	0.67	NA	NA	0.02	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.57	0.60	NA	NA	0.01	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.06	0.07	0.06	0.07	0.01	XXX
70100		A	X-ray exam of jaw	0.18	0.80	0.78	NA	NA	0.02	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.72	0.70	NA	NA	0.01	XXX
70100	26	A	X-ray exam of jaw	0.18	0.08	0.08	0.08	0.08	0.01	XXX
70110		A	X-ray exam of jaw	0.25	0.86	0.90	NA	NA	0.02	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.76	0.80	NA	NA	0.01	XXX
70110	26	A	X-ray exam of jaw	0.25	0.10	0.10	0.10	0.10	0.01	XXX
70120		A	X-ray exam of mastoids	0.18	0.85	0.85	NA	NA	0.02	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.77	0.77	NA	NA	0.01	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.08	0.08	0.08	0.08	0.01	XXX
70130		A	X-ray exam of mastoids	0.34	1.28	1.31	NA	NA	0.02	XXX
70130	TC	A	X-ray exam of mastoids	0.00	1.14	1.17	NA	NA	0.01	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.14	0.14	0.14	0.14	0.01	XXX
70134		A	X-ray exam of middle ear	0.34	0.95	1.02	NA	NA	0.02	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.82	0.88	NA	NA	0.01	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.13	0.14	0.13	0.14	0.01	XXX
70140		A	X-ray exam of facial bones	0.19	0.66	0.69	NA	NA	0.02	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70140	TC	A	X-ray exam of facial bones	0.00	0.56	0.60	NA	NA	0.01	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.10	0.09	0.10	0.09	0.01	XXX
70150		A	X-ray exam of facial bones	0.26	0.94	0.99	NA	NA	0.02	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.83	0.88	NA	NA	0.01	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.11	0.11	0.11	0.11	0.01	XXX
70160		A	X-ray exam of nasal bones	0.17	0.77	0.79	NA	NA	0.02	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.70	0.72	NA	NA	0.01	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.07	0.07	0.07	0.07	0.01	XXX
70170		C	X-ray exam of tear duct	0.00	0.00	0.00	NA	NA	0.00	XXX
70170	TC	C	X-ray exam of tear duct	0.00	0.00	0.00	NA	NA	0.00	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.11	0.12	0.11	0.12	0.03	XXX
70190		A	X-ray exam of eye sockets	0.21	0.80	0.84	NA	NA	0.02	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.71	0.75	NA	NA	0.01	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.09	0.09	0.09	0.09	0.01	XXX
70200		A	X-ray exam of eye sockets	0.28	0.94	1.01	NA	NA	0.02	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.83	0.89	NA	NA	0.01	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.11	0.12	0.11	0.12	0.01	XXX
7020F		I	Mammo assess cat in dbase	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70210		A	X-ray exam of sinuses	0.17	0.71	0.73	NA	NA	0.02	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.63	0.65	NA	NA	0.01	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.08	0.08	0.08	0.08	0.01	XXX
70220		A	X-ray exam of sinuses	0.25	0.85	0.89	NA	NA	0.02	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.74	0.79	NA	NA	0.01	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.11	0.10	0.11	0.10	0.01	XXX
70240		A	X-ray exam pituitary saddle	0.19	0.64	0.68	NA	NA	0.02	XXX
70240	TC	A	X-ray exam pituitary saddle	0.00	0.56	0.60	NA	NA	0.01	XXX
70240	26	A	X-ray exam pituitary saddle	0.19	0.08	0.08	0.08	0.08	0.01	XXX
70250		A	X-ray exam of skull	0.24	0.81	0.84	NA	NA	0.02	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70250	TC	A	X-ray exam of skull	0.00	0.70	0.73	NA	NA	0.01	XXX
70250	26	A	X-ray exam of skull	0.24	0.11	0.11	0.11	0.11	0.01	XXX
70260		A	X-ray exam of skull	0.34	0.99	1.05	NA	NA	0.02	XXX
70260	TC	A	X-ray exam of skull	0.00	0.84	0.91	NA	NA	0.01	XXX
70260	26	A	X-ray exam of skull	0.34	0.15	0.14	0.15	0.14	0.01	XXX
70300		A	X-ray exam of teeth	0.10	0.31	0.32	NA	NA	0.02	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.24	0.26	NA	NA	0.01	XXX
70300	26	A	X-ray exam of teeth	0.10	0.07	0.06	0.07	0.06	0.01	XXX
70310		A	X-ray exam of teeth	0.16	0.97	0.93	NA	NA	0.02	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.86	0.84	NA	NA	0.01	XXX
70310	26	A	X-ray exam of teeth	0.16	0.11	0.09	0.11	0.09	0.01	XXX
70320		A	Full mouth x-ray of teeth	0.22	1.26	1.25	NA	NA	0.02	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	1.13	1.14	NA	NA	0.01	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.13	0.11	0.13	0.11	0.01	XXX
70328		A	X-ray exam of jaw joint	0.18	0.70	0.72	NA	NA	0.02	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.62	0.64	NA	NA	0.01	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.08	0.08	0.08	0.08	0.01	XXX
70330		A	X-ray exam of jaw joints	0.24	1.14	1.17	NA	NA	0.02	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	1.02	1.06	NA	NA	0.01	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.12	0.11	0.12	0.11	0.01	XXX
70332		A	X-ray exam of jaw joint	0.54	1.88	1.95	NA	NA	0.04	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	1.57	1.68	NA	NA	0.01	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.31	0.27	0.31	0.27	0.03	XXX
70336		A	Magnetic image jaw joint	1.48	8.94	11.80	NA	NA	0.09	XXX
70336	TC	A	Magnetic image jaw joint	0.00	8.40	11.20	NA	NA	0.01	XXX
70336	26	A	Magnetic image jaw joint	1.48	0.54	0.60	0.54	0.60	0.08	XXX
70350		A	X-ray head for orthodontia	0.17	0.44	0.44	NA	NA	0.02	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.32	0.34	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70350	26	A	X-ray head for orthodontia	0.17	0.12	0.10	0.12	0.10	0.01	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.39	0.42	NA	NA	0.02	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.27	0.32	NA	NA	0.01	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.12	0.10	0.12	0.10	0.01	XXX
70360		A	X-ray exam of neck	0.17	0.60	0.63	NA	NA	0.02	XXX
70360	TC	A	X-ray exam of neck	0.00	0.53	0.56	NA	NA	0.01	XXX
70360	26	A	X-ray exam of neck	0.17	0.07	0.07	0.07	0.07	0.01	XXX
70370		A	Throat x-ray & fluoroscopy	0.32	2.14	2.08	NA	NA	0.02	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	2.00	1.94	NA	NA	0.01	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.14	0.14	0.14	0.14	0.01	XXX
70371		A	Speech evaluation complex	0.84	1.77	1.92	NA	NA	0.04	XXX
70371	TC	A	Speech evaluation complex	0.00	1.41	1.58	NA	NA	0.01	XXX
70371	26	A	Speech evaluation complex	0.84	0.36	0.34	0.36	0.34	0.03	XXX
70373		A	Contrast x-ray of larynx	0.44	1.92	1.97	NA	NA	0.02	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.74	1.80	NA	NA	0.01	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.18	0.17	0.18	0.17	0.01	XXX
70380		A	X-ray exam of salivary gland	0.17	1.00	0.98	NA	NA	0.02	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.89	0.89	NA	NA	0.01	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.11	0.09	0.11	0.09	0.01	XXX
70390		A	X-ray exam of salivary duct	0.38	2.48	2.60	NA	NA	0.04	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	2.33	2.44	NA	NA	0.01	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.15	0.16	0.15	0.16	0.03	XXX
70450		A	Ct head/brain w/o dye	0.85	3.85	4.92	NA	NA	0.05	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	3.53	4.57	NA	NA	0.01	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.32	0.35	0.32	0.35	0.04	XXX
70460		A	Ct head/brain w/dye	1.13	5.06	6.41	NA	NA	0.06	XXX
70460	TC	A	Ct head/brain w/dye	0.00	4.63	5.94	NA	NA	0.01	XXX
70460	26	A	Ct head/brain w/dye	1.13	0.43	0.47	0.43	0.47	0.05	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70470		A	Ct head/brain w/o & w/dye	1.27	6.18	7.84	NA	NA	0.08	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	5.70	7.31	NA	NA	0.01	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.48	0.53	0.48	0.53	0.07	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	6.66	7.98	NA	NA	0.08	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	6.17	7.44	NA	NA	0.01	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.49	0.54	0.49	0.54	0.07	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	7.78	9.36	NA	NA	0.09	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	7.26	8.79	NA	NA	0.01	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.52	0.57	0.52	0.57	0.08	XXX
70482		A	Ct orbit/ear/fossa w/o&w/dye	1.45	8.72	10.70	NA	NA	0.09	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	8.18	10.10	NA	NA	0.01	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.54	0.60	0.54	0.60	0.08	XXX
70486		A	Ct maxillofacial w/o dye	1.14	5.40	6.57	NA	NA	0.06	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	4.95	6.09	NA	NA	0.01	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.45	0.48	0.45	0.48	0.05	XXX
70487		A	Ct maxillofacial w/dye	1.30	6.52	7.99	NA	NA	0.08	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	6.03	7.45	NA	NA	0.01	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.49	0.54	0.49	0.54	0.07	XXX
70488		A	Ct maxillofacial w/o & w/dye	1.42	8.04	9.89	NA	NA	0.09	XXX
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	7.50	9.30	NA	NA	0.01	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.54	0.59	0.54	0.59	0.08	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	5.05	6.27	NA	NA	0.08	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	4.57	5.73	NA	NA	0.01	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.48	0.54	0.48	0.54	0.07	XXX
70491		A	Ct soft tissue neck w/dye	1.38	6.27	7.73	NA	NA	0.08	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	5.74	7.15	NA	NA	0.01	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.53	0.58	0.53	0.58	0.07	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	7.69	9.56	NA	NA	0.09	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	7.15	8.96	NA	NA	0.01	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.54	0.60	0.54	0.60	0.08	XXX
70496		A	Ct angiography head	1.75	12.58	15.76	NA	NA	0.11	XXX
70496	TC	A	Ct angiography head	0.00	11.93	15.03	NA	NA	0.01	XXX
70496	26	A	Ct angiography head	1.75	0.65	0.73	0.65	0.73	0.10	XXX
70498		A	Ct angiography neck	1.75	13.08	16.06	NA	NA	0.11	XXX
70498	TC	A	Ct angiography neck	0.00	12.43	15.32	NA	NA	0.01	XXX
70498	26	A	Ct angiography neck	1.75	0.65	0.74	0.65	0.74	0.10	XXX
70540		A	Mri orbit/face/neck w/o dye	1.35	10.35	13.38	NA	NA	0.09	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	9.85	12.83	NA	NA	0.01	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.50	0.55	0.50	0.55	0.08	XXX
70542		A	Mri orbit/face/neck w/dye	1.62	11.64	14.85	NA	NA	0.11	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	11.03	14.18	NA	NA	0.01	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.61	0.67	0.61	0.67	0.10	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	13.96	19.37	NA	NA	0.13	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	13.16	18.49	NA	NA	0.01	XXX
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.80	0.88	0.80	0.88	0.12	XXX
70544		A	Mr angiography head w/o dye	1.20	11.97	14.93	NA	NA	0.08	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	11.52	14.44	NA	NA	0.01	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.45	0.49	0.45	0.49	0.07	XXX
70545		A	Mr angiography head w/dye	1.20	11.86	14.83	NA	NA	0.08	XXX
70545	TC	A	Mr angiography head w/dye	0.00	11.41	14.34	NA	NA	0.01	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.45	0.49	0.45	0.49	0.07	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	18.13	23.45	NA	NA	0.12	XXX
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	17.45	22.71	NA	NA	0.01	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.68	0.74	0.68	0.74	0.11	XXX
70547		A	Mr angiography neck w/o dye	1.20	11.96	14.91	NA	NA	0.08	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	11.51	14.41	NA	NA	0.01	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.45	0.50	0.45	0.50	0.07	XXX
70548		A	Mr angiography neck w/dye	1.20	12.77	15.71	NA	NA	0.08	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	12.32	15.21	NA	NA	0.01	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.45	0.50	0.45	0.50	0.07	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	18.14	23.47	NA	NA	0.11	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	17.47	22.73	NA	NA	0.01	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.67	0.74	0.67	0.74	0.10	XXX
70551		A	Mri brain w/o dye	1.48	10.84	13.76	NA	NA	0.09	XXX
70551	TC	A	Mri brain w/o dye	0.00	10.28	13.15	NA	NA	0.01	XXX
70551	26	A	Mri brain w/o dye	1.48	0.56	0.61	0.56	0.61	0.08	XXX
70552		A	Mri brain w/dye	1.78	11.97	15.21	NA	NA	0.12	XXX
70552	TC	A	Mri brain w/dye	0.00	11.30	14.47	NA	NA	0.01	XXX
70552	26	A	Mri brain w/dye	1.78	0.67	0.74	0.67	0.74	0.11	XXX
70553		A	Mri brain w/o & w/dye	2.36	13.74	19.00	NA	NA	0.15	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	12.86	18.02	NA	NA	0.01	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.88	0.98	0.88	0.98	0.14	XXX
70554		A	Fmri brain by tech	2.11	12.07	14.68	NA	NA	0.13	XXX
70554	TC	A	Fmri brain by tech	0.00	11.25	13.78	NA	NA	0.01	XXX
70554	26	A	Fmri brain by tech	2.11	0.82	0.90	0.82	0.90	0.12	XXX
70555		C	Fmri brain by phys/psych	0.00	0.00	0.00	NA	NA	0.00	XXX
70555	TC	C	Fmri brain by phys/psych	0.00	0.00	0.00	NA	NA	0.00	XXX
70555	26	A	Fmri brain by phys/psych	2.54	0.93	1.06	0.93	1.06	0.24	XXX
70557		C	Mri brain w/o dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70557	TC	C	Mri brain w/o dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70557	26	A	Mri brain w/o dye	2.90	1.62	1.51	1.62	1.51	1.05	XXX
70558		C	Mri brain w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70558	TC	C	Mri brain w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70558	26	A	Mri brain w/dye	3.20	1.21	1.33	1.21	1.33	0.30	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
70559		C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70559	TC	C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70559	26	A	Mri brain w/o & w/dye	3.20	1.25	1.39	1.25	1.39	0.30	XXX
71010		A	Chest x-ray	0.18	0.46	0.50	NA	NA	0.02	XXX
71010	TC	A	Chest x-ray	0.00	0.39	0.43	NA	NA	0.01	XXX
71010	26	A	Chest x-ray	0.18	0.07	0.07	0.07	0.07	0.01	XXX
71015		A	Chest x-ray	0.21	0.62	0.67	NA	NA	0.02	XXX
71015	TC	A	Chest x-ray	0.00	0.54	0.58	NA	NA	0.01	XXX
71015	26	A	Chest x-ray	0.21	0.08	0.09	0.08	0.09	0.01	XXX
71020		A	Chest x-ray	0.22	0.62	0.68	NA	NA	0.02	XXX
71020	TC	A	Chest x-ray	0.00	0.53	0.59	NA	NA	0.01	XXX
71020	26	A	Chest x-ray	0.22	0.09	0.09	0.09	0.09	0.01	XXX
71021		A	Chest x-ray	0.27	0.79	0.85	NA	NA	0.02	XXX
71021	TC	A	Chest x-ray	0.00	0.67	0.73	NA	NA	0.01	XXX
71021	26	A	Chest x-ray	0.27	0.12	0.12	0.12	0.12	0.01	XXX
71022		A	Chest x-ray	0.31	1.00	1.05	NA	NA	0.02	XXX
71022	TC	A	Chest x-ray	0.00	0.87	0.92	NA	NA	0.01	XXX
71022	26	A	Chest x-ray	0.31	0.13	0.13	0.13	0.13	0.01	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	1.60	1.66	NA	NA	0.02	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	1.45	1.49	NA	NA	0.01	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.15	0.17	0.15	0.17	0.01	XXX
71030		A	Chest x-ray	0.31	0.96	1.04	NA	NA	0.02	XXX
71030	TC	A	Chest x-ray	0.00	0.84	0.91	NA	NA	0.01	XXX
71030	26	A	Chest x-ray	0.31	0.12	0.13	0.12	0.13	0.01	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	1.91	2.15	NA	NA	0.02	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.73	1.93	NA	NA	0.01	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.18	0.22	0.18	0.22	0.01	XXX
71035		A	Chest x-ray	0.18	0.81	0.86	NA	NA	0.02	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
71035	TC	A	Chest x-ray	0.00	0.74	0.78	NA	NA	0.01	XXX
71035	26	A	Chest x-ray	0.18	0.07	0.08	0.07	0.08	0.01	XXX
71040		A	Contrast x-ray of bronchi	0.58	2.15	2.27	NA	NA	0.02	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.94	2.03	NA	NA	0.01	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.21	0.24	0.21	0.24	0.01	XXX
71060		A	Contrast x-ray of bronchi	0.74	3.23	3.41	NA	NA	0.05	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.95	3.11	NA	NA	0.01	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.28	0.30	0.28	0.30	0.04	XXX
71090		C	X-ray & pacemaker insertion	0.00	0.00	0.00	NA	NA	0.00	XXX
71090	TC	C	X-ray & pacemaker insertion	0.00	0.00	0.00	NA	NA	0.00	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.21	0.26	0.21	0.26	0.04	XXX
71100		A	X-ray exam of ribs	0.22	0.69	0.73	NA	NA	0.02	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.60	0.64	NA	NA	0.01	XXX
71100	26	A	X-ray exam of ribs	0.22	0.09	0.09	0.09	0.09	0.01	XXX
71101		A	X-ray exam of ribs/chest	0.27	0.84	0.89	NA	NA	0.02	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.73	0.78	NA	NA	0.01	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.11	0.11	0.11	0.11	0.01	XXX
71110		A	X-ray exam of ribs	0.27	0.88	0.92	NA	NA	0.02	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.76	0.81	NA	NA	0.01	XXX
71110	26	A	X-ray exam of ribs	0.27	0.12	0.11	0.12	0.11	0.01	XXX
71111		A	X-ray exam of ribs/chest	0.32	1.19	1.23	NA	NA	0.02	XXX
71111	TC	A	X-ray exam of ribs/chest	0.00	1.05	1.09	NA	NA	0.01	XXX
71111	26	A	X-ray exam of ribs/chest	0.32	0.14	0.14	0.14	0.14	0.01	XXX
71120		A	X-ray exam of breastbone	0.20	0.67	0.73	NA	NA	0.02	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.59	0.65	NA	NA	0.01	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.08	0.08	0.08	0.08	0.01	XXX
71130		A	X-ray exam of breastbone	0.22	0.82	0.87	NA	NA	0.02	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.73	0.78	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
71130	26	A	X-ray exam of breastbone	0.22	0.09	0.09	0.09	0.09	0.01	XXX
71250		A	Ct thorax w/o dye	1.00	4.97	6.38	NA	NA	0.07	XXX
71250	TC	A	Ct thorax w/o dye	0.00	4.59	5.93	NA	NA	0.01	XXX
71250	26	A	Ct thorax w/o dye	1.00	0.38	0.45	0.38	0.45	0.06	XXX
71260		A	Ct thorax w/dye	1.24	6.24	7.90	NA	NA	0.08	XXX
71260	TC	A	Ct thorax w/dye	0.00	5.77	7.38	NA	NA	0.01	XXX
71260	26	A	Ct thorax w/dye	1.24	0.47	0.52	0.47	0.52	0.07	XXX
71270		A	Ct thorax w/o & w/dye	1.38	7.73	9.86	NA	NA	0.08	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	7.21	9.29	NA	NA	0.01	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.52	0.57	0.52	0.57	0.07	XXX
71275		A	Ct angiography chest	1.92	9.46	12.05	NA	NA	0.12	XXX
71275	TC	A	Ct angiography chest	0.00	8.74	11.25	NA	NA	0.01	XXX
71275	26	A	Ct angiography chest	1.92	0.72	0.80	0.72	0.80	0.11	XXX
71550		A	Mri chest w/o dye	1.46	12.02	15.21	NA	NA	0.09	XXX
71550	TC	A	Mri chest w/o dye	0.00	11.48	14.61	NA	NA	0.01	XXX
71550	26	A	Mri chest w/o dye	1.46	0.54	0.60	0.54	0.60	0.08	XXX
71551		A	Mri chest w/dye	1.73	13.59	17.05	NA	NA	0.11	XXX
71551	TC	A	Mri chest w/dye	0.00	12.94	16.34	NA	NA	0.01	XXX
71551	26	A	Mri chest w/dye	1.73	0.65	0.71	0.65	0.71	0.10	XXX
71552		A	Mri chest w/o & w/dye	2.26	16.70	22.48	NA	NA	0.13	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	15.86	21.54	NA	NA	0.01	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.84	0.94	0.84	0.94	0.12	XXX
71555		R	Mri angio chest w or w/o dye	1.81	11.59	14.53	NA	NA	0.11	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	10.91	13.77	NA	NA	0.01	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.68	0.76	0.68	0.76	0.10	XXX
72010		A	X-ray exam of spine	0.45	1.76	1.72	NA	NA	0.04	XXX
72010	TC	A	X-ray exam of spine	0.00	1.55	1.53	NA	NA	0.01	XXX
72010	26	A	X-ray exam of spine	0.45	0.21	0.19	0.21	0.19	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72020		A	X-ray exam of spine	0.15	0.50	0.54	NA	NA	0.02	XXX
72020	TC	A	X-ray exam of spine	0.00	0.44	0.47	NA	NA	0.01	XXX
72020	26	A	X-ray exam of spine	0.15	0.06	0.07	0.06	0.07	0.01	XXX
72040		A	X-ray exam of neck spine	0.22	0.89	0.90	NA	NA	0.04	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.79	0.80	NA	NA	0.01	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.10	0.10	0.10	0.10	0.03	XXX
72050		A	X-ray exam of neck spine	0.31	1.16	1.23	NA	NA	0.04	XXX
72050	TC	A	X-ray exam of neck spine	0.00	1.04	1.10	NA	NA	0.01	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.12	0.13	0.12	0.13	0.03	XXX
72052		A	X-ray exam of neck spine	0.36	1.55	1.61	NA	NA	0.04	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.40	1.45	NA	NA	0.01	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.15	0.16	0.15	0.16	0.03	XXX
72069		A	X-ray exam of trunk spine	0.22	0.85	0.86	NA	NA	0.04	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.75	0.76	NA	NA	0.01	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.10	0.10	0.10	0.10	0.03	XXX
72070		A	X-ray exam of thoracic spine	0.22	0.73	0.77	NA	NA	0.02	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.63	0.67	NA	NA	0.01	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.10	0.10	0.10	0.10	0.01	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.81	0.88	NA	NA	0.02	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.73	0.79	NA	NA	0.01	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.08	0.09	0.08	0.09	0.01	XXX
72074		A	X-ray exam of thoracic spine	0.22	1.01	1.09	NA	NA	0.02	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.92	1.00	NA	NA	0.01	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.09	0.09	0.09	0.09	0.01	XXX
72080		A	X-ray exam of trunk spine	0.22	0.81	0.83	NA	NA	0.04	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.71	0.73	NA	NA	0.01	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.10	0.10	0.10	0.10	0.03	XXX
72090		A	X-ray exam of trunk spine	0.28	1.15	1.15	NA	NA	0.05	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72090	TC	A	X-ray exam of trunk spine	0.00	1.02	1.02	NA	NA	0.01	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.13	0.13	0.13	0.13	0.04	XXX
72100		A	X-ray exam of lower spine	0.22	0.94	0.96	NA	NA	0.04	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.84	0.86	NA	NA	0.01	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.10	0.10	0.10	0.10	0.03	XXX
72110		A	X-ray exam of lower spine	0.31	1.26	1.30	NA	NA	0.04	XXX
72110	TC	A	X-ray exam of lower spine	0.00	1.13	1.17	NA	NA	0.01	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.13	0.13	0.13	0.13	0.03	XXX
72114		A	X-ray exam of lower spine	0.36	1.78	1.81	NA	NA	0.05	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.62	1.65	NA	NA	0.01	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.16	0.16	0.16	0.16	0.04	XXX
72120		A	X-ray exam of lower spine	0.22	1.29	1.28	NA	NA	0.04	XXX
72120	TC	A	X-ray exam of lower spine	0.00	1.18	1.18	NA	NA	0.01	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.11	0.10	0.11	0.10	0.03	XXX
72125		A	Ct neck spine w/o dye	1.00	5.01	6.42	NA	NA	0.07	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	4.64	5.97	NA	NA	0.01	XXX
72125	26	A	Ct neck spine w/o dye	1.00	0.37	0.45	0.37	0.45	0.06	XXX
72126		A	Ct neck spine w/dye	1.22	6.26	7.90	NA	NA	0.08	XXX
72126	TC	A	Ct neck spine w/dye	0.00	5.80	7.40	NA	NA	0.01	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.46	0.50	0.46	0.50	0.07	XXX
72127		A	Ct neck spine w/o & w/dye	1.27	7.70	9.80	NA	NA	0.08	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	7.23	9.28	NA	NA	0.01	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.47	0.52	0.47	0.52	0.07	XXX
72128		A	Ct chest spine w/o dye	1.00	5.01	6.40	NA	NA	0.07	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	4.63	5.95	NA	NA	0.01	XXX
72128	26	A	Ct chest spine w/o dye	1.00	0.38	0.45	0.38	0.45	0.06	XXX
72129		A	Ct chest spine w/dye	1.22	6.28	7.92	NA	NA	0.08	XXX
72129	TC	A	Ct chest spine w/dye	0.00	5.82	7.41	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72129	26	A	Ct chest spine w/dye	1.22	0.46	0.51	0.46	0.51	0.07	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	7.69	9.82	NA	NA	0.08	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	7.22	9.29	NA	NA	0.01	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.47	0.53	0.47	0.53	0.07	XXX
72131		A	Ct lumbar spine w/o dye	1.00	4.99	6.38	NA	NA	0.07	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	4.61	5.93	NA	NA	0.01	XXX
72131	26	A	Ct lumbar spine w/o dye	1.00	0.38	0.45	0.38	0.45	0.06	XXX
72132		A	Ct lumbar spine w/dye	1.22	6.25	7.90	NA	NA	0.08	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	5.79	7.39	NA	NA	0.01	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.46	0.51	0.46	0.51	0.07	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.27	7.69	9.81	NA	NA	0.08	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	7.21	9.28	NA	NA	0.01	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.48	0.53	0.48	0.53	0.07	XXX
72141		A	Mri neck spine w/o dye	1.60	9.36	12.13	NA	NA	0.11	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	8.75	11.47	NA	NA	0.01	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.61	0.66	0.61	0.66	0.10	XXX
72142		A	Mri neck spine w/dye	1.92	12.07	15.28	NA	NA	0.12	XXX
72142	TC	A	Mri neck spine w/dye	0.00	11.33	14.48	NA	NA	0.01	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.74	0.80	0.74	0.80	0.11	XXX
72146		A	Mri chest spine w/o dye	1.60	9.38	12.33	NA	NA	0.11	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	8.77	11.67	NA	NA	0.01	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.61	0.66	0.61	0.66	0.10	XXX
72147		A	Mri chest spine w/dye	1.92	10.52	13.58	NA	NA	0.12	XXX
72147	TC	A	Mri chest spine w/dye	0.00	9.79	12.78	NA	NA	0.01	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.73	0.80	0.73	0.80	0.11	XXX
72148		A	Mri lumbar spine w/o dye	1.48	9.31	12.26	NA	NA	0.11	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	8.74	11.65	NA	NA	0.01	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.57	0.61	0.57	0.61	0.10	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72149		A	Mri lumbar spine w/dye	1.78	11.85	15.14	NA	NA	0.12	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	11.17	14.39	NA	NA	0.01	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.68	0.75	0.68	0.75	0.11	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	13.54	18.76	NA	NA	0.17	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	12.57	17.70	NA	NA	0.01	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.97	1.06	0.97	1.06	0.16	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	12.42	17.49	NA	NA	0.17	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	11.46	16.43	NA	NA	0.01	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.96	1.06	0.96	1.06	0.16	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	13.41	18.64	NA	NA	0.17	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	12.52	17.67	NA	NA	0.01	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.89	0.97	0.89	0.97	0.16	XXX
72159		R	Mr angio spine w/o&w/dye	1.80	13.68	16.30	NA	NA	0.08	XXX
72159	TC	R	Mr angio spine w/o&w/dye	0.00	12.89	15.52	NA	NA	0.01	XXX
72159	26	R	Mr angio spine w/o&w/dye	1.80	0.79	0.78	0.79	0.78	0.07	XXX
72170		A	X-ray exam of pelvis	0.17	0.57	0.60	NA	NA	0.04	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.49	0.52	NA	NA	0.01	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.08	0.08	0.08	0.08	0.03	XXX
72190		A	X-ray exam of pelvis	0.21	0.99	1.00	NA	NA	0.04	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.89	0.90	NA	NA	0.01	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.10	0.10	0.10	0.10	0.03	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.81	8.98	11.56	NA	NA	0.13	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	8.31	10.81	NA	NA	0.01	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.67	0.75	0.67	0.75	0.12	XXX
72192		A	Ct pelvis w/o dye	1.09	4.71	6.06	NA	NA	0.06	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	4.30	5.60	NA	NA	0.01	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.41	0.46	0.41	0.46	0.05	XXX
72193		A	Ct pelvis w/dye	1.16	5.89	7.49	NA	NA	0.08	XXX
72193	TC	A	Ct pelvis w/dye	0.00	5.46	7.01	NA	NA	0.01	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.43	0.48	0.43	0.48	0.07	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	7.83	9.88	NA	NA	0.08	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	7.37	9.38	NA	NA	0.01	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.46	0.50	0.46	0.50	0.07	XXX
72195		A	Mri pelvis w/o dye	1.46	10.73	13.68	NA	NA	0.11	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	10.17	13.08	NA	NA	0.01	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.56	0.60	0.56	0.60	0.10	XXX
72196		A	Mri pelvis w/dye	1.73	11.81	15.05	NA	NA	0.11	XXX
72196	TC	A	Mri pelvis w/dye	0.00	11.15	14.33	NA	NA	0.01	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.66	0.72	0.66	0.72	0.10	XXX
72197		A	Mri pelvis w/o & w/dye	2.26	14.23	19.61	NA	NA	0.13	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	13.39	18.68	NA	NA	0.01	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.84	0.93	0.84	0.93	0.12	XXX
72198		A	Mr angio pelvis w/o & w/dye	1.80	11.58	14.47	NA	NA	0.11	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	10.91	13.73	NA	NA	0.01	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.67	0.74	0.67	0.74	0.10	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.66	0.69	NA	NA	0.02	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.59	0.62	NA	NA	0.01	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.07	0.07	0.07	0.07	0.01	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.77	0.83	NA	NA	0.02	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.70	0.75	NA	NA	0.01	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.07	0.08	0.07	0.08	0.01	XXX
72220		A	X-ray exam of tailbone	0.17	0.64	0.68	NA	NA	0.02	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.57	0.61	NA	NA	0.01	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.07	0.07	0.07	0.07	0.01	XXX
72240		A	Contrast x-ray of neck spine	0.91	2.74	3.33	NA	NA	0.06	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	2.39	2.95	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
72240	26	A	Contrast x-ray of neck spine	0.91	0.35	0.38	0.35	0.38	0.05	XXX
72255		A	Contrast x-ray thorax spine	0.91	2.66	3.07	NA	NA	0.05	XXX
72255	TC	A	Contrast x-ray thorax spine	0.00	2.29	2.70	NA	NA	0.01	XXX
72255	26	A	Contrast x-ray thorax spine	0.91	0.37	0.37	0.37	0.37	0.04	XXX
72265		A	Contrast x-ray lower spine	0.83	2.76	3.21	NA	NA	0.05	XXX
72265	TC	A	Contrast x-ray lower spine	0.00	2.43	2.86	NA	NA	0.01	XXX
72265	26	A	Contrast x-ray lower spine	0.83	0.33	0.35	0.33	0.35	0.04	XXX
72270		A	Contrast x-ray spine	1.33	4.26	4.97	NA	NA	0.08	XXX
72270	TC	A	Contrast x-ray spine	0.00	3.75	4.41	NA	NA	0.01	XXX
72270	26	A	Contrast x-ray spine	1.33	0.51	0.56	0.51	0.56	0.07	XXX
72275		A	Epidurography	0.76	2.68	2.50	NA	NA	0.05	XXX
72275	TC	A	Epidurography	0.00	2.30	2.18	NA	NA	0.01	XXX
72275	26	A	Epidurography	0.76	0.38	0.32	0.38	0.32	0.04	XXX
72285		A	X-ray c/t spine disk	1.16	2.28	3.15	NA	NA	0.06	XXX
72285	TC	A	X-ray c/t spine disk	0.00	1.67	2.64	NA	NA	0.01	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.61	0.51	0.61	0.51	0.05	XXX
72291		C	Perq verte/sacroplsty fluor	0.00	0.00	0.00	NA	NA	0.00	XXX
72291	TC	C	Perq verte/sacroplsty fluor	0.00	0.00	0.00	NA	NA	0.00	XXX
72291	26	A	Perq verte/sacroplsty fluor	1.31	0.60	0.61	0.60	0.61	0.22	XXX
72292		C	Perq verte/sacroplsty ct	0.00	0.00	0.00	NA	NA	0.00	XXX
72292	TC	C	Perq verte/sacroplsty ct	0.00	0.00	0.00	NA	NA	0.00	XXX
72292	26	A	Perq verte/sacroplsty ct	1.38	0.58	0.62	0.58	0.62	0.20	XXX
72295		A	X-ray of lower spine disk	0.83	2.12	2.97	NA	NA	0.05	XXX
72295	TC	A	X-ray of lower spine disk	0.00	1.70	2.60	NA	NA	0.01	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.42	0.37	0.42	0.37	0.04	XXX
73000		A	X-ray exam of collar bone	0.16	0.66	0.67	NA	NA	0.02	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.58	0.60	NA	NA	0.01	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.08	0.07	0.08	0.07	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73010		A	X-ray exam of shoulder blade	0.17	0.72	0.71	NA	NA	0.04	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.63	0.63	NA	NA	0.01	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.09	0.08	0.09	0.08	0.03	XXX
73020		A	X-ray exam of shoulder	0.15	0.52	0.55	NA	NA	0.02	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.45	0.48	NA	NA	0.01	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.07	0.07	0.07	0.07	0.01	XXX
73030		A	X-ray exam of shoulder	0.18	0.68	0.70	NA	NA	0.04	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.59	0.61	NA	NA	0.01	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.09	0.09	0.09	0.09	0.03	XXX
73040		A	Contrast x-ray of shoulder	0.54	2.48	2.62	NA	NA	0.05	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	2.25	2.38	NA	NA	0.01	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.23	0.24	0.23	0.24	0.04	XXX
73050		A	X-ray exam of shoulders	0.20	0.91	0.91	NA	NA	0.04	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.81	0.81	NA	NA	0.01	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.10	0.10	0.10	0.10	0.03	XXX
73060		A	X-ray exam of humerus	0.17	0.65	0.69	NA	NA	0.02	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.57	0.61	NA	NA	0.01	XXX
73060	26	A	X-ray exam of humerus	0.17	0.08	0.08	0.08	0.08	0.01	XXX
73070		A	X-ray exam of elbow	0.15	0.65	0.67	NA	NA	0.02	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.58	0.60	NA	NA	0.01	XXX
73070	26	A	X-ray exam of elbow	0.15	0.07	0.07	0.07	0.07	0.01	XXX
73080		A	X-ray exam of elbow	0.17	0.77	0.82	NA	NA	0.02	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.70	0.75	NA	NA	0.01	XXX
73080	26	A	X-ray exam of elbow	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73085		A	Contrast x-ray of elbow	0.54	2.22	2.32	NA	NA	0.04	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	1.97	2.08	NA	NA	0.01	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.25	0.24	0.25	0.24	0.03	XXX
73090		A	X-ray exam of forearm	0.16	0.62	0.65	NA	NA	0.02	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73090	TC	A	X-ray exam of forearm	0.00	0.55	0.58	NA	NA	0.01	XXX
73090	26	A	X-ray exam of forearm	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73092		A	X-ray exam of arm infant	0.16	0.76	0.73	NA	NA	0.02	XXX
73092	TC	A	X-ray exam of arm infant	0.00	0.69	0.66	NA	NA	0.01	XXX
73092	26	A	X-ray exam of arm infant	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73100		A	X-ray exam of wrist	0.16	0.73	0.73	NA	NA	0.04	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.65	0.65	NA	NA	0.01	XXX
73100	26	A	X-ray exam of wrist	0.16	0.08	0.08	0.08	0.08	0.03	XXX
73110		A	X-ray exam of wrist	0.17	0.90	0.89	NA	NA	0.02	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.82	0.81	NA	NA	0.01	XXX
73110	26	A	X-ray exam of wrist	0.17	0.08	0.08	0.08	0.08	0.01	XXX
73115		A	Contrast x-ray of wrist	0.54	2.67	2.65	NA	NA	0.05	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	2.42	2.40	NA	NA	0.01	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.25	0.25	0.25	0.25	0.04	XXX
73120		A	X-ray exam of hand	0.16	0.62	0.65	NA	NA	0.02	XXX
73120	TC	A	X-ray exam of hand	0.00	0.55	0.58	NA	NA	0.01	XXX
73120	26	A	X-ray exam of hand	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73130		A	X-ray exam of hand	0.17	0.75	0.76	NA	NA	0.02	XXX
73130	TC	A	X-ray exam of hand	0.00	0.67	0.69	NA	NA	0.01	XXX
73130	26	A	X-ray exam of hand	0.17	0.08	0.07	0.08	0.07	0.01	XXX
73140		A	X-ray exam of finger(s)	0.13	0.81	0.79	NA	NA	0.02	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.75	0.73	NA	NA	0.01	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.06	0.06	0.06	0.06	0.01	XXX
73200		A	Ct upper extremity w/o dye	1.00	4.95	6.19	NA	NA	0.07	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	4.57	5.76	NA	NA	0.01	XXX
73200	26	A	Ct upper extremity w/o dye	1.00	0.38	0.43	0.38	0.43	0.06	XXX
73201		A	Ct upper extremity w/dye	1.16	6.18	7.64	NA	NA	0.08	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	5.74	7.16	NA	NA	0.01	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.44	0.48	0.44	0.48	0.07	XXX
73202		A	Ct uppr extremity w/o&w/dye	1.22	8.13	10.06	NA	NA	0.08	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	7.67	9.56	NA	NA	0.01	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.22	0.46	0.50	0.46	0.50	0.07	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	8.51	10.99	NA	NA	0.09	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	7.84	10.22	NA	NA	0.01	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.67	0.77	0.67	0.77	0.08	XXX
73218		A	Mri upper extremity w/o dye	1.35	10.97	13.91	NA	NA	0.08	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	10.44	13.35	NA	NA	0.01	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.53	0.56	0.53	0.56	0.07	XXX
73219		A	Mri upper extremity w/dye	1.62	11.48	14.88	NA	NA	0.11	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	10.86	14.21	NA	NA	0.01	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.62	0.67	0.62	0.67	0.10	XXX
73220		A	Mri uppr extremity w/o&w/dye	2.15	14.27	19.66	NA	NA	0.13	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	13.46	18.77	NA	NA	0.01	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.15	0.81	0.89	0.81	0.89	0.12	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	10.17	13.00	NA	NA	0.11	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	9.63	12.43	NA	NA	0.01	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.54	0.57	0.54	0.57	0.10	XXX
73222		A	Mri joint upr extrem w/dye	1.62	10.81	14.03	NA	NA	0.11	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	10.19	13.36	NA	NA	0.01	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.62	0.67	0.62	0.67	0.10	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	13.30	18.55	NA	NA	0.13	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	12.48	17.66	NA	NA	0.01	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.82	0.89	0.82	0.89	0.12	XXX
73225		R	Mr angio upr extr w/o&w/dye	1.73	13.65	16.08	NA	NA	0.08	XXX
73225	TC	R	Mr angio upr extr w/o&w/dye	0.00	12.89	15.33	NA	NA	0.01	XXX
73225	26	R	Mr angio upr extr w/o&w/dye	1.73	0.76	0.75	0.76	0.75	0.07	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73500		A	X-ray exam of hip	0.17	0.58	0.59	NA	NA	0.04	XXX
73500	TC	A	X-ray exam of hip	0.00	0.50	0.51	NA	NA	0.01	XXX
73500	26	A	X-ray exam of hip	0.17	0.08	0.08	0.08	0.08	0.03	XXX
73510		A	X-ray exam of hip	0.21	0.89	0.90	NA	NA	0.04	XXX
73510	TC	A	X-ray exam of hip	0.00	0.79	0.80	NA	NA	0.01	XXX
73510	26	A	X-ray exam of hip	0.21	0.10	0.10	0.10	0.10	0.03	XXX
73520		A	X-ray exam of hips	0.26	0.90	0.92	NA	NA	0.04	XXX
73520	TC	A	X-ray exam of hips	0.00	0.78	0.81	NA	NA	0.01	XXX
73520	26	A	X-ray exam of hips	0.26	0.12	0.11	0.12	0.11	0.03	XXX
73525		A	Contrast x-ray of hip	0.54	2.38	2.40	NA	NA	0.05	XXX
73525	TC	A	Contrast x-ray of hip	0.00	2.11	2.14	NA	NA	0.01	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.27	0.26	0.27	0.26	0.04	XXX
73530		C	X-ray exam of hip	0.00	0.00	0.00	NA	NA	0.00	XXX
73530	TC	C	X-ray exam of hip	0.00	0.00	0.00	NA	NA	0.00	XXX
73530	26	A	X-ray exam of hip	0.29	0.11	0.12	0.11	0.12	0.03	XXX
73540		A	X-ray exam of pelvis & hips	0.20	1.04	0.98	NA	NA	0.04	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.94	0.89	NA	NA	0.01	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.10	0.09	0.10	0.09	0.03	XXX
73542		A	X-ray exam sacroiliac joint	0.59	1.85	1.82	NA	NA	0.04	XXX
73542	TC	A	X-ray exam sacroiliac joint	0.00	1.56	1.57	NA	NA	0.01	XXX
73542	26	A	X-ray exam sacroiliac joint	0.59	0.29	0.25	0.29	0.25	0.03	XXX
73550		A	X-ray exam of thigh	0.17	0.62	0.66	NA	NA	0.04	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.54	0.58	NA	NA	0.01	XXX
73550	26	A	X-ray exam of thigh	0.17	0.08	0.08	0.08	0.08	0.03	XXX
73560		A	X-ray exam of knee 1 or 2	0.17	0.69	0.70	NA	NA	0.04	XXX
73560	TC	A	X-ray exam of knee 1 or 2	0.00	0.61	0.62	NA	NA	0.01	XXX
73560	26	A	X-ray exam of knee 1 or 2	0.17	0.08	0.08	0.08	0.08	0.03	XXX
73562		A	X-ray exam of knee 3	0.18	0.87	0.87	NA	NA	0.04	XXX
73562	TC	A	X-ray exam of knee 3	0.00	0.78	0.78	NA	NA	0.01	XXX
73562	26	A	X-ray exam of knee 3	0.18	0.09	0.09	0.09	0.09	0.03	XXX
73564		A	X-ray exam knee 4 or more	0.22	1.00	1.00	NA	NA	0.04	XXX
73564	TC	A	X-ray exam knee 4 or more	0.00	0.90	0.90	NA	NA	0.01	XXX
73564	26	A	X-ray exam knee 4 or more	0.22	0.10	0.10	0.10	0.10	0.03	XXX
73565		A	X-ray exam of knees	0.17	0.83	0.80	NA	NA	0.04	XXX
73565	TC	A	X-ray exam of knees	0.00	0.74	0.71	NA	NA	0.01	XXX
73565	26	A	X-ray exam of knees	0.17	0.09	0.09	0.09	0.09	0.03	XXX
73580		A	Contrast x-ray of knee joint	0.54	3.44	3.31	NA	NA	0.06	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	3.14	3.04	NA	NA	0.01	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.30	0.27	0.30	0.27	0.05	XXX
73590		A	X-ray exam of lower leg	0.17	0.60	0.63	NA	NA	0.02	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.53	0.56	NA	NA	0.01	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73592		A	X-ray exam of leg infant	0.16	0.79	0.75	NA	NA	0.02	XXX
73592	TC	A	X-ray exam of leg infant	0.00	0.71	0.68	NA	NA	0.01	XXX
73592	26	A	X-ray exam of leg infant	0.16	0.08	0.07	0.08	0.07	0.01	XXX
73600		A	X-ray exam of ankle	0.16	0.66	0.66	NA	NA	0.02	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.59	0.59	NA	NA	0.01	XXX
73600	26	A	X-ray exam of ankle	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73610		A	X-ray exam of ankle	0.17	0.78	0.78	NA	NA	0.02	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.70	0.71	NA	NA	0.01	XXX
73610	26	A	X-ray exam of ankle	0.17	0.08	0.07	0.08	0.07	0.01	XXX
73615		A	Contrast x-ray of ankle	0.54	2.52	2.50	NA	NA	0.05	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	2.25	2.25	NA	NA	0.01	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.27	0.25	0.27	0.25	0.04	XXX
73620		A	X-ray exam of foot	0.16	0.64	0.64	NA	NA	0.02	XXX
73620	TC	A	X-ray exam of foot	0.00	0.58	0.58	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73620	26	A	X-ray exam of foot	0.16	0.06	0.06	0.06	0.06	0.01	XXX
73630		A	X-ray exam of foot	0.17	0.73	0.75	NA	NA	0.02	XXX
73630	TC	A	X-ray exam of foot	0.00	0.66	0.68	NA	NA	0.01	XXX
73630	26	A	X-ray exam of foot	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73650		A	X-ray exam of heel	0.16	0.65	0.66	NA	NA	0.02	XXX
73650	TC	A	X-ray exam of heel	0.00	0.58	0.59	NA	NA	0.01	XXX
73650	26	A	X-ray exam of heel	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73660		A	X-ray exam of toe(s)	0.13	0.74	0.72	NA	NA	0.02	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.68	0.67	NA	NA	0.01	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.06	0.05	0.06	0.05	0.01	XXX
73700		A	Ct lower extremity w/o dye	1.00	4.96	6.21	NA	NA	0.07	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	4.59	5.78	NA	NA	0.01	XXX
73700	26	A	Ct lower extremity w/o dye	1.00	0.37	0.43	0.37	0.43	0.06	XXX
73701		A	Ct lower extremity w/dye	1.16	6.25	7.73	NA	NA	0.08	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	5.82	7.24	NA	NA	0.01	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.43	0.49	0.43	0.49	0.07	XXX
73702		A	Ct lwr extremity w/o&w/dye	1.22	8.19	10.12	NA	NA	0.08	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	7.73	9.61	NA	NA	0.01	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.46	0.51	0.46	0.51	0.07	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	9.57	12.15	NA	NA	0.12	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	8.86	11.34	NA	NA	0.01	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.71	0.81	0.71	0.81	0.11	XXX
73718		A	Mri lower extremity w/o dye	1.35	10.68	13.60	NA	NA	0.09	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	10.17	13.04	NA	NA	0.01	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.51	0.56	0.51	0.56	0.08	XXX
73719		A	Mri lower extremity w/dye	1.62	11.61	14.83	NA	NA	0.11	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	11.00	14.17	NA	NA	0.01	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.61	0.66	0.61	0.66	0.10	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
73720		A	Mri lwr extremity w/o&w/dye	2.15	14.32	19.69	NA	NA	0.13	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	13.52	18.80	NA	NA	0.01	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.80	0.89	0.80	0.89	0.12	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	10.42	13.29	NA	NA	0.11	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	9.89	12.72	NA	NA	0.01	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.53	0.57	0.53	0.57	0.10	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	11.14	14.28	NA	NA	0.12	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	10.51	13.60	NA	NA	0.01	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.63	0.68	0.63	0.68	0.11	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	13.29	18.52	NA	NA	0.13	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	12.48	17.63	NA	NA	0.01	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.81	0.89	0.81	0.89	0.12	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	11.61	14.49	NA	NA	0.11	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	10.94	13.74	NA	NA	0.01	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.67	0.75	0.67	0.75	0.10	XXX
74000		A	X-ray exam of abdomen	0.18	0.49	0.54	NA	NA	0.02	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.42	0.47	NA	NA	0.01	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.07	0.07	0.07	0.07	0.01	XXX
74010		A	X-ray exam of abdomen	0.23	0.85	0.89	NA	NA	0.02	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.76	0.79	NA	NA	0.01	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.09	0.10	0.09	0.10	0.01	XXX
74020		A	X-ray exam of abdomen	0.27	0.85	0.90	NA	NA	0.02	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.75	0.79	NA	NA	0.01	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.10	0.11	0.10	0.11	0.01	XXX
74022		A	X-ray exam series abdomen	0.32	1.03	1.09	NA	NA	0.02	XXX
74022	TC	A	X-ray exam series abdomen	0.00	0.91	0.96	NA	NA	0.01	XXX
74022	26	A	X-ray exam series abdomen	0.32	0.12	0.13	0.12	0.13	0.01	XXX
74150		A	Ct abdomen w/o dye	1.19	4.73	6.05	NA	NA	0.08	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
74150	TC	A	Ct abdomen w/o dye	0.00	4.29	5.56	NA	NA	0.01	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.44	0.49	0.44	0.49	0.07	XXX
74160		A	Ct abdomen w/dye	1.27	6.86	8.55	NA	NA	0.08	XXX
74160	TC	A	Ct abdomen w/dye	0.00	6.38	8.02	NA	NA	0.01	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.48	0.53	0.48	0.53	0.07	XXX
74170		A	Ct abdomen w/o & w/dye	1.40	9.39	11.60	NA	NA	0.09	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	8.86	11.02	NA	NA	0.01	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.53	0.58	0.53	0.58	0.08	XXX
74175		A	Ct angio abdom w/o & w/dye	1.90	9.61	12.31	NA	NA	0.13	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	8.90	11.52	NA	NA	0.01	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.71	0.79	0.71	0.79	0.12	XXX
74176		A	Ct abd & pelvis w/o contrast	1.74	4.54	4.54	NA	NA	0.11	XXX
74176	TC	A	Ct abd & pelvis w/o contrast	0.00	3.89	3.89	NA	NA	0.01	XXX
74176	26	A	Ct abd & pelvis w/o contrast	1.74	0.65	0.65	0.65	0.65	0.10	XXX
74177		A	Ct abdomen&pelvis w/contrast	1.82	8.11	8.11	NA	NA	0.11	XXX
74177	TC	A	Ct abdomen&pelvis w/contrast	0.00	7.42	7.42	NA	NA	0.01	XXX
74177	26	A	Ct abdomen&pelvis w/contrast	1.82	0.69	0.69	0.69	0.69	0.10	XXX
74178		A	Ct abd&pelv 1+ section/regns	2.01	10.57	10.57	NA	NA	0.14	XXX
74178	TC	A	Ct abd&pelv 1+ section/regns	0.00	9.81	9.81	NA	NA	0.02	XXX
74178	26	A	Ct abd&pelv 1+ section/regns	2.01	0.76	0.76	0.76	0.76	0.12	XXX
74181		A	Mri abdomen w/o dye	1.46	9.33	12.10	NA	NA	0.09	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	8.79	11.50	NA	NA	0.01	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.54	0.60	0.54	0.60	0.08	XXX
74182		A	Mri abdomen w/dye	1.73	13.17	16.62	NA	NA	0.11	XXX
74182	TC	A	Mri abdomen w/dye	0.00	12.53	15.91	NA	NA	0.01	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.64	0.71	0.64	0.71	0.10	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	14.29	19.66	NA	NA	0.13	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	13.45	18.73	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.84	0.93	0.84	0.93	0.12	XXX
74185		R	Mri angio abdom w orw/o dye	1.80	11.57	14.44	NA	NA	0.11	XXX
74185	TC	R	Mri angio abdom w orw/o dye	0.00	10.90	13.70	NA	NA	0.01	XXX
74185	26	R	Mri angio abdom w orw/o dye	1.80	0.67	0.74	0.67	0.74	0.10	XXX
74190		C	X-ray exam of peritoneum	0.00	0.00	0.00	NA	NA	0.00	XXX
74190	TC	C	X-ray exam of peritoneum	0.00	0.00	0.00	NA	NA	0.00	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.18	0.20	0.18	0.20	0.04	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.86	1.94	NA	NA	0.02	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.72	1.79	NA	NA	0.01	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.14	0.15	0.14	0.15	0.01	XXX
74220		A	Contrast x-ray esophagus	0.46	2.10	2.18	NA	NA	0.04	XXX
74220	TC	A	Contrast x-ray esophagus	0.00	1.93	1.99	NA	NA	0.01	XXX
74220	26	A	Contrast x-ray esophagus	0.46	0.17	0.19	0.17	0.19	0.03	XXX
74230		A	Cine/vid x-ray throat/esoph	0.53	2.05	2.15	NA	NA	0.04	XXX
74230	TC	A	Cine/vid x-ray throat/esoph	0.00	1.85	1.93	NA	NA	0.01	XXX
74230	26	A	Cine/vid x-ray throat/esoph	0.53	0.20	0.22	0.20	0.22	0.03	XXX
74235		C	Remove esophagus obstruction	0.00	0.00	0.00	NA	NA	0.00	XXX
74235	TC	C	Remove esophagus obstruction	0.00	0.00	0.00	NA	NA	0.00	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.67	0.63	0.67	0.63	0.10	XXX
74240		A	X-ray exam upper gi tract	0.69	2.53	2.58	NA	NA	0.05	XXX
74240	TC	A	X-ray exam upper gi tract	0.00	2.26	2.29	NA	NA	0.01	XXX
74240	26	A	X-ray exam upper gi tract	0.69	0.27	0.29	0.27	0.29	0.04	XXX
74241		A	X-ray exam upper gi tract	0.69	2.71	2.79	NA	NA	0.04	XXX
74241	TC	A	X-ray exam upper gi tract	0.00	2.45	2.51	NA	NA	0.01	XXX
74241	26	A	X-ray exam upper gi tract	0.69	0.26	0.28	0.26	0.28	0.03	XXX
74245		A	X-ray exam upper gi tract	0.91	4.12	4.29	NA	NA	0.06	XXX
74245	TC	A	X-ray exam upper gi tract	0.00	3.78	3.91	NA	NA	0.01	XXX
74245	26	A	X-ray exam upper gi tract	0.91	0.34	0.38	0.34	0.38	0.05	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
74246		A	Contrst x-ray uppr gi tract	0.69	2.92	3.03	NA	NA	0.05	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	2.66	2.74	NA	NA	0.01	XXX
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.26	0.29	0.26	0.29	0.04	XXX
74247		A	Contrst x-ray uppr gi tract	0.69	3.36	3.45	NA	NA	0.05	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	3.10	3.16	NA	NA	0.01	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.26	0.29	0.26	0.29	0.04	XXX
74249		A	Contrst x-ray uppr gi tract	0.91	4.54	4.70	NA	NA	0.06	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	4.20	4.32	NA	NA	0.01	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.34	0.38	0.34	0.38	0.05	XXX
74250		A	X-ray exam of small bowel	0.47	2.60	2.65	NA	NA	0.04	XXX
74250	TC	A	X-ray exam of small bowel	0.00	2.42	2.46	NA	NA	0.01	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.18	0.19	0.18	0.19	0.03	XXX
74251		A	X-ray exam of small bowel	0.69	10.60	10.12	NA	NA	0.05	XXX
74251	TC	A	X-ray exam of small bowel	0.00	10.34	9.83	NA	NA	0.01	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.26	0.29	0.26	0.29	0.04	XXX
74260		A	X-ray exam of small bowel	0.50	8.75	8.42	NA	NA	0.04	XXX
74260	TC	A	X-ray exam of small bowel	0.00	8.56	8.22	NA	NA	0.01	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.19	0.20	0.19	0.20	0.03	XXX
74261		A	Ct colonography dx	2.40	12.76	12.76	NA	NA	0.14	XXX
74261	TC	A	Ct colonography dx	0.00	11.85	11.85	NA	NA	0.01	XXX
74261	26	A	Ct colonography dx	2.40	0.91	0.91	0.91	0.91	0.13	XXX
74262		A	Ct colonography dx w/dye	2.50	14.33	14.33	NA	NA	0.15	XXX
74262	TC	A	Ct colonography dx w/dye	0.00	13.39	13.39	NA	NA	0.01	XXX
74262	26	A	Ct colonography dx w/dye	2.50	0.94	0.94	0.94	0.94	0.14	XXX
74263		N	Ct colonography screening	2.28	20.17	20.17	NA	NA	0.13	XXX
74263	TC	N	Ct colonography screening	0.00	19.17	19.17	NA	NA	0.01	XXX
74263	26	N	Ct colonography screening	2.28	1.00	1.00	1.00	1.00	0.12	XXX
74270		A	Contrast x-ray exam of colon	0.69	3.74	3.81	NA	NA	0.05	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
74270	TC	A	Contrast x-ray exam of colon	0.00	3.48	3.52	NA	NA	0.01	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.26	0.29	0.26	0.29	0.04	XXX
74280		A	Contrast x-ray exam of colon	0.99	5.18	5.25	NA	NA	0.06	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	4.81	4.84	NA	NA	0.01	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.37	0.41	0.37	0.41	0.05	XXX
74283		A	Contrast x-ray exam of colon	2.02	3.77	4.00	NA	NA	0.06	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.99	3.16	NA	NA	0.01	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.78	0.84	0.78	0.84	0.05	XXX
74290		A	Contrast x-ray gallbladder	0.32	1.66	1.68	NA	NA	0.02	XXX
74290	TC	A	Contrast x-ray gallbladder	0.00	1.54	1.55	NA	NA	0.01	XXX
74290	26	A	Contrast x-ray gallbladder	0.32	0.12	0.13	0.12	0.13	0.01	XXX
74291		A	Contrast x-rays gallbladder	0.20	1.77	1.68	NA	NA	0.02	XXX
74291	TC	A	Contrast x-rays gallbladder	0.00	1.69	1.60	NA	NA	0.01	XXX
74291	26	A	Contrast x-rays gallbladder	0.20	0.08	0.08	0.08	0.08	0.01	XXX
74300		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74300	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.14	0.15	0.14	0.15	0.03	XXX
74301		C	X-rays at surgery add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
74301	TC	C	X-rays at surgery add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
74301	26	A	X-rays at surgery add-on	0.21	0.08	0.09	0.08	0.09	0.03	ZZZ
74305		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74305	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74305	26	A	X-ray bile ducts/pancreas	0.42	0.15	0.17	0.15	0.17	0.04	XXX
74320		A	Contrast x-ray of bile ducts	0.54	2.26	2.63	NA	NA	0.04	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	2.06	2.40	NA	NA	0.01	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.20	0.23	0.20	0.23	0.03	XXX
74327		A	X-ray bile stone removal	0.70	3.18	3.26	NA	NA	0.13	XXX
74327	TC	A	X-ray bile stone removal	0.00	2.92	2.97	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
74327	26	A	X-ray bile stone removal	0.70	0.26	0.29	0.26	0.29	0.12	XXX
74328		C	X-ray bile duct endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74328	TC	C	X-ray bile duct endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.29	0.31	0.29	0.31	0.05	XXX
74329		C	X-ray for pancreas endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74329	TC	C	X-ray for pancreas endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.29	0.31	0.29	0.31	0.05	XXX
74330		C	X-ray bile/panc endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74330	TC	C	X-ray bile/panc endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74330	26	A	X-ray bile/panc endoscopy	0.90	0.36	0.39	0.36	0.39	0.07	XXX
74340		C	X-ray guide for gi tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74340	TC	C	X-ray guide for gi tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74340	26	A	X-ray guide for gi tube	0.54	0.21	0.23	0.21	0.23	0.04	XXX
74355		C	X-ray guide intestinal tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74355	TC	C	X-ray guide intestinal tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74355	26	A	X-ray guide intestinal tube	0.76	0.31	0.33	0.31	0.33	0.07	XXX
