
Friday
December 8, 1995

Registered Federal

Briefings on How To Use the Federal Register
For information on briefings in Washington, DC, see
announcement on the inside cover of this issue.



FEDERAL REGISTER Published daily, Monday through Friday, (not published on Saturdays, Sundays, or on official holidays), by the Office of the Federal Register, National Archives and Records Administration, Washington, DC 20408, under the Federal Register Act (49 Stat. 500, as amended; 44 U.S.C. Ch. 15) and the regulations of the Administrative Committee of the Federal Register (1 CFR Ch. I). Distribution is made only by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

The Federal Register provides a uniform system for making available to the public regulations and legal notices issued by Federal agencies. These include Presidential proclamations and Executive Orders and Federal agency documents having general applicability and legal effect, documents required to be published by act of Congress and other Federal agency documents of public interest. Documents are on file for public inspection in the Office of the Federal Register the day before they are published, unless earlier filing is requested by the issuing agency.

The seal of the National Archives and Records Administration authenticates this issue of the Federal Register as the official serial publication established under the Federal Register Act. 44 U.S.C. 1507 provides that the contents of the Federal Register shall be judicially noticed.

The Federal Register is published in paper, 24x microfiche and as an online database through *GPO Access*, a service of the U.S. Government Printing Office. The online database is updated by 6 a.m. each day the Federal Register is published. The database includes both text and graphics from Volume 59, Number 1 (January 2, 1994) forward. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents home page address is http://www.access.gpo.gov/su_docs/, by using local WAIS client software, or by telnet to swais.access.gpo.gov, then login as guest, (no password required). Dial-in users should use communications software and modem to call (202) 512-1661; type swais, then login as guest (no password required). For general information about *GPO Access*, contact the *GPO Access* User Support Team by sending Internet e-mail to help@eids05.eids.gpo.gov; by faxing to (202) 512-1262; or by calling (202) 512-1530 between 7 a.m. and 5 p.m. Eastern time, Monday-Friday, except for Federal holidays.

The annual subscription price for the Federal Register paper edition is \$494, or \$544 for a combined Federal Register, Federal Register Index and List of CFR Sections Affected (LSA) subscription; the microfiche edition of the Federal Register including the Federal Register Index and LSA is \$433. Six month subscriptions are available for one-half the annual rate. The charge for individual copies in paper form is \$8.00 for each issue, or \$8.00 for each group of pages as actually bound; or \$1.50 for each issue in microfiche form. All prices include regular domestic postage and handling. International customers please add 25% for foreign handling. Remit check or money order, made payable to the Superintendent of Documents, or charge to your GPO Deposit Account, VISA or MasterCard. Mail to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954.

There are no restrictions on the republication of material appearing in the Federal Register.

How To Cite This Publication: Use the volume number and the page number. Example: 60 FR 12345.

SUBSCRIPTIONS AND COPIES

PUBLIC

Subscriptions:	
Paper or fiche	202-512-1800
Assistance with public subscriptions	512-1806
General online information	202-512-1530
Single copies/back copies:	
Paper or fiche	512-1800
Assistance with public single copies	512-1803

FEDERAL AGENCIES

Subscriptions:	
Paper or fiche	523-5243
Assistance with Federal agency subscriptions	523-5243
For other telephone numbers, see the Reader Aids section at the end of this issue.	

THE FEDERAL REGISTER

WHAT IT IS AND HOW TO USE IT

- FOR:** Any person who uses the Federal Register and Code of Federal Regulations.
- WHO:** Sponsored by the Office of the Federal Register.
- WHAT:** Free public briefings (approximately 3 hours) to present:
1. The regulatory process, with a focus on the Federal Register system and the public's role in the development of regulations.
 2. The relationship between the Federal Register and Code of Federal Regulations.
 3. The important elements of typical Federal Register documents.
 4. An introduction to the finding aids of the FR/CFR system.
- WHY:** To provide the public with access to information necessary to research Federal agency regulations which directly affect them. There will be no discussion of specific agency regulations.

WASHINGTON, DC

[Two Sessions]

- WHEN:** January 9, 1996 at 9:00 am and January 23, 1996 at 9:00 am
- WHERE:** Office of the Federal Register Conference Room, 800 North Capitol Street, NW., Washington, DC (3 blocks north of Union Station Metro)
- RESERVATIONS:** 202-523-4538



Contents

Federal Register

Vol. 60, No. 236

Friday, December 8, 1995

African Development Foundation

NOTICES

Meetings; Sunshine Act, 63121

Agriculture Department

See Animal and Plant Health Inspection Service

See Cooperative State Research, Education, and Extension Service

See Food and Consumer Service

Animal and Plant Health Inspection Service

RULES

Interstate transportation of animals and animal products (quarantine):

Tuberculosis in cattle and bison—

State and area classifications, 62988–62989

Blind or Severely Disabled, Committee for Purchase From People Who Are

See Committee for Purchase From People Who Are Blind or Severely Disabled

Coast Guard

NOTICES

Meetings:

Houston/Galveston Navigation Safety Advisory Committee, 63114–63115

Committee for Purchase From People Who Are Blind or Severely Disabled

NOTICES

Procurement list; additions and deletions, 63025–63027

Committee for the Implementation of Textile Agreements

NOTICES

Special access and special regime programs; participation denial:

Knight Industries, 63025

Community Development Financial Institutions Fund

NOTICES

Grants and cooperative agreements; availability, etc.:

Bank enterprise award and community development financial institutions programs; due date extension, 63120

Consumer Product Safety Commission

RULES

Bicycles introduced into interstate commerce from May 11, 1976 to May 11, 1978; labeling requirements revoked, 62989–62990

Cooperative State Research, Education, and Extension Service

RULES

Grants:

National competitive research initiative grants program, 63368–63370

Defense Department

PROPOSED RULES

Acquisition regulations:

Contracting by negotiation

Public meeting, 63023–63024

Drug Enforcement Administration

NOTICES

Applications, hearings, determinations, etc.:

Dupont Pharmaceuticals, 63057

Noramco of Delaware, Inc., 63057

Employment and Training Administration

NOTICES

Adjustment assistance:

Barrow Manufacturing Corp., 63058–63059

Gentek Building Products, Inc., 63059

Oxford Industries, Inc., 63059

Picker International, Inc., 63059

Woolrich, Inc., 63060

NAFTA transitional adjustment assistance:

Gentek Building Products, Inc., 63060

Samax II, Inc., et al., 63060

Employment Standards Administration

NOTICES

Minimum wages for Federal and federally-assisted

construction; general wage determination decisions, 63057–63058

Energy Department

See Federal Energy Regulatory Commission

Environmental Protection Agency

RULES

Air pollutants, hazardous; national emission standards:

Gasoline terminals and pipeline breakout stations; partial stay, 62991–62992

Air quality implementation plans; approval and promulgation; various States:

Virginia, 62990

Clean Air Act:

State operating permits program—

Washington, 62992–62998

PROPOSED RULES

Air quality implementation plans; approval and promulgation; various States:

Washington, 63019–63023

NOTICES

Agency information collection activities under OMB review, 63034–63035

Agency information collection activities under OMB review:

Proposed agency information collection activities; comment request, 63035–63044

Environmental statements; availability, etc.:

Agency statements—

Weekly receipts, 63044

Equal Employment Opportunity Commission**PROPOSED RULES**

Recordkeeping and reporting requirements:

Elementary-secondary staff information report (EEO-5);
discontinuation, 63010-63011

Executive Office of the President

See Presidential Documents

Federal Aviation Administration**PROPOSED RULES**

Class E airspace, 63007

NOTICES

Meetings:

RTCA, Inc., 63115

Federal Communications Commission**NOTICES**

Agency information collection activities under OMB
review:

Proposed agency information collection activities;
comment request, 63044-63045

Federal Contract Compliance Programs Office**NOTICES**

Construction contractors; affirmative action requirements;
reporting requirements rescission; Federal regulatory
review, 63061

Federal Deposit Insurance Corporation**NOTICES**

Financial institutions in receivership; insufficiency of
assets to satisfy all claims; determinations, 63045

Federal Energy Regulatory Commission**NOTICES**

Electric rate and corporate regulation filings:

China U.S. Power Partners I, Ltd., et al., 63027-63029

Seagull Power Services, Inc., et al., 63029-63031

Preliminary permits surrender:

Collins, J. Thomas, et al., 63031

Applications, hearings, determinations, etc.:

Citizens Utilities Co., 63032

PacifiCorp, 63032

Transcontinental Gas Pipe Line Corp., 63032-63033

Transwestern Pipeline Co., 63033-63034

Federal Labor Relations Authority**NOTICES**

Agency information collection activities under OMB
review:

Proposed agency information collection activities;
comment request, 63045-63046

Federal Maritime Commission**NOTICES**

Agreements filed, etc., 63046

Freight forwarder licenses:

Spartan Overseas Shipping Corp. et al., 63046-63047

Federal Railroad Administration**NOTICES**

Exemption petitions, etc.:

Tioga Central Railroad et al., 63115-63116

Traffic control systems; discontinuance and removal:

Burlington Northern Railroad Co. et al., 63116-63117

Federal Reserve System**NOTICES**

Meetings; Sunshine Act, 63121

Applications, hearings, determinations, etc.:

Scotland Bancorp, Inc., et al., 63047

Southern National Corp. et al., 63047

Fish and Wildlife Service**NOTICES**

Environmental statements; availability, etc.:

Incidental take permits—

Brevard County, FL; red-cockaded woodpecker, 63052-
63053

Hays County, TX; golden-cheeked warbler, 63053-
63054

Little River County, AR, et al.; American burying
beetle, 63054-63055

Travis County, TX; golden-cheeked warbler, etc., 63055

Food and Consumer Service**PROPOSED RULES**

Food distribution program:

Donation of foods for use in U.S., territories, and
possessions, and areas under jurisdiction—

Disaster and distress situations; food assistance, 62999-
63006

Food and Drug Administration**RULES**

Public information:

Communications with State and foreign government
officials, 63372-63382

NOTICES

Advertising and promotion; dissemination of reprints of
journal articles and reference texts to health care
professionals; guidance availability, 63384-63385

Biological products:

Well-characterized therapeutic recombinant DNA-Derived
and monoclonal antibody biotechnology products;
definition and elimination of lot-by-lot release,
63048-63049

Meetings:

Prescription drug product labeling; public patient
education workshop, 63049-63050

Health and Human Services Department

See Food and Drug Administration

See Health Care Financing Administration

See National Institutes of Health

See Substance Abuse and Mental Health Services
Administration

Health Care Financing Administration**RULES**

Medicare:

Physician fee schedule (1996 CY); payment policies and
relative value unit adjustments, 63124-63357

NOTICES

Medicare:

Physician fee schedule (1996 CY) and physician
performance standard rates of increase (1996 FY),
63358-63366

Housing and Urban Development Department**PROPOSED RULES**

Real Estate Settlement Procedures Act:

Mortgage Brokers Fee Disclosure Rule Negotiated
Rulemaking Advisory Committee—

Establishment and meeting, 63008-63009

NOTICES

Agency information collection activities under OMB review:

Proposed agency information collection activities; comment request, 63051

Grants and cooperative agreements; availability, etc.:

Facilities to assist homeless—

Excess and surplus Federal property, 63051–63052

Interior Department

See Fish and Wildlife Service

See Land Management Bureau

See Minerals Management Service

Internal Revenue Service**PROPOSED RULES**

Income taxes:

Controlled foreign corporation, foreign base company, and foreign personal holding company income; definitions

Hearing, 63009–63010

Interstate Commerce Commission**NOTICES**

Railroad services abandonment:

Boston & Maine Corp., 63056

Justice Department

See Drug Enforcement Administration

Labor Department

See Employment and Training Administration

See Employment Standards Administration

See Federal Contract Compliance Programs Office

See Labor Statistics Bureau

See Pension and Welfare Benefits Administration

Labor Statistics Bureau**NOTICES**

Agency information collection activities under OMB review:

Proposed agency information collection activities; comment request, 63061–63062

Land Management Bureau**NOTICES**

Meetings:

Utah Resource Advisory Council, 63055–63056

Realty actions; sales, leases, etc.:

Utah, 63056

Libraries and Information Science, National Commission

See National Commission on Libraries and Information Science

Maritime Administration**NOTICES**

Applications, hearings, determinations, etc.:

Mormac Marine Transport, Inc., 63119

Minerals Management Service**PROPOSED RULES**

Outer Continental Shelf; oil, gas, and sulphur operations:

Surety bond coverage for leases, 63011–63019

National Aeronautics and Space Administration**NOTICES**

Patent licenses; non-exclusive, exclusive, or partially exclusive:

MicroMed Systems Ltd., Co., 63070

National Commission on Libraries and Information Science**NOTICES**

Meetings; Sunshine Act, 63121

National Highway Traffic Safety Administration**NOTICES**

Motor vehicle safety standards:

Nonconforming vehicles—

Importation eligibility; determinations, 63117–63119

National Institutes of Health**NOTICES**

Meetings:

National Institutes of Mental Health, 63050–63051

Nuclear Regulatory Commission**NOTICES**

Applications, hearings, determinations, etc.:

GPU Nuclear Power Corp., 63070

PECO Energy Co., 63073–63075

Rochester Gas & Electric Corp., 63071–63073

Pension and Welfare Benefits Administration**NOTICES**

Employee benefit plans; prohibited transaction exemptions:

Kay Alden, Inc., et al., 63062–63064

Timberland Investment Group, Inc., et al., 63064–63070

Personnel Management Office**RULES**

Health benefits, Federal employees:

HMO plan applications, 62987–62988

NOTICES

Agency information collection activities under OMB review, 63075

Privacy Act:

Systems of records, 63075–63087

Postal Rate Commission**NOTICES**

Post office closings; petitions for appeal:

Sedan, MN, 63087

Presidential Documents**EXECUTIVE ORDERS**

Export controls; administration (EO 12981), 62981–62985

PROCLAMATIONS

Special observances:

Pearl Harbor Remembrance Day, National (Proc. 6856), 63389–63390

ADMINISTRATIVE ORDERS

North American Free Trade Agreement Implementation

Act; authority delegation to U.S. Trade Representative

(Memorandum of December 6, 1995), 63391

Public Health Service

See Food and Drug Administration

See National Institutes of Health

See Substance Abuse and Mental Health Services Administration

Securities and Exchange Commission**NOTICES**

Self-regulatory organizations; proposed rule changes:

Cincinnati Stock Exchange, Inc., 63087–63088

MBS Clearing Corp., 63089–63090

National Association of Securities Dealers, Inc., 63092–63106

National Securities Clearing Corp. et al., 63090–63092
Applications, hearings, determinations, etc.:
American Skandia Life Assurance Corp. et al., 63106–63110
Public utility holding company filings, 63110–63113
Smith Breeden Institutional Short Duration U.S. Government Fund, 63113–63114

Social Security Administration

NOTICES

Agency information collection activities under OMB review:

Proposed agency information collection activities; comment request, 63114

Substance Abuse and Mental Health Services Administration

NOTICES

Meetings:

Substance Abuse and Mental Health Services Administration National Advisory Council, 63047–63048

Textile Agreements Implementation Committee

See Committee for the Implementation of Textile Agreements

Transportation Department

See Coast Guard

See Federal Aviation Administration

See Federal Railroad Administration

See Maritime Administration

See National Highway Traffic Safety Administration

Treasury Department

See Community Development Financial Institutions Fund

See Internal Revenue Service

Veterans Affairs Department

NOTICES

Committees; establishment, renewal, termination, etc.:

Special Medical Advisory Group, 63120

Separate Parts In This Issue

Part II

Department of Health and Human Services, Health Care Financing Administration, 63124–63366

Part III

Department of Agriculture, Cooperative State Research, Education, and Extension Service, 63368–63370

Part IV

Department of Health and Human Services, Food and Drug Administration, 63372–63382

Part V

Department of Health and Human Services, Food and Drug Administration, 63384–63385

Part VI

The President, 63389–63391

Reader Aids

Additional information, including a list of public laws, telephone numbers, and finding aids, appears in the Reader Aids section at the end of this issue.

New Feature in the Reader Aids!

Beginning with the issue of December 4, 1995, a new listing will appear each day in the Reader Aids section of the Federal Register called “Reminders”. The Reminders will have two sections: “Rules Going Into Effect Today” and “Comments Due Next Week”. Rules Going Into Effect Today will remind readers about Rules documents published in the past which go into effect “today”. Comments Due Next Week will remind readers about impending closing dates for comments on Proposed Rules documents published in past issues. Only those documents published in the Rules and Proposed Rules sections of the Federal Register will be eligible for inclusion in the Reminders.

The Reminders feature is intended as a reader aid only. Neither inclusion nor exclusion in the listing has any legal significance.

The Office of the Federal Register has been compiling data for the Reminders since the issue of November 1, 1995. No documents published prior to November 1, 1995 will be listed in Reminders.

Electronic Bulletin Board

Free Electronic Bulletin Board service for Public Law numbers, Federal Register finding aids, and a list of documents on public inspection is available on 202–275–1538 or 275–0920.

CFR PARTS AFFECTED IN THIS ISSUE

A cumulative list of the parts affected this month can be found in the Reader Aids section at the end of this issue.

3 CFR**Proclamations:**

6856 63389

Executive Orders:

11533 (see EO
12981) 62981
12002 (continued by
EO 12981) 62981
12924 (see EO
12981) 62981
12981 62981

Administrative Orders:

Memorandum of
December 6, 1995 63391

5 CFR

890 62987

7 CFR

3200 63368
3411 63368

Proposed Rules:

250 62999

9 CFR

77 62988

14 CFR**Proposed Rules:**

71 63007

16 CFR

1512 62989

21 CFR

20 63372

24 CFR**Proposed Rules:**

3500 63008

26 CFR**Proposed Rules:**

1 63009

29 CFR**Proposed Rules:**

1602 63010

30 CFR**Proposed Rules:**

250 63011
251 63011
256 63011

40 CFR**Proposed Rules:**

52 62990, 63019
63 62991
70 62992

42 CFR

400 63124
405 63124
410 63124
411 63124
412 63124
413 63124
414 63124
415 63124
417 63124
489 63124

48 CFR**Proposed Rules:**

15 63023

Presidential Documents

Title 3—

Executive Order 12981 of December 5, 1995

The President

Administration of Export Controls

By the authority vested in me as President by the Constitution and the laws of the United States of America, including but not limited to the International Emergency Economic Powers Act (50 U.S.C. 1701 *et. seq.*) (“the Act”), and in order to take additional steps with respect to the national emergency described and declared in Executive Order No. 12924 of August 19, 1994, and continued on August 15, 1995, I, WILLIAM J. CLINTON, President of the United States of America, find that it is necessary for the procedures set forth below to apply to export license applications submitted under the Act and the Export Administration Regulations (15 C.F.R. Part 730 *et. seq.*) (“the Regulations”) or under any renewal of, or successor to, the Export Administration Act of 1979, as amended (50 U.S.C. App. 2401 *et. seq.*) (“the Export Administration Act”), and the Regulations. Accordingly, it is hereby ordered as follows:

Section 1. *License Review.* To the extent permitted by law and consistent with Executive Order No. 12924 of August 19, 1994, the power, authority, and discretion conferred upon the Secretary of Commerce (“the Secretary”) under the Export Administration Act to require, review, and make final determinations with regard to export licenses, documentation, and other forms of information submitted to the Department of Commerce pursuant to the Act and the Regulations or under any renewal of, or successor to, the Export Administration Act and the Regulations, with the power of successive redelegation, shall continue. The Departments of State, Defense, and Energy, and the Arms Control and Disarmament Agency each shall have the authority to review any export license application submitted to the Department of Commerce pursuant to the Act and the Regulations or under any renewal of, or successor to, the Export Administration Act and the Regulations. The Secretary may refer license applications to other United States Government departments or agencies for review as appropriate. In the event that a department or agency determines that certain types of applications need not be referred to it, such department or agency shall notify the Department of Commerce as to the specific types of such applications that it does not wish to review. All departments or agencies shall promptly respond, on a case-by-case basis, to requests from other departments or agencies for historical information relating to past license applications.

Sec. 2. *Determinations.* (a) All license applications submitted under the Act and the Regulations or any renewal of, or successor to, the Export Administration Act and the Regulations, shall be resolved or referred to the President no later than 90 calendar days after registration of the completed license application.

(b) The following actions related to processing a license application submitted under the Act and the Regulations or any renewal of, or successor to, the Export Administration Act and the Regulations shall not be counted in calculating the time periods prescribed in this order:

(1) *Agreement of the Applicant.* Delays upon which the Secretary and the applicant mutually agree.

(2) *Prelicense Checks.* Prelicense checks through government channels that may be required to establish the identity and reliability of the recipient of items controlled under the Act and the Regulations or any renewal of,

or successor to, the Export Administration Act and the Regulations, provided that:

(A) the need for such prelicense check is established by the Secretary, or by another department or agency if the request for prelicense check is made by such department or agency;

(B) the Secretary requests the prelicense check within 5 days of the determination that it is necessary; and

(C) the Secretary completes the analysis of the result of the prelicense check within 5 days.

(3) *Requests for Government-To-Government Assurances.* Requests for government-to-government assurances of suitable end-use of items approved for export under the Act and the Regulations or any renewal of, or successor to, the Export Administration Act and the Regulations, when failure to obtain such assurances would result in rejection of the application, provided that:

(A) the request for such assurances is sent to the Secretary of State within 5 days of the determination that the assurances are required;

(B) the Secretary of State initiates the request of the relevant government within 10 days thereafter; and

(C) the license is issued within 5 days of the Secretary's receipt of the requested assurances. Whenever such prelicense checks and assurances are not requested within the time periods set forth above, they must be accomplished within the time periods established by this section.

(4) *Multilateral Reviews.* Multilateral review of a license application as provided for under the Act and the Regulations or any renewal of, or successor to, the Export Administration Act and the Regulations, as long as multilateral review is required by the relevant multilateral regime.

(5) *Consultations.* Consultation with other governments, if such consultation is provided for by a relevant multilateral regime or bilateral arrangement as a precondition for approving a license.

Sec. 3. *Initial Processing.* Within 9 days of registration of any license application, the Secretary shall, as appropriate:

(a) request additional information from the applicant. The time required for the applicant to supply the additional information shall not be counted in calculating the time periods prescribed in this section.

(b) refer the application and pertinent information to agencies or departments as stipulated in section 1 of this order, and forward to the agencies any relevant information submitted by the applicant that could not be reduced to electronic form.

(c) assure that the stated classification on the application is correct; return the application if a license is not required; and, if referral to other departments or agencies is not required, grant the application or notify the applicant of the Secretary's intention to deny the application.

Sec. 4. *Department or Agency Review.* (a) Each reviewing department or agency shall specify to the Secretary, within 10 days of receipt of a referral as specified in subsection 3(b), any information not in the application that would be required to make a determination, and the Secretary shall promptly request such information from the applicant. If, after receipt of the information so specified or other new information, a reviewing department or agency concludes that additional information would be required to make a determination, it shall promptly specify that additional information to the Secretary, and the Secretary shall promptly request such information from the applicant. The time that may elapse between the date the information is requested by the reviewing department or agency and the date the information is received by the reviewing department or agency shall not be counted in calculating the time periods prescribed in this order. Such information specified by reviewing departments or agencies is in addition to any informa-

tion that may be requested by the Department of Commerce on its own initiative during the first 9 days after registration of an application.

(b) Within 30 days of receipt of a referral and all required information, a department or agency shall provide the Secretary with a recommendation either to approve or deny the license application. As appropriate, such recommendation may be with the benefit of consultation and discussions in interagency groups established to provide expertise and coordinate interagency consultation. A recommendation that the Secretary deny a license shall include a statement of the reasons for such recommendation that are consistent with the provisions of the Act and the Regulations or any renewal of, or successor to, the Export Administration Act and the Regulations and shall cite both the statutory and the regulatory bases for the recommendation to deny. A department or agency that fails to provide a recommendation within 30 days with a statement of reasons and the statutory and regulatory bases shall be deemed to have no objection to the decision of the Secretary.

Sec. 5. Interagency Dispute Resolution. (a) Committees. (1)(A) Export Administration Review Board. The Export Administration Review Board ("the Board"), which was established by Executive Order No. 11533 of June 4, 1970, and continued in Executive Order No. 12002 of July 7, 1977, is hereby continued. The Board shall have as its members, the Secretary, who shall be Chair of the Board, the Secretary of State, the Secretary of Defense, the Secretary of Energy, and the Director of the Arms Control and Disarmament Agency. The Chairman of the Joint Chiefs of Staff and the Director of Central Intelligence shall be nonvoting members of the Board. No alternate Board members shall be designated, but the acting head or deputy head of any member department or agency may serve in lieu of the head of the concerned department or agency. The Board may invite the heads of other United States Government departments or agencies, other than the departments or agencies represented by the Board members, to participate in the activities of the Board when matters of interest to such departments or agencies are under consideration.

(B) The Secretary may, from time to time, refer to the Board such particular export license matters, involving questions of national security or other major policy issues, as the Secretary shall select. The Secretary shall also refer to the Board any other such export license matter, upon the request of any other member of the Board or the head of any other United States Government department or agency having any interest in such matter. The Board shall consider the matters so referred to it, giving due consideration to the foreign policy of the United States, the national security, the domestic economy, and concerns about the proliferation of armaments, weapons of mass destruction, missile delivery systems, and advanced conventional weapons and shall make recommendations thereon to the Secretary.

(2) *Advisory Committee on Export Policy.* An Advisory Committee on Export Policy ("ACEP") is established and shall have as its members the Assistant Secretary of Commerce for Export Administration, who shall be Chair of the ACEP, and Assistant Secretary-level representatives of the Departments of State, Defense, and Energy, and the Arms Control and Disarmament Agency. Appropriate representatives of the Joint Chiefs of Staff and of the Nonproliferation Center of the Central Intelligence Agency shall be nonvoting members of the ACEP. Representatives of the departments or agencies shall be the appropriate Assistant Secretary or equivalent (or appropriate acting Assistant Secretary or equivalent in lieu of the Assistant Secretary or equivalent) of the concerned department or agency, or appropriate Deputy Assistant Secretary or equivalent (or the appropriate acting Deputy Assistant Secretary or equivalent in lieu of the Deputy Assistant Secretary or equivalent) of the concerned department or agency. Regardless of the department or agency representative's rank, such representative shall speak and vote at the ACEP on behalf of the appropriate Assistant Secretary or equivalent of such department or agency. The ACEP may invite Assistant Secretary-level representa-

tives of other United States Government departments or agencies, other than the departments and agencies represented by the ACEP members, to participate in the activities of the ACEP when matters of interest to such departments or agencies are under consideration.

(3)(A) *Operating Committee.* An Operating Committee ("OC") of the ACEP is established. The Secretary shall appoint its Chair, who shall also serve as Executive Secretary of the ACEP. Its other members shall be representatives of appropriate agencies in the Departments of Commerce, State, Defense, and Energy, and the Arms Control and Disarmament Agency. The appropriate representatives of the Joint Chiefs of Staff and the Nonproliferation Center of the Central Intelligence Agency shall be nonvoting members of the OC. The OC may invite representatives of other United States Government departments or agencies, other than the departments and agencies represented by the OC members, to participate in the activities of the OC when matters of interest to such departments or agencies are under consideration.

(B) The OC shall review all license applications on which the reviewing departments and agencies are not in agreement. The Chair of the OC shall consider the recommendations of the reviewing departments and agencies and inform them of his or her decision on any such matters within 14 days after the deadline for receiving department and agency recommendations. As described below, any reviewing department or agency may appeal the decision of the Chair of the OC to the Chair of the ACEP. In the absence of a timely appeal, the Chair's decision will be final.

(b) *Resolution Procedures.* (1) If any department or agency disagrees with a licensing determination of the Department of Commerce made through the OC, it may appeal the matter to the ACEP for resolution. A department or agency must appeal a matter within 5 days of such a decision. Appeals must be in writing from an official appointed by the President by and with the advice and consent of the Senate, or an officer properly acting in such capacity, and must cite both the statutory and the regulatory bases for the appeal. The ACEP shall review all departments' and agencies' information and recommendations, and the Chair of the ACEP shall inform the reviewing departments and agencies of the majority vote decision of the ACEP within 11 days from the date of receiving notice of the appeal. Within 5 days of the majority vote decision, any dissenting department or agency may appeal the decision by submitting a letter from the head of the department or agency to the Secretary in his or her capacity as the Chair of the Board. Such letter shall cite both the statutory and the regulatory bases for the appeal. Within the same period of time, the Secretary may call a meeting on his or her own initiative to consider a license application. In the absence of a timely appeal, the majority vote decision of the ACEP shall be final.

(2) The Board shall review all departments' and agencies' information and recommendations, and such other export control matters as may be appropriate. The Secretary shall inform the reviewing departments and agencies of the majority vote of the Board within 11 days from the date of receiving notice of appeal. Within 5 days of the decision, any department or agency dissenting from the majority vote decision of the Board may appeal the decision by submitting a letter from the head of the dissenting department or agency to the President. In the absence of a timely appeal, the majority vote decision of the Board shall be final.

Sec. 6. The license review process in this order shall take effect beginning with those license applications registered by the Secretary 60 days after the date of this order and shall continue in effect to the extent not inconsistent with any renewal of the Export Administration Act, or with any successor to that Act.

Sec. 7. *Judicial Review*. This order is intended only to improve the internal management of the executive branch and is not intended to, and does not, create any rights to administrative or judicial review, or any other right or benefit or trust responsibility, substantive or procedural, enforceable by a party against the United States, its agencies or instrumentalities, its officers or employees, or any other person.

A handwritten signature in black ink, reading "William Clinton". The signature is written in a cursive, flowing style with a large, prominent "W" and "C".

THE WHITE HOUSE,
December 5, 1995.

[FR Doc. 95-30106

Filed 12-6-95; 2:31 pm]

Billing code 3195-01-P

Rules and Regulations

Federal Register

Vol. 60, No. 236

Friday, December 8, 1995

This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510.

The Code of Federal Regulations is sold by the Superintendent of Documents. Prices of new books are listed in the first FEDERAL REGISTER issue of each week.

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

RIN 3206-AG40

Federal Employees Health Benefits Program; HMO Plan Applications

AGENCY: Office of Personnel Management.

ACTION: Final rule.

SUMMARY: The Office of Personnel Management (OPM) is issuing final regulations to clarify the policy under which it invites applications from comprehensive medical plans (CMP's), commonly referred to as Health Maintenance Organizations (HMO's), to participate in the Federal Employees Health Benefits (FEHB) Program. This clarification is necessary in order to ensure that OPM and the CMP's (HMO's) are providing the best possible service to FEHB enrollees.

EFFECTIVE DATE: February 6, 1996.

FOR FURTHER INFORMATION CONTACT: Faith M. Hannon, (202) 606-0004.

SUPPLEMENTARY INFORMATION: On December 5, 1994, OPM published an interim regulation in the Federal Register (59 FR 62283) to clarify the policy under which it invites applications from comprehensive medical plans (CMP's), commonly referred to as Health Maintenance Organizations (HMO's), to participate in the FEHB Program. OPM made a determination not to invite new plan applications, with a limited exception, for contract year 1996. In addition, OPM decided neither to accept benefit change proposals from plans already in the FEHB Program nor to print new plan brochures or a comparison guide for contract year 1996.

OPM received 15 written comments and numerous phone calls concerning the regulation. All of the commenters

objected that OPM did not give HMO's sufficient notice of its determination not to accept applications and benefit change proposals for the 1996 contract year. Among other issues, they contended that many HMO's had already expended a substantial amount of time preparing applications or developing plan benefit designs and that OPM's decision, therefore, caused them undue hardship. In addition, some commenters disagreed with OPM's position that this regulation clarified existing policy and that the Director of OPM had authority to determine when plan applications would be accepted.

After careful consideration of the comments received, OPM concluded that its time frames had, in fact, been too compressed to allow for a thorough review of all the consequences of the decision not to accept applications and that it had not allowed sufficient time for comments. As a result, OPM decided to accept applications and benefit change proposals for contract year 1996 and to provide the public with a longer comment period.

Therefore, OPM published a notice in the Federal Register on March 13, 1995, (60 FR 13491), which stated that OPM would accept applications from new HMO's for participation in the FEHB Program, and benefit change proposals from plans currently participating, for contract year 1996. In this notice, OPM extended the deadline for submission of the completed applications from January 31 to March 31, 1995, and allowed for a second extension if OPM requested additional information from the applicants. OPM also published the clarification of the policy under which it invites applications from HMO's as a proposed regulation in the Federal Register, (60 FR 15074), on March 22, 1995. This issuance was in response to those commenters who objected to the length of the comment period of the interim regulation and other alleged publication technicalities under the Administrative Procedure Act (APA).

OPM received seven written responses to the proposed regulation. The primary issues mentioned by most commenters were that closing the FEHB Program for an unlimited period of time would limit health plan choices for Federal employees, and would restrict competition within the FEHB Program. Both features are considered to be hallmarks of the Program. Some

commenters also opined that this regulation contravenes OPM's obligation to contract with federally qualified HMO's and the related HMO dual choice mandate. These comments may have originated from a misunderstanding of the extent of the regulation. It was never OPM's intention to close the FEHB Program to new HMO's for unlimited periods of time. Because this misconception appears to be widespread, the final rule states that it is OPM's intention to accept new HMO applications on an annual basis except in those rare instances when the Director decides it is not in the best interest of the Federal enrollees and the FEHB Program. If this should occur, sufficient advance notice would be given to the HMO industry, i.e., an entry in the Federal Register at least seven months prior to the date applications would be due for the contract year for which applications will not be accepted, allowing for a comment period of sixty days. Generally, there is eleven months lead time between when applications are due on January 31, and the start of the contract year for which the applications are being accepted.

Several commenters stated that it is their belief that the Federal Employees Health Benefits Act (FEHBA) does not grant the Director of OPM the authority to determine when it is beneficial to the FEHB Program to accept applications from HMO's for participation in the Program. It was, and is, the conclusion of OPM that the Director has always had this authority and that this regulation simply clarifies the policy under which this authority is administered. The final rule states this conclusion.

Many commenters offered to assist OPM in streamlining the application process so that OPM might utilize its resources in the most effective way to benefit Program enrollees. OPM is appreciative of these offers and is working closely with representatives of the industry and other knowledgeable organizations to improve the application process.

This Final Rule is also updating the mailing address of the Office of Insurance Programs listed in the final sentence of § 890.203(a)(5).