74360		C	X-ray guide gi dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74360	TC	C	X-ray guide gi dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74360	26	A	X-ray guide gi dilation	0.54	0.28	0.28	0.28	0.28	0.04	XXX
74363		C	X-ray bile duct dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74363	TC	C	X-ray bile duct dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74363	26	A	X-ray bile duct dilation	0.88	0.32	0.37	0.32	0.37	0.08	XXX
74400		A	Contrst x-ray urinary tract	0.49	2.65	2.79	NA	NA	0.04	XXX
74400	TC	A	Contrst x-ray urinary tract	0.00	2.47	2.59	NA	NA	0.01	XXX
74400	26	A	Contrst x-ray urinary tract	0.49	0.18	0.20	0.18	0.20	0.03	XXX
74410		A	Contrst x-ray urinary tract	0.49	2.66	2.89	NA	NA	0.04	XXX
74410	TC	A	Contrst x-ray urinary tract	0.00	2.47	2.68	NA	NA	0.01	XXX
74410	26	A	Contrst x-ray urinary tract	0.49	0.19	0.21	0.19	0.21	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
74415		A	Contrst x-ray urinary tract	0.49	3.36	3.52	NA	NA	0.04	XXX
74415	TC	A	Contrst x-ray urinary tract	0.00	3.18	3.32	NA	NA	0.01	XXX
74415	26	A	Contrst x-ray urinary tract	0.49	0.18	0.20	0.18	0.20	0.03	XXX
74420		C	Contrst x-ray urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	TC	C	Contrst x-ray urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	26	A	Contrst x-ray urinary tract	0.36	0.14	0.15	0.14	0.15	0.03	XXX
74425		C	Contrst x-ray urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74425	TC	C	Contrst x-ray urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74425	26	A	Contrst x-ray urinary tract	0.36	0.13	0.15	0.13	0.15	0.03	XXX
74430		A	Contrast x-ray bladder	0.32	0.82	1.47	NA	NA	0.02	XXX
74430	TC	A	Contrast x-ray bladder	0.00	0.70	1.34	NA	NA	0.01	XXX
74430	26	A	Contrast x-ray bladder	0.32	0.12	0.13	0.12	0.13	0.01	XXX
74440		A	X-ray male genital tract	0.38	2.03	2.15	NA	NA	0.04	XXX
74440	TC	A	X-ray male genital tract	0.00	1.88	1.99	NA	NA	0.01	XXX
74440	26	A	X-ray male genital tract	0.38	0.15	0.16	0.15	0.16	0.03	XXX
74445		C	X-ray exam of penis	0.00	0.00	0.00	NA	NA	0.00	XXX
74445	TC	C	X-ray exam of penis	0.00	0.00	0.00	NA	NA	0.00	XXX
74445	26	A	X-ray exam of penis	1.14	0.45	0.50	0.45	0.50	0.10	XXX
74450		C	X-ray urethra/bladder	0.00	0.00	0.00	NA	NA	0.00	XXX
74450	TC	C	X-ray urethra/bladder	0.00	0.00	0.00	NA	NA	0.00	XXX
74450	26	A	X-ray urethra/bladder	0.33	0.12	0.14	0.12	0.14	0.03	XXX
74455		A	X-ray urethra/bladder	0.33	2.11	2.31	NA	NA	0.02	XXX
74455	TC	A	X-ray urethra/bladder	0.00	1.98	2.17	NA	NA	0.01	XXX
74455	26	A	X-ray urethra/bladder	0.33	0.13	0.14	0.13	0.14	0.01	XXX
74470		C	X-ray exam of kidney lesion	0.00	0.00	0.00	NA	NA	0.00	XXX
74470	TC	C	X-ray exam of kidney lesion	0.00	0.00	0.00	NA	NA	0.00	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.20	0.23	0.20	0.23	0.04	XXX
74475		A	X-ray control cath insert	0.54	2.23	2.74	NA	NA	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
74475	TC	A	X-ray control cath insert	0.00	2.03	2.51	NA	NA	0.01	XXX
74475	26	A	X-ray control cath insert	0.54	0.20	0.23	0.20	0.23	0.03	XXX
74480		A	X-ray control cath insert	0.54	2.24	2.75	NA	NA	0.04	XXX
74480	TC	A	X-ray control cath insert	0.00	2.04	2.52	NA	NA	0.01	XXX
74480	26	A	X-ray control cath insert	0.54	0.20	0.23	0.20	0.23	0.03	XXX
74485		A	X-ray guide gu dilation	0.54	2.28	2.70	NA	NA	0.04	XXX
74485	TC	A	X-ray guide gu dilation	0.00	2.08	2.47	NA	NA	0.01	XXX
74485	26	A	X-ray guide gu dilation	0.54	0.20	0.23	0.20	0.23	0.03	XXX
74710		A	X-ray measurement of pelvis	0.34	0.68	0.82	NA	NA	0.02	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	0.55	0.68	NA	NA	0.01	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.13	0.14	0.13	0.14	0.01	XXX
74740		A	X-ray female genital tract	0.38	1.85	1.95	NA	NA	0.02	XXX
74740	TC	A	X-ray female genital tract	0.00	1.70	1.79	NA	NA	0.01	XXX
74740	26	A	X-ray female genital tract	0.38	0.15	0.16	0.15	0.16	0.01	XXX
74742		C	X-ray fallopian tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74742	TC	C	X-ray fallopian tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74742	26	A	X-ray fallopian tube	0.61	0.24	0.25	0.24	0.25	0.05	XXX
74775		C	X-ray exam of perineum	0.00	0.00	0.00	NA	NA	0.00	XXX
74775	TC	C	X-ray exam of perineum	0.00	0.00	0.00	NA	NA	0.00	XXX
74775	26	A	X-ray exam of perineum	0.62	0.23	0.26	0.23	0.26	0.05	XXX
75557		A	Cardiac mri for morph	2.35	8.14	10.81	NA	NA	0.11	XXX
75557	TC	A	Cardiac mri for morph	0.00	7.25	9.75	NA	NA	0.01	XXX
75557	26	A	Cardiac mri for morph	2.35	0.89	1.06	0.89	1.06	0.10	XXX
75559		A	Cardiac mri w/stress img	2.95	11.69	16.11	NA	NA	0.13	XXX
75559	TC	A	Cardiac mri w/stress img	0.00	10.56	14.72	NA	NA	0.01	XXX
75559	26	A	Cardiac mri w/stress img	2.95	1.13	1.39	1.13	1.39	0.12	XXX
75561		A	Cardiac mri for morph w/dye	2.60	11.40	15.24	NA	NA	0.12	XXX
75561	TC	A	Cardiac mri for morph w/dye	0.00	10.41	14.07	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75561	26	A	Cardiac mri for morph w/dye	2.60	0.99	1.17	0.99	1.17	0.11	XXX
75563		A	Card mri w/stress img & dye	3.00	13.60	18.75	NA	NA	0.12	XXX
75563	TC	A	Card mri w/stress img & dye	0.00	12.43	17.28	NA	NA	0.01	XXX
75563	26	A	Card mri w/stress img & dye	3.00	1.17	1.47	1.17	1.47	0.11	XXX
75565		A	Card mri veloc flow mapping	0.25	1.93	1.93	NA	NA	0.02	ZZZ
75565	TC	A	Card mri veloc flow mapping	0.00	1.82	1.82	NA	NA	0.01	ZZZ
75565	26	A	Card mri veloc flow mapping	0.25	0.11	0.11	0.11	0.11	0.01	ZZZ
75571		A	Ct hrt w/o dye w/ca test	0.58	2.56	2.56	NA	NA	0.02	XXX
75571	TC	A	Ct hrt w/o dye w/ca test	0.00	2.34	2.34	NA	NA	0.01	XXX
75571	26	A	Ct hrt w/o dye w/ca test	0.58	0.22	0.22	0.22	0.22	0.01	XXX
75572		A	Ct hrt w/3d image	1.75	6.84	6.84	NA	NA	0.06	XXX
75572	TC	A	Ct hrt w/3d image	0.00	6.17	6.17	NA	NA	0.01	XXX
75572	26	A	Ct hrt w/3d image	1.75	0.67	0.67	0.67	0.67	0.05	XXX
75573		A	Ct hrt w/3d image congen	2.55	9.14	9.14	NA	NA	0.09	XXX
75573	TC	A	Ct hrt w/3d image congen	0.00	8.14	8.14	NA	NA	0.01	XXX
75573	26	A	Ct hrt w/3d image congen	2.55	1.00	1.00	1.00	1.00	0.08	XXX
75574		A	Ct angio hrt w/3d image	2.40	10.67	10.67	NA	NA	0.09	XXX
75574	TC	A	Ct angio hrt w/3d image	0.00	9.75	9.75	NA	NA	0.01	XXX
75574	26	A	Ct angio hrt w/3d image	2.40	0.92	0.92	0.92	0.92	0.08	XXX
75600		A	Contrast x-ray exam of aorta	0.49	5.46	7.48	NA	NA	0.04	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	5.27	7.25	NA	NA	0.01	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.19	0.23	0.19	0.23	0.03	XXX
75605		A	Contrast x-ray exam of aorta	1.14	3.19	5.16	NA	NA	0.08	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	2.77	4.65	NA	NA	0.01	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.42	0.51	0.42	0.51	0.07	XXX
75625		A	Contrast x-ray exam of aorta	1.14	3.28	5.13	NA	NA	0.11	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	2.87	4.66	NA	NA	0.01	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.41	0.47	0.41	0.47	0.10	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75630		A	X-ray aorta leg arteries	1.79	3.52	5.53	NA	NA	0.11	XXX
75630	TC	A	X-ray aorta leg arteries	0.00	2.86	4.77	NA	NA	0.01	XXX
75630	26	A	X-ray aorta leg arteries	1.79	0.66	0.76	0.66	0.76	0.10	XXX
75635		A	Ct angio abdominal arteries	2.40	10.20	13.51	NA	NA	0.15	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	9.30	12.48	NA	NA	0.03	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.90	1.03	0.90	1.03	0.12	XXX
75650		A	Artery x-rays head & neck	1.49	3.45	5.32	NA	NA	0.11	XXX
75650	TC	A	Artery x-rays head & neck	0.00	2.90	4.69	NA	NA	0.01	XXX
75650	26	A	Artery x-rays head & neck	1.49	0.55	0.63	0.55	0.63	0.10	XXX
75658		A	Artery x-rays arm	1.31	4.07	5.69	NA	NA	0.09	XXX
75658	TC	A	Artery x-rays arm	0.00	3.60	5.18	NA	NA	0.01	XXX
75658	26	A	Artery x-rays arm	1.31	0.47	0.51	0.47	0.51	0.08	XXX
75660		A	Artery x-rays head & neck	1.31	4.18	5.84	NA	NA	0.05	XXX
75660	TC	A	Artery x-rays head & neck	0.00	3.65	5.26	NA	NA	0.01	XXX
75660	26	A	Artery x-rays head & neck	1.31	0.53	0.58	0.53	0.58	0.04	XXX
75662		A	Artery x-rays head & neck	1.66	5.07	6.80	NA	NA	0.10	XXX
75662	TC	A	Artery x-rays head & neck	0.00	4.40	6.04	NA	NA	0.03	XXX
75662	26	A	Artery x-rays head & neck	1.66	0.67	0.76	0.67	0.76	0.07	XXX
75665		A	Artery x-rays head & neck	1.31	4.42	6.08	NA	NA	0.12	XXX
75665	TC	A	Artery x-rays head & neck	0.00	3.89	5.51	NA	NA	0.01	XXX
75665	26	A	Artery x-rays head & neck	1.31	0.53	0.57	0.53	0.57	0.11	XXX
75671		A	Artery x-rays head & neck	1.66	5.26	6.95	NA	NA	0.13	XXX
75671	TC	A	Artery x-rays head & neck	0.00	4.61	6.23	NA	NA	0.03	XXX
75671	26	A	Artery x-rays head & neck	1.66	0.65	0.72	0.65	0.72	0.10	XXX
75676		A	Artery x-rays neck	1.31	4.04	5.77	NA	NA	0.12	XXX
75676	TC	A	Artery x-rays neck	0.00	3.53	5.21	NA	NA	0.01	XXX
75676	26	A	Artery x-rays neck	1.31	0.51	0.56	0.51	0.56	0.11	XXX
75680		A	Artery x-rays neck	1.66	4.58	6.39	NA	NA	0.11	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75680	TC	A	Artery x-rays neck	0.00	3.94	5.66	NA	NA	0.01	XXX
75680	26	A	Artery x-rays neck	1.66	0.64	0.73	0.64	0.73	0.10	XXX
75685		A	Artery x-rays spine	1.31	4.14	5.83	NA	NA	0.09	XXX
75685	TC	A	Artery x-rays spine	0.00	3.62	5.26	NA	NA	0.01	XXX
75685	26	A	Artery x-rays spine	1.31	0.52	0.57	0.52	0.57	0.08	XXX
75705		A	Artery x-rays spine	2.18	4.46	6.17	NA	NA	0.08	XXX
75705	TC	A	Artery x-rays spine	0.00	3.60	5.23	NA	NA	0.01	XXX
75705	26	A	Artery x-rays spine	2.18	0.86	0.94	0.86	0.94	0.07	XXX
75710		A	Artery x-rays arm/leg	1.14	3.93	5.71	NA	NA	0.06	XXX
75710	TC	A	Artery x-rays arm/leg	0.00	3.51	5.24	NA	NA	0.01	XXX
75710	26	A	Artery x-rays arm/leg	1.14	0.42	0.47	0.42	0.47	0.05	XXX
75716		A	Artery x-rays arms/legs	1.31	4.72	6.55	NA	NA	0.13	XXX
75716	TC	A	Artery x-rays arms/legs	0.00	4.24	6.01	NA	NA	0.03	XXX
75716	26	A	Artery x-rays arms/legs	1.31	0.48	0.54	0.48	0.54	0.10	XXX
75722		A	Artery x-rays kidney	1.14	3.55	5.48	NA	NA	0.08	XXX
75722	TC	A	Artery x-rays kidney	0.00	3.13	4.98	NA	NA	0.01	XXX
75722	26	A	Artery x-rays kidney	1.14	0.42	0.50	0.42	0.50	0.07	XXX
75724		A	Artery x-rays kidneys	1.49	4.22	6.37	NA	NA	0.08	XXX
75724	TC	A	Artery x-rays kidneys	0.00	3.65	5.65	NA	NA	0.03	XXX
75724	26	A	Artery x-rays kidneys	1.49	0.57	0.72	0.57	0.72	0.05	XXX
75726		A	Artery x-rays abdomen	1.14	3.85	5.63	NA	NA	0.09	XXX
75726	TC	A	Artery x-rays abdomen	0.00	3.44	5.16	NA	NA	0.01	XXX
75726	26	A	Artery x-rays abdomen	1.14	0.41	0.47	0.41	0.47	0.08	XXX
75731		A	Artery x-rays adrenal gland	1.14	3.82	5.77	NA	NA	0.05	XXX
75731	TC	A	Artery x-rays adrenal gland	0.00	3.39	5.24	NA	NA	0.01	XXX
75731	26	A	Artery x-rays adrenal gland	1.14	0.43	0.53	0.43	0.53	0.04	XXX
75733		A	Artery x-rays adrenals	1.31	4.46	6.64	NA	NA	0.07	XXX
75733	TC	A	Artery x-rays adrenals	0.00	3.95	6.00	NA	NA	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75733	26	A	Artery x-rays adrenals	1.31	0.51	0.64	0.51	0.64	0.04	XXX
75736		A	Artery x-rays pelvis	1.14	3.78	5.63	NA	NA	0.06	XXX
75736	TC	A	Artery x-rays pelvis	0.00	3.36	5.15	NA	NA	0.01	XXX
75736	26	A	Artery x-rays pelvis	1.14	0.42	0.48	0.42	0.48	0.05	XXX
75741		A	Artery x-rays lung	1.31	3.27	5.09	NA	NA	0.09	XXX
75741	TC	A	Artery x-rays lung	0.00	2.80	4.54	NA	NA	0.01	XXX
75741	26	A	Artery x-rays lung	1.31	0.47	0.55	0.47	0.55	0.08	XXX
75743		A	Artery x-rays lungs	1.66	3.66	5.49	NA	NA	0.11	XXX
75743	TC	A	Artery x-rays lungs	0.00	3.06	4.79	NA	NA	0.01	XXX
75743	26	A	Artery x-rays lungs	1.66	0.60	0.70	0.60	0.70	0.10	XXX
75746		A	Artery x-rays lung	1.14	3.63	5.42	NA	NA	0.08	XXX
75746	TC	A	Artery x-rays lung	0.00	3.20	4.94	NA	NA	0.01	XXX
75746	26	A	Artery x-rays lung	1.14	0.43	0.48	0.43	0.48	0.07	XXX
75756		A	Artery x-rays chest	1.14	3.83	5.79	NA	NA	0.23	XXX
75756	TC	A	Artery x-rays chest	0.00	3.41	5.25	NA	NA	0.01	XXX
75756	26	A	Artery x-rays chest	1.14	0.42	0.54	0.42	0.54	0.22	XXX
75774		A	Artery x-ray each vessel	0.36	2.51	4.31	NA	NA	0.04	ZZZ
75774	TC	A	Artery x-ray each vessel	0.00	2.38	4.16	NA	NA	0.01	ZZZ
75774	26	A	Artery x-ray each vessel	0.36	0.13	0.15	0.13	0.15	0.03	ZZZ
75791		A	Av dialysis shunt imaging	1.71	7.88	7.88	NA	NA	0.11	XXX
75791	TC	A	Av dialysis shunt imaging	0.00	7.25	7.25	NA	NA	0.01	XXX
75791	26	A	Av dialysis shunt imaging	1.71	0.63	0.63	0.63	0.63	0.10	XXX
75801		C	Lymph vessel x-ray arm/leg	0.00	0.00	0.00	NA	NA	0.00	XXX
75801	TC	C	Lymph vessel x-ray arm/leg	0.00	0.00	0.00	NA	NA	0.00	XXX
75801	26	A	Lymph vessel x-ray arm/leg	0.81	0.35	0.33	0.35	0.33	0.18	XXX
75803		C	Lymph vessel x-ray arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	TC	C	Lymph vessel x-ray arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	26	A	Lymph vessel x-ray arms/legs	1.17	0.44	0.50	0.44	0.50	0.10	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75805		C	Lymph vessel x-ray trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75805	TC	C	Lymph vessel x-ray trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75805	26	A	Lymph vessel x-ray trunk	0.81	0.31	0.34	0.31	0.34	0.07	XXX
75807		C	Lymph vessel x-ray trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75807	TC	C	Lymph vessel x-ray trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75807	26	A	Lymph vessel x-ray trunk	1.17	0.45	0.50	0.45	0.50	0.10	XXX
75809		A	Nonvascular shunt x-ray	0.47	2.50	2.39	NA	NA	0.04	XXX
75809	TC	A	Nonvascular shunt x-ray	0.00	2.31	2.19	NA	NA	0.01	XXX
75809	26	A	Nonvascular shunt x-ray	0.47	0.19	0.20	0.19	0.20	0.03	XXX
75810		C	Vein x-ray spleen/liver	0.00	0.00	0.00	NA	NA	0.00	XXX
75810	TC	C	Vein x-ray spleen/liver	0.00	0.00	0.00	NA	NA	0.00	XXX
75810	26	A	Vein x-ray spleen/liver	1.14	0.43	0.49	0.43	0.49	0.10	XXX
75820		A	Vein x-ray arm/leg	0.70	2.90	2.98	NA	NA	0.05	XXX
75820	TC	A	Vein x-ray arm/leg	0.00	2.64	2.68	NA	NA	0.01	XXX
75820	26	A	Vein x-ray arm/leg	0.70	0.26	0.30	0.26	0.30	0.04	XXX
75822		A	Vein x-ray arms/legs	1.06	3.37	3.42	NA	NA	0.08	XXX
75822	TC	A	Vein x-ray arms/legs	0.00	2.98	2.99	NA	NA	0.01	XXX
75822	26	A	Vein x-ray arms/legs	1.06	0.39	0.43	0.39	0.43	0.07	XXX
75825		A	Vein x-ray trunk	1.14	3.11	4.89	NA	NA	0.09	XXX
75825	TC	A	Vein x-ray trunk	0.00	2.70	4.43	NA	NA	0.01	XXX
75825	26	A	Vein x-ray trunk	1.14	0.41	0.46	0.41	0.46	0.08	XXX
75827		A	Vein x-ray chest	1.14	3.28	4.96	NA	NA	0.08	XXX
75827	TC	A	Vein x-ray chest	0.00	2.87	4.52	NA	NA	0.01	XXX
75827	26	A	Vein x-ray chest	1.14	0.41	0.44	0.41	0.44	0.07	XXX
75831		A	Vein x-ray kidney	1.14	3.22	4.99	NA	NA	0.25	XXX
75831	TC	A	Vein x-ray kidney	0.00	2.81	4.53	NA	NA	0.01	XXX
75831	26	A	Vein x-ray kidney	1.14	0.41	0.46	0.41	0.46	0.24	XXX
75833		A	Vein x-ray kidneys	1.49	3.86	5.59	NA	NA	0.09	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75833	TC	A	Vein x-ray kidneys	0.00	3.34	5.01	NA	NA	0.01	XXX
75833	26	A	Vein x-ray kidneys	1.49	0.52	0.58	0.52	0.58	0.08	XXX
75840		A	Vein x-ray adrenal gland	1.14	3.07	4.87	NA	NA	0.25	XXX
75840	TC	A	Vein x-ray adrenal gland	0.00	2.69	4.44	NA	NA	0.01	XXX
75840	26	A	Vein x-ray adrenal gland	1.14	0.38	0.43	0.38	0.43	0.24	XXX
75842		A	Vein x-ray adrenal glands	1.49	3.81	5.60	NA	NA	0.09	XXX
75842	TC	A	Vein x-ray adrenal glands	0.00	3.25	4.98	NA	NA	0.01	XXX
75842	26	A	Vein x-ray adrenal glands	1.49	0.56	0.62	0.56	0.62	0.08	XXX
75860		A	Vein x-ray neck	1.14	3.21	5.08	NA	NA	0.09	XXX
75860	TC	A	Vein x-ray neck	0.00	2.78	4.58	NA	NA	0.01	XXX
75860	26	A	Vein x-ray neck	1.14	0.43	0.50	0.43	0.50	0.08	XXX
75870		A	Vein x-ray skull	1.14	3.16	5.01	NA	NA	0.08	XXX
75870	TC	A	Vein x-ray skull	0.00	2.73	4.54	NA	NA	0.01	XXX
75870	26	A	Vein x-ray skull	1.14	0.43	0.47	0.43	0.47	0.07	XXX
75872		A	Vein x-ray skull	1.14	6.73	7.19	NA	NA	0.08	XXX
75872	TC	A	Vein x-ray skull	0.00	6.10	6.60	NA	NA	0.01	XXX
75872	26	A	Vein x-ray skull	1.14	0.63	0.59	0.63	0.59	0.07	XXX
75880		A	Vein x-ray eye socket	0.70	5.54	4.34	NA	NA	0.05	XXX
75880	TC	A	Vein x-ray eye socket	0.00	5.20	4.02	NA	NA	0.01	XXX
75880	26	A	Vein x-ray eye socket	0.70	0.34	0.32	0.34	0.32	0.04	XXX
75885		A	Vein x-ray liver	1.44	3.30	5.12	NA	NA	0.09	XXX
75885	TC	A	Vein x-ray liver	0.00	2.78	4.52	NA	NA	0.01	XXX
75885	26	A	Vein x-ray liver	1.44	0.52	0.60	0.52	0.60	0.08	XXX
75887		A	Vein x-ray liver	1.44	3.39	5.21	NA	NA	0.06	XXX
75887	TC	A	Vein x-ray liver	0.00	2.86	4.60	NA	NA	0.01	XXX
75887	26	A	Vein x-ray liver	1.44	0.53	0.61	0.53	0.61	0.05	XXX
75889		A	Vein x-ray liver	1.14	3.22	5.00	NA	NA	0.08	XXX
75889	TC	A	Vein x-ray liver	0.00	2.81	4.53	NA	NA	0.01	XXX
75889	26	A	Vein x-ray liver	1.14	0.41	0.47	0.41	0.47	0.07	XXX
75891		A	Vein x-ray liver	1.14	3.22	5.00	NA	NA	0.08	XXX
75891	TC	A	Vein x-ray liver	0.00	2.81	4.53	NA	NA	0.01	XXX
75891	26	A	Vein x-ray liver	1.14	0.41	0.47	0.41	0.47	0.07	XXX
75893		A	Venous sampling by catheter	0.54	2.95	4.72	NA	NA	0.02	XXX
75893	TC	A	Venous sampling by catheter	0.00	2.75	4.50	NA	NA	0.01	XXX
75893	26	A	Venous sampling by catheter	0.54	0.20	0.22	0.20	0.22	0.01	XXX
75894		C	X-rays transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75894	TC	C	X-rays transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75894	26	A	X-rays transcath therapy	1.31	0.48	0.54	0.48	0.54	0.16	XXX
75896		C	X-rays transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75896	TC	C	X-rays transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75896	26	A	X-rays transcath therapy	1.31	0.48	0.56	0.48	0.56	0.16	XXX
75898		C	Follow-up angiography	0.00	0.00	0.00	NA	NA	0.00	XXX
75898	TC	C	Follow-up angiography	0.00	0.00	0.00	NA	NA	0.00	XXX
75898	26	A	Follow-up angiography	1.65	0.62	0.71	0.62	0.71	0.20	XXX
75900		C	Intravascular cath exchange	0.00	0.00	0.00	NA	NA	0.00	XXX
75900	TC	C	Intravascular cath exchange	0.00	0.00	0.00	NA	NA	0.00	XXX
75900	26	A	Intravascular cath exchange	0.49	0.17	0.20	0.17	0.20	0.05	XXX
75901		A	Remove cva device obstruct	0.49	4.58	4.43	NA	NA	0.04	XXX
75901	TC	A	Remove cva device obstruct	0.00	4.40	4.23	NA	NA	0.01	XXX
75901	26	A	Remove cva device obstruct	0.49	0.18	0.20	0.18	0.20	0.03	XXX
75902		A	Remove cva lumen obstruct	0.39	1.77	1.86	NA	NA	0.05	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.63	1.70	NA	NA	0.01	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.14	0.16	0.14	0.16	0.04	XXX
75940		C	X-ray placement vein filter	0.00	0.00	0.00	NA	NA	0.00	XXX
75940	TC	C	X-ray placement vein filter	0.00	0.00	0.00	NA	NA	0.00	XXX
75940	26	A	X-ray placement vein filter	0.54	0.20	0.21	0.20	0.21	0.07	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75945		C	Intravascular us	0.00	0.00	0.00	NA	NA	0.00	XXX
75945	TC	C	Intravascular us	0.00	0.00	0.00	NA	NA	0.00	XXX
75945	26	A	Intravascular us	0.40	0.14	0.16	0.14	0.16	0.05	XXX
75946		C	Intravascular us add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75946	TC	C	Intravascular us add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75946	26	A	Intravascular us add-on	0.40	0.13	0.15	0.13	0.15	0.07	ZZZ
75952		C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	26	A	Endovasc repair abdom aorta	4.49	1.55	1.64	1.55	1.64	0.86	XXX
75953		C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75953	TC	C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.36	0.47	0.50	0.47	0.50	0.27	XXX
75954		C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75954	TC	C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	2.25	0.79	0.83	0.79	0.83	0.41	XXX
75956		C	Xray endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75956	TC	C	Xray endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75956	26	A	Xray endovasc thor ao repr	7.00	2.35	2.55	2.35	2.55	1.44	XXX
75957		C	Xray endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	TC	C	Xray endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	26	A	Xray endovasc thor ao repr	6.00	2.02	2.19	2.02	2.19	1.21	XXX
75958		C	Xray place prox ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75958	TC	C	Xray place prox ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75958	26	A	Xray place prox ext thor ao	4.00	1.34	1.42	1.34	1.42	0.81	XXX
75959		C	Xray place dist ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75959	TC	C	Xray place dist ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75959	26	A	Xray place dist ext thor ao	3.50	1.05	1.20	1.05	1.20	0.83	XXX
75960		A	Transcath iv stent rs&i	0.82	2.70	4.86	NA	NA	0.06	XXX
75960	TC	A	Transcath iv stent rs&i	0.00	2.40	4.52	NA	NA	0.01	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.30	0.34	0.30	0.34	0.05	XXX
75961		A	Retrieval broken catheter	4.24	4.79	6.40	NA	NA	0.28	XXX
75961	TC	A	Retrieval broken catheter	0.00	3.27	4.67	NA	NA	0.01	XXX
75961	26	A	Retrieval broken catheter	4.24	1.52	1.73	1.52	1.73	0.27	XXX
75962		A	Repair arterial blockage	0.54	3.47	5.71	NA	NA	0.04	XXX
75962	TC	A	Repair arterial blockage	0.00	3.27	5.49	NA	NA	0.01	XXX
75962	26	A	Repair arterial blockage	0.54	0.20	0.22	0.20	0.22	0.03	XXX
75964		A	Repair artery blockage each	0.36	2.35	3.52	NA	NA	0.05	ZZZ
75964	TC	A	Repair artery blockage each	0.00	2.22	3.38	NA	NA	0.01	ZZZ
75964	26	A	Repair artery blockage each	0.36	0.13	0.14	0.13	0.14	0.04	ZZZ
75966		A	Repair arterial blockage	1.31	3.72	6.17	NA	NA	0.08	XXX
75966	TC	A	Repair arterial blockage	0.00	3.23	5.59	NA	NA	0.01	XXX
75966	26	A	Repair arterial blockage	1.31	0.49	0.58	0.49	0.58	0.07	XXX
75968		A	Repair artery blockage each	0.36	2.21	3.46	NA	NA	0.02	ZZZ
75968	TC	A	Repair artery blockage each	0.00	2.08	3.30	NA	NA	0.01	ZZZ
75968	26	A	Repair artery blockage each	0.36	0.13	0.16	0.13	0.16	0.01	ZZZ
75970		C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
75970	TC	C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
75970	26	A	Vascular biopsy	0.83	0.30	0.35	0.30	0.35	0.07	XXX
75978		A	Repair venous blockage	0.54	3.64	5.73	NA	NA	0.04	XXX
75978	TC	A	Repair venous blockage	0.00	3.44	5.51	NA	NA	0.01	XXX
75978	26	A	Repair venous blockage	0.54	0.20	0.22	0.20	0.22	0.03	XXX
75980		C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75980	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.53	0.60	0.53	0.60	0.12	XXX
75982		C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75982	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
75982	26	A	Contrast xray exam bile duct	1.44	0.52	0.60	0.52	0.60	0.12	XXX
75984		A	Xray control catheter change	0.72	2.46	2.64	NA	NA	0.05	XXX
75984	TC	A	Xray control catheter change	0.00	2.20	2.34	NA	NA	0.01	XXX
75984	26	A	Xray control catheter change	0.72	0.26	0.30	0.26	0.30	0.04	XXX
75989		A	Abscess drainage under x-ray	1.19	2.38	2.78	NA	NA	0.06	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	1.94	2.28	NA	NA	0.01	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.44	0.50	0.44	0.50	0.05	XXX
76000		A	Fluoroscope examination	0.17	1.30	2.10	NA	NA	0.02	XXX
76000	TC	A	Fluoroscope examination	0.00	1.23	2.03	NA	NA	0.01	XXX
76000	26	A	Fluoroscope examination	0.17	0.07	0.07	0.07	0.07	0.01	XXX
76001		C	Fluoroscope exam extensive	0.00	0.00	0.00	NA	NA	0.00	XXX
76001	TC	C	Fluoroscope exam extensive	0.00	0.00	0.00	NA	NA	0.00	XXX
76001	26	A	Fluoroscope exam extensive	0.67	0.30	0.30	0.30	0.30	0.08	XXX
76010		A	X-ray nose to rectum	0.18	0.56	0.63	NA	NA	0.02	XXX
76010	TC	A	X-ray nose to rectum	0.00	0.49	0.55	NA	NA	0.01	XXX
76010	26	A	X-ray nose to rectum	0.18	0.07	0.08	0.07	0.08	0.01	XXX
76080		A	X-ray exam of fistula	0.54	1.15	1.27	NA	NA	0.04	XXX
76080	TC	A	X-ray exam of fistula	0.00	0.95	1.04	NA	NA	0.01	XXX
76080	26	A	X-ray exam of fistula	0.54	0.20	0.23	0.20	0.23	0.03	XXX
76098		A	X-ray exam breast specimen	0.16	0.33	0.39	NA	NA	0.02	XXX
76098	TC	A	X-ray exam breast specimen	0.00	0.27	0.32	NA	NA	0.01	XXX
76098	26	A	X-ray exam breast specimen	0.16	0.06	0.07	0.06	0.07	0.01	XXX
76100		A	X-ray exam of body section	0.58	2.34	3.00	NA	NA	0.06	XXX
76100	TC	A	X-ray exam of body section	0.00	2.03	2.72	NA	NA	0.01	XXX
76100	26	A	X-ray exam of body section	0.58	0.31	0.28	0.31	0.28	0.05	XXX
76101		A	Complex body section x-ray	0.58	3.73	4.56	NA	NA	0.09	XXX
76101	TC	A	Complex body section x-ray	0.00	3.32	4.23	NA	NA	0.01	XXX
76101	26	A	Complex body section x-ray	0.58	0.41	0.33	0.41	0.33	0.08	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76102		A	Complex body section x-rays	0.58	5.21	6.35	NA	NA	0.11	XXX
76102	TC	A	Complex body section x-rays	0.00	4.79	6.02	NA	NA	0.01	XXX
76102	26	A	Complex body section x-rays	0.58	0.42	0.33	0.42	0.33	0.10	XXX
76120		A	Cine/video x-rays	0.38	1.74	1.86	NA	NA	0.04	XXX
76120	TC	A	Cine/video x-rays	0.00	1.59	1.71	NA	NA	0.01	XXX
76120	26	A	Cine/video x-rays	0.38	0.15	0.15	0.15	0.15	0.03	XXX
76125		C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	TC	C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.11	0.13	0.11	0.13	0.03	ZZZ
76140		I	X-ray consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76376		A	3d render w/o postprocess	0.20	1.46	1.90	NA	NA	0.02	XXX
76376	TC	A	3d render w/o postprocess	0.00	1.38	1.81	NA	NA	0.01	XXX
76376	26	A	3d render w/o postprocess	0.20	0.08	0.09	0.08	0.09	0.01	XXX
76377		A	3d rendering w/postprocess	0.79	1.43	1.93	NA	NA	0.05	XXX
76377	TC	A	3d rendering w/postprocess	0.00	1.13	1.60	NA	NA	0.01	XXX
76377	26	A	3d rendering w/postprocess	0.79	0.30	0.33	0.30	0.33	0.04	XXX
76380		A	Cat scan follow-up study	0.98	3.71	4.59	NA	NA	0.05	XXX
76380	TC	A	Cat scan follow-up study	0.00	3.33	4.18	NA	NA	0.01	XXX
76380	26	A	Cat scan follow-up study	0.98	0.38	0.41	0.38	0.41	0.04	XXX
76390		N	Mr spectroscopy	1.40	11.95	12.57	NA	NA	0.06	XXX
76390	TC	N	Mr spectroscopy	0.00	11.33	11.97	NA	NA	0.01	XXX
76390	26	N	Mr spectroscopy	1.40	0.62	0.60	0.62	0.60	0.05	XXX
76496		C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76496	TC	C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76496	26	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497		C	Ct procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76497	TC	C	Ct procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76497	26	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76498		C	Mri procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76498	TC	C	Mri procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76498	26	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499		C	Radiographic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76499	TC	C	Radiographic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76506		A	Echo exam of head	0.63	2.83	2.91	NA	NA	0.05	XXX
76506	TC	A	Echo exam of head	0.00	2.59	2.65	NA	NA	0.01	XXX
76506	26	A	Echo exam of head	0.63	0.24	0.26	0.24	0.26	0.04	XXX
76510		A	Ophth us b & quant a	1.55	3.25	3.12	NA	NA	0.27	XXX
76510	TC	A	Ophth us b & quant a	0.00	2.17	2.19	NA	NA	0.01	XXX
76510	26	A	Ophth us b & quant a	1.55	1.08	0.93	1.08	0.93	0.26	XXX
76511		A	Ophth us quant a only	0.94	1.95	1.98	NA	NA	0.02	XXX
76511	TC	A	Ophth us quant a only	0.00	1.31	1.43	NA	NA	0.01	XXX
76511	26	A	Ophth us quant a only	0.94	0.64	0.55	0.64	0.55	0.01	XXX
76512		A	Ophth us b w/non-quant a	0.94	1.69	1.73	NA	NA	0.05	XXX
76512	TC	A	Ophth us b w/non-quant a	0.00	1.06	1.18	NA	NA	0.01	XXX
76512	26	A	Ophth us b w/non-quant a	0.94	0.63	0.55	0.63	0.55	0.04	XXX
76513		A	Echo exam of eye water bath	0.66	1.95	1.92	NA	NA	0.02	XXX
76513	TC	A	Echo exam of eye water bath	0.00	1.58	1.59	NA	NA	0.01	XXX
76513	26	A	Echo exam of eye water bath	0.66	0.37	0.33	0.37	0.33	0.01	XXX
76514		A	Echo exam of eye thickness	0.17	0.25	0.22	NA	NA	0.02	XXX
76514	TC	A	Echo exam of eye thickness	0.00	0.14	0.12	NA	NA	0.01	XXX
76514	26	A	Echo exam of eye thickness	0.17	0.11	0.10	0.11	0.10	0.01	XXX
76516		A	Echo exam of eye	0.54	1.62	1.57	NA	NA	0.02	XXX
76516	TC	A	Echo exam of eye	0.00	1.26	1.26	NA	NA	0.01	XXX
76516	26	A	Echo exam of eye	0.54	0.36	0.31	0.36	0.31	0.01	XXX
76519		A	Echo exam of eye	0.54	1.78	1.72	NA	NA	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76519	TC	A	Echo exam of eye	0.00	1.40	1.40	NA	NA	0.01	XXX
76519	26	A	Echo exam of eye	0.54	0.38	0.32	0.38	0.32	0.03	XXX
76529		A	Echo exam of eye	0.57	1.64	1.57	NA	NA	0.04	XXX
76529	TC	A	Echo exam of eye	0.00	1.24	1.23	NA	NA	0.01	XXX
76529	26	A	Echo exam of eye	0.57	0.40	0.34	0.40	0.34	0.03	XXX
76536		A	Us exam of head and neck	0.56	2.89	2.91	NA	NA	0.04	XXX
76536	TC	A	Us exam of head and neck	0.00	2.67	2.68	NA	NA	0.01	XXX
76536	26	A	Us exam of head and neck	0.56	0.22	0.23	0.22	0.23	0.03	XXX
76604		A	Us exam chest	0.55	1.91	2.02	NA	NA	0.04	XXX
76604	TC	A	Us exam chest	0.00	1.71	1.80	NA	NA	0.01	XXX
76604	26	A	Us exam chest	0.55	0.20	0.22	0.20	0.22	0.03	XXX
76645		A	Us exam breast(s)	0.54	2.21	2.26	NA	NA	0.05	XXX
76645	TC	A	Us exam breast(s)	0.00	2.01	2.04	NA	NA	0.01	XXX
76645	26	A	Us exam breast(s)	0.54	0.20	0.22	0.20	0.22	0.04	XXX
76700		A	Us exam abdom complete	0.81	3.17	3.31	NA	NA	0.05	XXX
76700	TC	A	Us exam abdom complete	0.00	2.86	2.98	NA	NA	0.01	XXX
76700	26	A	Us exam abdom complete	0.81	0.31	0.33	0.31	0.33	0.04	XXX
76705		A	Echo exam of abdomen	0.59	2.44	2.55	NA	NA	0.04	XXX
76705	TC	A	Echo exam of abdomen	0.00	2.22	2.30	NA	NA	0.01	XXX
76705	26	A	Echo exam of abdomen	0.59	0.22	0.25	0.22	0.25	0.03	XXX
76770		A	Us exam abdo back wall comp	0.74	3.00	3.18	NA	NA	0.05	XXX
76770	TC	A	Us exam abdo back wall comp	0.00	2.72	2.87	NA	NA	0.01	XXX
76770	26	A	Us exam abdo back wall comp	0.74	0.28	0.31	0.28	0.31	0.04	XXX
76775		A	Us exam abdo back wall lim	0.58	2.46	2.69	NA	NA	0.04	XXX
76775	TC	A	Us exam abdo back wall lim	0.00	2.24	2.44	NA	NA	0.01	XXX
76775	26	A	Us exam abdo back wall lim	0.58	0.22	0.25	0.22	0.25	0.03	XXX
76776		A	Us exam k transpl w/doppler	0.76	3.55	3.68	NA	NA	0.05	XXX
76776	TC	A	Us exam k transpl w/doppler	0.00	3.27	3.37	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76776	26	A	Us exam k transpl w/doppler	0.76	0.28	0.31	0.28	0.31	0.04	XXX
76800		A	Us exam spinal canal	1.13	2.92	2.77	NA	NA	0.05	XXX
76800	TC	A	Us exam spinal canal	0.00	2.42	2.32	NA	NA	0.01	XXX
76800	26	A	Us exam spinal canal	1.13	0.50	0.45	0.50	0.45	0.04	XXX
76801		A	Ob us < 14 wks single fetus	0.99	2.63	2.83	NA	NA	0.04	XXX
76801	TC	A	Ob us < 14 wks single fetus	0.00	2.22	2.41	NA	NA	0.01	XXX
76801	26	A	Ob us < 14 wks single fetus	0.99	0.41	0.42	0.41	0.42	0.03	XXX
76802		A	Ob us < 14 wks addl fetus	0.83	1.09	1.20	NA	NA	0.04	ZZZ
76802	TC	A	Ob us < 14 wks addl fetus	0.00	0.74	0.85	NA	NA	0.01	ZZZ
76802	26	A	Ob us < 14 wks addl fetus	0.83	0.35	0.35	0.35	0.35	0.03	ZZZ
76805		A	Ob us >/= 14 wks sngl fetus	0.99	3.24	3.39	NA	NA	0.04	XXX
76805	TC	A	Ob us >/= 14 wks sngl fetus	0.00	2.82	2.97	NA	NA	0.01	XXX
76805	26	A	Ob us >/= 14 wks sngl fetus	0.99	0.42	0.42	0.42	0.42	0.03	XXX
76810		A	Ob us >/= 14 wks addl fetus	0.98	1.81	1.88	NA	NA	0.04	ZZZ
76810	TC	A	Ob us >/= 14 wks addl fetus	0.00	1.39	1.46	NA	NA	0.01	ZZZ
76810	26	A	Ob us >/= 14 wks addl fetus	0.98	0.42	0.42	0.42	0.42	0.03	ZZZ
76811		A	Ob us detailed sngl fetus	1.90	3.45	3.76	NA	NA	0.06	XXX
76811	TC	A	Ob us detailed sngl fetus	0.00	2.58	2.95	NA	NA	0.01	XXX
76811	26	A	Ob us detailed sngl fetus	1.90	0.87	0.81	0.87	0.81	0.05	XXX
76812		A	Ob us detailed addl fetus	1.78	4.34	4.24	NA	NA	0.06	ZZZ
76812	TC	A	Ob us detailed addl fetus	0.00	3.53	3.48	NA	NA	0.01	ZZZ
76812	26	A	Ob us detailed addl fetus	1.78	0.81	0.76	0.81	0.76	0.05	ZZZ
76813		A	Ob us nuchal meas 1 gest	1.18	2.41	2.53	NA	NA	0.05	XXX
76813	TC	A	Ob us nuchal meas 1 gest	0.00	1.87	2.04	NA	NA	0.01	XXX
76813	26	A	Ob us nuchal meas 1 gest	1.18	0.54	0.49	0.54	0.49	0.04	XXX
76814		A	Ob us nuchal meas add-on	0.99	1.35	1.38	NA	NA	0.04	XXX
76814	TC	A	Ob us nuchal meas add-on	0.00	0.89	0.96	NA	NA	0.01	XXX
76814	26	A	Ob us nuchal meas add-on	0.99	0.46	0.42	0.46	0.42	0.03	XXX
76815		A	Ob us limited fetus(s)	0.65	1.93	2.04	NA	NA	0.02	XXX
76815	TC	A	Ob us limited fetus(s)	0.00	1.66	1.77	NA	NA	0.01	XXX
76815	26	A	Ob us limited fetus(s)	0.65	0.27	0.27	0.27	0.27	0.01	XXX
76816		A	Ob us follow-up per fetus	0.85	2.56	2.58	NA	NA	0.04	XXX
76816	TC	A	Ob us follow-up per fetus	0.00	2.18	2.22	NA	NA	0.01	XXX
76816	26	A	Ob us follow-up per fetus	0.85	0.38	0.36	0.38	0.36	0.03	XXX
76817		A	Transvaginal us obstetric	0.75	2.16	2.27	NA	NA	0.04	XXX
76817	TC	A	Transvaginal us obstetric	0.00	1.84	1.96	NA	NA	0.01	XXX
76817	26	A	Transvaginal us obstetric	0.75	0.32	0.31	0.32	0.31	0.03	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.46	2.54	NA	NA	0.04	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.98	2.09	NA	NA	0.01	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.48	0.45	0.48	0.45	0.03	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.77	1.92	NA	NA	0.04	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.43	1.59	NA	NA	0.01	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.34	0.33	0.34	0.33	0.03	XXX
76820		A	Umbilical artery echo	0.50	0.67	0.86	NA	NA	0.02	XXX
76820	TC	A	Umbilical artery echo	0.00	0.44	0.65	NA	NA	0.01	XXX
76820	26	A	Umbilical artery echo	0.50	0.23	0.21	0.23	0.21	0.01	XXX
76821		A	Middle cerebral artery echo	0.70	2.03	2.15	NA	NA	0.04	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.71	1.85	NA	NA	0.01	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.32	0.30	0.32	0.30	0.03	XXX
76825		A	Echo exam of fetal heart	1.67	4.66	4.71	NA	NA	0.05	XXX
76825	TC	A	Echo exam of fetal heart	0.00	3.93	4.01	NA	NA	0.01	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.73	0.70	0.73	0.70	0.04	XXX
76826		A	Echo exam of fetal heart	0.83	2.92	2.84	NA	NA	0.04	XXX
76826	TC	A	Echo exam of fetal heart	0.00	2.56	2.50	NA	NA	0.01	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.36	0.34	0.36	0.34	0.03	XXX
76827		A	Echo exam of fetal heart	0.58	1.17	1.37	NA	NA	0.02	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76827	TC	A	Echo exam of fetal heart	0.00	0.92	1.13	NA	NA	0.01	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.25	0.24	0.25	0.24	0.01	XXX
76828		A	Echo exam of fetal heart	0.56	0.73	0.87	NA	NA	0.02	XXX
76828	TC	A	Echo exam of fetal heart	0.00	0.48	0.63	NA	NA	0.01	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.25	0.24	0.25	0.24	0.01	XXX
76830		A	Transvaginal us non-ob	0.69	2.90	2.98	NA	NA	0.04	XXX
76830	TC	A	Transvaginal us non-ob	0.00	2.62	2.69	NA	NA	0.01	XXX
76830	26	A	Transvaginal us non-ob	0.69	0.28	0.29	0.28	0.29	0.03	XXX
76831		A	Echo exam uterus	0.72	2.91	2.96	NA	NA	0.04	XXX
76831	TC	A	Echo exam uterus	0.00	2.58	2.66	NA	NA	0.01	XXX
76831	26	A	Echo exam uterus	0.72	0.33	0.30	0.33	0.30	0.03	XXX
76856		A	Us exam pelvic complete	0.69	2.86	2.97	NA	NA	0.04	XXX
76856	TC	A	Us exam pelvic complete	0.00	2.59	2.68	NA	NA	0.01	XXX
76856	26	A	Us exam pelvic complete	0.69	0.27	0.29	0.27	0.29	0.03	XXX
76857		A	Us exam pelvic limited	0.38	2.34	2.59	NA	NA	0.04	XXX
76857	TC	A	Us exam pelvic limited	0.00	2.19	2.42	NA	NA	0.01	XXX
76857	26	A	Us exam pelvic limited	0.38	0.15	0.17	0.15	0.17	0.03	XXX
76870		A	Us exam scrotum	0.64	2.86	2.99	NA	NA	0.05	XXX
76870	TC	A	Us exam scrotum	0.00	2.62	2.72	NA	NA	0.01	XXX
76870	26	A	Us exam scrotum	0.64	0.24	0.27	0.24	0.27	0.04	XXX
76872		A	Us transrectal	0.69	3.06	3.43	NA	NA	0.05	XXX
76872	TC	A	Us transrectal	0.00	2.79	3.12	NA	NA	0.01	XXX
76872	26	A	Us transrectal	0.69	0.27	0.31	0.27	0.31	0.04	XXX
76873		A	Echograp trans r pros study	1.55	3.42	3.65	NA	NA	0.09	XXX
76873	TC	A	Echograp trans r pros study	0.00	2.76	2.98	NA	NA	0.01	XXX
76873	26	A	Echograp trans r pros study	1.55	0.66	0.67	0.66	0.67	0.08	XXX
76881		A	Us xtr non-vasc complete	0.59	2.76	2.76	NA	NA	0.05	XXX
76881	TC	A	Us xtr non-vasc complete	0.00	2.54	2.54	NA	NA	0.01	XXX
76881	26	A	Us xtr non-vasc complete	0.59	0.22	0.22	0.22	0.22	0.04	XXX
76882		A	Us xtr non-vasc lmtd	0.41	0.44	0.44	NA	NA	0.04	XXX
76882	TC	A	Us xtr non-vasc lmtd	0.00	0.29	0.29	NA	NA	0.01	XXX
76882	26	A	Us xtr non-vasc lmtd	0.41	0.15	0.15	0.15	0.15	0.03	XXX
76885		A	Us exam infant hips dynamic	0.74	3.50	3.52	NA	NA	0.05	XXX
76885	TC	A	Us exam infant hips dynamic	0.00	3.21	3.21	NA	NA	0.01	XXX
76885	26	A	Us exam infant hips dynamic	0.74	0.29	0.31	0.29	0.31	0.04	XXX
76886		A	Us exam infant hips static	0.62	3.04	2.78	NA	NA	0.02	XXX
76886	TC	A	Us exam infant hips static	0.00	2.74	2.50	NA	NA	0.01	XXX
76886	26	A	Us exam infant hips static	0.62	0.30	0.28	0.30	0.28	0.01	XXX
76930		A	Echo guide cardiocentesis	0.67	1.64	1.99	NA	NA	0.02	XXX
76930	TC	A	Echo guide cardiocentesis	0.00	1.38	1.67	NA	NA	0.01	XXX
76930	26	A	Echo guide cardiocentesis	0.67	0.26	0.32	0.26	0.32	0.01	XXX
76932		C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	TC	C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.26	0.33	0.26	0.33	0.04	XXX
76936		A	Echo guide for artery repair	1.99	6.29	6.98	NA	NA	0.24	XXX
76936	TC	A	Echo guide for artery repair	0.00	5.58	6.18	NA	NA	0.01	XXX
76936	26	A	Echo guide for artery repair	1.99	0.71	0.80	0.71	0.80	0.23	XXX
76937		A	Us guide vascular access	0.30	0.67	0.70	NA	NA	0.04	ZZZ
76937	TC	A	Us guide vascular access	0.00	0.56	0.58	NA	NA	0.01	ZZZ
76937	26	A	Us guide vascular access	0.30	0.11	0.12	0.11	0.12	0.03	ZZZ
76940		C	Us guide tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
76940	TC	C	Us guide tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
76940	26	A	Us guide tissue ablation	2.00	0.80	0.82	0.80	0.82	0.29	XXX
76941		C	Echo guide for transfusion	0.00	0.00	0.00	NA	NA	0.00	XXX
76941	TC	C	Echo guide for transfusion	0.00	0.00	0.00	NA	NA	0.00	XXX
76941	26	A	Echo guide for transfusion	1.34	0.62	0.58	0.62	0.58	0.11	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76942		A	Echo guide for biopsy	0.67	4.98	5.13	NA	NA	0.05	XXX
76942	TC	A	Echo guide for biopsy	0.00	4.72	4.85	NA	NA	0.01	XXX
76942	26	A	Echo guide for biopsy	0.67	0.26	0.28	0.26	0.28	0.04	XXX
76945		C	Echo guide villus sampling	0.00	0.00	0.00	NA	NA	0.00	XXX
76945	TC	C	Echo guide villus sampling	0.00	0.00	0.00	NA	NA	0.00	XXX
76945	26	A	Echo guide villus sampling	0.67	0.31	0.29	0.31	0.29	0.04	XXX
76946		A	Echo guide for amniocentesis	0.38	0.52	0.72	NA	NA	0.02	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	0.35	0.56	NA	NA	0.01	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.17	0.16	0.17	0.16	0.01	XXX
76948		A	Echo guide ova aspiration	0.38	0.54	0.72	NA	NA	0.04	XXX
76948	TC	A	Echo guide ova aspiration	0.00	0.36	0.56	NA	NA	0.01	XXX
76948	26	A	Echo guide ova aspiration	0.38	0.18	0.16	0.18	0.16	0.03	XXX
76950		A	Echo guidance radiotherapy	0.58	1.29	1.43	NA	NA	0.04	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	1.03	1.18	NA	NA	0.01	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.26	0.25	0.26	0.25	0.03	XXX
76965		A	Echo guidance radiotherapy	1.34	1.20	2.07	NA	NA	0.09	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	0.64	1.48	NA	NA	0.01	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.56	0.59	0.56	0.59	0.08	XXX
76970		A	Ultrasound exam follow-up	0.40	2.57	2.40	NA	NA	0.05	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	2.40	2.24	NA	NA	0.01	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.17	0.16	0.17	0.16	0.04	XXX
76975		C	Gi endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX
76975	TC	C	Gi endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX
76975	26	A	Gi endoscopic ultrasound	0.81	0.40	0.39	0.40	0.39	0.08	XXX
76977		A	Us bone density measure	0.05	0.14	0.24	NA	NA	0.02	XXX
76977	TC	A	Us bone density measure	0.00	0.12	0.22	NA	NA	0.01	XXX
76977	26	A	Us bone density measure	0.05	0.02	0.02	0.02	0.02	0.01	XXX
76998		C	Us guide intraop	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
76998	TC	C	Us guide intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
76998	26	A	Us guide intraop	1.20	0.47	0.47	0.47	0.47	0.26	XXX
76999		C	Echo examination procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76999	TC	C	Echo examination procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77001		A	Fluoroguide for vein device	0.38	3.00	2.97	NA	NA	0.04	ZZZ
77001	TC	A	Fluoroguide for vein device	0.00	2.86	2.81	NA	NA	0.01	ZZZ
77001	26	A	Fluoroguide for vein device	0.38	0.14	0.16	0.14	0.16	0.03	ZZZ
77002		A	Needle localization by xray	0.54	1.66	1.65	NA	NA	0.04	XXX
77002	TC	A	Needle localization by xray	0.00	1.41	1.41	NA	NA	0.01	XXX
77002	26	A	Needle localization by xray	0.54	0.25	0.24	0.25	0.24	0.03	XXX
77003		A	Fluoroguide for spine inject	0.60	1.25	1.20	NA	NA	0.04	XXX
77003	TC	A	Fluoroguide for spine inject	0.00	0.96	0.96	NA	NA	0.01	XXX
77003	26	A	Fluoroguide for spine inject	0.60	0.29	0.24	0.29	0.24	0.03	XXX
77011		A	Ct scan for localization	1.21	5.40	13.03	NA	NA	0.05	XXX
77011	TC	A	Ct scan for localization	0.00	4.85	12.49	NA	NA	0.01	XXX
77011	26	A	Ct scan for localization	1.21	0.55	0.54	0.55	0.54	0.04	XXX
77012		A	Ct scan for needle biopsy	1.16	2.47	3.63	NA	NA	0.05	XXX
77012	TC	A	Ct scan for needle biopsy	0.00	2.04	3.14	NA	NA	0.01	XXX
77012	26	A	Ct scan for needle biopsy	1.16	0.43	0.49	0.43	0.49	0.04	XXX
77013		C	Ct guide for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77013	TC	C	Ct guide for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77013	26	A	Ct guide for tissue ablation	3.99	1.46	1.66	1.46	1.66	0.37	XXX
77014		A	Ct scan for therapy guide	0.85	4.55	4.78	NA	NA	0.05	XXX
77014	TC	A	Ct scan for therapy guide	0.00	4.17	4.41	NA	NA	0.01	XXX
77014	26	A	Ct scan for therapy guide	0.85	0.38	0.37	0.38	0.37	0.04	XXX
77021		A	Mr guidance for needle place	1.50	9.82	11.20	NA	NA	0.13	XXX
77021	TC	A	Mr guidance for needle place	0.00	9.26	10.58	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77021	26	A	Mr guidance for needle place	1.50	0.56	0.62	0.56	0.62	0.12	XXX
77022		C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	TC	C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	26	A	Mri for tissue ablation	4.24	1.65	1.74	1.65	1.74	0.38	XXX
77031		A	Stereotact guide for brst bx	1.59	2.02	3.05	NA	NA	0.13	XXX
77031	TC	A	Stereotact guide for brst bx	0.00	1.41	2.40	NA	NA	0.01	XXX
77031	26	A	Stereotact guide for brst bx	1.59	0.61	0.65	0.61	0.65	0.12	XXX
77032		A	Guidance for needle breast	0.56	0.87	1.05	NA	NA	0.04	XXX
77032	TC	A	Guidance for needle breast	0.00	0.66	0.82	NA	NA	0.01	XXX
77032	26	A	Guidance for needle breast	0.56	0.21	0.23	0.21	0.23	0.03	XXX
77051		A	Computer dx mammogram add-on	0.06	0.20	0.26	NA	NA	0.02	ZZZ
77051	TC	A	Computer dx mammogram add-on	0.00	0.18	0.24	NA	NA	0.01	ZZZ
77051	26	A	Computer dx mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ
77052		A	Comp screen mammogram add-on	0.06	0.20	0.26	NA	NA	0.02	ZZZ
77052	TC	A	Comp screen mammogram add-on	0.00	0.18	0.24	NA	NA	0.01	ZZZ
77052	26	A	Comp screen mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ
77053		A	X-ray of mammary duct	0.36	1.27	1.62	NA	NA	0.02	XXX
77053	TC	A	X-ray of mammary duct	0.00	1.14	1.47	NA	NA	0.01	XXX
77053	26	A	X-ray of mammary duct	0.36	0.13	0.15	0.13	0.15	0.01	XXX
77054		A	X-ray of mammary ducts	0.45	1.75	2.23	NA	NA	0.04	XXX
77054	TC	A	X-ray of mammary ducts	0.00	1.58	2.04	NA	NA	0.01	XXX
77054	26	A	X-ray of mammary ducts	0.45	0.17	0.19	0.17	0.19	0.03	XXX
77055		A	Mammogram one breast	0.70	1.70	1.81	NA	NA	0.05	XXX
77055	TC	A	Mammogram one breast	0.00	1.44	1.52	NA	NA	0.01	XXX
77055	26	A	Mammogram one breast	0.70	0.26	0.29	0.26	0.29	0.04	XXX
77056		A	Mammogram both breasts	0.87	2.23	2.34	NA	NA	0.06	XXX
77056	TC	A	Mammogram both breasts	0.00	1.90	1.98	NA	NA	0.01	XXX
77056	26	A	Mammogram both breasts	0.87	0.33	0.36	0.33	0.36	0.05	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77057		A	Mammogram screening	0.70	1.51	1.65	NA	NA	0.05	XXX
77057	TC	A	Mammogram screening	0.00	1.24	1.36	NA	NA	0.01	XXX
77057	26	A	Mammogram screening	0.70	0.27	0.29	0.27	0.29	0.04	XXX
77058		A	Mri one breast	1.63	16.10	20.67	NA	NA	0.11	XXX
77058	TC	A	Mri one breast	0.00	15.49	20.00	NA	NA	0.01	XXX
77058	26	A	Mri one breast	1.63	0.61	0.67	0.61	0.67	0.10	XXX
77059		A	Mri both breasts	1.63	15.99	21.52	NA	NA	0.11	XXX
77059	TC	A	Mri both breasts	0.00	15.39	20.85	NA	NA	0.01	XXX
77059	26	A	Mri both breasts	1.63	0.60	0.67	0.60	0.67	0.10	XXX
77071		A	X-ray stress view	0.41	1.03	0.90	1.03	0.90	0.07	XXX
77072		A	X-rays for bone age	0.19	0.47	0.49	NA	NA	0.02	XXX
77072	TC	A	X-rays for bone age	0.00	0.39	0.41	NA	NA	0.01	XXX
77072	26	A	X-rays for bone age	0.19	0.08	0.08	0.08	0.08	0.01	XXX
77073		A	X-rays bone length studies	0.27	0.82	0.84	NA	NA	0.05	XXX
77073	TC	A	X-rays bone length studies	0.00	0.68	0.71	NA	NA	0.01	XXX
77073	26	A	X-rays bone length studies	0.27	0.14	0.13	0.14	0.13	0.04	XXX
77074		A	X-rays bone survey limited	0.45	1.49	1.59	NA	NA	0.04	XXX
77074	TC	A	X-rays bone survey limited	0.00	1.32	1.40	NA	NA	0.01	XXX
77074	26	A	X-rays bone survey limited	0.45	0.17	0.19	0.17	0.19	0.03	XXX
77075		A	X-rays bone survey complete	0.54	2.37	2.48	NA	NA	0.04	XXX
77075	TC	A	X-rays bone survey complete	0.00	2.16	2.25	NA	NA	0.01	XXX
77075	26	A	X-rays bone survey complete	0.54	0.21	0.23	0.21	0.23	0.03	XXX
77076		A	X-rays bone survey infant	0.70	2.26	2.22	NA	NA	0.05	XXX
77076	TC	A	X-rays bone survey infant	0.00	1.99	1.95	NA	NA	0.01	XXX
77076	26	A	X-rays bone survey infant	0.70	0.27	0.27	0.27	0.27	0.04	XXX
77077		A	Joint survey single view	0.31	0.82	0.89	NA	NA	0.05	XXX
77077	TC	A	Joint survey single view	0.00	0.67	0.75	NA	NA	0.01	XXX
77077	26	A	Joint survey single view	0.31	0.15	0.14	0.15	0.14	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77078		A	Ct bone density axial	0.25	3.55	4.40	NA	NA	0.02	XXX
77078	TC	A	Ct bone density axial	0.00	3.45	4.30	NA	NA	0.01	XXX
77078	26	A	Ct bone density axial	0.25	0.10	0.10	0.10	0.10	0.01	XXX
77079		A	Ct bone density peripheral	0.22	0.92	1.26	NA	NA	0.02	XXX
77079	TC	A	Ct bone density peripheral	0.00	0.82	1.17	NA	NA	0.01	XXX
77079	26	A	Ct bone density peripheral	0.22	0.10	0.09	0.10	0.09	0.01	XXX
77080		A	Dxa bone density axial	0.31	3.32	3.32	NA	NA	0.19	XXX
77080	TC	A	Dxa bone density axial	0.00	3.22	3.22	NA	NA	0.18	XXX
77080	26	A	Dxa bone density axial	0.31	0.10	0.10	0.10	0.10	0.01	XXX
77081		A	Dxa bone density/peripheral	0.22	0.61	0.61	NA	NA	0.02	XXX
77081	TC	A	Dxa bone density/peripheral	0.00	0.55	0.55	NA	NA	0.01	XXX
77081	26	A	Dxa bone density/peripheral	0.22	0.06	0.06	0.06	0.06	0.01	XXX
77082		A	Dxa bone density vert fx	0.18	0.84	0.84	NA	NA	0.06	XXX
77082	TC	A	Dxa bone density vert fx	0.00	0.78	0.78	NA	NA	0.05	XXX
77082	26	A	Dxa bone density vert fx	0.18	0.06	0.06	0.06	0.06	0.01	XXX
77083		A	Radiographic absorptiometry	0.20	0.47	0.53	NA	NA	0.02	XXX
77083	TC	A	Radiographic absorptiometry	0.00	0.38	0.45	NA	NA	0.01	XXX
77083	26	A	Radiographic absorptiometry	0.20	0.09	0.08	0.09	0.08	0.01	XXX
77084		A	Magnetic image bone marrow	1.60	11.03	13.94	NA	NA	0.11	XXX
77084	TC	A	Magnetic image bone marrow	0.00	10.42	13.27	NA	NA	0.01	XXX
77084	26	A	Magnetic image bone marrow	1.60	0.61	0.67	0.61	0.67	0.10	XXX
77261		A	Radiation therapy planning	1.39	0.67	0.65	0.67	0.65	0.10	XXX
77262		A	Radiation therapy planning	2.11	0.95	0.93	0.95	0.93	0.18	XXX
77263		A	Radiation therapy planning	3.14	1.40	1.37	1.40	1.37	0.26	XXX
77280		A	Set radiation therapy field	0.70	4.57	4.85	NA	NA	0.04	XXX
77280	TC	A	Set radiation therapy field	0.00	4.26	4.55	NA	NA	0.01	XXX
77280	26	A	Set radiation therapy field	0.70	0.31	0.30	0.31	0.30	0.03	XXX
77285		A	Set radiation therapy field	1.05	8.31	8.69	NA	NA	0.06	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77285	TC	A	Set radiation therapy field	0.00	7.84	8.24	NA	NA	0.01	XXX
77285	26	A	Set radiation therapy field	1.05	0.47	0.45	0.47	0.45	0.05	XXX
77290		A	Set radiation therapy field	1.56	13.80	14.04	NA	NA	0.08	XXX
77290	TC	A	Set radiation therapy field	0.00	13.10	13.37	NA	NA	0.01	XXX
77290	26	A	Set radiation therapy field	1.56	0.70	0.67	0.70	0.67	0.07	XXX
77295		A	Set radiation therapy field	4.56	8.01	11.86	NA	NA	0.28	XXX
77295	TC	A	Set radiation therapy field	0.00	5.97	9.89	NA	NA	0.04	XXX
77295	26	A	Set radiation therapy field	4.56	2.04	1.97	2.04	1.97	0.24	XXX
77299		C	Radiation therapy planning	0.00	0.00	0.00	NA	NA	0.00	XXX
77299	TC	C	Radiation therapy planning	0.00	0.00	0.00	NA	NA	0.00	XXX
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77300		A	Radiation therapy dose plan	0.62	1.27	1.41	NA	NA	0.04	XXX
77300	TC	A	Radiation therapy dose plan	0.00	0.99	1.14	NA	NA	0.01	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.28	0.27	0.28	0.27	0.03	XXX
77301		A	Radiotherapy dose plan imrt	7.99	45.27	53.19	NA	NA	0.63	XXX
77301	TC	A	Radiotherapy dose plan imrt	0.00	41.70	49.73	NA	NA	0.22	XXX
77301	26	A	Radiotherapy dose plan imrt	7.99	3.57	3.46	3.57	3.46	0.41	XXX
77305		A	Teletx isodose plan simple	0.70	0.98	1.22	NA	NA	0.04	XXX
77305	TC	A	Teletx isodose plan simple	0.00	0.67	0.92	NA	NA	0.01	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.31	0.30	0.31	0.30	0.03	XXX
77310		A	Teletx isodose plan intermed	1.05	1.38	1.68	NA	NA	0.06	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	0.91	1.22	NA	NA	0.01	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.47	0.46	0.47	0.46	0.05	XXX
77315		A	Teletx isodose plan complex	1.56	2.29	2.59	NA	NA	0.08	XXX
77315	TC	A	Teletx isodose plan complex	0.00	1.59	1.91	NA	NA	0.01	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.70	0.68	0.70	0.68	0.07	XXX
77321		A	Special teletx port plan	0.95	1.63	2.17	NA	NA	0.05	XXX
77321	TC	A	Special teletx port plan	0.00	1.21	1.76	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77321	26	A	Special teletx port plan	0.95	0.42	0.41	0.42	0.41	0.04	XXX
77326		A	Brachytx isodose calc simp	0.93	3.11	3.30	NA	NA	0.07	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.69	2.90	NA	NA	0.03	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.42	0.40	0.42	0.40	0.04	XXX
77327		A	Brachytx isodose calc interm	1.39	4.28	4.59	NA	NA	0.10	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.66	3.99	NA	NA	0.03	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.62	0.60	0.62	0.60	0.07	XXX
77328		A	Brachytx isodose plan compl	2.09	5.49	5.98	NA	NA	0.14	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.56	5.08	NA	NA	0.04	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.93	0.90	0.93	0.90	0.10	XXX
77331		A	Special radiation dosimetry	0.87	0.91	0.95	NA	NA	0.05	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.52	0.57	NA	NA	0.01	XXX
77331	26	A	Special radiation dosimetry	0.87	0.39	0.38	0.39	0.38	0.04	XXX
77332		A	Radiation treatment aid(s)	0.54	1.63	1.75	NA	NA	0.04	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.39	1.52	NA	NA	0.01	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.24	0.23	0.24	0.23	0.03	XXX
77333		A	Radiation treatment aid(s)	0.84	0.62	0.89	NA	NA	0.05	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	0.24	0.52	NA	NA	0.01	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.38	0.37	0.38	0.37	0.04	XXX
77334		A	Radiation treatment aid(s)	1.24	2.89	3.25	NA	NA	0.06	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	2.34	2.71	NA	NA	0.01	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.55	0.54	0.55	0.54	0.05	XXX
77336		A	Radiation physics consult	0.00	1.14	1.53	NA	NA	0.01	XXX
77338		A	Design mlc device for imrt	4.29	9.65	9.65	NA	NA	0.27	XXX
77338	TC	A	Design mlc device for imrt	0.00	7.73	7.73	NA	NA	0.04	XXX
77338	26	A	Design mlc device for imrt	4.29	1.92	1.92	1.92	1.92	0.23	XXX
77370		A	Radiation physics consult	0.00	3.04	3.41	NA	NA	0.04	XXX
77371		C	Srs multisource	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77372		A	Srs linear based	0.00	23.02	25.18	NA	NA	0.05	XXX
77373		A	Sbrt delivery	0.00	43.31	47.02	NA	NA	0.07	XXX
77399		C	External radiation dosimetry	0.00	0.00	0.00	NA	NA	0.00	XXX
77399	TC	C	External radiation dosimetry	0.00	0.00	0.00	NA	NA	0.00	XXX
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77401		A	Radiation treatment delivery	0.00	0.53	0.75	NA	NA	0.01	XXX
77402		A	Radiation treatment delivery	0.00	5.89	5.20	NA	NA	0.01	XXX
77403		A	Radiation treatment delivery	0.00	3.82	3.87	NA	NA	0.01	XXX
77404		A	Radiation treatment delivery	0.00	4.27	4.31	NA	NA	0.01	XXX
77406		A	Radiation treatment delivery	0.00	4.32	4.35	NA	NA	0.01	XXX
77407		A	Radiation treatment delivery	0.00	8.00	7.55	NA	NA	0.01	XXX
77408		A	Radiation treatment delivery	0.00	5.26	5.28	NA	NA	0.01	XXX
77409		A	Radiation treatment delivery	0.00	5.89	5.87	NA	NA	0.01	XXX
77411		A	Radiation treatment delivery	0.00	5.86	5.84	NA	NA	0.01	XXX
77412		A	Radiation treatment delivery	0.00	6.92	6.89	NA	NA	0.01	XXX
77413		A	Radiation treatment delivery	0.00	6.96	6.93	NA	NA	0.01	XXX
77414		A	Radiation treatment delivery	0.00	7.84	7.76	NA	NA	0.01	XXX
77416		A	Radiation treatment delivery	0.00	7.89	7.80	NA	NA	0.01	XXX
77417		A	Radiology port film(s)	0.00	0.37	0.43	NA	NA	0.01	XXX
77418		A	Radiation tx delivery imrt	0.00	13.38	15.38	NA	NA	0.01	XXX
77421		A	Stereoscopic x-ray guidance	0.39	2.46	2.84	NA	NA	0.02	XXX
77421	TC	A	Stereoscopic x-ray guidance	0.00	2.29	2.67	NA	NA	0.01	XXX
77421	26	A	Stereoscopic x-ray guidance	0.39	0.17	0.17	0.17	0.17	0.01	XXX
77422		A	Neutron beam tx simple	0.00	5.35	5.89	NA	NA	0.01	XXX
77423		A	Neutron beam tx complex	0.00	7.56	7.49	NA	NA	0.01	XXX
77427		A	Radiation tx management x5	2.92	1.52	1.59	1.52	1.59	0.23	XXX
77431		A	Radiation therapy management	1.81	0.99	0.97	0.99	0.97	0.14	XXX
77432		A	Stereotactic radiation trmt	7.92	3.57	3.49	3.57	3.49	0.65	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77435		A	Sbrt management	13.00	5.96	5.91	5.96	5.96	1.07	XXX
77470		A	Special radiation treatment	2.09	2.17	3.77	NA	NA	0.11	XXX
77470	TC	A	Special radiation treatment	0.00	1.24	2.87	NA	NA	0.01	XXX
77470	26	A	Special radiation treatment	2.09	0.93	0.90	0.93	0.90	0.10	XXX
77499		C	Radiation therapy management	0.00	0.00	0.00	NA	NA	0.00	XXX
77499	TC	C	Radiation therapy management	0.00	0.00	0.00	NA	NA	0.00	XXX
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77520		C	Proton trmt simple w/o comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77522		C	Proton trmt simple w/comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77523		C	Proton trmt intermediate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77525		C	Proton treatment complex	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77600		R	Hyperthermia treatment	1.56	10.46	10.41	NA	NA	0.10	XXX
77600	TC	R	Hyperthermia treatment	0.00	9.76	9.73	NA	NA	0.03	XXX
77600	26	R	Hyperthermia treatment	1.56	0.70	0.68	0.70	0.68	0.07	XXX
77605		R	Hyperthermia treatment	2.09	30.44	25.03	NA	NA	0.41	XXX
77605	TC	R	Hyperthermia treatment	0.00	29.53	24.20	NA	NA	0.03	XXX
77605	26	R	Hyperthermia treatment	2.09	0.91	0.83	0.91	0.83	0.38	XXX
77610		R	Hyperthermia treatment	1.56	27.92	23.41	NA	NA	0.10	XXX
77610	TC	R	Hyperthermia treatment	0.00	27.24	22.78	NA	NA	0.03	XXX
77610	26	R	Hyperthermia treatment	1.56	0.68	0.63	0.68	0.63	0.07	XXX
77615		R	Hyperthermia treatment	2.09	26.45	26.55	NA	NA	0.17	XXX
77615	TC	R	Hyperthermia treatment	0.00	25.51	25.65	NA	NA	0.07	XXX
77615	26	R	Hyperthermia treatment	2.09	0.94	0.90	0.94	0.90	0.10	XXX
77620		R	Hyperthermia treatment	1.56	14.24	12.57	NA	NA	0.08	XXX
77620	TC	R	Hyperthermia treatment	0.00	13.56	11.95	NA	NA	0.04	XXX
77620	26	R	Hyperthermia treatment	1.56	0.68	0.62	0.68	0.62	0.04	XXX
77750		A	Infuse radioactive materials	5.00	5.17	5.13	NA	NA	0.29	090
77750	TC	A	Infuse radioactive materials	0.00	2.94	2.98	NA	NA	0.03	090

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77750	26	A	Infuse radioactive materials	5.00	2.23	2.15	2.23	2.15	0.26	090
77761		A	Apply intrcav radiat simple	3.85	6.72	6.80	NA	NA	0.24	090
77761	TC	A	Apply intrcav radiat simple	0.00	5.02	5.17	NA	NA	0.04	090
77761	26	A	Apply intrcav radiat simple	3.85	1.70	1.63	1.70	1.63	0.20	090
77762		A	Apply intrcav radiat interm	5.76	8.35	8.52	NA	NA	0.35	090
77762	TC	A	Apply intrcav radiat interm	0.00	5.80	6.05	NA	NA	0.05	090
77762	26	A	Apply intrcav radiat interm	5.76	2.55	2.47	2.55	2.47	0.30	090
77763		A	Apply intrcav radiat compl	8.66	11.35	11.54	NA	NA	0.50	090
77763	TC	A	Apply intrcav radiat compl	0.00	7.52	7.82	NA	NA	0.07	090
77763	26	A	Apply intrcav radiat compl	8.66	3.83	3.72	3.83	3.72	0.43	090
77776		A	Apply interstit radiat simpl	4.70	7.17	7.42	NA	NA	0.36	090
77776	TC	A	Apply interstit radiat simpl	0.00	5.05	5.40	NA	NA	0.05	090
77776	26	A	Apply interstit radiat simpl	4.70	2.12	2.02	2.12	2.02	0.31	090
77777		A	Apply interstit radiat inter	7.52	8.83	9.22	NA	NA	0.54	090
77777	TC	A	Apply interstit radiat inter	0.00	5.48	5.90	NA	NA	0.05	090
77777	26	A	Apply interstit radiat inter	7.52	3.35	3.32	3.35	3.32	0.49	090
77778		A	Apply interstit radiat compl	11.32	12.62	12.88	NA	NA	0.68	090
77778	TC	A	Apply interstit radiat compl	0.00	7.63	8.02	NA	NA	0.08	090
77778	26	A	Apply interstit radiat compl	11.32	4.99	4.86	4.99	4.86	0.60	090
77785		A	Hdr brachytx 1 channel	1.42	5.60	4.99	NA	NA	0.10	XXX
77785	TC	A	Hdr brachytx 1 channel	0.00	4.97	4.37	NA	NA	0.03	XXX
77785	26	A	Hdr brachytx 1 channel	1.42	0.63	0.62	0.63	0.62	0.07	XXX
77786		A	Hdr brachytx 2-12 channel	3.25	12.46	13.44	NA	NA	0.21	XXX
77786	TC	A	Hdr brachytx 2-12 channel	0.00	11.00	12.07	NA	NA	0.05	XXX
77786	26	A	Hdr brachytx 2-12 channel	3.25	1.46	1.37	1.46	1.37	0.16	XXX
77787		A	Hdr brachytx over 12 chan	4.89	22.05	21.73	NA	NA	0.34	XXX
77787	TC	A	Hdr brachytx over 12 chan	0.00	19.85	19.58	NA	NA	0.08	XXX
77787	26	A	Hdr brachytx over 12 chan	4.89	2.20	2.15	2.20	2.15	0.26	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
77789		A	Apply surface radiation	1.14	2.12	2.09	NA	NA	0.06	000
77789	TC	A	Apply surface radiation	0.00	1.59	1.58	NA	NA	0.01	000
77789	26	A	Apply surface radiation	1.14	0.53	0.51	0.53	0.51	0.05	000
77790		A	Radiation handling	1.05	1.60	1.59	NA	NA	0.05	XXX
77790	TC	A	Radiation handling	0.00	1.13	1.14	NA	NA	0.01	XXX
77790	26	A	Radiation handling	1.05	0.47	0.45	0.47	0.45	0.04	XXX
77799		C	Radium/radioisotope therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78000		A	Thyroid single uptake	0.19	1.81	1.91	NA	NA	0.02	XXX
78000	TC	A	Thyroid single uptake	0.00	1.74	1.83	NA	NA	0.01	XXX
78000	26	A	Thyroid single uptake	0.19	0.07	0.08	0.07	0.08	0.01	XXX
78001		A	Thyroid multiple uptakes	0.26	2.32	2.43	NA	NA	0.04	XXX
78001	TC	A	Thyroid multiple uptakes	0.00	2.23	2.32	NA	NA	0.03	XXX
78001	26	A	Thyroid multiple uptakes	0.26	0.09	0.11	0.09	0.11	0.01	XXX
78003		A	Thyroid suppress/stimul	0.33	1.94	2.02	NA	NA	0.02	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	1.82	1.88	NA	NA	0.01	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.12	0.14	0.12	0.14	0.01	XXX
78006		A	Thyroid imaging with uptake	0.49	6.33	6.41	NA	NA	0.06	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	6.16	6.21	NA	NA	0.03	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.17	0.20	0.17	0.20	0.03	XXX
78007		A	Thyroid image mult uptakes	0.50	6.72	5.22	NA	NA	0.06	XXX
78007	TC	A	Thyroid image mult uptakes	0.00	6.54	5.01	NA	NA	0.03	XXX
78007	26	A	Thyroid image mult uptakes	0.50	0.18	0.21	0.18	0.21	0.03	XXX
78010		A	Thyroid imaging	0.39	4.34	4.39	NA	NA	0.04	XXX
78010	TC	A	Thyroid imaging	0.00	4.20	4.23	NA	NA	0.03	XXX
78010	26	A	Thyroid imaging	0.39	0.14	0.16	0.14	0.16	0.01	XXX
78011		A	Thyroid imaging with flow	0.45	4.56	4.80	NA	NA	0.06	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78011	TC	A	Thyroid imaging with flow	0.00	4.39	4.61	NA	NA	0.03	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.17	0.19	0.17	0.19	0.03	XXX
78015		A	Thyroid met imaging	0.67	5.44	5.62	NA	NA	0.07	XXX
78015	TC	A	Thyroid met imaging	0.00	5.22	5.36	NA	NA	0.03	XXX
78015	26	A	Thyroid met imaging	0.67	0.22	0.26	0.22	0.26	0.04	XXX
78016		A	Thyroid met imaging/studies	0.82	7.14	8.12	NA	NA	0.06	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	7.00	7.86	NA	NA	0.03	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.14	0.26	0.14	0.26	0.03	XXX
78018		A	Thyroid met imaging body	0.86	7.92	8.48	NA	NA	0.07	XXX
78018	TC	A	Thyroid met imaging body	0.00	7.64	8.15	NA	NA	0.03	XXX
78018	26	A	Thyroid met imaging body	0.86	0.28	0.33	0.28	0.33	0.04	XXX
78020		A	Thyroid met uptake	0.60	1.67	1.92	NA	NA	0.04	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.50	1.69	NA	NA	0.01	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.17	0.23	0.17	0.23	0.03	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	3.41	4.00	NA	NA	0.07	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	3.13	3.67	NA	NA	0.03	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.28	0.33	0.28	0.33	0.04	XXX
78075		A	Adrenal nuclear imaging	0.74	11.21	11.78	NA	NA	0.08	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	10.98	11.49	NA	NA	0.04	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.23	0.29	0.23	0.29	0.04	XXX
78099		C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78102		A	Bone marrow imaging ltd	0.55	4.08	4.31	NA	NA	0.06	XXX
78102	TC	A	Bone marrow imaging ltd	0.00	3.91	4.10	NA	NA	0.03	XXX
78102	26	A	Bone marrow imaging ltd	0.55	0.17	0.21	0.17	0.21	0.03	XXX
78103		A	Bone marrow imaging mult	0.75	5.27	5.67	NA	NA	0.07	XXX
78103	TC	A	Bone marrow imaging mult	0.00	5.05	5.39	NA	NA	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78103	26	A	Bone marrow imaging mult	0.75	0.22	0.28	0.22	0.28	0.04	XXX
78104		A	Bone marrow imaging body	0.80	5.98	6.50	NA	NA	0.07	XXX
78104	TC	A	Bone marrow imaging body	0.00	5.73	6.18	NA	NA	0.03	XXX
78104	26	A	Bone marrow imaging body	0.80	0.25	0.32	0.25	0.32	0.04	XXX
78110		A	Plasma volume single	0.19	2.18	2.22	NA	NA	0.04	XXX
78110	TC	A	Plasma volume single	0.00	2.11	2.14	NA	NA	0.03	XXX
78110	26	A	Plasma volume single	0.19	0.07	0.08	0.07	0.08	0.01	XXX
78111		A	Plasma volume multiple	0.22	1.81	2.33	NA	NA	0.04	XXX
78111	TC	A	Plasma volume multiple	0.00	1.76	2.25	NA	NA	0.03	XXX
78111	26	A	Plasma volume multiple	0.22	0.05	0.08	0.05	0.08	0.01	XXX
78120		A	Red cell mass single	0.23	2.14	2.33	NA	NA	0.04	XXX
78120	TC	A	Red cell mass single	0.00	2.05	2.23	NA	NA	0.03	XXX
78120	26	A	Red cell mass single	0.23	0.09	0.10	0.09	0.10	0.01	XXX
78121		A	Red cell mass multiple	0.32	2.25	2.62	NA	NA	0.04	XXX
78121	TC	A	Red cell mass multiple	0.00	2.13	2.49	NA	NA	0.03	XXX
78121	26	A	Red cell mass multiple	0.32	0.12	0.13	0.12	0.13	0.01	XXX
78122		A	Blood volume	0.45	2.09	2.83	NA	NA	0.04	XXX
78122	TC	A	Blood volume	0.00	1.96	2.66	NA	NA	0.03	XXX
78122	26	A	Blood volume	0.45	0.13	0.17	0.13	0.17	0.01	XXX
78130		A	Red cell survival study	0.61	3.58	3.89	NA	NA	0.08	XXX
78130	TC	A	Red cell survival study	0.00	3.35	3.63	NA	NA	0.04	XXX
78130	26	A	Red cell survival study	0.61	0.23	0.26	0.23	0.26	0.04	XXX
78135		A	Red cell survival kinetics	0.64	9.28	9.44	NA	NA	0.07	XXX
78135	TC	A	Red cell survival kinetics	0.00	9.03	9.17	NA	NA	0.03	XXX
78135	26	A	Red cell survival kinetics	0.64	0.25	0.27	0.25	0.27	0.04	XXX
78140		A	Red cell sequestration	0.61	2.90	3.43	NA	NA	0.07	XXX
78140	TC	A	Red cell sequestration	0.00	2.68	3.18	NA	NA	0.03	XXX
78140	26	A	Red cell sequestration	0.61	0.22	0.25	0.22	0.25	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78185		A	Spleen imaging	0.40	5.42	5.50	NA	NA	0.04	XXX
78185	TC	A	Spleen imaging	0.00	5.27	5.33	NA	NA	0.03	XXX
78185	26	A	Spleen imaging	0.40	0.15	0.17	0.15	0.17	0.01	XXX
78190		A	Platelet survival kinetics	1.09	9.56	10.02	NA	NA	0.07	XXX
78190	TC	A	Platelet survival kinetics	0.00	9.13	9.58	NA	NA	0.03	XXX
78190	26	A	Platelet survival kinetics	1.09	0.43	0.44	0.43	0.44	0.04	XXX
78191		A	Platelet survival	0.61	3.60	4.55	NA	NA	0.08	XXX
78191	TC	A	Platelet survival	0.00	3.37	4.30	NA	NA	0.04	XXX
78191	26	A	Platelet survival	0.61	0.23	0.25	0.23	0.25	0.04	XXX
78195		A	Lymph system imaging	1.20	8.87	9.11	NA	NA	0.10	XXX
78195	TC	A	Lymph system imaging	0.00	8.46	8.63	NA	NA	0.03	XXX
78195	26	A	Lymph system imaging	1.20	0.41	0.48	0.41	0.48	0.07	XXX
78199		C	Blood/lymph nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78201		A	Liver imaging	0.44	4.92	4.99	NA	NA	0.07	XXX
78201	TC	A	Liver imaging	0.00	4.77	4.82	NA	NA	0.03	XXX
78201	26	A	Liver imaging	0.44	0.15	0.17	0.15	0.17	0.04	XXX
78202		A	Liver imaging with flow	0.51	5.04	5.43	NA	NA	0.04	XXX
78202	TC	A	Liver imaging with flow	0.00	4.90	5.25	NA	NA	0.03	XXX
78202	26	A	Liver imaging with flow	0.51	0.14	0.18	0.14	0.18	0.01	XXX
78205		A	Liver imaging (3d)	0.71	5.18	5.94	NA	NA	0.07	XXX
78205	TC	A	Liver imaging (3d)	0.00	4.95	5.66	NA	NA	0.03	XXX
78205	26	A	Liver imaging (3d)	0.71	0.23	0.28	0.23	0.28	0.04	XXX
78206		A	Liver image (3d) with flow	0.96	8.72	9.25	NA	NA	0.07	XXX
78206	TC	A	Liver image (3d) with flow	0.00	8.40	8.87	NA	NA	0.03	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.32	0.38	0.32	0.38	0.04	XXX
78215		A	Liver and spleen imaging	0.49	4.89	5.13	NA	NA	0.06	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78215	TC	A	Liver and spleen imaging	0.00	4.71	4.93	NA	NA	0.03	XXX
78215	26	A	Liver and spleen imaging	0.49	0.18	0.20	0.18	0.20	0.03	XXX
78216		A	Liver & spleen image/flow	0.57	2.73	3.23	NA	NA	0.06	XXX
78216	TC	A	Liver & spleen image/flow	0.00	2.54	3.01	NA	NA	0.03	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.19	0.22	0.19	0.22	0.03	XXX
78220		A	Liver function study	0.49	3.01	3.51	NA	NA	0.04	XXX
78220	TC	A	Liver function study	0.00	2.84	3.32	NA	NA	0.03	XXX
78220	26	A	Liver function study	0.49	0.17	0.19	0.17	0.19	0.01	XXX
78223		A	Hepatobiliary imaging	0.84	8.74	8.86	NA	NA	0.07	XXX
78223	TC	A	Hepatobiliary imaging	0.00	8.44	8.52	NA	NA	0.03	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.30	0.34	0.30	0.34	0.04	XXX
78230		A	Salivary gland imaging	0.45	4.29	4.40	NA	NA	0.06	XXX
78230	TC	A	Salivary gland imaging	0.00	4.12	4.22	NA	NA	0.03	XXX
78230	26	A	Salivary gland imaging	0.45	0.17	0.18	0.17	0.18	0.03	XXX
78231		A	Serial salivary imaging	0.52	2.87	3.24	NA	NA	0.04	XXX
78231	TC	A	Serial salivary imaging	0.00	2.67	3.03	NA	NA	0.03	XXX
78231	26	A	Serial salivary imaging	0.52	0.20	0.21	0.20	0.21	0.01	XXX
78232		A	Salivary gland function exam	0.47	2.13	2.94	NA	NA	0.06	XXX
78232	TC	A	Salivary gland function exam	0.00	2.05	2.79	NA	NA	0.03	XXX
78232	26	A	Salivary gland function exam	0.47	0.08	0.15	0.08	0.15	0.03	XXX
78258		A	Esophageal motility study	0.74	5.70	5.94	NA	NA	0.06	XXX
78258	TC	A	Esophageal motility study	0.00	5.43	5.63	NA	NA	0.03	XXX
78258	26	A	Esophageal motility study	0.74	0.27	0.31	0.27	0.31	0.03	XXX
78261		A	Gastric mucosa imaging	0.69	6.31	6.62	NA	NA	0.07	XXX
78261	TC	A	Gastric mucosa imaging	0.00	6.05	6.33	NA	NA	0.03	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.26	0.29	0.26	0.29	0.04	XXX
78262		A	Gastroesophageal reflux exam	0.68	6.19	6.52	NA	NA	0.04	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	5.95	6.25	NA	NA	0.03	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.24	0.27	0.24	0.27	0.01	XXX
78264		A	Gastric emptying study	0.78	7.29	7.60	NA	NA	0.07	XXX
78264	TC	A	Gastric emptying study	0.00	7.01	7.28	NA	NA	0.03	XXX
78264	26	A	Gastric emptying study	0.78	0.28	0.32	0.28	0.32	0.04	XXX
78267		X	Breath tst attain/anal c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78268		X	Breath test analysis c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78270		A	Vit b-12 absorption exam	0.20	2.08	2.18	NA	NA	0.02	XXX
78270	TC	A	Vit b-12 absorption exam	0.00	2.00	2.10	NA	NA	0.01	XXX
78270	26	A	Vit b-12 absorption exam	0.20	0.08	0.08	0.08	0.08	0.01	XXX
78271		A	Vit b-12 absrp exam int fac	0.20	2.30	2.31	NA	NA	0.02	XXX
78271	TC	A	Vit b-12 absrp exam int fac	0.00	2.21	2.23	NA	NA	0.01	XXX
78271	26	A	Vit b-12 absrp exam int fac	0.20	0.09	0.08	0.09	0.08	0.01	XXX
78272		A	Vit b-12 absorp combined	0.27	2.21	2.38	NA	NA	0.04	XXX
78272	TC	A	Vit b-12 absorp combined	0.00	2.10	2.28	NA	NA	0.03	XXX
78272	26	A	Vit b-12 absorp combined	0.27	0.11	0.10	0.11	0.10	0.01	XXX
78278		A	Acute gi blood loss imaging	0.99	8.79	9.13	NA	NA	0.08	XXX
78278	TC	A	Acute gi blood loss imaging	0.00	8.44	8.73	NA	NA	0.03	XXX
78278	26	A	Acute gi blood loss imaging	0.99	0.35	0.40	0.35	0.40	0.05	XXX
78282		C	Gi protein loss exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78282	TC	C	Gi protein loss exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78282	26	A	Gi protein loss exam	0.38	0.14	0.16	0.14	0.16	0.03	XXX
78290		A	Meckels divert exam	0.68	8.69	8.75	NA	NA	0.07	XXX
78290	TC	A	Meckels divert exam	0.00	8.45	8.47	NA	NA	0.03	XXX
78290	26	A	Meckels divert exam	0.68	0.24	0.28	0.24	0.28	0.04	XXX
78291		A	Leveen/shunt patency exam	0.88	6.29	6.50	NA	NA	0.08	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	5.99	6.15	NA	NA	0.03	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.30	0.35	0.30	0.35	0.05	XXX
78299		C	Gi nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78299	TC	C	Gi nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78299	26	C	Gi nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78300		A	Bone imaging limited area	0.62	4.37	4.53	NA	NA	0.06	XXX
78300	TC	A	Bone imaging limited area	0.00	4.14	4.27	NA	NA	0.03	XXX
78300	26	A	Bone imaging limited area	0.62	0.23	0.26	0.23	0.26	0.03	XXX
78305		A	Bone imaging multiple areas	0.83	5.73	5.97	NA	NA	0.07	XXX
78305	TC	A	Bone imaging multiple areas	0.00	5.43	5.64	NA	NA	0.03	XXX
78305	26	A	Bone imaging multiple areas	0.83	0.30	0.33	0.30	0.33	0.04	XXX
78306		A	Bone imaging whole body	0.86	6.15	6.56	NA	NA	0.07	XXX
78306	TC	A	Bone imaging whole body	0.00	5.85	6.21	NA	NA	0.03	XXX
78306	26	A	Bone imaging whole body	0.86	0.30	0.35	0.30	0.35	0.04	XXX
78315		A	Bone imaging 3 phase	1.02	8.75	9.10	NA	NA	0.08	XXX
78315	TC	A	Bone imaging 3 phase	0.00	8.39	8.69	NA	NA	0.03	XXX
78315	26	A	Bone imaging 3 phase	1.02	0.36	0.41	0.36	0.41	0.05	XXX
78320		A	Bone imaging (3d)	1.04	5.33	6.09	NA	NA	0.08	XXX
78320	TC	A	Bone imaging (3d)	0.00	4.99	5.68	NA	NA	0.03	XXX
78320	26	A	Bone imaging (3d)	1.04	0.34	0.41	0.34	0.41	0.05	XXX
78350		N	Bone mineral single photon	0.22	0.68	0.74	NA	NA	0.02	XXX
78350	TC	N	Bone mineral single photon	0.00	0.58	0.65	NA	NA	0.01	XXX
78350	26	N	Bone mineral single photon	0.22	0.10	0.09	0.10	0.09	0.01	XXX
78351		N	Bone mineral dual photon	0.30	0.13	0.13	0.13	0.13	0.01	XXX
78399		C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78414		C	Non-imaging heart function	0.00	0.00	0.00	NA	NA	0.00	XXX
78414	TC	C	Non-imaging heart function	0.00	0.00	0.00	NA	NA	0.00	XXX
78414	26	A	Non-imaging heart function	0.45	0.20	0.18	0.20	0.18	0.03	XXX
78428		A	Cardiac shunt imaging	0.78	4.38	4.89	NA	NA	0.06	XXX
78428	TC	A	Cardiac shunt imaging	0.00	4.10	4.54	NA	NA	0.03	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.28	0.35	0.28	0.35	0.03	XXX
78445		A	Vascular flow imaging	0.49	4.32	4.53	NA	NA	0.04	XXX
78445	TC	A	Vascular flow imaging	0.00	4.16	4.34	NA	NA	0.03	XXX
78445	26	A	Vascular flow imaging	0.49	0.16	0.19	0.16	0.19	0.01	XXX
78451		A	Ht muscle image spect sing	1.38	8.62	8.62	NA	NA	0.08	XXX
78451	TC	A	Ht muscle image spect sing	0.00	8.10	8.10	NA	NA	0.03	XXX
78451	26	A	Ht muscle image spect sing	1.38	0.52	0.52	0.52	0.52	0.05	XXX
78452		A	Ht muscle image spect mult	1.62	12.40	12.40	NA	NA	0.09	XXX
78452	TC	A	Ht muscle image spect mult	0.00	11.78	11.78	NA	NA	0.04	XXX
78452	26	A	Ht muscle image spect mult	1.62	0.62	0.62	0.62	0.62	0.05	XXX
78453		A	Ht muscle image planar sing	1.00	7.58	7.58	NA	NA	0.08	XXX
78453	TC	A	Ht muscle image planar sing	0.00	7.21	7.21	NA	NA	0.03	XXX
78453	26	A	Ht muscle image planar sing	1.00	0.37	0.37	0.37	0.37	0.05	XXX
78454		A	Ht musc image planar mult	1.34	11.08	11.08	NA	NA	0.09	XXX
78454	TC	A	Ht musc image planar mult	0.00	10.58	10.58	NA	NA	0.04	XXX
78454	26	A	Ht musc image planar mult	1.34	0.50	0.50	0.50	0.50	0.05	XXX
78456		A	Acute venous thrombus image	1.00	8.79	9.40	NA	NA	0.06	XXX
78456	TC	A	Acute venous thrombus image	0.00	8.42	8.93	NA	NA	0.03	XXX
78456	26	A	Acute venous thrombus image	1.00	0.37	0.47	0.37	0.47	0.03	XXX
78457		A	Venous thrombosis imaging	0.77	4.70	4.93	NA	NA	0.07	XXX
78457	TC	A	Venous thrombosis imaging	0.00	4.42	4.62	NA	NA	0.03	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.28	0.31	0.28	0.31	0.04	XXX
78458		A	Ven thrombosis images bilat	0.90	4.08	4.82	NA	NA	0.08	XXX
78458	TC	A	Ven thrombosis images bilat	0.00	3.87	4.51	NA	NA	0.03	XXX
78458	26	A	Ven thrombosis images bilat	0.90	0.21	0.31	0.21	0.31	0.05	XXX
78459		C	Heart muscle imaging (pet)	0.00	0.00	0.00	NA	NA	0.00	XXX
78459	TC	C	Heart muscle imaging (pet)	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78459	26	A	Heart muscle imaging (pet)	1.50	0.45	0.62	0.45	0.62	0.10	XXX
78466		A	Heart infarct image	0.69	4.18	4.58	NA	NA	0.06	XXX
78466	TC	A	Heart infarct image	0.00	3.92	4.27	NA	NA	0.03	XXX
78466	26	A	Heart infarct image	0.69	0.26	0.31	0.26	0.31	0.03	XXX
78468		A	Heart infarct image (ef)	0.80	4.87	5.61	NA	NA	0.06	XXX
78468	TC	A	Heart infarct image (ef)	0.00	4.56	5.23	NA	NA	0.03	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.31	0.38	0.31	0.38	0.03	XXX
78469		A	Heart infarct image (3d)	0.92	6.09	6.64	NA	NA	0.06	XXX
78469	TC	A	Heart infarct image (3d)	0.00	5.69	6.19	NA	NA	0.03	XXX
78469	26	A	Heart infarct image (3d)	0.92	0.40	0.45	0.40	0.45	0.03	XXX
78472		A	Gated heart planar single	0.98	5.56	6.39	NA	NA	0.07	XXX
78472	TC	A	Gated heart planar single	0.00	5.21	5.96	NA	NA	0.03	XXX
78472	26	A	Gated heart planar single	0.98	0.35	0.43	0.35	0.43	0.04	XXX
78473		A	Gated heart multiple	1.47	6.89	8.28	NA	NA	0.08	XXX
78473	TC	A	Gated heart multiple	0.00	6.34	7.61	NA	NA	0.03	XXX
78473	26	A	Gated heart multiple	1.47	0.55	0.67	0.55	0.67	0.05	XXX
78481		A	Heart first pass single	0.98	4.21	5.19	NA	NA	0.04	XXX
78481	TC	A	Heart first pass single	0.00	3.83	4.71	NA	NA	0.01	XXX
78481	26	A	Heart first pass single	0.98	0.38	0.48	0.38	0.48	0.03	XXX
78483		A	Heart first pass multiple	1.47	5.55	7.06	NA	NA	0.08	XXX
78483	TC	A	Heart first pass multiple	0.00	4.98	6.33	NA	NA	0.03	XXX
78483	26	A	Heart first pass multiple	1.47	0.57	0.73	0.57	0.73	0.05	XXX
78491		C	Heart image (pet) single	0.00	0.00	0.00	NA	NA	0.00	XXX
78491	TC	C	Heart image (pet) single	0.00	0.00	0.00	NA	NA	0.00	XXX
78491	26	A	Heart image (pet) single	1.50	0.49	0.65	0.49	0.65	0.10	XXX
78492		C	Heart image (pet) multiple	0.00	0.00	0.00	NA	NA	0.00	XXX
78492	TC	C	Heart image (pet) multiple	0.00	0.00	0.00	NA	NA	0.00	XXX
78492	26	A	Heart image (pet) multiple	1.87	0.66	0.86	0.66	0.86	0.12	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78494		A	Heart image spect	1.19	5.59	6.66	NA	NA	0.07	XXX
78494	TC	A	Heart image spect	0.00	5.12	6.11	NA	NA	0.03	XXX
78494	26	A	Heart image spect	1.19	0.47	0.55	0.47	0.55	0.04	XXX
78496		A	Heart first pass add-on	0.50	0.74	1.88	NA	NA	0.02	ZZZ
78496	TC	A	Heart first pass add-on	0.00	0.55	1.64	NA	NA	0.01	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.19	0.24	0.19	0.24	0.01	ZZZ
78499		C	Cardiovascular nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78580		A	Lung perfusion imaging	0.74	5.15	5.48	NA	NA	0.06	XXX
78580	TC	A	Lung perfusion imaging	0.00	4.90	5.18	NA	NA	0.03	XXX
78580	26	A	Lung perfusion imaging	0.74	0.25	0.30	0.25	0.30	0.03	XXX
78584		A	Lung v/q image single breath	0.99	3.03	3.44	NA	NA	0.08	XXX
78584	TC	A	Lung v/q image single breath	0.00	2.66	3.03	NA	NA	0.03	XXX
78584	26	A	Lung v/q image single breath	0.99	0.37	0.41	0.37	0.41	0.05	XXX
78585		A	Lung v/q imaging	1.09	8.79	9.27	NA	NA	0.08	XXX
78585	TC	A	Lung v/q imaging	0.00	8.41	8.83	NA	NA	0.03	XXX
78585	26	A	Lung v/q imaging	1.09	0.38	0.44	0.38	0.44	0.05	XXX
78586		A	Aerosol lung image single	0.40	4.33	4.49	NA	NA	0.04	XXX
78586	TC	A	Aerosol lung image single	0.00	4.18	4.32	NA	NA	0.03	XXX
78586	26	A	Aerosol lung image single	0.40	0.15	0.17	0.15	0.17	0.01	XXX
78587		A	Aerosol lung image multiple	0.49	5.35	5.62	NA	NA	0.06	XXX
78587	TC	A	Aerosol lung image multiple	0.00	5.19	5.43	NA	NA	0.03	XXX
78587	26	A	Aerosol lung image multiple	0.49	0.16	0.19	0.16	0.19	0.03	XXX
78588		A	Perfusion lung image	1.09	8.87	8.95	NA	NA	0.08	XXX
78588	TC	A	Perfusion lung image	0.00	8.48	8.51	NA	NA	0.03	XXX
78588	26	A	Perfusion lung image	1.09	0.39	0.44	0.39	0.44	0.05	XXX
78591		A	Vent image 1 breath 1 proj	0.40	4.36	4.54	NA	NA	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78591	TC	A	Vent image 1 breath 1 proj	0.00	4.21	4.37	NA	NA	0.03	XXX
78591	26	A	Vent image 1 breath 1 proj	0.40	0.15	0.17	0.15	0.17	0.01	XXX
78593		A	Vent image 1 proj gas	0.49	4.96	5.24	NA	NA	0.06	XXX
78593	TC	A	Vent image 1 proj gas	0.00	4.79	5.04	NA	NA	0.03	XXX
78593	26	A	Vent image 1 proj gas	0.49	0.17	0.20	0.17	0.20	0.03	XXX
78594		A	Vent image mult proj gas	0.53	5.16	5.81	NA	NA	0.06	XXX
78594	TC	A	Vent image mult proj gas	0.00	5.00	5.61	NA	NA	0.03	XXX
78594	26	A	Vent image mult proj gas	0.53	0.16	0.20	0.16	0.20	0.03	XXX
78596		A	Lung differential function	1.27	9.03	9.68	NA	NA	0.07	XXX
78596	TC	A	Lung differential function	0.00	8.60	9.19	NA	NA	0.03	XXX
78596	26	A	Lung differential function	1.27	0.43	0.49	0.43	0.49	0.04	XXX
78599		C	Respiratory nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78599	TC	C	Respiratory nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78600		A	Brain image < 4 views	0.44	4.58	4.83	NA	NA	0.04	XXX
78600	TC	A	Brain image < 4 views	0.00	4.42	4.64	NA	NA	0.03	XXX
78600	26	A	Brain image < 4 views	0.44	0.16	0.19	0.16	0.19	0.01	XXX
78601		A	Brain image w/flow < 4 views	0.51	5.44	5.73	NA	NA	0.06	XXX
78601	TC	A	Brain image w/flow < 4 views	0.00	5.26	5.53	NA	NA	0.03	XXX
78601	26	A	Brain image w/flow < 4 views	0.51	0.18	0.20	0.18	0.20	0.03	XXX
78605		A	Brain image 4+ views	0.53	4.91	5.24	NA	NA	0.06	XXX
78605	TC	A	Brain image 4+ views	0.00	4.71	5.01	NA	NA	0.03	XXX
78605	26	A	Brain image 4+ views	0.53	0.20	0.23	0.20	0.23	0.03	XXX
78606		A	Brain image w/flow 4 + views	0.64	8.75	8.88	NA	NA	0.04	XXX
78606	TC	A	Brain image w/flow 4 + views	0.00	8.52	8.62	NA	NA	0.03	XXX
78606	26	A	Brain image w/flow 4 + views	0.64	0.23	0.26	0.23	0.26	0.01	XXX
78607		A	Brain imaging (3d)	1.23	8.70	9.42	NA	NA	0.08	XXX
78607	TC	A	Brain imaging (3d)	0.00	8.31	8.94	NA	NA	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78607	26	A	Brain imaging (3d)	1.23	0.39	0.48	0.39	0.48	0.05	XXX
78608		C	Brain imaging (pet)	0.00	0.00	0.00	NA	NA	0.00	XXX
78608	TC	C	Brain imaging (pet)	0.00	0.00	0.00	NA	NA	0.00	XXX
78608	26	A	Brain imaging (pet)	1.50	0.48	0.58	0.48	0.58	0.11	XXX
78609		N	Brain imaging (pet)	1.50	0.66	0.63	NA	NA	0.10	XXX
78609	TC	N	Brain imaging (pet)	0.00	0.00	0.00	NA	NA	0.00	XXX
78609	26	N	Brain imaging (pet)	1.50	0.66	0.63	0.66	0.63	0.10	XXX
78610		A	Brain flow imaging only	0.30	4.49	4.90	NA	NA	0.04	XXX
78610	TC	A	Brain flow imaging only	0.00	4.38	4.77	NA	NA	0.03	XXX
78610	26	A	Brain flow imaging only	0.30	0.11	0.13	0.11	0.13	0.01	XXX
78630		A	Cerebrospinal fluid scan	0.68	8.87	9.20	NA	NA	0.06	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	8.63	8.92	NA	NA	0.03	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.24	0.28	0.24	0.28	0.03	XXX
78635		A	Csf ventriculography	0.61	8.87	8.83	NA	NA	0.04	XXX
78635	TC	A	Csf ventriculography	0.00	8.64	8.57	NA	NA	0.03	XXX
78635	26	A	Csf ventriculography	0.61	0.23	0.26	0.23	0.26	0.01	XXX
78645		A	Csf shunt evaluation	0.57	8.52	8.72	NA	NA	0.06	XXX
78645	TC	A	Csf shunt evaluation	0.00	8.33	8.49	NA	NA	0.03	XXX
78645	26	A	Csf shunt evaluation	0.57	0.19	0.23	0.19	0.23	0.03	XXX
78647		A	Cerebrospinal fluid scan	0.90	8.80	9.30	NA	NA	0.08	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	8.51	8.95	NA	NA	0.03	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.29	0.35	0.29	0.35	0.05	XXX
78650		A	Csf leakage imaging	0.61	8.73	9.05	NA	NA	0.07	XXX
78650	TC	A	Csf leakage imaging	0.00	8.53	8.81	NA	NA	0.03	XXX
78650	26	A	Csf leakage imaging	0.61	0.20	0.24	0.20	0.24	0.04	XXX
78660		A	Nuclear exam of tear flow	0.53	4.65	4.64	NA	NA	0.06	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	4.43	4.41	NA	NA	0.03	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.22	0.23	0.22	0.23	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78699		C	Nervous system nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78699	TC	C	Nervous system nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78700		A	Kidney imaging morphol	0.45	4.41	4.70	NA	NA	0.06	XXX
78700	TC	A	Kidney imaging morphol	0.00	4.25	4.51	NA	NA	0.03	XXX
78700	26	A	Kidney imaging morphol	0.45	0.16	0.19	0.16	0.19	0.03	XXX
78701		A	Kidney imaging with flow	0.49	5.44	5.74	NA	NA	0.06	XXX
78701	TC	A	Kidney imaging with flow	0.00	5.27	5.54	NA	NA	0.03	XXX
78701	26	A	Kidney imaging with flow	0.49	0.17	0.20	0.17	0.20	0.03	XXX
78707		A	K flow/funct image w/o drug	0.96	5.47	5.99	NA	NA	0.07	XXX
78707	TC	A	K flow/funct image w/o drug	0.00	5.15	5.61	NA	NA	0.03	XXX
78707	26	A	K flow/funct image w/o drug	0.96	0.32	0.38	0.32	0.38	0.04	XXX
78708		A	K flow/funct image w/drug	1.21	3.37	4.04	NA	NA	0.08	XXX
78708	TC	A	K flow/funct image w/drug	0.00	2.96	3.55	NA	NA	0.03	XXX
78708	26	A	K flow/funct image w/drug	1.21	0.41	0.49	0.41	0.49	0.05	XXX
78709		A	K flow/funct image multiple	1.41	8.95	9.33	NA	NA	0.10	XXX
78709	TC	A	K flow/funct image multiple	0.00	8.47	8.76	NA	NA	0.03	XXX
78709	26	A	K flow/funct image multiple	1.41	0.48	0.57	0.48	0.57	0.07	XXX
78710		A	Kidney imaging (3d)	0.66	5.05	5.88	NA	NA	0.04	XXX
78710	TC	A	Kidney imaging (3d)	0.00	4.85	5.63	NA	NA	0.03	XXX
78710	26	A	Kidney imaging (3d)	0.66	0.20	0.25	0.20	0.25	0.01	XXX
78725		A	Kidney function study	0.38	2.49	2.61	NA	NA	0.04	XXX
78725	TC	A	Kidney function study	0.00	2.35	2.46	NA	NA	0.03	XXX
78725	26	A	Kidney function study	0.38	0.14	0.15	0.14	0.15	0.01	XXX
78730		A	Urinary bladder retention	0.15	1.80	2.04	NA	NA	0.02	ZZZ
78730	TC	A	Urinary bladder retention	0.00	1.74	1.96	NA	NA	0.01	ZZZ
78730	26	A	Urinary bladder retention	0.15	0.06	0.08	0.06	0.08	0.01	ZZZ
78740		A	Ureteral reflux study	0.57	5.88	5.91	NA	NA	0.06	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78740	TC	A	Ureteral reflux study	0.00	5.65	5.66	NA	NA	0.03	XXX
78740	26	A	Ureteral reflux study	0.57	0.23	0.25	0.23	0.25	0.03	XXX
78761		A	Testicular imaging w/flow	0.71	5.26	5.50	NA	NA	0.07	XXX
78761	TC	A	Testicular imaging w/flow	0.00	4.99	5.20	NA	NA	0.03	XXX
78761	26	A	Testicular imaging w/flow	0.71	0.27	0.30	0.27	0.30	0.04	XXX
78799		C	Genitourinary nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78800		A	Tumor imaging limited area	0.66	4.54	4.80	NA	NA	0.07	XXX
78800	TC	A	Tumor imaging limited area	0.00	4.29	4.54	NA	NA	0.03	XXX
78800	26	A	Tumor imaging limited area	0.66	0.25	0.26	0.25	0.26	0.04	XXX
78801		A	Tumor imaging mult areas	0.79	6.29	6.60	NA	NA	0.07	XXX
78801	TC	A	Tumor imaging mult areas	0.00	6.00	6.28	NA	NA	0.03	XXX
78801	26	A	Tumor imaging mult areas	0.79	0.29	0.32	0.29	0.32	0.04	XXX
78802		A	Tumor imaging whole body	0.86	8.15	8.72	NA	NA	0.07	XXX
78802	TC	A	Tumor imaging whole body	0.00	7.87	8.38	NA	NA	0.03	XXX
78802	26	A	Tumor imaging whole body	0.86	0.28	0.34	0.28	0.34	0.04	XXX
78803		A	Tumor imaging (3d)	1.09	8.38	9.21	NA	NA	0.08	XXX
78803	TC	A	Tumor imaging (3d)	0.00	8.05	8.79	NA	NA	0.03	XXX
78803	26	A	Tumor imaging (3d)	1.09	0.33	0.42	0.33	0.42	0.05	XXX
78804		A	Tumor imaging whole body	1.07	14.85	15.99	NA	NA	0.10	XXX
78804	TC	A	Tumor imaging whole body	0.00	14.50	15.57	NA	NA	0.05	XXX
78804	26	A	Tumor imaging whole body	1.07	0.35	0.42	0.35	0.42	0.05	XXX
78805		A	Abscess imaging ltd area	0.73	4.30	4.65	NA	NA	0.07	XXX
78805	TC	A	Abscess imaging ltd area	0.00	4.05	4.36	NA	NA	0.03	XXX
78805	26	A	Abscess imaging ltd area	0.73	0.25	0.29	0.25	0.29	0.04	XXX
78806		A	Abscess imaging whole body	0.86	8.40	9.07	NA	NA	0.07	XXX
78806	TC	A	Abscess imaging whole body	0.00	8.11	8.73	NA	NA	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
78806	26	A	Abscess imaging whole body	0.86	0.29	0.34	0.29	0.34	0.04	XXX
78807		A	Nuclear localization/abscess	1.09	8.36	9.21	NA	NA	0.07	XXX
78807	TC	A	Nuclear localization/abscess	0.00	8.04	8.79	NA	NA	0.03	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.32	0.42	0.32	0.42	0.04	XXX
78808		A	Iv inj ra drug dx study	0.18	0.89	1.06	NA	NA	0.03	XXX
78811		C	Pet image ltd area	0.00	0.00	0.00	NA	NA	0.00	XXX
78811	TC	C	Pet image ltd area	0.00	0.00	0.00	NA	NA	0.00	XXX
78811	26	A	Pet image ltd area	1.54	0.55	0.63	0.55	0.63	0.18	XXX
78812		C	Pet image skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78812	TC	C	Pet image skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78812	26	A	Pet image skull-thigh	1.93	0.66	0.78	0.66	0.78	0.16	XXX
78813		C	Pet image full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78813	TC	C	Pet image full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78813	26	A	Pet image full body	2.00	0.72	0.83	0.72	0.83	0.18	XXX
78814		C	Pet image w/ct lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	TC	C	Pet image w/ct lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	26	A	Pet image w/ct lmtd	2.20	0.73	0.87	0.73	0.87	0.20	XXX
78815		C	Pet image w/ct skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78815	TC	C	Pet image w/ct skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78815	26	A	Pet image w/ct skull-thigh	2.44	0.84	0.98	0.84	0.98	0.22	XXX
78816		C	Pet image w/ct full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78816	TC	C	Pet image w/ct full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78816	26	A	Pet image w/ct full body	2.50	0.80	0.98	0.80	0.98	0.22	XXX
78999		C	Nuclear diagnostic exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79005		A	Nuclear rx oral admin	1.80	1.93	2.33	NA	NA	0.08	XXX
79005	TC	A	Nuclear rx oral admin	0.00	1.27	1.61	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
79005	26	A	Nuclear rx oral admin	1.80	0.66	0.72	0.66	0.72	0.07	XXX
79101		A	Nuclear rx iv admin	1.96	2.25	2.72	NA	NA	0.08	XXX
79101	TC	A	Nuclear rx iv admin	0.00	1.35	1.74	NA	NA	0.01	XXX
79101	26	A	Nuclear rx iv admin	1.96	0.90	0.98	0.90	0.98	0.07	XXX
79200		A	Nuclear rx intracav admin	1.99	2.43	2.83	NA	NA	0.12	XXX
79200	TC	A	Nuclear rx intracav admin	0.00	1.67	1.99	NA	NA	0.01	XXX
79200	26	A	Nuclear rx intracav admin	1.99	0.76	0.84	0.76	0.84	0.11	XXX
79300		C	Nuclr rx interstit colloid	0.00	0.00	0.00	NA	NA	0.00	XXX
79300	TC	C	Nuclr rx interstit colloid	0.00	0.00	0.00	NA	NA	0.00	XXX
79300	26	A	Nuclr rx interstit colloid	1.60	0.61	0.66	0.61	0.66	0.14	XXX
79403		A	Hematopoietic nuclear tx	2.25	2.89	3.64	NA	NA	0.14	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	2.08	2.70	NA	NA	0.03	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.81	0.94	0.81	0.94	0.11	XXX
79440		A	Nuclear rx intra-articular	1.99	2.38	2.59	NA	NA	0.06	XXX
79440	TC	A	Nuclear rx intra-articular	0.00	1.46	1.67	NA	NA	0.01	XXX
79440	26	A	Nuclear rx intra-articular	1.99	0.92	0.92	0.92	0.92	0.05	XXX
79445		C	Nuclear rx intra-arterial	0.00	0.00	0.00	NA	NA	0.00	XXX
79445	TC	C	Nuclear rx intra-arterial	0.00	0.00	0.00	NA	NA	0.00	XXX
79445	26	A	Nuclear rx intra-arterial	2.40	0.77	0.94	0.77	0.94	0.20	XXX
79999		C	Nuclear medicine therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
79999	TC	C	Nuclear medicine therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
80500		A	Lab pathology consultation	0.37	0.19	0.21	0.12	0.14	0.03	XXX
80502		A	Lab pathology consultation	1.33	0.47	0.49	0.41	0.43	0.07	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.18	0.17	0.18	0.17	0.03	XXX
83912	26	A	Genetic examination	0.37	0.16	0.15	0.16	0.15	0.03	XXX
84165	26	A	Protein e-phoresis serum	0.37	0.18	0.16	0.18	0.16	0.03	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.18	0.16	0.18	0.16	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
84181	26	A	Western blot test	0.37	0.18	0.17	0.18	0.17	0.03	XXX
84182	26	A	Protein western blot test	0.37	0.17	0.16	0.17	0.16	0.03	XXX
85060		A	Blood smear interpretation	0.45	0.22	0.20	0.22	0.20	0.03	XXX
85097		A	Bone marrow interpretation	0.94	1.37	1.54	0.40	0.39	0.05	XXX
85390	26	A	Fibrinolysins screen	0.37	0.19	0.18	0.19	0.18	0.03	XXX
85396		A	Clotting assay whole blood	0.37	NA	NA	0.17	0.16	0.03	XXX
85576	26	A	Blood platelet aggregation	0.37	0.18	0.17	0.18	0.17	0.03	XXX
86077		A	Physician blood bank service	0.94	0.55	0.51	0.46	0.43	0.05	XXX
86078		A	Physician blood bank service	0.94	0.56	0.52	0.46	0.43	0.05	XXX
86079		A	Physician blood bank service	0.94	0.55	0.53	0.45	0.43	0.05	XXX
86255	26	A	Fluorescent antibody screen	0.37	0.18	0.17	0.18	0.17	0.03	XXX
86256	26	A	Fluorescent antibody titer	0.37	0.18	0.17	0.18	0.17	0.01	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.18	0.17	0.18	0.17	0.01	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.18	0.16	0.18	0.16	0.01	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.21	0.20	0.21	0.20	0.03	XXX
86334	26	A	Immunofix e-phoresis serum	0.37	0.18	0.17	0.18	0.17	0.03	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.18	0.17	0.18	0.17	0.03	XXX
86485		C	Skin test candida	0.00	0.00	0.00	0.00	0.00	0.00	XXX
86486		A	Skin test nos antigen	0.00	0.13	0.14	NA	NA	0.01	XXX
86490		A	Coccidioidomycosis skin test	0.00	0.17	0.19	NA	NA	0.01	XXX
86510		A	Histoplasmosis skin test	0.00	0.16	0.19	NA	NA	0.01	XXX
86580		A	Tb intradermal test	0.00	0.20	0.21	NA	NA	0.01	XXX
87164	26	A	Dark field examination	0.37	0.18	0.17	0.18	0.17	0.03	XXX
87207	26	A	Smear special stain	0.37	0.19	0.17	0.19	0.17	0.03	XXX
88104		A	Cytopath fl nongyn smears	0.56	1.36	1.35	NA	NA	0.02	XXX
88104	TC	A	Cytopath fl nongyn smears	0.00	1.11	1.11	NA	NA	0.01	XXX
88104	26	A	Cytopath fl nongyn smears	0.56	0.25	0.24	0.25	0.24	0.01	XXX
88106		A	Cytopath fl nongyn filter	0.56	1.74	1.78	NA	NA	0.02	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
88106	TC	A	Cytopath fl nongyn filter	0.00	1.49	1.55	NA	NA	0.01	XXX
88106	26	A	Cytopath fl nongyn filter	0.56	0.25	0.23	0.25	0.23	0.01	XXX
88107		A	Cytopath fl nongyn sm/fltr	0.76	2.07	2.15	NA	NA	0.04	XXX
88107	TC	A	Cytopath fl nongyn sm/fltr	0.00	1.73	1.82	NA	NA	0.01	XXX
88107	26	A	Cytopath fl nongyn sm/fltr	0.76	0.34	0.33	0.34	0.33	0.03	XXX
88108		A	Cytopath concentrate tech	0.56	1.59	1.64	NA	NA	0.02	XXX
88108	TC	A	Cytopath concentrate tech	0.00	1.35	1.41	NA	NA	0.01	XXX
88108	26	A	Cytopath concentrate tech	0.56	0.24	0.23	0.24	0.23	0.01	XXX
88112		A	Cytopath cell enhance tech	1.18	1.67	1.80	NA	NA	0.05	XXX
88112	TC	A	Cytopath cell enhance tech	0.00	1.21	1.35	NA	NA	0.01	XXX
88112	26	A	Cytopath cell enhance tech	1.18	0.46	0.45	0.46	0.45	0.04	XXX
88120		A	Cytp urne 3-5 probes ea spec	1.20	12.22	12.22	NA	NA	0.05	XXX
88120	TC	A	Cytp urne 3-5 probes ea spec	0.00	11.91	11.91	NA	NA	0.02	XXX
88120	26	A	Cytp urne 3-5 probes ea spec	1.20	0.31	0.31	0.31	0.31	0.03	XXX
88121		A	Cytp urine 3-5 probes cmptr	1.00	10.34	10.34	NA	NA	0.03	XXX
88121	TC	A	Cytp urine 3-5 probes cmptr	0.00	10.00	10.00	NA	NA	0.01	XXX
88121	26	A	Cytp urine 3-5 probes cmptr	1.00	0.34	0.34	0.34	0.34	0.02	XXX
88125		A	Forensic cytopathology	0.26	0.36	0.37	NA	NA	0.02	XXX
88125	TC	A	Forensic cytopathology	0.00	0.24	0.25	NA	NA	0.01	XXX
88125	26	A	Forensic cytopathology	0.26	0.12	0.12	0.12	0.12	0.01	XXX
88141		A	Cytopath c/v interpret	0.42	0.42	0.40	0.42	0.40	0.03	XXX
88160		A	Cytopath smear other source	0.50	1.08	1.08	NA	NA	0.02	XXX
88160	TC	A	Cytopath smear other source	0.00	0.86	0.87	NA	NA	0.01	XXX
88160	26	A	Cytopath smear other source	0.50	0.22	0.21	0.22	0.21	0.01	XXX
88161		A	Cytopath smear other source	0.50	1.01	1.08	NA	NA	0.02	XXX
88161	TC	A	Cytopath smear other source	0.00	0.82	0.89	NA	NA	0.01	XXX
88161	26	A	Cytopath smear other source	0.50	0.19	0.19	0.19	0.19	0.01	XXX
88162		A	Cytopath smear other source	0.76	1.39	1.51	NA	NA	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
88162	TC	A	Cytopath smear other source	0.00	1.10	1.21	NA	NA	0.01	XXX
88162	26	A	Cytopath smear other source	0.76	0.29	0.30	0.29	0.30	0.03	XXX
88172		A	Cytp dx eval fna 1st ea site	0.60	0.76	0.87	NA	NA	0.02	XXX
88172	TC	A	Cytp dx eval fna 1st ea site	0.00	0.47	0.60	NA	NA	0.01	XXX
88172	26	A	Cytp dx eval fna 1st ea site	0.60	0.29	0.27	0.29	0.27	0.01	XXX
88173		A	Cytopath eval fna report	1.39	2.56	2.62	NA	NA	0.05	XXX
88173	TC	A	Cytopath eval fna report	0.00	1.95	2.04	NA	NA	0.01	XXX
88173	26	A	Cytopath eval fna report	1.39	0.61	0.58	0.61	0.58	0.04	XXX
88177		A	Cytp c/v auto thin lyr addl	0.42	0.38	0.38	NA	NA	0.02	ZZZ
88177	TC	A	Cytp c/v auto thin lyr addl	0.00	0.18	0.18	NA	NA	0.01	ZZZ
88177	26	A	Cytp c/v auto thin lyr addl	0.42	0.20	0.20	0.20	0.20	0.01	ZZZ
88182		A	Cell marker study	0.77	2.08	2.24	NA	NA	0.06	XXX
88182	TC	A	Cell marker study	0.00	1.86	2.02	NA	NA	0.03	XXX
88182	26	A	Cell marker study	0.77	0.22	0.22	0.22	0.22	0.03	XXX
88184		A	Flowcytometry/ tc 1 marker	0.00	2.30	2.47	NA	NA	0.01	XXX
88185		A	Flowcytometry/tc add-on	0.00	1.40	1.48	NA	NA	0.01	ZZZ
88187		A	Flowcytometry/read 2-8	1.36	0.59	0.55	0.59	0.55	0.08	XXX
88188		A	Flowcytometry/read 9-15	1.69	0.76	0.68	0.76	0.68	0.10	XXX
88189		A	Flowcytometry/read 16 >	2.23	0.71	0.69	0.71	0.69	0.12	XXX
88199		C	Cytopathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88199	TC	C	Cytopathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88291		A	Cyto/molecular report	0.52	0.31	0.31	0.31	0.31	0.03	XXX
88299		C	Cytogenetic study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88300		A	Surgical path gross	0.08	0.71	0.69	NA	NA	0.02	XXX
88300	TC	A	Surgical path gross	0.00	0.67	0.65	NA	NA	0.01	XXX
88300	26	A	Surgical path gross	0.08	0.04	0.04	0.04	0.04	0.01	XXX
88302		A	Tissue exam by pathologist	0.13	1.41	1.43	NA	NA	0.02	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
88302	TC	A	Tissue exam by pathologist	0.00	1.35	1.38	NA	NA	0.01	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.06	0.05	0.06	0.05	0.01	XXX
88304		A	Tissue exam by pathologist	0.22	1.44	1.61	NA	NA	0.02	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.34	1.52	NA	NA	0.01	XXX
88304	26	A	Tissue exam by pathologist	0.22	0.10	0.09	0.10	0.09	0.01	XXX
88305		A	Tissue exam by pathologist	0.75	2.19	2.35	NA	NA	0.02	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.87	2.04	NA	NA	0.01	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.32	0.31	0.32	0.31	0.01	XXX
88307		A	Tissue exam by pathologist	1.59	5.09	5.04	NA	NA	0.05	XXX
88307	TC	A	Tissue exam by pathologist	0.00	4.34	4.33	NA	NA	0.01	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.75	0.71	0.75	0.71	0.04	XXX
88309		A	Tissue exam by pathologist	2.80	7.38	7.21	NA	NA	0.11	XXX
88309	TC	A	Tissue exam by pathologist	0.00	6.05	5.99	NA	NA	0.03	XXX
88309	26	A	Tissue exam by pathologist	2.80	1.33	1.22	1.33	1.22	0.08	XXX
88311		A	Decalcify tissue	0.24	0.30	0.29	NA	NA	0.02	XXX
88311	TC	A	Decalcify tissue	0.00	0.19	0.19	NA	NA	0.01	XXX
88311	26	A	Decalcify tissue	0.24	0.11	0.10	0.11	0.10	0.01	XXX
88312		A	Special stains group 1	0.54	2.53	2.59	NA	NA	0.02	XXX
88312	TC	A	Special stains group 1	0.00	2.31	2.37	NA	NA	0.01	XXX
88312	26	A	Special stains group 1	0.54	0.22	0.22	0.22	0.22	0.01	XXX
88313		A	Special stains group 2	0.24	1.97	2.04	NA	NA	0.02	XXX
88313	TC	A	Special stains group 2	0.00	1.87	1.95	NA	NA	0.01	XXX
88313	26	A	Special stains group 2	0.24	0.10	0.09	0.10	0.09	0.01	XXX
88314		A	Histochemical stains add-on	0.45	2.00	2.18	NA	NA	0.02	XXX
88314	TC	A	Histochemical stains add-on	0.00	1.79	1.98	NA	NA	0.01	XXX
88314	26	A	Histochemical stains add-on	0.45	0.21	0.20	0.21	0.20	0.01	XXX
88318		A	Chemical histochemistry	0.42	3.20	3.00	NA	NA	0.02	XXX
88318	TC	A	Chemical histochemistry	0.00	3.01	2.82	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
88318	26	A	Chemical histochemistry	0.42	0.19	0.18	0.19	0.18	0.01	XXX
88319		A	Enzyme histochemistry	0.53	3.58	3.75	NA	NA	0.04	XXX
88319	TC	A	Enzyme histochemistry	0.00	3.34	3.53	NA	NA	0.01	XXX
88319	26	A	Enzyme histochemistry	0.53	0.24	0.22	0.24	0.22	0.03	XXX
88321		A	Microslide consultation	1.63	0.97	0.94	0.72	0.67	0.10	XXX
88323		A	Microslide consultation	1.83	2.17	2.33	NA	NA	0.05	XXX
88323	TC	A	Microslide consultation	0.00	1.57	1.73	NA	NA	0.01	XXX
88323	26	A	Microslide consultation	1.83	0.60	0.60	0.60	0.60	0.04	XXX
88325		A	Comprehensive review of data	2.50	3.29	3.27	1.28	1.14	0.12	XXX
88329		A	Path consult introp	0.67	0.84	0.83	0.32	0.30	0.04	XXX
88331		A	Path consult intraop 1 bloc	1.19	1.52	1.49	NA	NA	0.02	XXX
88331	TC	A	Path consult intraop 1 bloc	0.00	0.93	0.94	NA	NA	0.01	XXX
88331	26	A	Path consult intraop 1 bloc	1.19	0.59	0.55	0.59	0.55	0.01	XXX
88332		A	Path consult intraop addl	0.59	0.59	0.58	NA	NA	0.02	XXX
88332	TC	A	Path consult intraop addl	0.00	0.31	0.32	NA	NA	0.01	XXX
88332	26	A	Path consult intraop addl	0.59	0.28	0.26	0.28	0.26	0.01	XXX
88333		A	Intraop cyto path consult 1	1.20	1.61	1.57	NA	NA	0.05	XXX
88333	TC	A	Intraop cyto path consult 1	0.00	1.04	1.03	NA	NA	0.01	XXX
88333	26	A	Intraop cyto path consult 1	1.20	0.57	0.54	0.57	0.54	0.04	XXX
88334		A	Intraop cyto path consult 2	0.73	1.00	0.97	NA	NA	0.04	XXX
88334	TC	A	Intraop cyto path consult 2	0.00	0.65	0.64	NA	NA	0.01	XXX
88334	26	A	Intraop cyto path consult 2	0.73	0.35	0.33	0.35	0.33	0.03	XXX
88342		A	Immunohistochemistry	0.85	2.12	2.18	NA	NA	0.04	XXX
88342	TC	A	Immunohistochemistry	0.00	1.78	1.85	NA	NA	0.01	XXX
88342	26	A	Immunohistochemistry	0.85	0.34	0.33	0.34	0.33	0.03	XXX
88346		A	Immunofluorescent study	0.86	2.04	2.13	NA	NA	0.02	XXX
88346	TC	A	Immunofluorescent study	0.00	1.68	1.79	NA	NA	0.01	XXX
88346	26	A	Immunofluorescent study	0.86	0.36	0.34	0.36	0.34	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
88347		A	Immunofluorescent study	0.86	1.27	1.41	NA	NA	0.02	XXX
88347	TC	A	Immunofluorescent study	0.00	1.03	1.15	NA	NA	0.01	XXX
88347	26	A	Immunofluorescent study	0.86	0.24	0.26	0.24	0.26	0.01	XXX
88348		A	Electron microscopy	1.51	17.96	18.48	NA	NA	0.12	XXX
88348	TC	A	Electron microscopy	0.00	17.34	17.88	NA	NA	0.08	XXX
88348	26	A	Electron microscopy	1.51	0.62	0.60	0.62	0.60	0.04	XXX
88349		A	Scanning electron microscopy	0.76	10.57	9.78	NA	NA	0.07	XXX
88349	TC	A	Scanning electron microscopy	0.00	10.19	9.43	NA	NA	0.04	XXX
88349	26	A	Scanning electron microscopy	0.76	0.38	0.35	0.38	0.35	0.03	XXX
88355		A	Analysis skeletal muscle	1.85	3.23	4.41	NA	NA	0.06	XXX
88355	TC	A	Analysis skeletal muscle	0.00	2.69	3.84	NA	NA	0.01	XXX
88355	26	A	Analysis skeletal muscle	1.85	0.54	0.57	0.54	0.57	0.05	XXX
88356		A	Analysis nerve	3.02	4.51	5.15	NA	NA	0.18	XXX
88356	TC	A	Analysis nerve	0.00	3.94	4.44	NA	NA	0.04	XXX
88356	26	A	Analysis nerve	3.02	0.57	0.71	0.57	0.71	0.14	XXX
88358		A	Analysis tumor	0.95	1.16	1.21	NA	NA	0.04	XXX
88358	TC	A	Analysis tumor	0.00	0.91	0.95	NA	NA	0.01	XXX
88358	26	A	Analysis tumor	0.95	0.25	0.26	0.25	0.26	0.03	XXX
88360		A	Tumor immunohistochem/manual	1.10	2.41	2.50	NA	NA	0.04	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	1.99	2.09	NA	NA	0.01	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.42	0.41	0.42	0.41	0.03	XXX
88361		A	Tumor immunohistochem/comput	1.18	3.02	3.24	NA	NA	0.05	XXX
88361	TC	A	Tumor immunohistochem/comput	0.00	2.58	2.82	NA	NA	0.01	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.44	0.42	0.44	0.42	0.04	XXX
88362		A	Nerve teasing preparations	2.17	6.06	6.03	NA	NA	0.14	XXX
88362	TC	A	Nerve teasing preparations	0.00	5.12	5.14	NA	NA	0.04	XXX
88362	26	A	Nerve teasing preparations	2.17	0.94	0.89	0.94	0.89	0.10	XXX
88363		A	Xm archive tissue molec anal	0.37	0.72	0.72	0.10	0.10	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
88365		A	Insitu hybridization (fish)	1.20	3.57	3.65	NA	NA	0.04	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	3.10	3.19	NA	NA	0.01	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.47	0.46	0.47	0.46	0.03	XXX
88367		A	Insitu hybridization auto	1.30	6.08	6.21	NA	NA	0.06	XXX
88367	TC	A	Insitu hybridization auto	0.00	5.63	5.77	NA	NA	0.01	XXX
88367	26	A	Insitu hybridization auto	1.30	0.45	0.44	0.45	0.44	0.05	XXX
88368		A	Insitu hybridization manual	1.40	4.83	5.04	NA	NA	0.05	XXX
88368	TC	A	Insitu hybridization manual	0.00	4.47	4.65	NA	NA	0.01	XXX
88368	26	A	Insitu hybridization manual	1.40	0.36	0.39	0.36	0.39	0.04	XXX
88371	26	A	Protein western blot tissue	0.37	0.18	0.16	0.18	0.16	0.03	XXX
88372	26	A	Protein analysis w/probe	0.37	0.18	0.17	0.18	0.17	0.03	XXX
88380		A	Microdissection laser	1.56	2.61	3.56	NA	NA	0.05	XXX
88380	TC	A	Microdissection laser	0.00	2.16	3.03	NA	NA	0.01	XXX
88380	26	A	Microdissection laser	1.56	0.45	0.53	0.45	0.53	0.04	XXX
88381		A	Microdissection manual	1.18	2.81	4.22	NA	NA	0.04	XXX
88381	TC	A	Microdissection manual	0.00	2.56	3.86	NA	NA	0.01	XXX
88381	26	A	Microdissection manual	1.18	0.25	0.36	0.25	0.36	0.03	XXX
88384		C	Eval molecular probes 11-50	0.00	0.00	0.00	NA	NA	0.00	XXX
88384	TC	C	Eval molecular probes 11-50	0.00	0.00	0.00	NA	NA	0.00	XXX
88384	26	C	Eval molecular probes 11-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88385		A	Eval molecul probes 51-250	1.50	15.14	15.40	NA	NA	0.07	XXX
88385	TC	A	Eval molecul probes 51-250	0.00	14.77	15.00	NA	NA	0.03	XXX
88385	26	A	Eval molecul probes 51-250	1.50	0.37	0.40	0.37	0.40	0.04	XXX
88386		A	Eval molecul probes 251-500	1.88	13.92	16.95	NA	NA	0.08	XXX
88386	TC	A	Eval molecul probes 251-500	0.00	13.57	16.34	NA	NA	0.03	XXX
88386	26	A	Eval molecul probes 251-500	1.88	0.35	0.61	0.35	0.61	0.05	XXX
88387		A	Tiss exam molecular study	0.62	0.55	0.55	NA	NA	0.02	XXX
88387	TC	A	Tiss exam molecular study	0.00	0.25	0.25	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
88387	26	A	Tiss exam molecular study	0.62	0.30	0.30	0.30	0.30	0.01	XXX
88388		A	Tiss ex molecul study add-on	0.45	0.22	0.22	NA	NA	0.02	XXX
88388	TC	A	Tiss ex molecul study add-on	0.00	0.12	0.12	NA	NA	0.01	XXX
88388	26	A	Tiss ex molecul study add-on	0.45	0.10	0.10	0.10	0.10	0.01	XXX
88399		C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	TC	C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
89049		A	Chct for mal hyperthermia	1.40	5.82	6.02	0.40	0.46	0.10	XXX
89060	26	A	Exam synovial fluid crystals	0.37	0.18	0.17	0.18	0.17	0.03	XXX
89220		A	Sputum specimen collection	0.00	0.44	0.46	NA	NA	0.01	XXX
89230		A	Collect sweat for test	0.00	0.06	0.08	NA	NA	0.01	XXX
89240		C	Pathology lab procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90281		I	Human ig im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90283		I	Human ig iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90284		X	Human ig sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90287		I	Botulinum antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90288		I	Botulism ig iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90291		I	Cmv ig iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90296		E	Diphtheria antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90371		E	Hep b ig im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90375		E	Rabies ig im/sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90376		E	Rabies ig heat treated	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90378		X	Rsv mab im 50mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90384		I	Rh ig full-dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90385		E	Rh ig minidose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90386		I	Rh ig iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90389		I	Tetanus ig im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90393		E	Vaccina ig im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
90396		E	Varicella-zoster ig im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90399		I	Immune globulin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90460		A	Imadm any route 1st vac/tox	0.17	0.50	0.50	NA	NA	0.01	XXX
90461		A	Inadm any route addl vac/tox	0.15	0.20	0.18	NA	NA	0.01	ZZZ
90470		I	Immune admin h1n1 im/nasal	0.20	0.40	0.40	NA	NA	0.01	XXX
90471		A	Immunization admin	0.17	0.50	0.50	NA	NA	0.01	XXX
90472		A	Immunization admin each add	0.15	0.20	0.18	NA	NA	0.01	ZZZ
90473		R	Immune admin oral/nasal	0.17	0.50	0.50	NA	NA	0.01	XXX
90474		R	Immune admin oral/nasal addl	0.15	0.20	0.18	NA	NA	0.01	ZZZ
90476		E	Adenovirus vaccine type 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90477		E	Adenovirus vaccine type 7	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90581		E	Anthrax vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90585		E	Bcg vaccine percut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90586		E	Bcg vaccine intravesical	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90632		E	Hep a vaccine adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90633		E	Hep a vacc ped/adol 2 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90634		E	Hep a vacc ped/adol 3 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90636		E	Hep a/hep b vacc adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90644		X	Meningoccl hib vac 4 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90645		E	Hib vaccine hboc im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90646		E	Hib vaccine prp-d im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90647		E	Hib vaccine prp-omp im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90648		E	Hib vaccine prp-t im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90649		E	Hpv vaccine 4 valent im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90650		E	Hpv vaccine 2 valent im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90654		X	Flu vaccine no preserv, id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90655		X	Flu vaccine no preserv 6-35m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90656		X	Flu vaccine no preserv 3 & >	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90657		X	Flu vaccine 3 yrs im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90658		I	Flu vaccine 3 yrs & > im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90660		X	Flu vaccine nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90661		X	Flu vacc cell cult prsv free	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90662		X	Flu vacc prsv free inc antig	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90663		X	Flu vacc pandemic h1n1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90664		X	Flu vacc pandemic intranasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90665		E	Lyme disease vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90666		X	Flu vac pandem prsrv free im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90667		X	Flu vac pandemic adjuvant im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90668		X	Flu vac pandemic splt im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90669		X	Pneumococcal vacc 7 val im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90670		X	Pneumococcal vacc 13 val im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90675		E	Rabies vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90676		E	Rabies vaccine id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90680		E	Rotovirus vacc 3 dose oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90681		E	Rotavirus vacc 2 dose oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90690		E	Typhoid vaccine oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90691		E	Typhoid vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90692		E	Typhoid vaccine h-p sc/id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90693		E	Typhoid vaccine akd sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90696		E	Dtap-ipv vacc 4-6 yr im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90698		E	Dtap-hib-ip vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90700		E	Dtap vaccine < 7 yrs im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90701		E	Dtp vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90702		E	Dt vaccine < 7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90703		E	Tetanus vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90704		E	Mumps vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
90705		E	Measles vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90706		E	Rubella vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90707		E	Mmr vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90708		E	Measles-rubella vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90710		E	Mmrv vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90712		E	Oral poliovirus vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90713		E	Poliovirus ipv sc/im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90714		E	Td vaccine no prsrv >/= 7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90715		E	Tdap vaccine >7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90716		E	Chicken pox vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90717		E	Yellow fever vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90718		E	Td vaccine > 7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90719		E	Diphtheria vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90720		E	Dtp/hib vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90721		E	Dtap/hib vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90723		I	Dtap-hep b-ipv vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90725		E	Cholera vaccine injectable	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90727		E	Plague vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90732		X	Pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90733		E	Meningococcal vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90734		E	Meningococcal vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90735		E	Encephalitis vaccine sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90736		E	Zoster vacc sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90738		I	Inactivated je vacc im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90740		X	Hepb vacc ill pat 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90743		X	Hep b vacc adol 2 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90744		X	Hepb vacc ped/adol 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90746		X	Hep b vaccine adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90747		X	Hepb vacc ill pat 4 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90748		I	Hep b/hib vaccine im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90749		E	Vaccine toxoid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.80	1.55	1.62	0.60	0.72	0.11	XXX
90802		A	Intac psy dx interview	3.01	1.83	1.80	0.78	0.84	0.12	XXX
90804		A	Psytx office 20-30 min	1.21	0.57	0.61	0.18	0.25	0.04	XXX
90805		A	Psytx off 20-30 min w/e&m	1.37	0.70	0.70	0.28	0.32	0.05	XXX
90806		A	Psytx off 45-50 min	1.86	0.46	0.58	0.25	0.37	0.07	XXX
90807		A	Psytx off 45-50 min w/e&m	2.02	0.83	0.85	0.42	0.47	0.08	XXX
90808		A	Psytx office 75-80 min	2.79	0.63	0.79	0.43	0.59	0.10	XXX
90809		A	Psytx off 75-80 w/e&m	2.95	1.03	1.07	0.64	0.71	0.12	XXX
90810		A	Intac psytx off 20-30 min	1.32	0.48	0.56	0.21	0.27	0.05	XXX
90811		A	Intac psytx 20-30 w/e&m	1.48	0.87	0.84	0.32	0.36	0.07	XXX
90812		A	Intac psytx off 45-50 min	1.97	0.57	0.70	0.26	0.39	0.07	XXX
90813		A	Intac psytx 45-50 min w/e&m	2.13	0.97	0.98	0.43	0.50	0.08	XXX
90814		A	Intac psytx off 75-80 min	2.90	0.74	0.94	0.38	0.62	0.11	XXX
90815		A	Intac psytx 75-80 w/e&m	3.06	1.35	1.30	0.82	0.82	0.14	XXX
90816		A	Psytx hosp 20-30 min	1.25	0.26	0.26	0.26	0.35	0.04	XXX
90817		A	Psytx hosp 20-30 min w/e&m	1.41	0.41	0.41	0.41	0.44	0.05	XXX
90818		A	Psytx hosp 45-50 min	1.89	0.34	0.34	0.34	0.48	0.07	XXX
90819		A	Psytx hosp 45-50 min w/e&m	2.05	0.55	0.55	0.55	0.60	0.08	XXX
90821		A	Psytx hosp 75-80 min	2.83	0.48	0.48	0.48	0.67	0.10	XXX
90822		A	Psytx hosp 75-80 min w/e&m	2.99	0.74	0.74	0.74	0.81	0.12	XXX
90823		A	Intac psytx hosp 20-30 min	1.36	0.29	0.29	0.29	0.38	0.04	XXX
90824		A	Intac psytx hsp 20-30 w/e&m	1.52	0.43	0.43	0.43	0.47	0.07	XXX
90826		A	Intac psytx hosp 45-50 min	2.01	0.38	0.38	0.38	0.51	0.07	XXX
90827		A	Intac psytx hsp 45-50 w/e&m	2.16	0.56	0.56	0.56	0.61	0.08	XXX
90828		A	Intac psytx hosp 75-80 min	2.94	0.51	0.51	0.51	0.71	0.10	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
90829		A	Intac psytx hsp 75-80 w/e&m	3.10	0.75	0.75	0.75	0.83	0.12	XXX
90845		A	Psychoanalysis	1.79	0.43	0.48	0.36	0.42	0.07	XXX
90846		R	Family psytx w/o patient	1.83	0.49	0.58	0.40	0.50	0.07	XXX
90847		R	Family psytx w/patient	2.21	0.70	0.81	0.44	0.57	0.08	XXX
90849		R	Multiple family group psytx	0.59	0.39	0.38	0.22	0.25	0.03	XXX
90853		A	Group psychotherapy	0.59	0.33	0.32	0.25	0.25	0.03	XXX
90857		A	Intac group psytx	0.63	0.44	0.43	0.30	0.29	0.03	XXX
90862		A	Medication management	0.95	0.73	0.71	0.32	0.33	0.04	XXX
90865		A	Narcosynthesis	2.84	1.77	1.70	0.70	0.80	0.11	XXX
90867		C	Tcranial magn stim tx plan	0.00	0.00	0.00	0.00	0.00	0.00	YYY
90868		C	Tcranial magn stim tx deli	0.00	0.00	0.00	0.00	0.00	0.00	YYY
90870		A	Electroconvulsive therapy	2.50	2.33	2.31	0.58	0.56	0.11	000
90875		N	Psychophysiological therapy	1.20	0.84	0.87	0.53	0.52	0.08	XXX
90876		N	Psychophysiological therapy	1.90	1.13	1.15	0.84	0.82	0.12	XXX
90880		A	Hypnotherapy	2.19	0.53	0.69	0.36	0.47	0.08	XXX
90882		N	Environmental manipulation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90885		B	Psy evaluation of records	0.97	0.43	0.42	0.43	0.42	0.07	XXX
90887		B	Consultation with family	1.48	0.99	0.99	0.65	0.64	0.10	XXX
90889		B	Preparation of report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90901		A	Biofeedback train any meth	0.41	0.70	0.66	0.19	0.17	0.01	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.47	1.61	0.37	0.38	0.07	000
90935		A	Hemodialysis one evaluation	1.48	NA	NA	0.57	0.64	0.08	000
90937		A	Hemodialysis repeated eval	2.11	NA	NA	0.82	0.93	0.11	000
90940		X	Hemodialysis access study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90945		A	Dialysis one evaluation	1.56	0.60	0.66	NA	NA	0.08	000
90947		A	Dialysis repeated eval	2.52	NA	NA	0.97	1.01	0.15	000
90951		A	Esrd serv 4 visits p mo <2	18.46	8.04	8.68	8.04	8.68	1.02	XXX
90952		C	Esrd serv 2-3 vsts p mo <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90953		C	Esrd serv 1 visit p mo <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90954		A	Esrd serv 4 vsts p mo 2-11	15.98	6.95	6.74	6.95	6.74	0.90	XXX
90955		A	Esrd srv 2-3 vsts p mo 2-11	8.79	4.09	4.07	4.09	4.07	0.49	XXX
90956		A	Esrd srv 1 visit p mo 2-11	5.95	2.99	2.87	2.99	2.87	0.34	XXX
90957		A	Esrd srv 4 vsts p mo 12-19	12.52	5.62	5.65	5.62	5.65	0.72	XXX
90958		A	Esrd srv 2-3 vsts p mo 12-19	8.34	3.99	3.98	3.99	3.98	0.48	XXX
90959		A	Esrd serv 1 vst p mo 12-19	5.50	2.84	2.71	2.84	2.71	0.31	XXX
90960		A	Esrd srv 4 visits p mo 20+	5.18	2.80	2.91	2.80	2.91	0.31	XXX
90961		A	Esrd srv 2-3 vsts p mo 20+	4.26	2.45	2.39	2.45	2.39	0.26	XXX
90962		A	Esrd serv 1 visit p mo 20+	3.15	2.02	1.81	2.02	1.81	0.20	XXX
90963		A	Esrd home pt serv p mo <2	10.56	4.78	4.93	4.78	4.93	0.60	XXX
90964		A	Esrd home pt serv p mo 2-11	9.14	4.23	4.01	4.23	4.01	0.52	XXX
90965		A	Esrd home pt serv p mo 12-19	8.69	4.06	3.85	4.06	3.85	0.49	XXX
90966		A	Esrd home pt serv p mo 20+	4.26	2.44	2.35	2.44	2.35	0.26	XXX
90967		A	Esrd home pt serv p day <2	0.35	0.16	0.19	0.16	0.19	0.01	XXX
90968		A	Esrd home pt srv p day 2-11	0.30	0.14	0.14	0.14	0.14	0.01	XXX
90969		A	Esrd home pt srv p day 12-19	0.29	0.14	0.14	0.14	0.14	0.01	XXX
90970		A	Esrd home pt serv p day 20+	0.14	0.08	0.08	0.08	0.08	0.01	XXX
90989		X	Dialysis training complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90993		X	Dialysis training incompl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90997		A	Hemoperfusion	1.84	NA	NA	0.69	0.69	0.10	000
90999		C	Dialysis procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91010		A	Esophagus motility study	1.28	3.73	4.17	NA	NA	0.08	000
91010	TC	A	Esophagus motility study	0.00	3.04	3.49	NA	NA	0.01	000
91010	26	A	Esophagus motility study	1.28	0.69	0.68	0.69	0.68	0.07	000
91013		A	Esophgl motil w/stim/perfus	0.18	0.48	0.48	NA	NA	0.02	ZZZ
91013	TC	A	Esophgl motil w/stim/perfus	0.00	0.38	0.38	NA	NA	0.01	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
91013	26	A	Esophgl motil w/stim/perfus	0.18	0.10	0.10	0.10	0.10	0.01	ZZZ
91020		A	Gastric motility studies	1.44	5.24	5.49	NA	NA	0.08	000
91020	TC	A	Gastric motility studies	0.00	4.46	4.72	NA	NA	0.01	000
91020	26	A	Gastric motility studies	1.44	0.78	0.77	0.78	0.77	0.07	000
91022		A	Duodenal motility study	1.44	3.47	3.92	NA	NA	0.06	000
91022	TC	A	Duodenal motility study	0.00	2.66	3.10	NA	NA	0.01	000
91022	26	A	Duodenal motility study	1.44	0.81	0.82	0.81	0.82	0.05	000
91030		A	Acid perfusion of esophagus	0.91	3.02	3.20	NA	NA	0.05	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.51	2.69	NA	NA	0.01	000
91030	26	A	Acid perfusion of esophagus	0.91	0.51	0.51	0.51	0.51	0.04	000
91034		A	Gastroesophageal reflux test	0.97	4.40	4.82	NA	NA	0.05	000
91034	TC	A	Gastroesophageal reflux test	0.00	3.87	4.31	NA	NA	0.01	000
91034	26	A	Gastroesophageal reflux test	0.97	0.53	0.51	0.53	0.51	0.04	000
91035		A	G-esoph reflx tst w/electrod	1.59	12.02	12.70	NA	NA	0.08	000
91035	TC	A	G-esoph reflx tst w/electrod	0.00	11.16	11.85	NA	NA	0.01	000
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.86	0.85	0.86	0.85	0.07	000
91037		A	Esoph imped function test	0.97	3.60	3.78	NA	NA	0.08	000
91037	TC	A	Esoph imped function test	0.00	3.07	3.25	NA	NA	0.01	000
91037	26	A	Esoph imped function test	0.97	0.53	0.53	0.53	0.53	0.07	000
91038		A	Esoph imped funct test > 1h	1.10	12.00	7.67	NA	NA	0.06	000
91038	TC	A	Esoph imped funct test > 1h	0.00	11.40	7.07	NA	NA	0.01	000
91038	26	A	Esoph imped funct test > 1h	1.10	0.60	0.60	0.60	0.60	0.05	000
91040		A	Esoph balloon distension tst	0.97	7.09	9.13	NA	NA	0.04	000
91040	TC	A	Esoph balloon distension tst	0.00	6.71	8.65	NA	NA	0.01	000
91040	26	A	Esoph balloon distension tst	0.97	0.38	0.48	0.38	0.48	0.03	000
91065		A	Breath hydrogen test	0.20	2.36	2.13	NA	NA	0.02	000
91065	TC	A	Breath hydrogen test	0.00	2.25	2.03	NA	NA	0.01	000
91065	26	A	Breath hydrogen test	0.20	0.11	0.10	0.11	0.10	0.01	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
91110		A	Gi tract capsule endoscopy	3.64	21.61	23.37	NA	NA	0.17	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	19.59	21.36	NA	NA	0.01	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	2.02	2.01	2.02	2.01	0.16	XXX
91111		A	Esophageal capsule endoscopy	1.00	19.45	20.72	NA	NA	0.05	XXX
91111	TC	A	Esophageal capsule endoscopy	0.00	18.90	20.15	NA	NA	0.01	XXX
91111	26	A	Esophageal capsule endoscopy	1.00	0.55	0.57	0.55	0.57	0.04	XXX
91117		A	Colon motility 6 hr study	2.45	1.36	1.36	1.64	1.64	0.38	000
91120		A	Rectal sensation test	0.97	9.11	10.31	NA	NA	0.09	XXX
91120	TC	A	Rectal sensation test	0.00	8.66	9.89	NA	NA	0.01	XXX
91120	26	A	Rectal sensation test	0.97	0.45	0.42	0.45	0.42	0.08	XXX
91122		A	Anal pressure record	1.77	4.46	4.86	NA	NA	0.11	000
91122	TC	A	Anal pressure record	0.00	3.67	4.09	NA	NA	0.01	000
91122	26	A	Anal pressure record	1.77	0.79	0.77	0.79	0.77	0.10	000
91132		A	Electrogastrography	0.52	3.61	3.62	NA	NA	0.04	XXX
91132	TC	A	Electrogastrography	0.00	3.34	3.34	NA	NA	0.01	XXX
91132	26	A	Electrogastrography	0.52	0.27	0.28	0.27	0.28	0.03	XXX
91133		A	Electrogastrography w/test	0.66	4.39	4.40	NA	NA	0.05	XXX
91133	TC	A	Electrogastrography w/test	0.00	4.02	4.02	NA	NA	0.01	XXX
91133	26	A	Electrogastrography w/test	0.66	0.37	0.38	0.37	0.38	0.04	XXX
91299		C	Gastroenterology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
91299	TC	C	Gastroenterology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92002		A	Eye exam new patient	0.88	1.37	1.28	0.49	0.43	0.07	XXX
92004		A	Eye exam new patient	1.82	2.37	2.19	1.05	0.92	0.12	XXX
92012		A	Eye exam established pat	0.92	1.48	1.37	0.60	0.51	0.07	XXX
92014		A	Eye exam & treatment	1.42	2.06	1.90	0.89	0.76	0.10	XXX
92015		N	Refraction	0.38	0.18	0.38	0.17	0.16	0.03	XXX
92018		A	New eye exam & treatment	2.50	NA	NA	1.66	1.43	0.16	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92019		A	Eye exam & treatment	1.31	NA	NA	0.67	0.60	0.07	XXX
92020		A	Special eye evaluation	0.37	0.40	0.37	0.24	0.21	0.03	XXX
92025		A	Corneal topography	0.35	0.71	0.66	NA	NA	0.02	XXX
92025	TC	A	Corneal topography	0.00	0.48	0.46	NA	NA	0.01	XXX
92025	26	A	Corneal topography	0.35	0.23	0.20	0.23	0.20	0.01	XXX
92060		A	Special eye evaluation	0.69	1.14	1.05	NA	NA	0.04	XXX
92060	TC	A	Special eye evaluation	0.00	0.71	0.67	NA	NA	0.01	XXX
92060	26	A	Special eye evaluation	0.69	0.43	0.38	0.43	0.38	0.03	XXX
92065		A	Orthoptic/pleoptic training	0.37	1.13	1.04	NA	NA	0.02	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.98	0.90	NA	NA	0.01	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.15	0.14	0.15	0.14	0.01	XXX
92070		A	Fitting of contact lens	0.70	1.30	1.24	0.43	0.37	0.04	XXX
92081		A	Visual field examination(s)	0.30	1.03	1.10	NA	NA	0.03	XXX
92081	TC	A	Visual field examination(s)	0.00	0.86	0.93	NA	NA	0.01	XXX
92081	26	A	Visual field examination(s)	0.30	0.17	0.17	0.17	0.17	0.02	XXX
92082		A	Visual field examination(s)	0.40	1.51	1.55	NA	NA	0.05	XXX
92082	TC	A	Visual field examination(s)	0.00	1.28	1.34	NA	NA	0.01	XXX
92082	26	A	Visual field examination(s)	0.40	0.23	0.21	0.23	0.21	0.04	XXX
92083		A	Visual field examination(s)	0.50	2.06	1.95	NA	NA	0.04	XXX
92083	TC	A	Visual field examination(s)	0.00	1.74	1.67	NA	NA	0.01	XXX
92083	26	A	Visual field examination(s)	0.50	0.32	0.28	0.32	0.28	0.03	XXX
92100		A	Serial tonometry exam(s)	0.92	1.82	1.70	0.55	0.47	0.05	XXX
92120		A	Tonography & eye evaluation	0.81	1.40	1.32	0.47	0.41	0.05	XXX
92130		A	Water provocation tonography	0.81	1.67	1.57	0.51	0.45	0.04	XXX
92132		A	Cmptr ophth dx img ant segmt	0.35	0.68	0.68	NA	NA	0.04	XXX
92132	TC	A	Cmptr ophth dx img ant segmt	0.00	0.44	0.44	NA	NA	0.01	XXX
92132	26	A	Cmptr ophth dx img ant segmt	0.35	0.24	0.24	0.24	0.24	0.03	XXX
92133		A	Cmptr ophth img optic nerve	0.50	0.77	0.77	NA	NA	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92133	TC	A	Cmptr ophth img optic nerve	0.00	0.44	0.44	NA	NA	0.01	XXX
92133	26	A	Cmptr ophth img optic nerve	0.50	0.33	0.33	0.33	0.33	0.03	XXX
92134		A	Cptr ophth dx img post segmt	0.50	0.77	0.77	NA	NA	0.04	XXX
92134	TC	A	Cptr ophth dx img post segmt	0.00	0.44	0.44	NA	NA	0.01	XXX
92134	26	A	Cptr ophth dx img post segmt	0.50	0.33	0.33	0.33	0.33	0.03	XXX
92136		A	Ophthalmic biometry	0.54	1.95	1.88	NA	NA	0.02	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.57	1.56	NA	NA	0.01	XXX
92136	26	A	Ophthalmic biometry	0.54	0.38	0.32	0.38	0.32	0.01	XXX
92140		A	Glaucoma provocative tests	0.50	1.26	1.20	0.28	0.24	0.03	XXX
92225		A	Special eye exam initial	0.38	0.39	0.34	0.24	0.21	0.03	XXX
92226		A	Special eye exam subsequent	0.33	0.38	0.33	0.23	0.19	0.01	XXX
92227		A	Remote dx retinal imaging	0.00	0.33	0.33	NA	NA	0.01	XXX
92228		A	Remote retinal imaging mgmt	0.30	0.56	0.56	NA	NA	0.02	XXX
92228	TC	A	Remote retinal imaging mgmt	0.00	0.36	0.36	NA	NA	0.01	XXX
92228	26	A	Remote retinal imaging mgmt	0.30	0.20	0.20	0.20	0.20	0.01	XXX
92230		A	Eye exam with photos	0.60	1.01	1.06	0.36	0.31	0.04	XXX
92235		A	Eye exam with photos	0.81	3.10	3.00	NA	NA	0.04	XXX
92235	TC	A	Eye exam with photos	0.00	2.53	2.51	NA	NA	0.01	XXX
92235	26	A	Eye exam with photos	0.81	0.57	0.49	0.57	0.49	0.03	XXX
92240		A	Icg angiography	1.10	5.87	5.90	NA	NA	0.04	XXX
92240	TC	A	Icg angiography	0.00	5.10	5.23	NA	NA	0.01	XXX
92240	26	A	Icg angiography	1.10	0.77	0.67	0.77	0.67	0.03	XXX
92250		A	Eye exam with photos	0.44	1.74	1.70	NA	NA	0.02	XXX
92250	TC	A	Eye exam with photos	0.00	1.48	1.47	NA	NA	0.01	XXX
92250	26	A	Eye exam with photos	0.44	0.26	0.23	0.26	0.23	0.01	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.33	0.32	0.13	0.11	0.01	XXX
92265		A	Eye muscle evaluation	0.81	1.60	1.48	NA	NA	0.02	XXX
92265	TC	A	Eye muscle evaluation	0.00	1.03	1.04	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92265	26	A	Eye muscle evaluation	0.81	0.57	0.44	0.57	0.44	0.01	XXX
92270		A	Electro-oculography	0.81	1.73	1.73	NA	NA	0.04	XXX
92270	TC	A	Electro-oculography	0.00	1.34	1.37	NA	NA	0.01	XXX
92270	26	A	Electro-oculography	0.81	0.39	0.36	0.39	0.36	0.03	XXX
92275		A	Electroretinography	1.01	3.40	3.13	NA	NA	0.05	XXX
92275	TC	A	Electroretinography	0.00	2.70	2.53	NA	NA	0.01	XXX
92275	26	A	Electroretinography	1.01	0.70	0.60	0.70	0.60	0.04	XXX
92283		A	Color vision examination	0.17	1.32	1.25	NA	NA	0.02	XXX
92283	TC	A	Color vision examination	0.00	1.23	1.17	NA	NA	0.01	XXX
92283	26	A	Color vision examination	0.17	0.09	0.08	0.09	0.08	0.01	XXX
92284		A	Dark adaptation eye exam	0.24	1.40	1.49	NA	NA	0.02	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.29	1.39	NA	NA	0.01	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.11	0.10	0.11	0.10	0.01	XXX
92285		A	Eye photography	0.05	0.49	0.75	NA	NA	0.02	XXX
92285	TC	A	Eye photography	0.00	0.46	0.69	NA	NA	0.01	XXX
92285	26	A	Eye photography	0.05	0.03	0.06	0.03	0.06	0.01	XXX
92286		A	Internal eye photography	0.66	2.81	2.82	NA	NA	0.02	XXX
92286	TC	A	Internal eye photography	0.00	2.39	2.46	NA	NA	0.01	XXX
92286	26	A	Internal eye photography	0.66	0.42	0.36	0.42	0.36	0.01	XXX
92287		A	Internal eye photography	0.81	2.67	2.58	0.57	0.47	0.04	XXX
92310		N	Contact lens fitting	1.17	1.50	1.51	0.51	0.51	0.08	XXX
92311		A	Contact lens fitting	1.08	1.82	1.68	0.56	0.49	0.08	XXX
92312		A	Contact lens fitting	1.26	2.11	1.91	0.64	0.57	0.05	XXX
92313		A	Contact lens fitting	0.92	2.00	1.82	0.58	0.49	0.05	XXX
92314		N	Prescription of contact lens	0.69	1.52	1.50	0.30	0.30	0.04	XXX
92315		A	Prescription of contact lens	0.45	1.70	1.58	0.22	0.20	0.04	XXX
92316		A	Prescription of contact lens	0.68	2.32	2.05	0.48	0.39	0.04	XXX
92317		A	Prescription of contact lens	0.45	1.68	1.60	0.18	0.17	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92325		A	Modification of contact lens	0.00	1.07	0.98	NA	NA	0.01	XXX
92326		A	Replacement of contact lens	0.00	0.93	1.04	NA	NA	0.01	XXX
92340		N	Fitting of spectacles	0.37	0.61	0.65	0.16	0.16	0.03	XXX
92341		N	Fitting of spectacles	0.47	0.65	0.69	0.21	0.20	0.03	XXX
92342		N	Fitting of spectacles	0.53	0.68	0.72	0.23	0.23	0.04	XXX
92352		B	Special spectacles fitting	0.37	0.76	0.78	0.16	0.16	0.03	XXX
92353		B	Special spectacles fitting	0.50	0.81	0.84	0.22	0.21	0.03	XXX
92354		B	Special spectacles fitting	0.00	0.36	1.67	NA	NA	0.01	XXX
92355		B	Special spectacles fitting	0.00	0.56	1.16	NA	NA	0.01	XXX
92358		B	Eye prosthesis service	0.00	0.30	0.42	NA	NA	0.01	XXX
92370		N	Repair & adjust spectacles	0.32	0.54	0.56	0.14	0.14	0.03	XXX
92371		B	Repair & adjust spectacles	0.00	0.30	0.37	NA	NA	0.01	XXX
92499		C	Eye service or procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
92499	TC	C	Eye service or procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92502		A	Ear and throat examination	1.51	NA	NA	1.36	1.28	0.07	000
92504		A	Ear microscopy examination	0.18	0.70	0.70	0.11	0.10	0.01	XXX
92506		A	Speech/hearing evaluation	0.86	0.66	2.26	NA	NA	0.05	XXX
92507		A	Speech/hearing therapy	1.30	0.69	1.05	NA	NA	0.07	XXX
92508		A	Speech/hearing therapy	0.33	0.24	0.45	NA	NA	0.01	XXX
92511		A	Nasopharyngoscopy	0.84	3.84	3.85	0.95	0.90	0.04	XXX
92512		A	Nasal function studies	0.55	1.22	1.24	0.31	0.27	0.03	XXX
92516		A	Facial nerve function test	0.43	1.61	1.54	0.25	0.23	0.03	XXX
92520		A	Laryngeal function studies	0.75	1.38	1.21	0.49	0.42	0.04	XXX
92526		A	Oral function therapy	1.34	0.78	1.36	NA	NA	0.07	XXX
92531		B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92532		B	Positional nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92533		B	Caloric vestibular test	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92534		B	Optokinetic nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92540		A	Basic vestibular evaluation	1.50	1.31	1.31	NA	NA	0.05	XXX
92540	TC	A	Basic vestibular evaluation	0.00	0.54	0.54	NA	NA	0.01	XXX
92540	26	A	Basic vestibular evaluation	1.50	0.77	0.77	0.77	0.77	0.04	XXX
92541		A	Spontaneous nystagmus test	0.40	0.46	0.92	NA	NA	0.02	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	0.25	0.73	NA	NA	0.01	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.21	0.19	0.21	0.19	0.01	XXX
92542		A	Positional nystagmus test	0.33	0.42	0.99	NA	NA	0.02	XXX
92542	TC	A	Positional nystagmus test	0.00	0.25	0.83	NA	NA	0.01	XXX
92542	26	A	Positional nystagmus test	0.33	0.17	0.16	0.17	0.16	0.01	XXX
92543		A	Caloric vestibular test	0.10	0.30	0.54	NA	NA	0.02	XXX
92543	TC	A	Caloric vestibular test	0.00	0.25	0.49	NA	NA	0.01	XXX
92543	26	A	Caloric vestibular test	0.10	0.05	0.05	0.05	0.05	0.01	XXX
92544		A	Optokinetic nystagmus test	0.26	0.37	0.81	NA	NA	0.02	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.24	0.69	NA	NA	0.01	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.13	0.12	0.13	0.12	0.01	XXX
92545		A	Oscillating tracking test	0.23	0.36	0.77	NA	NA	0.02	XXX
92545	TC	A	Oscillating tracking test	0.00	0.24	0.66	NA	NA	0.01	XXX
92545	26	A	Oscillating tracking test	0.23	0.12	0.11	0.12	0.11	0.01	XXX
92546		A	Sinusoidal rotational test	0.29	2.60	2.47	NA	NA	0.02	XXX
92546	TC	A	Sinusoidal rotational test	0.00	2.46	2.34	NA	NA	0.01	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.14	0.13	0.14	0.13	0.01	XXX
92547		A	Supplemental electrical test	0.00	0.15	0.14	0.15	0.14	0.01	ZZZ
92548		A	Posturography	0.50	2.66	2.50	NA	NA	0.02	XXX
92548	TC	A	Posturography	0.00	2.40	2.26	NA	NA	0.01	XXX
92548	26	A	Posturography	0.50	0.26	0.24	0.26	0.24	0.01	XXX
92550		A	Tympanometry & reflex thresh	0.35	0.25	0.25	NA	NA	0.01	XXX
92551		N	Pure tone hearing test air	0.00	0.31	0.33	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92552		A	Pure tone audiometry air	0.00	0.82	0.75	NA	NA	0.01	XXX
92553		A	Audiometry air & bone	0.00	0.99	0.94	NA	NA	0.01	XXX
92555		A	Speech threshold audiometry	0.00	0.59	0.54	NA	NA	0.01	XXX
92556		A	Speech audiometry complete	0.00	0.93	0.85	NA	NA	0.01	XXX
92557		A	Comprehensive hearing test	0.60	0.47	0.56	0.33	0.45	0.03	XXX
92559		N	Group audiometric testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92560		N	Bekesy audiometry screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92561		A	Bekesy audiometry diagnosis	0.00	1.04	0.96	NA	NA	0.01	XXX
92562		A	Loudness balance test	0.00	1.13	0.93	NA	NA	0.01	XXX
92563		A	Tone decay hearing test	0.00	0.81	0.72	NA	NA	0.01	XXX
92564		A	Sisi hearing test	0.00	0.70	0.65	NA	NA	0.01	XXX
92565		A	Stenger test pure tone	0.00	0.37	0.38	NA	NA	0.01	XXX
92567		A	Tympanometry	0.20	0.20	0.24	0.11	0.16	0.01	XXX
92568		A	Acoustic refl threshold tst	0.29	0.16	0.19	0.16	0.18	0.01	XXX
92570		A	Acoustic immitance testing	0.55	0.36	0.36	0.30	0.30	0.03	XXX
92571		A	Filtered speech hearing test	0.00	0.65	0.58	NA	NA	0.01	XXX
92572		A	Staggered spondaic word test	0.00	1.28	0.93	NA	NA	0.01	XXX
92575		A	Sensorineural acuity test	0.00	1.74	1.45	NA	NA	0.01	XXX
92576		A	Synthetic sentence test	0.00	0.90	0.78	NA	NA	0.01	XXX
92577		A	Stenger test speech	0.00	0.44	0.47	NA	NA	0.01	XXX
92579		A	Visual audiometry (vra)	0.70	0.56	0.56	0.41	0.43	0.03	XXX
92582		A	Conditioning play audiometry	0.00	1.70	1.50	NA	NA	0.01	XXX
92583		A	Select picture audiometry	0.00	1.06	1.04	NA	NA	0.01	XXX
92584		A	Electrocochleography	0.00	1.89	1.96	NA	NA	0.01	XXX
92585		A	Auditor evoke potent compre	0.50	3.07	2.82	NA	NA	0.02	XXX
92585	TC	A	Auditor evoke potent compre	0.00	2.80	2.58	NA	NA	0.01	XXX
92585	26	A	Auditor evoke potent compre	0.50	0.27	0.24	0.27	0.24	0.01	XXX
92586		A	Auditor evoke potent limit	0.00	2.21	2.07	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92587		A	Evoked auditory test	0.13	0.87	0.94	NA	NA	0.02	XXX
92587	TC	A	Evoked auditory test	0.00	0.80	0.87	NA	NA	0.01	XXX
92587	26	A	Evoked auditory test	0.13	0.07	0.07	0.07	0.07	0.01	XXX
92588		A	Evoked auditory test	0.36	1.62	1.57	NA	NA	0.02	XXX
92588	TC	A	Evoked auditory test	0.00	1.42	1.39	NA	NA	0.01	XXX
92588	26	A	Evoked auditory test	0.36	0.20	0.18	0.20	0.18	0.01	XXX
92590		N	Hearing aid exam one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92591		N	Hearing aid exam both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92592		N	Hearing aid check one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92593		N	Hearing aid check both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92594		N	Electro hearng aid test one	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92595		N	Electro hearng aid tst both	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92596		A	Ear protector evaluation	0.00	1.23	1.16	NA	NA	0.01	XXX
92597		A	Oral speech device eval	1.26	0.81	1.55	NA	NA	0.07	XXX
92601		A	Cochlear implt f/up exam < 7	2.30	1.52	1.89	1.01	1.41	0.11	XXX
92602		A	Reprogram cochlear implt < 7	1.30	1.02	1.29	0.57	0.86	0.07	XXX
92603		A	Cochlear implt f/up exam 7 >	2.25	1.87	1.84	1.22	1.31	0.11	XXX
92604		A	Reprogram cochlear implt 7 >	1.25	1.22	1.19	0.68	0.75	0.05	XXX
92605		B	Eval for nonspeech device rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92606		B	Non-speech device service	1.40	0.93	0.93	0.62	0.62	0.01	XXX
92607		A	Ex for speech device rx 1hr	1.85	1.50	3.25	NA	NA	0.01	XXX
92608		A	Ex for speech device rx addl	0.70	0.67	0.80	NA	NA	0.01	ZZZ
92609		A	Use of speech device service	1.50	1.04	1.84	NA	NA	0.01	XXX
92610		A	Evaluate swallowing function	1.30	0.93	1.73	0.67	0.67	0.07	XXX
92611		A	Motion fluoroscopy/swallow	1.34	1.10	1.93	NA	NA	0.08	XXX
92612		A	Endoscopy swallow tst (fees)	1.27	3.62	3.59	0.72	0.67	0.07	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.40	0.38	0.39	0.38	0.04	XXX
92614		A	Laryngoscopic sensory test	1.27	3.10	3.05	0.74	0.68	0.07	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92615		A	Eval laryngoscopy sense tst	0.63	0.37	0.35	0.37	0.35	0.03	XXX
92616		A	Fees w/laryngeal sense test	1.88	3.98	3.96	1.05	0.97	0.10	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.44	0.41	0.44	0.41	0.04	XXX
92620		A	Auditory function 60 min	1.50	1.17	0.86	0.88	0.71	0.07	XXX
92621		A	Auditory function + 15 min	0.35	0.28	0.20	0.18	0.15	0.01	ZZZ
92625		A	Tinnitus assessment	1.15	0.84	0.66	0.62	0.55	0.05	XXX
92626		A	Eval aud rehab status	1.40	1.12	1.01	0.74	0.82	0.07	XXX
92627		A	Eval aud status rehab add-on	0.33	0.29	0.26	0.17	0.20	0.01	ZZZ
92630		I	Aud rehab pre-ling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92633		I	Aud rehab postling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92640		A	Aud brainstem implt programg	1.76	1.23	0.78	0.91	0.62	0.37	XXX
92700		C	Ent procedure/service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92950		A	Heart/lung resuscitation cpr	3.79	4.20	4.20	1.07	1.05	0.30	000
92953		A	Temporary external pacing	0.23	NA	NA	0.07	0.09	0.01	000
92960		A	Cardioversion electric ext	2.25	3.64	4.72	1.13	1.41	0.14	000
92961		A	Cardioversion electric int	4.59	NA	NA	2.04	2.48	0.43	000
92970		A	Cardioassist internal	3.51	NA	NA	1.36	1.52	0.24	000
92971		A	Cardioassist external	1.77	NA	NA	0.83	1.05	0.11	000
92973		A	Percut coronary thrombectomy	3.28	NA	NA	1.28	1.65	0.71	ZZZ
92974		A	Cath place cardio brachytx	3.00	NA	NA	1.17	1.51	0.65	ZZZ
92975		A	Dissolve clot heart vessel	7.24	NA	NA	2.89	3.64	1.58	000
92977		A	Dissolve clot heart vessel	0.00	1.44	2.70	NA	NA	0.03	XXX
92978		C	Intravasc us heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92978	TC	C	Intravasc us heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92978	26	A	Intravasc us heart add-on	1.80	0.70	0.90	0.70	0.90	0.12	ZZZ
92979		C	Intravasc us heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92979	TC	C	Intravasc us heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92979	26	A	Intravasc us heart add-on	1.44	0.56	0.73	0.56	0.73	0.10	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92980		A	Insert intracoronary stent	14.82	NA	NA	5.99	7.67	3.23	000
92981		A	Insert intracoronary stent	4.16	NA	NA	1.63	2.09	0.90	ZZZ
92982		A	Coronary artery dilation	10.96	NA	NA	4.47	5.72	2.38	000
92984		A	Coronary artery dilation	2.97	NA	NA	1.16	1.49	0.64	ZZZ
92986		A	Revision of aortic valve	22.85	NA	NA	11.73	14.64	4.97	090
92987		A	Revision of mitral valve	23.63	NA	NA	11.96	15.06	5.13	090
92990		A	Revision of pulmonary valve	18.27	NA	NA	9.76	11.85	3.98	090
92992		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92993		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92995		A	Coronary atherectomy	12.07	NA	NA	4.91	6.30	2.62	000
92996		A	Coronary atherectomy add-on	3.26	NA	NA	1.28	1.64	0.71	ZZZ
92997		A	Pul art balloon repr percut	11.98	NA	NA	4.83	5.63	2.61	000
92998		A	Pul art balloon repr percut	5.99	NA	NA	2.33	2.87	1.30	ZZZ
93000		A	Electrocardiogram complete	0.17	0.32	0.40	NA	NA	0.02	XXX
93005		A	Electrocardiogram tracing	0.00	0.25	0.32	NA	NA	0.01	XXX
93010		A	Electrocardiogram report	0.17	0.07	0.08	0.07	0.08	0.01	XXX
93015		A	Cardiovascular stress test	0.75	1.59	1.95	NA	NA	0.03	XXX
93016		A	Cardiovascular stress test	0.45	0.18	0.22	0.18	0.22	0.01	XXX
93017		A	Cardiovascular stress test	0.00	1.29	1.58	NA	NA	0.01	XXX
93018		A	Cardiovascular stress test	0.30	0.12	0.15	0.12	0.15	0.01	XXX
93024		A	Cardiac drug stress test	1.17	1.90	2.23	NA	NA	0.05	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.44	1.67	NA	NA	0.01	XXX
93024	26	A	Cardiac drug stress test	1.17	0.46	0.56	0.46	0.56	0.04	XXX
93025		A	Microvolt t-wave assess	0.75	3.69	4.91	NA	NA	0.04	XXX
93025	TC	A	Microvolt t-wave assess	0.00	3.39	4.54	NA	NA	0.01	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.30	0.37	0.30	0.37	0.03	XXX
93040		A	Rhythm ecg with report	0.15	0.19	0.22	NA	NA	0.02	XXX
93041		A	Rhythm ecg tracing	0.00	0.14	0.16	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93042		A	Rhythm ecg report	0.15	0.05	0.06	0.05	0.06	0.01	XXX
93224		A	Ecg monit/reprt up to 48 hrs	0.52	1.97	2.54	NA	NA	0.03	XXX
93225		A	Ecg monit/reprt up to 48 hrs	0.00	0.90	1.01	NA	NA	0.01	XXX
93226		A	Ecg monit/reprt up to 48 hrs	0.00	0.83	1.26	NA	NA	0.01	XXX
93227		A	Ecg monit/reprt up to 48 hrs	0.52	0.24	0.27	0.24	0.27	0.01	XXX
93228		A	Remote 30 day ecg rev/report	0.52	0.21	0.21	0.21	0.21	0.03	XXX
93229		A	Remote 30 day ecg tech supp	0.00	20.13	20.13	NA	NA	0.01	XXX
93268		A	Ecg record/review	0.52	5.69	6.85	NA	NA	0.03	XXX
93270		A	Remote 30 day ecg rev/report	0.00	0.24	0.44	NA	NA	0.01	XXX
93271		A	Ecg/monitoring and analysis	0.00	5.25	6.18	NA	NA	0.01	XXX
93272		A	Ecg/review interpret only	0.52	0.20	0.23	0.20	0.23	0.01	XXX
93278		A	Ecg/signal-averaged	0.25	0.61	0.77	NA	NA	0.02	XXX
93278	TC	A	Ecg/signal-averaged	0.00	0.50	0.65	NA	NA	0.01	XXX
93278	26	A	Ecg/signal-averaged	0.25	0.11	0.12	0.11	0.12	0.01	XXX
93279		A	Pm device progr eval sngl	0.65	0.71	0.87	NA	NA	0.04	XXX
93279	TC	A	Pm device progr eval sngl	0.00	0.45	0.54	NA	NA	0.01	XXX
93279	26	A	Pm device progr eval sngl	0.65	0.26	0.33	0.26	0.33	0.03	XXX
93280		A	Pm device progr eval dual	0.77	0.81	1.02	NA	NA	0.04	XXX
93280	TC	A	Pm device progr eval dual	0.00	0.51	0.62	NA	NA	0.01	XXX
93280	26	A	Pm device progr eval dual	0.77	0.30	0.40	0.30	0.40	0.03	XXX
93281		A	Pm device progr eval multi	0.90	0.94	1.19	NA	NA	0.04	XXX
93281	TC	A	Pm device progr eval multi	0.00	0.59	0.72	NA	NA	0.01	XXX
93281	26	A	Pm device progr eval multi	0.90	0.35	0.47	0.35	0.47	0.03	XXX
93282		A	Icd device prog eval 1 sngl	0.85	0.85	1.07	NA	NA	0.04	XXX
93282	TC	A	Icd device prog eval 1 sngl	0.00	0.52	0.64	NA	NA	0.01	XXX
93282	26	A	Icd device prog eval 1 sngl	0.85	0.33	0.43	0.33	0.43	0.03	XXX
93283		A	Icd device progr eval dual	1.15	1.05	1.31	NA	NA	0.05	XXX
93283	TC	A	Icd device progr eval dual	0.00	0.60	0.74	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93283	26	A	Icd device progr eval dual	1.15	0.45	0.57	0.45	0.57	0.04	XXX
93284		A	Icd device progr eval mult	1.25	1.18	1.50	NA	NA	0.05	XXX
93284	TC	A	Icd device progr eval mult	0.00	0.69	0.85	NA	NA	0.01	XXX
93284	26	A	Icd device progr eval mult	1.25	0.49	0.65	0.49	0.65	0.04	XXX
93285		A	Ilr device eval progr	0.52	0.61	0.76	NA	NA	0.02	XXX
93285	TC	A	Ilr device eval progr	0.00	0.40	0.49	NA	NA	0.01	XXX
93285	26	A	Ilr device eval progr	0.52	0.21	0.27	0.21	0.27	0.01	XXX
93286		A	Pre-op pm device eval	0.30	0.41	0.46	NA	NA	0.02	XXX
93286	TC	A	Pre-op pm device eval	0.00	0.29	0.34	NA	NA	0.01	XXX
93286	26	A	Pre-op pm device eval	0.30	0.12	0.12	0.12	0.12	0.01	XXX
93287		A	Pre-op icd device eval	0.45	0.50	0.56	NA	NA	0.02	XXX
93287	TC	A	Pre-op icd device eval	0.00	0.32	0.38	NA	NA	0.01	XXX
93287	26	A	Pre-op icd device eval	0.45	0.18	0.18	0.18	0.18	0.01	XXX
93288		A	Pm device eval in person	0.43	0.58	0.73	NA	NA	0.02	XXX
93288	TC	A	Pm device eval in person	0.00	0.41	0.50	NA	NA	0.01	XXX
93288	26	A	Pm device eval in person	0.43	0.17	0.23	0.17	0.23	0.01	XXX
93289		A	Icd device interrogate	0.92	0.86	1.05	NA	NA	0.04	XXX
93289	TC	A	Icd device interrogate	0.00	0.50	0.62	NA	NA	0.01	XXX
93289	26	A	Icd device interrogate	0.92	0.36	0.43	0.36	0.43	0.03	XXX
93290		A	Icm device eval	0.43	0.41	0.45	NA	NA	0.02	XXX
93290	TC	A	Icm device eval	0.00	0.24	0.28	NA	NA	0.01	XXX
93290	26	A	Icm device eval	0.43	0.17	0.17	0.17	0.17	0.01	XXX
93291		A	Ilr device interrogate	0.43	0.54	0.69	NA	NA	0.02	XXX
93291	TC	A	Ilr device interrogate	0.00	0.37	0.46	NA	NA	0.01	XXX
93291	26	A	Ilr device interrogate	0.43	0.17	0.23	0.17	0.23	0.01	XXX
93292		A	Wcd device interrogate	0.43	0.45	0.56	NA	NA	0.02	XXX
93292	TC	A	Wcd device interrogate	0.00	0.28	0.34	NA	NA	0.01	XXX
93292	26	A	Wcd device interrogate	0.43	0.17	0.22	0.17	0.22	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93293		A	Pm phone r-strip device eval	0.32	1.15	1.32	NA	NA	0.02	XXX
93293	TC	A	Pm phone r-strip device eval	0.00	1.03	1.18	NA	NA	0.01	XXX
93293	26	A	Pm phone r-strip device eval	0.32	0.12	0.14	0.12	0.14	0.01	XXX
93294		A	Pm device interrogate remote	0.65	0.26	0.34	0.26	0.34	0.04	XXX
93295		A	Icd device interrogat remote	1.29	0.51	0.64	0.51	0.64	0.08	XXX
93296		A	Pm/icd remote tech serv	0.00	0.70	0.96	NA	NA	0.01	XXX
93297		A	Icm device interrogat remote	0.52	0.20	0.21	0.20	0.21	0.03	XXX
93298		A	Ilr device interrogat remote	0.52	0.20	0.27	0.20	0.27	0.03	XXX
93299		C	Icm/ilr remote tech serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93303		A	Echo transthoracic	1.30	4.25	4.86	NA	NA	0.05	XXX
93303	TC	A	Echo transthoracic	0.00	3.72	4.25	NA	NA	0.01	XXX
93303	26	A	Echo transthoracic	1.30	0.53	0.61	0.53	0.61	0.04	XXX
93304		A	Echo transthoracic	0.75	2.87	3.17	NA	NA	0.04	XXX
93304	TC	A	Echo transthoracic	0.00	2.57	2.83	NA	NA	0.01	XXX
93304	26	A	Echo transthoracic	0.75	0.30	0.34	0.30	0.34	0.03	XXX
93306		A	Tte w/doppler complete	1.30	4.03	5.53	NA	NA	0.05	XXX
93306	TC	A	Tte w/doppler complete	0.00	3.51	4.87	NA	NA	0.01	XXX
93306	26	A	Tte w/doppler complete	1.30	0.52	0.66	0.52	0.66	0.04	XXX
93307		A	Tte w/o doppler complete	0.92	2.28	3.41	NA	NA	0.04	XXX
93307	TC	A	Tte w/o doppler complete	0.00	1.90	2.96	NA	NA	0.01	XXX
93307	26	A	Tte w/o doppler complete	0.92	0.38	0.45	0.38	0.45	0.03	XXX
93308		A	Tte f-up or lmtd	0.53	2.17	2.56	NA	NA	0.02	XXX
93308	TC	A	Tte f-up or lmtd	0.00	1.96	2.30	NA	NA	0.01	XXX
93308	26	A	Tte f-up or lmtd	0.53	0.21	0.26	0.21	0.26	0.01	XXX
93312		A	Echo transesophageal	2.20	6.60	7.26	NA	NA	0.10	XXX
93312	TC	A	Echo transesophageal	0.00	5.81	6.29	NA	NA	0.03	XXX
93312	26	A	Echo transesophageal	2.20	0.79	0.97	0.79	0.97	0.07	XXX
93313		A	Echo transesophageal	0.95	NA	NA	0.23	0.20	0.07	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93314		A	Echo transesophageal	1.25	6.61	7.10	NA	NA	0.07	XXX
93314	TC	A	Echo transesophageal	0.00	6.14	6.54	NA	NA	0.03	XXX
93314	26	A	Echo transesophageal	1.25	0.47	0.56	0.47	0.56	0.04	XXX
93315		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	26	A	Echo transesophageal	2.78	1.05	1.29	1.05	1.29	0.23	XXX
93316		A	Echo transesophageal	0.95	NA	NA	0.28	0.30	0.07	XXX
93317		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	26	A	Echo transesophageal	1.83	0.67	0.73	0.67	0.73	0.23	XXX
93318		C	Echo transesophageal intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
93318	TC	C	Echo transesophageal intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
93318	26	A	Echo transesophageal intraop	2.20	0.77	0.87	0.77	0.87	0.31	XXX
93320		A	Doppler echo exam heart	0.38	0.88	1.45	NA	NA	0.02	ZZZ
93320	TC	A	Doppler echo exam heart	0.00	0.73	1.27	NA	NA	0.01	ZZZ
93320	26	A	Doppler echo exam heart	0.38	0.15	0.18	0.15	0.18	0.01	ZZZ
93321		A	Doppler echo exam heart	0.15	0.51	0.70	NA	NA	0.02	ZZZ
93321	TC	A	Doppler echo exam heart	0.00	0.45	0.63	NA	NA	0.01	ZZZ
93321	26	A	Doppler echo exam heart	0.15	0.06	0.07	0.06	0.07	0.01	ZZZ
93325		A	Doppler color flow add-on	0.07	0.47	0.97	NA	NA	0.02	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	0.44	0.94	NA	NA	0.01	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.03	0.03	0.03	0.03	0.01	ZZZ
93350		A	Stress tte only	1.46	4.20	4.69	NA	NA	0.06	XXX
93350	TC	A	Stress tte only	0.00	3.62	3.96	NA	NA	0.01	XXX
93350	26	A	Stress tte only	1.46	0.58	0.73	0.58	0.73	0.05	XXX
93351		A	Stress tte complete	1.75	4.76	5.49	NA	NA	0.08	XXX
93351	TC	A	Stress tte complete	0.00	4.07	4.58	NA	NA	0.03	XXX
93351	26	A	Stress tte complete	1.75	0.69	0.91	0.69	0.91	0.05	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93352		A	Admin ecg contrast agent	0.19	0.72	0.87	NA	NA	0.01	ZZZ
93451		A	Right heart cath	2.72	19.21	19.21	NA	NA	0.61	000
93451	TC	A	Right heart cath	0.00	18.14	18.14	NA	NA	0.03	000
93451	26	A	Right heart cath	2.72	1.07	1.07	1.07	1.07	0.58	000
93452		A	Left hrt cath w/ventrclgrphy	4.75	19.19	19.19	NA	NA	1.09	000
93452	TC	A	Left hrt cath w/ventrclgrphy	0.00	17.33	17.33	NA	NA	0.04	000
93452	26	A	Left hrt cath w/ventrclgrphy	4.75	1.86	1.86	1.86	1.86	1.05	000
93453		A	R&l hrt cath w/ventriclgrphy	6.24	25.10	25.10	NA	NA	1.42	000
93453	TC	A	R&l hrt cath w/ventriclgrphy	0.00	22.66	22.66	NA	NA	0.05	000
93453	26	A	R&l hrt cath w/ventriclgrphy	6.24	2.44	2.44	2.44	2.44	1.37	000
93454		A	Coronary artery angio s&i	4.79	19.94	19.94	NA	NA	1.10	000
93454	TC	A	Coronary artery angio s&i	0.00	18.06	18.06	NA	NA	0.04	000
93454	26	A	Coronary artery angio s&i	4.79	1.88	1.88	1.88	1.88	1.06	000
93455		A	Coronary art/grft angio s&i	5.54	23.33	23.33	NA	NA	1.25	000
93455	TC	A	Coronary art/grft angio s&i	0.00	21.16	21.16	NA	NA	0.05	000
93455	26	A	Coronary art/grft angio s&i	5.54	2.17	2.17	2.17	2.17	1.20	000
93456		A	R hrt coronary artery angio	6.15	24.78	24.78	NA	NA	1.39	000
93456	TC	A	R hrt coronary artery angio	0.00	22.37	22.37	NA	NA	0.05	000
93456	26	A	R hrt coronary artery angio	6.15	2.41	2.41	2.41	2.41	1.34	000
93457		A	R hrt art/grft angio	6.89	28.18	28.18	NA	NA	1.54	000
93457	TC	A	R hrt art/grft angio	0.00	25.48	25.48	NA	NA	0.05	000
93457	26	A	R hrt art/grft angio	6.89	2.70	2.70	2.70	2.70	1.49	000
93458		A	L hrt artery/ventricle angio	5.85	23.97	23.97	NA	NA	1.33	000
93458	TC	A	L hrt artery/ventricle angio	0.00	21.68	21.68	NA	NA	0.05	000
93458	26	A	L hrt artery/ventricle angio	5.85	2.29	2.29	2.29	2.29	1.28	000
93459		A	L hrt art/grft angio	6.60	26.33	26.33	NA	NA	1.48	000
93459	TC	A	L hrt art/grft angio	0.00	23.75	23.75	NA	NA	0.05	000
93459	26	A	L hrt art/grft angio	6.60	2.58	2.58	2.58	2.58	1.43	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93460		A	R&l hrt art/ventricle angio	7.35	27.83	27.83	NA	NA	1.64	000
93460	TC	A	R&l hrt art/ventricle angio	0.00	24.95	24.95	NA	NA	0.05	000
93460	26	A	R&l hrt art/ventricle angio	7.35	2.88	2.88	2.88	2.88	1.59	000
93461		A	R&l hrt art/ventricle angio	8.10	32.26	32.26	NA	NA	1.83	000
93461	TC	A	R&l hrt art/ventricle angio	0.00	29.09	29.09	NA	NA	0.06	000
93461	26	A	R&l hrt art/ventricle angio	8.10	3.17	3.17	3.17	3.17	1.77	000
93462		A	L hrt cath trnsptl puncture	3.73	1.48	1.48	1.48	1.48	0.80	ZZZ
93463		A	Drug admin & hemodynmic meas	2.00	0.79	0.79	0.79	0.79	0.39	ZZZ
93464		A	Exercise w/hemodynamic meas	1.80	5.28	5.28	NA	NA	0.36	ZZZ
93464	TC	A	Exercise w/hemodynamic meas	0.00	4.63	4.63	NA	NA	0.01	ZZZ
93464	26	A	Exercise w/hemodynamic meas	1.80	0.65	0.65	0.65	0.65	0.35	ZZZ
93503		A	Insert/place heart catheter	2.91	NA	NA	0.77	0.77	0.27	000
93505		A	Biopsy of heart lining	4.37	17.43	18.46	NA	NA	0.86	000
93505	TC	A	Biopsy of heart lining	0.00	15.71	16.29	NA	NA	0.03	000
93505	26	A	Biopsy of heart lining	4.37	1.72	2.17	1.72	2.17	0.83	000
93530		C	Rt heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93530	TC	C	Rt heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93530	26	A	Rt heart cath congenital	4.22	1.68	2.06	1.68	2.06	0.91	000
93531		C	R & l heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93531	TC	C	R & l heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93531	26	A	R & l heart cath congenital	8.34	3.30	3.98	3.30	3.98	1.82	000
93532		C	R & l heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93532	TC	C	R & l heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93532	26	A	R & l heart cath congenital	9.99	3.89	4.64	3.89	4.64	2.17	000
93533		C	R & l heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93533	TC	C	R & l heart cath congenital	0.00	NA	NA	NA	NA	0.00	000
93533	26	A	R & l heart cath congenital	6.69	2.60	3.13	2.60	3.13	1.47	000
93561		C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93561	TC	C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93561	26	A	Cardiac output measurement	0.50	0.20	0.19	0.20	0.19	0.04	000
93562		C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93562	TC	C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93562	26	A	Cardiac output measurement	0.16	0.06	0.05	0.06	0.05	0.01	000
93563		A	Inject congenital card cath	1.11	0.44	0.44	0.44	0.44	0.10	ZZZ
93564		A	Inject hrt congntl art/grft	1.13	0.45	0.45	0.45	0.45	0.10	ZZZ
93565		A	Inject l ventr/atrial angio	0.86	0.34	0.34	0.34	0.34	0.08	ZZZ
93566		A	Inject r ventr/atrial angio	0.86	4.06	4.06	0.34	0.34	0.07	ZZZ
93567		A	Inject suprvlv aortography	0.97	3.08	3.08	0.38	0.38	0.08	ZZZ
93568		A	Inject pulm art hrt cath	0.88	3.56	3.56	0.35	0.35	0.08	ZZZ
93571		C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93571	TC	C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93571	26	A	Heart flow reserve measure	1.80	0.71	0.90	0.71	0.90	0.11	ZZZ
93572		C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93572	TC	C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93572	26	A	Heart flow reserve measure	1.44	0.56	0.70	0.56	0.70	0.11	ZZZ
93580		A	Transcath closure of asd	17.97	NA	NA	7.41	9.22	3.91	000
93581		A	Transcath closure of vsd	24.39	NA	NA	9.83	11.58	5.31	000
93600		C	Bundle of his recording	0.00	0.00	0.00	NA	NA	0.00	000
93600	TC	C	Bundle of his recording	0.00	0.00	0.00	NA	NA	0.00	000
93600	26	A	Bundle of his recording	2.12	0.84	1.05	0.84	1.05	0.45	000
93602		C	Intra-atrial recording	0.00	0.00	0.00	NA	NA	0.00	000
93602	TC	C	Intra-atrial recording	0.00	0.00	0.00	NA	NA	0.00	000
93602	26	A	Intra-atrial recording	2.12	0.83	1.03	0.83	1.03	0.45	000
93603		C	Right ventricular recording	0.00	0.00	0.00	NA	NA	0.00	000
93603	TC	C	Right ventricular recording	0.00	0.00	0.00	NA	NA	0.00	000
93603	26	A	Right ventricular recording	2.12	0.82	1.03	0.82	1.03	0.45	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93609		C	Map tachycardia add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93609	TC	C	Map tachycardia add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93609	26	A	Map tachycardia add-on	4.99	1.96	2.48	1.96	2.48	1.09	ZZZ
93610		C	Intra-atrial pacing	0.00	0.00	0.00	NA	NA	0.00	000
93610	TC	C	Intra-atrial pacing	0.00	0.00	0.00	NA	NA	0.00	000
93610	26	A	Intra-atrial pacing	3.02	1.17	1.46	1.17	1.46	0.65	000
93612		C	Intraventricular pacing	0.00	0.00	0.00	NA	NA	0.00	000
93612	TC	C	Intraventricular pacing	0.00	0.00	0.00	NA	NA	0.00	000
93612	26	A	Intraventricular pacing	3.02	1.16	1.44	1.16	1.44	0.65	000
93613		A	Electrophys map 3d add-on	6.99	NA	NA	2.74	3.50	1.52	ZZZ
93615		C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93615	TC	C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93615	26	A	Esophageal recording	0.99	0.39	0.48	0.39	0.48	0.05	000
93616		C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93616	TC	C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93616	26	A	Esophageal recording	1.49	0.35	0.39	0.35	0.39	0.11	000
93618		C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	TC	C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	26	A	Heart rhythm pacing	4.25	1.66	2.14	1.66	2.14	0.91	000
93619		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	26	A	Electrophysiology evaluation	7.31	2.86	3.72	2.86	3.72	1.59	000
93620		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	26	A	Electrophysiology evaluation	11.57	4.54	5.82	4.54	5.82	2.51	000
93621		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93621	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93621	26	A	Electrophysiology evaluation	2.10	0.82	1.05	0.82	1.05	0.45	ZZZ
93622		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93622	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93622	26	A	Electrophysiology evaluation	3.10	1.22	1.52	1.22	1.52	0.67	ZZZ
93623		C	Stimulation pacing heart	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93623	TC	C	Stimulation pacing heart	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93623	26	A	Stimulation pacing heart	2.85	1.12	1.42	1.12	1.42	0.62	ZZZ
93624		C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	TC	C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	26	A	Electrophysiologic study	4.80	1.87	2.44	NA	NA	1.05	000
93631		C	Heart pacing mapping	0.00	0.00	0.00	NA	NA	0.00	000
93631	TC	C	Heart pacing mapping	0.00	0.00	0.00	NA	NA	0.00	000
93631	26	A	Heart pacing mapping	7.59	2.77	3.08	2.77	3.08	1.81	000
93640		C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	TC	C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	26	A	Evaluation heart device	3.51	1.39	1.74	1.39	1.74	0.76	000
93641		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93641	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93641	26	A	Electrophysiology evaluation	5.92	2.32	2.95	2.32	2.95	1.29	000
93642		A	Electrophysiology evaluation	4.88	5.71	7.53	NA	NA	0.21	000
93642	TC	A	Electrophysiology evaluation	0.00	3.79	5.04	NA	NA	0.03	000
93642	26	A	Electrophysiology evaluation	4.88	1.92	2.49	1.92	2.49	0.18	000
93650		A	Ablate heart dysrhythm focus	10.49	NA	NA	4.39	5.54	2.27	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	NA	6.36	8.09	3.53	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	NA	6.95	8.82	3.84	000
93660		A	Tilt table evaluation	1.89	2.37	2.88	NA	NA	0.08	000
93660	TC	A	Tilt table evaluation	0.00	1.62	1.94	NA	NA	0.01	000
93660	26	A	Tilt table evaluation	1.89	0.75	0.94	0.75	0.94	0.07	000
93662		C	Intracardiac ecg (ice)	0.00	0.00	0.00	NA	NA	0.00	ZZZ