Regulatory Flexibility Act

I certify that these regulations will not have a significant economic impact on a substantial number of small entities

because they primarily affect OPM's administrative procedures.

List of Subjects in 5 CFR Part 890

Administrative practice and procedure, Government employees, Health facilities, Health insurance, Health professions, Hostages, Iraq, Kuwait, Lebanon, Reporting and recordkeeping requirements, Retirement.

U.S. Office of Personnel Management.
James B. King,
Director.

Accordingly, OPM is amending 5 CFR Part 890 as follows:

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

1. The authority citation for part 890 continues to read as follows:

Authority: 5 U.S.C. 8913; § 890.803 also issued under 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c-1; Subpart L also issued under sec. 599C of Pub. L. 101-513, 104 Stat. 2064, as amended.

2. In § 890.203, paragraphs (a)(1) and (a)(2), and the last sentence in paragraph (a)(5) are revised to read as follows:

§ 890.203 Application for approval of, and proposal of amendments to, health benefits plans.

(a) *New plan applications.* (1) The Director of OPM shall consider applications to participate in the FEHB Program from comprehensive medical plans (CMP's) at his or her discretion. CMP's are automatically invited to submit applications annually to participate in the FEHB Program unless otherwise notified by OPM. If the Director should determine that it is not beneficial to the enrollees and the Program to consider applications for a specific contract year, OPM will publish a notice with a 60 day comment period in the Federal Register no less than 7 months prior to the date applications would be due for the specific contract year for which applications will not be accepted.

(2) When applications are considered, CMP's should apply for approval by writing to the Office of Personnel Management, Washington, DC 20415. Application letters must be accompanied by any descriptive material, financial data, or other documentation required by OPM. Plans must submit the letter and attachments in the OPM-specified format by January 31, or another date specified by OPM, of the year preceding the contract year for which applications are being accepted. Plans must submit evidence demonstrating they meet all requirements for approval by March 31

of the year preceding the contract year for which applications are being accepted. Plans that miss either deadline cannot be considered for participation in the next contract year. All newly approved plans must submit benefit and rate proposals to OPM by May 31 of the year preceding the contract year for which applications are being accepted in order to be considered for participation in that contract year. OPM may make counter-proposals at any time.

* * * * *

(5) * * * The extent of the data and documentation to be submitted by a plan so qualified by HHS, as well as by a non-qualified plan, for a particular review cycle may be obtained by writing directly to the Office of Insurance Programs, Retirement and Insurance Service, Office of Personnel Management, Washington, DC 20415.

* * * * *

[FR Doc. 95-29882 Filed 12-7-95; 8:45 am]

BILLING CODE 6325-01-P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Part 77

[Docket No. 95-072-1]

Tuberculosis in Cattle and Bison; State Designation

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Interim rule and request for comments.

SUMMARY: We are amending the tuberculosis regulations concerning the interstate movement of cattle and bison by reducing the designation of Wisconsin from an accredited-free State to an accredited-free (suspended) State. We have determined that Wisconsin no longer meets the criteria for designation as an accredited-free State but meets the criteria for designation as an accredited-free (suspended) State. This change is necessary to prevent the spread of tuberculosis in cattle and bison.

DATES: Interim rule effective December 8, 1995. Consideration will be given only to comments received on or before February 6, 1996.

ADDRESSES: Please send an original and three copies of your comments to Docket No. 95-072-1, Regulatory Analysis and Development, PPD, APHIS, Suite 3C03, 4700 River Road Unit 118, Riverdale, MD 20737-1238. Please state that your comments refer to

Docket No. 95-072-1. Comments received may be inspected at USDA, room 1141, South Building, 14th Street and Independence Avenue SW., Washington, DC, between 8 a.m. and 4:30 p.m., Monday through Friday, except holidays. Persons wishing to inspect comments are requested to call ahead on (202) 690-2817 to facilitate entry into the comment reading room.

FOR FURTHER INFORMATION CONTACT: Dr. Mitchell Essey, Senior Staff Veterinarian, Cattle Diseases and Surveillance, VS, APHIS, Suite 3B08, 4700 River Road Unit 36, Riverdale, MD 20737-1231, (301) 734-7727.

SUPPLEMENTARY INFORMATION:

Background

Bovine tuberculosis is the contagious, infectious, and communicable disease caused by *Mycobacterium bovis*. The tuberculosis regulations contained in 9 CFR part 77 (referred to below as the regulations), regulate the interstate movement of cattle and bison because of tuberculosis. Cattle and bison not known to be affected with or exposed to tuberculosis are eligible for interstate movement without restriction if those cattle or bison are moved from jurisdictions designated as accredited-free States, accredited-free (suspended) States, or modified accredited States. The regulations restrict the interstate movement of cattle or bison not known to be affected with or exposed to tuberculosis if those cattle or bison are moved from jurisdictions designated as nonmodified accredited States.

The status of a State is based on its freedom from evidence of tuberculosis, the effectiveness of the State's tuberculosis eradication program, and the degree of the State's compliance with the standards contained in a document captioned "Uniform Methods and Rules—Bovine Tuberculosis Eradication," which is incorporated by reference into the regulations.

An accredited-free State, as defined in § 77.1 of the regulations, is a State that has no findings of tuberculosis in any cattle or bison in the State for at least 5 years. The State must also comply with all the provisions of the "Uniform Methods and Rules—Bovine Tuberculosis Eradication" regarding accredited-free States.

An accredited-free (suspended) State is defined as a State with accredited-free status in which tuberculosis has been detected in any cattle or bison in the State. A State with accredited-free (suspended) status is qualified for redesignation of accredited-free status after the herd in which tuberculosis is detected has been quarantined, an

epidemiological investigation has confirmed that the disease has not spread from the herd, and all reactor cattle and bison have been destroyed. However, if tuberculosis is detected in two or more herds in the State within 48 months, the State's accredited-free status is revoked.

Before publication of this interim rule, Wisconsin was designated in § 77.1 of the regulations as an accredited-free State. However, because tuberculosis has recently been confirmed in one herd within the State, the Administrator has determined that Wisconsin no longer meets the criteria for designation as an accredited-free State, but instead meets the criteria for designation as an accredited-free (suspended) State. Therefore, we are amending the regulations by removing Wisconsin from the list of accredited-free States in § 77.1 and adding it to the list of accredited-free (suspended) States in that section.

Immediate Action

The Administrator of the Animal and Plant Health Inspection Service has determined that there is good cause for publishing this interim rule without prior opportunity for public comment. Immediate action is necessary to change the regulations so that they accurately reflect the current tuberculosis status of Wisconsin as an accredited-free (suspended) State. This will provide prospective cattle and bison buyers with accurate and up-to-date information.

Because prior notice and other public procedures with respect to this action are impracticable and contrary to the public interest under these conditions, we find good cause under 5 U.S.C. 553 to make it effective upon publication in the Federal Register. We will consider comments that are received within 60 days of publication of this rule in the Federal Register. After the comment period closes, we will publish another document in the Federal Register. It will include a discussion of any comments we receive and any amendments we are making to the rule as a result of the comments.

Executive Order 12866 and Regulatory Flexibility Act

This rule has been reviewed under Executive Order 12866. For this action, the Office of Management and Budget has waived its review process required by Executive Order 12866.

Wisconsin has approximately 61,000 cattle herds containing 3.85 million cattle and bison. An estimated 98 percent of these herds are owned by small businesses. Changing the status of Wisconsin may affect the marketability of cattle and bison from the State, since

some prospective cattle and bison buyers prefer to buy cattle and bison from accredited-free States. This may result in a small detrimental economic impact on some small entities. We anticipate that this action will not have a significant effect on marketing patterns in Wisconsin and will therefore not have a significant effect on those small entities affected by this action.

Under these circumstances, the Administrator of the Animal and Plant Health Inspection Service has determined that this action will not have a significant economic impact on a substantial number of small entities.

Executive Order 12372

This program/activity is listed in the Catalog of Federal Domestic Assistance under No. 10.025 and is subject to Executive Order 12372, which requires intergovernmental consultation with State and local officials. (See 7 CFR part 3015, subpart V.)

Executive Order 12778

This rule has been reviewed under Executive Order 12778, Civil Justice Reform. This rule: (1) Preempts all State and local laws and regulations that are in conflict with this rule; (2) has no retroactive effect; and (3) does not require administrative proceedings before parties may file suit in court challenging this rule.

Paperwork Reduction Act

This rule contains no information collection or recordkeeping requirements under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

List of Subjects in 9 CFR Part 77

Animal diseases, Bison, Cattle, Reporting and recordkeeping requirements, Transportation, Tuberculosis.

Accordingly, 9 CFR part 77 is amended as follows:

PART 77—TUBERCULOSIS

1. The authority citation for part 77 continues to read as follows:

Authority: 21 U.S.C. 111, 114, 114a, 115–117, 120, 121, 134b, 134f; 7 CFR 2.17, 2.51, and 371.2(d).

§ 77.1 [Amended]

2. In § 77.1, in the definition for *Accredited-free state*, paragraph (2) is amended by removing “Wisconsin,”.

3. In § 77.1, in the definition for *Accredited-free (suspended) State*, paragraph (2) is amended by removing “None” and adding “Wisconsin” in its place.

Done in Washington, DC, this 21st day of November 1995.

Lonnie J. King,

Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 95–30017 Filed 12–7–95; 8:45 am]

BILLING CODE 3410–34–P

CONSUMER PRODUCT SAFETY COMMISSION

16 CFR Part 1512

Requirements for Bicycles

AGENCY: Consumer Product Safety Commission.

ACTION: Revocation of rules.

SUMMARY: The Commission revokes two labeling rules applicable to bicycles introduced into interstate commerce between May 11, 1976, and May 11, 1978. The Commission is revoking these rules because no bicycles offered for sale at this time are subject to their requirements.

EFFECTIVE DATE: December 8, 1995.

FOR FURTHER INFORMATION CONTACT: Allen F. Brauninger, Attorney, Office of the General Counsel, Consumer Product Safety Commission, Washington, DC 20207; telephone (301) 504–0980, extension 2216.

SUPPLEMENTARY INFORMATION:

A. Background

In 1976, the Commission published regulations prescribing safety requirements for bicycles under the authority of the Federal Hazardous Substances Act (FHSA) (15 U.S.C. 1261 *et seq.*), to become effective on May 11, 1976. (See the Federal Register notice of January 28, 1976; 41 FR 4144.) These regulations are codified at 16 CFR Part 1512, and include requirements for the design, performance, and labeling of bicycles.

The regulations are applicable to bicycles introduced into interstate commerce on and after May 11, 1976. Bicycles introduced into interstate commerce before that date are not subject to their requirements. Consequently, on the effective date of the regulations, bicycles introduced into interstate commerce before May 11, 1976, could be sold without violating the regulations or the FHSA.

B. Issuance of Temporary Labeling Requirements

To help consumers identify bicycles manufactured to comply with the regulations, the Commission included a requirement in the regulations that bicycles introduced into interstate

commerce from May 11, 1976, through May 11, 1978, had to be labeled with a hang tag or other removable label stating: "Meets U.S. Consumer Product Safety Commission Regulations for Bicycles." See section 1512.19(d) of the regulations. Section 1512.19(d) specifies minimum dimensions for the label and the height of the lettering of the required statement.

After the effective date of the bicycle regulations, the Commission issued a statement of policy and interpretation to allow minor variations in the size of the hang tags or labels required by section 1512.19(d). See the Federal Register of May 27, 1976. The statement of policy and interpretation is codified as 16 CFR 1512.50.

C. Revocation

No bicycles introduced into commerce now or in the future are or will be subject to the labeling rule and policy statement codified at 16 CFR 1512.19(d) and 1512.50. For this reason, the Commission is revoking that rule and policy statement.

Generally, the Administrative Procedure Act (APA) (5 U.S.C. 553) requires agencies to publish a notice of proposed rulemaking and provide opportunity for public comment before issuing or revoking a regulation. However, the APA provides at 5 U.S.C. 553(b)(B) that the requirement for a notice of proposed rulemaking is not applicable when the agency finds for good cause that notice of proposed rulemaking and public participation are "impracticable, unnecessary, or contrary to the public interest."

The Commission finds for good cause that notice of proposed rulemaking and public participation are unnecessary. As noted, labeling under 16 CFR 1512.19(d) and 1512.50 was required only for bicycles introduced into commerce from May 11, 1976, to May 11, 1978. The rules being revoked have no effect on the rights or duties of any persons who manufacture, sell, or purchase bicycles at this time. Providing notice of proposed rulemaking and opportunity for submission of written comments on the proposal would be a meaningless procedure in this case.

The APA also requires at 5 U.S.C. 553(d) that a substantive rule must be published at least 30 days before its effective date unless the agency finds for good cause that such delay is not needed. Again, no bicycles offered for sale now or in the future are or will be subject to the rules being revoked. Therefore, the Commission finds for good cause that a delayed effective date is unnecessary, and this revocation shall become effective immediately.

D. Conclusion

Therefore, under the authority of section 553 of the Administrative Procedure Act and sections 2 and 3 of the Federal Hazardous Substances Act, the Commission hereby amends title 16 of the Code of Federal Regulations, Chapter II, Subchapter C, Part 1512 to read as follows:

PART 1512—[AMENDED]

1. The authority for Part 1512 continues to read as follows:

Authority: Sec. 2(f)(1)(D), (q)(1)(A), (s), 3(e)(1), 74 Stat. 372, 374, as amended, 80 Stat. 1304–05, 83 Stat. 187–89 (15 U.S.C. 1261, 1262).

§ 1512.19 [Removed and Reserved]

§ 1512.50 [Removed and Reserved]

2. Sections 1512.19(d) and 1512.50 are removed and reserved effective December 8, 1995.

Dated: December 4, 1995.

Sadye E. Dunn,
Secretary, Consumer Product Safety
Commission.

[FR Doc. 95–29898 Filed 12–7–95; 8:45 am]

BILLING CODE 6355–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[VA21–1–5883a; A–1–FRL–5342–1]

Approval and Promulgation of Air Quality Plans; Virginia; Withdrawal of Final Rule Pertaining to VOC RACT Requirements

AGENCY: Environmental Protection
Agency (EPA).

ACTION: Direct final rulemaking.

SUMMARY: On September 27, 1995, EPA published approval of a State Implementation Plan (SIP) revision submitted by the Commonwealth of Virginia (60 FR 49767) pertaining to amendments to Virginia's major source volatile organic compound (VOC) reasonably available control technology (RACT) requirements, applicable in the Richmond ozone nonattainment area and the Virginia portion of the Washington, DC ozone nonattainment area. This action was published without prior proposal because EPA anticipated no adverse comments. Because EPA received adverse comments on this action, EPA is removing the amendments made by the September 27, 1995 final rule pertaining to VOC RACT requirements in Virginia.

EFFECTIVE DATE: November 27, 1995.

FOR FURTHER INFORMATION CONTACT:

Maria A. Pino, (215) 597–9337.

SUPPLEMENTARY INFORMATION: On September 27, 1995, EPA published approval of a SIP revision pertained to amendments to Virginia's major source VOC RACT requirements (60 FR 49767). The intended effect of this action was to approve the submitted amendments to Virginia's major source VOC RACT requirements because they strengthen Virginia's SIP. EPA approved this direct final rulemaking without prior proposal because the Agency viewed it as a noncontroversial amendment and anticipated no adverse comments. The final rule was published in the Federal Register with a provision for a 30 day comment period (60 FR 49767).

A proposed rule pertaining to the same amendments to Virginia's VOC RACT requirements was also published in the Federal Register on September 27, 1995 (60 FR 49813). EPA announced that the final rule would convert to a proposed rule in the event that adverse comments were submitted to EPA within 30 days of publication of the rule in the Federal Register (60 FR 49767). The final action would be withdrawn by publishing a document announcing withdrawal of the final rulemaking action. EPA received adverse comment within the prescribed comment period. Therefore, EPA is removing the amendments made by the September 27, 1995 final rulemaking action. All public comments received will be addressed in a subsequent rulemaking action based on the proposed rule.

List of Subjects in 40 CFR Part 52

Environmental protection, Air
pollution control, Hydrocarbons,
Intergovernmental relations, Ozone.

Dated: November 3, 1995.

Stanley Laskowski,

Acting Regional Administrator, Region III.

For the reasons set out in the preamble, 40 CFR Part 52 is amended as follows:

PART 52—[AMENDED]

1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401–7671q.

Subpart VV—Virginia

§ 52.2420 [Amended]

2. Section 52.2420 is amended by removing paragraph (c)(106).
[FR Doc. 95–29927 Filed 12–07–95; 8:45 am]

BILLING CODE 6560–50–P

40 CFR Part 63**[FRL-5343-5]****National Emission Standards for Hazardous Air Pollutants for Source Categories: Gasoline Distribution (Stage 1)****AGENCY:** Environmental Protection Agency (EPA).**ACTION:** Notice of partial stay and reconsideration.

SUMMARY: Today's action provided in this document announces a partial 3-month stay of the December 14, 1995 compliance date for certain provisions of the December 14, 1994 "National Emission Standards for Hazardous Air Pollutants for Source Categories: Gasoline Distribution (Stage 1)". The December 14, 1995 compliance date for leak detection and repair provisions and initial notifications is stayed for existing facilities until March 7, 1996. The EPA is issuing this stay pursuant to Clean Air Act section 307(d)(7)(B), 42 U.S.C. 7607(d)(7)(B), which provides the Administrator authority to stay the effectiveness of a rule during reconsideration.

EFFECTIVE DATE: December 8, 1995.

FOR FURTHER INFORMATION CONTACT: Mr. Stephen Shedd at (919) 541-5397, Emission Standards Division (MD-13), U.S. Environmental Protection Agency, Research Triangle Park, North Carolina 27711.

SUPPLEMENTARY INFORMATION:**I. Background**

On December 14, 1994 (59 FR 64303), the Environmental Protection Agency (EPA) promulgated in the Federal Register a rule, "National Emission Standards for Hazardous Air Pollutants for Source Categories: Gasoline Distribution (Stage 1)" (the "Gasoline Distribution NESHAP"). The Gasoline Distribution NESHAP regulates all hazardous air pollutants emitted from new and existing bulk gasoline terminals and pipeline breakout stations that are major sources of HAP emissions or are located at sites that are major sources of HAP emissions. Among the promulgated requirements for existing sources under this rule are the requirements that existing sources institute an equipment leak program and provide an initial notification of regulatory status and use of a screening equation before December 15, 1995 (40 CFR 63.424(e) and 40 CFR 63.428(a), (i)(1), and (j)(1)).

Whether a bulk gasoline terminal or pipeline breakout station is a major source or at a site that is a major source

is determined by a site's "potential to emit considering controls." CAA 112(a), 42 U.S.C. 7412(a). In the Gasoline Distribution NESHAP, the EPA promulgated two mechanisms for determining major source status that are specific to this rule: first, the NESHAP included equations for determining potential emissions from terminals and breakout stations based on the HAP content of gasoline, gasoline throughput, and emission rates from equipment used to handle gasoline; and second, the NESHAP allowed for case-by-case review or "emissions inventory" of a site's emissions. 40 CFR § 63.420. The equations could be used only by bulk terminals and pipeline breakout stations that were at sites that had no other sources of HAPs. Other facilities would be able to establish potential to emit either by an emissions inventory or by using other means (outside the rule) that are generally available to sources under Subpart A of part 63, the General Provisions, and related guidance.

The American Petroleum Institute (API) submitted to the EPA a petition for reconsideration (API Petition) of provisions of the Gasoline Distribution NESHAP affecting how bulk gasoline terminals and pipeline breakout stations may establish "area source" status (i.e., non-major source status), including the timing and method of obtaining potential to emit limits. Several developments since the promulgation of the Gasoline Distribution NESHAP have led the EPA to stay this compliance date to respond to the petition for reconsideration. In particular, as discussed in the Federal Register notice (60 FR 56133, November 7, 1995) proposing amendments of the compliance dates for the initial notification and the equipment leak detection provisions of the NESHAP, new information indicates that many sources that were assumed to be area sources may be unable to use the mechanisms for establishing area source status under the rule. The EPA is currently reconsidering certain provisions in the Gasoline Distribution NESHAP by collecting and considering comments on the November 7, 1995 proposal. The EPA plans to take final action on the proposed rule prior to the end of the stay announced in today's notice. The information being considered during this reconsideration of the Gasoline Distribution NESHAP is contained in Docket No. A-92-38 (See 40 FR 56133).

When the EPA promulgated the Gasoline Distribution NESHAP, the EPA anticipated that about 75 percent of all gasoline bulk terminals and pipeline breakout stations would be able to

establish area source status before the first compliance date of this rule. Therefore, today's stay will apply to all existing sources.

II. Issuance of Stay

The EPA hereby issues a 3-month (from today's date) administrative stay of the December 14, 1995 compliance date (40 CFR 63.424(e) and 40 CFR 63.428(a), (i)(1), and (j)(1)) in the Gasoline Distribution NESHAP. The December 14, 1995 compliance date is stayed until March 7, 1996. The EPA is reconsidering the compliance date in the rule and, following notice and comment procedures under section 307(d) of the Clean Air Act, will take appropriate action.

III. Authority for Stay and Reconsideration

The administrative stay and reconsideration of the Gasoline Distribution NESHAP and its associated compliance periods announced in this notice are being undertaken pursuant to section 307(d)(7)(B) of the Clean Air Act, 42 U.S.C. 7607(d)(7)(B). That provision authorizes the Administrator to stay the effectiveness of a rule for 3-months to consider a request for reconsideration. Reconsideration is appropriate if the grounds for an objection arose after the period for public comment and if the objection is of central relevance to the outcome of the rule. The grounds for reconsideration of this rule arose after the public comment period. The timing of when potential to emit limits have to be in place, the types of acceptable methods for limiting potential to emit, and the scope of the emissions equations only became apparent subsequent to the comment period on the rule. Therefore, EPA is staying the effectiveness of the rule for 3 months in order to allow time to reconsider this issue.

Pursuant to the provisions of 5 U.S.C. 605(b), I hereby certify that this rule will not have a significant economic impact of a substantial number of small business entities.

Dated: November 27, 1995.

Carol M. Browner,
Administrator.

Title 40 of the Code of Federal Regulations, chapter I, part 63, subpart R, is amended as follows:

PART 63—NATIONAL EMISSION STANDARDS FOR HAZARDOUS AIR POLLUTANTS FOR SOURCE CATEGORIES

1. The authority citation for part 63 continues to read as follows:

Authority: 42 U.S.C. 7401 et seq.

2. Section 63.420 is amended by adding paragraph (j) to read as follows:

§ 63.420 Applicability.

* * * * *

(j) *Rules Stayed for Reconsideration.* Notwithstanding any other provision of this subpart, the December 14, 1995 compliance date for existing facilities in § 63.424(e) and § 63.428(a), (i)(1), and (j)(1) of this subpart is stayed from December 8, 1995, to March 7, 1996.

[FR Doc. 95-29992 Filed 12-7-95; 8:45 am]

BILLING CODE 6560-50-M

40 CFR Part 70

[AD-FRL-5343-3]

Clean Air Act Final Interim Approval of Operating Permits Program; Washington

AGENCY: U.S. Environmental Protection Agency (EPA).

ACTION: Final interim approval and notice of correction.

SUMMARY: EPA is repromulgating final interim approval of one element of the State of Washington's title V air operating permits program. On November 9, 1994, EPA granted interim approval to Washington's operating permits program. 59 FR 55813 (November 9, 1994). One of the bases for granting Washington's program interim rather than full approval was that EPA determined that Washington's exemption for "insignificant emission units" exceeded the exemption authorized for such units under the Clean Air Act. A coalition of industries filed a petition for review of EPA's decision to condition full approval on changes to Washington's treatment of insignificant emission units. Upon EPA's request for a voluntary remand, the Court remanded this interim approval issue to EPA for reconsideration. EPA continues to believe that Washington has impermissibly expanded the exemption for insignificant emission units and therefore again conditions full approval of the Washington operating permits program on changes to Washington's treatment of insignificant emission units.

EPA is also approving a change to the jurisdiction of the Benton County Clean Air Authority.

Finally, EPA is correcting the date for expiration of the interim approval and the due date of the required submission addressing the interim approval issues.

EFFECTIVE DATE: January 8, 1996.

ADDRESSES: Copies of Washington's submittal and other supporting information used in developing this action are available for inspection during normal business hours at the address indicated.

FOR FURTHER INFORMATION CONTACT: Elizabeth Waddell, 1200 Sixth Avenue, Seattle, Washington 98101.

SUPPLEMENTARY INFORMATION:

I. Background and Purpose

A. Introduction

As required under title V of the 1990 Clean Air Act Amendments (sections 501-507 of the Clean Air Act ("the Act")), EPA has promulgated rules which define the minimum elements of an approvable State operating permits program and the corresponding standards and procedures by which the EPA will approve, oversee, and withdraw approval of State operating permits programs (see 57 FR 32250 (July 21, 1992)). These rules are codified at 40 Code of Federal Regulations (CFR) Part 70. Title V requires States to develop, and submit to EPA, programs for issuing these operating permits to all major stationary sources and to certain other sources.

The Act requires that States develop and submit these programs to EPA by November 15, 1993, and that EPA act to approve or disapprove each program within 1 year after receiving the submittal. EPA's program review occurs pursuant to section 502 of the Act and the part 70 regulations, which together outline criteria for approval or disapproval. Where a program substantially, but not fully, meets the requirements of part 70, EPA may grant the program interim approval for a period of up to 2 years. If EPA has not fully approved a program by 2 years after the November 15, 1993 date, or by the end of an interim program, it must establish and implement a Federal program.

B. Previous Action on Washington's Program

Washington submitted its operating permits program to EPA in November 1993. In November 1994, EPA granted interim approval to Washington's program and conditioned full approval on, among other things, revisions to Washington's regulations pertaining to the treatment of insignificant emission units (IEUs).¹ See 59 FR 55813

¹ For the purpose of this action, "IEU" refers to activities and emission units that are defined as insignificant under WAC 173-401-200(16) and 173-401-530, when used in discussing Washington's program, and refers to the generic

(November 9, 1994). On January 9, 1995, the Western States Petroleum Association, Northwest Pulp & Paper Association, Aluminum Company of America, Columbia Aluminum Corporation, Intalco Aluminum Corporation, Kaiser Aluminum & Chemical Corporation and Vanalco Inc. (collectively, "Petitioners") filed a petition with the United States Court of Appeals for the Ninth Circuit seeking review of the conditions in EPA's final interim approval of Washington's operating permits program. *Western States Petroleum Association, et al. v. EPA, et al.*, No. 95-70034 (9th Cir., Jan. 6, 1995). In their petition and subsequent brief, Petitioners claimed that EPA had exceeded its authority in requiring Washington to revise its IEU rules as a condition of full approval and that this condition was arbitrary, capricious, an abuse of discretion, and not otherwise in accordance with the law. Petitioners' brief clarified that Petitioners were challenging only EPA's requirement that Washington revise its IEU rules to obtain full approval and did not challenge any of the four other conditions for full approval. The State of Washington filed a brief as intervenor in the matter.

In reviewing the issue, EPA determined that the Petitioners and the State of Washington had raised a substantial question concerning EPA's interpretation of the IEU provisions of part 70 and the specific regulatory revisions EPA had ordered the State to make to its IEU rules as a condition of full approval. EPA therefore moved the Court on May 23, 1995, to vacate and remand to EPA those portions of EPA's final interim approval of Washington's operating permits program concerning IEUs. The Court granted EPA's motion on July 7, 1995.

Following the Court's order, EPA again reviewed the part 70 regulations and Washington's IEU provisions and, on September 28, 1995, again proposed interim approval of the State's program (60 FR 50166). EPA explained in the proposal that EPA continued to believe that Washington's IEU provisions did not comport with the requirements of part 70 with respect to permit content because the State's regulations expressly excluded IEUs subject to generally applicable requirements of the Washington State Implementation Plan (SIP) from all the requirements of 40 CFR 70.6, except for the requirement to include in the permit all applicable requirements. EPA also expressed its concern that the State's definition of

concept under part 70, when used in discussing the requirements of part 70.

IEU excluded, perhaps unintentionally, IEUs from certain permit application requirements that apply to IEUs and possibly from even title V applicability determinations.

During the public comment period on the September 1995 proposal, EPA received comments from the Petitioners, the State of Washington, Department of Ecology ("State" or "Ecology"), and the Boeing Corporation, an aerospace manufacturing concern with major operations in Washington State (collectively, the "commenters"). The commenters addressed only EPA's proposed interim approval of the Washington IEU program. No comments were received regarding the change in jurisdiction of Benton County Clean Air Authority or the correction of the expiration date for interim approval.

EPA has carefully reviewed the comments and continues to believe that the Washington IEU program must be revised as a condition of full approval. As discussed in more detail below, EPA grants deference to the State's interpretation of its IEU regulations, and is therefore satisfied, based on the State's interpretation, that the State's IEU regulations meet the requirements of part 70 with respect to permit applications and title V applicability. The problems with the permit content requirements of section 70.6 which EPA addressed in the September 1995 proposal, however, arise not from a difference of opinion as to the interpretation of Washington's regulations, but instead from a difference of opinion as to the plain meaning and intent of the part 70 regulations themselves. EPA continues to believe that part 70 does not exempt IEUs subject to applicable requirements from the testing, monitoring, recordkeeping, reporting, compliance, and compliance certification requirements of 40 CFR 70.6(a)(1), (a)(3) and (c). Because Washington's title V program expressly excludes IEUs subject to generally applicable requirements from these requirements of section 70.6, EPA continues to believe that the Washington IEU regulations do not qualify for full approval.

II. Final Action and Implications

A. Response to Comments

As discussed above, the comments addressed only EPA's proposed interim approval of Washington's IEU regulations.

1. Permit Content

As the State of Washington and Petitioners concede, the Washington program expressly exempts IEUs subject

to generally applicable requirements from the testing, monitoring, recordkeeping, reporting, compliance, and compliance certification requirements of section 70.6.² See WAC 173-401-200(16), 173-401-530(2)(c) and 173-401-530(2)(d). Instead, for IEUs subject to generally applicable requirements of the Washington SIP, the Washington program requires only that the permit contain the generally applicable requirements that apply to such IEUs. WAC 173-401-530(2)(b). The commenters argue that the language and intent of the part 70 regulations allow such an exemption from the permit content requirements of section 70.6 for IEUs. EPA disagrees.

The commenters acknowledge that there is no reference in 40 CFR 70.6 to IEUs. They argue, however, that this fact "in no way undermines the authority granted to states in section 70.5 to exempt insignificant emission units from permit program requirements." Section 70.5, however, does not exempt IEUs from "permit program requirements" in general, but instead exempts IEUs only from certain permit application requirements. There is *nothing* in the language of section 70.5 or elsewhere in the part 70 regulations to support the commenters' argument that, because a State may exempt IEUs from certain permit application requirements in section 70.5, a State may also exempt IEUs from certain permit content requirements in section 70.6.

The commenters' reliance on EPA's inherent power to exempt emission units with *de minimis* emissions from certain permit content requirements is also misplaced. EPA did indeed rely on *Alabama Power Co. v. Costle*, 636 F.2d 323 (D.C. Cir. 1980), to exempt IEUs from certain permit application requirements in section 70.5. See 57 FR 32250, 32273 (July 21, 1992). Whether EPA could have relied on this same authority to exempt IEUs from certain permit content requirements in section 70.6, however, is irrelevant at this point. As stated above, nothing in the language of the part 70 regulations themselves or in the preamble to the proposed or final part 70 regulations supports the commenters' argument that the limited

exemption in certain permit application requirements in section 70.5 also extends to the permit content requirements of section 70.6. The commenters' concern appears to be with the part 70 regulations themselves, that is, the failure of the part 70 regulations to exempt IEUs subject to applicable requirements from certain permit content requirements of section 70.6. The time for raising such an issue has long since past.

Unable to point to any language in the part 70 regulations supporting their interpretation, the commenters rely on "logic." The commenters first argue that "it is entirely illogical for EPA to specifically exempt these IEUs from the application and then attempt to regulate these same IEUs in the final permit." The commenters go on to state that EPA's decision undermines the broad purpose of part 70's IEU program exemption. The commenters appear to misunderstand the purpose and scope of the part 70 program for insignificant emissions units and activities. In promulgating section 70.5(c), EPA crafted a limited exemption regarding the *information* required in part 70 permit applications. Notwithstanding this general exemption from certain permit application requirements, section 70.5(c) requires that an application "may not omit information needed to determine the applicability of, or to impose, any applicable requirement." This means that when information is needed in an application to determine whether substantive requirements apply to an IEU, even this limited exemption to the permit application requirements provided in section 70.5 falls away.

In a similar vein is the comment that not allowing IEUs to be exempted from permit content requirements "essentially obliterates the exemption." EPA disagrees. An emission unit that is not exempted from the application must be addressed in accordance with section 70.5(c)(3), which among other things requires a physical description of the emissions points, information about the emissions, raw materials and production rate, and any air pollution control equipment. EPA therefore sees no basis for the argument that extension of the IEU exemption to the permit content requirements of section 70.6 is necessary in order to give meaning to the IEU exemption.

The commenters also argue that "If insignificant emission units are not entirely exempted from the monitoring, recordkeeping, reporting and certification requirements of a permit, both sources and permitting agencies will be forced to expend substantial

²This includes the requirement to include "gapfilling" testing, monitoring, recordkeeping and reporting requirements for IEUs, as required by 40 CFR 70.6(a)(3)(i), (ii) and (iii); compliance certification, testing, monitoring, reporting and recordkeeping requirements sufficient to assure compliance with the generally applicable requirements for subject IEUs, as required by 40 CFR 70.6(c)(1); compliance certification for IEUs, as required by 40 CFR 70.6(c)(5); and, for IEUs not in compliance, a compliance schedule and progress reports, as required by 40 CFR 70.6(c)(3) and (4).

resources without compensating environmental benefit.” As an initial matter, EPA again points out that this concern challenges the part 70 regulations themselves and should have been raised following final promulgation of the part 70 regulations. Such concerns are untimely when raised in the context of EPA’s action on Washington’s title V program. In any event, EPA disagrees that applying the testing monitoring, recordkeeping, reporting, and compliance certification requirements of section 70.6 to IEUs with applicable requirements will be unduly burdensome or result in no compensating environmental benefit.