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93662	TC	C	Intracardiac ecg (ice)	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93662	26	A	Intracardiac ecg (ice)	2.80	1.09	1.39	1.09	1.39	0.20	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.51	0.54	NA	NA	0.01	XXX
93701		A	Bioimpedance cv analysis	0.00	0.65	0.78	NA	NA	0.01	XXX
93720		A	Total body plethysmography	0.17	1.23	1.25	NA	NA	0.02	XXX
93721		A	Plethysmography tracing	0.00	1.17	1.19	NA	NA	0.01	XXX
93722		A	Plethysmography report	0.17	0.06	0.06	0.06	0.06	0.01	XXX
93724		A	Analyze pacemaker system	4.88	2.67	3.78	NA	NA	0.19	000
93724	TC	A	Analyze pacemaker system	0.00	0.72	1.35	NA	NA	0.01	000
93724	26	A	Analyze pacemaker system	4.88	1.95	2.43	1.95	2.43	0.18	000
93740		B	Temperature gradient studies	0.16	0.07	0.07	NA	NA	0.02	XXX
93740	TC	B	Temperature gradient studies	0.00	0.00	0.04	NA	NA	0.01	XXX
93740	26	B	Temperature gradient studies	0.16	0.07	0.07	0.07	0.07	0.01	XXX
93745		C	Set-up cardiovert-defibrill	0.00	0.00	0.00	NA	NA	0.00	XXX
93745	TC	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	NA	NA	0.00	XXX
93745	26	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93750		A	Interrogation vad in person	0.92	0.54	0.54	0.34	0.34	0.05	XXX
93770		B	Measure venous pressure	0.16	0.07	0.07	NA	NA	0.02	XXX
93770	TC	B	Measure venous pressure	0.00	0.00	0.01	NA	NA	0.01	XXX
93770	26	B	Measure venous pressure	0.16	0.07	0.07	0.07	0.07	0.01	XXX
93784		A	Ambulatory bp monitoring	0.38	1.13	1.42	NA	NA	0.03	XXX
93786		A	Ambulatory bp recording	0.00	0.83	0.91	NA	NA	0.01	XXX
93788		A	Ambulatory bp analysis	0.00	0.14	0.34	NA	NA	0.01	XXX
93790		A	Review/report bp recording	0.38	0.16	0.17	0.16	0.17	0.01	XXX
93797		A	Cardiac rehab	0.18	0.30	0.34	0.08	0.09	0.01	000
93798		A	Cardiac rehab/monitor	0.28	0.41	0.47	0.12	0.14	0.01	000
93799		C	Cardiovascular procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
93799	TC	C	Cardiovascular procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93875		A	Extracranial study	0.22	2.75	2.88	NA	NA	0.02	XXX
93875	TC	A	Extracranial study	0.00	2.66	2.79	NA	NA	0.01	XXX
93875	26	A	Extracranial study	0.22	0.09	0.09	0.09	0.09	0.01	XXX
93880		A	Extracranial study	0.60	6.26	6.75	NA	NA	0.05	XXX
93880	TC	A	Extracranial study	0.00	6.03	6.50	NA	NA	0.01	XXX
93880	26	A	Extracranial study	0.60	0.23	0.25	0.23	0.25	0.04	XXX
93882		A	Extracranial study	0.40	4.58	4.67	NA	NA	0.06	XXX
93882	TC	A	Extracranial study	0.00	4.43	4.52	NA	NA	0.01	XXX
93882	26	A	Extracranial study	0.40	0.15	0.15	0.15	0.15	0.05	XXX
93886		A	Intracranial study	0.94	9.14	8.80	NA	NA	0.05	XXX
93886	TC	A	Intracranial study	0.00	8.72	8.40	NA	NA	0.01	XXX
93886	26	A	Intracranial study	0.94	0.42	0.40	0.42	0.40	0.04	XXX
93888		A	Intracranial study	0.62	5.38	5.56	NA	NA	0.05	XXX
93888	TC	A	Intracranial study	0.00	5.12	5.30	NA	NA	0.01	XXX
93888	26	A	Intracranial study	0.62	0.26	0.26	0.26	0.26	0.04	XXX
93890		A	Tcd vasoreactivity study	1.00	6.76	6.95	NA	NA	0.05	XXX
93890	TC	A	Tcd vasoreactivity study	0.00	6.34	6.54	NA	NA	0.01	XXX
93890	26	A	Tcd vasoreactivity study	1.00	0.42	0.41	0.42	0.41	0.04	XXX
93892		A	Tcd emboli detect w/o inj	1.15	8.65	8.24	NA	NA	0.06	XXX
93892	TC	A	Tcd emboli detect w/o inj	0.00	8.13	7.75	NA	NA	0.01	XXX
93892	26	A	Tcd emboli detect w/o inj	1.15	0.52	0.49	0.52	0.49	0.05	XXX
93893		A	Tcd emboli detect w/inj	1.15	9.49	8.65	NA	NA	0.06	XXX
93893	TC	A	Tcd emboli detect w/inj	0.00	8.97	8.15	NA	NA	0.01	XXX
93893	26	A	Tcd emboli detect w/inj	1.15	0.52	0.50	0.52	0.50	0.05	XXX
93922		A	Upr/l xtremity art 2 levels	0.25	2.39	2.99	NA	NA	0.02	XXX
93922	TC	A	Upr/l xtremity art 2 levels	0.00	2.29	2.89	NA	NA	0.01	XXX
93922	26	A	Upr/l xtremity art 2 levels	0.25	0.10	0.10	0.10	0.10	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93923		A	Upr/lxtr art stdy 3+ lvls	0.45	3.65	4.54	NA	NA	0.05	XXX
93923	TC	A	Upr/lxtr art stdy 3+ lvls	0.00	3.48	4.36	NA	NA	0.01	XXX
93923	26	A	Upr/lxtr art stdy 3+ lvls	0.45	0.17	0.18	0.17	0.18	0.04	XXX
93924		A	Lwr xtr vasc stdy bilat	0.50	4.72	5.76	NA	NA	0.05	XXX
93924	TC	A	Lwr xtr vasc stdy bilat	0.00	4.53	5.55	NA	NA	0.01	XXX
93924	26	A	Lwr xtr vasc stdy bilat	0.50	0.19	0.21	0.19	0.21	0.04	XXX
93925		A	Lower extremity study	0.58	8.12	8.70	NA	NA	0.07	XXX
93925	TC	A	Lower extremity study	0.00	7.90	8.47	NA	NA	0.03	XXX
93925	26	A	Lower extremity study	0.58	0.22	0.23	0.22	0.23	0.04	XXX
93926		A	Lower extremity study	0.39	5.37	5.63	NA	NA	0.06	XXX
93926	TC	A	Lower extremity study	0.00	5.23	5.48	NA	NA	0.01	XXX
93926	26	A	Lower extremity study	0.39	0.14	0.15	0.14	0.15	0.05	XXX
93930		A	Upper extremity study	0.46	6.49	6.87	NA	NA	0.05	XXX
93930	TC	A	Upper extremity study	0.00	6.32	6.68	NA	NA	0.01	XXX
93930	26	A	Upper extremity study	0.46	0.17	0.19	0.17	0.19	0.04	XXX
93931		A	Upper extremity study	0.31	4.31	4.58	NA	NA	0.04	XXX
93931	TC	A	Upper extremity study	0.00	4.20	4.46	NA	NA	0.01	XXX
93931	26	A	Upper extremity study	0.31	0.11	0.12	0.11	0.12	0.03	XXX
93965		A	Extremity study	0.35	3.12	3.35	NA	NA	0.04	XXX
93965	TC	A	Extremity study	0.00	2.99	3.21	NA	NA	0.01	XXX
93965	26	A	Extremity study	0.35	0.13	0.14	0.13	0.14	0.03	XXX
93970		A	Extremity study	0.68	6.49	6.87	NA	NA	0.08	XXX
93970	TC	A	Extremity study	0.00	6.24	6.60	NA	NA	0.01	XXX
93970	26	A	Extremity study	0.68	0.25	0.27	0.25	0.27	0.07	XXX
93971		A	Extremity study	0.45	4.23	4.51	NA	NA	0.05	XXX
93971	TC	A	Extremity study	0.00	4.06	4.33	NA	NA	0.01	XXX
93971	26	A	Extremity study	0.45	0.17	0.18	0.17	0.18	0.04	XXX
93975		A	Vascular study	1.80	8.57	9.27	NA	NA	0.17	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93975	TC	A	Vascular study	0.00	7.89	8.53	NA	NA	0.03	XXX
93975	26	A	Vascular study	1.80	0.68	0.74	0.68	0.74	0.14	XXX
93976		A	Vascular study	1.21	4.74	5.12	NA	NA	0.09	XXX
93976	TC	A	Vascular study	0.00	4.28	4.62	NA	NA	0.01	XXX
93976	26	A	Vascular study	1.21	0.46	0.50	0.46	0.50	0.08	XXX
93978		A	Vascular study	0.65	6.08	6.44	NA	NA	0.08	XXX
93978	TC	A	Vascular study	0.00	5.84	6.18	NA	NA	0.01	XXX
93978	26	A	Vascular study	0.65	0.24	0.26	0.24	0.26	0.07	XXX
93979		A	Vascular study	0.44	4.22	4.48	NA	NA	0.05	XXX
93979	TC	A	Vascular study	0.00	4.06	4.31	NA	NA	0.01	XXX
93979	26	A	Vascular study	0.44	0.16	0.17	0.16	0.17	0.04	XXX
93980		A	Penile vascular study	1.25	3.52	3.89	NA	NA	0.08	XXX
93980	TC	A	Penile vascular study	0.00	3.03	3.34	NA	NA	0.01	XXX
93980	26	A	Penile vascular study	1.25	0.49	0.55	0.49	0.55	0.07	XXX
93981		A	Penile vascular study	0.44	2.70	3.09	NA	NA	0.04	XXX
93981	TC	A	Penile vascular study	0.00	2.53	2.91	NA	NA	0.01	XXX
93981	26	A	Penile vascular study	0.44	0.17	0.18	0.17	0.18	0.03	XXX
93982		R	Aneurysm pressure sens study	0.30	0.87	0.92	NA	NA	0.05	XXX
93990		A	Doppler flow testing	0.25	5.89	5.92	NA	NA	0.05	XXX
93990	TC	A	Doppler flow testing	0.00	5.80	5.83	NA	NA	0.01	XXX
93990	26	A	Doppler flow testing	0.25	0.09	0.09	0.09	0.09	0.04	XXX
94002		A	Vent mgmt inpat init day	1.99	NA	NA	0.60	0.52	0.16	XXX
94003		A	Vent mgmt inpat subq day	1.37	NA	NA	0.50	0.45	0.10	XXX
94004		A	Vent mgmt nf per day	1.00	NA	NA	0.36	0.33	0.07	XXX
94005		B	Home vent mgmt supervision	1.50	1.10	1.10	NA	NA	0.10	XXX
94010		A	Breathing capacity test	0.17	0.83	0.85	NA	NA	0.02	XXX
94010	TC	A	Breathing capacity test	0.00	0.76	0.78	NA	NA	0.01	XXX
94010	26	A	Breathing capacity test	0.17	0.07	0.07	0.07	0.07	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
94011		A	Spirometry up to 2 yrs old	2.00	NA	NA	0.77	0.77	0.14	XXX
94012		A	Spirmtry w/brnchdil inf-2 yr	3.10	NA	NA	1.16	1.16	0.23	XXX
94013		A	Meas lung vol thru 2 yrs	0.66	NA	NA	0.22	0.22	0.04	XXX
94014		A	Patient recorded spirometry	0.52	0.84	0.91	NA	NA	0.02	XXX
94015		A	Patient recorded spirometry	0.00	0.65	0.72	NA	NA	0.01	XXX
94016		A	Review patient spirometry	0.52	0.19	0.19	0.19	0.19	0.01	XXX
94060		A	Evaluation of wheezing	0.31	1.44	1.47	NA	NA	0.02	XXX
94060	TC	A	Evaluation of wheezing	0.00	1.32	1.36	NA	NA	0.01	XXX
94060	26	A	Evaluation of wheezing	0.31	0.12	0.11	0.12	0.11	0.01	XXX
94070		A	Evaluation of wheezing	0.60	1.11	1.13	NA	NA	0.04	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.88	0.92	NA	NA	0.01	XXX
94070	26	A	Evaluation of wheezing	0.60	0.23	0.21	0.23	0.21	0.03	XXX
94150		B	Vital capacity test	0.07	0.61	0.63	NA	NA	0.02	XXX
94150	TC	B	Vital capacity test	0.00	0.58	0.60	NA	NA	0.01	XXX
94150	26	B	Vital capacity test	0.07	0.03	0.03	0.03	0.03	0.01	XXX
94200		A	Lung function test (mbc/mvv)	0.11	0.57	0.58	NA	NA	0.02	XXX
94200	TC	A	Lung function test (mbc/mvv)	0.00	0.53	0.54	NA	NA	0.01	XXX
94200	26	A	Lung function test (mbc/mvv)	0.11	0.04	0.04	0.04	0.04	0.01	XXX
94240		A	Residual lung capacity	0.26	0.86	0.90	NA	NA	0.02	XXX
94240	TC	A	Residual lung capacity	0.00	0.77	0.81	NA	NA	0.01	XXX
94240	26	A	Residual lung capacity	0.26	0.09	0.09	0.09	0.09	0.01	XXX
94250		A	Expired gas collection	0.11	0.57	0.62	NA	NA	0.02	XXX
94250	TC	A	Expired gas collection	0.00	0.53	0.58	NA	NA	0.01	XXX
94250	26	A	Expired gas collection	0.11	0.04	0.04	0.04	0.04	0.01	XXX
94260		A	Thoracic gas volume	0.13	0.78	0.81	NA	NA	0.02	XXX
94260	TC	A	Thoracic gas volume	0.00	0.73	0.77	NA	NA	0.01	XXX
94260	26	A	Thoracic gas volume	0.13	0.05	0.04	0.05	0.04	0.01	XXX
94350		A	Lung nitrogen washout curve	0.26	0.69	0.74	NA	NA	0.02	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.59	0.65	NA	NA	0.01	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.10	0.09	0.10	0.09	0.01	XXX
94360		A	Measure airflow resistance	0.26	1.00	1.03	NA	NA	0.02	XXX
94360	TC	A	Measure airflow resistance	0.00	0.91	0.94	NA	NA	0.01	XXX
94360	26	A	Measure airflow resistance	0.26	0.09	0.09	0.09	0.09	0.01	XXX
94370		A	Breath airway closing volume	0.26	0.69	0.73	NA	NA	0.02	XXX
94370	TC	A	Breath airway closing volume	0.00	0.59	0.64	NA	NA	0.01	XXX
94370	26	A	Breath airway closing volume	0.26	0.10	0.09	0.10	0.09	0.01	XXX
94375		A	Respiratory flow volume loop	0.31	0.78	0.81	NA	NA	0.02	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.66	0.70	NA	NA	0.01	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.12	0.11	0.12	0.11	0.01	XXX
94400		A	Co2 breathing response curve	0.40	1.14	1.17	NA	NA	0.02	XXX
94400	TC	A	Co2 breathing response curve	0.00	1.00	1.03	NA	NA	0.01	XXX
94400	26	A	Co2 breathing response curve	0.40	0.14	0.14	0.14	0.14	0.01	XXX
94450		A	Hypoxia response curve	0.40	1.48	1.33	NA	NA	0.02	XXX
94450	TC	A	Hypoxia response curve	0.00	1.31	1.18	NA	NA	0.01	XXX
94450	26	A	Hypoxia response curve	0.40	0.17	0.15	0.17	0.15	0.01	XXX
94452		A	Hast w/report	0.31	1.29	1.37	NA	NA	0.02	XXX
94452	TC	A	Hast w/report	0.00	1.18	1.27	NA	NA	0.01	XXX
94452	26	A	Hast w/report	0.31	0.11	0.10	0.11	0.10	0.01	XXX
94453		A	Hast w/oxygen titrate	0.40	1.78	1.87	NA	NA	0.02	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.64	1.73	NA	NA	0.01	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.14	0.14	0.14	0.14	0.01	XXX
94610		A	Surfactant admin thru tube	1.16	0.57	0.51	0.57	0.51	0.07	XXX
94620		A	Pulmonary stress test/simple	0.64	0.89	1.19	NA	NA	0.04	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	0.66	0.96	NA	NA	0.01	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.23	0.23	0.23	0.23	0.03	XXX
94621		A	Pulm stress test/complex	1.42	3.12	3.33	NA	NA	0.06	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
94621	TC	A	Pulm stress test/complex	0.00	2.59	2.77	NA	NA	0.01	XXX
94621	26	A	Pulm stress test/complex	1.42	0.53	0.56	0.53	0.56	0.05	XXX
94640		A	Airway inhalation treatment	0.00	0.49	0.46	NA	NA	0.01	XXX
94642		C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94644		A	Cbt 1st hour	0.00	1.22	1.17	NA	NA	0.01	XXX
94645		A	Cbt each addl hour	0.00	0.40	0.42	NA	NA	0.01	XXX
94660		A	Pos airway pressure cpap	0.76	0.96	0.94	0.30	0.27	0.05	XXX
94662		A	Neg press ventilation cnp	0.76	NA	NA	0.26	0.26	0.05	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.47	0.46	NA	NA	0.01	XXX
94667		A	Chest wall manipulation	0.00	0.67	0.66	NA	NA	0.01	XXX
94668		A	Chest wall manipulation	0.00	0.64	0.63	NA	NA	0.01	XXX
94680		A	Exhaled air analysis o2	0.26	1.36	1.45	NA	NA	0.02	XXX
94680	TC	A	Exhaled air analysis o2	0.00	1.25	1.35	NA	NA	0.01	XXX
94680	26	A	Exhaled air analysis o2	0.26	0.11	0.10	0.11	0.10	0.01	XXX
94681		A	Exhaled air analysis o2/co2	0.20	1.20	1.46	NA	NA	0.02	XXX
94681	TC	A	Exhaled air analysis o2/co2	0.00	1.12	1.39	NA	NA	0.01	XXX
94681	26	A	Exhaled air analysis o2/co2	0.20	0.08	0.07	0.08	0.07	0.01	XXX
94690		A	Exhaled air analysis	0.07	1.32	1.44	NA	NA	0.02	XXX
94690	TC	A	Exhaled air analysis	0.00	1.29	1.41	NA	NA	0.01	XXX
94690	26	A	Exhaled air analysis	0.07	0.03	0.03	0.03	0.03	0.01	XXX
94720		A	Monoxide diffusing capacity	0.26	1.19	1.27	NA	NA	0.02	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	1.10	1.18	NA	NA	0.01	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.09	0.09	0.09	0.09	0.01	XXX
94725		A	Membrane diffusion capacity	0.26	1.17	1.48	NA	NA	0.02	XXX
94725	TC	A	Membrane diffusion capacity	0.00	1.07	1.38	NA	NA	0.01	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.10	0.10	0.10	0.10	0.01	XXX
94750		A	Pulmonary compliance study	0.23	2.04	2.05	NA	NA	0.02	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.95	1.97	NA	NA	0.01	XXX
94750	26	A	Pulmonary compliance study	0.23	0.09	0.08	0.09	0.08	0.01	XXX
94760		T	Measure blood oxygen level	0.00	0.08	0.07	NA	NA	0.01	XXX
94761		T	Measure blood oxygen level	0.00	0.12	0.12	NA	NA	0.01	XXX
94762		A	Measure blood oxygen level	0.00	0.29	0.58	NA	NA	0.01	XXX
94770		A	Exhaled carbon dioxide test	0.15	0.07	0.50	0.07	0.50	0.02	XXX
94772		C	Breath recording infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	TC	C	Breath recording infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	26	C	Breath recording infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94774		C	Ped home apnea rec compl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94775		C	Ped home apnea rec hk-up	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94776		C	Ped home apnea rec downld	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94777		C	Ped home apnea rec report	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94799		C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.01	0.17	0.17	NA	NA	0.01	XXX
95010		A	Percut allergy titrate test	0.15	0.38	0.38	NA	NA	0.01	XXX
95012		A	Exhaled nitric oxide meas	0.00	0.55	0.60	NA	NA	0.01	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.29	0.26	0.07	0.07	0.01	XXX
95024		A	Id allergy test drug/bug	0.01	0.19	0.20	NA	NA	0.01	XXX
95027		A	Id allergy titrate-airborne	0.01	0.11	0.12	NA	NA	0.01	XXX
95028		A	Id allergy test-delayed type	0.00	0.38	0.37	NA	NA	0.01	XXX
95044		A	Allergy patch tests	0.00	0.15	0.17	NA	NA	0.01	XXX
95052		A	Photo patch test	0.00	0.17	0.20	NA	NA	0.01	XXX
95056		A	Photosensitivity tests	0.00	1.24	1.20	NA	NA	0.01	XXX
95060		A	Eye allergy tests	0.00	0.91	0.84	0.91	0.84	0.01	XXX
95065		A	Nose allergy test	0.00	0.72	0.71	0.72	0.71	0.01	XXX
95070		A	Bronchial allergy tests	0.00	0.81	1.11	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95071		A	Bronchial allergy tests	0.00	1.24	1.50	NA	NA	0.01	XXX
95075		A	Ingestion challenge test	0.95	0.91	0.91	0.44	0.42	0.04	XXX
95115		A	Immunotherapy one injection	0.00	0.26	0.29	NA	NA	0.01	XXX
95117		A	Immunotherapy injections	0.00	0.31	0.36	NA	NA	0.01	XXX
95120		I	Immunotherapy one injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95125		I	Immunotherapy many antigens	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95130		I	Immunotherapy insect venom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95131		I	Immunotherapy insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95132		I	Immunotherapy insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95133		I	Immunotherapy insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95134		I	Immunotherapy insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95144		A	Antigen therapy services	0.06	0.30	0.30	0.03	0.03	0.01	XXX
95145		A	Antigen therapy services	0.06	0.56	0.49	0.03	0.03	0.01	XXX
95146		A	Antigen therapy services	0.06	1.06	0.91	0.03	0.03	0.01	XXX
95147		A	Antigen therapy services	0.06	0.96	0.85	0.03	0.03	0.01	XXX
95148		A	Antigen therapy services	0.06	1.46	1.27	0.03	0.03	0.01	XXX
95149		A	Antigen therapy services	0.06	1.98	1.71	0.03	0.03	0.01	XXX
95165		A	Antigen therapy services	0.06	0.30	0.30	0.03	0.03	0.01	XXX
95170		A	Antigen therapy services	0.06	0.21	0.22	0.03	0.03	0.01	XXX
95180		A	Rapid desensitization	2.01	1.95	2.08	1.00	1.03	0.07	XXX
95199		C	Allergy immunology services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95250		A	Glucose monitoring cont	0.00	4.37	4.36	NA	NA	0.01	XXX
95251		A	Gluc monitor cont phys i&r	0.85	0.39	0.34	0.39	0.34	0.04	XXX
95800		A	Slp stdy unattended	1.05	37.51	37.51	NA	NA	0.05	XXX
95800	TC	A	Slp stdy unattended	0.00	36.89	36.89	NA	NA	0.01	XXX
95800	26	A	Slp stdy unattended	1.05	0.62	0.62	0.62	0.62	0.04	XXX
95801		A	Slp stdy unatnd w/anal	1.00	64.32	64.32	NA	NA	0.05	XXX
95801	TC	A	Slp stdy unatnd w/anal	0.00	63.85	63.85	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95801	26	A	Slp stdy unatnd w/anal	1.00	0.47	0.47	0.47	0.47	0.04	XXX
95803		A	Actigraphy testing	0.90	3.84	3.84	NA	NA	0.04	XXX
95803	TC	A	Actigraphy testing	0.00	3.40	3.40	NA	NA	0.01	XXX
95803	26	A	Actigraphy testing	0.90	0.44	0.44	0.44	0.44	0.03	XXX
95805		A	Multiple sleep latency test	1.20	10.18	10.84	NA	NA	0.08	XXX
95805	TC	A	Multiple sleep latency test	0.00	9.70	10.26	NA	NA	0.04	XXX
95805	26	A	Multiple sleep latency test	1.20	0.48	0.58	0.48	0.58	0.04	XXX
95806		A	Sleep study unatt&resp efft	1.25	3.50	4.05	NA	NA	0.08	XXX
95806	TC	A	Sleep study unatt&resp efft	0.00	3.01	3.50	NA	NA	0.03	XXX
95806	26	A	Sleep study unatt&resp efft	1.25	0.49	0.55	0.49	0.55	0.05	XXX
95807		A	Sleep study attended	1.28	10.80	12.45	NA	NA	0.15	XXX
95807	TC	A	Sleep study attended	0.00	10.33	11.92	NA	NA	0.10	XXX
95807	26	A	Sleep study attended	1.28	0.47	0.53	0.47	0.53	0.05	XXX
95808		A	Polysomnography 1-3	1.74	16.53	17.28	NA	NA	0.17	XXX
95808	TC	A	Polysomnography 1-3	0.00	15.80	16.44	NA	NA	0.10	XXX
95808	26	A	Polysomnography 1-3	1.74	0.73	0.84	0.73	0.84	0.07	XXX
95810		A	Polysomnography 4 or more	2.50	14.60	17.80	NA	NA	0.21	XXX
95810	TC	A	Polysomnography 4 or more	0.00	13.63	16.70	NA	NA	0.11	XXX
95810	26	A	Polysomnography 4 or more	2.50	0.97	1.10	0.97	1.10	0.10	XXX
95811		A	Polysomnography w/cpap	2.60	15.34	19.30	NA	NA	0.23	XXX
95811	TC	A	Polysomnography w/cpap	0.00	14.34	18.15	NA	NA	0.12	XXX
95811	26	A	Polysomnography w/cpap	2.60	1.00	1.15	1.00	1.15	0.11	XXX
95812		A	Eeg 41-60 minutes	1.08	9.79	8.16	NA	NA	0.07	XXX
95812	TC	A	Eeg 41-60 minutes	0.00	9.27	7.68	NA	NA	0.03	XXX
95812	26	A	Eeg 41-60 minutes	1.08	0.52	0.48	0.52	0.48	0.04	XXX
95813		A	Eeg over 1 hour	1.73	9.79	8.64	NA	NA	0.11	XXX
95813	TC	A	Eeg over 1 hour	0.00	8.99	7.90	NA	NA	0.04	XXX
95813	26	A	Eeg over 1 hour	1.73	0.80	0.74	0.80	0.74	0.07	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95816		A	Eeg awake and drowsy	1.08	9.02	7.46	NA	NA	0.08	XXX
95816	TC	A	Eeg awake and drowsy	0.00	8.50	6.98	NA	NA	0.03	XXX
95816	26	A	Eeg awake and drowsy	1.08	0.52	0.48	0.52	0.48	0.05	XXX
95819		A	Eeg awake and asleep	1.08	10.49	8.47	NA	NA	0.07	XXX
95819	TC	A	Eeg awake and asleep	0.00	9.97	7.99	NA	NA	0.03	XXX
95819	26	A	Eeg awake and asleep	1.08	0.52	0.48	0.52	0.48	0.04	XXX
95822		A	Eeg coma or sleep only	1.08	9.31	7.84	NA	NA	0.07	XXX
95822	TC	A	Eeg coma or sleep only	0.00	8.79	7.36	NA	NA	0.03	XXX
95822	26	A	Eeg coma or sleep only	1.08	0.52	0.48	0.52	0.48	0.04	XXX
95824		C	Eeg cerebral death only	0.00	0.00	0.00	NA	NA	0.00	XXX
95824	TC	C	Eeg cerebral death only	0.00	0.00	0.00	NA	NA	0.00	XXX
95824	26	A	Eeg cerebral death only	0.74	0.35	0.33	0.35	0.33	0.05	XXX
95827		A	Eeg all night recording	1.08	19.36	15.31	NA	NA	0.13	XXX
95827	TC	A	Eeg all night recording	0.00	18.83	14.84	NA	NA	0.08	XXX
95827	26	A	Eeg all night recording	1.08	0.53	0.47	0.53	0.47	0.05	XXX
95829		A	Surgery electrocorticogram	6.20	42.66	37.71	NA	NA	0.21	XXX
95829	TC	A	Surgery electrocorticogram	0.00	39.65	34.96	NA	NA	0.05	XXX
95829	26	A	Surgery electrocorticogram	6.20	3.01	2.75	3.01	2.75	0.16	XXX
95830		A	Insert electrodes for eeg	1.70	3.87	3.79	0.75	0.71	0.14	XXX
95831		A	Limb muscle testing manual	0.28	0.57	0.54	0.14	0.13	0.03	XXX
95832		A	Hand muscle testing manual	0.29	0.57	0.50	0.17	0.14	0.03	XXX
95833		A	Body muscle testing manual	0.47	0.61	0.60	0.16	0.18	0.01	XXX
95834		A	Body muscle testing manual	0.60	0.82	0.73	0.26	0.25	0.03	XXX
95851		A	Range of motion measurements	0.16	0.35	0.34	0.06	0.06	0.01	XXX
95852		A	Range of motion measurements	0.11	0.35	0.32	0.05	0.05	0.01	XXX
95857		A	Cholinesterase challenge	0.53	0.92	0.82	0.30	0.27	0.04	XXX
95860		A	Muscle test one limb	0.96	1.84	1.67	NA	NA	0.04	XXX
95860	TC	A	Muscle test one limb	0.00	1.34	1.20	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95860	26	A	Muscle test one limb	0.96	0.50	0.47	0.50	0.47	0.03	XXX
95861		A	Muscle test 2 limbs	1.54	2.60	2.26	NA	NA	0.06	XXX
95861	TC	A	Muscle test 2 limbs	0.00	1.80	1.52	NA	NA	0.01	XXX
95861	26	A	Muscle test 2 limbs	1.54	0.80	0.74	0.80	0.74	0.05	XXX
95863		A	Muscle test 3 limbs	1.87	3.17	2.73	NA	NA	0.08	XXX
95863	TC	A	Muscle test 3 limbs	0.00	2.23	1.86	NA	NA	0.01	XXX
95863	26	A	Muscle test 3 limbs	1.87	0.94	0.87	0.94	0.87	0.07	XXX
95864		A	Muscle test 4 limbs	1.99	3.35	3.06	NA	NA	0.08	XXX
95864	TC	A	Muscle test 4 limbs	0.00	2.35	2.13	NA	NA	0.01	XXX
95864	26	A	Muscle test 4 limbs	1.99	1.00	0.93	1.00	0.93	0.07	XXX
95865		A	Muscle test larynx	1.57	2.06	1.90	NA	NA	0.05	XXX
95865	TC	A	Muscle test larynx	0.00	1.22	1.12	NA	NA	0.01	XXX
95865	26	A	Muscle test larynx	1.57	0.84	0.78	0.84	0.78	0.04	XXX
95866		A	Muscle test hemidiaphragm	1.25	2.03	1.75	NA	NA	0.06	XXX
95866	TC	A	Muscle test hemidiaphragm	0.00	1.42	1.16	NA	NA	0.01	XXX
95866	26	A	Muscle test hemidiaphragm	1.25	0.61	0.59	0.61	0.59	0.05	XXX
95867		A	Muscle test cran nerv unilat	0.79	1.74	1.54	NA	NA	0.04	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	1.33	1.16	NA	NA	0.01	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.41	0.38	0.41	0.38	0.03	XXX
95868		A	Muscle test cran nerve bilat	1.18	2.26	1.98	NA	NA	0.05	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	1.66	1.43	NA	NA	0.01	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.60	0.55	0.60	0.55	0.04	XXX
95869		A	Muscle test thor paraspinal	0.37	1.63	1.34	NA	NA	0.02	XXX
95869	TC	A	Muscle test thor paraspinal	0.00	1.44	1.16	NA	NA	0.01	XXX
95869	26	A	Muscle test thor paraspinal	0.37	0.19	0.18	0.19	0.18	0.01	XXX
95870		A	Muscle test nonparaspinal	0.37	1.60	1.29	NA	NA	0.02	XXX
95870	TC	A	Muscle test nonparaspinal	0.00	1.41	1.12	NA	NA	0.01	XXX
95870	26	A	Muscle test nonparaspinal	0.37	0.19	0.17	0.19	0.17	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95872		A	Muscle test one fiber	2.88	2.58	2.25	NA	NA	0.12	XXX
95872	TC	A	Muscle test one fiber	0.00	1.20	1.03	NA	NA	0.01	XXX
95872	26	A	Muscle test one fiber	2.88	1.38	1.22	1.38	1.22	0.11	XXX
95873		A	Guide nerv destr elec stim	0.37	1.61	1.34	NA	NA	0.02	ZZZ
95873	TC	A	Guide nerv destr elec stim	0.00	1.40	1.13	NA	NA	0.01	ZZZ
95873	26	A	Guide nerv destr elec stim	0.37	0.21	0.21	0.21	0.21	0.01	ZZZ
95874		A	Guide nerv destr needle emg	0.37	1.54	1.25	NA	NA	0.02	ZZZ
95874	TC	A	Guide nerv destr needle emg	0.00	1.34	1.07	NA	NA	0.01	ZZZ
95874	26	A	Guide nerv destr needle emg	0.37	0.20	0.18	0.20	0.18	0.01	ZZZ
95875		A	Limb exercise test	1.10	2.22	1.94	NA	NA	0.06	XXX
95875	TC	A	Limb exercise test	0.00	1.69	1.44	NA	NA	0.01	XXX
95875	26	A	Limb exercise test	1.10	0.53	0.50	0.53	0.50	0.05	XXX
95900		A	Motor nerve conduction test	0.42	1.45	1.33	NA	NA	0.02	XXX
95900	TC	A	Motor nerve conduction test	0.00	1.23	1.13	NA	NA	0.01	XXX
95900	26	A	Motor nerve conduction test	0.42	0.22	0.20	0.22	0.20	0.01	XXX
95903		A	Motor nerve conduction test	0.60	1.54	1.42	NA	NA	0.04	XXX
95903	TC	A	Motor nerve conduction test	0.00	1.25	1.15	NA	NA	0.01	XXX
95903	26	A	Motor nerve conduction test	0.60	0.29	0.27	0.29	0.27	0.03	XXX
95904		A	Sense nerve conduction test	0.34	1.29	1.20	NA	NA	0.02	XXX
95904	TC	A	Sense nerve conduction test	0.00	1.12	1.04	NA	NA	0.01	XXX
95904	26	A	Sense nerve conduction test	0.34	0.17	0.16	0.17	0.16	0.01	XXX
95905		A	Motor/sens nrve conduct test	0.05	2.42	2.42	NA	NA	0.02	XXX
95905	TC	A	Motor/sens nrve conduct test	0.00	2.39	2.39	NA	NA	0.01	XXX
95905	26	A	Motor/sens nrve conduct test	0.05	0.03	0.03	0.03	0.03	0.01	XXX
95920		A	Intraop nerve test add-on	2.11	2.70	2.47	NA	NA	0.09	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.67	1.52	NA	NA	0.01	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	1.03	0.95	1.03	0.95	0.08	ZZZ
95921		A	Autonomic nerv function test	0.90	1.53	1.41	NA	NA	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95921	TC	A	Autonomic nerv function test	0.00	1.12	1.03	NA	NA	0.01	XXX
95921	26	A	Autonomic nerv function test	0.90	0.41	0.38	0.41	0.38	0.03	XXX
95922		A	Autonomic nerv function test	0.96	2.10	1.90	NA	NA	0.04	XXX
95922	TC	A	Autonomic nerv function test	0.00	1.66	1.49	NA	NA	0.01	XXX
95922	26	A	Autonomic nerv function test	0.96	0.44	0.41	0.44	0.41	0.03	XXX
95923		A	Autonomic nerv function test	0.90	3.93	3.33	NA	NA	0.05	XXX
95923	TC	A	Autonomic nerv function test	0.00	3.49	2.92	NA	NA	0.01	XXX
95923	26	A	Autonomic nerv function test	0.90	0.44	0.41	0.44	0.41	0.04	XXX
95925		A	Somatosensory testing	0.54	4.94	4.07	NA	NA	0.02	XXX
95925	TC	A	Somatosensory testing	0.00	4.68	3.83	NA	NA	0.01	XXX
95925	26	A	Somatosensory testing	0.54	0.26	0.24	0.26	0.24	0.01	XXX
95926		A	Somatosensory testing	0.54	4.66	3.90	NA	NA	0.04	XXX
95926	TC	A	Somatosensory testing	0.00	4.41	3.66	NA	NA	0.01	XXX
95926	26	A	Somatosensory testing	0.54	0.25	0.24	0.25	0.24	0.03	XXX
95927		A	Somatosensory testing	0.54	4.06	3.64	NA	NA	0.02	XXX
95927	TC	A	Somatosensory testing	0.00	3.80	3.39	NA	NA	0.01	XXX
95927	26	A	Somatosensory testing	0.54	0.26	0.25	0.26	0.25	0.01	XXX
95928		A	C motor evoked uppr limbs	1.50	6.24	5.31	NA	NA	0.10	XXX
95928	TC	A	C motor evoked uppr limbs	0.00	5.51	4.64	NA	NA	0.03	XXX
95928	26	A	C motor evoked uppr limbs	1.50	0.73	0.67	0.73	0.67	0.07	XXX
95929		A	C motor evoked lwr limbs	1.50	6.70	5.71	NA	NA	0.10	XXX
95929	TC	A	C motor evoked lwr limbs	0.00	5.97	5.04	NA	NA	0.03	XXX
95929	26	A	C motor evoked lwr limbs	1.50	0.73	0.67	0.73	0.67	0.07	XXX
95930		A	Visual evoked potential test	0.35	4.10	3.56	NA	NA	0.02	XXX
95930	TC	A	Visual evoked potential test	0.00	3.92	3.40	NA	NA	0.01	XXX
95930	26	A	Visual evoked potential test	0.35	0.18	0.16	0.18	0.16	0.01	XXX
95933		A	Blink reflex test	0.59	1.79	1.56	NA	NA	0.04	XXX
95933	TC	A	Blink reflex test	0.00	1.49	1.29	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95933	26	A	Blink reflex test	0.59	0.30	0.27	0.30	0.27	0.03	XXX
95934		A	H-reflex test	0.51	1.31	1.13	NA	NA	0.02	XXX
95934	TC	A	H-reflex test	0.00	1.06	0.89	NA	NA	0.01	XXX
95934	26	A	H-reflex test	0.51	0.25	0.24	0.25	0.24	0.01	XXX
95936		A	H-reflex test	0.55	0.90	0.80	NA	NA	0.02	XXX
95936	TC	A	H-reflex test	0.00	0.63	0.55	NA	NA	0.01	XXX
95936	26	A	H-reflex test	0.55	0.27	0.25	0.27	0.25	0.01	XXX
95937		A	Neuromuscular junction test	0.65	1.40	1.20	NA	NA	0.05	XXX
95937	TC	A	Neuromuscular junction test	0.00	1.08	0.91	NA	NA	0.01	XXX
95937	26	A	Neuromuscular junction test	0.65	0.32	0.29	0.32	0.29	0.04	XXX
95950		A	Ambulatory eeg monitoring	1.51	7.13	6.38	NA	NA	0.10	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	6.40	5.71	NA	NA	0.03	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.73	0.67	0.73	0.67	0.07	XXX
95951		C	Eeg monitoring/videorecord	0.00	0.00	0.00	NA	NA	0.00	XXX
95951	TC	C	Eeg monitoring/videorecord	0.00	0.00	0.00	NA	NA	0.00	XXX
95951	26	A	Eeg monitoring/videorecord	5.99	2.91	2.67	2.91	2.67	0.48	XXX
95953		A	Eeg monitoring/computer	3.08	9.05	8.93	NA	NA	0.18	XXX
95953	TC	A	Eeg monitoring/computer	0.00	7.55	7.53	NA	NA	0.03	XXX
95953	26	A	Eeg monitoring/computer	3.08	1.50	1.40	1.50	1.40	0.15	XXX
95954		A	Eeg monitoring/giving drugs	2.45	8.00	6.55	NA	NA	0.15	XXX
95954	TC	A	Eeg monitoring/giving drugs	0.00	7.11	5.76	NA	NA	0.04	XXX
95954	26	A	Eeg monitoring/giving drugs	2.45	0.89	0.79	0.89	0.79	0.11	XXX
95955		A	Eeg during surgery	1.01	4.63	3.90	NA	NA	0.05	XXX
95955	TC	A	Eeg during surgery	0.00	4.15	3.47	NA	NA	0.01	XXX
95955	26	A	Eeg during surgery	1.01	0.48	0.43	0.48	0.43	0.04	XXX
95956		A	Eeg monitor technol attended	3.61	32.20	25.89	NA	NA	0.32	XXX
95956	TC	A	Eeg monitor technol attended	0.00	30.54	24.44	NA	NA	0.16	XXX
95956	26	A	Eeg monitor technol attended	3.61	1.66	1.45	1.66	1.45	0.16	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95957		A	Eeg digital analysis	1.98	9.75	7.92	NA	NA	0.11	XXX
95957	TC	A	Eeg digital analysis	0.00	8.80	7.04	NA	NA	0.01	XXX
95957	26	A	Eeg digital analysis	1.98	0.95	0.88	0.95	0.88	0.10	XXX
95958		A	Eeg monitoring/function test	4.24	10.48	8.89	NA	NA	0.26	XXX
95958	TC	A	Eeg monitoring/function test	0.00	8.51	7.04	NA	NA	0.04	XXX
95958	26	A	Eeg monitoring/function test	4.24	1.97	1.85	1.97	1.85	0.22	XXX
95961		A	Electrode stimulation brain	2.97	5.00	4.29	NA	NA	0.15	XXX
95961	TC	A	Electrode stimulation brain	0.00	3.52	2.92	NA	NA	0.01	XXX
95961	26	A	Electrode stimulation brain	2.97	1.48	1.37	1.48	1.37	0.14	XXX
95962		A	Electrode stim brain add-on	3.21	3.78	3.31	NA	NA	0.15	ZZZ
95962	TC	A	Electrode stim brain add-on	0.00	2.20	1.87	NA	NA	0.01	ZZZ
95962	26	A	Electrode stim brain add-on	3.21	1.58	1.44	1.58	1.44	0.14	ZZZ
95965		C	Meg spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	TC	C	Meg spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	26	A	Meg spontaneous	7.99	3.90	3.71	3.90	3.71	0.64	XXX
95966		C	Meg evoked single	0.00	0.00	0.00	NA	NA	0.00	XXX
95966	TC	C	Meg evoked single	0.00	0.00	0.00	NA	NA	0.00	XXX
95966	26	A	Meg evoked single	3.99	1.95	1.86	1.95	1.86	0.31	XXX
95967		C	Meg evoked each addl	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	TC	C	Meg evoked each addl	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	26	A	Meg evoked each addl	3.49	1.70	1.56	1.70	1.56	0.29	ZZZ
95970		A	Analyze neurostim no prog	0.45	1.41	1.25	0.21	0.19	0.04	XXX
95971		A	Analyze neurostim simple	0.78	0.82	0.85	0.34	0.33	0.07	XXX
95972		A	Analyze neurostim complex	1.50	1.56	1.49	0.70	0.64	0.14	XXX
95973		A	Analyze neurostim complex	0.92	0.86	0.76	0.46	0.39	0.08	ZZZ
95974		A	Cranial neurostim complex	3.00	2.50	2.19	1.41	1.29	0.26	XXX
95975		A	Cranial neurostim complex	1.70	1.28	1.12	0.83	0.75	0.12	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	3.11	2.72	1.73	1.56	0.38	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
95979		A	Analyz neurostim brain addon	1.64	1.25	1.10	0.81	0.74	0.14	ZZZ
95980		A	Io anal gast n-stim init	0.80	NA	NA	0.44	0.37	0.16	XXX
95981		A	Io anal gast n-stim subsq	0.30	0.60	0.57	0.20	0.18	0.03	XXX
95982		A	Io ga n-stim subsq w/reprog	0.65	0.81	0.71	0.36	0.31	0.05	XXX
95990		A	Spin/brain pump refil & main	0.00	2.48	2.20	NA	NA	0.03	XXX
95991		A	Spin/brain pump refil & main	0.77	2.64	2.29	0.36	0.29	0.05	XXX
95992		A	Canalith repositioning proc	0.75	0.46	0.45	0.33	0.32	0.05	XXX
95999		C	Neurological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96000		A	Motion analysis video/3d	1.80	NA	NA	0.93	0.77	0.11	XXX
96001		A	Motion test w/ft press meas	2.15	NA	NA	0.65	0.68	0.12	XXX
96002		A	Dynamic surface emg	0.41	NA	NA	0.21	0.18	0.03	XXX
96003		A	Dynamic fine wire emg	0.37	NA	NA	0.18	0.15	0.03	XXX
96004		A	Phys review of motion tests	2.14	1.03	1.00	1.03	1.00	0.14	XXX
96020		C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	TC	C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	26	A	Functional brain mapping	3.43	1.28	1.46	1.28	1.46	0.31	XXX
96040		B	Genetic counseling 30 min	0.00	1.23	1.29	NA	NA	0.03	XXX
96101		A	Psycho testing by psych/phys	1.86	0.49	0.51	0.29	0.40	0.07	XXX
96102		A	Psycho testing by technician	0.50	1.74	1.43	0.17	0.16	0.03	XXX
96103		A	Psycho testing admin by comp	0.51	1.30	1.12	0.19	0.18	0.03	XXX
96105		A	Assessment of aphasia	1.75	0.17	1.21	NA	NA	0.04	XXX
96110		A	Developmental test lim	0.00	0.24	0.23	NA	NA	0.01	XXX
96111		A	Developmental test extend	2.60	0.84	0.93	0.67	0.79	0.16	XXX
96116		A	Neurobehavioral status exam	1.86	0.70	0.73	0.55	0.56	0.10	XXX
96118		A	Neuropsych tst by psych/phys	1.86	0.69	0.93	0.26	0.38	0.07	XXX
96119		A	Neuropsych testing by tec	0.55	1.39	1.51	0.09	0.13	0.01	XXX
96120		A	Neuropsych tst admin w/comp	0.51	2.08	1.88	0.18	0.17	0.03	XXX
96125		A	Cognitive test by hc pro	1.70	1.04	1.00	NA	NA	0.07	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
96150		A	Assess hlth/behave init	0.50	0.07	0.11	0.07	0.10	0.01	XXX
96151		A	Assess hlth/behave subseq	0.48	0.08	0.11	0.07	0.10	0.01	XXX
96152		A	Intervene hlth/behave indiv	0.46	0.07	0.10	0.06	0.09	0.01	XXX
96153		A	Intervene hlth/behave group	0.10	0.02	0.03	0.02	0.02	0.01	XXX
96154		A	Interv hlth/behav fam w/pt	0.45	0.07	0.10	0.06	0.09	0.01	XXX
96155		N	Interv hlth/behav fam no pt	0.44	0.20	0.20	0.19	0.19	0.03	XXX
96360		A	Hydration iv infusion init	0.17	1.34	1.48	NA	NA	0.03	XXX
96361		A	Hydrate iv infusion add-on	0.09	0.31	0.36	NA	NA	0.01	ZZZ
96365		A	Ther/proph/diag iv inf init	0.21	1.71	1.86	NA	NA	0.03	XXX
96366		A	Ther/proph/diag iv inf addon	0.18	0.42	0.45	NA	NA	0.01	ZZZ
96367		A	Tx/proph/dg addl seq iv inf	0.19	0.66	0.77	NA	NA	0.01	ZZZ
96368		A	Ther/diag concurrent inf	0.17	0.35	0.40	NA	NA	0.01	ZZZ
96369		A	Sc ther infusion up to 1 hr	0.21	4.84	4.81	NA	NA	0.03	XXX
96370		A	Sc ther infusion addl hr	0.18	0.26	0.26	NA	NA	0.01	ZZZ
96371		A	Sc ther infusion reset pump	0.00	2.25	2.35	NA	NA	0.01	ZZZ
96372		A	Ther/proph/diag inj sc/im	0.17	0.50	0.50	NA	NA	0.01	XXX
96373		A	Ther/proph/diag inj ia	0.17	0.38	0.38	NA	NA	0.01	XXX
96374		A	Ther/proph/diag inj iv push	0.18	1.29	1.44	NA	NA	0.03	XXX
96375		A	Tx/pro/dx inj new drug addon	0.10	0.49	0.56	NA	NA	0.01	ZZZ
96376		X	Tx/pro/dx inj same drug adon	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
96379		C	Ther/prop/diag inj/inf proc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96401		A	Chemo anti-neopl sq/im	0.21	1.77	1.90	NA	NA	0.04	XXX
96402		A	Chemo hormon antineopl sq/im	0.19	0.67	0.84	NA	NA	0.01	XXX
96405		A	Chemo intralesional up to 7	0.52	1.79	1.99	0.37	0.34	0.03	000
96406		A	Chemo intralesional over 7	0.80	2.36	2.65	0.51	0.46	0.04	000
96409		A	Chemo iv push sngl drug	0.24	2.65	3.04	NA	NA	0.05	XXX
96411		A	Chemo iv push addl drug	0.20	1.42	1.64	NA	NA	0.03	ZZZ
96413		A	Chemo iv infusion 1 hr	0.28	3.44	4.00	NA	NA	0.05	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
96415		A	Chemo iv infusion addl hr	0.19	0.62	0.72	NA	NA	0.01	ZZZ
96416		A	Chemo prolong infuse w/pump	0.21	3.87	4.49	NA	NA	0.07	XXX
96417		A	Chemo iv infus each addl seq	0.21	1.64	1.90	NA	NA	0.03	ZZZ
96420		A	Chemo ia push tecnique	0.17	2.58	2.97	NA	NA	0.08	XXX
96422		A	Chemo ia infusion up to 1 hr	0.17	4.27	4.93	NA	NA	0.08	XXX
96423		A	Chemo ia infuse each addl hr	0.17	1.89	2.15	NA	NA	0.04	ZZZ
96425		A	Chemotherapy infusion method	0.17	4.57	5.04	NA	NA	0.10	XXX
96440		A	Chemotherapy intracavitary	2.37	19.93	18.62	1.51	1.45	0.54	000
96446		A	Chemotx admn prtl cavity	0.37	4.79	4.79	0.19	0.19	0.07	XXX
96450		A	Chemotherapy into cns	1.53	3.38	4.23	0.76	0.88	0.11	000
96521		A	Refill/maint portable pump	0.21	3.36	3.67	NA	NA	0.05	XXX
96522		A	Refill/maint pump/resvr syst	0.21	2.71	3.02	NA	NA	0.05	XXX
96523		T	Irrig drug delivery device	0.04	0.61	0.70	NA	NA	0.01	XXX
96542		A	Chemotherapy injection	0.75	2.38	2.96	0.46	0.50	0.04	XXX
96549		C	Chemotherapy unspecified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96567		A	Photodynamic tx skin	0.00	3.78	3.86	NA	NA	0.01	XXX
96570		A	Photodynmc tx 30 min add-on	1.10	0.44	0.47	0.44	0.47	0.18	ZZZ
96571		A	Photodynamic tx addl 15 min	0.55	0.19	0.21	0.19	0.21	0.04	ZZZ
96900		A	Ultraviolet light therapy	0.00	0.57	0.60	NA	NA	0.01	XXX
96902		B	Trichogram	0.41	0.20	0.20	0.18	0.18	0.03	XXX
96904		R	Whole body photography	0.00	1.82	2.00	NA	NA	0.01	XXX
96910		A	Photochemotherapy with uv-b	0.00	1.99	2.04	NA	NA	0.01	XXX
96912		A	Photochemotherapy with uv-a	0.00	2.56	2.62	NA	NA	0.01	XXX
96913		A	Photochemotherapy uv-a or b	0.00	3.61	3.65	NA	NA	0.01	XXX
96920		A	Laser tx skin < 250 sq cm	1.15	3.83	3.92	0.85	0.79	0.04	000
96921		A	Laser tx skin 250-500 sq cm	1.17	3.95	3.91	0.85	0.77	0.04	000
96922		A	Laser tx skin > 500 sq cm	2.10	5.09	5.19	1.56	1.39	0.08	000
96999		C	Dermatological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
97001		A	Pt evaluation	1.20	0.92	0.89	NA	NA	0.05	XXX
97002		A	Pt re-evaluation	0.60	0.58	0.55	NA	NA	0.03	XXX
97003		A	Ot evaluation	1.20	1.23	1.11	NA	NA	0.05	XXX
97004		A	Ot re-evaluation	0.60	0.90	0.80	NA	NA	0.03	XXX
97005		I	Athletic train eval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97006		I	Athletic train reeval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97010		B	Hot or cold packs therapy	0.06	0.10	0.09	NA	NA	0.01	XXX
97012		A	Mechanical traction therapy	0.25	0.20	0.19	NA	NA	0.01	XXX
97014		I	Electric stimulation therapy	0.18	0.27	0.24	NA	NA	0.01	XXX
97016		A	Vasopneumatic device therapy	0.18	0.35	0.32	NA	NA	0.01	XXX
97018		A	Paraffin bath therapy	0.06	0.23	0.21	NA	NA	0.01	XXX
97022		A	Whirlpool therapy	0.17	0.47	0.42	NA	NA	0.01	XXX
97024		A	Diathermy eg microwave	0.06	0.12	0.11	NA	NA	0.01	XXX
97026		R	Infrared therapy	0.06	0.10	0.09	NA	NA	0.01	XXX
97028		A	Ultraviolet therapy	0.08	0.12	0.11	NA	NA	0.01	XXX
97032		A	Electrical stimulation	0.25	0.28	0.26	NA	NA	0.01	XXX
97033		A	Electric current therapy	0.26	0.64	0.56	NA	NA	0.01	XXX
97034		A	Contrast bath therapy	0.21	0.29	0.26	NA	NA	0.01	XXX
97035		A	Ultrasound therapy	0.21	0.14	0.13	NA	NA	0.01	XXX
97036		A	Hydrotherapy	0.28	0.63	0.57	NA	NA	0.01	XXX
97039		C	Physical therapy treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97110		A	Therapeutic exercises	0.45	0.45	0.42	NA	NA	0.01	XXX
97112		A	Neuromuscular reeducation	0.45	0.49	0.45	NA	NA	0.01	XXX
97113		A	Aquatic therapy/exercises	0.44	0.76	0.69	NA	NA	0.01	XXX
97116		A	Gait training therapy	0.40	0.39	0.36	NA	NA	0.01	XXX
97124		A	Massage therapy	0.35	0.38	0.35	NA	NA	0.01	XXX
97139		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97140		A	Manual therapy	0.43	0.41	0.38	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
97150		A	Group therapeutic procedures	0.27	0.31	0.28	NA	NA	0.01	XXX
97530		A	Therapeutic activities	0.44	0.54	0.50	NA	NA	0.01	XXX
97532		A	Cognitive skills development	0.44	0.31	0.29	NA	NA	0.01	XXX
97533		A	Sensory integration	0.44	0.38	0.36	NA	NA	0.01	XXX
97535		A	Self care mngment training	0.45	0.53	0.49	NA	NA	0.01	XXX
97537		A	Community/work reintegration	0.45	0.40	0.37	NA	NA	0.01	XXX
97542		A	Wheelchair mngment training	0.45	0.41	0.38	NA	NA	0.01	XXX
97545		R	Work hardening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97546		R	Work hardening add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
97597		A	Rmvl devital tis 20 cm/<	0.51	1.56	1.56	0.15	0.15	0.05	000
97598		A	Rmvl devital tis addl 20 cm<	0.24	0.44	0.44	0.07	0.07	0.03	ZZZ
97602		B	Wound(s) care non-selective	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97605		A	Neg press wound tx < 50 cm	0.55	0.58	0.53	0.16	0.17	0.08	XXX
97606		A	Neg press wound tx > 50 cm	0.60	0.59	0.54	0.17	0.18	0.10	XXX
97750		A	Physical performance test	0.45	0.47	0.44	NA	NA	0.03	XXX
97755		A	Assistive technology assess	0.62	0.39	0.37	NA	NA	0.03	XXX
97760		A	Orthotic mgmt and training	0.45	0.61	0.56	NA	NA	0.03	XXX
97761		A	Prosthetic training	0.45	0.47	0.43	NA	NA	0.03	XXX
97762		A	C/o for orthotic/prosth use	0.25	1.06	0.93	NA	NA	0.01	XXX
97799		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97802		A	Medical nutrition indiv in	0.53	0.42	0.38	0.36	0.32	0.03	XXX
97803		A	Med nutrition indiv subseq	0.45	0.37	0.34	0.31	0.28	0.03	XXX
97804		A	Medical nutrition group	0.25	0.18	0.15	0.17	0.15	0.01	XXX
97810		N	Acupunct w/o stimul 15 min	0.60	0.41	0.42	0.26	0.26	0.04	XXX
97811		N	Acupunct w/o stimul addl 15m	0.50	0.27	0.27	0.22	0.21	0.03	ZZZ
97813		N	Acupunct w/stimul 15 min	0.65	0.44	0.44	0.29	0.28	0.04	XXX
97814		N	Acupunct w/stimul addl 15m	0.55	0.32	0.32	0.24	0.24	0.04	ZZZ
98925		A	Osteopathic manipulation	0.45	0.44	0.41	0.21	0.18	0.03	000

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
98926		A	Osteopathic manipulation	0.65	0.56	0.52	0.28	0.26	0.03	000
98927		A	Osteopathic manipulation	0.87	0.71	0.64	0.35	0.33	0.04	000
98928		A	Osteopathic manipulation	1.03	0.79	0.73	0.41	0.39	0.05	000
98929		A	Osteopathic manipulation	1.19	0.92	0.84	0.48	0.45	0.07	000
98940		A	Chiropractic manipulation	0.45	0.30	0.29	0.16	0.15	0.01	000
98941		A	Chiropractic manipulation	0.65	0.39	0.37	0.23	0.23	0.03	000
98942		A	Chiropractic manipulation	0.87	0.47	0.44	0.31	0.30	0.03	000
98943		N	Chiropractic manipulation	0.40	0.28	0.28	0.18	0.17	0.03	XXX
98960		B	Self-mgmt educ & train 1 pt	0.00	0.73	0.76	NA	NA	0.01	XXX
98961		B	Self-mgmt educ/train 2-4 pt	0.00	0.35	0.37	NA	NA	0.01	XXX
98962		B	Self-mgmt educ/train 5-8 pt	0.00	0.25	0.27	NA	NA	0.01	XXX
98966		N	Hc pro phone call 5-10 min	0.25	0.15	0.15	0.11	0.10	0.01	XXX
98967		N	Hc pro phone call 11-20 min	0.50	0.26	0.25	0.22	0.21	0.03	XXX
98968		N	Hc pro phone call 21-30 min	0.75	0.37	0.36	0.33	0.32	0.05	XXX
98969		N	Online service by hc pro	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99000		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99001		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99002		B	Device handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99024		B	Postop follow-up visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99026		N	In-hospital on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99027		N	Out-of-hosp on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99050		B	Medical services after hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99051		B	Med serv eve/wkend/holiday	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99053		B	Med serv 10pm-8am 24 hr fac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99056		B	Med service out of office	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99058		B	Office emergency care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99060		B	Out of office emerg med serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99070		B	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99071		B	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075		N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	1.10	0.48	0.47	NA	NA	0.07	XXX
99100		B	Special anesthesia service	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99116		B	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99135		B	Special anesthesia procedure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99140		B	Emergency anesthesia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99143		C	Mod cs by same phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99144		C	Mod cs by same phys 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99145		C	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99148		C	Mod cs diff phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99149		C	Mod cs diff phys 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99150		C	Mod cs diff phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99170		A	Anogenital exam child	1.75	2.19	2.39	0.86	0.91	0.12	000
99172		N	Ocular function screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99173		N	Visual acuity screen	0.00	0.07	0.07	NA	NA	0.01	XXX
99174		N	Ocular photoscreening	0.00	0.78	0.81	NA	NA	0.01	XXX
99175		A	Induction of vomiting	0.00	0.66	0.71	NA	NA	0.01	XXX
99183		A	Hyperbaric oxygen therapy	2.34	3.69	3.54	0.99	0.89	0.26	XXX
99190		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99191		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99192		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99195		A	Phlebotomy	0.00	2.62	2.50	NA	NA	0.05	XXX
99199		C	Special service/proc/report	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99201		A	Office/outpatient visit new	0.48	0.73	0.70	0.26	0.24	0.04	XXX
99202		A	Office/outpatient visit new	0.93	1.16	1.09	0.49	0.44	0.07	XXX
99203		A	Office/outpatient visit new	1.42	1.57	1.48	0.72	0.64	0.14	XXX
99204		A	Office/outpatient visit new	2.43	2.15	2.01	1.21	1.06	0.23	XXX
99205		A	Office/outpatient visit new	3.17	2.52	2.37	1.50	1.34	0.27	XXX
99211		A	Office/outpatient visit est	0.18	0.37	0.39	0.08	0.08	0.01	XXX
99212		A	Office/outpatient visit est	0.48	0.73	0.70	0.24	0.22	0.04	XXX
99213		A	Office/outpatient visit est	0.97	1.06	0.99	0.47	0.42	0.07	XXX
99214		A	Office/outpatient visit est	1.50	1.49	1.42	0.71	0.63	0.10	XXX
99215		A	Office/outpatient visit est	2.11	1.91	1.81	1.00	0.90	0.14	XXX
99217		A	Observation care discharge	1.28	NA	NA	0.73	0.68	0.08	XXX
99218		A	Initial observation caree	1.28	NA	NA	0.58	0.54	0.08	XXX
99219		A	Initial observation care	2.14	NA	NA	0.98	0.89	0.14	XXX
99220		A	Initial observation care	2.99	NA	NA	1.35	1.24	0.20	XXX
99221		A	Initial hospital care	1.92	NA	NA	0.86	0.76	0.18	XXX
99222		A	Initial hospital care	2.61	NA	NA	1.21	1.06	0.22	XXX
99223		A	Initial hospital care	3.86	NA	NA	1.78	1.56	0.29	XXX
99224		A	Subsequent observation care	0.54	NA	NA	0.24	0.24	0.04	XXX
99225		A	Subsequent observation care	0.96	NA	NA	0.44	0.44	0.05	XXX
99226		A	Subsequent observation care	1.44	NA	NA	0.65	0.65	0.08	XXX
99231		A	Subsequent hospital care	0.76	NA	NA	0.34	0.32	0.05	XXX
99232		A	Subsequent hospital care	1.39	NA	NA	0.64	0.58	0.08	XXX
99233		A	Subsequent hospital care	2.00	NA	NA	0.90	0.82	0.12	XXX
99234		A	Observ/hosp same date	2.56	NA	NA	1.16	1.10	0.22	XXX
99235		A	Observ/hosp same date	3.41	NA	NA	1.56	1.43	0.23	XXX
99236		A	Observ/hosp same date	4.26	NA	NA	1.90	1.75	0.29	XXX
99238		A	Hospital discharge day	1.28	NA	NA	0.74	0.69	0.07	XXX
99239		A	Hospital discharge day	1.90	NA	NA	1.09	0.98	0.11	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99241		I	Office consultation	0.64	0.66	0.66	0.24	0.24	0.07	XXX
99242		I	Office consultation	1.34	1.10	1.10	0.51	0.51	0.14	XXX
99243		I	Office consultation	1.88	1.46	1.46	0.71	0.71	0.18	XXX
99244		I	Office consultation	3.02	1.96	1.96	1.14	1.14	0.22	XXX
99245		I	Office consultation	3.77	2.30	2.30	1.38	1.38	0.29	XXX
99251		I	Inpatient consultation	1.00	NA	NA	0.32	0.32	0.07	XXX
99252		I	Inpatient consultation	1.50	NA	NA	0.52	0.52	0.12	XXX
99253		I	Inpatient consultation	2.27	NA	NA	0.84	0.84	0.15	XXX
99254		I	Inpatient consultation	3.29	NA	NA	1.23	1.23	0.18	XXX
99255		I	Inpatient consultation	4.00	NA	NA	1.44	1.44	0.24	XXX
99281		A	Emergency dept visit	0.45	NA	NA	0.15	0.13	0.03	XXX
99282		A	Emergency dept visit	0.88	NA	NA	0.27	0.24	0.07	XXX
99283		A	Emergency dept visit	1.34	NA	NA	0.39	0.36	0.10	XXX
99284		A	Emergency dept visit	2.56	NA	NA	0.67	0.62	0.22	XXX
99285		A	Emergency dept visit	3.80	NA	NA	0.91	0.88	0.30	XXX
99288		B	Direct advanced life support	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99291		A	Critical care first hour	4.50	3.04	2.95	1.68	1.56	0.34	XXX
99292		A	Critical care addl 30 min	2.25	1.13	1.07	0.84	0.78	0.18	ZZZ
99304		A	Nursing facility care init	1.64	0.94	0.82	0.94	0.82	0.14	XXX
99305		A	Nursing facility care init	2.35	1.28	1.09	1.28	1.09	0.20	XXX
99306		A	Nursing facility care init	3.06	1.59	1.34	1.59	1.34	0.23	XXX
99307		A	Nursing fac care subseq	0.76	0.49	0.44	0.49	0.44	0.04	XXX
99308		A	Nursing fac care subseq	1.16	0.77	0.68	0.77	0.68	0.07	XXX
99309		A	Nursing fac care subseq	1.55	1.00	0.88	1.00	0.88	0.08	XXX
99310		A	Nursing fac care subseq	2.35	1.41	1.24	1.41	1.24	0.14	XXX
99315		A	Nursing fac discharge day	1.13	0.70	0.61	0.70	0.61	0.07	XXX
99316		A	Nursing fac discharge day	1.50	0.87	0.77	0.87	0.77	0.08	XXX
99318		A	Annual nursing fac assessmnt	1.71	0.99	0.84	0.99	0.84	0.10	XXX
99324		A	Domicil/r-home visit new pat	1.01	0.55	0.54	NA	NA	0.07	XXX
99325		A	Domicil/r-home visit new pat	1.52	0.73	0.73	NA	NA	0.10	XXX
99326		A	Domicil/r-home visit new pat	2.63	1.31	1.19	NA	NA	0.16	XXX
99327		A	Domicil/r-home visit new pat	3.46	1.74	1.55	NA	NA	0.22	XXX
99328		A	Domicil/r-home visit new pat	4.09	2.00	1.78	NA	NA	0.24	XXX
99334		A	Domicil/r-home visit est pat	1.07	0.62	0.58	NA	NA	0.07	XXX
99335		A	Domicil/r-home visit est pat	1.72	0.94	0.84	NA	NA	0.10	XXX
99336		A	Domicil/r-home visit est pat	2.46	1.32	1.15	NA	NA	0.14	XXX
99337		A	Domicil/r-home visit est pat	3.58	1.83	1.60	NA	NA	0.23	XXX
99339		B	Domicil/r-home care supervis	1.25	0.92	0.91	NA	NA	0.08	XXX
99340		B	Domicil/r-home care supervis	1.80	1.23	1.22	NA	NA	0.12	XXX
99341		A	Home visit new patient	1.01	0.52	0.53	NA	NA	0.07	XXX
99342		A	Home visit new patient	1.52	0.70	0.71	NA	NA	0.11	XXX
99343		A	Home visit new patient	2.53	1.15	1.11	NA	NA	0.18	XXX
99344		A	Home visit new patient	3.38	1.75	1.54	NA	NA	0.22	XXX
99345		A	Home visit new patient	4.09	2.06	1.81	NA	NA	0.26	XXX
99347		A	Home visit est patient	1.00	0.55	0.53	NA	NA	0.07	XXX
99348		A	Home visit est patient	1.56	0.80	0.76	NA	NA	0.10	XXX
99349		A	Home visit est patient	2.33	1.27	1.11	NA	NA	0.14	XXX
99350		A	Home visit est patient	3.28	1.70	1.50	NA	NA	0.22	XXX
99354		A	Prolonged service office	1.77	1.01	0.93	0.82	0.75	0.11	ZZZ
99355		A	Prolonged service office	1.77	0.96	0.90	0.78	0.72	0.11	ZZZ
99356		A	Prolonged service inpatient	1.71	NA	NA	0.85	0.76	0.11	ZZZ
99357		A	Prolonged service inpatient	1.71	NA	NA	0.85	0.76	0.11	ZZZ
99358		B	Prolong service w/o contact	2.10	0.96	0.94	0.96	0.94	0.14	XXX
99359		B	Prolong serv w/o contact add	1.00	0.48	0.47	0.48	0.47	0.07	ZZZ
99360		X	Physician standby services	1.20	NA	NA	0.53	0.51	0.08	XXX
99363		B	Anticoag mgmt init	1.65	1.87	1.89	0.73	0.70	0.11	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99364		B	Anticoag mgmt subseq	0.63	0.57	0.57	0.28	0.27	0.04	XXX
99366		B	Team conf w/pat by hc pro	0.82	0.38	0.37	0.36	0.35	0.05	XXX
99367		B	Team conf w/o pat by phys	1.10	NA	NA	0.48	0.47	0.07	XXX
99368		B	Team conf w/o pat by hc pro	0.72	NA	NA	0.32	0.31	0.04	XXX
99374		B	Home health care supervision	1.10	0.85	0.85	0.48	0.48	0.07	XXX
99375		I	Home health care supervision	1.73	1.20	1.28	0.76	0.88	0.11	XXX
99377		B	Hospice care supervision	1.10	0.85	0.85	0.48	0.48	0.07	XXX
99378		I	Hospice care supervision	1.73	1.20	1.34	0.76	0.94	0.11	XXX
99379		B	Nursing fac care supervision	1.10	0.85	0.85	0.48	0.48	0.07	XXX
99380		B	Nursing fac care supervision	1.73	1.20	1.20	0.76	0.75	0.11	XXX
99381		N	Init pm e/m new pat inf	1.19	1.43	1.49	0.52	0.51	0.08	XXX
99382		N	Init pm e/m new pat 1-4 yrs	1.36	1.50	1.56	0.60	0.59	0.08	XXX
99383		N	Prev visit new age 5-11	1.36	1.49	1.54	0.60	0.59	0.08	XXX
99384		N	Prev visit new age 12-17	1.53	1.56	1.62	0.67	0.66	0.10	XXX
99385		N	Prev visit new age 18-39	1.53	1.56	1.62	0.67	0.66	0.10	XXX
99386		N	Prev visit new age 40-64	1.88	1.72	1.78	0.83	0.81	0.12	XXX
99387		N	Init pm e/m new pat 65+ yrs	2.06	1.91	1.97	0.91	0.90	0.14	XXX
99391		N	Per pm reeval est pat inf	1.02	1.23	1.25	0.45	0.44	0.07	XXX
99392		N	Prev visit est age 1-4	1.19	1.30	1.32	0.52	0.51	0.08	XXX
99393		N	Prev visit est age 5-11	1.19	1.30	1.31	0.52	0.51	0.08	XXX
99394		N	Prev visit est age 12-17	1.36	1.37	1.39	0.60	0.59	0.08	XXX
99395		N	Prev visit est age 18-39	1.36	1.38	1.39	0.60	0.59	0.08	XXX
99396		N	Prev visit est age 40-64	1.53	1.45	1.47	0.67	0.66	0.10	XXX
99397		N	Per pm reeval est pat 65+ yr	1.71	1.65	1.67	0.75	0.75	0.11	XXX
99401		N	Preventive counseling indiv	0.48	0.52	0.56	0.21	0.21	0.03	XXX
99402		N	Preventive counseling indiv	0.98	0.74	0.78	0.43	0.42	0.07	XXX
99403		N	Preventive counseling indiv	1.46	0.95	1.00	0.64	0.63	0.10	XXX
99404		N	Preventive counseling indiv	1.95	1.17	1.22	0.86	0.85	0.12	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99406		A	Behav chng smoking 3-10 min	0.24	0.16	0.15	0.10	0.10	0.01	XXX
99407		A	Behav chng smoking > 10 min	0.50	0.27	0.25	0.22	0.20	0.03	XXX
99408		N	Audit/dast 15-30 min	0.65	0.34	0.33	0.29	0.28	0.04	XXX
99409		N	Audit/dast over 30 min	1.30	0.62	0.61	0.57	0.56	0.08	XXX
99411		N	Preventive counseling group	0.15	0.30	0.30	0.07	0.06	0.01	XXX
99412		N	Preventive counseling group	0.25	0.34	0.34	0.11	0.11	0.01	XXX
99420		N	Health risk assessment test	0.00	0.28	0.29	NA	NA	0.01	XXX
99429		N	Unlisted preventive service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99441		N	Phone e/m by phys 5-10 min	0.25	0.15	0.15	0.11	0.10	0.01	XXX
99442		N	Phone e/m by phys 11-20 min	0.50	0.26	0.25	0.22	0.21	0.03	XXX
99443		N	Phone e/m by phys 21-30 min	0.75	0.37	0.36	0.33	0.32	0.05	XXX
99444		N	Online e/m by phys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99450		N	Basic life disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99455		R	Work related disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99456		R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99460		A	Init nb em per day hosp	1.17	NA	NA	0.55	0.48	0.05	XXX
99461		A	Init nb em per day non-fac	1.26	1.45	1.35	0.55	0.54	0.08	XXX
99462		A	Sbsq nb em per day hosp	0.62	NA	NA	0.29	0.26	0.04	XXX
99463		A	Same day nb discharge	1.50	NA	NA	0.86	0.76	0.08	XXX
99464		A	Attendance at delivery	1.50	NA	NA	0.60	0.54	0.07	XXX
99465		A	Nb resuscitation	2.93	NA	NA	0.68	0.93	0.22	XXX
99466		A	Ped crit care transport	4.79	NA	NA	2.24	1.99	1.02	XXX
99467		A	Ped crit care transport addl	2.40	NA	NA	1.06	0.95	0.14	ZZZ
99468		A	Neonate crit care initial	18.46	NA	NA	7.42	6.50	1.52	XXX
99469		A	Neonate crit care subsq	7.99	NA	NA	3.52	3.12	0.42	XXX
99471		A	Ped critical care initial	15.98	NA	NA	6.42	5.97	0.87	XXX
99472		A	Ped critical care subsq	7.99	NA	NA	3.29	3.01	0.48	XXX
99475		A	Ped crit care age 2-5 init	11.25	4.53	4.01	4.53	4.01	0.86	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
99476		A	Ped crit care age 2-5 subsq	6.75	2.90	2.50	2.90	2.50	0.52	XXX
99477		A	Init day hosp neonate care	7.00	NA	NA	3.08	2.81	0.38	XXX
99478		A	Ic lbw inf < 1500 gm subsq	2.75	NA	NA	1.11	1.11	0.18	XXX
99479		A	Ic lbw inf 1500-2500 g subsq	2.50	NA	NA	1.22	1.05	0.16	XXX
99480		A	Ic inf pbw 2501-5000 g subsq	2.40	NA	NA	0.96	0.91	0.16	XXX
99499		C	Unlisted e&m service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99500		I	Home visit prenatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99501		I	Home visit postnatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99502		I	Home visit nb care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99503		I	Home visit resp therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99504		I	Home visit mech ventilator	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99505		I	Home visit stoma care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99506		I	Home visit im injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99507		I	Home visit cath maintain	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99509		I	Home visit day life activity	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99510		I	Home visit sing/m/fam couns	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99511		I	Home visit fecal/enema mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99512		I	Home visit for hemodialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99600		I	Home visit nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99601		I	Home infusion/visit 2 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99602		I	Home infusion each addtl hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99605		X	Mtms by pharm np 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99606		X	Mtms by pharm est 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99607		X	Mtms by pharm addl 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4641		C	Radiopharm dx agent noc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4642		C	In111 satumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4890		R	Repair/maint cont hemo equip	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9500		C	Tc99m sestamibi	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
A9501		C	Technetium tc-99m teboroxime	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9502		C	Tc99m tetrofosmin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9503		C	Tc99m medronate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9504		C	Tc99m apcitide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9505		C	Tl201 thallium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9507		C	In111 capromab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9508		C	I131 iodobenguate, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9509		C	Iodine i-123 sod iodide mil	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9510		C	Tc99m disofenin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9512		C	Tc99m pertechnetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9516		C	Iodine i-123 sod iodide mic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9517		C	I131 iodide cap, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9521		C	Tc99m exametazime	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9524		C	I131 serum albumin, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9526		C	Nitrogen n-13 ammonia	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9527		C	Iodine i-125 sodium iodide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9528		C	Iodine i-131 iodide cap, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9529		C	I131 iodide sol, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9530		C	I131 iodide sol, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9531		C	I131 max 100uci	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9532		C	I125 serum albumin, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9536		C	Tc99m depreotide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9537		C	Tc99m mebrofenin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9538		C	Tc99m pyrophosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9539		C	Tc99m pentetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9540		C	Tc99m maa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9541		C	Tc99m sulfur colloid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9542		C	In111 ibritumomab, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
A9543		C	Y90 ibritumomab, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9544		C	I131 tositumomab, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9545		C	I131 tositumomab, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9546		C	Co57/58	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9547		C	In111 oxyquinoline	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9548		C	In111 pentetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9550		C	Tc99m gluceptate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9551		C	Tc99m succimer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9552		C	F18 fdg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9553		C	Cr51 chromate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9554		C	I125 iothalamate, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9555		C	Rb82 rubidium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9556		C	Ga67 gallium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9557		C	Tc99m bicisate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9558		C	Xe133 xenon 10mci	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9559		C	Co57 cyano	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9560		C	Tc99m labeled rbc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9561		C	Tc99m oxidronate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9562		C	Tc99m mertiatide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9563		C	P32 na phosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9564		C	P32 chromic phosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9566		C	Tc99m fanolesomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9567		C	Technetium tc-99m aerosol	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9568		C	Technetium tc99m arcitumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9569		C	Technetium tc-99m auto wbc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9570		C	Indium in-111 auto wbc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9571		C	Indium in-111 auto platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9572		C	Indium in-111 pentetreotide	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
A9580		C	Sodium fluoride f-18	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9600		C	Sr89 strontium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9699		C	Radiopharm rx agent noc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0008		X	Admin influenza virus vac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0009		X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0010		X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0027		X	Semen analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0101		A	Ca screen;pelvic/breast exam	0.45	0.61	0.61	0.32	0.32	0.03	XXX
G0102		A	Prostate ca screening; dre	0.17	0.37	0.39	0.08	0.08	0.01	XXX
G0103		X	Psa screening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0104		A	Ca screen;flexi sigmoidscope	0.96	2.93	2.96	0.80	0.77	0.14	000
G0105		A	Colorectal scrn; hi risk ind	3.69	7.15	7.41	2.27	2.23	0.58	000
G0105	53	A	Colorectal scrn; hi risk ind	0.96	2.93	2.96	0.80	0.77	0.14	000
G0106		A	Colon ca screen;barium enema	0.99	5.18	5.25	NA	NA	0.04	XXX
G0106	TC	A	Colon ca screen;barium enema	0.00	4.81	4.84	NA	NA	0.01	XXX
G0106	26	A	Colon ca screen;barium enema	0.99	0.37	0.41	0.37	0.41	0.03	XXX
G0108		A	Diab manage trn per indiv	0.90	0.55	0.66	NA	NA	0.05	XXX
G0109		A	Diab manage trn ind/group	0.25	0.15	0.29	NA	NA	0.01	XXX
G0117		T	Glaucoma scrn hgh risk direc	0.45	1.03	0.98	NA	NA	0.03	XXX
G0118		T	Glaucoma scrn hgh risk direc	0.17	0.87	0.83	NA	NA	0.01	XXX
G0120		A	Colon ca scrn; barium enema	0.99	5.18	5.25	NA	NA	0.04	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	4.81	4.84	NA	NA	0.01	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.37	0.41	0.37	0.41	0.03	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	7.15	7.41	2.27	2.23	0.58	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.93	2.96	0.80	0.77	0.14	000
G0122		N	Colon ca scrn; barium enema	0.99	7.18	6.90	NA	NA	0.05	XXX
G0122	TC	N	Colon ca scrn; barium enema	0.00	6.74	6.47	NA	NA	0.01	XXX
G0122	26	N	Colon ca scrn; barium enema	0.99	0.44	0.43	0.44	0.43	0.04	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G0123		X	Screen cerv/vag thin layer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0124		A	Screen c/v thin layer by md	0.42	0.42	0.40	0.42	0.40	0.03	XXX
G0127		R	Trim nail(s)	0.17	0.48	0.45	0.05	0.06	0.01	000
G0128		R	Corf skilled nursing service	0.08	0.20	0.19	NA	NA	0.01	XXX
G0130		A	Single energy x-ray study	0.22	0.72	0.74	NA	NA	0.02	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.62	0.65	NA	NA	0.01	XXX
G0130	26	A	Single energy x-ray study	0.22	0.10	0.09	0.10	0.09	0.01	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.42	0.40	0.42	0.40	0.03	XXX
G0143		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0144		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0145		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0147		X	Scr c/v cyto, automated sys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0148		X	Scr c/v cyto, autosys, rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0157		E	Hhc pt assistant ea 15	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0158		E	Hhc ot assistant ea 15	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0159		E	Hhc pt maint ea 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0160		E	Hhc occup therapy ea 15	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0161		E	Hhc slp ea 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0162		E	Hhc rn e&m plan svs, 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0163		E	Hhc lpn/rn obs/asses ea 15	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0164		E	Hhc lis nurse train ea 15	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0166		A	Extrnl counterpulse, per tx	0.07	3.86	4.43	NA	NA	0.03	XXX
G0168		A	Wound closure by adhesive	0.45	2.14	2.07	0.30	0.28	0.03	000
G0173		X	Linear acc stereo radsur com	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0175		X	Opps service,sched team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0176		X	Opps/php;activity therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0177		X	Opps/php; train & educ serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0179		A	Md recertification hha pt	0.45	0.68	0.72	NA	NA	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G0180		A	Md certification hha patient	0.67	0.80	0.85	NA	NA	0.04	XXX
G0181		A	Home health care supervision	1.73	1.28	1.24	NA	NA	0.10	XXX
G0182		A	Hospice care supervision	1.73	1.29	1.28	NA	NA	0.10	XXX
G0186		C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0202		A	Screeningmammographydigital	0.70	3.34	3.39	NA	NA	0.05	XXX
G0202	TC	A	Screeningmammographydigital	0.00	3.06	3.10	NA	NA	0.01	XXX
G0202	26	A	Screeningmammographydigital	0.70	0.28	0.29	0.28	0.29	0.04	XXX
G0204		A	Diagnosticmammographydigital	0.87	4.06	4.03	NA	NA	0.06	XXX
G0204	TC	A	Diagnosticmammographydigital	0.00	3.70	3.67	NA	NA	0.01	XXX
G0204	26	A	Diagnosticmammographydigital	0.87	0.36	0.36	0.36	0.36	0.05	XXX
G0206		A	Diagnosticmammographydigital	0.70	3.18	3.17	NA	NA	0.05	XXX
G0206	TC	A	Diagnosticmammographydigital	0.00	2.90	2.88	NA	NA	0.01	XXX
G0206	26	A	Diagnosticmammographydigital	0.70	0.28	0.29	0.28	0.29	0.04	XXX
G0219		N	Pet img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	TC	N	Pet img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	26	N	Pet img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0235		N	Pet not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	TC	N	Pet not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	26	N	Pet not otherwise specified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0237		A	Therapeutic procd strg endur	0.00	0.25	0.29	NA	NA	0.01	XXX
G0238		A	Oth resp proc, indiv	0.00	0.26	0.31	NA	NA	0.01	XXX
G0239		A	Oth resp proc, group	0.00	0.31	0.34	NA	NA	0.01	XXX
G0245		R	Initial foot exam pt lops	0.88	1.16	1.09	0.49	0.44	0.05	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.73	0.70	0.24	0.22	0.03	XXX
G0247		R	Routine footcare pt w lops	0.50	1.56	1.17	0.15	0.18	0.04	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	3.23	4.13	NA	NA	0.01	XXX
G0249		R	Provide inr test mater/equip	0.00	3.02	3.65	NA	NA	0.01	XXX
G0250		R	Md inr test revie inter mgmt	0.18	0.07	0.08	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G0251		E	Linear acc based stero radio	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0252		N	Pet imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	TC	N	Pet imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	26	N	Pet imaging initial dx	1.50	0.66	0.70	0.66	0.70	0.10	XXX
G0255		N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX
G0255	TC	N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX
G0255	26	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0257		E	Unsched dialysis esrd pt hos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0259		E	Inject for sacroiliac joint	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0260		E	Inj for sacroiliac jt anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0268		A	Removal of impacted wax md	0.61	0.91	0.86	0.36	0.31	0.03	000
G0269		B	Occlusive device in vein art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0270		A	Mnt subs tx for change dx	0.45	0.37	0.34	0.31	0.28	0.03	XXX
G0271		A	Group mnt 2 or more 30 mins	0.25	0.18	0.15	0.17	0.15	0.01	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	NA	0.10	0.13	0.01	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	NA	0.10	0.13	0.01	ZZZ
G0281		A	Elec stim unattend for press	0.18	0.20	0.18	NA	NA	0.01	XXX
G0282		N	Elect stim wound care not pd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0283		A	Elec stim other than wound	0.18	0.20	0.18	NA	NA	0.01	XXX
G0288		A	Recon, cta for surg plan	0.00	1.00	2.56	NA	NA	0.01	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	NA	0.88	0.85	0.29	ZZZ
G0290		E	Drug-eluting stents, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0291		E	Drug-eluting stents,each add	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0293		E	Non-cov surg proc,clin trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0294		E	Non-cov proc, clinical trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0295		N	Electromagnetic therapy onc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0302		X	Pre-op service lvrs complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0303		X	Pre-op service lvrs 10-15dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G0304		X	Pre-op service lvrs 1-9 dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0305		X	Post op service lvrs min 6	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0306		X	Cbc/diffwbc w/o platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0307		X	Cbc without platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0328		X	Fecal blood scrn immunoassay	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0329		A	Electromagntic tx for ulcers	0.06	0.22	0.20	NA	NA	0.01	XXX
G0333		X	Dispense fee initial 30 day	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0337		X	Hospice evaluation preelecti	1.42	0.63	0.63	0.63	0.63	0.10	XXX
G0339		C	Robot lin-radsurg com, first	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0340		C	Robt lin-radsurg fractx 2-5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0341		A	Percutaneous islet celltrans	6.98	53.67	29.60	3.01	3.85	0.49	000
G0342		A	Laparoscopy islet cell trans	11.92	NA	NA	7.86	7.17	0.84	090
G0343		A	Laparotomy islet cell transp	19.85	NA	NA	13.34	12.14	1.40	090
G0364		A	Bone marrow aspirate &biopsy	0.16	0.19	0.19	0.09	0.09	0.01	ZZZ
G0365		A	Vessel mapping hemo access	0.25	5.89	5.92	NA	NA	0.04	XXX
G0365	TC	A	Vessel mapping hemo access	0.00	5.80	5.83	NA	NA	0.01	XXX
G0365	26	A	Vessel mapping hemo access	0.25	0.09	0.09	0.09	0.09	0.03	XXX
G0372		A	Md service required for pmd	0.17	0.08	0.12	0.08	0.07	0.01	XXX
G0378		X	Hospital observation per hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0379		X	Direct refer hospital observ	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0389		A	Ultrasound exam aaa screen	0.58	2.46	2.69	NA	NA	0.04	XXX
G0389	TC	A	Ultrasound exam aaa screen	0.00	2.24	2.44	NA	NA	0.01	XXX
G0389	26	A	Ultrasound exam aaa screen	0.58	0.22	0.25	0.22	0.25	0.03	XXX
G0396		A	Alcohol/subs interv 15-30mn	0.65	0.32	0.29	0.27	0.23	0.04	XXX
G0397		A	Alcohol/subs interv >30 min	1.30	0.79	0.62	0.74	0.56	0.08	XXX
G0398		C	Home sleep test/type 2 porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0398	TC	C	Home sleep test/type 2 porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0398	26	C	Home sleep test/type 2 porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G0399		C	Home sleep test/type 3 porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0399	TC	C	Home sleep test/type 3 porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0399	26	C	Home sleep test/type 3 porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0400		C	Home sleep test/type 4 porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0400	TC	C	Home sleep test/type 4 porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0400	26	C	Home sleep test/type 4 porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0402		A	Initial preventive exam	2.43	2.20	1.80	1.15	1.15	0.12	XXX
G0403		A	Ekg for initial prevent exam	0.17	0.32	0.40	NA	NA	0.02	XXX
G0404		A	Ekg tracing for initial prev	0.00	0.25	0.32	NA	NA	0.01	XXX
G0405		A	Ekg interpret & report preve	0.17	0.07	0.08	0.07	0.07	0.01	XXX
G0406		A	Telhealth inpt consult 15min	0.76	NA	NA	0.34	0.32	0.05	XXX
G0407		A	Telheath inpt consult 25min	1.39	NA	NA	0.64	0.58	0.08	XXX
G0408		A	Telhealth inpt consult 35min	2.00	NA	NA	0.90	0.82	0.12	XXX
G0409		A	Corf related serv 15 mins ea	0.00	0.29	0.29	NA	NA	0.01	XXX
G0410		X	Grp psych partial hosp 45-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0411		X	Inter active grp psych parti	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0412		A	Open tx iliac spine uni/bil	10.45	NA	NA	9.26	8.76	2.04	090
G0413		A	Pelvic ring fracture uni/bil	15.73	NA	NA	12.80	12.27	3.06	090
G0414		A	Pelvic ring fx treat int fix	14.65	NA	NA	12.64	12.05	2.85	090
G0415		A	Open tx post pelvic fxcture	20.93	NA	NA	16.42	15.41	4.20	090
G0416		A	Sat biopsy prostate 1-20 spc	3.09	13.96	13.96	NA	NA	0.12	XXX
G0416	TC	A	Sat biopsy prostate 1-20 spc	0.00	12.14	12.14	NA	NA	0.01	XXX
G0416	26	A	Sat biopsy prostate 1-20 spc	3.09	1.82	1.82	1.82	1.82	0.11	XXX
G0417		A	Sat biopsy prostate 21-40	5.86	27.26	27.26	NA	NA	0.25	XXX
G0417	TC	A	Sat biopsy prostate 21-40	0.00	23.71	23.71	NA	NA	0.01	XXX
G0417	26	A	Sat biopsy prostate 21-40	5.86	3.55	3.55	3.55	3.55	0.24	XXX
G0418		A	Sat biopsy prostate 41-60	10.30	46.56	46.56	NA	NA	0.42	XXX
G0418	TC	A	Sat biopsy prostate 41-60	0.00	40.50	40.50	NA	NA	0.01	XXX
G0418	26	A	Sat biopsy prostate 41-60	10.30	6.06	6.06	6.06	6.06	0.41	XXX
G0419		A	Sat biopsy prostate: >60	11.61	55.86	55.86	NA	NA	0.46	XXX
G0419	TC	A	Sat biopsy prostate: >60	0.00	48.60	48.60	NA	NA	0.01	XXX
G0419	26	A	Sat biopsy prostate: >60	11.61	7.26	7.26	7.26	7.26	0.45	XXX
G0420		A	Ed svc ckd ind per session	2.12	1.03	1.03	NA	NA	0.11	XXX
G0421		A	Ed svc ckd grp per session	0.50	0.24	0.24	NA	NA	0.03	XXX
G0422		A	Intens cardiac rehab w/exerc	1.41	1.21	1.21	1.21	1.21	0.08	XXX
G0423		A	Intens cardiac rehab no exer	1.41	1.21	1.21	1.21	1.21	0.08	XXX
G0424		A	Pulmonary rehab w exer	0.28	0.59	0.59	0.12	0.12	0.03	XXX
G0425		A	Inpt telehealth consult 30m	1.92	NA	NA	0.86	0.86	0.18	XXX
G0426		A	Inpt telehealth consult 50m	2.61	NA	NA	1.21	1.21	0.22	XXX
G0427		A	Inpt telehealth con 70/>m	3.86	NA	NA	1.78	1.78	0.29	XXX
G0428		N	Collagen meniscus implant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0429		A	Dermal filler injection(s)	1.19	1.19	1.19	0.56	0.56	0.24	000
G0431		X	Drug screen multip class	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0432		X	Eia hiv-1/hiv-2 screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0433		X	Elisa hiv-1/hiv-2 screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0434		X	Drug screen multi drug class	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0435		X	Oral hiv-1/hiv-2 screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0436		A	Tobacco-use counsel 3-10 min	0.24	0.16	0.16	0.10	0.10	0.01	XXX
G0437		A	Tobacco-use counsel>10min	0.50	0.30	0.30	0.24	0.24	0.03	XXX
G0438		A	Ppps, initial visit	2.43	2.19	2.19	NA	NA	0.12	XXX
G0439		A	Ppps, subseq visit	1.50	1.63	1.63	NA	NA	0.03	XXX
G0440		A	Skin/dermal subs init 25or<	2.22	2.72	2.72	1.02	1.02	0.27	000
G0441		A	Skin/dermal subs each additi	0.50	0.82	0.82	0.20	0.20	0.07	000
G3001		X	Admin + supply, tositumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9001		X	Mccd, initial rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9002		X	Mccd,maintenance rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
G9003		X	Mccd, risk adj hi, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9004		X	Mccd, risk adj lo, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9005		X	Mccd, risk adj, maintenance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9006		X	Mccd, home monitoring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9007		X	Mccd, sch team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9008		X	Mccd,phys coor-care ovrsght	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9009		X	Mccd, risk adj, level 3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9010		X	Mccd, risk adj, level 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9011		X	Mccd, risk adj, level 5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9012		X	Other specified case mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9013		N	Esrd demo bundle level i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9014		N	Esrd demo bundle-level ii	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9016		N	Demo-smoking cessation coun	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9017		X	Amantadine hcl 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9018		X	Zanamivir,inhalation pwd 10m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9019		X	Oseltamivir phosphate 75mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9020		X	Rimantadine hcl 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9033		X	Amantadine hcl oral brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9034		X	Zanamivir, inh pwdr, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9035		X	Oseltamivir phosp, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9036		X	Rimantadine hcl, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9041		A	Low vision rehab occupationa	0.69	0.28	0.28	0.28	0.28	0.04	XXX
G9042		A	Low vision rehab orient/mobi	0.25	0.25	0.25	0.25	0.25	0.01	XXX
G9043		A	Low vision lowvision therapi	0.25	0.25	0.25	0.25	0.25	0.01	XXX
G9044		A	Low vision rehabilate teache	0.24	0.19	0.19	0.19	0.19	0.01	XXX
G9140		X	Frontier extended stay demo	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9141		X	Influenza a h1n1,admin w cou	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9142		X	Influenza a h1n1, vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9143		X	Warfarin respon genetic test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9147		N	Outpt iv insulin tx any mea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
M0064		A	Visit for drug monitoring	0.37	1.08	0.99	0.08	0.09	0.01	XXX
P3001		A	Screening pap smear by phys	0.42	0.42	0.40	0.42	0.40	0.03	XXX
Q0035		A	Cardiokymography	0.17	0.31	0.36	NA	NA	0.02	XXX
Q0035	TC	A	Cardiokymography	0.00	0.25	0.30	NA	NA	0.01	XXX
Q0035	26	A	Cardiokymography	0.17	0.06	0.06	0.06	0.06	0.01	XXX
Q0091		A	Obtaining screen pap smear	0.37	0.88	0.88	0.17	0.15	0.03	XXX
Q0092		A	Set up port xray equipment	0.00	0.65	0.59	0.65	0.59	0.01	XXX
Q3001		C	Brachytherapy radioelements	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Q3014		X	Telehealth facility fee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0070		C	Transport portable x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0075		C	Transport port x-ray multipl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0076		B	Transport portable ekg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
V5299		R	Hearing service	0.00	0.00	0.00	0.00	0.00	0.00	XXX