The commenters imply that requiring the provisions of section 70.6 to be met with respect to IEUs subject to applicable requirements will result in unnecessary paperwork. As EPA discussed in its September 1995 proposal on this action, part 70 allows States flexibility in tailoring the amount and quality of information required in the permit application, and the rigor of compliance requirements in the permit, to the type of emission unit and applicable requirement in question. See 60 FR 50170; *See also White Paper for Streamlined Development of Part 70 Permit Applications*, from Lydia Wegman, Deputy Director of EPA’s Office of Air Quality Planning and Standards, to EPA Regional Air Directors (July 10, 1995). The requirement to include in a permit testing, monitoring, recordkeeping, reporting, and compliance certification *sufficient to assure compliance* with the terms and conditions of the permit does not require the permit to impose the same level of rigor with respect to emission units that do not require extensive testing or monitoring in order to assure compliance with the applicable requirements as it does with respect to emission units that do require extensive testing or monitoring because of their potential to violate emission limitations or other requirements under normal operating conditions. As provided for in 40 CFR 70.6(a)(3)(B), recordkeeping may be used to provide reliable data that are representative of the source’s compliance with the permit. For example, records showing the use of natural gas as the fuel for combustion sources would, in most cases, provide reliable data for a certification of compliance with sulfur dioxide emission limits.

The burden of ensuring that a permit meets the requirements of section 70.6 can also be significantly minimized by using standard permit terms to address testing, monitoring, recordkeeping, reporting, compliance and compliance

certification requirements for common generally applicable requirements that apply to IEUs. Permits could, for example, contain a chart summarizing the monitoring, recordkeeping, and reporting requirements that would form the basis for compliance certifications for the generally applicable requirements for IEUs.

In the September 1995 proposal on this action, EPA pointed to the Oregon operating permits program as an example of a program that had effectively implemented the requirements of section 70.6 for IEUs. The Oregon program received interim approval effective January 3, 1995, (59 FR 61820 (December 2, 1994)),³ one month after Washington’s program first received final interim approval. Since that time, Oregon permitting authorities have received complete title V permit applications from over 86 sources, have issued 12 final title V permits and have submitted to EPA an additional 5 proposed title V permits. As discussed in the September 1995 proposal on this action, Oregon has used standard permit terms in its title V permits to address generally applicable requirements for IEUs as well as the associated testing, monitoring, recordkeeping, reporting, compliance, and compliance certification requirements for such IEUs. See 60 FR 50170–50171. Based on EPA’s review of public comments on the 5 proposed and 12 final permits issued to date, Oregon sources have not objected to the permit terms relating to IEUs.

EPA is committed to issuing additional guidance to aid State and local permitting authorities in drafting permits which comply with the permit content requirements of section 70.6. EPA intends to issue such guidance with respect to IEUs with applicable requirements within the next several months. This guidance will address such things as streamlining the permit by using general conditions which apply to categories of IEUs; appropriate monitoring, recordkeeping and reporting requirements for IEUs; and the appropriate level of information (i.e., reasonable inquiry) upon which compliance certifications would be based.

One commenter on the Washington title V program has stated, without any substantiation, that “a comparison of title V applications for similar sources in the two states reveals that Oregon applications were several times larger

than those prepared in Washington, with the difference attributable to emissions units making up one or two percent of the source’s total emissions.” Although EPA has to date received only 16 permit applications from title V sources in Washington, a comparison of five Washington title V applications to Oregon title V applications for sources with the same SIC codes does not substantiate the commenter’s claim. Although the Oregon permit applications that EPA reviewed were generally one-and-one-half times larger than their Washington counterparts, two of the five Washington applications contained more pages addressing IEUs and facility-wide applicable requirements than did their Oregon counterparts and one had the same number of pages. More importantly, none of these 10 permit applications for Washington and Oregon contained any significant number of pages addressing IEUs. The IEU-related portions of the Oregon applications ranged from 5 to 25 pages and the IEU-related portions of the Washington applications ranged from 3 to 19 pages. As indicated by the sample Oregon permit which was included in the docket for the proposal on this action, and the accompanying application for the permit which EPA has added to the docket, only 8 of the 165 pages of the permit application are devoted to IEUs, which includes three pages of checklists for categorically exempt IEUs, one page of brief descriptions/equations addressing aggregate insignificant IEUs, two pages listing facility-wide applicable requirements, and two pages listing compliance methods for the facility-wide applicable requirements. Note as well that not even two of the 27 pages of the Oregon permit for this source are devoted to IEUs. Any difference in the size of Oregon and Washington title V permit applications appears to be attributable to the difference in the forms required to be submitted for emission units other than IEUs and other differences in the Oregon and Washington air programs, such as the unique plant site emissions limit (PSEL) provisions of Oregon’s rules. In short, Oregon permitting authorities and sources do not appear to be awash in the avalanche of paperwork for IEUs predicted by the commenters.

EPA also vigorously disagrees that requiring permits to address the testing, monitoring, reporting, recordkeeping, compliance, and compliance certification requirements of section 70.6 for IEUs will have little or no environmental benefit. For example, the Washington IEU program lists “vents

³ Oregon’s IEU provisions received full approval when EPA granted the Oregon title V program final interim approval, see 59 FR 61820 (December 2, 1994), and the entire Oregon title V program has now received final full approval. See 60 FR 50106 (September 28, 1995).

from rooms, buildings and enclosures that contain permitted emissions units or activities from which local ventilation, controls and separate exhaust are provided" as "categorically exempt" IEUs if they are subject to no applicable requirements other than the generally applicable requirements of the Washington SIP. WAC 173-401-532(9) and 173-401-530(2)(a). EPA has received a title V application from one Washington facility which lists "furnace building roof monitor and other vents, doorways" as collectively emitting 922 tons of particulate per year. The application also indicates that these emission points are subject only to the generally applicable opacity limit (WAC 173-400-040(1)), grain loading standard (WAC 173-400-060), and sulfur dioxide standard (WAC 173-400-040(6)) in the Washington SIP. Based on the description provided in the application, EPA believes that these emission units would qualify as IEUs under WAC 173-401-532(9) and 173-401-530(2)(a). The application indicates that these emissions units are not in compliance with the State's opacity limit. Washington's current regulations would require that the title V permit for this source contain the generally applicable requirements that apply to these IEUs, but would exempt them from any other requirements of section 70.6, including the requirement to submit an annual compliance certification. The environmental benefit of requiring the title V permit for such a source to include an appropriate level of testing, monitoring, recordkeeping, and reporting, and to require annual certification of the compliance status of these IEUs, should be obvious. Requiring IEUs to be addressed in the permit puts the burden on sources to ensure that they are in compliance with the applicable requirements, rather than on permitting authorities to document that such sources are out of compliance. This shift in responsibility for ensuring compliance is one of the major objectives of the title V program.

The commenters final comment on the permit content issue is that, in finding that Washington's IEU regulations fail to meet the permit content requirements of section 70.6, EPA is holding the Washington program to a different standard than the agency has applied to other States. The commenters can point to no instance, however, in which EPA has given approval to an IEU program which expressly exempts IEUs from some or all permit content requirements, as does the Washington program. Instead, the commenters' argument appears to be

that EPA has approved State programs that exempt or require only the summary listing of IEUs in permit applications and that, "Because the [IEU] units are not listed in the permit application there is a clear inference to sources, and the tacit understanding by the permitting agencies that IEUs are not included in the operating permit." This is not the case.

EPA has approved State title V programs that exempt or allow sources to omit IEUs from or merely list IEUs in the permit application, but only if the States have shown to EPA's satisfaction that their programs meet the two minimum requirements of section 70.5(c) for the treatment of IEUs in permit applications. First, insignificant activities which are exempt because of size or production rate must be listed in the permit application. Second, the permit application may not omit information needed to determine the applicability of, or to impose, any applicable requirement or any required fee.⁴ EPA also required the State of Washington to satisfy these requirements as a condition of full approval of its IEU provisions and, as discussed below, EPA now finds that Washington has satisfied these requirements for permit applications.

But, contrary to the commenters' assertion, EPA has also required, as a condition for full approval of a State's IEU program, that the State ensure that permits issued for such sources comply with the requirements of section 70.6 with respect to all IEUs subject to applicable requirements. EPA disagrees with the inference drawn by the commenters, namely, that other State programs might be interpreted to exempt IEU's from permit content requirements because the State programs have provided sources relief from certain permit application requirements. Such an inference is not reasonable or appropriate given the fact that there is no language in the State program regulations cited by the commenters which contain or suggest an exemption from the permit content requirements and given the fact that the federal regulation under which the State programs have been approved does not allow for this result. Indeed, for obvious reasons, EPA's approval of these programs has been based on the assumption that State program

⁴The Wisconsin program does not specifically contain this requirement. As EPA clarified in its technical support document supporting EPA's approval of the Wisconsin program, however, because the State very narrowly defined IEUs and required that all IEUs be listed in the application, the Wisconsin program met the requirements of section 70.5(c).

regulations will be interpreted in the same way that EPA has interpreted part 70. That is, where the State program does not specifically exempt IEU's from permit content requirements, EPA has assumed that no such exemption will be inferred. Where EPA has been concerned that a State program could be interpreted to provide an exemption from permit content requirements for IEUs subject to applicable requirements, EPA has clarified its expectation in the Federal Register notice acting on such programs that the permitting authorities must ensure that all permits issued "assure compliance with all applicable requirements at the time of permit issuance." See 60 FR 32603, 32608 (June 23, 1995); 60 FR 44799, 44801 (August 29, 1995). If, during implementation of such programs, permits are issued which do not comply with the requirements of section 70.6 with respect to IEUs subject to applicable requirements, EPA would consider this grounds for objecting to individual permits, 40 CFR 70.8(c)(1), as well as grounds for withdrawing approval of such State programs, 40 CFR 70.10(c)(1)(ii)(B).

In summary, the commenters can point to no instance in which EPA has approved a State program which expressly exempts IEUs with applicable requirements from the permit content requirements of section 70.6. Moreover, the commenters can point to no action on the part of EPA which has expressly or implicitly condoned a tacit exemption from the permit content requirements for such IEUs. EPA's decision to grant interim rather than full approval to the Washington IEU regulations for failing to comply with the requirements of section 70.6 is fully consistent with EPA's actions on other State IEU programs.

2. Permit Application Requirements

The commenters also objected to EPA's proposed finding that the Washington regulations fail to meet the requirements of section 70.5 for permit applications with respect to IEUs. The basis of EPA's position was that WAC 173-401-200(16) appears to specifically exempt activities and units deemed insignificant under WAC 173-401-530 from all of Washington's permit program requirements, except as provided in WAC 173-401-530. WAC 173-401-530, however, does not include all of the requirements of section 70.5 which a State must meet with respect to IEUs, most importantly, the requirement of section 70.5(c) that a permit application may not omit information needed to determine the applicability or to impose any

applicable requirement or to evaluate any required fee (the “applicable requirements gatekeeper”).⁵ WAC 173–401–530 also does not incorporate the requirement that all applications be certified as to truth, accuracy and completeness, which is contained in WAC 173–401–500(7)(c) and 173–401–520. Another problem noted by EPA was the fact that WAC 173–401–500(7) could be interpreted as allowing a permit application to be deemed complete even if the source had not provided the information in the permit application required by Washington’s regulations for IEUs.

The commenters, including the State of Washington, responded that EPA was taking an overly broad interpretation of the exclusion contained in WAC 173–401–200(16), thereby giving other provisions of Washington’s IEU regulations no effect. Upon further review and based on the State’s interpretation of its regulations, EPA finds that the Washington IEU provisions meet the requirements of section 70.5(c).

The definition of IEU at WAC 173–401–200(16) does appear to exclude IEUs from all requirements except those contained in WAC 173–401–530. Certain other requirements of Washington’s regulations for title V permit applications, however, specifically refer to IEUs. Importantly, WAC 173–401–510, which sets forth the permit application requirements for all sources in Washington, specifically refers to IEUs by stating:

Information as described below for each emissions unit at a chapter 401 source other than insignificant emissions units shall be included in the application. However, an application may not omit information need to determine the applicability of, or to impose, any applicable requirement or to evaluate the fee amount required under the permitting authority’s schedule.

WAC 173–401–510(1). The State has argued that this provision would be nullified if WAC 173–401–200(16) was interpreted to exempt IEUs from those provisions outside of WAC 173–401–530 that specifically refer to IEUs, such as 173–401–510(1). The State has assured EPA that this was not its intent. Instead, the State has stated that the “applicable requirements gatekeeper” of

WAC 173–401–510(1) was specifically included to limit the statements in WAC 173–401–200(16) and 173–401–510(1) that IEUs are not subject to the permit program requirements, including the application requirements, except as provided by WAC 173–401–530.

In response to the EPA’s concern with respect to the requirement to certify the truth, accuracy and completeness of the permit application, the commenters state that “Statements in a Washington operating permit application, including those regarding IEUs made in accordance with WAC 173–401–530, are plainly subject to the certification requirements of WAC 173–401–500(7)(c).” The State further argues that the State’s standard permit application form requires certification of all information in the application and that if a source attempted to limit its certification with respect to IEUs, the State would view the application incomplete.

In response to EPA’s concern that the criteria for determining completeness in WAC 173–401–500(7) could be interpreted to allow an application to be deemed complete even if it omits all required information on IEUs, the commenters again point out that the specific provisions in WAC 173–401–510(1) and –500(4) require an application to include necessary information regarding IEUs to be complete and that interpreting WAC 173–401–200(16) to vitiate those provisions would render the specific references to IEUs in WAC 173–401–500 and 173–401–510 meaningless.

Although EPA believes the interrelationship among the various provisions in Washington’s regulations for IEUs is far from clear, EPA is willing to grant deference to the State’s interpretation of its own rules. Accordingly, EPA now finds that Washington’s program fully meets the requirements of 40 CFR 70.5 regarding permit applications. Because the State will need to revise its title V rules to get full title V approval, EPA strongly encourages the State to revise its IEU provisions to clarify the relationship among WAC 173–401–200(16), 173–401–500, 173–401–510, 173–401–520 and 173–401–530. EPA will also pay close attention during program implementation to permit applications and proposed permits to ensure that the Washington rules are implemented consistently with the State’s assertions.

3. Applicability Determinations

A final concern raised by EPA was that State law could be interpreted so as to exclude emissions from IEUs in the calculation of a source’s potential to

emit for purposes of determining whether the source was a major source and thereby subject to Washington’s title V program in the first instance. Again, EPA’s concern hinged on the extent of the exemption in WAC 173–401–200(16). The commenters responded by pointing out that the definition of “insignificant activity” or “insignificant emission unit” requires the unit or activity to be “located at a chapter 401 source” before it can qualify as insignificant and thus be exempted from certain permit program requirements. The commenters argue that this requires that a source first be determined to be a major source before any emission unit can be deemed insignificant, thus requiring all emissions, including emissions from IEUs, to be considered when determining if a source is a major source.

Again, EPA is willing to grant deference to the State’s interpretation of its own rules and finds that this provision complies with the requirements of 40 CFR Part 70. EPA will also pay close attention to applicability determinations during program implementation to ensure that the Washington rules are implemented consistently with the State’s assertions.

B. Interim Approval Action

EPA is promulgating interim approval of Washington’s regulations addressing IEUs. Ecology must make the following revisions to its IEU provisions as a condition of full approval:

(5) Revise WAC 173–401–200(16) (Definition of “insignificant activity” and “insignificant emissions unit”); WAC 173–401–530 (Insignificant emission units); WAC 173–401–532 (Categorically exempt insignificant emission units); and WAC 173–401–533 (Units and activities defined as insignificant based on size or production rate) to ensure that permits contain all applicable requirements and meet all permit content requirements of 40 CFR 70.6 for all emission units, even for IEUs.

This requirement replaces Condition 5 under the heading “Ecology” in section II.B. of EPA’s November 9, 1994, Federal Register notice granting final interim approval of the Washington operating permits program. See 59 FR 55818. Note that this action in no way affects the changes necessary to address all other interim approval issues identified in the November 9, 1994 Federal Register notice. In other words, as a condition of full approval, Washington must also correct the four other deficiencies in its program identified in the November 9, 1994, notice and the other Washington permitting authorities must correct all

⁵ Although, in the September 1995 proposal on this action, EPA did not specifically discuss the applicable requirements gatekeeper as one of the examples where the Washington program fails to satisfy the requirements of part 70 with respect to permit applications, the opening sentence of the discussion in the proposal on permit applications clearly expressed EPA’s concern that the exemption in WAC 173–401–200(16) appeared to extend to the gatekeeper itself, which is contained in WAC 173–401–510(1). See 60 FR 50169.

deficiencies in their respective programs identified in the November 9, 1994, notice. See 59 FR 55818–55819.

EPA is also approving as a program revision the transfer of title V permitting and enforcement authority for sources in Franklin County to the Washington Department of Ecology.

Finally, EPA is correcting the dates in 40 CFR Part 70, Appendix A for expiration of the interim approval of the Washington State and local operating permits programs from November 9, 1996, to December 9, 1996, and is correcting the date by which the State is required to submit a corrective program from May 9, 1996, to June 9, 1996.

C. Effective Date of Interim Approval

This action does not change the time period for the initial interim approval, which is December 9, 1996. During this ongoing interim approval period, the State is protected from sanctions for failure to have a program, and EPA is not obligated to promulgate, administer and enforce a Federal permits program for the State of Washington. Permits issued under the Washington program have full standing with respect to part 70. In addition, the 1-year deadline for submittal of permit applications by subject sources and the 3-year time period for processing the initial permit applications began upon the effective date of interim approval, which in this case was December 9, 1994.

If the State of Washington were to fail to submit a complete corrective program for full approval by the date 6 months before expiration of the interim approval (by June 9, 1996) EPA would start an 18-month clock for mandatory sanctions. If the State of Washington were then to fail to submit a complete corrective program before the expiration of that 18-month period, EPA would be required to apply one of the sanctions in section 179(b) of the Act, which would remain in effect until EPA determined that the State of Washington had corrected the deficiency by submitting a complete corrective program. Moreover, if the Administrator were to find a lack of good faith on the part of the State of Washington both sanctions under section 179(b) would apply after the expiration of the 18-month period until the Administrator determined that the State of Washington had come into compliance. In any case, if, 6 months after application of the first sanction, the State of Washington still had not submitted a corrective program that EPA found complete, a second sanction would be required.

If, following expiration of final interim approval, EPA were to

disapprove the State of Washington's complete corrective program, EPA would be required to apply one of the section 179(b) sanctions on the date 18 months after the effective date of the disapproval, unless prior to that date the State or Washington had submitted a revised program and EPA had determined that it corrected the deficiencies that prompted the disapproval. Moreover, if the Administrator found a lack of good faith on the part of the State of Washington both sanctions under section 179(b) would apply after the expiration of the 18-month period until the Administrator determined that the State of Washington had come into compliance. In all cases, if, 6 months after EPA applied the first sanction, the State of Washington had not submitted a revised program that EPA had determined corrected the deficiencies that prompted disapproval, a second sanction would be required.

In addition, discretionary sanctions may be applied where warranted any time after the end of an interim approval period if a State has not timely submitted a complete corrective program or EPA has disapproved a submitted corrective program. Moreover, if EPA has not granted full approval to a State program by the expiration of an interim approval and that expiration occurs after November 15, 1995, EPA must promulgate, administer and enforce a Federal permit's program for that State upon expiration of interim approval.

III. Administrative Requirements

A. Docket

Copies of the State's submittal and other information relied upon for this action are contained in a docket maintained at the EPA Regional Office. The docket is an organized and complete file of all the information submitted to, or otherwise considered by, EPA in the development of this final interim approval. The docket is available for public inspection at the location listed under the **ADDRESSES** section of this document.

B. Executive Order 12866

The Office of Management and Budget has exempted this action from Executive Order 12866 review.

C. Regulatory Flexibility Act

EPA's actions under section 502 of the Act do not create any new requirements, but simply address operating permits programs submitted to satisfy the requirements of 40 CFR part 70. Because this proposed action does not impose

any new requirements, it does not have a significant impact on a substantial number of small entities.

D. Unfunded Mandates

Under section 202 of the Unfunded Mandates Reform Act of 1995, signed into law on March 22, 1995, EPA must prepare a budgetary impact statement to accompany any proposed or final rule that includes a Federal mandate that may result in estimated costs to State, local, or tribal governments in the aggregate; or to the private sector, of \$100 million or more. Under section 205, EPA must select the most cost-effective and least burdensome alternative that achieves the objectives of the rule and is consistent with statutory requirements. Section 203 requires EPA to establish a plan for informing and advising any small governments that may be significantly or uniquely impacted by the rule.

EPA has determined that the action proposed today does not include a Federal mandate that may result in estimated costs of \$100 million or more to either State, local, or tribal governments in the aggregate, or to the private sector. This Federal action approves pre-existing requirements under State or local law, and imposes no new Federal requirements. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, result from this action.

List of Subjects in 40 CFR Part 70

Environmental protection, Administrative practice and procedure, Air pollution control, Intergovernmental relations, Operating permits, Reporting and recordkeeping requirements.

Authority: 42 U.S.C. sections 7401–7671q.

Final Interim Approval of the part 70 operating permits program for the Washington Department of Ecology, the Washington Energy Facility Site Evaluation Council, the Benton County Clean Air Authority, the Northwest Air Pollution Authority, the Olympic Air Pollution Control Authority, the Puget Sound Air Pollution Control Agency, the Spokane County Air Pollution Control Authority, the Southwest Air Pollution Control Authority, and the Yakima County Clean Air Authority.

Dated: November 15, 1995.

Chuck Clarke,
Regional Administrator.

PART 70—[AMENDED]

Part 70, chapter I, title 40 of the Code of Federal Regulations is amended as follows:

1. The authority citation for part 70 continues to read as follows:

Authority: 42 U.S.C. 7401, *et seq.*

2. Part 70 is amended by revising the Washington paragraph of Appendix A as follows:

Appendix A—Approval Status of State and Local Operating Permits Programs

* * * * *

Washington

(a) Department of Ecology (Ecology): submitted on November 1, 1993; effective on December 9, 1994; interim approval expires December 9, 1996.

(b) Energy Facility Site Evaluation Council (EFSEC): submitted on November 1, 1993;

effective on December 9, 1994; interim approval expires December 9, 1996.

(c) Benton County Clean Air Authority (BCCAA): submitted on November 1, 1993 and amended on September 29, 1994 and April 12, 1995; effective on December 9, 1994; interim approval expires December 9, 1996.

(d) Northwest Air Pollution Authority (NWAPA): submitted on November 1, 1993; effective on December 9, 1994; interim approval expires December 9, 1996.

(e) Olympic Air Pollution Control Authority (OAPCA): submitted on November 1, 1993; effective on December 9, 1994; interim approval expires December 9, 1996.

(f) Puget Sound Air Pollution Control Agency (PSAPCA): submitted on November 1, 1993; effective on December 9, 1994; interim approval expires December 9, 1996.

(g) Southwest Air Pollution Control Authority (SWAPCA): submitted on November 1, 1993; effective on December 9, 1994; interim approval expires December 9, 1996.

(h) Spokane County Air Pollution Control Authority (SCAPCA): submitted on November 1, 1993; effective on December 9, 1994; interim approval expires December 9, 1996.

(i) Yakima County Clean Air Authority (YCCAA): submitted on November 1, 1993 and amended on September 29, 1994; effective on December 9, 1994; interim approval expires December 9, 1996.

* * * * *

[FR Doc. 95-29994 Filed 12-7-95; 8:45 am]

BILLING CODE 6560-50-P

Proposed Rules

Federal Register

Vol. 60, No. 236

Friday, December 8, 1995

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF AGRICULTURE

Food and Consumer Service

7 CFR Part 250

RIN 0584-AB55

Food Assistance in Disaster and Distress Situations

AGENCY: Food and Consumer Service, USDA.

ACTION: Proposed rule.

SUMMARY: This rule proposes to amend the provisions of the Food Distribution Program Regulations that relate to food assistance provided in response to Presidentially declared disasters and emergencies and in other situations of distress. The proposals contained in this rule address: (1) Simultaneous issuance of commodities and food stamps in a disaster; (2) distribution of commodities to households in situations of distress; (3) authorization for providing commodity assistance; (4) reporting requirements; and (5) the replacement of commodities. In addition, revised definitions are being proposed which encompass the definitions contained in the Robert T. Stafford Disaster Relief and Emergency Assistance Act. These revisions will help ensure that commodity assistance is made available to victims of disasters and to those in situations of distress in the most efficient and effective manner possible while maintaining the integrity of the program.

DATES: To be assured of consideration, comments must be postmarked on or before February 6, 1996.

ADDRESSES: Comments should be sent to: Lillie Ragan, Section Head, Household Programs Section, Policy and Program Development Branch, Food Distribution Division, Food and

Consumer Service, U.S. Department of Agriculture, Park Office Center, Room 502, 3101 Park Center Drive, Alexandria, Virginia 22302-1594.

Comments in response to this rule may be inspected at 3101 Park Center Drive, Room 502, Alexandria, Virginia, during normal business hours (8:30 a.m. to 5 p.m.), Monday through Friday.

FOR FURTHER INFORMATION CONTACT:

Lillie Ragan at the above address or telephone (703) 305-2661.

SUPPLEMENTARY INFORMATION:

Executive Order 12866

This proposed rule has been determined to be not significant for purposes of Executive Order 12866, and, therefore, has not been reviewed by the Office of Management and Budget.

Regulatory Flexibility Act

This action has been reviewed with regard to the requirements of the Regulatory Flexibility Act (5 U.S.C. 601-612). The Administrator of the Food and Consumer Service (FCS) has certified that this action will not have a significant economic impact on a substantial number of small entities. The primary impact of the procedures in this rulemaking would be on FCS Regional Offices, State governments and individuals who might apply for disaster or distress commodity benefits. To the extent that county or other local governments assist in the distribution of commodities at a disaster or distress feeding site, they would also be affected.

Executive Order 12372

These programs are listed in the Catalog of Federal Domestic Assistance under 10.550 and are subject to the provisions of Executive Order 12372, which requires intergovernmental consultation with State and local officials (7 CFR part 3015, Subpart V and final rule-related notices published at 48 FR 29114, June 24, 1983 and 49 FR 22676, May 31, 1984).

Information Collection

This proposed rule contains information collection requirements which are subject to review and

approval by the Office of Management and Budget (OMB). As required by section 3504(h) of the Paperwork Reduction Act of 1980 (44 U.S.C. 3504(h)), FCS has submitted a copy of this proposed rule to OMB for review of these information collection requirements. The title, description, and respondent description of the information collections are shown below with an estimate of the annual reporting and recordkeeping burdens.

Title: Commodity Assistance to Households in Disasters and Situations of Distress.

Description: In instances when the Food Stamp Program is in operation and commodities are being made available for distribution to households, this proposed rule increases the reporting and recordkeeping burden by requiring the collection of the following minimal information from each household receiving commodities during Presidentially declared disasters and other situations of distress: (1) name of one household member; (2) address; (3) number of persons in the household; and (4) a signed statement of assurance that the household is not receiving food stamp benefits. Such information is necessary in that it can be used by local organizations involved in the distribution of commodities to determine if a household is receiving food stamp benefits, thus significantly reducing the possibility of both food stamp and commodity assistance being provided to households simultaneously.

The reporting and recordkeeping requirements identified below have been submitted to OMB for approval and are not effective until such approval is obtained. The new information collection requirements will not become effective until OMB has assigned a control number. Current reporting and recordkeeping requirements for disaster assistance were approved under Control Number 0584-0037.

Description of Respondents: Relief organizations, households receiving commodities for home consumption in Presidentially declared disasters and other situations of distress when the situation warrants.

FOOD ASSISTANCE IN DISASTER AND DISTRESS SITUATIONS DESCRIPTION OF RESPONDENT'S ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

Section 7 CFR part	Annual Number respondents	Annual frequency response	Average burden per hours	Annual burden
7 CFR 250.43:				
Previous	0	0	0	0
Proposed	1000	1	.020	20
7 CFR 250.44:				
Previous	0	0	0	0
Proposed	1000	1	.020	20

Total Previous Burden Hours: 0; Total Proposed Burden Hours: 66; Total Difference: +66.

Executive Order 12778

This proposed rule has been reviewed under Executive Order 12778, Civil Justice Reform. This rule is intended to have preemptive effect with respect to any State or local laws, regulations or policies which conflict with its provisions or which would otherwise impede its full implementation. This rule is not intended to have retroactive effect unless so specified in the "Effective Date" section of the preamble of the final rule. All available administrative procedures must be exhausted prior to any judicial challenge to the provisions of this rule or the application of its provisions.

Background

On October 13, 1994, the President signed the Federal Crop Insurance Reform and Department of Agriculture Reorganization Act of 1994, Pub. L. 103-354. One of the provisions of the Act eliminated the Food and Nutrition Service (FNS) and replaced it with the Food and Consumer Service (FCS). Therefore, references to FNS throughout this proposed rule have been changed to FCS. References to FNS in the remainder of 7 CFR Part 250 will be changed through rulemaking at a later date.

The Department makes commodities available for use in providing food assistance to victims of disasters and emergencies, and to those in situations of distress, in accordance with authority contained in several statutes. Donated commodities are made available for use in providing food assistance to victims of Presidentially declared disasters and emergencies in accordance with the provisions contained in sections 412 and 413 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (DREAA). DREAA was formerly known as "The Disaster Relief Act of 1974." It was amended and its title changed to DREAA by Public Law 100-707 (November 23, 1988), the Disaster Relief and Emergency Assistance Amendments of 1988.

Donated commodities are made available for use in non-Presidentially declared emergencies (i.e., situations of distress) in accordance with section 32 of the Act of August 24, 1935, section 416 of the Agricultural Act of 1949, and section 4(a) of the Agriculture and Consumer Protection Act of 1973.

The regulations governing the Food Distribution Program (7 CFR Part 250) outline the responsibilities of FCS and distributing agencies with regard to the distribution of donated commodities during a disaster or emergency, and in situations of distress.

As discussed in detail below, some proposals contained in this proposed rule reflect amendments which have been made to the authorizing legislation. This proposed rule also includes regulatory changes recommended by the Task Force for Disaster Preparedness established by the Department of Agriculture (USDA or Department) in response to issues which arose in the course of providing food assistance to victims of several disasters and other types of emergencies in the past several years. The Task Force was comprised of representatives from USDA, the Federal Emergency Management Agency (FEMA), private national organizations such as the Red Cross, and State and local agencies. One of the objectives of the Task Force was to identify current Federal disaster policies that are in need of revision. Regulatory amendments embodying Task Force recommendations are proposed in this rule under the discretionary authority granted to the Secretary by section 32 of the Act of August 24, 1935, section 416 of the Agricultural Act of 1949, and the DREAA. The discretionary changes are part of the Department's effort to ensure that commodity assistance is made available to victims of disasters, emergencies and situations of distress in the most efficient and effective manner possible while maintaining the integrity of the program.

Definitions

Section 250.3 of the current regulations contains definitions of "Emergency" and "Major Disaster" derived from the Disaster Relief Act of 1974 (now "DREAA"). Pub. L. 100-707 amended the Disaster Relief Act of 1974 to revise these definitions.

The DREAA defines "Emergency" as "any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States."

A "Major Disaster" is defined under the DREAA as "any natural catastrophe (including any hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under the DREAA to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby."

The majority of the general public is not familiar with the specific terms contained in the DREAA (i.e. "Emergency" and "Major Disaster"). Furthermore, this rulemaking establishes no distinctions between the situations these terms represent regarding types of benefits or procedures for authorizing, utilizing, reporting on utilization of, or replacing commodities. Therefore, this rule proposes to: (1) add to Section 250.3 the term "Disaster," which would incorporate the definitions of "Emergency" and "Major Disaster" contained in the DREAA; and (2) delete the terms "Emergency" and "Major

Disaster” currently contained in Section 250.3. These proposed revisions would not impact on program operations or benefits in any way.

The key distinction between disasters and situations of distress with regard to food assistance is whether a Presidential declaration is made. However, there is no definition of “Situation of Distress” under Section 250.3 of the current regulations to make this distinction immediately clear.

Therefore, this rule also proposes to amend Section 250.3 to add a definition for “Situation of Distress.” Under this proposal, a “Situation of Distress” is defined as “(1) a hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, drought, fire, explosion, or other natural catastrophe not declared by the President to be an emergency or disaster, but which, in the judgment of a State distributing agency, warrants the use of USDA commodities for congregate feeding; and (2) any other situation not declared by the President to be an emergency or disaster, but which, in the judgment of FCS, warrants the use of USDA commodities for congregate feeding or household distribution.” This proposed definition will: (1) clarify that a situation of distress lacks a Presidential declaration; and (2) clearly identify those situations in which State distributing agencies can independently initiate USDA commodity assistance, on the one hand, and those in which prior approval by FCS is required.

Reference to the Disaster Relief Act of 1974

The Disaster Relief Act of 1974 is referenced in Sections 250.43(a) and 250.43(e) of the current regulations. Following publication of the regulations, the Disaster Relief Act of 1974 was amended and renamed the DREAA. Therefore, this rule proposes to amend Section 250.43(e) to remove the outdated reference and replace it with a reference to the DREAA, and proposes to remove all reference to any statutory authority in Section 250.43(a) since such reference is unnecessary.

Distribution of Commodities to Households in Presidentially Declared Disaster Areas

This section of the preamble addresses “disasters,” the proposed definition for which encompasses only situations in which a Presidential declaration has been issued. “Situations of distress,” proposed to be defined as situations lacking a Presidential

declaration, are discussed later in this preamble.

On August 19, 1985, an overall revision of Part 250 was published as a proposed rule in the Federal Register (50 FR 33470). Section 250.43 of the proposed rule limited the distribution of commodities to households residing in areas served by the Food Stamp Program to those instances in which commercial channels of trade have been disrupted due to a major disaster or emergency.

Approval of requests to make commodities available for distribution to households was made contingent upon commercial channels of trade having been disrupted because it is in these circumstances that households would have no way of using food stamps. Thus, such a contingency would ensure that commodity and food stamp assistance would not be provided in any area simultaneously, thereby eliminating any possibility of households receiving dual benefits.

In general, commenters on the proposed rule of August 1985 opposed limiting the distribution of commodities to households in this manner. However, the interim rule published in the Federal Register on June 3, 1988, (53 FR 20416) retained the provision as proposed on the premise that in instances in which commercial channels of trade are intact, nutritional needs of disaster victims can be met through the Food Stamp Program.

Since implementation of the interim rule, several disasters have occurred in response to which the Department provided food assistance. This experience, and recommendations of the Task Force for Disaster Preparedness, have led the Department to reevaluate the current regulatory provisions. While the Department still believes that the Food Stamp Program should be the primary food assistance program for disaster victims whenever commercial channels of trade are intact, it also acknowledges that there are instances in which such facilities remain in operation yet are inaccessible to some disaster victims. For example, where roads have been heavily damaged or flooded, some individuals residing in households in that area may not be able to reach food stamp certification offices or local grocery stores. They may, however, have access to emergency commodity distribution sites strategically located in response to the specific situation.

Therefore, in accordance with the discretionary authority provided under the DREAA, to facilitate reasonable access to food assistance for all disaster victims, this rule proposes to amend Section 250.43 of the current regulations

to establish FCS’s authority to permit distribution of commodities to households regardless of whether commercial channels of trade have been disrupted or the Food Stamp Program is in operation in instances in which such distributions are warranted. However, the Department believes that most disaster situations will not warrant the simultaneous operation of the Food Stamp Program and a household commodity distribution program in the same area.

Submission of Requests

Section 250.43(c) of the current regulations requires that distributing agencies submit requests to the appropriate FCS Regional Office (FCSRO) for approval prior to making commodities available for distribution to households. However, the process for approving such requests has not been clearly understood.

While the regulations require submission of such requests to the appropriate FCSRO, the requests are forwarded to FCS Headquarters for actual approval. In an effort to eliminate any confusion regarding the approval process, this rule proposes to revise Section 250.43(c) to require that requests be submitted to the FCSRO for forwarding to FCS for approval. Since the FCSRO is typically very close to or on the scene of a disaster, the FCSRO will be expected to submit a recommendation to FCS along with the application for use in making appropriate determinations. In addition, this rule proposes to revise this section to clarify the information currently required to be submitted as part of such requests.

This rule also proposes to apply information requirements established under current rules for approval to make household distributions in situations when commercial channels of trade have been disrupted to situations in which commercial channels are intact. The proposal would also establish additional requirements in both types of situations. In addition to the information distributing agencies are currently required to submit when requesting approval for the distribution of commodities to households, requests would be required to include, at a minimum, the following information: (1) An explanation as to why the distribution of commodities to households is warranted; (2) identification of the specific area(s) included in the request; (3) a statement of assurance that simultaneous food stamp and commodity assistance will not be provided to individual households; and (4) a description of the

system that will be implemented to prevent dual participation.

Submission of such information is necessary in order for FCS to determine if the situation warrants the simultaneous distribution of food stamps and commodities and to ensure that the State has a viable system to prevent dual benefits from being provided to households.

Collection of Household Information

While various forms have been developed by States for use in collecting household data, current regulations contain no provisions concerning the collection of information from households for the receipt of donated foods during a disaster. Under the provisions contained in this proposed rule, food stamp benefits can be issued and commodities distributed for home consumption in areas where it has been determined by the Department that the situation warrants such simultaneous operations. However, the Department is concerned that in such instances food stamp benefits and commodities may be provided to the same household simultaneously. In an effort to ensure that information necessary to prevent the issuance of dual benefits and for establishing and pursuing claims action is available, this rule proposes to amend section 250.43(c) to require that organizations distributing donated foods to households in areas where the Food Stamp Program is in operation obtain, at a minimum, the name of the household member applying for assistance, number of members in the household, and the household's address. Such information must be recorded in whatever format the State deems appropriate.

In addition to providing the above information, organizations distributing donated foods to households would be required to obtain a signed statement of assurance from the adult member of the household applying for benefits to the effect that the household: (1) Is in need of food assistance as a result of the disaster; (2) understands that misrepresentation of need and the sale or exchange of the donated food are prohibited and could result in a fine, imprisonment, or both; (3) is not residing in a shelter which provides food assistance; and (4) is not receiving food stamp assistance. While the intent of this signed statement is to prevent applicants from receiving duplicative food assistance benefits, it should be reasonably interpreted in the context of the individual case. For example, a household which applies for commodity assistance en route from a shelter where food assistance was provided to reoccupy its permanent residence

should not be considered to be "residing in a shelter." The signing of such statements will ensure that households understand the conditions under which the food assistance is being provided. Such statements will also provide further support for pursuing a claim against a household in instances in which both food stamp and commodity assistance were provided. Under the proposal, all signed statements must be provided to the distributing agency unless the organization distributing the commodities is an agency of the State. At the discretion of the distributing agency, non-State agencies may be assigned responsibility of retaining such statements rather than forwarding them to the State.

In instances when it is determined that claims action against a household is warranted due to the receipt of both food stamp and commodity assistance, the Department intends to pursue such action through establishment of a claim against the household for the value of the food stamps issued. This course of action is preferred since the recordkeeping requirements that would have to be imposed on a disaster organization to ensure availability of information necessary to establish a claim for the value of commodities would be significant, while recording the value of the food stamp benefit provided is already required and much less time consuming.

There have been instances in past years in which other Federal agencies have been involved in providing food assistance to disaster victims with USDA commodities. Questions were raised as to whether these agencies were subject to the requirements set forth for disaster situations. In instances in which it has been determined that the collection of certain information is necessary and the regulations contain information collection requirements, all organizations, regardless of the type, must comply with the requirements. This proposed rule will clarify that any entity, including Federal, State, and local agencies, involved in the distribution of USDA commodities must comply with all such regulatory requirements. In addition, this proposed rule will clarify that State and Federal agencies can act as a disaster organization in providing food assistance during disasters and situations of distress.

Replacement of Commodities

Section 250.43(g) of the current regulations states that USDA commodities used from the State's inventory for a major disaster or

emergency will be replaced by FCS to the extent that foods are available.

Section 413(b) of the DREAA authorizes the use of funds under section 32 of the Act of August 24, 1935, to purchase food necessary to provide adequate supplies for use in a major disaster or emergency. This rule proposes to amend paragraph (g) of Section 250.43 to reflect the statutory authority. This change will guarantee that USDA commodities used by a State for disaster assistance are replaced, provided that a timely request is submitted by the distributing agency.

Use of Commodities in Situations of Distress

The primary difference between a disaster and a situation of distress, with regard to USDA food assistance, is that a situation of distress is not of a magnitude to warrant an emergency or disaster declaration by the President. This section of the preamble addresses only such situations of distress.

Section 250.44 of the current regulations permits, upon approval by the Secretary, the distribution of donated foods to organizations for use in preparing meals in situations in which the need for food assistance cannot be met through other provisions of Part 250 regulations. Prior to the overall revision of Part 250, which was published as an interim rule in the Federal Register on June 3, 1988, (53 FR 20416), the regulations also permitted the Department to authorize distribution of commodities to households in all such situations. In drafting the overall revision, the Department decided to delete those provisions relative to household distribution in situations of distress on the premise that food assistance to households can be provided through the Food Stamp Program.

Since implementation of the interim rule, the Department has determined that the Food Stamp Program may not be able to meet the nutritional needs of all affected households in situations of distress. For example, it may not be possible for some households to obtain food stamp benefits due to certain eligibility requirements, such as resource limits on the value of vehicles, or citizenship. In addition, there may be instances in which certain areas are hard hit by a non-Presidentially declared disaster (i.e., situation of distress) and using food stamps is not feasible because commercial channels of trade in those particular areas are disrupted.

Therefore, to ensure that food assistance can be made available to households in these types of situations,

this rule proposes to revise Section 250.44 to reinstate the Department's authority to permit the distribution of commodities to households in situations of distress. This discretionary authority is afforded the Secretary under section 416 of the Agricultural Act of 1949, and section 32 of the Act of August 24, 1935.

Section 250.44 is being revised instead of Section 250.43, which sets forth provisions relative to disasters, in order to clarify and underscore the different treatment of Presidentially declared "disasters," on the one hand, and "situations of distress," on the other.

Submission of Requests

Section 250.44 of the current regulations requires that all requests for the donation of commodities for use in situations of distress be submitted for approval by the Secretary.

This rule proposes to revise Section 250.44 to delegate the authority for approving requests for the donation of commodities for use in congregate feeding to the distributing agency in instances in which the need for such assistance meets the conditions of paragraph (1) of the definition of "Situation of Distress" set forth in Section 250.3. Those instances include "a hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, drought, fire, explosion, or other natural catastrophe not declared by the President to be an emergency or disaster." This delegation of authority is consistent with the delegation of authority contained in Section 250.43 for the use of commodities for congregate feeding in Presidentially declared disasters. While the Department recognizes that instances other than those included above may warrant the donation of commodities for use in preparing congregate meals, such donations should be limited to those situations where it can be determined that other traditional Federal or State assistance programs cannot meet the needs of individuals who have been adversely affected by the situation. Thus, in an effort to ensure consistency in such determinations, Section 250.44 of this rule proposes to require that requests for the donation of commodities for use in preparing congregate meals in instances when the situation of distress does not fit the above criteria be submitted for approval by FCS. Approval by FCS, instead of by the Secretary, will facilitate expeditious handling of requests, while still maintaining an appropriate level of oversight.

Section 250.44(c)(2) of this rule also proposes to require that requests for the donation of commodities for distribution to households in situations of distress, regardless of the type of situation, be submitted for approval by FCS. The proposal would require this level of approval in an effort to ensure that: (1) Such distributions are limited to situations that warrant this type of assistance; and (2) households will not be receiving food stamp and commodity assistance simultaneously.

As discussed in the Definitions section earlier in this preamble, for purposes of clarification, this rule also proposes to specify the above-described approval authorities for congregate feeding and household distribution, respectively, in the definition of "Situation of Distress" contained in Section 250.3.

This rule also proposes to amend Section 250.44 to require that organizations requesting the donation of commodities for use in congregate meal service for victims of situations of distress provide the following information to the distributing agency: (1) A description of the distress situation; (2) number of people requiring meals; (3) period of time for which the donations are being requested; and (4) quantity and types of food needed. In addition, information on the number and location of sites providing meals will be provided as sites are established.

It is imperative that this information be provided so that FCS and the distributing agency are able to determine if: (1) The donation of commodities is warranted; (2) the amount and types of commodities requested are appropriate for the situation; and (3) there is sufficient food in inventory within the State to meet the needs of the organizations. When the distributing agency has approved requests for the donation of commodities for congregate feeding in accordance with the delegation of authority prescribed above, it must forward this information to the appropriate FCSRO.

This rule proposes to revise Section 250.44 to require that requests to FCS for permission to distribute commodities to households contain, at a minimum, the following information: (1) A description of the situation; (2) an explanation as to why such distributions are warranted; (3) period of time for which the request is being made; (4) identification of the specific area(s) included in the request; (5) number of households expected to participate; (6) quantity and types of food needed; (7) a statement of

assurance that both food stamp and commodity assistance will not be provided to individual households simultaneously; and (8) a description of the system that will be implemented to prevent dual participation in the Food Stamp Program and the commodity household distribution program. In addition, information relative to the number and location of distribution sites must be provided to FCS as sites are established.

Collection of Household Information

Section 250.44 is also revised in this proposed rule to require that any entity, including Federal, State, and local agencies, involved in the distribution of USDA commodities comply with the requirements contained in Section 250.43(c) of this proposed rule regarding the collection and submission of information (i.e., household information, and statements of assurance). As with Presidentially declared disasters, this information will be used to ensure that such distributions are warranted and to enhance program accountability.

Submission of Form FNS-292

This rule proposes to incorporate in Section 250.44 a requirement that distributing agencies submit a summary report to the FCSRO using Form FNS-292, Report of Coupon Issuance and Commodity Distribution for Disaster Relief, within 30 days following termination of the distribution period. This requirement is being incorporated to ensure timely reporting, strengthen program accountability, and facilitate timely replacement of State inventories of USDA commodities in instances in which replacement commodities are available.

Thirty-Day Restriction

Section 250.44 of the current regulations limits the distribution of commodities in situations of distress to a period of 30 days. However, it is the opinion of the Department that some situations of distress may warrant a longer distribution period. Thus, this rule proposes to amend Section 250.44 to permit the distribution of commodities for longer periods of time when the situation warrants. In instances in which the distributing agency approves the distribution of commodities for use in preparing congregate meals, such approval may be granted for a period not to exceed 30 days. Should the distributing agency determine that the situation warrants a longer distribution period, the distributing agency must submit a request to justify an extension to FCS for

approval. These provisions will afford FCS increased flexibility in responding to situations of distress, and at the same time ensure that the use of USDA commodities in these situations is warranted.

In addition, this rule proposes to clarify in Section 250.44 that the determination as to the appropriate period of time for which commodities will be made available would be subject to revision as developing circumstances dictate. In instances when the distributing agency extends the distributions within the 30-day period discussed above, it must notify the FCSRO of such extensions. Submission of this information to the FCSRO is

necessary to facilitate accurate replacement of USDA commodities, as discussed below.

Replacement of Commodities

Section 250.44 of the current regulations does not contain provisions relative to the replacement of the USDA commodities that States use to provide assistance during a situation of distress. USDA has limited funding to purchase commodities for use in providing food assistance in situations of distress, and can also donate for this use commodities purchased under price-support and surplus removal authorities. Therefore, USDA commodities that are used from the

State's inventory for a situation of distress will be replaced at the request of the distributing agency to the extent that inventories of price-support and surplus-removal commodities permit. This rule proposes to amend Section 250.44 to include this replacement policy. In addition, to ensure timely submission of requests for replacement, this rule proposes to incorporate a requirement that such requests be submitted within 30 days following termination of the distributions.

The attached chart has been included in this preamble to assist readers in understanding the basic provisions set forth in this proposed rule.

	Disaster		Situation of distress	
Definition	(1) any natural catastrophe (including any hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, drought), or, regardless of cause, any fire, flood, or explosion, in any part of the U.S., which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under the DREAA to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby; or (2) any other occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the U.S.		(1) a hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, drought, fire, explosion, or other natural catastrophe not declared by the President to be an emergency or disaster, but which, in the judgment of the distributing agency, warrants the use of USDA commodities for congregate feeding; and (2) any other situation not declared by the President to be an emergency or disaster, but which, in the judgment of FCS, warrants the use of USDA commodities for congregate feeding or household distribution.	
Food assistance authorized	Congregate feeding	Household distribution	Congregate feeding	Household distribution
Approval authority	State distributing agency.	FCS HQ	If distress situation in accordance with (1) in above definition, State distributing agency; Otherwise, FCS HQ.	FCS HQ.
Applicable sections of regulations.	250.43(b)	250.43(c)	250.44(b)	250.44(c).
Household information required.	None	Name; Address; Number in Household; Assurance Statement re: need and dual participation in food stamps; Signature (in instances when the Food Stamp Program is in operation).	None	Name; Address; Number in Household; Assurance Statement re: need and dual participation in food stamps; Signature (in instances when the Food Stamp Program is in operation).
Replacement of USDA commodities.	Yes	Yes	To the extent available	To the extent available.

List of Subjects

7 CFR Part 250

Aged, Agricultural commodities, Business and industry, Food assistance programs, Food donations, Food processing, Grant programs-social programs, Indian, Infants and children, Price support programs, Reporting and recordkeeping requirements, School breakfast and lunch programs, Surplus agricultural commodities.

Accordingly, 7 CFR Part 250 is proposed to be amended as follows:

PART 250—DONATION OF FOODS FOR USE IN THE UNITED STATES, ITS TERRITORIES AND POSSESSIONS AND AREAS UNDER ITS JURISDICTION

1. The authority citation for Part 250 continues to read as follows:

Authority: 5 U.S.C. 301; 7 U.S.C. 612c, 612 note, 612c note, 1431, 1431b, 1431e, 1431 note, 1446a-1, 1859; 15 U.S.C. 713c; 22 U.S.C. 1922; 42 U.S.C. 1755, 1758, 1760, 1761, 1762a, 1766, 3030a, 5179, 5180.

2. In Section 250.3:

- The definitions of *Emergency* and *Major Disaster* are removed; and
- definitions of *Disaster* and *Situation of Distress* are added in alphabetical order.

The additions read as follows:

§ 250.3 Definitions.

* * * * *

Disaster means:

(a) any natural catastrophe (including any hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, drought), or, regardless of

cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under the Disaster Relief and Emergency Assistance Act to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby; or

(b) any other occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.

* * * *

Situation of Distress means:

(a) a hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, drought, fire, explosion, or other natural catastrophe not declared by the President to be an emergency or disaster, but which, in the judgment of the distributing agency, warrants the use of USDA commodities for congregate feeding; and

(b) any other situation not declared by the President to be an emergency or disaster, but which, in the judgment of FCS, warrants the use of USDA commodities for congregate feeding or household distribution.

* * * *

3. Section 250.43 is revised to read as follows:

§ 250.43 Disaster Food Assistance.

(a) *Organizational eligibility.* In instances in which the President has declared a disaster and FCS has determined that, as a result of the disaster, low-income households are unable to purchase adequate amounts of nutritious food, disaster organizations (including agencies of State and Federal government) may be eligible to receive donated foods for congregate meal service or household distribution to disaster victims. Applications submitted for the receipt and distribution of donated foods in accordance with paragraphs (b)(2) and (c)(2) of this section shall be initially submitted in writing if circumstances permit and, if not, confirmed in writing in a timely manner. Both the applications and the written approval for the use of USDA commodities shall be maintained in accordance with the recordkeeping requirements of this Part.

(b) *Congregate meal service.* (1) *Approval authority and duration.* Distributing agencies may review and approve applications submitted by disaster organizations for the donation of foods for use in preparing congregate meals for disaster victims. Distributing agencies also shall determine the length of such donations, taking into consideration the magnitude of the situation, and may extend the duration of such donations as developing circumstances dictate. Following approval of a request for donated foods, the distributing agency shall make appropriate donated foods available from any source within the State to the disaster organization(s) and within 24 hours of approving the application shall report the information listed in paragraph (b)(2) of this section to the appropriate FCSRO.

(2) *Applications.* Disaster organizations shall submit applications for the receipt and distribution of donated foods for use in providing congregate meal service to the distributing agency. Applications shall, to the extent possible, include the following information:

- (i) Description of disaster or emergency situation;
- (ii) Number of people requiring meals;
- (iii) Period of time for which commodities are requested; and
- (iv) Quantity and types of food needed for congregate meal service.

In addition, organizations shall report the number and location of sites providing congregate meal service as sites are established.

(c) *Household distribution.* (1) *Approval authority and duration.* Distributing agencies shall submit applications for the distribution of donated foods to households to the appropriate FCSRO for submission to FCS for approval. FCS will determine the length of time such donations will be made, taking into consideration the magnitude of the situation, and may extend the duration of such donations as developing circumstances dictate.

(2) *Applications.* Disaster organizations shall submit applications for the receipt and distribution of donated foods to households to the distributing agency. Applications shall, to the extent possible, include the following information:

- (i) Description of disaster or emergency situation;
- (ii) Identification of the specific area(s) included in the request;
- (iii) Number of households affected;
- (iv) Explanation as to why the distribution of commodities to households is warranted;
- (v) Anticipated distribution period;

- (vi) Method of distribution available;
- (vii) Quantity and types of food needed for distribution;
- (viii) Statement of assurance that simultaneous food stamp and commodity assistance will not be provided to individual households; and
- (ix) Description of the system that will be implemented to prevent dual participation.

Information on the number and location of sites where commodities are to be distributed shall be provided as sites are established.

(3) *Collection of household information.* In instances in which the Food Stamp Program is in operation, any entity (i.e. Federal, State, or local) distributing donated foods to households shall, at a minimum, collect the information listed below in a format prescribed by the distributing agency. Such information shall be forwarded to the distributing agency and maintained by the distributing agency in accordance with the recordkeeping requirements contained in this Part, *except* that such information may, at the discretion of the distributing agency, be maintained by the organization distributing commodities if such organization is an agency of the State government.

- (i) Name of household member applying for assistance;
- (ii) Address;
- (iii) Number of household members; and
- (iv) Statement signed by the household certifying that the household:
 - (A) is in need of food assistance;
 - (B) understands that misrepresentation of need, and the sale or exchange of the donated food are prohibited and could result in a fine, imprisonment, or both;
 - (C) is not residing in a shelter which provides food assistance; and
 - (D) is not receiving food stamp assistance.

(d) *Quantities and value of donated foods.* The distributing agency shall make donated foods available to eligible disaster organizations based on the caseload factor information provided by the disaster organizations.

(e) *Types of donated foods authorized for donation.* Disaster organizations providing food assistance under this Section are eligible to receive donated foods under section 416, section 32, section 709, section 4(a), and sections 412 and 413 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5181–82).

(f) *Summary report.* Within 30 days following termination of the disaster assistance, the distributing agency shall provide a summary report to the appropriate FCSRO using Form FNS–

292, Report of Coupon Issuance and Commodity Distribution for Disaster Relief.

(g) *Replacement.* The distributing agency shall request, in writing to the FCSRO, the replacement of foods used for disaster assistance within 30 days following termination of the assistance. FCS will replace donated foods used from State and/or local inventories for disaster assistance in instances when a request for replacement is submitted within the required 30 days or sufficient justification exists to waive the 30-day requirement.

4. Section 250.44 is revised to read as follows:

§ 250.44 Food Assistance in Situations of Distress.

(a) *Organizational eligibility.* In situations of distress in which needs for food assistance cannot be met under other provisions of this Part, organizations (including agencies of State and Federal government) may be eligible to receive donated foods for congregate meal service or household distribution to victims of the situation of distress. Applications submitted for the receipt and distribution of donated foods in accordance with paragraphs (b)(2) and (c)(2) of this section shall be initially submitted in writing if circumstances permit and, if not, confirmed in writing in a timely manner. Both the applications and the written approval for the use of USDA commodities shall be maintained in accordance with the recordkeeping requirements of this Part.

(b) *Congregate meal service.* (1) *Approval authority and duration.* Distributing agencies may review and approve applications for the donation of foods for use in preparing congregate meals for a period not to exceed 30 days for victims of situations of distress in instances in which the need for such assistance meets the conditions of paragraph (a) of the definition of *Situation of Distress* in Section 250.3. Following approval of a request, distributing agencies shall report the information listed in paragraph (b)(2) of this section to the appropriate FCSRO within 24 hours. In instances when the distributing agency extends the distribution period initially approved up to the 30-day limit, it shall notify the FCSRO of such extensions. Distributing agencies shall request approval from FCS, via the appropriate FCSRO, for donations to exceed 30 days. Applications for the donation of foods for congregate meals in instances other than those that meet the criteria in paragraph (a) of the definition of *Situation of Distress* in Section 250.3

shall be forwarded by the distributing agency to the appropriate FCSRO for submission to FCS for approval. FCS will determine the duration of such donations, taking into consideration the magnitude of the situation. Determinations as to the length of donations may be revised as developing circumstances dictate.

(2) *Applications.* (i) Organizations shall submit applications for the receipt and distribution of donated foods for use in providing congregate meal service to the distributing agency. Applications shall, to the extent possible, include the following information:

(A) Description of the situation of distress;

(B) Number of people requiring meals and congregate meal service period; and

(C) Quantity and types of food needed.

(ii) In addition, information on the number and location of sites providing meals shall be submitted as sites are established.

(c) *Household distribution.* (1) *Approval authority and duration.* Applications for the donation of foods for distribution to households shall be forwarded by the distributing agency to the appropriate FCSRO for submission to FCS for approval. FCS will determine the duration of the donations, taking into consideration the magnitude of the situation. Such determinations may be revised as developing circumstances dictate.

(2) *Applications.* Organizations shall submit applications for the receipt and distribution of donated foods to households to the distributing agency. The distributing agency shall review and submit applications to the appropriate FCSRO. Applications shall, to the extent possible, include the following information:

(i) Description of the situation of distress;

(ii) Explanation as to why the distribution of commodities to households is warranted;

(iii) Identification of the specific area(s) included in the request;

(iv) Anticipated distribution period;

(v) Number of households expected to participate;

(vi) Quantity and types of food needed for distribution;

(vii) Statement of assurance that simultaneous food stamp and commodity assistance will not be provided to individual households; and

(viii) Description of the system that will be implemented to prevent dual participation.

In addition, information on the number and location of sites shall be provided as sites are established.

(3) *Collection of household information.* In a format prescribed by the distributing agency, any entity (i.e. Federal, State, or local) distributing donated foods to households in an area where the Food Stamp Program is in operation shall, at a minimum, collect the information listed below. Such information shall be forwarded to the distributing agency and maintained by the distributing agency in accordance with the recordkeeping requirements contained in this Part, *except* that such information may, at the discretion of the distributing agency, be maintained by the organization distributing commodities if such organization is an agency of the State government.

(i) Name of household member applying for assistance;

(ii) Address;

(iii) Number of household members; and

(iv) Statement signed by the household certifying that the household:

(A) is in need of food assistance;

(B) understands that misrepresentation of need, and the sale or exchange of the donated food are prohibited and could result in a fine, imprisonment, or both;

(C) is not residing in a shelter which provides food assistance; and

(D) is not receiving food stamp assistance.

(d) *Quantities and value of donated foods.* The distributing agency shall make donated foods available to eligible organizations based on the caseload factor information provided by the organizations.

(e) *Types of donated foods authorized for donation.* Organizations providing food assistance in situations of distress are eligible to receive donated foods under section 416, section 32, section 709, and section 4(a).

(f) *Summary report.* Within 30 days following termination of the assistance, the distributing agency shall provide a summary report to the appropriate FCSRO using Form FNS-292, Report of Coupon Issuance and Commodity Distribution for Disaster Relief.

(g) *Replacement.* The distributing agency shall request, in writing to the FCSRO, the replacement of foods used for a situation of distress within 30 days following termination of the assistance. FCS will replace donated foods used from State and/or local inventories for situations of distress to the extent that foods are available.

Dated: November 28, 1995.

William E. Ludwig,
Administrator.

[FR Doc. 95-29923 Filed 12-7-95; 8:45 am]

BILLING CODE 3410-30-U

DEPARTMENT OF TRANSPORTATION**Federal Aviation Administration****14 CFR Part 71****[Airspace Docket No. 95-AEA-12]****Proposed Establishment of Class E2 Airspace; Lewisburg, WV****AGENCY:** Federal Aviation Administration (FAA), DOT.**ACTION:** Notice of proposed rulemaking.

SUMMARY: This proposed rule would establish Class E2 airspace designated as a surface area for Greenbrier Valley Airport, Lewisburg, West Virginia. The airport has a VOR or GPS-A (circling) Standard Instrument Approach Procedure (SIAP), an NDB or GPS RWY 4 SIAP and an ILS RWY 4 SIAP. Class E2 airspace would be established to accommodate these SIAPs and for instrument flight rules (IFR) operations at this airport.

DATES: Comments must be received on or before January 29, 1996.

ADDRESSES: Send comments on the rule in triplicate to: Manager, System Management Branch, AEA-530, Docket No. 95-AEA-12, F.A.A. Eastern Region, Federal Building # 111, John F. Kennedy International Airport, Jamaica, NY 11430.

The official docket may be examined in the Office of the Assistant Chief Counsel, AEA-7, F.A.A. Eastern Region, Federal Building # 111, John F. Kennedy International Airport, Jamaica, NY 11430. An informal docket may also be examined during normal business hours in the System Management Branch, AEA-530, F.A.A. Eastern Region, Federal Building # 111, John F. Kennedy International Airport, Jamaica, NY 11430.

FOR FURTHER INFORMATION CONTACT: Mr Francis T. Jordan, Jr., Airspace Specialist, System Management Branch, AEA-530, F.A.A. Eastern Region, Federal Building # 111, John F. Kennedy International Airport, Jamaica, NY 11430; telephone: (718) 553-4521.

SUPPLEMENTARY INFORMATION:**Comments Invited**

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specially invited on the overall regulatory, aeronautical, environmental,

and energy-related aspects of the proposal. Communications should identify the airspace docket number and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: "Comments to Airspace Docket No. 95-AEA-12". The postcard will be date/time stamped and returned to the commenter.

All communications received before the specified closing date for comments will be considered before taking action on the rule. The rule contained in this notice may be changed in the light of comments received. All comments received will be available for examination in the Rules Docket both before and after the closing date for comments. A report summarizing each substantive public contact with the FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRMs

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Office of the Assistant Chief Counsel, AEA-7, F.A.A. Eastern Region, Federal Building # 111, John F. Kennedy International Airport, Jamaica, NY 11430. Identify the notice number of this NPRM. Persons interested in being placed on a mailing list for future NPRMs should also request a copy of Advisory Circular No. 11-2A, which describes the application procedure.

The Proposal

The FAA is considering amending part 71 of the Federal Aviation Regulations (14 CFR part 71) by establishing Class E2 airspace, designated as a surface area for an airport, at Lewisburg, WV, to accommodate current SIAPs and for IFR operations at the Greenbrier Valley Airport.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Class E2 airspace areas designated as a surface area for an airport are published in Paragraph 6002 of FAA Order 7400.9C, dated August 17, 1995 and effective September 16, 1995. The Class E airspace designation listed in this document would be published subsequently in the Order. It therefore—(1) is not a "significant regulatory action" under Executive Order 12866;

(2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this proposed rule would not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—[AMENDED]

1. The authority citation for part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR 1959-1963 Comp., p. 389; 14 CFR 11.69.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9C, Airspace Designations and Reporting Points, dated August 17, 1995 and effective September 16, 1995, is amended as follows:

Paragraph 6002 Class E airspace areas designated as a surface area for an airport.

* * * * *

AEA WV E2 Lewisburg, WV [New]

Greenbrier Valley Airport, WV
(lat. 37°51'30" N, long. 80°23'58" W)
Bushy NDB (LOM)
(lat. 37°46'56" N., long. 80°28'06" W)

Within a 4-mile radius of Greenbrier Valley Airport. This Class E area is effective during the specific dates and times established in advance by a Notice To Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

* * * * *

Issued in Jamaica, New York, on November 30, 1995.

John S. Walker,
Manager, Air Traffic Division.

[FR Doc. 95-29965 Filed 12-7-95; 8:45 am]

BILLING CODE 4910-13-M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of the Assistant Secretary for Housing—Federal Housing Commissioner

24 CFR Part 3500

[Docket No. FR-3780-N-03]

RIN 2502-AG40

Mortgage Broker Fee Disclosure Rule: Notice of Establishment of Negotiated Rulemaking Advisory Committee and of First Meeting

AGENCY: Office of the Assistant Secretary for Housing—Federal Housing Commissioner, HUD.

ACTION: Notice of establishment of a negotiated rulemaking advisory committee and of first meeting.

SUMMARY: The Department is announcing the establishment of a Negotiated Rulemaking Advisory Committee under the Federal Advisory Committee Act (FACA). The first objective of the committee would be to determine whether or not the amount and nature of indirect payments to mortgage brokers and certain other mortgage originators (retail lenders) should be disclosed to consumers. Second, the committee will seek to resolve whether the Real Estate Settlement Procedures Act (RESPA) permits volume-based compensation from wholesale lenders, entities that purchase mortgage loans, to mortgage brokers and, if such compensation is found permissible, whether and how the compensation should be disclosed. The committee consists of representatives with a definable stake in the outcome of a proposed rule. A charter for the committee has been approved pursuant to the FACA, Executive Order 12838, and the implementing regulations. This notice also announces the time and place of the first committee meeting, which will be open to the public.

DATES: The first meeting of the committee will take place December 13–14, 1995, and will be open to the public. On Wednesday, December 13, the meeting will start at 9:30 a.m. and run until completion; on Thursday, December 14, the meeting will start at 9:00 a.m. and run until approximately 1:00 p.m. If participants and the facilitator agree, the second day of the meeting may be extended beyond the projected completion time of 1:00 p.m.

ADDRESSES: The first meeting of the committee will be held in Courtroom A of the International Trade Commission

Building, 500 E Street, SW., Washington, DC 20436.

FOR FURTHER INFORMATION CONTACT:

David R. Williamson, Director, RESPA Enforcement Unit, Department of Housing and Urban Development, Room 5241, 451 Seventh Street, SW., Washington, DC 20410–0500; telephone (202) 708–4560, or on e-mail through Internet at drwilliamson@hud.gov. The TDD number for persons who are hearing- or speech-impaired is (202) 708–4594 (TDD). (These telephone numbers are not toll-free.)

SUPPLEMENTARY INFORMATION:

Background

On October 25, 1995 (60 FR 54794), HUD published a notice of intent to establish a Negotiated Rulemaking Advisory Committee to discuss and negotiate a proposed rule to discuss the treatment under RESPA, including disclosure requirements, of indirect payments to retail lenders and of volume-based compensation to mortgage brokers. The October 25 notice also announced that the first meeting of the committee could be held in late 1995, if the charter for the committee was approved. Subsequent to the publication of the October 25 notice, the charter for the committee was approved pursuant to the FACA, Executive Order 12838, and the implementing regulations at 41 CFR 101–6.1007. Because the Department noted the tentative schedule for the first meeting in the October 25 notice and wants to commence the negotiating process quickly, the first meeting has been scheduled for December 13–14, 1995. Members of the committee have been contacted directly by the Department about this schedule.

The October 25 notice requested comment concerning the proposed membership of the Committee. After review of the comments and for the reasons stated in the notice of intent, the Department has determined that establishing a negotiated rulemaking advisory committee on this subject is necessary and in the public interest.

The Department received eight comments on the October 25 notice. Six of the eight commenters requested that a member of their organization be included in the negotiating committee.

Specifically, four commenters suggested that lenders who concentrate on other mortgage products, such as home equity loans, B and C loans, and reverse mortgages, should be included. These commenters were the American Financial Services Association, the National Home Equity Mortgage Association, the Title One Home

Improvement Lenders Association, and Transamerica HomeFirst, a reverse mortgage lender. In order to keep the negotiated rulemaking body manageable and balanced, the Department concluded that with the addition of the American Financial Services Association, the most diverse of these organizations, the interests of junior lien and reverse mortgage lenders would be adequately represented. Moreover, the American Financial Services Association has indicated that it would itself consult with other affected organizations.

Two additional national industry groups requested membership. HUD has determined that these organizations should be added to the committee because they represented types of lending institutions that are not already adequately represented on the committee: the Independent Bankers Association of America represents community banks and the National Association of Federal Credit Unions represents Federal credit unions.

All those who expressed interest in participating in the negotiated rulemaking committee are reminded that meetings of the committee are open to the public.

Facilitator

As stated in the October 25 notice, the Honorable Alan W. Heifetz, Chief Administrative Law Judge, will be the facilitator for the Committee.