[1] CPT codes and descriptors only are copyright 2010 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

ADDENDUM C: CODES WITH INTERIM RVUs

				RVUs Open for Comment									
CPT[1]/ HCPCS	Mod	Status	Description	Work	Practice Expense	Mal-practice	Physi-cian Work RVUs[2]	Fully Imple-mented Non-Facility PE RVUs[2]	Year 2011 Transi-tional Non-Facility PE RVUs[2]	Fully Imple-mented Facility PE RVUs[2]	Year 2011 Transi-tional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
11010		A	Debride skin at fx site	W	PE		4.19	9.45	8.94	3.49	3.28	0.76	010
11011		A	Debride skin musc at fx site	W	PE		4.94	9.62	9.33	3.11	2.92	0.98	000
11012		A	Deb skin bone at fx site	W	PE		6.87	12.49	12.28	4.68	4.46	1.30	000
11042		A	Deb subq tissue 20 sq cm/<	W	PE	MP	0.80	2.13	1.66	0.62	0.50	0.10	000
11043		A	Deb musc/fascia 20 sq cm/<	W	PE	MP	2.00	3.30	3.30	1.28	1.28	0.33	000
11044		A	Deb bone 20 sq cm/<	W	PE	MP	3.60	4.34	4.34	2.03	2.03	0.62	000
11045		A	Deb subq tissue add-on	W	PE	MP	0.33	0.51	0.51	0.13	0.13	0.07	ZZZ
11046		A	Deb musc/fascia add-on	W	PE	MP	0.70	0.77	0.77	0.31	0.31	0.12	ZZZ
11047		A	Deb bone add-on	W	PE	MP	1.20	1.19	1.19	0.54	0.54	0.22	ZZZ
11900		A	Injection into skin lesions	W	PE	MP	0.52	1.04	1.04	0.38	0.34	0.07	000
11901		A	Added skin lesions injection	W	PE	MP	0.80	1.18	1.16	0.59	0.54	0.11	000
12001		A	Repair superficial wound(s)	W	PE	MP	0.84	1.52	1.84	0.38	0.64	0.14	000
12002		A	Repair superficial wound(s)	W	PE	MP	1.14	1.72	1.98	0.46	0.75	0.19	000
12004		A	Repair superficial wound(s)	W	PE	MP	1.44	1.92	2.25	0.55	0.85	0.24	000
12005		A	Repair superficial wound(s)	W	PE	MP	1.97	2.39	2.76	0.73	1.03	0.33	000
12006		A	Repair superficial wound(s)	W	PE	MP	2.39	2.87	3.31	0.91	1.27	0.41	000
12007		A	Repair superficial wound(s)	W	PE	MP	2.90	3.20	3.72	1.07	1.50	0.50	000
12011		A	Repair superficial wound(s)	W	PE	MP	1.07	1.87	2.12	0.43	0.68	0.19	000
12013		A	Repair superficial wound(s)	W	PE	MP	1.22	1.88	2.21	0.46	0.77	0.20	000
12014		A	Repair superficial wound(s)	W	PE	MP	1.57	2.08	2.47	0.57	0.89	0.26	000
12015		A	Repair superficial wound(s)	W	PE	MP	1.98	2.46	2.96	0.67	1.03	0.33	000
12016		A	Repair superficial wound(s)	W	PE	MP	2.68	2.92	3.45	0.91	1.29	0.46	000
12017		A	Repair superficial wound(s)	W	PE	MP	3.18	NA	NA	0.76	1.34	0.56	000
12018		A	Repair superficial wound(s)	W	PE	MP	3.61	NA	NA	0.85	1.78	0.64	000
15823		A	Revision of upper eyelid	W	PE	MP	6.81	10.15	9.79	8.49	8.16	1.26	090
19357		A	Breast reconstruction	W	PE	MP	18.50	NA	NA	23.79	21.54	3.61	090
20005		A	I&d abscess subfascial	W	PE		3.58	4.64	4.54	2.66	2.62	0.58	010
20664		A	Application of halo	W	PE		10.06	NA	NA	10.63	10.16	3.60	090
20930		B	Sp bone algrft morsel add-on	W	PE		0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931		A	Sp bone algrft struct add-on	W	PE		1.81	NA	NA	1.03	0.99	0.56	ZZZ
22315		A	Treat spine fracture	W	PE		10.11	13.56	12.81	10.46	9.83	2.54	090
22551		A	Neck spine fuse&remove addl	W	PE	MP	25.00	NA	NA	18.65	18.65	7.55	090
22552		A	Addl neck spine fusion	W	PE	MP	6.50	NA	NA	3.65	3.65	1.78	ZZZ
22554		A	Neck spine fusion	W	PE		17.69	NA	NA	14.70	14.28	5.46	090
22585		A	Additional spinal fusion	W	PE		5.52	NA	NA	3.10	3.00	1.59	ZZZ
22851		A	Apply spine prosth device	W	PE		6.70	NA	NA	3.82	3.68	1.89	ZZZ
23430		A	Repair biceps tendon	W	PE	MP	10.17	NA	NA	10.07	9.51	1.97	090
27065		A	Remove hip bone les super	W	PE		6.55	NA	NA	7.14	6.82	1.28	090
27066		A	Remove hip bone les deep	W	PE		11.20	NA	NA	10.81	10.26	2.20	090
27067		A	Remove/graft hip bone lesion	W	PE		14.72	NA	NA	13.30	12.66	2.91	090

				RVUs Open for Comment									
CPT[1]/ HCPCS	Mod	Status	Description	Work	Practice Expense	Mal-practice	Physi-cian Work RVUs[2]	Fully Imple-mented Non-Facility PE RVUs[2]	Year 2011 Transi-tional Non-Facility PE RVUs[2]	Fully Imple-mented Facility PE RVUs[2]	Year 2011 Transi-tional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27070		A	Part remove hip bone super	W	PE		11.56	NA	NA	11.52	10.99	2.27	090
27071		A	Part removal hip bone deep	W	PE		12.39	NA	NA	12.28	11.76	2.43	090
29540		A	Strapping of ankle and/or ft	W	PE	MP	0.32	0.63	0.62	0.32	0.35	0.03	000
29550		A	Strapping of toes	W	PE	MP	0.15	0.62	0.62	0.27	0.31	0.01	000
29914		A	Hip arthro w/femoroplasty	W	PE	MP	14.67	NA	NA	12.79	12.79	2.91	090
29915		A	Hip arthro acetabuloplasty	W	PE	MP	15.00	NA	NA	12.99	12.99	2.95	090
29916		A	Hip arthro w/labral repair	W	PE	MP	15.00	NA	NA	12.99	12.99	2.95	090
30901		A	Control of nosebleed	W	PE	MP	1.10	1.55	1.57	0.47	0.43	0.16	000
31256		A	Exploration maxillary sinus	W	PE		3.29	NA	NA	2.42	2.26	0.41	000
31267		A	Endoscopy maxillary sinus	W	PE		5.45	NA	NA	3.70	3.43	0.69	000
31276		A	Sinus endoscopy surgical	W	PE		8.84	NA	NA	5.69	5.27	1.14	000
31287		A	Nasal/sinus endoscopy surg	W	PE		3.91	NA	NA	2.79	2.59	0.50	000
31288		A	Nasal/sinus endoscopy surg	W	PE		4.57	NA	NA	3.18	2.96	0.60	000
31295		A	Sinus endo w/balloon dil	W	PE	MP	2.70	57.07	57.07	2.12	2.12	0.35	000
31296		A	Sinus endo w/balloon dil	W	PE	MP	3.29	108.70	108.70	2.47	2.47	0.42	000
31297		A	Sinus endo w/balloon dil	W	PE	MP	2.64	108.37	108.37	2.08	2.08	0.34	000
31634		A	Bronch w/balloon occlusion	W	PE	MP	4.00	48.98	48.98	1.76	1.76	0.33	000
33411		A	Replacement of aortic valve	W	PE		62.07	NA	NA	26.37	26.58	14.90	090
33620		A	Apply r&l pulm art bands	W	PE	MP	30.00	NA	NA	13.45	13.45	7.48	090
33621		A	Transthor cath for stent	W	PE	MP	16.18	NA	NA	7.42	7.42	3.75	090
33622		A	Redo compl cardiac anomaly	W	PE	MP	64.00	NA	NA	28.32	28.32	14.94	090
33860		A	Ascending aortic graft	W	PE		59.46	NA	NA	25.09	25.17	14.22	090
33863		A	Ascending aortic graft	W	PE		58.79	NA	NA	24.02	24.63	14.04	090
33864		A	Ascending aortic graft	W	PE		60.08	NA	NA	24.42	25.40	14.29	090
34900		A	Endovasc iliac repr w/graft	W	PE		16.85	NA	NA	7.63	7.96	3.57	090
35471		A	Repair arterial blockage	W	PE		10.05	61.23	75.23	3.99	4.80	1.98	000
36410		A	Non-routine bl draw > 3 yrs	W	PE	MP	0.18	0.27	0.33	0.08	0.07	0.03	XXX
37205		A	Transcath iv stent percut	W	PE		8.27	108.43	118.66	3.05	3.64	1.56	000
37206		A	Transcath iv stent/perc addl	W	PE		4.12	65.91	72.34	1.49	1.71	0.81	ZZZ
37207		A	Transcath iv stent open	W	PE		8.27	NA	NA	3.23	3.27	1.86	000
37208		A	Transcath iv stent/open addl	W	PE		4.12	NA	NA	1.42	1.43	0.92	ZZZ
37220		A	Iliac revasc	W	PE	MP	8.15	83.88	83.88	3.03	3.03	1.67	000
37221		A	Iliac revasc w/stent	W	PE	MP	10.00	126.56	126.56	3.75	3.75	1.89	000
37222		A	Iliac revasc add-on	W	PE	MP	3.73	22.52	22.52	1.34	1.34	0.76	ZZZ
37223		A	Iliac revasc w/stent add-on	W	PE	MP	4.25	132.39	132.39	1.53	1.53	0.84	ZZZ
37224		A	Fem/popl revas w/tla	W	PE	MP	9.00	101.76	101.76	3.34	3.34	1.81	000
37225		A	Fem/popl revas w/ather	W	PE	MP	12.00	303.34	303.34	4.55	4.55	2.51	000
37226		A	Fem/popl revasc w/stent	W	PE	MP	10.49	254.28	254.28	3.93	3.93	1.29	000
37227		A	Fem/popl revasc stnt & ather	W	PE	MP	14.50	412.19	412.19	5.48	5.48	3.04	000
37228		A	Tib/per revasc w/tla	W	PE	MP	11.00	146.98	146.98	4.04	4.04	2.25	000
37229		A	Tib/per revasc w/ather	W	PE	MP	14.05	298.12	298.12	5.30	5.30	2.97	000
37230		A	Tib/per revasc w/stent	W	PE	MP	13.80	231.18	231.18	5.13	5.13	2.61	000
37231		A	Tib/per revasc stent & ather	W	PE	MP	15.00	379.46	379.46	5.57	5.57	2.84	000

CPT[1]/ HCPCS	Mod	Status	Description	RVUs Open for Comment Work	Practice Expense	Mal-practice	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
37232		A	Tib/per revasc add-on	W	PE	MP	4.00	31.17	31.17	1.43	1.43	0.81	ZZZ
37233		A	Tibper revasc w/ather add-on	W	PE	MP	6.50	36.11	36.11	2.41	2.41	1.37	ZZZ
37234		A	Revsc opn/prq tib/pero stent	W	PE	MP	5.50	108.02	108.02	1.98	1.98	1.09	ZZZ
37235		A	Tib/per revasc stnt & ather	W	PE	MP	7.80	113.10	113.10	2.81	2.81	1.55	ZZZ
37765		A	Stab phleb veins xtr 10-20	W	PE		7.71	10.69	10.69	4.68	4.75	1.56	090
37766		A	Phleb veins - extrem 20+	W	PE		9.66	12.11	12.11	5.44	5.51	2.01	090
38900		A	Io map of sent lymph node	W	PE	MP	2.50	1.02	1.02	1.02	1.02	0.53	ZZZ
43283		A	Lap esoph lengthening	W	PE	MP	2.95	NA	NA	1.29	1.29	0.60	ZZZ
43327		A	Esoph fundoplasty lap	W	PE	MP	13.35	NA	NA	8.16	8.16	2.84	090
43328		A	Esoph fundoplasty thor	W	PE	MP	19.91	NA	NA	10.87	10.87	4.97	090
43332		A	Transab esoph hiat hern rpr	W	PE	MP	19.62	NA	NA	11.07	11.07	4.17	090
43333		A	Transab esoph hiat hern rpr	W	PE	MP	21.46	NA	NA	11.85	11.85	4.54	090
43334		A	Transthor diaphrag hern rpr	W	PE	MP	22.12	NA	NA	11.44	11.44	4.70	090
43335		A	Transthor diaphrag hern rpr	W	PE	MP	23.97	NA	NA	12.18	12.18	5.07	090
43336		A	Thorabd diaphr hern repair	W	PE	MP	25.81	NA	NA	13.52	13.52	5.84	090
43337		A	Thorabd diaphr hern repair	W	PE	MP	27.65	NA	NA	15.40	15.40	6.26	090
43338		A	Esoph lengthening	W	PE	MP	2.21	NA	NA	1.30	1.30	0.50	ZZZ
43605		A	Biopsy of stomach	W	PE		13.72	NA	NA	8.67	7.71	2.87	090
43753		A	Tx gastro intub w/asp	W	PE	MP	0.45	NA	NA	0.13	0.13	0.03	000
43754		A	Dx gastr intub w/asp spec	W	PE	MP	0.45	1.84	1.84	0.44	0.44	0.04	000
43755		A	Dx gastr intub w/asp specs	W	PE	MP	0.94	2.53	2.53	0.68	0.68	0.08	000
43756		A	Dx duod intub w/asp spec	W	PE	MP	0.77	5.62	5.62	0.71	0.71	0.05	000
43757		A	Dx duod intub w/asp specs	W	PE	MP	1.26	6.95	6.95	0.87	0.87	0.08	000
47480		A	Incision of gallbladder	W	PE		13.25	NA	NA	9.90	9.03	2.74	090
47490		A	Incision of gallbladder	W	PE	MP	4.76	NA	NA	4.32	5.57	0.43	010
49324		A	Lap insert tunnel ip cath	W	PE		6.32	NA	NA	4.13	3.82	1.33	010
49327		A	Lap ins device for rt	W	PE	MP	2.38	NA	NA	1.04	1.04	0.48	ZZZ
49400		A	Air injection into abdomen		PE		1.88	1.81	2.53	0.70	0.77	0.24	000
49412		A	Ins device for rt guide open	W	PE	MP	1.50	NA	NA	0.63	0.63	0.30	ZZZ
49418		A	Insert tun ip cath perc	W	PE	MP	4.21	40.03	40.03	2.07	2.07	0.62	000
49419		A	Insert tun ip cath w/port	W	PE		7.08	NA	NA	4.81	4.61	1.22	090
49421		A	Ins tun ip cath for dial opn	W	PE	MP	4.21	NA	NA	1.91	2.90	0.83	000
49422		A	Remove tunneled ip cath	W	PE		6.29	NA	NA	3.84	3.63	1.29	010
50250		A	Cryoablate renal mass open	W	PE		22.22	NA	NA	11.40	12.86	2.17	090
50542		A	Laparo ablate renal mass	W	PE		21.36	NA	NA	10.92	12.17	2.09	090
50590		A	Fragmenting of kidney stone		PE		9.77	11.28	15.39	5.83	6.50	0.95	090
50684		A	Injection for ureter x-ray		PE		0.76	2.15	3.63	0.62	0.68	0.07	000
51736		A	Urine flow measurement	W	PE	MP	0.17	0.66	0.85	NA	NA	0.02	XXX
51736	TC	A	Urine flow measurement	W	PE	MP	0.00	0.59	0.67	NA	NA	0.01	XXX
51736	26	A	Urine flow measurement	W	PE	MP	0.17	0.07	0.18	0.07	0.18	0.01	XXX
51741		A	Electro-uroflowmetry first	W	PE	MP	0.17	0.76	1.09	NA	NA	0.02	XXX
51741	TC	A	Electro-uroflowmetry first	W	PE	MP	0.00	0.69	0.78	NA	NA	0.01	XXX
51741	26	A	Electro-uroflowmetry first	W	PE	MP	0.17	0.07	0.31	0.07	0.31	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	RVUs Open for Comment Work	Practice Expense	Mal-practice	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
52281		A	Cystoscopy and treatment	W	PE	MP	2.60	4.57	5.80	1.40	1.61	0.27	000
52332		A	Cystoscopy and treatment	W	PE	MP	1.47	10.39	11.72	0.95	1.39	0.15	000
53860		A	Transurethral rf treatment	W	PE	MP	3.97	38.52	38.52	2.24	2.24	0.68	090
55866		A	Laparo radical prostatectomy	W	PE	MP	32.06	NA	NA	16.00	17.65	3.18	090
55876		A	Place rt device/marker pros	W	PE		1.73	1.98	2.27	1.05	1.20	0.16	000
57155		A	Insert uteri tandems/ovoids	W	PE	MP	3.37	6.05	6.05	1.69	1.69	0.30	000
57156		A	Ins vag brachytx device	W	PE	MP	1.87	2.41	2.41	1.01	1.01	0.16	000
59400		A	Obstetrical care	W	PE	MP	28.69	NA	NA	20.68	19.40	7.97	MMM
59409		A	Obstetrical care	W	PE	MP	12.82	NA	NA	6.02	5.65	3.54	MMM
59410		A	Obstetrical care	W	PE	MP	16.07	NA	NA	8.03	7.40	4.44	MMM
59412		A	Antepartum manipulation	W	PE	MP	1.53	NA	NA	0.88	0.87	0.43	MMM
59414		A	Deliver placenta	W	PE	MP	1.44	NA	NA	0.67	0.65	0.45	MMM
59425		A	Antepartum care only	W	PE	MP	5.63	5.34	5.31	2.62	2.43	1.55	MMM
59426		A	Antepartum care only	W	PE	MP	9.96	9.73	9.67	4.64	4.30	2.69	MMM
59430		A	Care after delivery	W	PE	MP	2.20	2.27	1.84	1.03	1.00	0.60	MMM
59510		A	Cesarean delivery	W	PE	MP	31.80	NA	NA	22.68	21.59	9.04	MMM
59514		A	Cesarean delivery only	W	PE	MP	14.39	NA	NA	6.77	6.53	4.07	MMM
59515		A	Cesarean delivery	W	PE	MP	19.15	NA	NA	10.07	9.25	5.42	MMM
59610		A	Vbac delivery	W	PE	MP	30.22	NA	NA	21.32	20.17	8.68	MMM
59612		A	Vbac delivery only	W	PE	MP	14.35	NA	NA	6.70	6.35	4.11	MMM
59614		A	Vbac care after delivery	W	PE	MP	17.60	NA	NA	8.66	7.92	5.04	MMM
59618		A	Attempted vbac delivery	W	PE	MP	32.26	NA	NA	22.83	22.08	9.26	MMM
59620		A	Attempted vbac delivery only	W	PE	MP	14.86	NA	NA	6.93	6.92	4.26	MMM
59622		A	Attempted vbac after care	W	PE	MP	19.63	NA	NA	10.32	9.78	5.64	MMM
61781		A	Scan proc cranial intra	W	PE	MP	3.75	NA	NA	2.14	2.14	1.25	ZZZ
61782		A	Scan proc cranial extra	W	PE	MP	3.18	NA	NA	1.81	1.81	0.87	ZZZ
61783		A	Scan proc spinal	W	PE	MP	3.75	NA	NA	2.14	2.14	0.15	ZZZ
61885		A	Insrt/redo neurostim 1 array	W	PE	MP	6.05	NA	NA	7.22	7.82	2.06	090
62268		A	Drain spinal cord cyst		PE		4.73	2.04	5.21	2.53	2.46	0.45	000
62269		A	Needle biopsy spinal cord		PE		5.01	1.92	5.61	2.31	2.27	0.56	000
62281		A	Treat spinal cord lesion		PE		2.66	4.03	4.71	1.73	1.48	0.27	010
62319		A	Inject spine w/cath l/s (cd)		PE		1.87	2.98	3.54	0.87	0.74	0.16	000
63075		A	Neck spine disk surgery	W	PE		19.60	NA	NA	15.40	14.78	6.10	090
63076		A	Neck spine disk surgery	W	PE		4.04	NA	NA	2.29	2.21	1.25	ZZZ
63610		A	Stimulation of spinal cord		PE		8.72	2.03	15.94	2.41	2.33	0.68	000
64415		A	N block inj brachial plexus	W	PE	MP	1.48	1.90	2.02	0.36	0.40	0.11	000
64445		A	N block inj sciatic sng	W	PE	MP	1.48	2.30	2.30	0.54	0.58	0.16	000
64447		A	N block inj fem single	W	PE	MP	1.50	1.89	1.89	0.36	0.33	0.11	000
64479		A	Inj foramen epidural c/t	W	PE	MP	2.29	4.76	5.27	1.54	1.30	0.27	000
64480		A	Inj foramen epidural add-on	W	PE	MP	1.20	2.36	2.35	0.64	0.59	0.18	ZZZ
64483		A	Inj foramen epidural l/s	W	PE	MP	1.90	4.55	5.23	1.35	1.16	0.16	000
64484		A	Inj foramen epidural add-on	W	PE	MP	1.00	1.61	2.06	0.52	0.48	0.08	ZZZ
64508		A	N block carotid sinus s/p		PE		1.12	0.50	1.72	0.94	0.85	0.24	000