Substantive Issues for Negotiation

The issues identified in the convening report were identified and discussed in the October 25 notice and in a proposed rule on this same subject recently published by the Department (60 FR 47650, September 13, 1995). The Department received approximately 800 comments on the proposed rule; these comments are available for public inspection and copying between 7:30 a.m. and 5:30 p.m. weekdays at the Rules Docket Clerk, Office of General Counsel, Room 10276, Department of Housing and Urban Development, 451 Seventh Street SW., Washington, DC 20410. The comments also will be made available to the members of the committee for their consideration as they are negotiating a new proposed rule.

Committee Membership

Including the members added in response to comments received on the October 25 notice, the members of the committee will include:

National Industry Groups

- Paul Reid, President, American Home Funding, Richmond, VA, President-Elect, Mortgage Bankers Association of America, 1125 15th Street, NW., Washington, DC 20005-2766
- Kay Kinney, Executive Vice President, National Association of Mortgage Brokers, 1735 N. Lynn Street, Suite 950, Arlington, VA 22209
- John Rasmus, Esq., Senior Federal Administrative Counsel/Manager, Agency Relations, American Bankers Association, 1120 Connecticut Avenue, NW., Washington, DC 20036
- Glen Gimble, Esq., Program Manager and Counsel, Real Estate Lending Compliance, America's Community Bankers, 900 19th Street, NW., Washington, DC 20006
- Roy DeLoach, Policy Representative, Business Issues, National Association of Realtors, 700 11th Street, NW., Washington, DC 20001-4507
- Sue Johnson, President and Executive Director, RESPRO, 1800 M Street, NW., Suite 900 South, Washington, DC 20036
- David Goldberg, The Mortgage Capitol Group, Senior Vice President, Administration, PHH Mortgage Services Corporation, 6000 Atrium Way, Mt. Laurel, NJ 08054
- Thomas J. Sheehan, Chairman, IBAA Bank Operations Committee, Independent Bankers Association of America, One Thomas Circle, NW., Suite 950, Washington, DC 20005-5802
- Brian McDonnell, Senior Executive Vice-President, of Navy Federal Credit Union, National Association of Federal Credit Unions, P.O. Box 3769, Washington, DC 20007
- Robert E. McKew, Vice President and General Counsel, American Financial Services Association, 919 18th Street, NW., Washington, DC 20006

Consumer Groups

- Robert Creamer, Citizen Action, 68 East Wacker Place, Chicago, IL 60601
- William J. Brennan, Jr., Esq., (Member, Board of Directors, National Association of Consumer Advocates), Home Defense Program of the Atlanta Legal Aid Society, 340 West Ponce De Leon Avenue, Decatur, Georgia 30030
- Nina Simon, Esq., Jean Davis, Esq., Legal Counsel for the Elderly, American Association of Retired Persons, 601 E Street, N.W., Washington, D.C. 20049

State Organizations

- Craig Jordan, Esq., Assistant Attorney General for the State of Texas, Consumer Affairs Division, 714

Jackson Street, Suite 800, Dallas, Texas 75202

- Daniel Muccia, President, American Association of Residential Mortgage Regulators and Deputy Superintendent of Banks, State of New York Banking Department, Two Rector Street, New York, New York 10006

Government-Sponsored Enterprises

- Jim Newell, Esq., Associate General Counsel, Federal Home Loan Mortgage Corporation, 8200 Jones Branch Drive, McLean, VA 22102-3107
- JoAnn Carpenter, Esq., Vice President and Deputy General Counsel, Federal National Mortgage Association, 3900 Wisconsin Ave., N.W., Washington, D.C. 20016-2899

Federal Government

- Designated Federal Officer: Sarah X. Rosen, Esq., Special Assistant to the Assistant Secretary for Housing, Room 9100, U.S. Department of Housing and Urban Development, 451 7th Street, S.W., Washington, D.C. 20410, (202) 708-3600

Schedule

HUD will hold the first meeting of the committee on December 13-14, 1995. On Wednesday, December 13, the meeting will start at 9:30 a.m. and run until completion; on Thursday, December 14, the meeting will start at 9:00 a.m. and run until approximately 1:00 p.m. If participants and the facilitator agree, the second day of the meeting may be extended beyond the projected completion time of 1:00 p.m. The location of the meeting will be Courtroom A of the International Trade Commission Building, 500 E Street, S.W., Washington, D.C. 20436. The purpose of the meeting will be to orient members to the negotiated rulemaking (reg-neg) process, establish a basic set of understandings and ground rules (protocols) regarding the process that will be followed in seeking a consensus, and begin to address the issues. This meeting is open to the public.

Decisions with respect to future meetings will be made at the first meeting and from time to time thereafter. Notices of future meetings will be published in the Federal Register if time permits.

To prevent delays that might postpone timely issuance of a proposed rule, HUD intends to terminate the committee's activities if it does not reach consensus within 5 months of the first meeting. The process may end earlier if the facilitator believes that sufficient progress cannot be made or

that an impasse has developed that cannot be resolved.

Authority: 42 U.S.C. 1437g, 3535(d).

Dated: December 5, 1995.

Stephanie A. Smith,
Acting General Deputy Assistant Secretary for Housing.

[FR Doc. 95-30067 Filed 12-6-95; 1:38 pm]

BILLING CODE 4210-27-P

DEPARTMENT OF THE TREASURY**Internal Revenue Service****26 CFR Part 1**

[INTL-0075-92]

RIN 1545-AR31

Definition of Foreign Base Company Income and Foreign Personal Holding Company Income of a Controlled Foreign Corporation; Hearing

AGENCY: Internal Revenue Service, Treasury.

ACTION: Change of location of public hearing.

SUMMARY: This document changes the location of the public hearing on proposed regulations relating to the definitions of subpart F income and foreign personal holding company income of a controlled foreign corporation and the allocation of deficits for purposes of computing the deemed-paid foreign tax credit.

DATES: The public hearing is being held on Thursday, January 4, 1996, beginning at 10:00 a.m.

ADDRESSES: The public hearing originally scheduled in the IRS Auditorium, Seventh floor, 7400 Corridor, Internal Revenue Building, 1111 Constitution Avenue, NW., Washington, DC is changed to room 2615, Internal Revenue Building, 1111 Constitution Avenue, NW., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Mike Slaughter of the Regulations Unit, Assistant Chief Counsel (Corporate), (202) 622-7190, (not a toll-free number).

SUPPLEMENTARY INFORMATION: A notice of public hearing appearing in the Federal Register on Thursday, September 7, 1995 (60 FR 46548), announced that a public hearing relating to proposed regulations under sections 952, 954(c), and 960 of the Internal Revenue Code will be held Thursday, January 4, 1996, beginning at 10:00 a.m. in the IRS Auditorium, Seventh floor, 7400 Corridor, Internal Revenue Building, 1111 Constitution Avenue, NW., Washington, DC and that requests

to speak and outlines of oral comments should be received by Tuesday, June 21, 1994.

The location of the public hearing has changed. The hearing is being held in room 2615 on Thursday, January 4, 1996, beginning at 10:00 a.m. The requests to speak and outlines of oral comments should be received by Thursday, December 14, 1995. Because of controlled access restrictions, attenders cannot be admitted beyond the lobby of the Internal Revenue Building until 9:45 a.m.

Copies of the agenda are available free of charge at the hearing.

Michael L. Slaughter,
Acting Chief, Regulations Unit, Assistant Chief Counsel (Corporate).

[FR Doc. 95-29933 Filed 12-7-95; 8:45 am]

BILLING CODE 4830-01-M

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

29 CFR Part 1602

Elementary-Secondary Staff Information Report EEO-5

AGENCY: Equal Employment Opportunity Commission.

ACTION: Proposed rule.

SUMMARY: The Equal Employment Opportunity Commission (EEOC) has voted to discontinue the requirement for filing the Elementary-Secondary Staff Information Report EEO-5 for individual schools and annexes within school systems or districts. This proposed rule amends the school filing requirement in subpart M of 29 CFR Part 1602. The recordkeeping requirements for elementary and secondary public school systems and districts, including individual schools and annexes, remain unchanged. This action is being taken in the interest of streamlining the survey process and reducing the burden on respondents, while maintaining sufficient data to meet the EEOC's program needs. The change is planned to become effective beginning with the 1996 EEO-5 survey.

DATES: Written comments on this proposed rule must be submitted on or before February 6, 1996.

ADDRESSES: Comments should be submitted to Frances M. Hart, Executive Officer, Executive Secretariat, Equal Employment Opportunity Commission, 10th Floor, 1801 L Street, NW., Washington, DC 20507. As a convenience to commentators, the Executive Secretariat will accept comments transmitted by facsimile ("FAX") machine. The telephone

number of the FAX receiver is (202) 663-4114. (This is not a toll free number.) Only comments of six or fewer pages will be accepted via FAX transmittal. This limitation is necessary to assure access to the equipment. Receipt of FAX transmittals will not be acknowledged, except that the sender may request confirmation of receipt by calling the Executive Secretariat staff at (202) 663-4078 (voice) or (202) 663-4077 (TDD). (These are not toll-free numbers.) Copies of comments submitted by the public will be available for review at the EEOC's library, Room 6502, 1801 L Street, NW., Washington, DC between the hours of 9:30 a.m. and 5:00 p.m.

FOR FURTHER INFORMATION CONTACT:

Joachim Neckere, Director, Program Research and Surveys Division, at (202) 663-4958 (voice) or (202) 663-7063 (TDD).

SUPPLEMENTARY INFORMATION: Section 709(c) of Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000e-8(c), requires employers to make and keep records relevant to a determination of whether unlawful employment practices have been or are being committed and to make reports therefrom as required by the EEOC. Accordingly, the EEOC has issued regulations which set forth the reporting requirements for various kinds of employers. Elementary and secondary public school systems and districts have been required to submit EEO-5 reports to the EEOC since 1974 (biennially in even numbered years since 1982). Two types of EEO-5 reports have been used: EEOC Form 168A, covering the entire public school system or district; and EEOC Form 168B, covering each individual school and annex within the system or district.

EEO-5 data are used by the EEOC to investigate charges of employment discrimination against elementary and secondary public school systems and districts. The data are used to support EEOC decisions and conciliations, and in systemic program activities. The data also enhance the Commission's ability to perform research, analysis, technical assistance, and public education. In addition, data are shared with the Department of Education (Office for Civil Rights and the National Center for Education Statistics) and the Department of Justice. EEO-5 data also are shared with approximately 23 state and 56 local Fair Employment Practice Agencies.

On October 5, 1995, the EEOC voted to discontinue the EEO-5 Report 168B for individual schools and annexes. The primary reason for the discontinuance

of the reporting requirement for individual schools is to reduce the reporting burden on respondents and to streamline the collection of information required for enforcement purposes. The recordkeeping requirements of subpart L of 29 CFR 1602, however, remain in effect and unchanged.

Paperwork Reduction Act

This action will result in a reduced expense and reporting burden for school systems and districts as required under the Paperwork Reduction Act of 1995, 44 U.S.C. 3502(1). The reporting burden for this collection is based upon an average estimate per response and takes into consideration the large number of school systems and districts that submit their reports on diskettes or magnetic tapes. Burden hours for any particular school system or district may differ from this average estimate depending on the accessibility of information and the degree of automation. The burden estimate includes the time needed for reviewing instructions, searching existing data sources, gathering and maintaining the data, and completing and reviewing the collection of information. Public comments on the accuracy of the burden estimates as well as suggestions for further reducing the burden are welcome. The EEOC has encouraged and will continue to encourage the use of magnetic media (diskettes, computer tapes, etc.) as a means of submitting information on the EEO-5 report.

(1) Type of review: Extension (Discontinuance of individual school reports).

(2) Agency: Equal Employment Opportunity Commission.

(3) Title: Elementary-Secondary Staff Information (EEO-5).

(4) OMB Number: 0346-0003.

(5) Frequency: Biennially.

(6) Affected Public: State and Local Government.

(7) Number of Respondents: 5,000.

(8) Estimated Time Per Respondent: 5 Hours during a survey year.

(9) Total Burden Hours: 25,000 Hours.

The Office of Management and Budget (OMB) approval of the current EEO-5 collection of information, OMB Control Number 0346-0003, will expire on January 31, 1996. In order to comply with new information collection clearance procedures that OMB has instituted pursuant to the act, set forth at 29 CFR 1320.8, .9, and .11, the EEOC has obtained a 90 day extension of the current OMB collection approval in which to notice the proposed change in the EEO-5 collection and also to notice the extension.

Pursuant to 29 CFR 1320.8(d)(1), the EEOC solicits public comment to enable it to:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the EEOC's functions, including whether the information will have practical utility;

(2) Evaluate the accuracy of the EEOC's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Regulatory Flexibility Act

The Commission certifies pursuant to 5 U.S.C. 605(b), enacted by the Regulatory Flexibility Act, Pub. L. No. 96-354, that this proposed change will not result in significant impact on small employers or other entities because the change involves elimination of reporting requirements, and that a regulatory flexibility analysis therefore is not required. The Commission hereby publishes this proposed rule for public information and comment. The rule appears below.

List of Subjects in 29 CFR Part 1602

Reporting and recordkeeping requirements.

Dated: November 30, 1995.

For the Commission.

Gilbert F. Casellas,
Chairman.

Accordingly, it is proposed to amend 29 CFR Part 1602 as follows:

1. The authority citation for part 1602 continues to read as follows:

Authority: 42 U.S.C. 2000e-8, 2000e-12; 44 U.S.C. 3501 *et seq.*; 42 U.S.C. 12117.

§ 1602.41 [Amended]

2. Section 1602.41 is amended as follows:

(a) In the introductory text, in the first sentence, delete the phrase "and individual schools within such systems or district".

(b) In the concluding text, in the first sentence, delete the phrase, " , or the individual school which is the subject of the report, where more convenient,"

3. Section 1602.43 is revised to read as follows:

§ 1602.43 Commission's remedy for school systems' or districts' failure to file report.

Any school system or district failing or refusing to file report EEO-5 when required to do so may be compelled to file by order of a U.S. district court, upon application of the Commission or the Attorney General.

4. Section 1602.44 is revised to read as follows:

§ 1602.44 School systems' or districts' exemption from reporting requirements.

If it is claimed that the preparation or filing of the report would create undue hardship, the school system or district may apply to the Commission for an exemption from the requirements set forth in this part by submitting to the Commission or its delegate a specific proposal for an alternative reporting system prior to the date on which the report is due.

[FR Doc. 95-29552 Filed 12-7-95; 8:45 am]

BILLING CODE 6750-01-M

DEPARTMENT OF THE INTERIOR

Minerals Management Service

30 CFR Part 250, 251, and 256

RIN 1010-AB92

Revision of Requirements Governing Surety Bonds for Outer Continental Shelf Leases

AGENCY: Minerals Management Service (MMS), Interior.

ACTION: Notice of proposed rulemaking.

SUMMARY: The proposed rule would establish a deadline of 2 years for all Outer Continental Shelf (OCS) oil and gas and sulphur lessees to bring their bond coverage into compliance with the new levels of coverage established in 1993; clarify MMS's position that assignees, assignors, and co-lessees are jointly and severally liable for compliance with OCS oil and gas and sulphur leases; establish a regulatory framework for lease-specific abandonment accounts and acceptance of a third-party guarantee; and update the bond coverage required of right-of-way holders and Geological and Geophysical (G&G) exploration permittees. These changes are needed to reduce the risk of default by an underfunded company operating a lease or holding a right-of-way.

DATES: Comments must be received or postmarked no later than March 7, 1996 to be considered in this rulemaking.

ADDRESSES: Written comments must be mailed or hand-carried to the Department of the Interior; Minerals Management Service; 381 Elden Street; Mail Stop 4700; Herndon, Virginia 22070-4817; Attention: Chief, Engineering and Standards Branch.

FOR FURTHER INFORMATION CONTACT: Gerald D. Rhodes, Engineering and Technology Division, telephone (703) 787-1609.

SUPPLEMENTARY INFORMATION: The MMS regulations at 30 CFR Part 250, Subpart G, Abandonment of Wells, Subpart I, Platforms and Structures, and Subpart J, Pipelines and Pipeline Rights-of-Way, specify that OCS lessees, right-of-way holders, and G&G exploration permittees are liable for all end-of-lease financial obligations including unpaid royalties; costs of well plugging and abandonment; removal of pipe, equipment, platform(s), and facilities; and clearance of obstructions to other uses of the sea. The levels of bond coverage required by the regulations do not limit the obligations of OCS oil and gas or sulphur lessees, holders of an OCS pipeline right-of-way, or exploration permittees conducting deep stratigraphic tests.

The transfer of OCS leases from large producing companies to smaller producers, some of which are marginally financed, has increased the risk that the responsible party will not be able to satisfy end-of-lease obligations.

The MMS continues to investigate ways to provide more flexibility to lessees in meeting bonding requirements. For example, MMS has allowed third-party guarantees and escrow accounts as alternatives to traditional bonds. These methods would be specifically addressed in regulations to facilitate their use. The MMS encourages lessees to suggest other alternatives to traditional bonds. The regulations provide flexibility to the Regional Director to consider alternate forms of surety.

Oil and Gas and Sulphur Lease Bond Coverage Requirements: To reduce the number of cases of underfunded liabilities, MMS published revised rules on August 27, 1993 (58 FR 45255), increasing the bond coverage required for OCS oil and gas or sulphur leases.

The MMS is phasing in the increases in the minimum levels of bond coverage as part of the process of reviewing requests for approval of lease assignments, Exploration Plans (EP), Development and Production Plans

(DPP), or Development Operations Coordination Documents (DOCD). The 1993 regulation replaced the requirement for a \$50,000 bond for oil and gas and sulphur leases with requirements based upon the drilling or production stage of a lease as follows:

State of development	Lease bond	Areawide bond
Issuance of lease ..	\$50,000	\$300,000
EP approval	200,000	1,000,000
DPP and DOCD approval	500,000	3,000,000

This proposed rule would require lessees not already in compliance with the higher bond levels to submit and maintain the higher lease or areawide bonds within 2 years of the promulgation of a final rule.

Assignors, Assignees, and Co-Lessees Liable for Compliance: When the designated operator is unable to meet end-of-lease obligations, MMS will require any or all of the lessees to bring the lease into compliance. If there is no lessee able to perform, MMS will require the prior lessee(s) to perform these functions.

Relationship Between these Regulations and The Liability Regulations Published by MMS's Royalty Management Program: This proposed rule clarifies MMS's position with respect to the liability of assignees, assignors, and lessees (record title owners) for the plugging and abandonment of wells, removal of platforms and other facilities, and clearance of well and platform locations. These obligations are joint and several in nature. The obligations are not divisible, and a degree of residual liability is attached (i.e., an assignor may be required to perform lease and well abandonment and clearance obligations when an assignee refuses or is unable to carry out any or all of these responsibilities).

The indivisible nature of these obligations distinguishes them from the royalty and other payment obligations addressed in the regulations proposed for modification by the notice of proposed rulemaking (NPR) published on June 9, 1995, by MMS's Royalty Management Program (RMP) (60 FR 30492). The provisions of that NPR would establish liability for the payment of royalty due on Federal and Indian leases and establish responsibility to pay and report royalty and other payments.

The RMP's NPR dated June 9, 1995, proposes that royalty and other payment obligations be treated as divisible according to the division of the record title interests in a lease and proposes

that a record title owner's (lessee's) liability for the payment of royalty and other payments be proportionate to percentage of the record title interest owned. That NPR also points out that lease obligations such as leasehold and well abandonment and reclamation are not divisible.

Neither of these NPR's address against whom MMS will take enforcement action if MMS discovers noncompliance either in payments due or required leases abandonment and reclamation activities. In every instance, MMS retains the discretion to determine which person to pursue. Once the lease has been brought into compliance, the person MMS takes enforcement action against could seek contributions from other liable persons.

While these proposed rule should make it easier to determine who the liable parties are, it is not MMS's intention that these rules govern the relationship or liabilities between and among the affected parties other than MMS.

Means for Financing Abandonment and Clearance Obligations: Since no revenues are being generated from a lease at the time lease wells are to be plugged and abandoned, platforms are to be removed, and the seafloor cleared of obstructions, MMS wants assurances that OCS lessees establish some means of funding their end-of-lease obligations.

Similarly, no revenues are generated by pipeline operations at the time the right-of-way holder is called upon to remove all platforms, structures, domes over valves, pipes, taps, and valves along the right-of-way in compliance with MMS regulations. The MMS wants assurances that holders of OCS pipeline right-of-way grants provide some means of funding their right-of-way abandonment obligations.

Supplemental bonds: The MMS's Regional Directors may require OCS lessees, on a case-by-case basis. To provide additional security in the form of a supplemental bond or bonds or an increase in the amount of coverage under an existing bond. The additional security is required when the Regional director deems it necessary to ensure that the lessee or its guarantor will be able to comply with all end-of-lease obligations. The Regional Director will also consider the added liability created when new leases are added to an existing areawide bond.

The proposed rule would increase the level of bond coverage for G&G exploration permittees drilling a deep stratigraphic test well and would provide authority for MMS's Regional Directors to require right-of-way holders and G&G exploration permittees, on a

case-by-case basis, to post additional bonds or other security in the form of a supplemental bond or bonds or an increase in the amount of coverage under an existing bond. These changes recognize that the current bonding requirements found in §§ 250.159(b) and 251.6-4 are inadequate and also recognize the variation in costs associated with the abandonment of deep stratigraphic test wells and pipelines constructed on OCS right-of-ways.

Lease-Specific Abandonment Accounts and Third-Party Guarantee: Proposed § 256.56, Lease-specific abandonment accounts, and § 256.57, Third-party guarantee, would establish specific regulatory authority under which MMS's Regional Director may approve these alternate methods for funding end-of-lease abandonment obligations. Regional Directors already accept lease-specific abandonment accounts. A third-party guarantee or a supplemental bond may cover specific obligations, such as plugging and abandonment of specified leases or wells. However, the Regional Director's approval will depend on how well the combination of all bonds and guarantees is able to ensure that the lessee will meet all obligations.

Section-by-Section Discussion

Part 250—Oil and Gas and Sulphur Operations in the OCS

Section 250.110 General Requirements

Current rules at § 256.62(d) provide that assignors remain "liable for all obligations under the lease accruing prior to the approval of the assignment." The rule at § 250.110 of subpart G, Abandonment of Wells, is being amended to clarify existing requirements that when a well is drilled, a platform or other facility is installed, or an obstruction is created, the lessee's obligation accrues to properly plug and abandon the wellbore, remove the platform or other facility, and clear the ocean of obstructions in accordance with procedures specified in subpart G of 30 CFR part 250. When an assignment occurs, the assignor continues to have residual liability should the assignee fail to fully perform obligations that accrued before assignment with respect to wells and structures in existence at the time of the assignment.

The clarification also provides that when there are several responsible lessees, they are jointly and severally liable for end-of-lease obligations.

Section 250.159, General requirements for a pipeline right-of-way grant, would be modified to add a

provision under which the Regional Director could require the holder of a right-of-way to submit and maintain additional security in the form of a supplemental bond or bonds or by increasing the amount of coverage provided under an existing surety bond.

Part 251—G&G Explorations of the OCS

Section 251.6–4, Bonds, would be modified to increase the bond coverage required to \$200,00 for drilling a deep stratigraphic test well unless an areawide bond is maintained. A provision would be added under which the Regional Director could require a permittee under a G&G Exploration permit to submit and maintain additional security in the form of a supplemental bond or bonds or by increasing the amount of coverage provided under an existing surety bond. Compliance with the increased amount of bond coverage would be required for all permits granted after the effective date of a final rule.

Part 256—Leasing of Sulphur or Oil and Gas in the OCS

Subpart I—Bonding

Section 256.52 Requirement to File a Bond

Proposed § 256.52, Requirement to file a bond (current § 256.58, Acceptable bonds/alternate security instruments), expands upon the provisions of § 256.58 and establishes the bonding requirements for lessees. This section establishes the time at which a bond must be provided and recognizes alternate methods that a Regional Director may approve for providing additional security.

Proposed § 256.52(d) expands upon the provisions of current § 256.58(d) with regard to the results of a payment of a claim in the face amount of the surety.

Proposed § 256.52(f) expands upon the provisions of current § 256.58(f) with regard to the responsibility of the lessee to monitor the value of U.S. Department of the Treasury (U.S. Treasury) instruments provided to MMS and to submit additional U.S. Treasury instruments if the value of the instruments previously provided falls below the level of bond required.

In § 256.52, new paragraph (i) requires the lessee to give notice and to cease operations if the lease ceases to be in compliance with bonding requirements. Paragraph (i) also authorizes the Regional Director to allow continued operations when ceasing operations would pose a danger to the environment or to the producing reservoir but with

all proceeds being paid into lease abandonment accounts.

Section 256.53 Additional Bonds

Proposed § 256.53, Additional bonds (existing § 256.61, Additional bonds), expands the provisions of current § 256.61 to establish a deadline (2 years after promulgation of a final rule) for lessees of existing leases to provide the required increased amounts of bond coverage.

Proposed § 256.53(d) modifies the generic criteria used by the Regional Director to assess the ability of a lessee to carry out its present and future financial obligations and the need for supplemental bond.

Proposed § 256.53(e) would expand § 256.61 to establish regulatory provisions for determining the amount of additional bond coverage to be required.

Section 256.54 Bond Form

Section 256.59, Form of bond, would be renumbered and renamed § 256.54, Bond form. New § 256.54 establishes certain required terms of surety bonds including a requirement that the bond be noncancellable.

Proposed § 256.54(d)(3) authorizes the submission of U.S. Treasury securities in lieu of surety bond, in accordance with 31 U.S.C. 9303. It specifies that the lessee using such Treasury securities shall also submit authorization for the Regional Director to sell such securities upon the lessee's default on its lease obligations.

The MMS is concerned that, should the lessee file for bankruptcy and MMS merely have a security interest in the Treasury securities, it will not be able to obtain prompt access to funds to provide for remediation of leaking wells and or other critical environmental problems. In that event, the Treasury bills or notes will not give MMS the same assurance of timely performance of lease obligations that a surety bond provides. Accordingly, MMS is exploring with the Department of the Treasury alternative procedures under which the lessee would transfer title to its book-entry Treasury bills to MMS or a third-party escrow agent, so that the bills would not be property of the bankruptcy estate in the event of insolvency. The MMS requests comments on its alternative approach which it may adopt in the final version of this rule.

Section 256.55 General Terms and Conditions of Bond

Proposed new § 256.55 would establish general terms and conditions

of a bond and includes language which specifies that bonds are to be payable to the MMS Regional Director and conditioned upon compliance with all terms and conditions of the OCS oil and gas or sulphur leases and governing regulations. Lessees or sureties may propose alternate forms of bond for the Director's approval but should submit therewith an opinion of qualified counsel that the proposed bond form provides security equivalent to that of the standard MMS bond forms.

Proposed § 256.55(d) adds a requirement that the lessee give prompt notice to the Regional Director of any action alleging the insolvency or bankruptcy of the surety or alleging any matter which could result in suspension or revocation of the surety's charter or license to do business.

Section 256.56 Lease-Specific Abandonment Accounts

Proposed new § 256.56, Lease-specific abandonment accounts, establishes regulatory guidance for the establishment of lease-specific abandonment accounts in addition to the Treasury pledge accounts currently established to permit lessees to fund end-of-lease abandonment and clearance costs through scheduled payments into a lease-specific escrow account dedicated to lease abandonment and cleanup.

Section 256.57 Third-Party Guarantee

The third-party guarantee provisions of proposed § 256.57 would establish a regulatory framework for identifying some of the criteria that the Regional Director would use to approve a third-party guarantee of a lessee's compliance with its lease obligations and for establishing how MMS will obtain needed information.

Section 256.58 Termination of the Period of Liability and Cancellation of a Bond

Proposed new § 256.58(a) provides for termination of the period of liability under a bond and allows the Regional Director to permit a lessee to replace existing bonds with other forms of security that provide equivalent protection. Replacement of a bond pursuant to § 256.58(b) would conditionally release the existing bond.

Section 256.59 Forfeiture of Bonds and/or Other Securities

Proposed new § 256.59 specifies that if a lessee refuses or is unable to comply

with lease terms or if the lessee defaults on the conditions under which a bond and other security was accepted, the Regional Director will take action to forfeit all or part of a bond or other security.

Section 256.62 Assignment of Leases or Interests Therein

Under the proposed rulemaking, § 256.62 would be modified to clarify and make explicit existing authority that—

(1) The approval of a lease assignment is subject to the lessee furnishing bond coverage pursuant to the revised bonding requirements.

(2) Having a lease assignment become effective any date other than the first day of the lease month following the filing of documents is at the discretion of the Regional Director.

(3) Approval of an assignment by the Regional Director does not relieve the assignor of accrued lease obligations if the assignee subsequently fails to perform.

(4) Approval of an assignment will not be given until the assignee submits an acceptable level of surety coverage.

(5) When the lessee is not the sole lessee, the Regional Director will look first to the designated operator to perform lease obligations, but all lessees are jointly and severally liable for their performance.

(6) The assignee assumes a responsibility to remedy all existing environmental problems on the tract and to properly abandon all wells and reclaim the lease site.

Section 256.64 Requirements for Filing Transfers

Under the proposed rulemaking, § 256.64 would be modified to clarify that—

(1) Neither the transfer of operating rights, nor the creation of a sublease(s), releases the lessee from performance of any obligation under any lease or under any regulation.

(2) The lessee(s) are jointly and severally liable with sublessees and operating rights owners (to the extent of their interests) for the performance of each obligation under the lease and under the governing regulations with each party holding an interest at the time the obligation was accruing.

The provisions of these proposed rules have been designed to meet the objectives to: (1) ensure lessee's financial capability to perform lease obligations, (2) protect the environment from threat of harm which might result from a lessee's failure to timely carry out proper well abandonment and site clearance operations on a lease, (3)

achieve a reasonable degree of protection at a minimum increase in costs to the lessee or lease operator, and (4) select a method of attaining these goals which impact equitably on all parties who would be affected.

The MMS does not have authorized funds available to use to correct a noncompliance or default when the cost of corrective action exceeds the funds available under a forfeited bond and other security.

Author: This document was prepared by Gerald D. Rhodes, Engineering and Technology Division, MMS.

Executive Order (E.O.) 12866

This proposed rule is not a significant rule under E.O. 12866.

Regulatory Flexibility Act

The Department of the Interior (DOI) has determined that this proposed rule will not have a significant effect on a substantial number of small entities because, in general, the entities that engage in offshore exploration, development, and production activities including pipeline transportation across the OCS are not considered small due to the technical expertise, financial resources, and experience necessary to safely conduct such activities in an environmentally responsible manner.

Paperwork Reduction Act

This proposed rule does not contain new information collection requirements which require approval by the Office of Management and Budget (OMB). The information collection requirements in 30 CFR part 256 are approved by OMB under approval No. 1010-0006.

Takings Implication Assessment

The DOI certifies that this proposed rule does not represent a governmental action capable of interference with constitutionally protected property rights. Thus, a Takings Implication Assessment need not be prepared pursuant to E.O. 12630, Government Action and Interference with Constitutionally Protected Property Rights.

E.O. 12778

The DOI has certified to OMB that this proposed rule meets the applicable civil justice reform standards provided in Sections 2(a) and 2(b)(2) of E.O. 12778.

National Environmental Policy Act

The DOI determined that this action does not constitute a major Federal action significantly affecting the quality of the human environment; therefore, an

Environment Impact Statement is not required.

List of Subjects

30 CFR Part 250

Continental shelf, Environmental impact statements, Environmental protection, Government contracts, Incorporation by reference, Investigations, Mineral royalties, Oil and gas development and production, Oil and gas exploration, Oil and gas reserves, Penalties, Pipelines, Public lands—mineral resources, Public lands—rights-of-way, Reporting and recordkeeping requirements, Sulphur development and production, Sulphur exploration, Surety bonds.

30 CFR Part 251

Continental shelf, Freedom of information, Oil and gas exploration, Public lands—mineral resources, Reporting and recordkeeping requirements, Research.

30 CFR Part 256

Administrative practice and procedure, Continental shelf, Government contracts, Incorporation by reference, Oil and gas exploration, Public lands—mineral resources, Reporting and recordkeeping requirements, Surety bonds.

Dated: September 5, 1995.

Bob Armstrong,
Assistant Secretary, Land and Minerals Management.

For the reasons set forth in the preamble, MMS proposes to amend 30 CFR parts 250, 251, and 256 as follows:

PART 250—OIL AND GAS AND SULPHUR OPERATIONS IN THE OUTER CONTINENTAL SHELF

1. The authority citation for part 250 is revised to read as follows:

Authority: 43 U.S.C. 1334.

2. In § 250.110, the existing paragraph is designated as paragraph (a) and a new paragraph (b) is added to read as follows:

§ 250.110 General requirements.

* * * * *

(b) The obligations to plug and abandon wellbores, remove platforms or other facilities, and to clear the ocean of obstructions accrue when the well is drilled, the platform or other facility is installed, or the obstruction is created and continue until the requirements of subpart G are fully accomplished. These obligations are the joint and several responsibility of all lessees.

3. In § 250.159, paragraph (b)(1) is revised to read as follows:

§ 250.159 General requirements for a pipeline right-of-way grant.

* * * * *

(b) (1) When applying for a right-of-way grant, the applicant or the right-of-way holder shall provide the surety bonds described in this section in addition to the bonds required of a lessee in 30 CFR part 256.

(i) Each applicant or holder of a right-of-way shall furnish the Regional Supervisor a \$300,000 corporate surety bond conditioned on compliance with the terms of all right-of-way grants held by the applicant in the Outer Continental Shelf (OCS) area in which the right-of-way is located.

(ii) If the Regional Director determines that a surety bond in excess of \$300,000 is necessary to cover the costs and liabilities of compliance with the terms of the right-of-way, he/she may require the applicant or the holder of the right-of-way to submit additional security in the form of a supplemental bond or an increase in the amount of the existing surety bond.

* * * * *

PART 251—GEOLOGICAL AND GEOPHYSICAL (G&G) EXPLORATIONS OF THE OUTER CONTINENTAL SHELF

4. The authority citation for part 251 is revised to read as follows:

Authority: 43 U.S.C. 1331 et seq.

5. Section 251.6–4 is revised to read as follows:

§ 251.6–4 Bonds.

(a) Before the Minerals Management Service (MMS) will issue a permit authorizing the drilling of a deep stratigraphic test well, the applicant must either:

(1) Furnish MMS a bond of not less than \$200,000 conditioned on compliance with the terms of the permit; or

(2) Maintain with or furnish to MMS a \$1 million bond conditioned on compliance with the terms of the permit issued to him/her for the area of the OCS where the applicant proposes to drill a deep stratigraphic test.