CPT[1]/ HCPCS	Mod	Status	Description	RVUs Open for Comment			Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
				Work	Practice Expense	Mal-practice							
64561		A	Implant neuroelectrodes		PE		7.15	14.88	20.88	3.88	4.17	0.77	010
64566		A	Neuroeltrd stim post tibial	W	PE	MP	0.60	3.17	3.17	0.23	0.23	0.05	000
64568		A	Inc for vagus n elect impl	W	PE	MP	9.00	NA	NA	8.67	8.67	1.25	090
64569		A	Revise/repl vagus n eltrd	W	PE	MP	11.00	NA	NA	4.50	4.50	3.15	090
64570		A	Remove vagus n eltrd	W	PE	MP	9.10	NA	NA	4.06	4.06	3.26	090
64581		A	Implant neuroelectrodes	W	PE		12.20	NA	NA	6.04	7.05	1.58	090
64611		A	Chemodenerv saliv glands	W	PE	MP	1.03	1.64	1.64	1.35	1.35	0.29	010
64708		A	Revise arm/leg nerve	W	PE		6.36	NA	NA	7.09	6.63	1.15	090
64712		A	Revision of sciatic nerve	W	PE		8.07	NA	NA	7.25	6.71	1.33	090
64713		A	Revision of arm nerve(s)	W	PE		11.40	NA	NA	9.05	8.55	2.34	090
64714		A	Revise low back nerve(s)	W	PE		10.55	NA	NA	8.66	7.44	1.71	090
65778		A	Cover eye w/membrane	W	PE	MP	1.19	35.71	35.71	0.84	0.84	0.18	010
65779		A	Cover eye w/membrane stent	W	PE	MP	3.92	29.05	29.05	4.09	4.09	0.56	010
65780		A	Ocular reconst transplant	W	PE		10.73	NA	NA	14.18	12.94	1.39	090
66174		A	Translum dil eye canal	W	PE	MP	12.85	NA	NA	13.84	13.84	2.27	090
66175		A	Trnslum dil eye canal w/stnt	W	PE	MP	13.60	NA	NA	14.37	14.37	4.86	090
66761		A	Revision of iris	W	PE	MP	3.00	5.25	5.85	3.63	4.46	0.45	010
67028		A	Injection eye drug	W	PE	MP	1.44	1.43	2.15	1.38	1.52	0.20	000
69801		A	Incise inner ear	W	PE	MP	2.06	3.63	3.63	1.58	6.61	0.27	000
69802		A	Incise inner ear	W	PE		13.50	NA	NA	16.79	15.85	1.71	090
70010		A	Contrast x-ray of brain		PE		1.19	0.80	2.39	0.80	2.39	0.16	XXX
71250		A	Ct thorax w/o dye	W	PE	MP	1.00	4.97	6.38	NA	NA	0.07	XXX
71250	TC	A	Ct thorax w/o dye	W	PE	MP	0.00	4.59	5.93	NA	NA	0.01	XXX
71250	26	A	Ct thorax w/o dye	W	PE	MP	1.00	0.38	0.45	0.38	0.45	0.06	XXX
72125		A	Ct neck spine w/o dye	W	PE	MP	1.00	5.01	6.42	NA	NA	0.07	XXX
72125	TC	A	Ct neck spine w/o dye	W	PE	MP	0.00	4.64	5.97	NA	NA	0.01	XXX
72125	26	A	Ct neck spine w/o dye	W	PE	MP	1.00	0.37	0.45	0.37	0.45	0.06	XXX
72128		A	Ct chest spine w/o dye	W	PE	MP	1.00	5.01	6.40	NA	NA	0.07	XXX
72128	TC	A	Ct chest spine w/o dye	W	PE	MP	0.00	4.63	5.95	NA	NA	0.01	XXX
72128	26	A	Ct chest spine w/o dye	W	PE	MP	1.00	0.38	0.45	0.38	0.45	0.06	XXX
72131		A	Ct lumbar spine w/o dye	W	PE	MP	1.00	4.99	6.38	NA	NA	0.07	XXX
72131	TC	A	Ct lumbar spine w/o dye	W	PE	MP	0.00	4.61	5.93	NA	NA	0.01	XXX
72131	26	A	Ct lumbar spine w/o dye	W	PE	MP	1.00	0.38	0.45	0.38	0.45	0.06	XXX
73080		A	X-ray exam of elbow	W	PE	MP	0.17	0.77	0.82	NA	NA	0.02	XXX
73080	TC	A	X-ray exam of elbow	W	PE	MP	0.00	0.70	0.75	NA	NA	0.01	XXX
73080	26	A	X-ray exam of elbow	W	PE	MP	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73200		A	Ct upper extremity w/o dye	W	PE	MP	1.00	4.95	6.19	NA	NA	0.07	XXX
73200	TC	A	Ct upper extremity w/o dye	W	PE	MP	0.00	4.57	5.76	NA	NA	0.01	XXX
73200	26	A	Ct upper extremity w/o dye	W	PE	MP	1.00	0.38	0.43	0.38	0.43	0.06	XXX
73510		A	X-ray exam of hip	W	PE	MP	0.21	0.89	0.90	NA	NA	0.04	XXX
73510	TC	A	X-ray exam of hip	W	PE	MP	0.00	0.79	0.80	NA	NA	0.01	XXX
73510	26	A	X-ray exam of hip	W	PE	MP	0.21	0.10	0.10	0.10	0.10	0.03	XXX
73610		A	X-ray exam of ankle	W	PE	MP	0.17	0.78	0.78	NA	NA	0.02	XXX
73610	TC	A	X-ray exam of ankle	W	PE	MP	0.00	0.70	0.71	NA	NA	0.01	XXX
73610	26	A	X-ray exam of ankle	W	PE	MP	0.17	0.08	0.07	0.08	0.07	0.01	XXX
73630		A	X-ray exam of foot	W	PE	MP	0.17	0.73	0.75	NA	NA	0.02	XXX
73630	TC	A	X-ray exam of foot	W	PE	MP	0.00	0.66	0.68	NA	NA	0.01	XXX
73630	26	A	X-ray exam of foot	W	PE	MP	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73700		A	Ct lower extremity w/o dye	W	PE	MP	1.00	4.96	6.21	NA	NA	0.07	XXX
73700	TC	A	Ct lower extremity w/o dye	W	PE	MP	0.00	4.59	5.78	NA	NA	0.01	XXX
73700	26	A	Ct lower extremity w/o dye	W	PE	MP	1.00	0.37	0.43	0.37	0.43	0.06	XXX
74176		A	Ct abd & pelvis w/o contrast	W	PE	MP	1.74	4.54	4.54	NA	NA	0.11	XXX
74176	TC	A	Ct abd & pelvis w/o contrast	W	PE	MP	0.00	3.89	3.89	NA	NA	0.01	XXX
74176	26	A	Ct abd & pelvis w/o contrast	W	PE	MP	1.74	0.65	0.65	0.65	0.65	0.10	XXX
74177		A	Ct abdomen&pelvis w/contrast	W	PE	MP	1.82	8.11	8.11	NA	NA	0.11	XXX
74177	TC	A	Ct abdomen&pelvis w/contrast	W	PE	MP	0.00	7.42	7.42	NA	NA	0.01	XXX
74177	26	A	Ct abdomen&pelvis w/contrast	W	PE	MP	1.82	0.69	0.69	0.69	0.69	0.10	XXX
74178		A	Ct abd&pelv 1+ section/regns	W	PE	MP	2.01	10.57	10.57	NA	NA	0.14	XXX
74178	TC	A	Ct abd&pelv 1+ section/regns	W	PE	MP	0.00	9.81	9.81	NA	NA	0.02	XXX
74178	26	A	Ct abd&pelv 1+ section/regns	W	PE	MP	2.01	0.76	0.76	0.76	0.76	0.12	XXX
74430		A	Contrast x-ray bladder		PE		0.32	0.82	1.47	NA	NA	0.02	XXX
74430	TC	A	Contrast x-ray bladder		PE		0.00	0.70	1.34	NA	NA	0.01	XXX
74430	26	A	Contrast x-ray bladder		PE		0.32	0.12	0.13	0.12	0.13	0.01	XXX
75954		C	Iliac aneurysm endovas rpr	W	PE		0.00	0.00	0.00	NA	NA	0.00	XXX
75954	TC	C	Iliac aneurysm endovas rpr	W	PE		0.00	0.00	0.00	NA	NA	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	W	PE		2.25	0.79	0.83	0.79	0.83	0.41	XXX
75960		A	Transcath iv stent rs&i	W	PE		0.82	2.70	4.86	NA	NA	0.06	XXX
75960	TC	A	Transcath iv stent rs&i	W	PE		0.00	2.40	4.52	NA	NA	0.01	XXX
75960	26	A	Transcath iv stent rs&i	W	PE		0.82	0.30	0.34	0.30	0.34	0.05	XXX
75962		A	Repair arterial blockage	W	PE		0.54	3.47	5.71	NA	NA	0.04	XXX
75962	TC	A	Repair arterial blockage	W	PE		0.00	3.27	5.49	NA	NA	0.01	XXX
75962	26	A	Repair arterial blockage	W	PE		0.54	0.20	0.22	0.20	0.22	0.03	XXX
75964		A	Repair artery blockage each	W	PE		0.36	2.35	3.52	NA	NA	0.05	ZZZ
75964	TC	A	Repair artery blockage each	W	PE		0.00	2.22	3.38	NA	NA	0.01	ZZZ
75964	26	A	Repair artery blockage each	W	PE		0.36	0.13	0.14	0.13	0.14	0.04	ZZZ
76000		A	Fluoroscope examination		PE		0.17	1.30	2.10	NA	NA	0.02	XXX
76000	TC	A	Fluoroscope examination		PE		0.00	1.23	2.03	NA	NA	0.01	XXX
76000	26	A	Fluoroscope examination		PE		0.17	0.07	0.07	0.07	0.07	0.01	XXX
76881		A	Us xtr non-vasc complete	W	PE	MP	0.59	2.76	2.76	NA	NA	0.05	XXX
76881	TC	A	Us xtr non-vasc complete	W	PE	MP	0.00	2.54	2.54	NA	NA	0.01	XXX
76881	26	A	Us xtr non-vasc complete	W	PE	MP	0.59	0.22	0.22	0.22	0.22	0.04	XXX
76882		A	Us xtr non-vasc lmtd	W	PE	MP	0.41	0.44	0.44	NA	NA	0.04	XXX
76882	TC	A	Us xtr non-vasc lmtd	W	PE	MP	0.00	0.29	0.29	NA	NA	0.01	XXX
76882	26	A	Us xtr non-vasc lmtd	W	PE	MP	0.41	0.15	0.15	0.15	0.15	0.03	XXX
76942		A	Echo guide for biopsy	W	PE		0.67	4.98	5.13	NA	NA	0.05	XXX
76942	TC	A	Echo guide for biopsy	W	PE		0.00	4.72	4.85	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	RVUs Open for Comment			Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
				Work	Practice Expense	Mal-practice							
76942	26	A	Echo guide for biopsy	W	PE		0.67	0.26	0.28	0.26	0.28	0.04	XXX
77003		A	Fluoroguide for spine inject	W	PE		0.60	1.25	1.20	NA	NA	0.04	XXX
77003	TC	A	Fluoroguide for spine inject	W	PE		0.00	0.96	0.96	NA	NA	0.01	XXX
77003	26	A	Fluoroguide for spine inject	W	PE		0.60	0.29	0.24	0.29	0.24	0.03	XXX
77011		A	Ct scan for localization		PE		1.21	5.40	13.03	NA	NA	0.05	XXX
77011	TC	A	Ct scan for localization		PE		0.00	4.85	12.49	NA	NA	0.01	XXX
77011	26	A	Ct scan for localization		PE		1.21	0.55	0.54	0.55	0.54	0.04	XXX
77012		A	Ct scan for needle biopsy	W	PE		1.16	2.47	3.63	NA	NA	0.05	XXX
77012	TC	A	Ct scan for needle biopsy	W	PE		0.00	2.04	3.14	NA	NA	0.01	XXX
77012	26	A	Ct scan for needle biopsy	W	PE		1.16	0.43	0.49	0.43	0.49	0.04	XXX
77301		A	Radiotherapy dose plan imrt		PE		7.99	45.27	53.19	NA	NA	0.63	XXX
77301	TC	A	Radiotherapy dose plan imrt		PE		0.00	41.70	49.73	NA	NA	0.22	XXX
77301	26	A	Radiotherapy dose plan imrt		PE		7.99	3.57	3.46	3.57	3.46	0.41	XXX
77427		A	Radiation tx management x5	W	PE	MP	2.92	1.52	1.59	1.52	1.59	0.23	XXX
88120		A	Cytp urne 3-5 probes ea spec	W	PE	MP	1.20	12.22	12.22	NA	NA	0.05	XXX
88120	TC	A	Cytp urne 3-5 probes ea spec	W	PE	MP	0.00	11.91	11.91	NA	NA	0.02	XXX
88120	26	A	Cytp urne 3-5 probes ea spec	W	PE	MP	1.20	0.31	0.31	0.31	0.31	0.03	XXX
88121		A	Cytp urine 3-5 probes cmptr	W	PE	MP	1.00	10.34	10.34	NA	NA	0.03	XXX
88121	TC	A	Cytp urine 3-5 probes cmptr	W	PE	MP	0.00	10.00	10.00	NA	NA	0.01	XXX
88121	26	A	Cytp urine 3-5 probes cmptr	W	PE	MP	1.00	0.34	0.34	0.34	0.34	0.02	XXX
88172		A	Cytp dx eval fna 1st ea site	W	PE	MP	0.60	0.76	0.87	NA	NA	0.02	XXX
88172	TC	A	Cytp dx eval fna 1st ea site	W	PE	MP	0.00	0.47	0.60	NA	NA	0.01	XXX
88172	26	A	Cytp dx eval fna 1st ea site	W	PE	MP	0.60	0.29	0.27	0.29	0.27	0.01	XXX
88173		A	Cytopath eval fna report	W	PE		1.39	2.56	2.62	NA	NA	0.05	XXX
88173	TC	A	Cytopath eval fna report	W	PE		0.00	1.95	2.04	NA	NA	0.01	XXX
88173	26	A	Cytopath eval fna report	W	PE		1.39	0.61	0.58	0.61	0.58	0.04	XXX
88177		A	Cytp c/v auto thin lyr addl	W	PE	MP	0.42	0.38	0.38	NA	NA	0.02	ZZZ
88177	TC	A	Cytp c/v auto thin lyr addl	W	PE	MP	0.00	0.18	0.18	NA	NA	0.01	ZZZ
88177	26	A	Cytp c/v auto thin lyr addl	W	PE	MP	0.42	0.20	0.20	0.20	0.20	0.01	ZZZ
88300		A	Surgical path gross	W	PE	MP	0.08	0.71	0.69	NA	NA	0.02	XXX
88300	TC	A	Surgical path gross	W	PE	MP	0.00	0.67	0.65	NA	NA	0.01	XXX
88300	26	A	Surgical path gross	W	PE	MP	0.08	0.04	0.04	0.04	0.04	0.01	XXX
88302		A	Tissue exam by pathologist	W	PE	MP	0.13	1.41	1.43	NA	NA	0.02	XXX
88302	TC	A	Tissue exam by pathologist	W	PE	MP	0.00	1.35	1.38	NA	NA	0.01	XXX
88302	26	A	Tissue exam by pathologist	W	PE	MP	0.13	0.06	0.05	0.06	0.05	0.01	XXX
88304		A	Tissue exam by pathologist	W	PE	MP	0.22	1.44	1.61	NA	NA	0.02	XXX
88304	TC	A	Tissue exam by pathologist	W	PE	MP	0.00	1.34	1.52	NA	NA	0.01	XXX
88304	26	A	Tissue exam by pathologist	W	PE	MP	0.22	0.10	0.09	0.10	0.09	0.01	XXX
88305		A	Tissue exam by pathologist	W	PE	MP	0.75	2.19	2.35	NA	NA	0.02	XXX
88305	TC	A	Tissue exam by pathologist	W	PE	MP	0.00	1.87	2.04	NA	NA	0.01	XXX
88305	26	A	Tissue exam by pathologist	W	PE	MP	0.75	0.32	0.31	0.32	0.31	0.01	XXX
88307		A	Tissue exam by pathologist	W	PE	MP	1.59	5.09	5.04	NA	NA	0.05	XXX
88307	TC	A	Tissue exam by pathologist	W	PE	MP	0.00	4.34	4.33	NA	NA	0.01	XXX
88307	26	A	Tissue exam by pathologist	W	PE	MP	1.59	0.75	0.71	0.75	0.71	0.04	XXX
88309		A	Tissue exam by pathologist	W	PE		2.80	7.38	7.21	NA	NA	0.11	XXX
88309	TC	A	Tissue exam by pathologist	W	PE		0.00	6.05	5.99	NA	NA	0.03	XXX
88309	26	A	Tissue exam by pathologist	W	PE		2.80	1.33	1.22	1.33	1.22	0.08	XXX
88363		A	Xm archive tissue molec anal	W	PE	MP	0.37	0.72	0.72	0.10	0.10	0.03	XXX
88367		A	Insitu hybridization auto	W	PE		1.30	6.08	6.21	NA	NA	0.06	XXX
88367	TC	A	Insitu hybridization auto	W	PE		0.00	5.63	5.77	NA	NA	0.01	XXX
88367	26	A	Insitu hybridization auto	W	PE		1.30	0.45	0.44	0.45	0.44	0.05	XXX
88368		A	Insitu hybridization manual	W	PE		1.40	4.83	5.04	NA	NA	0.05	XXX
88368	TC	A	Insitu hybridization manual	W	PE		0.00	4.47	4.65	NA	NA	0.01	XXX
88368	26	A	Insitu hybridization manual	W	PE		1.40	0.36	0.39	0.36	0.39	0.04	XXX
90460		A	Imadm any route 1st vac/tox	W	PE	MP	0.17	0.50	0.50	NA	NA	0.01	XXX
90461		A	Inadm any route addl vac/tox	W	PE	MP	0.15	0.20	0.18	NA	NA	0.01	ZZZ
90870		A	Electroconvulsive therapy	W	PE	MP	2.50	2.33	2.31	0.58	0.56	0.11	000
90935		A	Hemodialysis one evaluation	W	PE	MP	1.48	NA	NA	0.57	0.64	0.08	000
90937		A	Hemodialysis repeated eval	W	PE	MP	2.11	NA	NA	0.82	0.93	0.11	000
90945		A	Dialysis one evaluation	W	PE	MP	1.56	0.60	0.66	NA	NA	0.08	000
90947		A	Dialysis repeated eval	W	PE	MP	2.52	NA	NA	0.97	1.01	0.15	000
91010		A	Esophagus motility study	W	PE	MP	1.28	3.73	4.17	NA	NA	0.08	000
91010	TC	A	Esophagus motility study	W	PE	MP	0.00	3.04	3.49	NA	NA	0.01	000
91010	26	A	Esophagus motility study	W	PE	MP	1.28	0.69	0.68	0.69	0.68	0.07	000
91013		A	Esophgl motil w/stim/perfus	W	PE	MP	0.18	0.48	0.48	NA	NA	0.02	ZZZ
91013	TC	A	Esophgl motil w/stim/perfus	W	PE	MP	0.00	0.38	0.38	NA	NA	0.01	ZZZ
91013	26	A	Esophgl motil w/stim/perfus	W	PE	MP	0.18	0.10	0.10	0.10	0.10	0.01	ZZZ
91038		A	Esoph imped funct test > 1h	W			1.10	12.00	7.67	NA	NA	0.06	000
91038	TC	A	Esoph imped funct test > 1h	W			0.00	11.40	7.07	NA	NA	0.01	000
91038	26	A	Esoph imped funct test > 1h	W			1.10	0.60	0.60	0.60	0.60	0.05	000
91117		A	Colon motility 6 hr study	W	PE	MP	2.45	1.36	1.36	1.64	1.64	0.38	000
91132		A	Electrogastrography	W			0.52	3.61	3.62	NA	NA	0.04	XXX
91132	TC	A	Electrogastrography	W			0.00	3.34	3.34	NA	NA	0.01	XXX
91132	26	A	Electrogastrography	W			0.52	0.27	0.28	0.27	0.28	0.03	XXX
91133		A	Electrogastrography w/test	W			0.66	4.39	4.40	NA	NA	0.05	XXX
91133	TC	A	Electrogastrography w/test	W			0.00	4.02	4.02	NA	NA	0.01	XXX
91133	26	A	Electrogastrography w/test	W			0.66	0.37	0.38	0.37	0.38	0.04	XXX
92081		A	Visual field examination(s)	W	PE	MP	0.30	1.03	1.10	NA	NA	0.03	XXX
92081	TC	A	Visual field examination(s)	W	PE	MP	0.00	0.86	0.93	NA	NA	0.01	XXX
92081	26	A	Visual field examination(s)	W	PE	MP	0.30	0.17	0.17	0.17	0.17	0.02	XXX
92082		A	Visual field examination(s)	W	PE	MP	0.40	1.51	1.55	NA	NA	0.05	XXX
92082	TC	A	Visual field examination(s)	W	PE	MP	0.00	1.28	1.34	NA	NA	0.01	XXX
92082	26	A	Visual field examination(s)	W	PE	MP	0.40	0.23	0.21	0.23	0.21	0.04	XXX
92132		A	Cmptr ophth dx img ant segmt	W	PE	MP	0.35	0.68	0.68	NA	NA	0.04	XXX
92132	TC	A	Cmptr ophth dx img ant segmt	W	PE	MP	0.00	0.44	0.44	NA	NA	0.01	XXX
92132	26	A	Cmptr ophth dx img ant segmt	W	PE	MP	0.35	0.24	0.24	0.24	0.24	0.03	XXX

CPT[1]/ HCPCS	Mod	Status	Description	RVUs Open for Comment			Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
				Work	Practice Expense	Mal-practice							
92133		A	Cmptr ophth img optic nerve	W	PE	MP	0.50	0.77	0.77	NA	NA	0.04	XXX
92133	TC	A	Cmptr ophth img optic nerve	W	PE	MP	0.00	0.44	0.44	NA	NA	0.01	XXX
92133	26	A	Cmptr ophth img optic nerve	W	PE	MP	0.50	0.33	0.33	0.33	0.33	0.03	XXX
92134		A	Cptr ophth dx img post segmt	W	PE	MP	0.50	0.77	0.77	NA	NA	0.04	XXX
92134	TC	A	Cptr ophth dx img post segmt	W	PE	MP	0.00	0.44	0.44	NA	NA	0.01	XXX
92134	26	A	Cptr ophth dx img post segmt	W	PE	MP	0.50	0.33	0.33	0.33	0.33	0.03	XXX
92227		A	Remote dx retinal imaging	W	PE		0.00	0.33	0.33	NA	NA	0.01	XXX
92228		A	Remote retinal imaging mgmt	W	PE	MP	0.30	0.56	0.56	NA	NA	0.02	XXX
92228	TC	A	Remote retinal imaging mgmt	W	PE	MP	0.00	0.36	0.36	NA	NA	0.01	XXX
92228	26	A	Remote retinal imaging mgmt	W	PE	MP	0.30	0.20	0.20	0.20	0.20	0.01	XXX
92285		A	Eye photography	W	PE	MP	0.05	0.49	0.75	NA	NA	0.02	XXX
92285	TC	A	Eye photography	W	PE	MP	0.00	0.46	0.69	NA	NA	0.01	XXX
92285	26	A	Eye photography	W	PE	MP	0.05	0.03	0.06	0.03	0.06	0.01	XXX
92504		A	Ear microscopy examination	W	PE	MP	0.18	0.70	0.70	0.11	0.10	0.01	XXX
92507		A	Speech/hearing therapy	W	PE	MP	1.30	0.69	1.05	NA	NA	0.07	XXX
92508		A	Speech/hearing therapy	W	PE	MP	0.33	0.24	0.45	NA	NA	0.01	XXX
92606		B	Non-speech device service	W	PE	MP	1.40	0.93	0.93	0.62	0.62	0.01	XXX
92607		A	Ex for speech device rx 1hr	W	PE	MP	1.85	1.50	3.25	NA	NA	0.01	XXX
92608		A	Ex for speech device rx addl	W	PE	MP	0.70	0.67	0.80	NA	NA	0.01	ZZZ
92609		A	Use of speech device service	W	PE	MP	1.50	1.04	1.84	NA	NA	0.01	XXX
93040		A	Rhythm ecg with report	W	PE	MP	0.15	0.19	0.22	NA	NA	0.02	XXX
93041		A	Rhythm ecg tracing		PE		0.00	0.14	0.16	NA	NA	0.01	XXX
93042		A	Rhythm ecg report	W	PE	MP	0.15	0.05	0.06	0.05	0.06	0.01	XXX
93224		A	Ecg monit/reprt up to 48 hrs	W	PE	MP	0.52	1.97	2.54	NA	NA	0.03	XXX
93225		A	Ecg monit/reprt up to 48 hrs		PE		0.00	0.90	1.01	NA	NA	0.01	XXX
93226		A	Ecg monit/reprt up to 48 hrs		PE		0.00	0.83	1.26	NA	NA	0.01	XXX
93227		A	Ecg monit/reprt up to 48 hrs	W	PE	MP	0.52	0.24	0.27	0.24	0.27	0.01	XXX
93228		A	Remote 30 day ecg rev/report	W	PE		0.52	0.21	0.21	0.21	0.21	0.03	XXX
93229		A	Remote 30 day ecg tech supp		PE		0.00	20.13	20.13	NA	NA	0.01	XXX
93268		A	Ecg record/review	W	PE	MP	0.52	5.69	6.85	NA	NA	0.03	XXX
93270		A	Remote 30 day ecg rev/report		PE		0.00	0.24	0.44	NA	NA	0.01	XXX
93271		A	Ecg/monitoring and analysis		PE		0.00	5.25	6.18	NA	NA	0.01	XXX
93272		A	Ecg/review interpret only	W	PE	MP	0.52	0.20	0.23	0.20	0.23	0.01	XXX
93451		A	Right heart cath	W	PE	MP	2.72	19.21	19.21	NA	NA	0.61	000
93451	TC	A	Right heart cath	W	PE	MP	0.00	18.14	18.14	NA	NA	0.03	000
93451	26	A	Right heart cath	W	PE	MP	2.72	1.07	1.07	1.07	1.07	0.58	000
93452		A	Left hrt cath w/ventrclgrphy	W	PE	MP	4.75	19.19	19.19	NA	NA	1.09	000
93452	TC	A	Left hrt cath w/ventrclgrphy	W	PE	MP	0.00	17.33	17.33	NA	NA	0.04	000
93452	26	A	Left hrt cath w/ventrclgrphy	W	PE	MP	4.75	1.86	1.86	1.86	1.86	1.05	000
93453		A	R&l hrt cath w/ventriclgrphy	W	PE	MP	6.24	25.10	25.10	NA	NA	1.42	000
93453	TC	A	R&l hrt cath w/ventriclgrphy	W	PE	MP	0.00	22.66	22.66	NA	NA	0.05	000
93453	26	A	R&l hrt cath w/ventriclgrphy	W	PE	MP	6.24	2.44	2.44	2.44	2.44	1.37	000
93454		A	Coronary artery angio s&i	W	PE	MP	4.79	19.94	19.94	NA	NA	1.10	000
93454	TC	A	Coronary artery angio s&i	W	PE	MP	0.00	18.06	18.06	NA	NA	0.04	000
93454	26	A	Coronary artery angio s&i	W	PE	MP	4.79	1.88	1.88	1.88	1.88	1.06	000
93455		A	Coronary art/grft angio s&i	W	PE	MP	5.54	23.33	23.33	NA	NA	1.25	000
93455	TC	A	Coronary art/grft angio s&i	W	PE	MP	0.00	21.16	21.16	NA	NA	0.05	000
93455	26	A	Coronary art/grft angio s&i	W	PE	MP	5.54	2.17	2.17	2.17	2.17	1.20	000
93456		A	R hrt coronary artery angio	W	PE	MP	6.15	24.78	24.78	NA	NA	1.39	000
93456	TC	A	R hrt coronary artery angio	W	PE	MP	0.00	22.37	22.37	NA	NA	0.05	000
93456	26	A	R hrt coronary artery angio	W	PE	MP	6.15	2.41	2.41	2.41	2.41	1.34	000
93457		A	R hrt art/grft angio	W	PE	MP	6.89	28.18	28.18	NA	NA	1.54	000
93457	TC	A	R hrt art/grft angio	W	PE	MP	0.00	25.48	25.48	NA	NA	0.05	000
93457	26	A	R hrt art/grft angio	W	PE	MP	6.89	2.70	2.70	2.70	2.70	1.49	000
93458		A	L hrt artery/ventricle angio	W	PE	MP	5.85	23.97	23.97	NA	NA	1.33	000
93458	TC	A	L hrt artery/ventricle angio	W	PE	MP	0.00	21.68	21.68	NA	NA	0.05	000
93458	26	A	L hrt artery/ventricle angio	W	PE	MP	5.85	2.29	2.29	2.29	2.29	1.28	000
93459		A	L hrt art/grft angio	W	PE	MP	6.60	26.33	26.33	NA	NA	1.48	000
93459	TC	A	L hrt art/grft angio	W	PE	MP	0.00	23.75	23.75	NA	NA	0.05	000
93459	26	A	L hrt art/grft angio	W	PE	MP	6.60	2.58	2.58	2.58	2.58	1.43	000
93460		A	R&l hrt art/ventricle angio	W	PE	MP	7.35	27.83	27.83	NA	NA	1.64	000
93460	TC	A	R&l hrt art/ventricle angio	W	PE	MP	0.00	24.95	24.95	NA	NA	0.05	000
93460	26	A	R&l hrt art/ventricle angio	W	PE	MP	7.35	2.88	2.88	2.88	2.88	1.59	000
93461		A	R&l hrt art/ventricle angio	W	PE	MP	8.10	32.26	32.26	NA	NA	1.83	000
93461	TC	A	R&l hrt art/ventricle angio	W	PE	MP	0.00	29.09	29.09	NA	NA	0.06	000
93461	26	A	R&l hrt art/ventricle angio	W	PE	MP	8.10	3.17	3.17	3.17	3.17	1.77	000
93462		A	L hrt cath trnsptl puncture	W	PE	MP	3.73	1.48	1.48	1.48	1.48	0.80	ZZZ
93463		A	Drug admin & hemodynmic meas	W	PE	MP	2.00	0.79	0.79	0.79	0.79	0.39	ZZZ
93464		A	Exercise w/hemodynamic meas	W	PE	MP	1.80	5.28	5.28	NA	NA	0.36	ZZZ
93464	TC	A	Exercise w/hemodynamic meas	W	PE	MP	0.00	4.63	4.63	NA	NA	0.01	ZZZ
93464	26	A	Exercise w/hemodynamic meas	W	PE	MP	1.80	0.65	0.65	0.65	0.65	0.35	ZZZ
93563		A	Inject congenital card cath	W	PE	MP	1.11	0.44	0.44	0.44	0.44	0.10	ZZZ
93564		A	Inject hrt congntl art/grft	W	PE	MP	1.13	0.45	0.45	0.45	0.45	0.10	ZZZ
93565		A	Inject l ventr/atrial angio	W	PE	MP	0.86	0.34	0.34	0.34	0.34	0.08	ZZZ
93566		A	Inject r ventr/atrial angio	W	PE	MP	0.86	4.06	4.06	0.34	0.34	0.07	ZZZ
93567		A	Inject suprvlv aortography	W	PE	MP	0.97	3.08	3.08	0.38	0.38	0.08	ZZZ
93568		A	Inject pulm art hrt cath	W	PE	MP	0.88	3.56	3.56	0.35	0.35	0.08	ZZZ
93652		A	Ablate heart dysrhythm focus	W	PE	MP	17.65	NA	NA	6.95	8.82	3.84	000
93922		A	Upr/l xtremity art 2 levels	W	PE	MP	0.25	2.39	2.99	NA	NA	0.02	XXX
93922	TC	A	Upr/l xtremity art 2 levels	W	PE	MP	0.00	2.29	2.89	NA	NA	0.01	XXX
93922	26	A	Upr/l xtremity art 2 levels	W	PE	MP	0.25	0.10	0.10	0.10	0.10	0.01	XXX
93923		A	Upr/lxtr art stdy 3+ lvls	W	PE	MP	0.45	3.65	4.54	NA	NA	0.05	XXX
93923	TC	A	Upr/lxtr art stdy 3+ lvls	W	PE	MP	0.00	3.48	4.36	NA	NA	0.01	XXX
93923	26	A	Upr/lxtr art stdy 3+ lvls	W	PE	MP	0.45	0.17	0.18	0.17	0.18	0.04	XXX
93924		A	Lwr xtr vasc stdy bilat	W	PE	MP	0.50	4.72	5.76	NA	NA	0.05	XXX
93924	TC	A	Lwr xtr vasc stdy bilat	W	PE	MP	0.00	4.53	5.55	NA	NA	0.01	XXX

CPT[1]/ HCPCS	Mod	Status	Description	RVUs Open for Comment Work	Practice Expense	Mal-practice	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2011 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2011 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
93924	26	A	Lwr xtr vasc stdy bilat	W	PE	MP	0.50	0.19	0.21	0.19	0.21	0.04	XXX
95800		A	Slp stdy unattended	W	PE	MP	1.05	37.51	37.51	NA	NA	0.05	XXX
95800	TC	A	Slp stdy unattended	W	PE	MP	0.00	36.89	36.89	NA	NA	0.01	XXX
95800	26	A	Slp stdy unattended	W	PE	MP	1.05	0.62	0.62	0.62	0.62	0.04	XXX
95801		A	Slp stdy unatnd w/anal	W	PE	MP	1.00	64.32	64.32	NA	NA	0.05	XXX
95801	TC	A	Slp stdy unatnd w/anal	W	PE	MP	0.00	63.85	63.85	NA	NA	0.01	XXX
95801	26	A	Slp stdy unatnd w/anal	W	PE	MP	1.00	0.47	0.47	0.47	0.47	0.04	XXX
95803		A	Actigraphy testing	W	PE	MP	0.90	3.84	3.84	NA	NA	0.04	XXX
95803	TC	A	Actigraphy testing	W	PE	MP	0.00	3.40	3.40	NA	NA	0.01	XXX
95803	26	A	Actigraphy testing	W	PE	MP	0.90	0.44	0.44	0.44	0.44	0.03	XXX
95805		A	Multiple sleep latency test	W	PE	MP	1.20	10.18	10.84	NA	NA	0.08	XXX
95805	TC	A	Multiple sleep latency test	W	PE	MP	0.00	9.70	10.26	NA	NA	0.04	XXX
95805	26	A	Multiple sleep latency test	W	PE	MP	1.20	0.48	0.58	0.48	0.58	0.04	XXX
95806		A	Sleep study unatt&resp efft	W	PE	MP	1.25	3.50	4.05	NA	NA	0.08	XXX
95806	TC	A	Sleep study unatt&resp efft	W	PE	MP	0.00	3.01	3.50	NA	NA	0.03	XXX
95806	26	A	Sleep study unatt&resp efft	W	PE	MP	1.25	0.49	0.55	0.49	0.55	0.05	XXX
95807		A	Sleep study attended	W	PE	MP	1.28	10.80	12.45	NA	NA	0.15	XXX
95807	TC	A	Sleep study attended	W	PE	MP	0.00	10.33	11.92	NA	NA	0.10	XXX
95807	26	A	Sleep study attended	W	PE	MP	1.28	0.47	0.53	0.47	0.53	0.05	XXX
95808		A	Polysomnography 1-3	W	PE	MP	1.74	16.53	17.28	NA	NA	0.17	XXX
95808	TC	A	Polysomnography 1-3	W	PE	MP	0.00	15.80	16.44	NA	NA	0.10	XXX
95808	26	A	Polysomnography 1-3	W	PE	MP	1.74	0.73	0.84	0.73	0.84	0.07	XXX
95810		A	Polysomnography 4 or more	W	PE	MP	2.50	14.60	17.80	NA	NA	0.21	XXX
95810	TC	A	Polysomnography 4 or more	W	PE	MP	0.00	13.63	16.70	NA	NA	0.11	XXX
95810	26	A	Polysomnography 4 or more	W	PE	MP	2.50	0.97	1.10	0.97	1.10	0.10	XXX
95811		A	Polysomnography w/cpap	W	PE	MP	2.60	15.34	19.30	NA	NA	0.23	XXX
95811	TC	A	Polysomnography w/cpap	W	PE	MP	0.00	14.34	18.15	NA	NA	0.12	XXX
95811	26	A	Polysomnography w/cpap	W	PE	MP	2.60	1.00	1.15	1.00	1.15	0.11	XXX
95857		A	Cholinesterase challenge	W	PE		0.53	0.92	0.82	0.30	0.27	0.04	XXX
95950		A	Ambulatory eeg monitoring	W	PE	MP	1.51	7.13	6.38	NA	NA	0.10	XXX
95950	TC	A	Ambulatory eeg monitoring	W	PE	MP	0.00	6.40	5.71	NA	NA	0.03	XXX
95950	26	A	Ambulatory eeg monitoring	W	PE	MP	1.51	0.73	0.67	0.73	0.67	0.07	XXX
95953		A	Eeg monitoring/computer	W	PE	MP	3.08	9.05	8.93	NA	NA	0.18	XXX
95953	TC	A	Eeg monitoring/computer	W	PE	MP	0.00	7.55	7.53	NA	NA	0.03	XXX
95953	26	A	Eeg monitoring/computer	W	PE	MP	3.08	1.50	1.40	1.50	1.40	0.15	XXX
95956		A	Eeg monitor technol attended	W	PE	MP	3.61	32.20	25.89	NA	NA	0.32	XXX
95956	TC	A	Eeg monitor technol attended	W	PE	MP	0.00	30.54	24.44	NA	NA	0.16	XXX
95956	26	A	Eeg monitor technol attended	W	PE	MP	3.61	1.66	1.45	1.66	1.45	0.16	XXX
96105		A	Assessment of aphasia	W	PE	MP	1.75	0.17	1.21	NA	NA	0.04	XXX
96446		A	Chemotx admn prtl cavity	W	PE	MP	0.37	4.79	4.79	0.19	0.19	0.07	XXX
97597		A	Rmvl devital tis 20 cm/<	W	PE	MP	0.51	1.56	1.56	0.15	0.15	0.05	000
97598		A	Rmvl devital tis addl 20 cm<	W	PE	MP	0.24	0.44	0.44	0.07	0.07	0.03	ZZZ
99224		A	Subsequent observation care	W	PE	MP	0.54	NA	NA	0.24	0.24	0.04	XXX
99225		A	Subsequent observation care	W	PE	MP	0.96	NA	NA	0.44	0.44	0.05	XXX
99226		A	Subsequent observation care	W	PE	MP	1.44	NA	NA	0.65	0.65	0.08	XXX

[1] CPT codes and descriptors only are copyright 2010 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

ADDENDUM D: FINAL CY 2011 GEOGRAPHIC ADJUSTMENT FACTORS (GAFs)

Contractor	Locality	Locality Name	2010 GAF[1]	2011 GAF[2]	Percentage Change (2010 to 2011)
10102	00	Alabama	0.949	0.938	-1.16%
00831	01	Alaska**	1.288	1.289	0.08%
03102	00	Arizona	0.984	0.980	-0.41%
00520	13	Arkansas	0.945	0.926	-2.01%
01192	26	Anaheim/Santa Ana, CA	1.128	1.129	0.09%
01192	18	Los Angeles, CA	1.112	1.106	-0.54%
01102	03	Marin/Napa/Solano, CA	1.112	1.119	0.63%
01102	07	Oakland/Berkeley, CA	1.130	1.133	0.27%
01102	05	San Francisco, CA	1.201	1.198	-0.25%
01102	06	San Mateo, CA	1.203	1.199	-0.33%
01102	09	Santa Clara, CA	1.148	1.156	0.70%
01192	17	Ventura, CA	1.121	1.113	-0.71%
01102	99	Rest of California*	1.012	1.025	1.28%
01192	99	Rest of California*	1.012	1.025	1.28%
04102	01	Colorado	0.984	0.984	0.00%
13102	00	Connecticut	1.100	1.094	-0.55%
12202	01	DC + MD/VA Suburbs	1.121	1.124	0.27%
12102	01	Delaware	1.013	1.012	-0.10%
09102	03	Fort Lauderdale, FL	1.056	1.057	0.09%
09102	04	Miami, FL	1.114	1.107	-0.63%
09102	99	Rest of Florida	1.015	1.003	-1.18%
10202	01	Atlanta, GA	1.004	1.002	-0.20%
10202	99	Rest of Georgia	0.968	0.959	-0.93%
01202	01	Hawaii/Guam	1.057	1.074	1.61%
05130	00	Idaho	0.957	0.945	-1.25%
00952	16	Chicago, IL	1.084	1.081	-0.28%
00952	12	East St. Louis, IL	1.013	1.010	-0.30%
00952	15	Suburban Chicago, IL	1.063	1.061	-0.19%
00952	99	Rest of Illinois	0.982	0.972	-1.02%
00630	00	Indiana	0.967	0.954	-1.34%
05102	00	Iowa	0.950	0.930	-2.11%
05202	00	Kansas	0.957	0.946	-1.15%
00660	00	Kentucky	0.956	0.944	-1.26%
00528	01	New Orleans, LA	1.018	0.997	-2.06%
00528	99	Rest of Louisiana	0.969	0.949	-2.06%
14102	03	Southern Maine	0.991	0.987	-0.40%
14102	99	Rest of Maine	0.957	0.942	-1.57%
12302	01	Baltimore/Surr. Cntys, MD	1.035	1.052	1.64%
12302	99	Rest of Maryland	0.991	1.004	1.31%
14202	01	Metropolitan Boston	1.133	1.106	-2.38%
14202	99	Rest of Massachusetts	1.041	1.040	-0.10%
00953	01	Detroit, MI	1.071	1.060	-1.03%
00953	99	Rest of Michigan	0.987	0.983	-0.41%
00954	00	Minnesota	0.967	0.966	-0.10%
00512	00	Mississippi	0.961	0.940	-2.19%
05302	02	Metropolitan Kansas City, MO	0.995	0.989	-0.60%
05302	01	Metropolitan St Louis, MO	0.988	0.984	-0.40%
05302	99	Rest of Missouri	0.961	0.938	-2.39%
03202	01	Montana ***	0.954	0.968	1.47%
05402	00	Nebraska	0.947	0.928	-2.01%
01302	00	Nevada***	1.016	1.024	0.79%
14302	40	New Hampshire	0.996	1.000	0.40%
12402	01	Northern NJ	1.134	1.120	-1.23%
12402	99	Rest of New Jersey	1.082	1.074	-0.74%
04202	05	New Mexico	0.980	0.969	-1.12%
13202	01	Manhattan, NY	1.164	1.153	-0.95%
13202	02	NYC Suburbs/Long I., NY	1.162	1.161	-0.09%
13202	03	Poughkpsie/N NYC Suburbs, NY	1.034	1.037	0.29%
13292	04	Queens, NY	1.130	1.140	0.88%
13282	99	Rest of New York	0.961	0.961	0.00%
05535	00	North Carolina	0.970	0.955	-1.55%
03302	01	North Dakota***	0.942	0.956	1.49%
00883	00	Ohio	0.993	0.990	-0.30%
04302	00	Oklahoma	0.953	0.934	-1.99%
00835	01	Portland, OR	0.987	0.991	0.41%
00835	99	Rest of Oregon	0.964	0.955	-0.93%
12502	01	Metropolitan Philadelphia, PA	1.075	1.068	-0.65%
12502	99	Rest of Pennsylvania	0.987	0.980	-0.71%
09202	20	Puerto Rico	0.904	0.854	-5.53%
14402	01	Rhode Island	1.045	1.042	-0.29%
00880	01	South Carolina	0.959	0.946	-1.36%
03402	02	South Dakota***	0.948	0.949	0.11%
10302	35	Tennessee	0.961	0.947	-1.46%
04402	31	Austin, TX	0.995	0.986	-0.90%
04402	20	Beaumont, TX	0.986	0.966	-2.03%

Contractor	Locality	Locality Name	2010 GAF[1]	2011 GAF[2]	Percentage Change (2010 to 2011)
04402	09	Brazoria, TX	1.002	0.996	-0.60%
04402	11	Dallas, TX	1.009	1.004	-0.50%
04402	28	Fort Worth, TX	0.994	0.990	-0.40%
04402	15	Galveston, TX	1.000	0.997	-0.30%
04402	18	Houston, TX	1.019	1.008	-1.08%
04402	99	Rest of Texas	0.976	0.959	-1.74%
03502	09	Utah	0.981	0.969	-1.22%
14502	50	Vermont	0.977	0.968	-0.92%
00904	00	Virginia	0.975	0.972	-0.31%
09202	50	Virgin Islands	0.996	0.997	0.10%
00836	02	Seattle (King Cnty), WA	1.033	1.045	1.16%
00836	99	Rest of Washington	0.983	0.982	-0.10%
00884	16	West Virginia	0.976	0.956	-2.05%
00951	00	Wisconsin	0.960	0.959	-0.10%
03602	21	Wyoming***	0.961	0.983	2.29%

* Indicates multiple contractors.
** GAF reflects a 1.5 work GPCI floor in Alaska established by the MIPPA.
*** 2011 GAF reflects a 1.0 PE GPCI floor for frontier states as required by the ACA.
[1] 2010 GAF equation: (0.52466*work GPCI)+(0.43669*PE GPCI)+(0.03865*MP GPCI).
2010 GAF contains a 1.0 work GPCI floor and reflects a limited recognition of cost differences for the rent and employee compensation components of the PE GPCI and hold harmless provision as required by the ACA.
[2] 2011 GAF equation: (0.52466*work GPCI)+(0.43669*PE GPCI)+(0.03865*MP GPCI).
2011 GAF does not contain a 1.0 work GPCI floor which expires December 31, 2010 as required by the ACA.
2011 GAF reflects a limited recognition of cost differences for the rent and employee compensation components of the PE GPCI, hold harmless provision and 1.0 PE GPCI floor for frontier States as required by the ACA.

ADDENDUM E: FINAL CY 2011**** GEOGRAPHIC PRACTICE COST INDICES (GPCIs) BY STATE AND MEDICARE LOCALITY

Contractor	Locality	Locality Name	2010 Work GPCI[1]	2010 PE GPCI[2]	2010 MP GPCI	2011 Work GPCI[3]	2011 PE GPCI[2]	2011 MP GPCI	2012 Work GPCI[3]	2012 PE GPCI[4]	2012 MP GPCI
10102	00	Alabama	1.000	0.927	0.496	0.979	0.928	0.484	0.976	0.859	0.471
00831	01	Alaska**	1.500	1.090	0.646	1.500	1.092	0.648	1.500	1.093	0.649
03102	00	Arizona	1.000	0.979	0.822	0.983	0.983	0.913	0.977	0.974	1.003
00520	13	Arkansas	1.000	0.923	0.446	0.964	0.923	0.444	0.967	0.844	0.441
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811	1.039	1.271	0.742	1.043	1.273	0.673
01192	18	Los Angeles, CA	1.041	1.225	0.804	1.039	1.220	0.722	1.036	1.215	0.639
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432	1.042	1.272	0.443	1.050	1.278	0.454
01102	07	Oakland/Berkeley, CA	1.053	1.286	0.425	1.055	1.286	0.469	1.057	1.286	0.513
01102	05	San Francisco, CA	1.059	1.441	0.414	1.065	1.422	0.464	1.071	1.403	0.513
01102	06	San Mateo, CA	1.072	1.433	0.394	1.072	1.418	0.454	1.071	1.403	0.513
01102	09	Santa Clara, CA	1.083	1.294	0.377	1.080	1.310	0.445	1.077	1.326	0.513
01192	17	Ventura, CA	1.027	1.265	0.766	1.030	1.251	0.684	1.033	1.237	0.601
01102	99	Rest of California*	1.007	1.058	0.549	1.016	1.078	0.546	1.024	1.098	0.543
01192	99	Rest of California*	1.007	1.058	0.549	1.016	1.078	0.546	1.024	1.098	0.543
04102	01	Colorado	1.000	0.996	0.641	0.991	0.997	0.754	0.996	0.993	0.866
13102	00	Connecticut	1.038	1.185	0.980	1.031	1.168	1.102	1.023	1.150	1.224
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032	1.048	1.218	1.081	1.048	1.217	1.130
12102	01	Delaware	1.011	1.046	0.678	1.012	1.041	0.678	1.012	1.036	0.678
09102	03	Fort Lauderdale, FL	1.000	1.018	2.250	0.992	1.041	2.112	0.994	1.063	1.973
09102	04	Miami, FL	1.000	1.069	3.167	0.998	1.072	2.984	0.996	1.075	2.800
09102	99	Rest of Florida	1.000	0.970	1.724	0.978	0.976	1.635	0.983	0.964	1.545
10202	01	Atlanta, GA	1.009	1.014	0.836	1.006	1.006	0.890	1.002	0.995	0.944
10202	99	Rest of Georgia	1.000	0.942	0.829	0.978	0.943	0.876	0.977	0.887	0.922
01202	01	Hawaii/Guam	1.000	1.161	0.665	0.999	1.198	0.685	1.000	1.234	0.705

Contractor	Locality	Locality Name	2010 Work GPCI[1]	2010 PE GPCI[2]	2010 MP GPCI	2011 Work GPCI[3]	2011 PE GPCI[2]	2011 MP GPCI	2012 Work GPCI[3]	2012 PE GPCI[4]	2012 MP GPCI
05130	00	Idaho	1.000	0.942	0.546	0.974	0.943	0.572	0.981	0.889	0.597
00952	16	Chicago, IL	1.025	1.080	1.940	1.028	1.062	2.005	1.030	1.044	2.069
00952	12	East St. Louis, IL	1.000	0.960	1.793	0.988	0.962	1.851	0.987	0.928	1.908
00952	15	Suburban Chicago, IL	1.017	1.068	1.629	1.021	1.056	1.665	1.024	1.044	1.700
00952	99	Rest of Illinois	1.000	0.940	1.219	0.976	0.941	1.274	0.976	0.885	1.329
00630	00	Indiana	1.000	0.960	0.599	0.978	0.957	0.603	0.969	0.907	0.607
05102	00	Iowa	1.000	0.935	0.434	0.962	0.934	0.443	0.958	0.865	0.451
05202	00	Kansas	1.000	0.941	0.557	0.966	0.939	0.746	0.962	0.875	0.935
00660	00	Kentucky	1.000	0.930	0.652	0.971	0.932	0.701	0.972	0.866	0.749
00528	01	New Orleans, LA	1.000	1.044	0.956	0.985	1.018	0.933	0.983	0.982	0.910
00528	99	Rest of Louisiana	1.000	0.939	0.892	0.969	0.936	0.816	0.967	0.865	0.740
14102	03	Southern Maine	1.000	1.025	0.492	0.982	1.029	0.584	0.984	1.032	0.675
14102	99	Rest of Maine	1.000	0.947	0.492	0.964	0.947	0.584	0.965	0.892	0.675
12302	01	Baltimore/Surr. Cntys, MD	1.012	1.057	1.086	1.019	1.084	1.147	1.026	1.111	1.207
12302	99	Rest of Maryland	1.000	0.991	0.874	1.002	1.013	0.930	1.010	1.044	0.985
14202	01	Metropolitan Boston	1.029	1.291	0.764	1.021	1.238	0.776	1.013	1.185	0.787
14202	99	Rest of Massachusetts	1.007	1.106	0.764	1.010	1.100	0.776	1.013	1.093	0.787
00953	01	Detroit, MI	1.036	1.040	1.906	1.029	1.026	1.855	1.021	1.012	1.803
00953	99	Rest of Michigan	1.000	0.962	1.083	0.995	0.960	1.075	0.991	0.917	1.067
00954	00	Minnesota	1.000	0.992	0.245	0.995	0.994	0.262	0.997	0.993	0.279
00512	00	Mississippi	1.000	0.927	0.808	0.961	0.929	0.782	0.962	0.861	0.756
05302	02	Metropolitan Kansas City, MO	1.000	0.973	1.188	0.986	0.973	1.204	0.982	0.946	1.220
05302	01	Metropolitan St Louis, MO	1.000	0.966	1.075	0.992	0.968	1.064	0.990	0.940	1.052
05302	99	Rest of Missouri	1.000	0.911	0.997	0.953	0.913	1.004	0.956	0.830	1.011
03202	01	Montana ***	1.000	0.924	0.673	0.948	1.000	0.887	0.946	1.000	1.100
05402	00	Nebraska	1.000	0.946	0.245	0.964	0.943	0.280	0.968	0.881	0.314
01302	00	Nevada ***	1.002	1.026	1.083	0.999	1.042	1.149	0.996	1.057	1.215

Contractor	Locality	Locality Name	2010 Work GPCI[1]	2010 PE GPCI[2]	2010 MP GPCI	2011 Work GPCI[3]	2011 PE GPCI[2]	2011 MP GPCI	2012 Work GPCI[3]	2012 PE GPCI[4]	2012 MP GPCI
14302	40	New Hampshire	1.000	1.039	0.462	0.987	1.046	0.658	0.991	1.052	0.853
12402	01	Northern NJ	1.057	1.228	1.116	1.051	1.206	1.077	1.044	1.184	1.037
12402	99	Rest of New Jersey	1.042	1.126	1.116	1.031	1.125	1.077	1.020	1.123	1.037
04202	05	New Mexico	1.000	0.946	1.096	0.981	0.947	1.054	0.989	0.895	1.011
13202	01	Manhattan, NY	1.064	1.298	1.010	1.063	1.263	1.137	1.062	1.227	1.263
13202	02	NYC Suburbs/Long I., NY	1.051	1.289	1.235	1.050	1.278	1.335	1.048	1.267	1.434
13202	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822	1.013	1.074	0.945	1.011	1.070	1.067
13292	04	Queens, NY	1.032	1.239	1.220	1.047	1.233	1.351	1.062	1.227	1.482
13282	99	Rest of New York	1.000	0.961	0.425	0.993	0.964	0.492	0.988	0.934	0.559
05535	00	North Carolina	1.000	0.963	0.634	0.972	0.960	0.664	0.971	0.912	0.693
03302	01	North Dakota ***	1.000	0.922	0.387	0.957	1.000	0.453	0.966	1.000	0.519
00883	00	Ohio	1.000	0.964	1.232	0.996	0.961	1.230	0.998	0.914	1.227
04302	00	Oklahoma	1.000	0.925	0.627	0.960	0.927	0.671	0.955	0.859	0.715
00835	01	Portland, OR	1.002	1.015	0.472	1.003	1.016	0.542	1.004	1.017	0.612
00835	99	Rest of Oregon	1.000	0.964	0.472	0.974	0.968	0.542	0.980	0.943	0.612
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617	1.015	1.084	1.619	1.014	1.071	1.621
12502	99	Rest of Pennsylvania	1.000	0.963	1.081	0.990	0.958	1.101	0.987	0.906	1.120
09202	20	Puerto Rico	1.000	0.847	0.250	0.907	0.845	0.249	0.909	0.686	0.248
14402	01	Rhode Island	1.013	1.088	0.996	1.015	1.071	1.089	1.016	1.053	1.182
00880	01	South Carolina	1.000	0.954	0.446	0.976	0.952	0.482	0.976	0.900	0.518
03402	02	South Dakota***	1.000	0.932	0.420	0.946	1.000	0.424	0.950	1.000	0.428
10302	35	Tennessee	1.000	0.945	0.608	0.976	0.945	0.566	0.973	0.888	0.523
04402	31	Austin, TX	1.000	0.992	0.969	0.988	0.995	0.859	0.984	0.994	0.748
04402	20	Beaumont, TX	1.000	0.938	1.346	0.978	0.937	1.131	0.971	0.870	0.916
04402	09	Brazoria, TX	1.019	0.961	1.223	1.014	0.967	1.070	1.008	0.945	0.916
04402	11	Dallas, TX	1.009	1.001	1.110	1.009	1.001	0.969	1.008	0.999	0.828
04402	28	Fort Worth, TX	1.000	0.977	1.110	0.999	0.982	0.966	0.999	0.974	0.821

Contractor	Locality	Locality Name	2010 Work GPCI[1]	2010 PE GPCI[2]	2010 MP GPCI	2011 Work GPCI[3]	2011 PE GPCI[2]	2011 MP GPCI	2012 Work GPCI[3]	2012 PE GPCI[4]	2012 MP GPCI
04402	15	Galveston, TX	1.000	0.980	1.223	1.000	0.985	1.100	1.008	0.980	0.977
04402	18	Houston, TX	1.016	0.994	1.345	1.012	0.992	1.131	1.008	0.980	0.916
04402	99	Rest of Texas	1.000	0.940	1.065	0.974	0.943	0.936	0.979	0.892	0.806
03502	09	Utah	1.000	0.954	1.026	0.975	0.953	1.059	0.972	0.901	1.091
14502	50	Vermont	1.000	0.992	0.489	0.973	1.002	0.523	0.977	1.020	0.557
00904	00	Virginia	1.000	0.972	0.657	0.988	0.978	0.692	0.993	0.967	0.727
09202	50	Virgin Islands	1.000	0.990	1.009	0.998	0.994	1.007	0.998	0.995	1.004
00836	02	Seattle (King Cnty), WA	1.014	1.085	0.706	1.020	1.098	0.785	1.025	1.111	0.864
00836	99	Rest of Washington	1.000	0.988	0.693	0.991	0.991	0.770	0.994	0.986	0.846
00884	16	West Virginia	1.000	0.914	1.353	0.968	0.912	1.279	0.963	0.821	1.205
00951	00	Wisconsin	1.000	0.961	0.409	0.988	0.966	0.476	0.987	0.940	0.543
03602	21	Wyoming ***	1.000	0.921	0.889	0.964	1.000	1.052	0.972	1.000	1.215

[1] 2010 work GPCI reflects a 1.0 floor required by the ACA.
[2] 2010 and 2011 PE GPCI reflects a limited recognition of cost differences for the rent and employee compensation components and application of the hold harmless provision as required by ACA.
[3] 2011 and 2012 work GPCI does not reflect a 1.0 floor which expires December 31, 2010 as required by the ACA.
[4] 2012 PE GPCI does not reflect a limited recognition of cost differences for the rent and employee compensation components which expires December 31, 2011 as required by the ACA.
* Indicates multiple contractors.
** Work GPCI reflects a 1.5 floor in Alaska established by the MIPPA.
*** 2011 and 2012 PE GPCIs reflect a 1.0 floor for frontier states as required by the ACA.
**** 2011 GPCIs are the first year of the update transition, 2012 GPCIs are the fully implemented updated GPCIs.
2011 work GPCI transition: ½ the difference between 2010 (without 1.0 work GPCI floor) and 2012 work GPCI.
2011 PE GPCI transition (and hold harmless as required by the ACA): Greater of ½ the difference between 2010 PE GPCI and 2012 PE GPCI with limited recognition of cost differences for the rent and employee compensation components (as required by ACA) or ½ the difference between 2010 PE GPCI and 2012 PE GPCI without the limited recognition of cost differences for the rent and employee compensation components.
2011 MP GPCI transition: ½ the difference between 2010 MP GPCI and 2012 MP GPCI.

ADDENDUM F: CY 2011 DIAGNOSTIC IMAGING SERVICES SUBJECT TO THE MULTIPLE PROCEDURE PAYMENT REDUCTION

CPT/HCPCS Code	Short Descriptor
70336	Magnetic image, jaw joint
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o & w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o & w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o & w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70554	Fmri brain by tech
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye

CPT/HCPCS Code	Short Descriptor
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72191	Ct angiograph pelv w/o & w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o & w/dye
73206	Ct angio upr extrm w/o & w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o & w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o & w/dye
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o & w/dye
73706	Ct angio lwr extr w/o & w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye

CPT/HCPCS Code	Short Descriptor
73720	Mri lwr extremity w/o & w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o & w/dye
73725	Mr ang lwr ext w or w/o dye
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w or w/o dye
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75574	Ct angio hrt w/3d image
75635	Ct angio abdominal arteries
76604	Us exam, chest
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
77058	Mri, one breast
77059	Mri, both breasts

ADDENDUM G: CPT/HCPCS IMAGING CODES DEFINED BY SECTION 5102(b) OF THE DRA

CPT/HCPCS Code	Short Descriptor
70015	Contrast x-ray of brain
70030	X-ray eye for foreign body
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70170	X-ray exam of tear duct
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70332	X-ray exam of jaw joint
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70373	Contrast x-ray of larynx
70380	X-ray exam of salivary gland
70390	X-ray exam of salivary duct
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70557	Mri brain w/o dye
70558	Mri brain w/dye
70559	Mri brain w/o & w/dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71040	Contrast x-ray of bronchi
71060	Contrast x-ray of bronchi
71090	X-ray & pacemaker insertion

CPT/HCPCS Code	Short Descriptor
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye

CPT/HCPCS Code	Short Descriptor
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spine w/o&w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
72240	Contrast x-ray of neck spine
72255	Contrast x-ray, thorax spine
72265	Contrast x-ray, lower spine
72270	Contrast x-ray, spine
72275	Epidurography
72285	X-ray c/t spine disk
72291	Percut vertebroplasty fluor
72295	X-ray of lower spine disk
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73040	Contrast x-ray of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus

CPT/HCPCS Code	Short Descriptor
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73085	Contrast x-ray of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73115	Contrast x-ray of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73225	Mr angio upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73525	Contrast x-ray of hip
73530	X-ray exam of hip
73540	X-ray exam of pelvis & hips
73542	X-ray exam, sacroiliac joint
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73580	Contrast x-ray of knee joint
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73615	Contrast x-ray of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74176	Ct abd & pelvis w/o contrast
74177	Ct abdomen & pelvis w/ contrast
74178	Ct abd & pelv 1+ section/regns
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74190	X-ray exam of peritoneum
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74235	Remove esophagus obstruction
74240	X-ray exam, upper gi tract

CPT/HCPCS Code	Short Descriptor
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74251	X-ray exam of small bowel
74260	X-ray exam of small bowel
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
74270	Contrast x-ray exam of colon
74280	Contrast x-ray exam of colon
74283	Contrast x-ray exam of colon
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74300	X-ray bile ducts/pancreas
74301	X-rays at surgery add-on
74305	X-ray bile ducts/pancreas
74320	Contrast x-ray of bile ducts
74327	X-ray bile stone removal
74328	X-ray bile duct endoscopy
74329	X-ray for pancreas endoscopy
74330	X-ray bile/panc endoscopy
74340	X-ray guide for GI tube
74355	X-ray guide, intestinal tube
74360	X-ray guide, GI dilation
74363	X-ray, bile duct dilation
74400	Contrst x-ray, urinary tract
74410	Contrst x-ray, urinary tract
74415	Contrst x-ray, urinary tract
74420	Contrst x-ray, urinary tract
74425	Contrst x-ray, urinary tract
74430	Contrast x-ray, bladder
74440	X-ray, male genital tract
74445	X-ray exam of penis
74450	X-ray, urethra/bladder
74455	X-ray, urethra/bladder
74470	X-ray exam of kidney lesion

CPT/HCPCS Code	Short Descriptor
74475	X-ray control, cath insert
74480	X-ray control, cath insert
74485	X-ray guide, GU dilation
74710	X-ray measurement of pelvis
74740	X-ray, female genital tract
74742	X-ray, fallopian tube
74775	X-ray exam of perineum
75557	Cardiac MRI w/o contrast
75559	Cardiac MRI w/ stress imaging
75561	Cardiac MRI w/ & w/o contrast
75563	Cardiac MRI w/ stress imaging
75565	Card mri vel flw map add-on
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75600	Contrast x-ray exam of aorta
75605	Contrast x-ray exam of aorta
75625	Contrast x-ray exam of aorta
75630	X-ray aorta, leg arteries
75635	Ct angio abdominal arteries
75650	Artery x-rays, head & neck
75658	Artery x-rays, arm
75660	Artery x-rays, head & neck
75662	Artery x-rays, head & neck
75665	Artery x-rays, head & neck
75671	Artery x-rays, head & neck
75676	Artery x-rays, neck
75680	Artery x-rays, neck
75685	Artery x-rays, spine
75705	Artery x-rays, spine
75710	Artery x-rays, arm/leg
75716	Artery x-rays, arms/legs
75722	Artery x-rays, kidney
75724	Artery x-rays, kidneys
75726	Artery x-rays, abdomen
75731	Artery x-rays, adrenal gland
75733	Artery x-rays, adrenals

CPT/HCPCS Code	Short Descriptor
75736	Artery x-rays, pelvis
75741	Artery x-rays, lung
75743	Artery x-rays, lungs
75746	Artery x-rays, lung
75756	Artery x-rays, chest
75774	Artery x-ray, each vessel
75791	Av dialysis shunt imaging
75801	Lymph vessel x-ray, arm/leg
75803	Lymph vessel x-ray, arms/legs
75805	Lymph vessel x-ray, trunk
75807	Lymph vessel x-ray, trunk
75809	Nonvascular shunt, x-ray
75810	Vein x-ray, spleen/liver
75820	Vein x-ray, arm/leg
75822	Vein x-ray, arms/legs
75825	Vein x-ray, trunk
75827	Vein x-ray, chest
75831	Vein x-ray, kidney
75833	Vein x-ray, kidneys
75840	Vein x-ray, adrenal gland
75842	Vein x-ray, adrenal glands
75860	Vein x-ray, neck
75870	Vein x-ray, skull
75872	Vein x-ray, skull
75880	Vein x-ray, eye socket
75885	Vein x-ray, liver
75887	Vein x-ray, liver
75889	Vein x-ray, liver
75891	Vein x-ray, liver
75893	Venous sampling by catheter
75894	X-rays, transcath therapy
75896	X-rays, transcath therapy
75898	Follow-up angiography
75900	Intravascular cath exchange
75901	Remove cva device obstruct
75902	Remove cva lumen obstruct
75940	X-ray placement, vein filter
75945	Intravascular us

CPT/HCPCS Code	Short Descriptor
75946	Intravascular us add-on
75953	Abdom aneurysm endovas rpr
75956	Xray, endovasc thor ao repr
75957	Xray, endovasc thor ao repr
75958	Xray, place prox ext thor ao
75959	Xray, place dist ext thor ao
75960	Transcath iv stent rs&i
75961	Retrieval, broken catheter
75962	Repair arterial blockage
75964	Repair artery blockage, each
75966	Repair arterial blockage
75968	Repair artery blockage, each
75970	Vascular biopsy
75978	Repair venous blockage
75980	Contrast xray exam bile duct
75982	Contrast xray exam bile duct
75984	Xray control catheter change
75989	Abscess drainage under x-ray
76000	Fluoroscope examination
76001	Fluoroscope exam, extensive
76010	X-ray, nose to rectum
76080	X-ray exam of fistula
76098	X-ray exam, breast specimen
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76496	Fluoroscopic procedure
76497	Ct procedure
76498	Mri procedure
76499	Radiographic procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only

CPT/HCPCS Code	Short Descriptor
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76529	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest, b-scan
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus
76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76817	Transvaginal us, obstetric
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76830	Transvaginal us, non-ob
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76872	Us, transrectal
76873	Echograp trans r, pros study

CPT/HCPCS Code	Short Descriptor
76881	Us xtr non-vasc complete
76882	Us xtr non-vasc lmtd
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76930	Echo guide, cardiocentesis
76932	Echo guide for heart biopsy
76936	Echo guide for artery repair
76937	Us guide, vascular access
76940	Us guide, tissue ablation
76941	Echo guide for transfusion
76942	Echo guide for biopsy
76945	Echo guide, villus sampling
76946	Echo guide for amniocentesis
76948	Echo guide, ova aspiration
76950	Echo guidance radiotherapy
76965	Echo guidance radiotherapy
76970	Ultrasound exam follow-up
76975	GI endoscopic ultrasound
76977	Us bone density measure
76998	Ultrasound guide intraoper
77001	Fluoroguide for vein device
77002	Needle localization by x-ray
77003	Fluoroguide for spine inject
77011	Ct scan for localization
77012	Ct scan for needle biopsy
77013	Ct guide for tissue ablation
77014	Ct scan for therapy guide
77021	Mr guidance for needle place
77022	Mri for tissue ablation
77031	Stereotactic breast biopsy
77032	X-ray of needle wire, breast
77053	X-ray of mammary duct
77054	X-ray of mammary ducts
77058	Magnetic image, breast
77059	Magnetic image, both breasts
77072	X-rays for bone age
77073	X-rays, bone evaluation
77074	X-rays, bone survey

CPT/HCPCS Code	Short Descriptor
77075	X-rays, bone survey
77076	X-rays, bone evaluation
77077	Joint survey, single view
77078	Ct bone density, axial
77079	Ct bone density, peripheral
77081	Dxa bone density/peripheral
77083	Radiographic absorptiometry
77084	Magnetic image, bone marrow
77417	Radiology port film(s)
77421	Stereoscopic x-ray guidance
78006	Thyroid imaging with uptake
78007	Thyroid image, mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging
78016	Thyroid met imaging/studies
78018	Thyroid met imaging, body
78020	Thyroid met uptake
78070	Parathyroid nuclear imaging
78075	Adrenal nuclear imaging
78102	Bone marrow imaging, ltd
78103	Bone marrow imaging, mult
78104	Bone marrow imaging, body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging
78190	Platelet survival, kinetics
78195	Lymph system imaging
78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging

CPT/HCPCS Code	Short Descriptor
78232	Salivary gland function exam
78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckel's divert exam
78291	Leveen/shunt patency exam
78300	Bone imaging, limited area
78305	Bone imaging, multiple areas
78306	Bone imaging, whole body
78315	Bone imaging, 3 phase
78320	Bone imaging (3D)
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78451	Ht muscle image spect, sing
78452	Ht muscle image spect, mult
78453	Ht muscle image,planar,sing
78454	Ht musc image, planar, mult
78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Ven thrombosis images, bilat
78459	Heart muscle imaging (PET)
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)
78472	Gated heart, planar, single
78473	Gated heart, multiple
78481	Heart first pass, single
78483	Heart first pass, multiple
78491	Heart image (pet), single
78492	Heart image (pet), multiple
78494	Heart image, spect
78496	Heart first pass add-on
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging

CPT/HCPCS Code	Short Descriptor
78586	Aerosol lung image, single
78587	Aerosol lung image, multiple
78588	Perfusion lung image
78591	Vent image, 1 breath, 1 proj
78593	Vent image, 1 proj, gas
78594	Vent image, mult proj, gas
78596	Lung differential function
78600	Brain imaging, ltd static
78601	Brain imaging, ltd w/flow
78605	Brain imaging, complete
78606	Brain imaging, compl w/flow
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78610	Brain flow imaging only
78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78700	Kidney imaging, static
78701	Kidney imaging with flow
78707	Kidney flow/function image
78708	Kidney flow/function image
78709	Kidney flow/function image
78710	Kidney imaging (3D)
78730	Urinary bladder retention
78740	Ureteral reflux study
78761	Testicular imaging/flow
78800	Tumor imaging, limited area
78801	Tumor imaging, mult areas
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78804	Tumor imaging, whole body
78805	Abscess imaging, ltd area
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess
78811	Tumor imaging (pet), limited

CPT/HCPCS Code	Short Descriptor
78812	Tumor image (pet)/skul-thigh
78813	Tumor image (pet) full body
78814	Tumor image pet/ct, limited
78815	Tumorimage pet/ct skul-thigh
78816	Tumor image pet/ct full body
92132	Cmptr ophth dx img ant segmt
92133	Cmptr ophth dx img optic nerve
92134	Cptr ophth dx img post segmt
92227	remote dx retinal imaging
92228	remote dx retinal imaging mgmt
92235	Fluorscein angioscopy
92240	IDC green angiography
92250	Fundus photography
92285	External ocular photography
92286	Anterior segment photography
93303	Echo transthoracic
93304	Echo transthoracic
93306	Tte w/doppler, complete
93307	Echo exam of heart
93308	Echo exam of heart
93312	Echo transesophageal
93314	Echo transesophageal
93315	Echo transesophageal
93317	Echo transesophageal
93318	Echo transesophageal intraop
93320	Doppler echo exam, heart
93321	Doppler echo exam, heart
93325	Doppler color flow add-on
93350	Echo transthoracic
93351	Stress tte complete
93571	Heart flow reserve measure
93572	Heart flow reserve measure
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj

CPT/HCPCS Code	Short Descriptor
93893	Tcd, emboli detect w/inj
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
0042T	Ct perfusion w/contrast, cbf
0080T	Endovasc aort repr rad s&i
0081T	Endovasc visc extnsn s&i
0174T	Cad cxr with interp
0175T	Cad cxr remote
G0120	Colon ca scrn; barium enema
G0130	Single energy x-ray study
G0288	Recon, CTA for surg plan
G0365	Vessel mapping hemo access

ADDENDUM H--CY 2011 "ALWAYS THERAPY" SERVICES SUBJECT TO THE MULTIPLE PROCEDURE PAYMENT REDUCTION*

CPT/HCPCS Code	Short Descriptor
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx, 1hr
92609	Use of speech device service
96125	Cognitive test by hc pro
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97750	Physical performance test
97755	Assistive technology assess

CPT/HCPCS Code	Short Descriptor
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/o for orthotic/prosth use
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers

*Excludes contractor-priced and bundled codes.