(b) If the Regional Director determines that security in excess of \$1 million is needed, he/she may require the permittee to provide additional security in the form of a supplemental bond or bonds or an increase in the amount of the existing surety bond.

(c) The Director of MMS may require the submission of a bond before authorizing shallow test drilling.

(d) Any bond furnished shall be on a form approved or prescribed by the Director, MMS.

PART 256—LEASING OF SULPHUR OR OIL AND GAS IN THE OUTER CONTINENTAL SHELF

6. The authority citation for part 256 is revised to read as follows:

Authority: 43 U.S.C. 1331 et seq.

7. Section 256.58 is redesignated as § 256.52.

8. Newly designated § 256.52 is amended by revising the heading and paragraphs (a), (c), (d), (f), and (g); and by adding a new paragraph (i) to read as follows:

§ 256.52 Requirement to file a bond.

(a) Before an oil and gas or sulphur lease will be issued the successful bidder must:

(1) Furnish the Regional Director a \$50,000 lease surety bond, conditioned on compliance with all the terms and conditions of the lease;

(2) Maintain or furnish a \$300,000 areawide bond, issued by a qualified surety and conditioned on compliance with all the terms and conditions of oil and gas and sulphur leases held by the bidder in the OCS for the area in which the lease to be issued is situated;

(3) Maintain or furnish an areawide bond under § 256.53 (a)(2) or (b)(2) of this part; or

(4) Furnish a substitute security instrument in accordance with paragraphs (f) and (g) of this section.

* * * * *

(c) The lessee shall maintain a separate areawide surety bond as required by paragraph (a) of this section for each of the areas identified in paragraph (b) of this section.

(1) If the Regional Director approves, the lessee may substitute for its bond either:

(i) An operator's bond in the same amount as the lease bond required under paragraph (a); or

(ii) Alternate security instruments as provided in paragraphs (f) and (g) of this section.

(2) The lessee(s)' substitution of an operator's bond or an alternate form of security for its bond does not relieve the lessee(s) of its (their) obligation to comply with all the terms and conditions of the lease.

(d) If a default causes the surety or other guarantor to pay the United States any indebtedness under a lease secured by a bond or alternate form of security, the face amount of the bond or alternate form of security and the surety's liability will be reduced by the amount of the payment.

* * * * *

(f) U.S. Department of the Treasury (Treasury) securities (U.S. Bonds or

Notes) may be submitted in lieu of a bond, provided the Treasury instrument or legal tender submitted is negotiable at the time of submission for an amount of cash equal to the value of the required bond. The entity submitting Treasury instruments under this paragraph is responsible for monitoring the value of those instruments. If the value of those instruments falls below the level of bond required, the entity must submit additional Treasury instruments or legal tender to raise the value of the securities held by MMS to the value of the required bond.

(g) As provided in § 256.54, the Regional Director may accept alternate types of security instruments in lieu of the surety bonds required by this section if he/she determines that the interests of the Government are protected to the same extent that these interests would be protected by the required surety bond.

* * * * *

(i) Any time that a lease is not in compliance with bonding requirements of this subpart, the Regional Director will notify the lessee in writing and specify a reasonable period, not to exceed 90 days, to post an adequate bond.

(1) If an adequate bond or other guarantee is not provided by the end of the period allowed, the lessee shall cease mineral production, unless the Regional Director authorizes continued production from the lease to avoid premature lease abandonment or damage to the environment or to the producing reservoir(s).

(2) The lessee shall immediately begin preparation for lease abandonment and clearance and shall submit to the Regional Director its plans for paying outstanding royalty underpayments and for meeting all regulatory and lease requirements.

(3) Mineral production shall not resume until the Regional Director determines that an adequate bond has been posted or other guarantee provided.

(4) When the Regional Director authorizes continued production under this section, the net proceeds from that production, less the royalties paid to the United States, shall be paid into one or more lease-specific abandonment accounts approved by the Regional Director.

9. Section 256.61 is redesignated as § 256.53; paragraphs (a)(1), (b)(1), and (d) are revised; and paragraphs (a) introductory text, (b) introductory text, (e), (f), and (g) are added to read as follows:

§ 256.53 Additional bonds.

(a) Activities under an Exploration Plan (EP).

(1) When submitting a proposed EP, when submitting a proposed assignment of a lease with an approved EP, or 2 years after publication of a final rule, whichever is earliest, a lessee must submit a \$200,000 surety bond issued by a qualified surety and conditioned on compliance with all the terms and conditions of the lease shall be furnished to the Regional Director. Approval of the EP or assignment shall be conditioned upon receipt of a \$200,000 lease surety bond, unless the Regional Director authorizes the submission of the \$200,000 lease exploration bond after the submission of the EP but before approval of drilling activities under the EP. This bond coverage may be provided by increasing the bond coverage provided in § 256.52(a) of this part.

(2) * * *

(b) Operations under a Development and Production Plan (DPP) or a Development Operations Coordination Document (DOCD).

(1) When submitting a proposed DPP or DOCD, when submitting a proposed assignment of a lease with an approved DPP or DOCD, or 2 years after publication of a final rule, whichever is earliest, a lessee must submit a \$500,000 surety issued by a qualified surety and conditioned on compliance with all the terms and conditions of the lease shall be furnished to the Regional Director. Approval of a DPP, a DOCD, or an assignment of a lease with an approved DPP or DOCD shall be conditioned on receipt of a \$500,000 lease surety bond, unless the Regional Director authorizes the submission of the \$500,000 lease development bond after the submission of the DPP or DOCD, but prior to the approval of platform installation or drilling activities under the approved DPP or DOCD. The lessee may provide this additional bond by submission of a new bond or by increasing the lease bond coverage provided under paragraph (a) of this section.

(2) * * *

* * * * *

(d) The Regional Director may require additional security (i.e., security over and above the amounts prescribed in §§ 256.52(a) and 256.53 (a) and (b) of this part) in the form of a supplemental bond or bonds or increased amount of coverage of an existing surety bond when he/she determines that additional security is necessary to cover royalty due the Government, penalties and interest assessed against the lessee, and/or costs and liabilities of the lessee for

regulatory compliance. The Regional Director shall base the decision on an evaluation of the ability of the lessee to carry out its present and future financial obligations as demonstrated by factors such as:

(1) Financial capacity substantially in excess of existing and anticipated lease and other obligations (e.g., costs of well abandonment and platform removal, amount of underpaid royalties, and penalties and interest assessed by the Government), as evidenced by audited financial statements (including auditor's certificate, balance sheet, and profit and loss sheet);

(2) Projected financial strength as evidenced by existing OCS production and proven reserves of future production valued significantly in excess of existing and future lease obligations;

(3) Business stability as evidenced by 5 years of continuous operation and production of oil and gas or sulphur in the OCS or in the onshore oil and gas industry;

(4) Reliability in meeting obligations as evidenced by:

(i) Credit rating; or

(ii) Trade references including names and addresses of other lessees, drilling contractors, and suppliers with whom lessee has dealt; and

(5) Record of compliance with laws, regulations, and lease terms.

(e) The amount of the bond shall be sufficient to ensure the compliance with all lease terms and conditions, including any outstanding underpayment of royalty and cumulative end-of-lease obligations to abandon wells, remove platforms and facilities, and clear the seafloor in the event of default. The Regional Director will determine the amount of supplemental bond required based on an analysis conducted by MMS. The lessee may submit data for consideration by MMS.

(f) The Regional Director may adjust the amount of supplemental bond or deposit required and the terms for the acceptance of the lessee's bond if the liability for outstanding underpaid royalties and end-of-lease abandonment and clearance either increases or decreases. The Regional Director shall:

(1) Notify the lessee and the surety of any proposed adjustment to the amount of bond required; and

(2) Give the lessee an opportunity to submit written or oral comment on the adjustment.

(g) A lessee may request a reduction of the amount of supplemental bond required by submitting to the Regional Director evidence demonstrating that the projected royalties and costs of end-

of-lease abandonment and clearance of the seafloor are less than the specified bond coverage.

10. Section 256.59 is redesignated as § 256.54 and revised to read as follows:

§ 256.54 Bond form.

(a) All bonds must be on a form or in a form approved by the Director. Bonds submitted after November 26, 1993, must be issued by a qualified surety certified by the U.S. Treasury as an acceptable surety on Federal bonds and listed in the current U.S. Treasury Circular No. 570 which is available from the Surety Bond Branch, Financial Management Service, Department of the Treasury, 401 14th Street SW., Washington, D.C. 20227.

(b) A surety bond must be executed by the lessee and a qualified surety.

(c) Surety bonds must be noncancellable.

(d) Lease bonds must be:

(1) A surety bond;

(2) A lease-specific abandonment account in accordance with § 256.56;

(3) United States Treasury securities negotiable for an amount equal to the amount of bond required, accompanied by a conveyance of full authority to the Secretary to sell the securities in case of default;

(4) A combination of these security methods; or

(5) Another form of security approved by the Regional Director.

11. Sections 256.55, 256.56, 256.57, 256.58, and 256.59 are added to read as follows:

§ 256.55 General terms and conditions of bond.

(a) The Regional Director shall determine the amount of the lease bond as provided in §§ 256.52 and 256.53 of this part.

(b) A lease bond must be payable to MMS.

(c) A lease bond shall be conditioned upon compliance with all the terms and conditions of the lease and governing regulations.

(d) Lessees must notify the Regional Director of any action filed alleging the insolvency or bankruptcy of the lessee, a surety company, or a third-party guarantor. The lessee shall notify the Regional Director within 72 hours of any such action filed or within 72 hours of learning of an action that involves a company other than the lessee. Lease bonds must require the surety to provide this information to the lessee and directly to MMS.

(e) Upon the incapacity of a surety company by reason of bankruptcy, insolvency, or suspension or revocation of its charter or license, the lessee is deemed to be without bond coverage

and must promptly notify the Regional Director.

§ 256.56 Lease-specific abandonment accounts.

(a) The Regional Director may authorize the lessee or guarantor to supplement its bond(s) by establishing a lease(s)-specific abandonment account in one or more federally insured accounts made payable upon demand to the Regional Director. The total security, including the lease-specific abandonment account(s), shall not be less than the amount required to meet outstanding underpayments of royalty and lessee's end-of-lease abandonment and clearance obligations.

(b) Any interest paid on an abandonment account shall be retained in the account unless the Regional Director approves the payment of the interest to the lessee or guarantor.

(c) When authorized by the Regional Director, U.S. Treasury obligations may be substituted for payments into an abandonment account.

(d) An individual abandonment account shall not contain more than \$100,000 or the maximum insurable amount as determined by the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation.

(e) The Regional Director may require the lessee to make an overriding royalty or production payment into an escrow account. The required overriding royalty or payment out of production may be associated with production from a lease(s) other than the lease(s) bonded through the escrow account.

§ 256.57 Third-party guarantee.

(a) The Regional Director may accept a third party's written guarantee as surety for a lessee's lease obligations, following a review of:

(1) The period of time that the guarantor has been in continuous operation as a business entity;

(i) Continuous operation is the time that business was conducted immediately preceding the posting of a guarantee.

(ii) Continuous operation excludes periods of interruption in operations that were beyond the guarantor's control and that do not affect the guarantor's likelihood of remaining in business during lease exploration, development, production, abandonment, and clearance operations.

(2) Financial information available in the public record or submitted by the guarantor, on its own initiative, in sufficient detail to show to the Regional Director's satisfaction that the guarantor is qualified based on:

(i) The guarantor's current rating for its most recent bond issuance by either Moody's Investor Service or Standard and Poor's Corporation;

(ii) The guarantor's net worth taking into account liabilities under this and other guarantees.

(iii) The guarantor's ratio of current assets to current liabilities taking into account liabilities under this and other guarantees; and

(iv) The guarantor's unencumbered fixed assets in the United States.

(3) When the information required by paragraph (2) is not publicly available, the guarantor may submit the information voluntarily. If this is done, the guarantor must update the information annually within 90 days of the end of the fiscal year or as otherwise approved by the Regional Director. The information should include:

(i) Financial statements for the most recently completed fiscal year accompanied by a report prepared by an independent certified public accountant in conformance with generally accepted accounting principles and containing the accountant's audit opinion or review opinion of the financial statements, with no adverse opinion;

(ii) Financial statements, certified to be correct by the guarantor's financial officer, for completed quarters in the current fiscal year; and

(iii) Additional information, certified to be correct by the guarantor's financial officer, as requested by the Regional Director.

(b) The terms of a third-party guarantee shall provide for the following:

(1) If the lessee fails to comply with any governing lease term, the guarantor shall take corrective actions or be liable under the indemnity agreement to provide funds to the Regional Director sufficient to complete the required corrective action.

(2) If the guarantor wishes to terminate the period of liability under a third-party guarantee it must:

(i) Notify the Regional Director and the lessee at least 90 days before the proposed termination date; and

(ii) Obtain the Regional Director's approval for the termination of the period of liability for all or a specified portion of its guarantee.

(3) The lessee must obtain a suitable replacement security instrument before the proposed termination date or if no activities have taken place on the lease(s) for which the guarantee was approved, before any activities take place.

(c) The total amount of all outstanding and proposed guarantees by the guarantor must not exceed 25 percent of

that guarantor's unencumbered net worth in the United States.

(d) If the Regional Director approves a third-party guarantee, the guarantor must submit an indemnity agreement.

(1) The indemnity agreement shall be executed by all persons and parties who are to be bound by it, including the guarantor, and shall bind each jointly and severally.

(2) Two corporate officers who are authorized to bind their corporation must sign the indemnity agreement.

(3) The guarantor must provide the Regional Director copies of:

(i) The authorization of the signatory officials to bind the corporation;

(ii) An affidavit certifying that the agreement is valid under all applicable laws; and

(iii) The corporate authorization, demonstrating that the corporation can guarantee the obligation and execute the indemnity agreement.

(4) If the third-party guarantor is a partnership, joint venture, or syndicate, the agreement shall:

(i) Bind each partner or party who has a beneficial interest, directly or indirectly, in the guarantor; and

(ii) Provide that, if the third-party guarantee is forfeited, each partner or party shall be jointly and severally liable for compliance with all terms and conditions of the lease(s).

(5) Pursuant to § 256.59 of this chapter, the guarantor shall bring the lease into compliance or pay the Regional Director the amount necessary to bring the lease into compliance. The indemnity agreement, upon default by the lessee or operator, shall operate as a judgment against those parties liable under the indemnity agreement.

(e) If during the life a third-party guarantee the guarantor no longer meets the criteria of paragraphs (a)(3) and (c) of this section, the lessee must:

(i) Notify the Regional Director immediately; and

(ii) Bring the lease into compliance with the requirements of this subpart within 90 days.

§ 256.58 Termination of the period of liability and cancellation of a bond.

(a) The Regional Director shall terminate the period of liability under a bond upon the request of the surety and demand a replacement bond of equivalent amount from the lessee. The termination of the period of liability under a bond does not constitute release of the bond. The surety continues to be responsible for all obligations and liabilities accruing before the effective date of the termination of the period of liability.

(b) The Regional Director will cancel or release a bond as to obligations that

accrued before the cancellation only upon:

(1) Being furnished a replacement bond in which the surety agrees to assume all outstanding liabilities under the bond to be cancelled, in an amount equal to or greater than the amount of the bond to be cancelled; or

(2) The determination that all outstanding obligations have been fulfilled. Such cancellation shall be by a written instrument that subjects the bond to automatic reinstatement, as if no cancellation had occurred, if at any time within 6 years of such cancellation:

(i) Any payment made by the principal(s) is rescinded or must be restored due to insolvency, bankruptcy, reorganization, or receivership; or

(ii) The principal's representation to MMS that it has paid its financial obligations or performed the other obligations of the lease in accordance with MMS specifications is materially false at the time of cancellation.

(c) Failure of the lessee to replace a deficient bond could result in penalties under subpart N of part 250 of this Title or suspension of production or other operations in accordance with § 250.10.

§ 256.59 Forfeiture of bonds and/or other securities.

(a) If a lessee refuses or is unable to comply with lease terms or defaults on the conditions under which a bond, third-party guarantee, and/or other form of security was accepted, the Regional Director shall:

(1) Notify in writing the lessee, third-party guarantor, and any surety on the bond or other form of guarantee of the determination to call or forfeit all or part of the bond or guarantee, the reasons for the forfeiture, and the amount to be forfeited. The amount shall be based on the estimated total cost of correcting the lessee's noncompliance or default.

(2) Advise the lessee, third-party guarantor, and any surety that they can avoid forfeiture by:

(i) Agreeing to correct the noncompliance or default and demonstrating that they have the ability to do so; or

(ii) Agreeing that the surety will complete actions required for compliance in accordance with a schedule that meets the conditions of the lease and governing regulations if the surety can demonstrate the ability to carry out the action required.

(b) If there is a default, the Regional Director may cause the forfeiture of any and all bonds or other security deposited on condition of compliance with all the terms and conditions of the lease or leases.

(c) If forfeiture of the bond or security is required by this section, the Regional Director shall:

(1) Collect the forfeited amount, and

(2) Use funds collected from bond or security forfeiture to correct the noncompliance or default.

(d) If the amount forfeited is insufficient to pay for the full cost of corrective actions:

(1) the lessee(s) and any third-party guarantor(s) are jointly and severally liable for the remaining costs of obtaining full compliance with the terms and conditions of the lease, and

(2) The Regional Director may take or authorize required corrective action to obtain full compliance and may recover from the lessee(s) and any third-party guarantor(s) all costs in excess of the amount forfeited.

(3) If the amount of bond or security forfeited exceeds the total costs of the corrective actions required to obtain compliance, the Regional Director shall return the excess amount to the party from whom it was collected.

12. In § 256.62, paragraphs (a), (d), and (e) are revised, and paragraph (f) is added to read as follows:

§ 256.62 Assignment of leases or interests therein.

(a) Subject to the approval of the Regional Director and the furnishing of bond coverage pursuant to the requirements of subpart I of this part, leases, or any undivided interests therein, may be assigned in whole, or as to any officially designated subdivision, to anyone qualified under § 256.35(b) of this part to hold a lease.

(d) The assignor is liable for all obligations under the lease accruing before the approval of the lease assignment. Approval of the assignment by the Regional Director does not relieve the assignor of accrued lease obligations which the assignee subsequently fails to perform.

(e) After the Regional Director approves a lease assignment, the assignee is liable for all obligations under the lease and must comply with all regulations issued under the Act. The assignee must remedy all existing environmental problems on the tract, properly abandon all wells, and reclaim the lease site in accordance with part 250, subpart G. Before MMS approves an assignment, the assignee must submit acceptable bond coverage as required by §§ 256.52 and 256.53 of this part.

(f) Where there is more than one lessee, the lessees are jointly and severally responsible for performing the obligations of the lease, unless provided otherwise in these regulations. The

Regional Director will look to the designated operator to perform lessee obligations under any lease and under any regulations in this chapter. Should the operator fail or be unable to perform any obligation of the lessee(s), the Regional Director will require any or all the lessee(s) to bring the lease into compliance. If there is no lessee able to perform, the Regional Director will require prior lessees to bring the lease into compliance to the extent that the obligation accrued before assignment.

13. In § 256.64, paragraphs (a)(1), (c), and (g) are revised to read as follows:

§ 256.64 Requirements for filing transfers.

(a) All instruments of transfer of a lease or of an interest therein as to any officially designated subdivision, including operating rights, subleases and record title interests, shall be submitted in duplicate to the Regional Director for approval within 90 days from the date of final execution. Instruments of transfer shall include a statement over the transferee's own signature with respect to citizenship and qualifications similar to that required of a lessee and shall contain all of the terms and conditions agreed upon by the parties thereto.

(1) Neither the transfer of operating rights or creation of a sublease(s) releases the lessee from any obligation under the lease or regulations.

(2) The assignment of record title interests does not release the lessee from any accrued obligation under any lease or regulations.

(3) Carried working interests, overriding royalty interests, or payments out of production may be created or transferred without filing an approval.

(c) Where an assignment is of all the lease title interest in a lease or creates a segregated lease, the assignee must furnish a bond in the amount prescribed in §§ 256.52 and 256.53 of this part. Where an assignment is of less than all the lease title and the assignment does not create separate leases, the assignee, if the assignment provides and the surety consents, may become a joint principal on the bond with the assignor.

(g) Each obligation under any lease and under the regulations in this part binds the heirs, executors, administrators, successors, and assignees of the lessee. Except as otherwise provided in the regulations in this chapter, the lessee(s) (and to the extent of their interests, sublessees and operating rights owners) are jointly and severally liable for the performance of each obligation under the lease and

under the governing regulations with each prior lessee and operating rights owner holding an interest when the obligation was accruing.

* * * * *

[FR Doc. 95-29864 Filed 12-07-95; 8:45 am]

BILLING CODE 4310-MR-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[WA7-1-5542; FRL-5343-2]

Approval and Promulgation of State Implementation Plans: Washington

AGENCY: Environmental Protection Agency.

ACTION: Notice of proposed rulemaking.

SUMMARY: In this action, Environmental Protection Agency (EPA) invites public comment on its proposed granting of a temporary waiver of the attainment date for the Wallula, Washington particulate nonattainment area. This is based on EPA's review of the State implementation plan (SIP) revision submitted by the State of Washington for the purpose of bringing about attainment of the national ambient air quality standards (NAAQS) for particulate matter with an aerodynamic diameter less than or equal to a nominal 10 micrometers (PM-10). The implementation plan was submitted by the State to satisfy certain federal Clean Air Act requirements for an approvable moderate nonattainment area PM-10 SIP for a geographic area referred to as Wallula, Washington due on November 15, 1991.

DATES: Comments on this proposed action must be postmarked by January 8, 1996.

ADDRESSES: Written comments should be addressed to: Montel Livingston, SIP Manager, United States Environmental Protection Agency, Air Programs Branch (AT-082), 1200 Sixth Avenue, Seattle, Washington 98101.

Copies of the State's submittals and other information supporting this proposed action are available for inspection during normal business hours at the following locations: United States Environmental Protection Agency, Office of Air, 1200 Sixth Avenue (AT-082), Seattle, Washington 98101, and the State of Washington Department of Ecology, 4450 Third Ave. SE, Lacey, Washington 98504.

FOR FURTHER INFORMATION CONTACT: George Lauderdale, Office of Air (AT-082), US Environmental Protection

Agency, 1200 Sixth Avenue, Seattle, Washington 98101, (206) 553-6511.

SUPPLEMENTARY INFORMATION:

I. Background

The Wallula, Washington, area was designated nonattainment for PM-10 and classified as moderate under sections 107(d)(4)(B) and 188(a) of the Clean Air Act, by operation of law upon enactment of the Clean Air Act Amendments of 1990.¹ See 56 FR 56694 (Nov. 6, 1991) (official designation codified at 40 CFR 81.348). The air quality planning requirements for moderate PM-10 nonattainment areas are set out in subparts 1 and 4 of Part D, Title I of the Act.² The EPA has issued a "General Preamble" describing EPA's preliminary views on how EPA intends to review SIP's and SIP revisions submitted under Title I of the Act, including those State submittals containing moderate PM-10 nonattainment area SIP requirements [see generally 57 FR 13498 (April 16, 1992) and 57 FR 18070 (April 28, 1992)]. Because EPA is describing its interpretations here only in broad terms, the reader should refer to the General Preamble for a more detailed discussion of the interpretations of Title I advanced in this proposal and the supporting rationale. In this rulemaking action on the Washington moderate PM-10 SIP for the Wallula nonattainment area, EPA is proposing to apply its interpretations, taking into consideration the specific factual issues presented. Additional information supporting EPA's action on this particular area is available for inspection at the address indicated above. EPA will consider any timely submitted comments before taking final action on today's proposal.

Those States containing initial moderate PM-10 nonattainment areas (those areas designated nonattainment under section 107(d)(4)(B)) were required to submit, among other things, the following provisions by November 15, 1991:

1. Provisions to assure that reasonably available control measures (RACM) (including such reductions in emissions from existing sources in the area as may

be obtained through the adoption, at a minimum, of reasonably available control technology—RACT) shall be implemented no later than December 10, 1993;

2. Either a demonstration (including air quality modeling) that the plan will provide for attainment as expeditiously as practicable but no later than December 31, 1994, or a demonstration that attainment by that date is impracticable;

3. Quantitative milestones which are to be achieved every 3 years and which demonstrate reasonable further progress (RFP) toward attainment by December 31, 1994; and

4. Provisions to assure that the control requirements applicable to major stationary sources of PM-10 also apply to major stationary sources of PM-10 precursors except where the Administrator determines that such sources do not contribute significantly to PM-10 levels which exceed the NAAQS in the area. See sections 172(c), 188, and 189 of the Act.

Some provisions were due at a date later than November 15, 1991. States with initial moderate PM-10 nonattainment areas were required to submit a permit program for the construction and operation of new and modified major stationary sources of PM-10 by June 30, 1992 (see section 189(a)). Such States also were to submit contingency measures by November 15, 1993 which become effective without further action by the State or EPA, upon a determination by EPA that the area has failed to achieve RFP or to attain the PM-10 NAAQS by the applicable statutory deadline (see section 172(c)(9) and 57 FR 13543-44).

II. Today's Action

Section 110(k) of the Act sets out provisions governing EPA's review of SIP submittals (see 57 FR 13565-66). For PM-10 nonattainment areas Section 188(f), Waivers for Certain Areas, can apply as well.

In this action, EPA is proposing to grant a temporary waiver of the attainment date for the Wallula nonattainment area. Discussion of EPA's requirements for a temporary waiver are detailed in 59 FR 41998-42017 (August 16, 1994). In this guidance EPA provides certain flexibility for areas where the significance of anthropogenic and nonanthropogenic sources is unknown. The Washington Department of Ecology (Ecology) has presented preliminary data, based on a crude emission inventory of eastern Washington, indicating that nonanthropogenic sources may be significant in the Wallula situation. EPA

¹ The 1990 Amendments to the Clean Air Act made significant changes to the Act. See Pub. L. 101-549, 104 Stat. 2399. References herein are to the Clean Air Act, as amended ("the Act"). The Clean Air Act is codified, as amended, in the U.S. Code at 42 U.S.C. sections 7401, *et seq.*

² Subpart 1 contains provisions applicable to nonattainment areas generally and subpart 4 contains provisions specifically applicable to PM-10 nonattainment areas. At times, subpart 1 and subpart 4 overlap or conflict. EPA has attempted to clarify the relationship among these provisions in the "General Preamble" and, as appropriate, in today's notice and supporting information.

proposes to accept this preliminary information and grant a temporary waiver of the moderate area attainment date to allow Ecology and EPA to evaluate further the Wallula nonattainment area. Once the evaluation is completed, and/or the temporary waiver expires, EPA will make a final determination on the plan for the Wallula nonattainment area, including the applicability of a permanent waiver for the area.

The preliminary information presented by Ecology to date indicates that windblown dust from both anthropogenic and nonanthropogenic sources are impacting the Columbia Plateau geographic area which includes most of eastern Washington as well as northern Idaho and northeastern Oregon. In addition, the primary sources causing exceedences of the PM-10 standard may be many miles outside of the currently designated nonattainment areas in the Columbia Plateau region. Additional monitoring has been initiated in the region to evaluate further the extent of the problem. Extensive analysis is being done to distinguish anthropogenic sources from nonanthropogenic sources.

If granted, the proposed temporary waiver will extend the attainment date to December 31, 1997. The temporary three-year waiver will provide Ecology and EPA sufficient time to determine conclusively the significance of anthropogenic and nonanthropogenic PM-10 sources that are impacting the area. As required in the EPA guidance, Ecology and EPA are proceeding under a written agreement which sets out the protocol for both technical analysis (emission inventory, emission factor development, dispersion modeling, receptor modeling, etc.) and evaluation of alternative control measures, including Best Available Control Measures. The activities required under the protocol are generally referred to as the Columbia Plateau PM-10 Project funded by EPA, Ecology and USDA. Cooperating agencies include USDA's Agricultural Research Service and Natural Resources Conservation Service, as well as several local conservation districts, Washington State University, the University of Idaho, and others. Once the technical information from this project is finalized, EPA will determine if a permanent waiver of the attainment date is appropriate for the Wallula area or if the area should be reclassified as a serious PM-10 nonattainment area.

The temporary waiver of the attainment date, if finalized by EPA, will defer approval/disapproval actions on several otherwise required elements

of the moderate area plan for Wallula. The submission of the attainment demonstration, emission inventory, and contingency measures will be deferred. EPA will take final action on these elements after the analysis is completed and/or the expiration of the temporary waiver along with a decision on the eligibility of the area for a permanent waiver. EPA's reasoning for this approach is described in more detail under the various SIP element headings of this notice.

The Wallula plan was submitted to EPA on November 15, 1991. Ecology also submitted additional information on May 18, 1993 which further described the control measures being implemented in the area (letter from Joseph R. Williams to Jim McCormick, forwarding a report titled, "Addendum to the State Implementation Plan for the Wallula PM-10 Nonattainment Area, Reasonably Available Control Measure Analysis", undated). Additional information describing the status of the control measures and forwarding an analysis of windblown dust in the area was submitted on June 23, 1994 (letter from Joseph R. Williams to Jim McCormick). In a June 1, 1995, letter Ecology provided information on allowable emissions. Finally, Ecology forwarded a revised emission inventory for point sources within the nonattainment area on September 6, 1995 (letter from Joseph R. Williams to Michael A. Bussell).

EPA is proposing to approve the exclusion from precursor controls as described in part II. 5 below. EPA invites public comment on the proposed action described in this section.

A. Analysis of State Submission

1. Procedural Background

The Act requires States to observe certain procedural requirements in developing implementation plans and plan revisions for submission to EPA. Section 110(a)(2) of the Act provides that each implementation plan submitted by a State must be adopted after reasonable notice and public hearing.³ Section 110(l) of the Act similarly provides that each revision to an implementation plan submitted by a State under the Act must be adopted by such State after reasonable notice and public hearing. The EPA also must determine whether a submittal is complete and therefore warrants further EPA review and action (see section 110(k)(1) and 57 FR 13565). The EPA's completeness criteria for SIP submittals

are set out at 40 CFR Part 51, Appendix V (1992). The EPA attempts to make completeness determinations within 60 days of receiving a submission. However, a submittal is deemed complete by operation of law if a completeness determination is not made by EPA six months after receipt of the submission.

Ecology held a public hearing to receive public comment on the Wallula implementation plan on October 23, 1991. WDOE adopted the implementation plan for the area on November 14, 1991 and the plan was submitted to EPA on November 15, 1991. The SIP submittal was reviewed by EPA to determine completeness in accordance with the completeness criteria set out at 40 CFR Part 51, Appendix V. A letter dated May 5, 1992, was forwarded to the WDOE indicating the completeness of the submittal and the next steps to be taken in the review process.

2. PM-10 Emissions Inventory

Section 172(c)(3) of the Act requires that nonattainment plan provisions include a comprehensive, accurate, current inventory of actual emissions from all sources of relevant pollutants in the nonattainment area. Because the submission of the emissions inventory is a necessary adjunct to an area's attainment demonstration (or demonstration that the area cannot practicably attain) the emissions inventory must be received with the demonstration (see 57 FR 13539).

In the 1991 plan Ecology submitted an emissions inventory of estimated actual emissions for the base year of 1990 and the attainment year of 1994, and the 3-year maintenance year of 1997. Ecology sent a letter to EPA on September 6, 1995, partially amending that 1991 inventory. The amended inventory adds an additional point source and revises emission from one area source. EPA considers the changes as minor and they do not significantly impact the overall inventory for the area. Based on the 1995 letter the base year (1990) inventory the major source of particulate matter impacting the area was wind blown dust (98%, an average of 1,553,334 kilograms/day). The remainder of the emission inventory included point sources (less than 1%, 693 kilograms/day) and other area sources (less than 1%, 1215 kilograms/day).

A report titled "An Analysis of the Impact of Biogenic PM-10 Sources on the Spokane PM-10 Nonattainment Area", prepared by the Washington State Department of Ecology, February 1992, presents the most recent

³ Section 172(c)(7) of the Act requires that plan provisions for nonattainment areas meet the applicable provisions of section 110(a)(2).

information on the emission sources in the Columbia Plateau region of eastern Washington (which includes both the Spokane and Wallula nonattainment areas). The report attempts to determine gross annual emissions from anthropogenic and nonanthropogenic sources of PM-10. Preliminary information is presented indicating that about 40% of the annual emissions in eastern Washington are from anthropogenic sources and 60% from nonanthropogenic sources. No attempt was made to estimate the highest 24-hour emissions which, depending on the location, is expected to vary greatly. As discussed previously, the emission inventory information suggests, but does not conclusively show, that nonanthropogenic sources contribute significantly to the Wallula nonattainment area.

The emissions inventory estimating actual emissions generally appears to be accurate and comprehensive consistent with the requirements of section 172(c)(3) of the Clean Air Act and national guidance.⁴ Although, recent information from studies being conducted in eastern Washington indicate that the emission factors used for wind blown dust in the SIP revision are probably inappropriate, EPA thinks that the assumptions were the best available at the time the plan was prepared. The Columbia Plateau PM-10 Project will include the development of emission factors specifically for eastern Washington and preparation of regional emission inventories that will be used to update the Wallula plan.

One additional emission inventory issue relates to the actual and allowable emissions from stack sources. Ecology used highest actuals in the 1991 SIP submission. For one of the point sources, a papermill, allowable emissions are much greater (by a factor of 9) from the actual emissions used in the plan. However, by using the higher allowable emission estimates submitted in the September 6, 1995, letter, the papermill still only represents less than 1% of the emission inventory.

EPA proposes to take no approval or disapproval action on the emission inventory at this time. EPA is requiring, as well as participating in, the development of a detailed emission inventory as part of the Columbia Plateau project. When completed the detailed emission inventory will be used to supplement the current one.

3. RACM (Including RACT)

As noted, the initial moderate PM-10 nonattainment areas must submit provisions to assure that RACM (including RACT) are implemented no later than December 10, 1993 (see sections 172(c)(1) and 189(a)(1)(C)). The General Preamble contains a detailed discussion of EPA's interpretation of the RACM (including RACT) requirement (see 57 FR 13539-45 and 13560-61).

The current Wallula emission inventory identified wind blown dust as the dominant contributor of PM-10 emissions. There are two principal sources of windblown dust: Undisturbed land and agricultural fields. Ecology submitted an analysis of RACM for agricultural sources of PM-10 based on soil conservation measures required by the federal government's implementation of the United States Department of Agriculture's (USDA) Food Security Act (FSA) of 1985, in the Wallula nonattainment area and surrounding areas. EPA Title I preamble guidance suggests states "rely upon the soil conservation requirements (e.g. conservation plans, conservation reserve) of the Food Security Act to reduce emissions from agricultural operations" (see 57 FR 18072).

EPA proposes to accept Ecology's RACM analysis and concludes that RACM is being applied to agricultural sources not only in the nonattainment area but throughout the region surrounding Wallula. Ecology did not evaluate the application of reasonable controls on undisturbed lands. This analysis will be accomplished as part of the Columbia Plateau PM-10 Project.

The 1991 SIP revision contained a commitment from Ecology to adopt provisions of the FSA into state regulation. Ecology has not developed such a regulation. EPA proposes to determine that Ecology need not develop, adopt and submit state regulations that accomplish the same results as the current federal law and regulations. Such action would be unnecessary since the federal government (USDA) has the primary responsibility for implementation, and enforcement, of provisions of the FSA.

Where sources of PM-10 contribute insignificantly to the PM-10 problem in the area, EPA's policy is that it would be unreasonable (and would not constitute RACM) to require the implementation of potentially available control measures. 57 FR 13540. Further, EPA has indicated that for some sources in areas which demonstrate attainment, RACM does not require the implementation of otherwise available control measures that are not

"reasonably" available because their implementation would not expedite attainment (See 57 FR 13543).

In the Wallula situation, RACM for agricultural windblown dust is necessary and all other sources combined do not meet the de minimus guidance for requiring RACM. Even though not required under PM-10 SIP development guidance, Ecology did justify that RACM (including RACT) requirements were being met for two additional sources in the Wallula nonattainment area. Boise Cascade paper mill and the Simplot Feeders Limited Partnership cattle feedlot were evaluated by Ecology and found to be implementing RACM.

The only major (greater than 100 tons per year) stationary source facility within the nonattainment area, the Boise Cascade paper mill, was evaluated in the 1991 SIP submittal. Ecology concluded and documented that RACT is being applied to all stack sources in the facility. The SIP revision does not include any additional control of stack emissions. However, Ecology's RACT analysis did note that one unpaved road needed paving to meet RACT for fugitive dust sources within the facility. Ecology's June 23, 1994 letter documented that the road was paved, thus meeting the final RACT requirement. EPA proposes to accept Ecology's determination and considers the papermill to be at RACT.

The second source, the cattle feedlot, was determined by Ecology as meeting RACM in the 1991 SIP submittal. In 1992, new owners of the feedlot implemented an additional dust abatement measure, a sprinkler system to further reduce fugitive emissions. EPA proposes to accept Ecology's determination of RACM being applied at the feedlot.

EPA is proposing to grant a temporary waiver of the attainment date to December 31, 1997, which will allow Ecology and EPA to determine conclusively the significance of anthropogenic and nonanthropogenic sources impacting Wallula. This action does not relieve the area from the requirement to implement RACM. In the Wallula situation EPA thinks the significant source, as well as the two less significant sources, of PM-10 in the area have been reasonably controlled. Thus, EPA thinks it would be unreasonable to require other smaller sources of PM-10 in the area to implement potentially available control measures or technology. Further, EPA believes implementation of such additional controls in this area would not expedite attainment.

⁴The EPA issued guidance on PM-10 emissions inventories prior to the enactment of the Clean Air Act Amendments in the form of the 1987 PM-10 SIP Development Guideline. The guidance provided in this document appears to be consistent with the Act.

A more detailed discussion of the individual source contributions, their associated control measures and an explanation as to why certain available control measures were not implemented, can be found in the TSD. EPA has reviewed the State's explanation and associated documentation and is proposing to conclude that it adequately justifies the control measures to be implemented.

4. Demonstration

As noted, the initial moderate PM-10 nonattainment areas must submit a demonstration (including air quality modeling) showing that the plan will provide for attainment as expeditiously as practicable but no later than December 31, 1994 (see section 189(a)(1)(B) of the Act). The General Preamble sets out EPA's guidance on the use of modeling for moderate area attainment demonstrations (57 FR 13539). Alternatively, if the State does not submit a demonstration of attainment, the State must show that attainment by December 31, 1994 is impracticable (section 189(a)(1)(B)(ii)).

In the 1991, Wallula SIP submission, Ecology demonstrated attainment of the annual and 24-hour PM-10 standards by 1994. The SIP utilized simple rollback modeling for the demonstration. As with the emission inventory discussion above, EPA finds the attainment evaluation is inadequate. The emission inventory does not adequately document the anthropogenic and nonanthropogenic mix in the dominant emission source, windblown dust. However, since EPA is proposing to grant a temporary, three year, waiver of the attainment date, the approval or disapproval of the attainment demonstration will be deferred until after expiration of the temporary waiver. EPA proposes to make a final decision on the attainment status and classification of the area soon after the temporary waiver expires on December 31, 1997. The alternative decisions include reclassifying the area to a serious PM-10 nonattainment area or granting the area a permanent waiver. EPA invites comments on this approach.

5. PM-10 Precursors

The control requirements which are applicable to major stationary sources of PM-10, also apply to major stationary sources of PM-10 precursors unless EPA determines such sources do not contribute significantly to PM-10 levels in excess of the NAAQS in that area (see section 189(e) of the Act). The General Preamble contains guidance addressing how EPA intends to implement section

189(e) (see 57 FR 13539-40 and 13541-42).

Ecology submitted the emission inventory for PM-10 from the one major stationary source and several small sources. Due to the small contribution of stationary sources to the Wallula nonattainment area, EPA believes that stationary sources of precursors provide an insignificant contribution to the Wallula, Washington, ambient PM-10 concentration and EPA is proposing to grant the area an exclusion from PM-10 precursor control requirements authorized under section 189(e) of the act. Note that while EPA is proposing to make a general finding for this area, this proposed finding is based on the current character of the area including, for example, the existing mix of sources in the area. It is possible, therefore, that future growth could change the significance of precursors in the area. EPA intends to issue future guidance addressing such potential changes in the significance of precursor emissions in an area.

6. Quantitative Milestones and Reasonable Further Progress (RFP)

The PM-10 nonattainment area plan revisions demonstrating attainment must contain quantitative milestones which are to be achieved every three (3) years until the area is redesignated attainment and which demonstrate RFP, as defined in section 171(1), toward attainment by December 31, 1994 (see section 189(c) of the Act). Reasonable further progress is defined in section 171(1) as such annual incremental reductions in emissions of the relevant air pollutant as are required by Part D or may reasonably be required by the Administrator for the purpose of ensuring attainment of the applicable NAAQS by the applicable date.

As stated earlier, EPA is proposing to grant a temporary waiver of the attainment date for the Wallula area. If granted, the area would not be required to meet RFP because in 1998 EPA would determine if the area would receive a permanent waiver or be reclassified to serious.

7. Enforceability Issues

All measures and other elements in the SIP must be enforceable by Ecology and EPA (see sections 172(c)(6), 110(a)(2)(A) and 57 FR 13556). EPA criteria addressing the enforceability of SIP's and SIP revisions were stated in a September 23, 1987 memorandum (with attachments) from J. Craig Potter, Assistant Administrator for Air and Radiation, et al. (see 57 FR 13541). Nonattainment area plan provisions must also contain a program that

provides for enforcement of the control measures and other elements in the SIP (see section 110(a)(2)(C)).

WDOE's control measures and regulations for control of Particulate Matter, which are contained in the SIP, are addressed above under the section headed "RACM (including RACT)." These control measures apply to the types of activities identified in that discussion including, for example, fugitive emissions from agricultural sources. The SIP provides that the affected activities will be controlled throughout the entire nonattainment area.

The SIP requires that all the applicable SIP provisions be implemented by December 10, 1993 (section 189(a)(1)(C)). In addition to the applicable control measures, this includes the applicable record-keeping requirements which are addressed in the supporting technical information document (TSD).

The TSD contains further information on enforceability requirements including enforceable emission limitations; a description of the rules contained in the SIP and the source types subject to them; test methods and compliance schedules; malfunction provisions; excess emission provisions; correctly cited references of incorporated methods/rules; and reporting and recordkeeping requirements. Ecology has the primary responsibility for implementing the measures in the plan. Ecology has compliance inspectors and EPA considers the staffing level adequate to assure that the RACM provision in the Wallula attainment plan are fully implemented. As a necessary adjunct of its enforcement program, Ecology also has broad powers to adopt rules and regulations, issue orders, require access to records and information, and receive and disburse funds.

8. Contingency Measures

As provided in section 172(c)(9) of the Act, all moderate nonattainment area SIP's that demonstrate attainment must include contingency measures (see generally 57 FR 13543-44). These measures must be submitted by November 15, 1993 for the initial moderate nonattainment areas. Contingency measures should consist of other available measures that are not part of the area's control strategy. These measures must take effect without further action by the State or EPA, upon a determination by EPA that the area has failed to make RFP or attain the PM-10 NAAQS by the applicable statutory deadline. Since the action proposed in this Federal Register notice

allows for a temporary extension of the attainment date, EPA proposes to take no action on the contingency measures until after the temporary waiver has elapsed and EPA has determined the eligibility of the area for a permanent waiver.

III. Implications of Today's Action

EPA is proposing to grant a temporary waiver of the December 31, 1994, attainment date to December 31, 1997. If granted, the Washington Department of Ecology will proceed with determining the significance of anthropogenic and nonanthropogenic sources impacting the Wallula PM-10 nonattainment area. When Ecology has completed its analysis, and/or the temporary waiver expires, EPA will make a final determination of the status of the Wallula nonattainment area. EPA is proposing to approve the control measures submitted by Ecology as meeting RACM and as having been fully implemented by December 10, 1993. Finally, EPA is also proposing to grant an exclusion from precursor control requirements as described in part II. 5 of this notice.

IV. Request for Public Comments

EPA is requesting comments on all aspects of today's proposal. As indicated at the beginning of this notice, EPA will consider any comments postmarked by January 8, 1996.

V. Administrative Review

Under the Regulatory Flexibility Act, 5 U.S.C. 600 *et seq.*, EPA must prepare a regulatory flexibility analysis assessing the impact of any proposed or final rule on small entities. 5 U.S.C. 603 and 604. Alternatively, EPA may certify that the rule will not have a significant impact on a substantial number of small entities. Small entities include small businesses, small not-for-profit enterprises, and government entities with jurisdiction over populations of less than 50,000.

SIP approvals under section 110 and subchapter I, Part D of the CAA do not create any new requirements, but simply approve requirements that the state is already imposing. Therefore, because the federal SIP-approval does not impose any new requirements, I certify that it does not have a significant impact on any small entities affected. Moreover, due to the nature of the federal-state relationship under the CAA, preparation of a regulatory flexibility analysis would constitute federal inquiry into the economic reasonableness of state action. The CAA forbids EPA to base its actions concerning SIPs on such grounds.

Union Electric Co. v. U.S.E.P.A., 427 U.S. 246, 256-66 (S.Ct. 1976); 42 U.S.C. 7410(a)(2).

Under Section 202 of the Unfunded Mandates Reform Act of 1995 ("Unfunded Mandates Act"), signed into law on March 22, 1995, EPA must prepare a budgetary impact statement to accompany any proposed or final rule that includes a Federal mandate that may result in estimated costs to State, local, or tribal governments in the aggregate; or to the private sector, of \$100 million or more. Under Section 205, EPA must select the most cost-effective and least burdensome alternative that achieves the objectives of the rule and is consistent with statutory requirements. Section 203 requires EPA to establish a plan for informing and advising any small governments that may be significantly or uniquely impacted by the rule.

EPA has determined that the proposed action promulgated does not include a Federal mandate that may result in estimated costs of \$100 million or more to either State, local, or tribal governments in the aggregate, or to the private sector. This Federal action approves pre-existing requirements under State or local law, and imposes no new Federal requirements. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, result from this action.

Nothing in this action should be construed as permitting or allowing or establishing a precedent for any future request for revision to any SIP. Each request for revision to any SIP shall be considered separately in light of specific technical, economic, and environmental factors and in relation to relevant statutory and regulatory requirements.

This action has been classified as a Table 3 action by the Regional Administrator under the procedures published in the Federal Register on January 19, 1989 (54 FR 2214-2224), as revised by a July 10, 1995 memorandum from Mary Nichols, Assistant Administrator for Air and Radiation. The Office of Management and Budget (OMB) has exempted this regulatory action from E.O. 12866 review.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Intergovernmental relations, Particulate matter, and Reporting and recordkeeping requirements.

Authority: 42 U.S.C. 7401-7671q.

Dated: November 7, 1995.

Chuck Clarke,

Regional Administrator.

[FR Doc. 95-29995 Filed 12-7-95; 8:45 am]

BILLING CODE 6560-50-P

DEPARTMENT OF DEFENSE

48 CFR Part 15

Federal Acquisition Regulation; Contracting by Negotiation (FAR Part 15 Rewrite)

AGENCY: Department of Defense (DoD).

ACTION: Notice of public meeting.

SUMMARY: The Director of Defense Procurement, in concert with the Federal Acquisition Regulations Council, is sponsoring an initiative to rewrite the Federal Acquisition Regulation (FAR) Part 15, Contracting by Negotiation. The intent is to make Part 15 easier to understand and to eliminate policies, procedures, or requirements that impose unnecessary burdens on contractors or contracting officers. Regulatory requirements that are not required by statute, required to ensure adequately standardized government business practices, or required to protect the public interest will be considered for elimination. Innovative means of simplifying the procurement process and enhancing its efficiency will be considered for incorporation into the regulation. The rewrite team will use a number of fora to facilitate the exchange of ideas and information. Comments are solicited from both government and industry personnel, and notices of public meetings will be published in the Federal Register. To initiate the rewrite effort, interested parties are invited to present statements or provide suggestions on how to improve FAR Part 15 at a public meeting.

DATES: *Public Meeting:* A public meeting will be conducted at the address shown below from 1 p.m. to 3 p.m., Eastern standard time, on January 23, 1996.

Statements: Statements from interested parties for presentation at the public meeting should be submitted to the address below on or before January 16, 1996.

ADDRESSES: *Public Meeting:* The location of the public meeting is the General Services Administration auditorium, 18th and F Streets NW., Washington, D.C. 20405. Individuals wishing to attend the meeting, including individuals wishing to make presentations on the topic scheduled for discussion should contact the Part 15 Rewrite Committee Chair, Ms. Melissa

Rider, DAR Council, Attn: IMD 3D139,
PDUSD (A&T) DP/DAR, 3062 Defense
Pentagon, Washington, D.C. 20301–
3062.

FOR FURTHER INFORMATION CONTACT:

Ms. Melissa Rider, telephone (703) 602–
0131. FAX (703) 602–0350.

Michele P. Peterson,
*Executive Editor, Defense Acquisition
Regulations Council.*

[FR Doc. 95–29909 Filed 12–7–95; 8:45 am]

BILLING CODE 5000–04–M

Notices

Federal Register

Vol. 60, No. 236

Friday, December 8, 1995

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Denial of Participation in the Special Access Program

December 4, 1995.

AGENCY: Committee for the Implementation of Textile Agreements (CITA).

ACTION: Issuing a directive to the Commissioner of Customs denying the right to participate in the Special Access Program.

EFFECTIVE DATE: December 4, 1995.

FOR FURTHER INFORMATION CONTACT: Lori E. Mennitt, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 482-3400.

SUPPLEMENTARY INFORMATION:

Authority: Executive Order 11651 of March 3, 1972, as amended; section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854).

The Committee for the Implementation of Textile Agreements (CITA) has determined that Knight Industries is in violation of the requirements set forth for participation in the Special Access Program.

In the letter published below, the Chairman of CITA directs the Commissioner of Customs, effective on December 4, 1995, to deny Knight Industries the right to participate in the Special Access Program, for a period of one year, from December 4, 1995 through December 3, 1996.

Requirements for participation in the Special Access Program are available in Federal Register notices 51 FR 21208, published on June 11, 1986; 52 FR 26057, published on July 10, 1987; 54 FR 50425, published on December 6,

1989; and 58 FR 41245, published on August 3, 1993.

Troy H. Cribb,
Chairman, Committee for the Implementation of Textile Agreements.

Committee for the Implementation of Textile Agreements

December 4, 1995.

Commissioner of Customs,
Department of the Treasury, Washington, DC 20229.

Dear Commissioner: The purpose of this directive is to notify you that the Committee for the Implementation of Textile Agreements has determined that Knight Industries is in violation of the requirements for participation in the Special Access Program.

Effective on December 4, 1995, you are directed to prohibit Knight Industries from further participation in the Special Access Program, for a period of one year, from December 4, 1995 through December 3, 1996. For the period December 4, 1995 through December 3, 1996, goods accompanied by Form ITA-370P which are presented to U.S. Customs for entry under the Special Access Program will not be accepted. In addition, for the period December 4, 1995 through December 3, 1996, you are directed not to sign ITA-370P forms for export of U.S.-formed and cut fabric for Knight Industries.

Sincerely,
Troy H. Cribb,
Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc. 95-29996 Filed 12-7-95; 8:45 am]

BILLING CODE 3510-DR-F

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List; Additions

AGENCY: Committee for Purchase From People Who Are Blind or Severely Disabled.

ACTION: Additions to the Procurement List.

SUMMARY: This action adds to the Procurement List services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities.

EFFECTIVE DATE: January 8, 1996.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Crystal Square 3, Suite 403, 1735 Jefferson Davis Highway, Arlington, Virginia 22202-3461.

FOR FURTHER INFORMATION CONTACT: Beverly Milkman (703) 603-7740.

SUPPLEMENTARY INFORMATION: On June 16 and October 6, 1995, the Committee for Purchase From People Who Are Blind or Severely Disabled published notices (60 F.R. 31706 and 52388) of proposed additions to the Procurement List.

After consideration of the material presented to it concerning capability of qualified nonprofit agencies to provide the services, fair market price, and impact of the addition on the current or most recent contractors, the Committee has determined that the services listed below are suitable for procurement by the Federal Government under 41 U.S.C. 46-48c and 41 CFR 51-2.4.

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the services to the Government.

2. The action will not have a severe economic impact on current contractors for the services.

3. The action will result in authorizing small entities to furnish the services to the Government.

4. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46-48c) in connection with the service proposed for addition to the Procurement List.

Accordingly, the following services are hereby added to the Procurement List:

Grounds Maintenance, Nogales Border Station (West), Nogales, Arizona
Mailroom Operation, Internal Revenue Service, 300 North Los Angeles Street, Los Angeles, California.

This action does not affect current contracts awarded prior to the effective date of this addition or options exercised under those contracts.

Beverly L. Milkman,
Executive Director.

[FR Doc. 95-29959 Filed 12-7-95; 8:45 am]

BILLING CODE 6820-33-P

Procurement List; Proposed Additions

AGENCY: Committee for Purchase From People Who Are Blind or Severely Disabled.

ACTION: Proposed additions to Procurement List.

SUMMARY: The Committee has received proposals to add to the Procurement List services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities.

COMMENTS MUST BE RECEIVED ON OR BEFORE: January 8, 1996.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Crystal Square 3, Suite 403, 1735 Jefferson Davis Highway, Arlington, Virginia 22202-3461.

FOR FURTHER INFORMATION CONTACT: Beverly Milkman (703) 603-7740.

SUPPLEMENTARY INFORMATION: This notice is published pursuant to 41 U.S.C. 47(a) (2) and 41 CFR 51-2.3. Its purpose is to provide interested persons an opportunity to submit comments on the possible impact of the proposed actions.

If the Committee approves the proposed additions, all entities of the Federal Government (except as otherwise indicated) will be required to procure the services listed below from nonprofit agencies employing persons who are blind or have other severe disabilities.

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the services to the Government.

2. The action does not appear to have a severe economic impact on current contractors for the services.

3. The action will result in authorizing small entities to furnish the services to the Government.

4. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46-48c) in connection with the services proposed for addition to the Procurement List.

Comments on this certification are invited. Commenters should identify the statement(s) underlying the certification on which they are providing additional information.

The following services have been proposed for addition to Procurement List for production by the nonprofit agencies listed:

Administrative Services, Social Security Administration, Great Lakes Program Service Center, Chicago, Illinois, NPA: Lester & Rosalie ANIXTER CENTER, Chicago, Illinois

Grounds Maintenance, Base Command, Building 2750, Burger King, Building 6006, Edwards Air Force Base, California, NPA: Desert Haven Enterprises, Inc., Lancaster, California.

Beverly L. Milkman,
Executive Director.

[FR Doc. 95-29958 Filed 12-7-95; 8:45 am]

BILLING CODE 6820-33-P

Procurement List; Addition

AGENCY: Committee for Purchase From People Who Are Blind or Severely Disabled.

ACTION: Addition to the Procurement List.

SUMMARY: This action adds to the Procurement List a service to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities.

EFFECTIVE DATE: January 8, 1996.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Crystal Square 3, Suite 403, 1735 Jefferson Davis Highway, Arlington, Virginia 22202-3461.

FOR FURTHER INFORMATION CONTACT: Beverly Milkman (703) 603-7740.

SUPPLEMENTARY INFORMATION: On September 29, 1995, the Committee for Purchase From People Who Are Blind or Severely Disabled published notice (60 F.R. 50558) of proposed addition to the Procurement List.

Comments were received from the current contractor for this service before the notice of proposed rulemaking was published in the Federal Register. Some of these comments were transmitted to the Committee by a Member of Congress. The Committee initially was asked to add janitorial services at a group of buildings to the Procurement List, but the request was revised to include only the Ariel Rios Building to minimize the impact on the current contractor.

Despite the limitation, the contractor continued to claim that the proposed addition would have a severe impact on the company. The contractor claimed that the percentage of contract revenues it would lose on its award for the remaining buildings exceeds a "rule of thumb" percentage beyond which the Committee will consider impact to be severe. The contractor also indicated that it has been a continuous supplier of building maintenance at various Government sites and is thus more dependent on such sales to the Government. The contractor claimed that the remaining buildings in the

group would soon be closing for extensive renovations, so the limitation of the Procurement List addition to the one building would not lessen the impact on the contractor.

The Committee's criteria on permissible impact on a current contractor for a Procurement List addition, at 41 CFR 51-2.4(a)(4), look at the impact on the total sales of a company, not the percentage of revenue for a particular contract. The Committee has no "rule of thumb" for total sales percentage, as impact determinations are made on the facts of each situation. In this situation, the percentage of sales which the contractor will lose is well below the percentage cited as the "rule of thumb" level and, even when consideration is given to the contractor's dependence on Government sales, does not reach a level which would be considered severe adverse impact. In addition, the contracting activity has informed the Committee that the other two buildings in the group will not close for renovation until April and December 1997, respectively, later than the contractor contended, which should give the contractor ample time to develop other business to replace business temporarily lost to the renovations.

The contractor also claimed that addition of the services at the Ariel Rios Building does not meet the legislative intent of the Committee's statute, the Javits-Wagner-O'Day (JWOD) Act, 41 U.S.C. 46-48c, in regard to the labor operations to be performed. According to the contractor, the JWOD Act requires that 75 percent of the total labor operations to be performed in providing these services must be done by people with a severe disability.

The contractor has misconstrued the labor requirement in the JWOD Act. In order to qualify for participation in the JWOD Program, a nonprofit agency employing people with severe disabilities must employ such people for not less than 75 percent of the overall total of direct labor performed on commodities and services which the nonprofit agency provides, whether or not these commodities or services are provided to the Government under the JWOD Program. 41 U.S.C. 48b(4)(C). There is no statutory requirement for a specific percentage of direct labor on a JWOD contract, although it is anticipated that the designated nonprofit agency performing the services at the Ariel Rios Building will reach a 75 percent disabled direct labor level on that contract. Addition of these services to the Procurement List will thus create substantial work for people with disabilities, and is not a "front" for

awarding a contract to people without disabilities as the contractor contended. The statutory definition of direct labor, at 41 U.S.C. 48b(5), excludes activities such as supervision, administration, inspection and shipping, which are considered indirect labor by the Committee and not counted in assessing direct labor ratios.

The contractor also contended that the Committee has abused its authority to the disadvantage of small businesses and the competitive process of Government contracting. While the JWOD Program's share of Government contracts has grown in recent years, it is still only a very small part of total Government contracting, and is dwarfed by the share of Government contracts which goes to small businesses. The contractor's claim that the JWOD Program has permitted abuses of the competitive contracting process is based on the contractor's just-discussed misunderstanding of the JWOD Act's direct labor requirement, and is thus without foundation.

The contractor also attempted, in its comments relayed by a Member of Congress, to characterize the JWOD Act as requiring only that a Government agency give "priority consideration" to purchasing JWOD commodities and services, with the mandatory nature of such procurements coming only from a Committee regulation. However, the mandate comes directly from the JWOD Act, at 41 U.S.C. 48, which requires Government agencies intending to procure commodities or services on the Procurement List to buy them from a JWOD nonprofit agency, unless they are not available or are commodities available from Federal Prison Industries.

After consideration of the material presented to it concerning capability of qualified nonprofit agencies to provide the service, fair market price, and impact of the addition on the current or most recent contractors, the Committee has determined that the service listed below is a suitable for procurement by the Federal Government under 41 U.S.C. 46-48c and 41 CFR 51-2.4.

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the service to the Government.
2. The action will not have a severe economic impact on current contractors for the service.

3. The action will result in authorizing small entities to furnish the service to the Government.

4. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46-48c) in connection with the service proposed for addition to the Procurement List.

Accordingly, the following service is hereby added to the Procurement List: Janitorial/Custodial, Ariel Rios Federal Building, 12th & Pennsylvania Avenue, NW, Washington, DC.

This action does not affect current contracts awarded prior to the effective date of this addition or options exercised under those contracts.

Beverly L. Milkman,
Executive Director.

[FR Doc. 95-29957 Filed 12-7-95; 8:45 am]

BILLING CODE 6820-33-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EG96-20-000, et al.]

China U.S. Power Partners I, Ltd., et al.; Electric Rate and Corporate Regulation Filings

December 1, 1995.

Take notice that the following filings have been made with the Commission:

1. China U.S. Power Partners I, Ltd.

[Docket No. EG96-20-000]

On November 20, 1995, China U.S. Power Partners I, Ltd. ("CUPPI"), with its principal office at Church Street, Clarendon House, Hamilton HM11, Bermuda filed with the Federal Energy Regulatory Commission an application for determination of exempt wholesale generator status pursuant to Part 365 of the Commission's Regulations.

CUPPI is a limited liability company organized under the laws of Bermuda. CUPPI will be engaged indirectly through an Affiliate as defined in Section 2(a)(11)(B) of the Public Utility Holding Company Act of 1935, and exclusively in owning, or both owning and operating a proposed coal-fired electric generating facility consisting of two electric generating units, each with a net rating of approximately 300,000 kilowatts to be located in the People's Republic of China and to engage in project development activities with respect thereto.

Comment date: December 21, 1995, in accordance with Standard Paragraph E at the end of this notice. The Commission will limit its consideration of comments to those that concern the adequacy or accuracy of the application.

2. Cenergy, Inc.

[Docket No. ER94-1402-002]

Take notice that on November 9, 1995, Cenergy, Inc. (Cenergy) tendered for filing a letter supporting Cenergy's position in the above-referenced docket.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

3. Mock Resources, Inc.

[Docket No. ER95-300-004]

Take notice that on November 15, 1995, Mock Resources, Inc. tendered for filing an amendment to its October 30, 1995 quarterly report filed in the above-reference docket.

4. Commonwealth Edison Company

[Docket No. ER95-901-000]

Take notice that on November 13, 1995, Commonwealth Edison Company tendered for filing an amendment in the above-referenced docket.

Comment date: December 15, 1995, in accordance with Standard Paragraph E at the end of this notice.

5. Consolidated Edison Company of New York, Inc.

[Docket No. ER95-1694-000]

Take notice that on October 20, 1995, Consolidated Edison Company of New York, Inc. tendered for filing an amendment in the above-referenced docket.

Comment date: December 15, 1995, in accordance with Standard Paragraph E at the end of this notice.

6. Greenwich Energy Partners, L.P.

[Docket No. ER96-116-000]

Take notice that on November 16, 1995, Greenwich Energy Partners, L.P. tendered for filing an amendment in the above-referenced docket.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

7. Texas Utilities Electric Company

[Docket No. ER96-267-000]

Take notice that on November 2, 1995, Texas Utilities Electric Company (TU) tendered for filing three executed transmission service agreements (TSA's) with LG&E Power Marketing, Inc., Enron Power Marketing, Inc., and Electric Clearinghouse, Inc. for certain Economy Energy Transmission Service under TU Electric's Tariff for Transmission Service To, From and Over Certain HVDC Interconnections.

TU Electric requests effective dates for the TSA's that will permit them to become effective on or before the service commencement date under each of the three TSA's. Accordingly, TU Electric

seeks waiver of the Commission's notice requirements. Copies of the filing were served on LG&E Power Marketing, Inc., Enron Power Marketing, Inc., and Electric Clearinghouse, Inc., as well as the Public Utility Commission of Texas.

Comment date: December 15, 1995, in accordance with Standard Paragraph E at the end of this notice.

8. Columbus Southern Power Company
[Docket No. ER96-346-000]

Take notice that on November 14, 1995, Columbus Southern Power Company tendered for filing a Notice of Cancellation of FERC Rate Schedule Nos. 13 and 38.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

9. Kentucky Utilities Company
[Docket No. ER96-364-000]

Take notice that on November 15, 1995, Kentucky Utilities Company tendered for filing information on transactions that occurred during July 1, 1995 through October 31, 1995, pursuant to the Power Services Tariff accepted by the Commission in Docket No. ER95-854-000.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

10. Pennsylvania Power & Light Company
[Docket No. ER96-366-000]

Take notice that on November 15, 1995, Pennsylvania Power & Light Company (PP&L), tendered for filing with the Federal Energy Regulatory Commission two Service Agreements (the Agreements) between PP&L and American Municipal Power—Ohio (AMP-Ohio), dated November 1, 1995; and (2) Northeast Utilities Service Company, dated November 8, 1995.

The Agreements supplement a Short Term Capacity and Energy Sales umbrella tariff approved by the Commission in Docket No. ER95-782-000 on June 21, 1995.

In accordance with the policy announced in *Prior Notice and Filing Requirements Under Part II of the Federal Power Act*, 64 FERC ¶ 61,139, clarified and reh'g granted in part and denied in part, 65 FERC ¶ 61,081 (1995), PP&L requests the Commission to make the Agreement effective as of the date of execution of each, because service will be provided under an umbrella tariff and each service agreement is filed within 30 days after the commencement of service. In accordance with 18 CFR 35.11, PP&L has requested waiver of the sixty-day notice period in 18 CFR

35.2(e). PP&L has also requested waiver of certain filing requirements for information previously filed with the Commission in Docket No. ER95-782-000.

PP&L states that a copy of its filing was provided to the customers involved and to the Pennsylvania Public Utility Commission.

Comment date: December 15, 1995, in accordance with Standard Paragraph E at the end of this notice.

11. Florida Power Corporation
[Docket No. ER96-85-000]

Take notice that on November 21, 1995 and November 28, 1995, Florida Power Corporation tendered for filing amendments in the above-referenced dockets.

Comment date: December 15, 1995, in accordance with Standard Paragraph E at the end of this notice.

12. The Washington Water Power Company
[Docket No. ER96-367-000]

Take notice that on November 15, 1995, The Washington Water Power Company (WWP), tendered for filing with the Federal Energy Regulatory Commission pursuant to 18 CFR 35.12, an Agreement for the sale of up to 130,000 megawatt hours of energy during the period January 15 through April 15 for each of the years 1996 and 1997 to the City of Seattle, Washington.

Comment date: December 15, 1995, in accordance with Standard Paragraph E at the end of this notice.

13. Florida Power & Light Company
[Docket No. ER96-368-000]

Take notice that on November 15, 1995, Florida Power & Light Company (FPL), tendered for filing proposed service agreements with Industrial Energy Applications, Inc. for transmission service under FPL's Transmission Tariff No. 2 and FPL's Transmission Tariff No. 3.

FPL requests that the proposed service agreements be permitted to become effective on December 1, 1995, or as soon thereafter as practicable.

FPL states that this filing is in accordance with Part 35 of the Commission's Regulations.

Comment date: December 15, 1995, in accordance with Standard Paragraph E at the end of this notice.

14. Florida Power & Light Company
[Docket No. ER96-369-000]

Take notice that on November 15, 1995, Florida Power & Light Company (FPL) filed the Contract for Purchases and Sales of Power and Energy between

FPL and Koch Power Services Inc. FPL requests an effective date of November 16, 1995.

Comment date: December 15, 1995, in accordance with Standard Paragraph E at the end of this notice.

15. Maine Public Service Company
[Docket No. ER96-370-000]

Take notice that on November 15, 1995, Maine Public Service Company (Maine Public) tendered for filing an unexecuted Transmission Service Agreement for Network Service for Houlton Water Company under Maine Public's Transmission and Ancillary Services Tariff.

Maine Public has requested that the service agreement become effective on January 1, 1996 and requests waiver of the Commission's regulations regarding filing.

Comment date: December 15, 1995, in accordance with Standard Paragraph E at the end of this notice.

16. Cleveland Electric Illuminating Company
[Docket No. ER96-371-000]

Take notice that on November 15, 1995, Cleveland Electric Illuminating Company (CEI), tendered for filing its proposed FERC Tariff No. ____ under which it is proposing to sell capacity and energy to eligible purchasers for resale under competitive market conditions and Electric Power Sales Agreements between CEI and each of the following power marketers that desire to purchase power and energy from CEI at non-cost-based rates: A. Catex Vitol Electric, L.I.C., B. Citizens Lehman Power Sales, C. Enron Power Marketing, Inc., D. Louis Dreyfus Electric Power Inc.

CEI proposes to make the Tariff and each of the accompanying Electric Power Sales Agreements effective as of January 16, 1995.

Comment date: December 15, 1995, in accordance with Standard Paragraph E at the end of this notice.

17. Southern California Edison Company
[Docket No. ER96-385-000]

Take notice that on November 17, 1995, Southern California Edison Company (Edison), tendered for filing a Letter Agreement (Letter Agreement) with the City of Banning (Banning). The Letter Agreement modifies the Rated Capacity and Minimum Take Obligation referenced in the Supplemental Agreement to the 1990 Integrated Operations Agreement for the integration of Banning's entitlement in San Juan Unit 3, Commission Rate Schedule No. 248.28.