ADDENDUM I: [Reserved]

ADDENDUM J: LIST OF CPT[1]/HCPCS CODES USED TO DEFINE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES[2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT EFFECTIVE JANUARY 1, 2011

CLINICAL LABORATORY SERVICES	
INCLUDE CPT codes for all clinical laboratory services in the 80000 series, except EXCLUDE CPT codes for the following blood component collection services:	
86890	Autologous blood process
86891	Autologous blood op salvage
86927	Plasma fresh frozen
86930	Frozen blood prep
86931	Frozen blood thaw
86932	Frozen blood freeze/thaw
86945	Blood product/irradiation
86950	Leukacyte transfusion
86960	Vol reduction of blood/prod
86965	Pooling blood platelets
86985	Split blood or products
INCLUDE the following CPT and HCPCS level 2 codes for other clinical laboratory services:	
0030T	Antiprothrombin antibody
0058T	Cryopreservation ovary tiss
0059T	Cryopreservation oocyte
0103T	Holotranscobalamin
0111T	RBC membranes fatty acids
36415	Routine venipuncture
78110	Plasma volume single
78111	Plasma volume multiple
78120	Red cell mass single
78121	Red cell mass multiple
78122	Blood volume
78130	Red cell survival study
78191	Platelet survival
78267	Breath tst attain/anal c-14
78268	Breath test analysis c-14
78270	Vit B-12 absorption exam
78271	Vit B-12 absrp exam int fac
78272	Vit B-12 absorp combined
78725	Kidney function study
G0027	Semen analysis
G0103	Psa screening
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
G0328	Fecal blood scrn immunoassay
G0416	Sat biopsy prostate 1-20 spc
G0417	Sat biopsy prostate 21-40
G0418	Sat biopsy prostate 41-60
G0419	Sat biopsy prostate: >60
G0431	Drug screen single class
G0432	EIA HIV-1/HIV-2 screen
G0433	ELISA HIV-1/HIV-2 screen
G0434	Drug screen multi drug class
G0435	Oral HIV-1/HIV-2 screen
G9143	Warfarin respon genetic test
P2028	Cephalin floculation test
P2029	Congo red blood test
P2033	Blood thymol turbidity
P2038	Blood mucoprotein
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
P9612	Catheterize for urine spec
P9615	Urine specimen collect mult
Q0111	Wet mounts/ w preparations
Q0112	Potassium hydroxide preps
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital mucous exam

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
INCLUDE the following CPT and HCPCS codes for physical therapy/occupational therapy/outpatient speech-language pathology services:	
0019T	Extracorp shock wv tx ms nos
0183T	Wound ultrasound
64550	Apply neurostimulator
90901	Biofeedback train any meth
90911	Biofeedback peri/uro/rectal
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92520	Laryngeal function studies
92526	Oral function therapy
92597	Oral speech device eval

92607	Ex for speech device rx 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
93797	Cardiac rehab
93798	Cardiac rehab/monitor
95831	Limb muscle testing manual
95832	Hand muscle testing manual
95833	Body muscle testing manual
95834	Body muscle testing manual
95851	Range of motion measurements
95852	Range of motion measurements
95992	Canalith repositioning proc
96000	Motion analysis video/3d
96001	Motion test w/ft press meas
96002	Dynamic surface emg
96003	Dynamic fine wire emg
96105	Assessment of aphasia
96110	Developmental test lim
96111	Developmental test extend
96125	Cognitive test by HC pro
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation

97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97545	Work hardening
97546	Work hardening add-on
97597	RMVL devital tis 20cm/<
97598	RMVL devital tis addl 20 cm<
97602	Wound(s) care non-selective
97605	Neg press wound tx < 50 cm
97606	Neg press wound tx > 50 cm
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/O for orthotic/prosth use
97799	Physical medicine procedure
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
INCLUDE the following CPT and HCPCS codes:	
0042T	Ct perfusion w/contrast cbf
0159T	Cad breast mri
0174T	Cad cxr with interp
0175T	Cad cxr remote
51798	Us urine capacity measure
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets

70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70336	Magnetic image jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation complex
70380	X-ray exam of salivary gland
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography head
70498	Ct angiography neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o & w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o & w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70554	Fmri brain by tech
70555	Fmri brain by phys/psych

71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye

72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spine w/o & w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o & w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o & w/dye
73206	Ct angio upr extrm w/o & w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o & w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o & w/dye
73225	Mr angio upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73540	X-ray exam of pelvis & hips
73550	X-ray exam of thigh
73560	X-ray exam of knee 1 or 2
73562	X-ray exam of knee 3
73564	X-ray exam knee 4 or more
73565	X-ray exam of knees
73590	X-ray exam of lower leg
73592	X-ray exam of leg infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o & w/dye
73706	Ct angio lwr extr w/o &w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o &w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o & w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74176	Ct angio abd & pelvis
74177	Ct angio abd&pelv w/contrast
74178	Ct angio abd & pelv 1+ regns

74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio abdom w or w/o dye
74210	Contrst x-ray exam of throat
74220	Contrast x-ray esophagus
74230	Cine/vid x-ray throat/esoph
74240	X-ray exam upper gi tract
74241	X-ray exam upper gi tract
74245	X-ray exam upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74261	Ct colonography dx
74262	Ct colonography dx w/dye
74290	Contrast x-ray gallbladder
74291	Contrast x-rays gallbladder
74710	X-ray measurement of pelvis
75557	Cardiac MRI for morph
75559	Cardiac MRI w/stress img
75561	Cardiac MRI for morph w/dye
75563	Card MRI w/stress img & dye
75565	Card MRI veloc flow mapping
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image congen
75574	Ct angio hrt w/3d image
75635	Ct angio abdominal arteries
76000	Fluoroscope examination
76010	X-ray nose to rectum
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76499	Radiographic procedure
76506	Echo exam of head
76510	Ophth us b & quant a
76511	Ophth us quant a only
76512	Ophth us b w/non-quant a
76513	Echo exam of eye water bath

76514	Echo exam of eye thickness
76516	Echo exam of eye
76519	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam chest
76645	Us exam breast(s)
76700	Us exam abdom complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall comp
76775	Us exam abdo back wall lim
76776	Us exam k transpl w/Doppler
76800	Us exam spinal canal
76801	Ob us < 14 wks single fetus
76802	Ob us < 14 wks addl fetus
76805	Ob us >/= 14 wks sngl fetus
76810	Ob us >/= 14 wks addl fetus
76811	Ob us detailed sngl fetus
76812	Ob us detailed addl fetus
76815	Ob us limited fetus(s)
76816	Ob us follow-up per fetus
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76856	Us exam pelvic complete
76857	Us exam pelvic limited
76870	Us exam scrotum
76881	Us xtr non-vasc complete
76882	Us xtr non-vasc lmtd
76885	Us exam infant hips dynamic
76886	Us exam infant hips static
76970	Ultrasound exam follow-up
76977	Us bone density measure
76999	Echo examination procedure
77051	Computer dx mammogram add-on
77052	Comp screen mammogram add-on
77055	Mammogram one breast
77056	Mammogram both breasts
77057	Mammogram screening
77058	Mri one breast
77059	Mri both breasts

77071	X-ray stress view
77072	X-rays for bone age
77073	X-rays bone length studies
77074	X-rays bone survey limited
77075	X-rays bone survey complete
77076	X-rays bone survey infant
77077	Joint survey single view
77078	Ct bone density axial
77079	Ct bone density peripheral
77080	Dxa bone density axial
77081	Dxa bone density/peripheral
77082	Dxa bone density vert fx
77083	Radiographic absorptiometry
77084	Magnetic image bone marrow
78006	Thyroid imaging with uptake
78007	Thyroid image mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging
78016	Thyroid met imaging/studies
78018	Thyroid met imaging body
78020	Thyroid met uptake
78070	Parathyroid nuclear imaging
78075	Adrenal nuclear imaging
78099	Endocrine nuclear procedure
78102	Bone marrow imaging ltd
78103	Bone marrow imaging mult
78104	Bone marrow imaging body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging
78190	Platelet survival kinetics
78195	Lymph system imaging
78199	Blood/lymph nuclear exam
78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging
78232	Salivary gland function exam
78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckels divert exam
78291	Leveen/shunt patency exam
78299	GI nuclear procedure
78300	Bone imaging limited area
78305	Bone imaging multiple areas
78306	Bone imaging whole body
78315	Bone imaging 3 phase
78320	Bone imaging (3D)
78399	Musculoskeletal nuclear exam
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78451	Ht muscle image spect sing
78452	Ht muscle image spect mult
78453	Ht muscle image planar sing
78454	Ht musc image planar mult
78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Ven thrombosis images bilat
78459	Heart muscle imaging (PET)
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)
78472	Gated heart planar single
78473	Gated heart multiple
78481	Heart first pass single
78483	Heart first pass multiple
78491	Heart image (pet) single
78492	Heart image (pet) multiple
78494	Heart image spect
78496	Heart first pass add-on
78499	Cardiovascular nuclear exam
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging
78586	Aerosol lung image single
78587	Aerosol lung image multiple
78588	Perfusion lung image
78591	Vent image 1 breath 1 proj
78593	Vent image 1 proj gas

78594	Vent image mult proj gas
78596	Lung differential function
78599	Respiratory nuclear exam
78600	Brain image < 4 views
78601	Brain image w/flow < 4 views
78605	Brain image 4+ views
78606	Brain image w/flow 4 + views
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78610	Brain flow imaging only
78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78699	Nervous system nuclear exam
78700	Kidney imaging morphol
78701	Kidney imaging with flow
78707	K flow/funct image w/o drug
78708	K flow/funct image w/drug
78709	K flow/funct image multiple
78710	Kidney imaging (3D)
78730	Urinary bladder retention
78740	Ureteral reflux study
78761	Testicular imaging w/flow
78799	Genitourinary nuclear exam
78800	Tumor imaging limited area
78801	Tumor imaging mult areas
78802	Tumor imaging whole body
78803	Tumor imaging (3D)
78804	Tumor imaging whole body
78805	Abscess imaging ltd area
78806	Abscess imaging whole body
78807	Nuclear localization/abscess
78811	PET image ltd area
78812	PET image skull-thigh
78813	PET image full body
78814	PET image w/ct lmtd
78815	PET image w/ct skull-thigh
78816	PET image w/ct full body
78999	Nuclear diagnostic exam
91110	Gi tract capsule endoscopy
91111	Esophageal capsule endoscopy
92132	Cpmtr ophth dx img ant segmt

92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92227	Remote dx retinal imaging
92228	Remote retinal imaging mgmt
93303	Echo transthoracic
93304	Echo transthoracic
93306	TTE w/Doppler complete
93307	TTE w/o Doppler complete
93308	TTE f-up or lmtd
93320	Doppler echo exam heart [if used in conjunction with 93303-93304]
93321	Doppler echo exam heart [if used in conjunction with 93303, 93304, 93308]
93325	Doppler color flow add-on [if used in conjunction with 76825, 76826, 76827,76828, 93303, 93304, 93308]
93875	Extracranial study
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd vasoreactivity study
93892	Tcd emboli detect w/o inj
93922	Upr/l xtremity art 2 levels
93923	Upr/lxtr art stdy 3+ lvls
93924	Lwr xtr vasc stdy bilat
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
A4641	Radiopharm dx agent noc
A4642	In111 satumomab
A9500	Tc99m sestamibi
A9501	Technetium TC-99m teboroxime
A9502	Tc99m tetrofosmin
A9503	Tc99m medronate

A9504	Tc99m apcitide
A9505	TL201 thallium
A9507	In111 capromab
A9508	I131 iodobenguate, dx
A9509	Iodine I-123 sod iodide mil
A9510	Tc99m disofenin
A9512	Tc99m pertechnetate
A9516	Iodine I-123 sod iodide mic
A9521	Tc99m exametazime
A9524	I131 serum albumin, dx
A9526	Nitrogen N-13 ammonia
A9528	Iodine I-131 iodide cap, dx
A9529	I131 iodide sol, dx
A9531	I131 max 100uCi
A9532	I125 serum albumin, dx
A9536	TC99m depreotide
A9537	Tc99m mebrofenin
A9538	Tc99m pyrophosphate
A9539	Tc99m pentetate
A9540	Tc99m MAA
A9541	Tc99m sulfur colloid
A9542	In111 ibritumomab, dx
A9544	I131 tositumomab, dx
A9546	CO57/58
A9547	In111 oxyquinoline
A9548	In111 pentetate
A9550	Tc99m gluceptate
A9551	Tc99m succimer
A9552	F18 fdg
A9553	Cr51 chromate
A9554	I125 iothalamate, dx
A9555	Rb82 rubidium
A9556	Ga67 gallium
A9557	Tc99m bicisate
A9558	Xe133 xenon 10mci
A9559	Co57 cyano
A9560	Tc99m labeled rbc
A9561	Tc99m oxidronate
A9562	Tc99m mertiatide
A9566	Tc99m fanolesomab
A9567	Technetium TC-99m aerosol
A9568	Technetium tc99m arcitumomab
A9569	Technetium TC-99m auto WBC
A9570	Indium In-111 auto WBC
A9571	Indium In-111 auto platelet

A9572	Indium In-111 pentetreotide
A9576	Inj prohance multipack
A9577	Inj multihance
A9578	Inj multihance multipack
A9579	Gad-base MR contrast NOS,1ml
A9580	Sodium fluoride F-18
A9700	Echocardiography contrast
G0130	Single energy x-ray study
G0202	Screeningmammographydigital
G0204	Diagnosticmammographydigital
G0206	Diagnosticmammographydigital
G0288	Recon, CTA for surg plan
G0389	Ultrasound exam AAA screen
Q0092	Set up port xray equipment
Q9951	LOCM>=400 mg/ml iodine,1ml
Q9953	Inj Fe-based MR contrast,1ml
Q9954	Oral MR contrast, 100ml
Q9955	Inj perflexane lip micros,ml
Q9956	Inj octafluoropropane mic,ml
Q9957	Inj perflutren lip micros,ml
Q9958	HOCM <=149 mg/ml iodine, 1ml
Q9959	HOCM 150-199mg/ml iodine,1ml
Q9960	HOCM 200-249mg/ml iodine,1ml
Q9961	HOCM 250-299mg/ml iodine,1ml
Q9962	HOCM 300-349mg/ml iodine,1ml
Q9963	HOCM 350-399mg/ml iodine,1ml
Q9964	HOCM>= 400mg/ml iodine, 1ml
Q9965	LOCM 100-199mg/ml iodine,1ml
Q9966	LOCM 200-299mg/ml iodine,1ml
Q9967	LOCM 300-399mg/ml iodine,1ml
R0070	Transport portable x-ray
R0075	Transport port x-ray multipl
RADIATION THERAPY SERVICES AND SUPPLIES	
INCLUDE the following CPT and HCPCS codes:	
0073T	Delivery comp imrt
0182T	HDR elect brachytherapy
0190T	Place intraoc radiation src
0197T	Intrafraction track motion
19296	Place po breast cath for rad
19297	Place breast cath for rad
19298	Place breast rad tube/caths
20555	Place ndl musc/tis for rt
31643	Diag bronchoscope/catheter
32553	Ins mark thor for rt perq
41019	Place needles h & n for rt

49327	Lap ins device for rt
49411	Ins mark abd/pel for rt perq
49412	Ins device for rt guide open
55875	Transperi needle place pros
55876	Place rt device/marker pros
55920	Place needles pelvic for rt
57155	Insert uteri tandems/ovoids
57156	Ins vag brachytx device
58346	Insert heyman uteri capsule
61770	Incise skull for treatment
61796	SRS cranial lesion simple
61797	SRS cran les simple addl
61798	SRS cranial lesion complex
61799	SRS cran les complex addl
61800	Apply SRS headframe add-on
63620	SRS spinal lesion
63621	SRS spinal lesion addl
77261	Radiation therapy planning
77262	Radiation therapy planning
77263	Radiation therapy planning
77280	Set radiation therapy field
77285	Set radiation therapy field
77290	Set radiation therapy field
77295	Set radiation therapy field
77299	Radiation therapy planning
77300	Radiation therapy dose plan
77301	Radiotherapy dose plan imrt
77305	Teletx isodose plan simple
77310	Teletx isodose plan intermed
77315	Teletx isodose plan complex
77321	Special teletx port plan
77326	Brachytx isodose calc simp
77327	Brachytx isodose calc interm
77328	Brachytx isodose plan compl
77331	Special radiation dosimetry
77332	Radiation treatment aid(s)
77333	Radiation treatment aid(s)
77334	Radiation treatment aid(s)
77336	Radiation physics consult
77338	Design mlc device for imrt
77370	Radiation physics consult
77371	Srs multisource
77372	Srs linear based
77373	Sbrt delivery
77399	External radiation dosimetry

77401	Radiation treatment delivery
77402	Radiation treatment delivery
77403	Radiation treatment delivery
77404	Radiation treatment delivery
77406	Radiation treatment delivery
77407	Radiation treatment delivery
77408	Radiation treatment delivery
77409	Radiation treatment delivery
77411	Radiation treatment delivery
77412	Radiation treatment delivery
77413	Radiation treatment delivery
77414	Radiation treatment delivery
77416	Radiation treatment delivery
77417	Radiology port film(s)
77418	Radiation tx delivery imrt
77421	Stereoscopic x-ray guidance
77422	Neutron beam tx simple
77423	Neutron beam tx complex
77427	Radiation tx management x5
77431	Radiation therapy management
77432	Stereotactic radiation trmt
77435	Sbrt management
77470	Special radiation treatment
77499	Radiation therapy management
77520	Proton trmt simple w/o comp
77522	Proton trmt simple w/comp
77523	Proton trmt intermediate
77525	Proton treatment complex
77600	Hyperthermia treatment
77605	Hyperthermia treatment
77610	Hyperthermia treatment
77615	Hyperthermia treatment
77620	Hyperthermia treatment
77750	Infuse radioactive materials
77761	Apply intrcav radiat simple
77762	Apply intrcav radiat interm
77763	Apply intrcav radiat compl
77776	Apply interstit radiat simpl
77777	Apply interstit radiat inter
77778	Apply interstit radiat compl
77785	HDR brachytx 1 channel
77786	HDR brachytx 2-12 channel
77787	HDR brachytx over 12 chan
77789	Apply surface radiation
77790	Radiation handling

77799	Radium/radioisotope therapy
79005	Nuclear rx oral admin
79101	Nuclear rx iv admin
79200	Nuclear rx intracav admin
79300	Nuclr rx interstit colloid
79403	Hematopoietic nuclear tx
79440	Nuclear rx intra-articular
79445	Nuclear rx intra-arterial
79999	Nuclear medicine therapy
92974	Cath place cardio brachytx
A4650	Implant radiation dosimeter
A9517	I131 iodide cap, rx
A9527	Iodine I-125 sodium iodide
A9530	I131 iodide sol, rx
A9543	Y90 ibritumomab, rx
A9545	I131 tositumomab, rx
A9563	P32 Na phosphate
A9564	P32 chromic phosphate
A9600	Sr89 strontium
A9604	Sm 153 lexidronam
A9699	Radiopharm rx agent noc
C1716	Brachytx, non-str, Gold-198
C1717	Brachytx, non-str,HDR Ir-192
C1719	Brachytx, NS, Non-HDRIr-192
C2616	Brachytx, non-str,Yttrium-90
C2634	Brachytx, non-str, HA, I-125
C2635	Brachytx, non-str, HA, P-103
C2636	Brachy linear, non-str,P-103
C2638	Brachytx, stranded, I-125
C2639	Brachytx,non-stranded,I-125
C2640	Brachytx, stranded, P-103
C2641	Brachytx, non-stranded,P-103
C2642	Brachytx, stranded, C-131
C2643	Brachytx, non-stranded,C-131
C2698	Brachytx, stranded, NOS
C2699	Brachytx, non-stranded, NOS
G0173	Linear acc stereo radsur com
G0251	Linear acc based stero radio
G0339	Robot lin-radsurg com, first
G0340	Robt lin-radsurg fractx 2-5
Q3001	Brachytherapy Radioelements
EPO AND OTHER DIALYSIS-RELATED DRUGS	
The physician self-referral prohibition does not apply to the following codes for dialysis-related drugs furnished in or by an ESRD facility if the conditions in §411.355(g) are satisfied:	
No codes reported at this time.	

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
The physician self-referral prohibition does not apply to the following tests if they are performed for screening purposes and satisfy the conditions in §411.355(h):	
77052	Comp screen mammogram add-on
77057	Mammogram screening
80061	Lipid panel [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V81.2]
82270	Occult blood feces
82465	Assay bld/serum cholesterol [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V81.2]
82947	Assay glucose blood quant [only when billed with ICD-9-CM code V77.1]
82950	Glucose test [only when billed with ICD-9-CM code V77.1]
82951	Glucose tolerance test (GTT) [only when billed with ICD-9-CM code V77.1]
83718	Assay of lipoprotein [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V81.2]
84478	Assay of triglycerides [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V81.2]
G0103	PSA screening
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0202	Screeningmammographydigital
G0328	Fecal blood scrn immunoassay
G0389	Ultrasound exam AAA screen
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
The physician self-referral prohibition does not apply to the following immunization and vaccine codes if they satisfy the conditions in §411.355(h):	
90655	Flu vaccine no preserv 6-35m
90656	Flu vaccine no preserv 3 & >
90657	Flu vaccine 3 yrs im
90660	Flu vaccine nasal
90662	Flu vacc prsv free inc antig
90669	Pneumococcal vacc 7 val im
90670	Pneumococcal vacc 13 val im
90732	Pneumococcal vaccine
90740	Hepb vacc ill pat 3 dose im

90743	Hep b vacc adol 2 dose im
90744	Hepb vacc ped/adol 3 dose im
90746	Hep b vaccine adult im
90747	Hepb vacc ill pat 4 dose im
G0432	EIA HIV-1/HIV-2 screen
G0433	ELISA HIV-1/HIV-2 screen
G0435	Oral HIV-1/HIV-2 screen
Q2035	Afluria vacc, 3 yrs & >, im
Q2036	Flulaval vacc, 3 yrs & >, im
Q2037	Fluvirin vacc, 3 yrs & >, im
Q2038	Fluzone vacc, 3 yrs & >, im
Q2039	NOS flu vacc, 3 yrs & >, im

[1] CPT codes and descriptions only are copyright 2010 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

[2] This list does not include codes for the following designated health service (DHS) categories: durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. For the definitions of these DHS categories, refer to §411.351. For more information, refer to the CMS Web site at http://www.cms.gov/PhysicianSelfReferral/.

ADDENDUM K--CY 2011 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8459	0.8003
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.6342	0.6000
10420	Akron, OH Portage County, OH Summit County, OH	0.9346	0.8843
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9550	0.9036
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.9146	0.8653
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9994	0.9456
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8450	0.7995
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9717	0.9194
11020	Altoona, PA Blair County, PA	0.9111	0.8620

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
11100	Amarillo, TX	0.9136	0.8644
	Armstrong County, TX		
	Carson County, TX		
	Potter County, TX		
	Randall County, TX		
11180	Ames, IA	1.0538	0.9970
	Story County, IA		
11260	Anchorage, AK	1.2645	1.1964
	Anchorage Municipality, AK		
	Matanuska-Susitna Borough, AK		
11300	Anderson, IN	0.9715	0.9192
	Madison County, IN		
11340	Anderson, SC	0.9186	0.8691
	Anderson County, SC		
11460	Ann Arbor, MI	1.0700	1.0124
	Washtenaw County, MI		
11500	Anniston-Oxford, AL	0.8369	0.7918
	Calhoun County, AL		
11540	Appleton, WI	0.9491	0.9361
	Calumet County, WI		
	Outagamie County, WI		
11700	Asheville, NC	0.9513	0.9001
	Buncombe County, NC		
	Haywood County, NC		
	Henderson County, NC		
	Madison County, NC		
12020	Athens-Clarke County, GA	1.0209	0.9659
	Clarke County, GA		
	Madison County, GA		
	Oconee County, GA		
	Oglethorpe County, GA		
12060	Atlanta-Sandy Springs-Marietta, GA	1.00093	0.9549
	Barrow County, GA		
	Bartow County, GA		
	Butts County, GA		
	Carroll County, GA		
	Cherokee County, GA		
	Clayton County, GA		
	Cobb County, GA		
	Coweta County, GA		
	Dawson County, GA		
	DeKalb County, GA		
	Douglas County, GA		
	Fayette County, GA		
	Forsyth County, GA		
	Fulton County, GA		
	Gwinnett County, GA		
	Haralson County, GA		
	Heard County, GA		
	Henry County, GA		
	Jasper County, GA		
	Lamar County, GA		
	Meriwether County, GA		
	Newton County, GA		
	Paulding County, GA		
	Pickens County, GA		
	Pike County, GA		
	Rockdale County, GA		
	Spalding County, GA		
	Walton County, GA		
12100	Atlantic City-Hammonton, NJ	1.1763	1.1129
	Atlantic County, NJ		
12220	Auburn-Opelika, AL	0.7599	0.7190
	Lee County, AL		
12260	Augusta-Richmond County, GA-SC	1.0081	0.9538
	Burke County, GA		
	Columbia County, GA		
	McDuffie County, GA		
	Richmond County, GA		
	Aiken County, SC		
	Edgefield County, SC		
12420	Austin-Round Rock-San Marcos, TX	1.0056	0.9514
	Bastrop County, TX		
	Caldwell County, TX		
	Hays County, TX		
	Travis County, TX		
	Williamson County, TX		

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
12540	Bakersfield-Delano, CA Kern County, CA	1.2373	1.1707
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0839	1.0255
12620	Bangor, ME Penobscot County, ME	1.0334	0.9777
12700	Barnstable Town, MA Barnstable County, MA	1.3553	1.2823
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.9072	0.8583
12980	Battle Creek, MI Calhoun County, MI	1.0206	0.9656
13020	Bay City, MI Bay County, MI	0.9746	0.9221
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8971	0.8488
13380	Bellingham, WA Whatcom County, WA	1.2038	1.1390
13460	Bend, OR Deschutes County, OR	1.2019	1.1372
13644	Bethesda-Rockville-Frederick, MD Frederick County, MD Montgomery County, MD	1.1124	1.0525
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.9168	0.8674
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.9215	0.8719

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.9101	0.8611
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7766	0.7348
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8787	0.8314
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9501	0.8989
14060	Bloomington-Normal, IL McLean County, IL	0.9976	0.9439
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9801	0.9273
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2871	1.2178
14500	Boulder, CO Boulder County, CO	1.0638	1.0065
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.9159	0.8666
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.1274	1.0667
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.3261	1.2547
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9695	0.9173
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9733	0.9209

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	1.0073	0.9530
15500	Burlington, NC Alamance County, NC	0.9368	0.8863
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0513	0.9947
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1890	1.1250
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0977	1.0386
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.9247	0.8749
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9718	0.9195
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.9494	0.8983
16180	Carson City, NV Carson City, NV	1.1061	1.0465
16220	Casper, WY Natrona County, WY	1.0205	0.9655
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.9347	0.8844
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0818	1.0235
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8344	0.7895
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9887	0.9354
16740	Charlotte-Gastonia-Rock Hill, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9956	0.9420
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9874	0.9342
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9332	0.8829
16940	Cheyenne, WY Laramie County, WY	0.9927	0.9392
16974	Chicago-Joliet-Naperville, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.1196	1.0593
17020	Chico, CA Butte County, CA	1.2190	1.1533

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
17140	Cincinnati-Middletown, OH-KY-IN	1.0251	0.9699
	Dearborn County, IN		
	Franklin County, IN		
	Ohio County, IN		
	Boone County, KY		
	Bracken County, KY		
	Campbell County, KY		
	Gallatin County, KY		
	Grant County, KY		
	Kenton County, KY		
	Pendleton County, KY		
	Brown County, OH		
	Butler County, OH		
	Clermont County, OH		
	Hamilton County, OH		
	Warren County, OH		
17300	Clarksville, TN-KY	0.8337	0.7888
	Christian County, KY		
	Trigg County, KY		
	Montgomery County, TN		
	Stewart County, TN		
17420	Cleveland, TN	0.8171	0.7731
	Bradley County, TN		
	Polk County, TN		
17460	Cleveland-Elyria-Mentor, OH	0.9565	0.9050
	Cuyahoga County, OH		
	Geauga County, OH		
	Lake County, OH		
	Lorain County, OH		
	Medina County, OH		
17660	Coeur d'Alene, ID	0.9897	0.9364
	Kootenai County, ID		
17780	College Station-Bryan, TX	1.0134	0.9588
	Brazos County, TX		
	Burleson County, TX		
	Robertson County, TX		
17820	Colorado Springs, CO	1.0021	0.9481
	El Paso County, CO		
	Teller County, CO		
17860	Columbia, MO	0.8753	0.8282
	Boone County, MO		
	Howard County, MO		
17900	Columbia, SC	0.9230	0.8733
	Calhoun County, SC		
	Fairfield County, SC		
	Kershaw County, SC		
	Lexington County, SC		
	Richland County, SC		
	Saluda County, SC		
17980	Columbus, GA-AL	0.9541	0.9027
	Russell County, AL		
	Chattahoochee County, GA		
	Harris County, GA		
	Marion County, GA		
	Muscogee County, GA		
18020	Columbus, IN	0.9971	0.9434
	Bartholomew County, IN		
18140	Columbus, OH	1.0718	1.0141
	Delaware County, OH		
	Fairfield County, OH		
	Franklin County, OH		
	Licking County, OH		
	Madison County, OH		
	Morrow County, OH		
	Pickaway County, OH		
	Union County, OH		
18580	Corpus Christi, TX	0.9074	0.8585
	Aransas County, TX		
	Nueces County, TX		
	San Patricio County, TX		
18700	Corvallis, OR	1.1050	1.0455
	Benton County, OR		
18880	Crestview-Fort Walton Beach-Destin, FL	0.9345	0.8842
	Okaloosa, FL		
19060	Cumberland, MD-WV	0.8582	0.8186
	Allegany County, MD		
	Mineral County, WV		
19124	Dallas-Plano-Irving, TX	1.0421	0.9860
	Collin County, TX		
	Dallas County, TX		
	Delta County, TX		
	Denton County, TX		
	Ellis County, TX		
	Hunt County, TX		
	Kaufman County, TX		
	Rockwall County, TX		
19140	Dalton, GA	0.9113	0.8622
	Murray County, GA		
	Whitfield County, GA		

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
19180	Danville, IL Vermilion County, IL	1.0245	0.9693
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8633	0.8168
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8878	0.8400
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9660	0.9140
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8055	0.7621
19500	Decatur, IL Macon County, IL	0.8367	0.7916
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.9233	0.8736
19740	Denver-Aurora-Broomfield, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.1328	1.0718
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	1.0169	0.9621
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0251	0.9699
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7858	0.7435
20100	Dover, DE Kent County, DE	1.0486	0.9921
20220	Dubuque, IA Dubuque County, IA	0.9273	0.8774
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.1166	1.0565
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0214	0.9664
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	1.0188	0.9639
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1633	1.1006
20940	El Centro, CA Imperial County, CA	0.9785	0.9258
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8930	0.8449
21140	Elkhart-Goshen, IN Elkhart County, IN	1.0004	0.9465
21300	Elmira, NY Chemung County, NY	0.8926	0.8445
21340	El Paso, TX El Paso County, TX	0.8957	0.8475
21500	Erie, PA Erie County, PA	0.8836	0.8360
21660	Eugene-Springfield, OR Lane County, OR	1.2032	1.1384
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8913	0.8433
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1711	1.1080
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.6342	0.6000

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8523	0.8064
22140	Farmington, NM San Juan County, NM	0.9871	0.9339
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9854	0.9323
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9107	0.8616
22380	Flagstaff, AZ Coconino County, AZ	1.3151	1.2443
22420	Flint, MI Genesee County, MI	1.2150	1.1496
22500	Florence, SC Darlington County, SC Florence County, SC	0.8722	0.8252
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8608	0.8144
22540	Fond du Lac, WI Fond du Lac County, WI	0.9748	0.9223
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0455	0.9892
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0738	1.0160
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8032	0.7599
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9895	0.9362
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	1.0013	0.9474
23420	Fresno, CA Fresno County, CA	1.2072	1.1422
23460	Gadsden, AL Etowah County, AL	0.7589	0.7180
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9681	0.9160
23580	Gainesville, GA Hall County, GA	0.9748	0.9223
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9601	0.9084
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8991	0.8507
24140	Goldsboro, NC Wayne County, NC	0.9583	0.9067
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.8156	0.7717
24300	Grand Junction, CO Mesa County, CO	1.0411	0.9850
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9691	0.9169
24500	Great Falls, MT Cascade County, MT	0.8761	0.8289
24540	Greeley, CO Weld County, CO	1.0037	0.9496
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	1.0132	0.9586
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9388	0.8882
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9903	0.9370
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	1.0193	0.9644

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
25020	Guayama, PR	0.6342	0.6000
	Arroyo Municipio, PR		
	Guayama Municipio, PR		
	Patillas Municipio, PR		
25060	Gulfport-Biloxi, MS	0.9382	0.8877
	Hancock County, MS		
	Harrison County, MS		
	Stone County, MS		
25180	Hagerstown-Martinsburg, MD-WV	0.9781	0.9254
	Washington County, MD		
	Berkeley County, WV		
	Morgan County, WV		
25260	Hanford-Corcoran, CA	1.1843	1.1205
	Kings County, CA		
25420	Harrisburg-Carlisle, PA	0.9825	0.9296
	Cumberland County, PA		
	Dauphin County, PA		
	Perry County, PA		
25500	Harrisonburg, VA	0.9679	0.9158
	Rockingham County, VA		
	Harrisonburg City, VA		
25540	Hartford-West Hartford-East Hartford, CT	1.1549	1.0927
	Hartford County, CT		
	Middlesex County, CT		
	Tolland County, CT		
25620	Hattiesburg, MS	0.8153	0.7714
	Forrest County, MS		
	Lamar County, MS		
	Perry County, MS		
25860	Hickory-Lenoir-Morganton, NC	0.9188	0.8693
	Alexander County, NC		
	Burke County, NC		
	Caldwell County, NC		
	Catawba County, NC		
25980	Hinesville-Fort Stewart, GA	0.9468	0.8958
	Liberty County, GA		
	Long County, GA		
26100	Holland-Grand Haven, MI	0.9123	0.8632
	Ottawa County, MI		
26180	Honolulu, HI	1.2479	1.1807
	Honolulu County, HI		
26300	Hot Springs, AR	0.9672	0.9151
	Garland County, AR		
26380	Houma-Bayou Cane-Thibodaux, LA	0.8299	0.7852
	Lafourche Parish, LA		
	Terrebonne Parish, LA		
726420	Houston-Sugar Land-Baytown, TX	1.0383	0.9824
	Austin County, TX		
	Brazoria County, TX		
	Chambers County, TX		
	Fort Bend County, TX		
	Galveston County, TX		
	Harris County, TX		
	Liberty County, TX		
	Montgomery County, TX		
	San Jacinto County, TX		
	Waller County, TX		
26580	Huntington-Ashland, WV-KY-OH	0.9463	0.8953
	Boyd County, KY		
	Greenup County, KY		
	Lawrence County, OH		
	Cabell County, WV		
	Wayne County, WV		
26620	Huntsville, AL	0.9714	0.9191
	Limestone County, AL		
	Madison County, AL		
26820	Idaho Falls, ID	1.0213	0.9663
	Bonneville County, ID		
	Jefferson County, ID		
26900	Indianapolis-Carmel, IN	1.0223	0.9672
	Boone County, IN		
	Brown County, IN		
	Hamilton County, IN		
	Hancock County, IN		
	Hendricks County, IN		
	Johnson County, IN		
	Marion County, IN		
	Morgan County, IN		
	Putnam County, IN		
	Shelby County, IN		
26980	Iowa City, IA	1.0207	0.9657
	Johnson County, IA		
	Washington County, IA		
27060	Ithaca, NY	1.0402	0.9842
	Tompkins County, NY		
27100	Jackson, MI	0.9676	0.9155
	Jackson County, MI		
27140	Jackson, MS	0.8500	0.8042
	Copiah County, MS		
	Hinds County, MS		
	Madison County, MS		
	Rankin County, MS		
	Simpson County, MS		

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
27180	Jackson, TN Chester County, TN Madison County, TN	0.8882	0.8404
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9390	0.8884
27340	Jacksonville, NC Onslow County, NC	0.8251	0.7807
27500	Janesville, WI Rock County, WI	0.9951	0.9415
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8914	0.8434
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7566	0.8150
27780	Johnstown, PA Cambria County, PA	0.8551	0.8090
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.8199	0.7757
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8682	0.8214
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0878	1.0292
28100	Kankakee-Bradley, IL Kankakee County, IL	1.1224	1.0619
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	1.0201	0.9652
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	1.0544	0.9976
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9299	0.8798
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.8020	0.7588
28740	Kingston, NY Ulster County, NY	0.9592	0.9075
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8288	0.7842
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9650	0.9130
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	1.0361	0.9803
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9818	0.9289

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
29180	Lafayette, LA	0.8972	0.8489
	Lafayette Parish, LA		
	St. Martin Parish, LA		
29340	Lake Charles, LA	0.8663	0.8196
	Calcasieu Parish, LA		
	Cameron Parish, LA		
29404	Lake County-Kenosha County, IL-WI	1.1395	1.0781
	Lake County, IL		
	Kenosha County, WI		
29420	Lake Havasu City-Kingman, AZ	1.0818	1.0235
	Mohave County, AZ		
29460	Lakeland-Winter Haven, FL	0.8928	0.8447
	Polk County, FL		
29540	Lancaster, PA	0.9876	0.9344
	Lancaster County, PA		
29620	Lansing-East Lansing, MI	1.0884	1.0298
	Clinton County, MI		
	Eaton County, MI		
	Ingham County, MI		
29700	Laredo, TX	0.8365	0.7914
	Webb County, TX		
29740	Las Cruces, NM	0.9825	0.9296
	Dona Ana County, NM		
29820	Las Vegas-Paradise, NV	1.2788	1.2099
	Clark County, NV		
29940	Lawrence, KS	0.9019	0.8533
	Douglas County, KS		
30020	Lawton, OK	0.8757	0.8285
	Comanche County, OK		
30140	Lebanon, PA	0.8251	0.7807
	Lebanon County, PA		
30300	Lewiston, ID-WA	0.9891	0.9358
	Nez Perce County, ID		
	Asotin County, WA		
30340	Lewiston-Auburn, ME	0.9410	0.8903
	Androscoggin County, ME		
30460	Lexington-Fayette, KY	0.9319	0.8817
	Bourbon County, KY		
	Clark County, KY		
	Fayette County, KY		
	Jessamine County, KY		
	Scott County, KY		
	Woodford County, KY		
30620	Lima, OH	0.9799	0.9271
	Allen County, OH		
30700	Lincoln, NE	1.0164	0.9617
	Lancaster County, NE		
	Seward County, NE		
30780	Little Rock-North Little Rock-Conway, AR	0.9033	0.8546
	Faulkner County, AR		
	Grant County, AR		
	Lonoke County, AR		
	Perry County, AR		
	Pulaski County, AR		
	Saline County, AR		
30860	Logan, UT-ID	0.9295	0.8794
	Franklin County, ID		
	Cache County, UT		
30980	Longview, TX	0.9050	0.8563
	Gregg County, TX		
	Rusk County, TX		
	Upshur County, TX		
31020	Longview, WA	1.0882	1.0296
	Cowlitz County, WA		
31084	Los Angeles-Long Beach-Santa Ana, CA	1.2821	1.2130
	Los Angeles County, CA		
31140	Louisville-Jefferson County, KY-IN	0.9402	0.8896
	Clark County, IN		
	Floyd County, IN		
	Harrison County, IN		
	Washington County, IN		
	Bullitt County, KY		
	Henry County, KY		
	Meade County, KY		
	Nelson County, KY		
	Oldham County, KY		
	Shelby County, KY		
	Spencer County, KY		
	Trimble County, KY		
31180	Lubbock, TX	0.9351	0.8847
	Crosby County, TX		
	Lubbock County, TX		
31340	Lynchburg, VA	0.9189	0.8694
	Amherst County, VA		
	Appomattox County, VA		
	Bedford County, VA		
	Campbell County, VA		
	Bedford City, VA		
	Lynchburg City, VA		

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
31420	Macon, GA	0.9726	0.9202
	Bibb County, GA		
	Crawford County, GA		
	Jones County, GA		
	Monroe County, GA		
	Twiggs County, GA		
31460	Madera-Chowchilla, CA	0.8441	0.7986
	Madera County, CA		
31540	Madison, WI	1.1937	1.1294
	Columbia County, WI		
	Dane County, WI		
	Iowa County, WI		
31700	Manchester-Nashua, NH	1.0431	0.9869
	Hillsborough County, NH		
31740	Manhattan, KS	0.8294	0.7847
	Geary County, KS		
	Pottawatomie County, KS		
	Riley County, KS		
31860	Mankato-North Mankato, MN	0.9600	0.9083
	Blue Earth County, MN		
	Nicollet County, MN		
31900	Mansfield, OH	0.9426	0.8918
	Richland County, OH		
32420	Mayagüez, PR	0.6342	0.6000
	Hormigueros Municipio, PR		
	Mayagüez Municipio, PR		
32580	McAllen-Edinburg-Mission, TX	0.9340	0.8837
	Hidalgo County, TX		
32780	Medford, OR	1.0634	1.0061
	Jackson County, OR		
32820	Memphis, TN-MS-AR	0.9796	0.9268
	Crittenden County, AR		
	DeSoto County, MS		
	Marshall County, MS		
	Tate County, MS		
	Tunica County, MS		
	Fayette County, TN		
	Shelby County, TN		
	Tipton County, TN		
32900	Merced, CA	1.3063	1.2359
	Merced County, CA		
33124	Miami-Miami Beach-Kendall, FL	1.0705	1.0128
	Miami-Dade County, FL		
33140	Michigan City-La Porte, IN	1.0009	0.9470
	LaPorte County, IN		
33260	Midland, TX	1.0264	0.9711
	Midland County, TX		
33340	Milwaukee-Waukesha-West Allis, WI	1.0763	1.0183
	Milwaukee County, WI		
	Ozaukee County, WI		
	Washington County, WI		
	Waukesha County, WI		
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.1777	1.1143
	Anoka County, MN		
	Carver County, MN		
	Chisago County, MN		
	Dakota County, MN		
	Hennepin County, MN		
	Isanti County, MN		
	Ramsey County, MN		
	Scott County, MN		
	Sherburne County, MN		
	Washington County, MN		
	Wright County, MN		
	Pierce County, WI		
	St. Croix County, WI		
33540	Missoula, MT	0.9429	0.8921
	Missoula County, MT		
33660	Mobile, AL	0.8413	0.7960
	Mobile County, AL		
33700	Modesto, CA	1.2793	1.2104
	Stanislaus County, CA		
33740	Monroe, LA	0.8448	0.7993
	Ouachita Parish, LA		
	Union Parish, LA		
33780	Monroe, MI	0.9178	0.8684
	Monroe County, MI		
33860	Montgomery, AL	0.8923	0.8442
	Autauga County, AL		
	Elmore County, AL		
	Lowndes County, AL		
	Montgomery County, AL		
34060	Morgantown, WV	0.8600	0.8137
	Monongalia County, WV		
	Preston County, WV		
34100	Morristown, TN	0.7442	0.7041
	Grainger County, TN		
	Hamblen County, TN		
	Jefferson County, TN		
34580	Mount Vernon-Anacortes, WA	1.0953	1.0363
	Skagit County, WA		
34620	Muncie, IN	0.8673	0.8206
	Delaware County, IN		

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
34740	Muskegon-Norton Shores, MI	1.0367	0.9809
	Muskegon County, MI		
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	0.9235	0.8738
	Horry County, SC		
34900	Napa, CA	1.5435	1.4604
	Napa County, CA		
34940	Naples-Marco Island, FL	1.0250	0.9698
	Collier County, FL		
34980	Nashville-Davidson-—Murfreesboro--Franklin, TN	0.9995	0.9457
	Cannon County, TN		
	Cheatham County, TN		
	Davidson County, TN		
	Dickson County, TN		
	Hickman County, TN		
	Macon County, TN		
	Robertson County, TN		
	Rutherford County, TN		
	Smith County, TN		
	Sumner County, TN		
	Trousdale County, TN		
	Williamson County, TN		
	Wilson County, TN		
35004	Nassau-Suffolk, NY	1.3016	1.2315
	Nassau County, NY		
	Suffolk County, NY		
35084	Newark-Union, NJ-PA	1.2112	1.1460
	Essex County, NJ		
	Hunterdon County, NJ		
	Morris County, NJ		
	Sussex County, NJ		
	Union County, NJ		
	Pike County, PA		
35300	New Haven-Milford, CT	1.2171	1.1515
	New Haven County, CT		
35380	New Orleans-Metairie-Kenner, LA	0.9568	0.9070
	Jefferson Parish, LA		
	Orleans Parish, LA		
	Plaquemines Parish, LA		
	St. Bernard Parish, LA		
	St. Charles Parish, LA		
	St. John the Baptist Parish, LA		
	St. Tammany Parish, LA		

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
35644	New York-White Plains-Wayne, NY-NJ	1.3693	1.2955
	Bergen County, NJ		
	Hudson County, NJ		
	Passaic County, NJ		
	Bronx County, NY		
	Kings County, NY		
	New York County, NY		
	Putnam County, NY		
	Queens County, NY		
	Richmond County, NY		
	Rockland County, NY		
	Westchester County, NY		
35660	Niles-Benton Harbor, MI	0.9377	0.8872
	Berrien County, MI		
35840	North Port-Bradenton-Sarasota, FL	1.0021	0.9481
	New London County, CT		
35980	Norwich-New London, CT	1.1853	1.1215
	New London County, CT		
36084	Oakland-Fremont-Hayward, CA	1.7285	1.6354
	Alameda County, CA		
	Contra Costa County, CA		
36100	Ocala, FL	0.8950	0.8468
	Marion County, FL		
36140	Ocean City, NJ	1.1498	1.0879
	Cape May County, NJ		
36220	Odessa, TX	0.9973	0.9436
	Ector County, TX		
36260	Ogden-Clearfield, UT	0.9795	0.9267
	Davis County, UT		
	Morgan County, UT		
	Weber County, UT		
36420	Oklahoma City, OK	0.9382	0.8877
	Canadian County, OK		
	Cleveland County, OK		
	Grady County, OK		
	Lincoln County, OK		
	Logan County, OK		
	McClain County, OK		
	Oklahoma County, OK		
36500	Olympia, WA	1.1911	1.1269
	Thurston County, WA		

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	1.0129	0.9583
36740	Orlando-Kissimmee-Sanford, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9685	0.9163
36780	Oshkosh-Neenah, WI Winnebago County, WI	1.0111	0.9566
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8846	0.8370
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.3082	1.2377
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9735	0.9211
37380	Palm Coast, FL Flagler County, FL	0.8883	0.8405
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL	0.8407	0.7954
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7879	0.7455
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8771	0.8299
37764	Peabody, MA Essex County, MA	1.1604	1.0979
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8724	0.8254
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9670	0.9149

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.1418	1.0803
38060	Phoenix-Mesa-Glendale, AZ Maricopa County, AZ Pinal County, AZ	1.1248	1.0642
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.8468	0.8012
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.9095	0.8605
38340	Pittsfield, MA Berkshire County, MA	1.0961	1.0371
38540	Pocatello, ID Bannock County, ID Power County, ID	1.0048	0.9507
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.6342	0.6000
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0463	0.9899
38900	Portland-Vancouver-Hillsboro, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.2129	1.1476
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.1333	1.0723

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.2000	1.1354
39140	Prescott, AZ Yavapai County, AZ	1.2930	1.2234
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.1324	1.0714
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9852	0.9321
39380	Pueblo, CO Pueblo County, CO	0.9217	0.8721
39460	Punta Gorda, FL Charlotte County, FL	0.9258	0.8759
39540	Racine, WI Racine County, WI	1.1182	1.0580
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	1.0370	0.9811
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.1036	1.0442
39740	Reading, PA Berks County, PA	0.9411	0.8904
39820	Redding, CA Shasta County, CA	1.4939	1.4134
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.1012	1.0419

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	1.0211	0.9661
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.2229	1.1570
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.9330	0.8827
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1565	1.0942
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.9084	0.8595
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0604	1.0033
40484	Rockingham, NH Rockingham County, NH Strafford County, NH	1.0597	1.0026

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9548	0.9034
40660	Rome, GA Floyd County, GA	0.9127	0.8635
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4853	1.4053
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9225	0.8708
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1671	1.1042
41100	St. George, UT Washington County, UT	0.9653	0.9133
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0888	1.0302
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9607	0.9090
41420	Salem, OR Marion County, OR Polk County, OR	1.1767	1.1133
41500	Salinas, CA Monterey County, CA	1.6579	1.5686
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9518	0.9005
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9794	0.9266
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8776	0.8303
41700	San Antonio- New Braunfels, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.9510	0.8998
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.2661	1.1979
41780	Sandusky, OH Erie County, OH	0.9180	0.8686
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.6629	1.5733
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.6342	0.6000
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.7654	1.6703

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
41980	San Juan-Caguas-Guaynabo, PR	0.6342	0.6000
	Aguas Buenas Municipio, PR		
	Aibonito Municipio, PR		
	Arecibo Municipio, PR		
	Barceloneta Municipio, PR		
	Barranquitas Municipio, PR		
	Bayamón Municipio, PR		
	Caguas Municipio, PR		
	Camuy Municipio, PR		
	Canóvanas Municipio, PR		
	Carolina Municipio, PR		
	Cataño Municipio, PR		
	Cayey Municipio, PR		
	Ciales Municipio, PR		
	Cidra Municipio, PR		
	Comerío Municipio, PR		
	Corozal Municipio, PR		
	Dorado Municipio, PR		
	Florida Municipio, PR		
	Guaynabo Municipio, PR		
	Gurabo Municipio, PR		
	Hatillo Municipio, PR		
	Humacao Municipio, PR		
	Juncos Municipio, PR		
	Las Piedras Municipio, PR		
	Loíza Municipio, PR		
	Manatí Municipio, PR		
	Maunabo Municipio, PR		
	Morovis Municipio, PR		
	Naguabo Municipio, PR		
	Naranjito Municipio, PR		
	Orocovis Municipio, PR		
	Quebradillas Municipio, PR		
	Río Grande Municipio, PR		
	San Juan Municipio, PR		
	San Lorenzo Municipio, PR		
	Toa Alta Municipio, PR		
	Toa Baja Municipio, PR		
	Trujillo Alto Municipio, PR		
	Vega Alta Municipio, PR		
	Vega Baja Municipio, PR		
	Yabucoa Municipio, PR		
42020	San Luis Obispo-Paso Robles, CA	1.3650	1.2915
	San Luis Obispo County, CA		
42044	Santa Ana-Anaheim-Irvine, CA	1.2854	1.2162
	Orange County, CA		
42060	Santa Barbara-Santa Maria-Goleta, CA	1.2587	1.1909
	Santa Barbara County, CA		
42100	Santa Cruz-Watsonville, CA	1.7693	1.6740
	Santa Cruz County, CA		
42140	Santa Fe, NM	1.1465	1.0847
	Santa Fe County, NM		
42220	Santa Rosa-Petaluma, CA	1.7062	1.6143
	Sonoma County, CA		
42340	Savannah, GA	0.9414	0.8907
	Bryan County, GA		
	Chatham County, GA		
	Effingham County, GA		
42540	Scranton--Wilkes-Barre, PA	0.8707	0.8238
	Lackawanna County, PA		
	Luzerne County, PA		
	Wyoming County, PA		
42644	Seattle-Bellevue-Everett, WA	1.2214	1.1556
	King County, WA		
	Snohomish County, WA		
42680	Sebastian-Vero Beach, FL	0.9615	0.9097
	Indian River County, FL		
43100	Sheboygan, WI	0.9759	0.9233
	Sheboygan County, WI		
43300	Sherman-Denison, TX	0.8750	0.8279
	Grayson County, TX		
43340	Shreveport-Bossier City, LA	0.9022	0.8536
	Bossier Parish, LA		
	Caddo Parish, LA		
	De Soto Parish, LA		
43580	Sioux City, IA-NE-SD	0.9609	0.9091
	Woodbury County, IA		
	Dakota County, NE		
	Dixon County, NE		
	Union County, SD		
43620	Sioux Falls, SD	0.9828	0.9299
	Lincoln County, SD		
	McCook County, SD		
	Minnehaha County, SD		
	Turner County, SD		
43780	South Bend-Mishawaka, IN-MI	1.0514	0.99648
	St. Joseph County, IN		
	Cass County, MI		
43900	Spartanburg, SC	0.9917	0.9383
	Spartanburg County, SC		
44060	Spokane, WA	1.1173	1.0571
	Spokane County, WA		

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9650	0.9130
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0835	1.0251
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8848	0.8371
44220	Springfield, OH Clark County, OH	0.9760	0.9234
44300	State College, PA Centre County, PA	0.9279	0.8779
44600	Steubenville-Weirton, OH-WV Centre County, PA	0.7731	0.7315
44700	Stockton, CA San Joaquin County, CA	1.3364	1.2644
44940	Sumter, SC Sumter County, SC	0.8307	0.7860
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	1.0469	0.9905
45104	Tacoma, WA Pierce County, WA	1.1989	1.1343
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.9307	0.8806
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9569	0.9054
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9729	0.9205
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8189	0.7748

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9969	0.9432
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.9462	0.8952
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0728	1.0150
46060	Tucson, AZ Pima County, AZ	1.0020	0.9480
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.9294	0.8793
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.9346	0.8843
46340	Tyler, TX Smith County, TX	0.8524	0.8065
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8953	0.8471
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8393	0.7941
46700	Vallejo-Fairfield, CA Solano County, CA	1.5781	1.4931
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8687	0.8219
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.1134	1.0534

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.9471	0.8961
	Currituck County, NC		
	Gloucester County, VA		
	Isle of Wight County, VA		
	James City County, VA		
	Mathews County, VA		
	Surry County, VA		
	York County, VA		
	Chesapeake City, VA		
	Hampton City, VA		
	Newport News City, VA		
	Norfolk City, VA		
	Poquoson City, VA		
	Portsmouth City, VA		
	Suffolk City, VA		
	Virginia Beach City, VA		
	Williamsburg City, VA		
47300	Visalia-Porterville, CA	1.1349	1.0738
	Tulare County, CA		
47380	Waco, TX	0.8881	0.8403
	McLennan County, TX		
47580	Warner Robins, GA	0.8485	0.8028
	Houston County, GA		
47644	Warren-Troy-Farmington Hills, MI	1.0197	0.9648
	Lapeer County, MI		
	Livingston County, MI		
	Macomb County, MI		
	Oakland County, MI		
	St. Clair County, MI		
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	1.1333	1.0723
	District of Columbia, DC		
	Calvert County, MD		
	Charles County, MD		
	Prince George's County, MD		
	Arlington County, VA		
	Clarke County, VA		
	Fairfax County, VA		
	Fauquier County, VA		
	Loudoun County, VA		
	Prince William County, VA		
	Spotsylvania County, VA		
	Stafford County, VA		
	Warren County, VA		
	Alexandria City, VA		
	Fairfax City, VA		
	Falls Church City, VA		
	Fredericksburg City, VA		
	Manassas City, VA		
	Manassas Park City, VA		
	Jefferson County, WV		
47940	Waterloo-Cedar Falls, IA	0.8944	0.8462
	Black Hawk County, IA		
	Bremer County, IA		
	Grundy County, IA		
48140	Wausau, WI	1.0107	0.9563
	Marathon County, WI		
48300	Wenatchee-East Wenatchee, WA	1.0162	0.9615
	Chelan County, WA		
	Douglas County, WA		
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0500	0.9934
	Palm Beach County, FL		
48540	Wheeling, WV-OH	0.7055	0.6675
	Belmont County, OH		
	Marshall County, WV		
	Ohio County, WV		
48620	Wichita, KS	0.9405	0.8898
	Butler County, KS		
	Harvey County, KS		
	Sedgwick County, KS		
	Sumner County, KS		
48660	Wichita Falls, TX	1.0111	0.9566
	Archer County, TX		
	Clay County, TX		
	Wichita County, TX		
48700	Williamsport, PA	0.7669	0.7256
	Lycoming County, PA		

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.1182	1.0580
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9726	0.9202
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0571	1.0002
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9448	0.8939
49340	Worcester, MA Worcester County, MA	1.1639	1.1012
49420	Yakima, WA Yakima County, WA	1.0640	1.0067
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.6342	0.6000
49620	York-Hanover, PA York County, PA	1.0551	0.9983
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9116	0.8625
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1672	1.1043
49740	Yuma, AZ Yuma County, AZ	0.9811	0.9283

ADDENDUM L--CY 2011 ESRD WAGE INDEX FOR RURAL AREAS BASED ON CBSA LABOR MARKET AREAS

State Code	Nonurban Area	Composite Rate Wage Index	ESRD PPS Wage Index
1	Alabama	0.7800	0.7380
2	Alaska	1.3458	1.2626
3	Arizona	0.9613	0.9095
4	Arkansas	0.7633	0.7222
5	California	1.2742	1.2056
6	Colorado	1.0498	0.9933
7	Connecticut	1.1762	1.1128
8	Delaware	1.0312	0.9757
10	Florida	0.8888	0.8409
11	Georgia	0.7997	0.7566
12	Hawaii	1.1826	1.1189
13	Idaho	0.7986	0.7556
14	Illinois	0.8818	0.8343
15	Indiana	0.8869	0.8391
16	Iowa	0.9031	0.8545
17	Kansas	0.8435	0.7981
18	Kentucky	0.8276	0.7830
19	Louisiana	0.8151	0.7712
20	Maine	0.9077	0.8588
21	Maryland	0.9697	0.9175
22	Massachusetts[1]	1.2439	1.1769
23	Michigan	0.9042	0.8555
24	Minnesota	0.9553	0.9038
25	Mississippi	0.8054	0.7620
26	Missouri	0.8091	0.7655
27	Montana	0.9002	0.8517
28	Nebraska	0.9418	0.8911
29	Nevada	0.9882	0.9350
30	New Hampshire	1.0788	1.0207
31	New Jersey[1]	-----	------
32	New Mexico	0.9418	0.8911
33	New York	0.8651	0.8185
34	North Carolina	0.8835	0.8359
35	North Dakota	0.7220	0.6831
36	Ohio	0.9048	0.8561
37	Oklahoma	0.8307	0.7860
38	Oregon	1.0600	1.0029
39	Pennsylvania	0.8963	0.8480
40	Puerto Rico	0.6342	0.6000
41	Rhode Island[1]	-----	-----
42	South Carolina	0.8892	0.8413
43	South Dakota	0.9022	0.8536
44	Tennessee	0.8335	0.7886
45	Texas	0.8250	0.7806

State Code	Nonurban Area	Composite Rate Wage Index	ESRD PPS Wage Index
46	Utah	0.9141	0.8649
47	Vermont	1.0137	0.9591
48	Virgin Islands	0.8448	0.7993
49	Virginia	0.8287	0.7841
50	Washington	1.0764	1.0184
51	West Virginia	0.7899	0.7474
52	Wisconsin	0.9709	0.9186
53	Wyoming	1.0070	0.9528

[1] All counties within the State are classified as urban.

[FR Doc. 2010–27969 Filed 11–2–10; 4:15 pm]

BILLING CODE 4120–01–C