Edison requests an effective date of January 1, 1996.

Copies of this filing were served upon the Public Utilities Commission of the State of California and all interested parties.

Comment date: December 15, 1995, in accordance with Standard Paragraph E at the end of this notice.

18. Public Service Electric and Gas Company

[Docket No. ER96-386-000]

Take notice that on November 17, 1995, Public Service Electric and Gas Company (PSE&G), tendered for filing an initial rate schedule to provide fully interruptible transmission service to National Fuel Resources, Inc., for delivery of non-firm wholesale electrical power and associated energy output utilizing the PSE&G bulk power transmission system.

Comment date: December 15, 1995, in accordance with Standard Paragraph E at the end of this notice.

Standard Paragraph

E. Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 18 CFR 385.214). All such motions or protests should be filed on or before the comment date. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Lois D. Cashell,
Secretary.

[FR Doc. 95-29925 Filed 12-07-95; 8:45 am]

BILLING CODE 6717-01-P

Federal Energy Regulatory Commission

[Docket No. ER96-342-000, et al. ER96-342-000, et al.]

Electric Rate and Corporate Regulation Filings

November 30, 1995.

Take notice that the following filings have been made with the Commission:

1. Seagull Power Services, Inc.

[Docket No. ER96-342-000]

Take notice that on November 13, 1995, Seagull Power Services, Inc. (SPS), tendered for filing pursuant to 18 CFR 385.205, a petition for waivers and blanket approvals under various regulations of the Commission and for an order accepting its FERC Electric Rate Schedule No. 1 to be effective January 7, 1996.

SPS intends to engage in electric power and energy transmissions as a marketer and a broker. In transactions where SPS sells electric energy it proposes to make such sales on rates, terms, and conditions to be mutually agreed to with the purchasing party. Neither SPS nor any of its affiliates are in the business of generating, transmitting, or distributing electric power. Rate Schedule No. 1 provides for the sale of energy and capacity at agreed prices.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

2. Entergy Services, Inc.

[Docket No. ER96-343-000]

Take notice that on November 13, 1995, Entergy Services, Inc. (Entergy Services), on behalf of Arkansas Power & Light Company, Gulf States Utilities Company, Louisiana Power & Light Company, Mississippi Power & Light Company, and New Orleans Public Service Inc. (Entergy Operating Companies), tendered for filing a Transmission Service Agreement (TSA) between Entergy Services, Inc. and Delhi Energy Services, Inc. Entergy Services states that the TSA sets out the transmission arrangements under which the Entergy Operating Companies provides non-firm transmission service under their Transmission Service Tariff.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

3. Entergy Services, Inc.

[Docket No. ER96-344-000]

Take notice that on November 13, 1995, Entergy Services, Inc. (Entergy Services), on behalf of Arkansas Power & Light Company, Gulf States Utilities Company, Louisiana Power & Light Company, Mississippi Power & Light Company, and New Orleans Public Service Inc. (Entergy Operating Companies), tendered for filing a Transmission Service Agreement (TSA) between Entergy Services, Inc. and Associated Power Services, Inc. Entergy Services states that the TSA sets out the transmission arrangements under which the Entergy Operating Companies

provide non-firm transmission service under their Transmission Service Tariff.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

4. Indeck Pepperell Power Associates, Inc.

[Docket No. ER96-345-000]

Take notice that on November 13, 1995, pursuant to Rules 205 and 207 of the Rules of Practice and Procedure of the Federal Energy Regulatory Commission (the Commission), 18 CFR 385.205, 385.207, Indeck Pepperell, Inc. (Indeck Pepperell) filed a petition for waivers, blanket approvals and an order approving its Rate Schedule No. 1, to be effective within 60 days of the date of filing or on the date of the Commission's Acceptance Letter, whichever is earlier.

Indeck Pepperell intends to sell energy and capacity from the Indeck Pepperell 38 MW combined-cycle cogeneration facility located in Pepperell, Massachusetts. The rates charged by Indeck Pepperell will be mutually agreed upon by the parties to each particular transaction.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

5. UtiliCorp United Inc.

[Docket No. ER96-347-000]

Take notice that on November 14, 1995, UtiliCorp United Inc. tendered for filing on behalf of its operating division, WestPlains Energy-Kansas, a Service Agreement under its Power Sales Tariff, FERC Electric Tariff Original Volume No. 12, with *Industrial Energy Applications, Inc.* The Service Agreement provides for the sale of capacity and energy by WestPlains Energy-Kansas to *Industrial Energy Applications, Inc.* pursuant to the tariff, and for the sale of capacity and energy by *Industrial Energy Applications, Inc.* to WestPlains Energy-Kansas pursuant to *Industrial Energy Applications, Inc.*'s Rate Schedule No. 1.

UtiliCorp also has tendered for filing a Certificate of Concurrence by *Industrial Energy Applications, Inc.*

UtiliCorp requests waiver of the Commission's regulations to permit the Service Agreement to become effective in accordance with its terms.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

6. UtiliCorp United Inc.

[Docket No. ER96-348-000]

Take notice that on November 14, 1995, UtiliCorp United Inc. tendered for filing on behalf of its operating division,

Missouri Public Service, a Service Agreement under its Power Sales Tariff, FERC Electric Tariff Original Volume No. 10, with *Industrial Energy Applications, Inc.* The Service Agreement provides for the sale of capacity and energy by Missouri Public Service to *Industrial Energy Applications, Inc.* pursuant to the tariff, and for the sale of capacity and energy by *Industrial Energy Applications, Inc.* to Missouri Public Service pursuant to *Industrial Energy Applications, Inc.'s* Rate Schedule No. 1.

UtiliCorp also has tendered for filing a Certificate of Concurrence by *Industrial Energy Applications, Inc.*

UtiliCorp requests waiver of the Commission's regulations to permit the Service Agreement to become effective in accordance with its terms.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

7. UtiliCorp United Inc.

[Docket No. ER96-349-000]

Take notice that on November 14, 1995, UtiliCorp United Inc. tendered for filing on behalf of its operating division, Missouri Public Service, a Service Agreement under its Power Sales Tariff, FERC Electric Tariff Original Volume No. 10, with *Tennessee Valley Authority*. The Service Agreement provides for the sale of capacity and energy by Missouri Public Service to *Tennessee Valley Authority* pursuant to the tariff, and for the sale of capacity and energy by *Tennessee Valley Authority* to Missouri Public Service.

UtiliCorp requests waiver of the Commission's regulations to permit the Service Agreement to become effective in accordance with its terms.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

8. Idaho Power Company

[Docket No. ER96-350-000]

Take notice that on November 14, 1995, Idaho Power Company, tendered for filing in accordance with 18 CFR Part 35 of the Commission's Rules and Regulations, a copy of its proposed FERC Electric Tariff, Original Volume No. 3 (Point-to-Point Transmission Service Tariff) and its proposed FERC Electric Tariff, Original Volume No. 4 (Network Integration Transmission Service Tariff).

Idaho Power Company requests that an effective date of February 1, 1996 be assigned to the Tariff.

Copies of this filing were supplied to the Idaho Public Utility Commission, the Public Utility Commission of

Oregon, the Wyoming Public Utility Commission, and the Nevada Public Utility Commission.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

9. Florida Power Corporation

[Docket No. ER96-351-000]

Take notice that on November 14, 1995, Florida Power Corporation (FPC), tendered for filing a contract for the provision of interchange service between itself and MidCon Power Services Corp. (MidCon). The contract provides for service under Schedule J, Negotiated Interchange Service and OS, Opportunity Sales. Cost support for both schedules has been previously filed and approved by the Commission. No specifically assignable facilities have been or will be installed or modified in order to supply service under the proposed rates.

FPC requests Commission waiver of the 60-day notice requirement in order to allow the contract to become effective as a rate schedule on November 15, 1995. Waiver is appropriate because this filing does not change the rate under these two Commission accepted, existing rate schedules.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

10. Florida Power Corporation

[Docket No. ER96-352-000]

Take notice that on November 14, 1995, Florida Power Corporation (FPC), tendered for filing a contract for the provision of interchange service between itself and Koch Power Services Inc. (Koch). The contract provides for service under Schedule J, Negotiated Interchange Service and OS, Opportunity Sales. Cost support for both schedules has been previously filed and approved by the Commission. No specifically assignable facilities have been or will be installed or modified in order to supply service under the proposed rates.

FPC requests Commission waiver of the 60-day notice requirement in order to allow the contract to become effective as a rate schedule on November 15, 1995. Waiver is appropriate because this filing does not change the rate under these two Commission accepted, existing rate schedules.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

11. Cinergy Services, Inc.

[Docket No. ER96-353-000]

Take notice that on November 14, 1995, Cinergy Services, Inc. (Cinergy),

tendered for filing on behalf of its operating company, PSI Energy, Inc. (PSI), a First Supplemental Agreement, dated October 1, 1995, to the Interconnection Agreement, dated June 1, 1994 between Louis Dreyfus Electric Power, Inc. (Dreyfus) and PSI.

The First Supplemental Agreement revises the definitions for Emission Allowances and provides for Cinergy Services to act as agent for PSI. The following Exhibit has also been revised:

B Power Sales by Cinergy

Cinergy and Dreyfus have requested an effective date of December 1, 1995.

Copies of the filing were served on Louis Dreyfus Electric Power, Inc., the Connecticut Dept. of Public Utility Control, the Kentucky Public Service Commission, Public Utilities Commission of Ohio and the Indiana Utility Regulatory Commission.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

12. Central Power and Light Company; West Texas Utilities Company

[Docket No. ER96-355-000]

Take notice that on November 14, 1995 Central Power and Light Company (CPL) and West Texas Utilities Company (WTU) (jointly, the Companies) submitted a Transmission Service Agreement, dated October 30, 1995, establishing Coastal Electric Services Company (CES) as a customer under the terms of the ERCOT Interpool Transmission Service Tariff.

The Companies request an effective date of November 15, 1995, for the service agreement. Accordingly, the Companies request waiver of the Commission's notice requirements. Copies of the filing were served upon CES and the Public Utility Commission of Texas.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

13. Central Power and Light Company and West Texas Utilities Company

[Docket No. ER96-356-000]

Take notice that on November 14, 1995, Central Power and Light Company (CPL) and West Texas Utilities Company (WTU) (jointly, the Companies) submitted a Transmission Service Agreement, dated October 30, 1995, establishing Coastal Electric Services Company (CES) as a customer under the terms of the ERCOT Coordination Transmission Service Tariff.

The Companies request an effective date of November 15, 1995, for the service agreement. Accordingly, the

Companies request waiver of the Commission's notice requirements. Copies of this filing have been served upon CES and the Public Utility Commission of Texas.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

14. Public Service Company of Oklahoma; Southwestern Electric Power Company

[Docket No. ER96-357-000]

Take notice that on November 14, 1995, Public Service Company of Oklahoma (PSO) and Southwestern Electric Power Company (SWEPCO) (jointly, the Companies) submitted a Transmission Service Agreement, dated October 30, 1995, establishing Coastal Electric Services Company (CES) as a customer under the terms of the Companies' SPP Interpool Transmission Service Tariff.

The Companies request an effective date of November 15, 1995, for the Service Agreement. Accordingly, the Companies request waiver of the Commission's notice requirements. Copies of this filing were served upon CES, the Public Utility Commission of Texas, the Louisiana Public Service Commission and the Oklahoma Corporation Commission.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

15. Energy Resource Management Corporation

[Docket No. ER96-358-000]

Take notice that on November 14, 1995, Energy Resource Management Corporation (ERM), tendered for filing pursuant to 18 CFR 35.12, an application for waivers and blanket approvals under various regulations of the Commission, and an order accepting its Rate Schedule No. 1.

ERM intends to engage in electric power and energy transactions as a marketer and a broker. In transactions where ERM purchases power, including capacity and related services from electric utilities, qualifying facilities and independent power producers, and resells such power to other purchasers, ERM will be functioning as a marketer. In ERM's marketing transactions, ERM proposes to charge rates mutually agreed upon by the Parties. All sales will be at arms-length, and no sales will be made to affiliated entities. In transactions where ERM does not take title to the electric power and/or energy, ERM will be limited to the role of a broker and charge a fee for its services. ERM is not in the business of producing

or transmitting electric power. ERM does not currently have or contemplate acquiring title to any electric power transmission or generation facilities.

Rate Schedule No. 1 provides for the sale of energy and capacity at agreed upon prices. Rate Schedule No. 1 also provides that no sales may be made to affiliate.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

16. CMEX Energy, Inc.; Global Petroleum Corp.

[Docket No. ER96-359-000]

Take notice that on November 3, 1995, CMEX Energy, Inc. (CMEX) tendered for filing pursuant to 18 CFR 35.15 a notice of withdrawal of its FERC Electric Rate Schedule No. 1, effective no later than sixty (60) days from the date of filing. CMEX is canceling its rate schedule so that Global Petroleum Corp. (Global) can take over its electric power marketing business. Global, in turn, tendered for filing pursuant to 18 CFR 385.205, a petition for waivers and blanket approvals under various regulations of the Commission and for an order accepting its FERC Electric Rate Schedule No. 1 to be effective no later than sixty (60) days from the date of its filing.

Global intends to engage in electric power and energy transactions as a marketer and a broker. In transactions where Global sells electric energy it proposes to make such sales on rates, terms, and conditions to be mutually agreed to with the purchasing party. Global is not in the business of generating, transmitting, or distributing electric power.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

17. Kentucky Utilities Company

[Docket No. ER96-363-000]

Take notice that on November 13, 1995, Kentucky Utilities Company (KU), tendered for filing a service agreement between KU and KOCH Power Services, Inc. under its TS Tariff. KU requests an effective date of October 13, 1995.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

18. Kentucky Utilities Company

[Docket No. ER96-365-000]

Take notice that on November 15, 1995, Kentucky Utilities Company (KU), tendered for filing a service agreement between KU and Industrial Energy Applications, Inc. under its TS Tariff. KU requests an effective date of October 20, 1995.

Comment date: December 14, 1995, in accordance with Standard Paragraph E at the end of this notice.

Standard Paragraph

E. Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 18 CFR 385.214). All such motions or protests should be filed on or before the comment date. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Lois D. Cashell,

Secretary.

[FR Doc. 95-29912 Filed 12-7-95; 8:45 am]

BILLING CODE 6717-01-P

[Project No. 11372-001 Illinois]

Thomas J. Collins and Andrew Blystra; Notice of Surrender of Preliminary Permit

December 4, 1995.

Take notice that Thomas J. Collins and Andrew Blystra, permittee for the Oregon Project No. 11372, located on the Rock River in Ogle County, Illinois, has requested that its preliminary permit be terminated. The preliminary permit was issued on April 27, 1993, and would have expired on March 31, 1996. The permittee states that the project would be economically infeasible.

The permittee filed the request on November 21, 1995, and the preliminary permit for Project No. 11372 shall remain in effect through the thirtieth day after issuance of this notice unless that day is a Saturday, Sunday or holiday as described in 18 CFR 385.2007, in which case the permit shall remain in effect through the first business day following that day. New applications involving this project site, to the extent provided for under 18 CFR Part 4, may be filed on the next business day.

Lois D. Cashell,

Secretary.

[FR Doc. 95-29913 Filed 12-7-95; 8:45 am]

BILLING CODE 6717-01-M

[Docket Nos. ER95-1586-000 and EL96-17-000]

Citizens Utilities Company; Notice of Initiation of Proceeding and Refund Effective Date

December 5, 1995.

Take notice that on November 30, 1995, the Commission issued an order in the above-indicated dockets initiating a proceeding in Docket No. EL96-17-000 under section 206 of the Federal Power Act.

The refund effective date in Docket No. EL96-17-000 will be 60 days after publication of this notice in the Federal Register.

Lois D. Cashell,
Secretary.

[FR Doc. 95-29947 Filed 12-7-95; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. ER95-1838-000]

PacifiCorp; Notice of Filing

December 4, 1995.

Take notice that on November 8, 1995 and November 14, 1995 Black Hills Power & Light Company tendered for filing amendments in the above-referenced docket.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 18 CFR 385.214). All such motions or protests should be filed on or before December 14, 1995. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Lois D. Cashell,
Secretary.

[FR Doc. 95-29948 Filed 12-7-95; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. CP96-89-000]

Transcontinental Gas Pipe Line Corporation; Notice of Application

December 4, 1995.

Take notice that on November 30, 1995, Transcontinental Gas Pipe Line Corporation ("Transco"), P.O. Box 1396, Houston, Texas 77251, filed in the

above an abbreviated application pursuant to Section 7(c) and Section 7(b) of the Natural Gas Act and the Regulations of the Federal Energy Regulatory Commission ("Commission") for (1) a certificate of public convenience and necessity authorizing certain Tombigbee River replacement crossings and certain interconnections at that location for downstream delivery of gas to an industrial plant, and (2) an order permitting and approving the abandonment of existing facilities at the same location. For the reasons described herein, Transco requests a certificate and construction clearance by January 8, 1996.

Transco states that it has four pipelines across the Tombigbee River in Alabama 30-inch diameter Main Line A, 30-inch diameter Main Line B, 36-inch diameter Main Line C and 42-inch diameter Main Line D. This river crossing is 29.03 miles east of the location where Transco's system crosses the Mississippi-Alabama state line. At this location, the Tombigbee River forms the boundary between Choctaw and Marengo Counties, Alabama. Transco states that all gas produced onshore and offshore, Texas and Louisiana, onshore Mississippi and the Mobile Bay offshore Alabama area which moves on Transco's system to Transco's markets in the Deep South, Atlantic Seaboard and eastern markets flows through this Tombigbee River crossing.

Transco states that because of chronic mass erosion of the river banks, Main Line C is exposed and subject to potential physical damage from boat and barge traffic. Main Line D is not yet exposed, but Transco is concerned that it will become exposed because of the continuing bank erosion.

Transco states that it cannot perform these replacements pursuant to Section 2.55(b) of the Regulations because of the Commission's clarification of Section 2.55(b) in the order issued on May 12, 1994 in Arkla Energy Resources Company, Docket No. CP91-2069-000 (67 FERC ¶ 61,173) (replacements outside of existing right-of-way cannot be performed pursuant to Section 2.55(b)). Transco states that it is imperative that Transco complete the new crossings soon to ensure that gas from the production areas described above is able to flow to Transco's markets. Transco states that it proposes to install approximately 2,000 feet of new 36-inch diameter Main Line C by horizontal directional drilling under the Tombigbee River, at the location of its existing pipeline crossings of the

Tombigbee River.¹ The alignment of the new Main Line C will parallel Main Line B (installed in 1991 by horizontal directional drilling) with a spacing of approximately 75 feet to the south of Main Line B. Approximately 950 feet of 36-inch diameter pipe will be conventionally installed by trenching from the entrance and exit of the bore and tied in to existing Main Line C.

Transco states that it also proposes to install approximately 2,300 feet of new 42-inch diameter Main Line D by horizontal directional drilling under the Tombigbee River. Approximately 500 feet of 42-inch diameter pipe will be conventionally installed from the entrance and exit of the bore and tied in to existing Main Line D. The alignment of the Main Line D will parallel the new Main Line C with a spacing of approximately 75 feet to the south of Main Line C.

Transco states that the proposed replacements will restore the long-term integrity of Transco's transmission system at the Tombigbee River crossings. Since 36-inch and 42-inch diameter crossings are being replaced by identical 36-inch and 42-inch diameter crossings, system capacity across the Tombigbee River will remain unchanged at 33,639,606 MCFD. The existing shallow, conventionally installed Main Lines C and D at this location will be retired—portions by removal and portions in place.

The cost of installation of new Main Line C is estimated to be \$2,029,007, and the cost of installation of new Main Line D is estimated to be \$2,925,170.

It is stated that Transco needs to replace Main Line C as soon as possible because of its vulnerable condition. Coming quickly thereafter, Transco plans to replace Main Line D beginning in May 1996 because of Transco's concern that its condition could rapidly worsen.

Transco states that issuance of a certificate to Transco and construction clearance by January 8 is justified for two reasons: (1) the above-described need for security of gas service to Transco's market areas, and (2) the de minimis impact on the environment of the crossing project (as described below). With respect to the environment, Transco states that the following are the significant points:

1. On the east side of the river (where the drilling rig will be set up) temporary

¹ Transco states that directionally drilled pipelines under rivers are significantly more secure than the older pipelines which are installed by way of trenching the river bed. The 36-inch and 42-inch pipeline crossings will be at an approximate depth of 45 feet beneath the Tombigbee River navigation channel.

work space will occupy 8.82 acres. Of this east side work space only 0.54 acre is presently forested (0.25 acres is forested wetland). The remainder of the work space on the east side is located either on existing permanent right-of-way or in a cultivated field, both of which have previously been cleared.

On the west side of the river (where crossing segment fabrication and pre-testing will occur) temporary work space will occupy 22.94 acres. Of this west side work space only 3.12 acres is presently forested (2.56 acres is forested wetland). The remainder of the work space on the west side is located either on existing permanent right-of-way or in a cultivated field, both of which have previously been cleared.

In summary, areas requiring additional clearing for the installation of Main Lines C and D are relatively minor. Of these additional cleared areas only 3.66 acres are forested and of those only 2.81 acres are forested wetland.

2. Clearance has been received with respect to endangered/threatened species from the U.S. Fish and Wildlife Service. The Alabama Natural Heritage Program provided Transco with a list of candidate and protected species within the general area of the project. Transco evaluated this list in the context of the project to ensure that the project will not impact these species; the evaluation verified that the project will not impact these species.

3. Clearance has been received from the Alabama State Historical Preservation Officer ("SHPO") with respect to cultural resources related to the project area. There is a known archaeological site on the east bank of the Tombigbee River to the north of the project area that will not be impacted by this project; thus, the SHPO has no concern with regard to this site. Transco has contacted several Native American groups. Transco states that it does not consider in situ replacement a practical option because such conventional replacement would be subject to the same erosive forces of the river.

4. Transco states that the proposed installation and removals will improve the visual or aesthetic value of the river banks at the Tombigbee River crossing by allowing native revegetation and dynamics of the river to control the natural succession of the banks at the crossing. Transco will implement measures to restore and stabilize the construction work spaces and abandoned rights-of-way.

Therefore, Transco states that in view of (1) the essential need for the Tombigbee River crossings to be able to move gas from Transco's production areas to Transco's market areas, and (2)

the de minimis environmental impact of such project, Transco requests the Commission to issue a certificate and construction clearance by January 8, 1996 so that security of the Tombigbee River crossings can be assured as soon as possible. By this application, Transco also seeks authorization to abandon in place and by removal the portions of its Main Lines C and D at the Tombigbee River which will be replaced. Gas transmission across the Tombigbee River will be unaffected by these abandonments. The cost of the Line C removal work is estimated to be \$140,000. The cost of the Line D removal work is estimated to be \$201,540.

It is further stated that on the west bank at the location of the Tombigbee River crossings, Transco has interconnections on Main Lines C and D that enable gas to flow into a meter and regulator (M&R) station for downstream delivery to a plant owned by American Can Company ("American Can"), which is north of the crossings on the west bank. As a result of the replacements of Lines C and D, as above described, a reconfiguration of the American Can interconnections will be necessary. One new interconnection with the M&R station will involve conventional installation of approximately 1,200 feet of 4-inch diameter pipe from the M&R station west to a tap on the new segment of Line C. This will effectuate delivery of gas from of Line C to the M&R station. A second new interconnection will involve conventional installation of approximately 30 feet of 4-inch diameter pipe from a new tap on Line D to a tee near the western terminus of the above-described 1,200-foot 4-inch line. This will effectuate delivery of gas from Line D to the M&R station.

The estimated cost of installation of the 1,200-foot line is \$154,718. The estimated cost of installation of the 30-foot line is \$83,924.

By this application, Transco also seeks authorization to abandon by removal the interconnections between existing Main Lines C and D and the M&R station. Gas supply to the American Can plant will be unaffected by these abandonments. The estimated cost of removal of the interconnection between Main Line C and the M&R station is \$5,000. The estimated cost of removal of the interconnection between Main Line D and the M&R station is \$12,000.

Any person desiring to be heard or to make any protest with reference to said application should on or before December 14 1995, file with the Federal Energy Regulatory Commission, Washington, DC 20426, a motion to

intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the Natural Gas Act (18 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken, but will not serve to make the protestants parties to the proceedings. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Take further notice that, pursuant to the authority contained in and subject to the jurisdiction conferred upon the Federal Energy Regulatory Commission by Sections 7 and 15 of the Natural Gas Act and Commission's Rules of Practice and Procedure, a hearing will be held without further notice before the Commission or its designee on this application if not motion to intervene is filed within the time required herein, if the Commission on its own review of the matter finds that a grant of the certificate is required by the public convenience and necessity. If a motion for leave to intervene is timely filed, or if the Commission on its own motion believes that a formal hearing is required, further notice of such hearing will be duly given.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Transco to appear or be represented at the hearing.

Lois D. Cashell,

Secretary.

[FR Doc. 95-29915 Filed 12-7-95; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. CP96-10-001]

Transwestern Pipeline Company; Notice of Amendment to Application

December 4, 1995.

Take notice that on November 29, 1995, Transwestern Pipeline Company (Transwestern), P.O. Box 1188, Houston, Texas 77251-1188 filed an amendment (Amendment) to its original application in Docket No. CP96-10-000, which was filed pursuant to Section 7(c) of the Natural Gas Act, the purpose of which is to conform Transwestern's application to the following: (1) The Purchase and Sale Agreement and Ownership and Operating Agreement executed November 3, 1995 between Transwestern and Northwest Pipeline Corporation (Northwest); and (2) Northwest's application for abandonment authorization filed on

November 13, 1995 in Docket No. CP96-60-000, all as more fully set forth in the application which is on file with the Commission and open to public inspection.

Transwestern states that on September 22, 1995, Transwestern and Northwest executed a Letter of Intent (LOI) providing for the purchase by Transwestern and the sale by Northwest of a 77.7 percent ownership interest in Northwest's south-end mainline extension facilities extending from the Ignacio Compressor Station near Ignacio, Colorado to the Blanco Hub near Bloomfield, New Mexico (the La Plata Facilities). It is stated that the LOI provides that the exact level of interest and capacity was subject to change in order to permit Northwest to serve changes in receipt and delivery points which were made by Northwest's customers as of October 20, 1995.

Transwestern states that in its application, Northwest would retain 24,000 Dth/d of south flow delivery capacity, but Transwestern did not specify a specific amount of north flow delivery capacity which would be retained by Northwest. It is stated that in the Sales Agreement, Northwest and Transwestern agreed that Northwest would retain 23,811 Dth/d of south flow delivery capacity and 212,788 Dth/d of north flow delivery capacity, subject to adjustment to reflect in-kind fuel reimbursement. Under the terms of the Sales Agreement, Transwestern will acquire all capacity on the facilities not specifically retained by Northwest, which will include approximately 276,300 Dth/d of north to south capacity through the La Plata A compressor. Inasmuch as Transwestern's application listed such figure as 276,000 Dth/d, Transwestern amends that figure to reflect that it will hold 276,300 Dth/d of north to south capacity through the La Plata A compressor.

In the text of its application, Transwestern stated that it would take assignment of seven firm transportation contracts subscribing a total of 201,000 Dth/d of capacity. However, since the actual capacity subscribed under the seven firm contracts to be assigned is 201,900 Dth/d, Transwestern proposes to amend the application to reflect the actual figure.

Transwestern states that its application reflected a total estimated purchase price of \$21 million, which included Transwestern's payment of a portion of the cost of certain necessary modifications to be constructed prior to closing. The application stated that the total cost of such modifications was \$4.9 million. It is stated that in the Sales Agreement, the list of modifications was

amended, which resulted in a reduction in the total cost to construct such facilities from \$4.9 million to \$3.9 million. In addition, it is stated that the Sales Agreement contains minor revisions to the property description and net book value contemplated by the LOI, which in turn also affected the purchase price.

In addition, under the Sales Agreement, Transwestern is also required to reimburse Northwest for 77.7 percent of the reasonable cost incurred by Northwest prior to closing to overhaul the La Plata A compressor station, with Transwestern's cost not to exceed \$300,000. Transwestern states that such cost is to be added to the purchase price to be paid by Transwestern at closing for the La Plata Facilities.

Transwestern contends that the Sales Agreement further obligates Transwestern to pay 100 percent of the cost for Northwest to install, prior to closing, a regulator at the interconnection of the La Plata Facilities at El Paso-Blanco. It is stated that the regulator will become a part of the La Plata facilities to be acquired by Transwestern at closing, but is not included as part of the necessary modification. Transwestern states that the total cost for such regulator is estimated to be \$346,000.

Transwestern also seeks to have the application amended to reflect the revised estimated purchase cost of \$20.6 million. In addition, Transwestern states that the depreciation expense and other taxes have been reduced to reflect the lower purchase price for the La Plata Facilities.

Any person desiring to be heard or to make any protest with reference to said amendment should on or before December 26, 1995, file with the Federal Energy Regulatory Commission, Washington, DC 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the Natural Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Take further notice that, pursuant to the authority contained in and subject to jurisdiction conferred upon the Federal Energy Regulatory Commission by

Sections 7 and 15 of the Natural Gas Act and the Commission's Rules of Practice and procedure, a hearing will be held with further notice before the Commission or its designee on this application if no motion to intervene is filed within the time required herein, if the Commission on its own review of the matter finds that a grant of the certificate is required by the public convenience and necessity. If a motion for leave to intervene is timely filed, or if the Commission on its own motion believes that a formal hearing is required, further notice of such hearing will be duly given.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Transwestern to appear or be represented at the hearing.

Lois D. Cashell,
Secretary.

[FR Doc. 95-29914 Filed 12-7-95; 8:45 am]

BILLING CODE 6717-01-M

ENVIRONMENTAL PROTECTION AGENCY

[FRL-5343-4]

Agency Information Collection Activities Under OMB Review; Approval of State Coastal Nonpoint Pollution Control Programs Under CZARA Section 6217

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this notice announces that the extension for the currently approved Information Collection Request (ICR) for the Approval of State Coastal Nonpoint Pollution Control Programs under CZARA Section 6217 described below has been forwarded to the Office of Management and Budget (OMB) for review and comment. The ICR extension describes the nature of the information collection and its expected burden and cost.

DATES: Comments must be submitted on or before January 8, 1996, to Sandy Farmer, Mail Code 2136, Regulatory Management Division, U.S. Environmental Protection Agency, 401 M St., SW., Washington, DC 20460.

FOR FURTHER INFORMATION OR A COPY CALL: Sandy Farmer at EPA, (202) 260-2740, and refer to EPA ICR No. 1569.03.

SUPPLEMENTARY INFORMATION: *Title:* Approval of State Coastal Nonpoint Pollution Control Programs under CZARA Section 6217 (OMB Control No. 2040-0153; EPA ICR No. 1569.03). This

is a request for extension of a currently approved collection.

Abstract: The Program Development and Approval Guidance implements Section 6217 of the 1990 Coastal Zone Management Act Reauthorization Amendments. The guidance requires 24 coastal States and 5 coastal Territories with approved Coastal Zone Management Programs to submit Coastal Nonpoint Programs to EPA and NOAA for joint review in July 1995. This one-time submittal will be used to determine if States and Territories receiving Clean Water Act Section 319 and Coastal Zone Management Act Section 306 Federal grants will face reductions.

The original Information Collection Request estimated that the reporting burden to develop coastal nonpoint programs under the Program Development and Approval Guidance would average 1,874 hours per response (29 respondents), including the time for reviewing instruction, searching existing data sources, completing and reviewing the information, and preparing the final report. Based on initial reviews of many of the Coastal Nonpoint Programs that have been submitted for review, EPA and NOAA anticipate that many programs are likely to receive conditional approvals. These conditional approvals may require States and Territories to submit additional information at a later date prior to receiving final program approval. The extension for the currently approved ICR will allow States to complete development of their programs and submit their programs to EPA and NOAA for final program approval by fulfilling any conditions that the Federal agencies place on final program approval.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR Part 9 and 48 CFR Chapter 15. The Federal Register notice required under 5 CFR 1320.8(d), soliciting comments on this collection of information was published on 9/27/95 (60 FR 49833).

Burden Statement: Because the coastal States and Territories have completed a substantial majority of their program development at this time, EPA estimates that the remaining reporting burden will be approximately 20 percent of the original burden estimate, or an average of approximately 375 hours per response. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide

information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

Respondents/Affected Entities:

Coastal States and Territories.

Estimated Number of Respondents: 29.

Frequency of Response: Once for each affected program element.

Estimated Total Annual Hour Burden: 3,625 hours.

Send comments on the Agency's need for this information, the accuracy of the provided burden estimates, and any suggested methods for minimizing respondent burden, including through the use of automated collection techniques to the following addresses. Please refer to EPA ICR No. 1569.03 and OMB Control No. 2040-0153 in any correspondence.

Ms. Sandy Farmer, U.S. Environmental Protection Agency, OPPE Regulatory Information Division (2136), 401 M St., SW., Washington, DC 20460 and

Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: Desk Officer for EPA, 725 17th Street, NW., Washington, DC 20503.

Dated: December 5, 1995.

Joseph Retzer,

Director, Regulatory Information Division.

[FR Doc. 95-29993 Filed 12-7-95; 8:45 am]

BILLING CODE 6560-50-P

[FRL-5339-9]

Agency Information Collection Activities up for Renewal; New Source Performance Standards for Subparts Db, Ea, EE, H, VV, L and Y

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this notice announces that the EPA is planning to submit the following proposed and/or continuing Information Collection Requests (ICRs) to the Office of Management and Budget

(OMB). Before submitting the ICRs to OMB for review and approval, EPA is soliciting comments on specific aspects of the proposed information collections as described below.

DATES: Comments must be submitted on or before February 6, 1996.

ADDRESSES: Office of Enforcement and Compliance Assurance, Office of Compliance. People interested in getting copies of or making comments about any of these ICRs may contact the Office of Compliance, Mail Code: 2224A, 401 M Street SW., Washington, DC 20460. This information may also be acquired electronically through the EnviroSense Bulletin Board, 703-908-2092 or the EnviroSense WWW/Internet Address, <http://wastenot.inel.gov/envirosense/>. All responses and comments will be collected regularly from EnviroSense.

FOR FURTHER INFORMATION CONTACT: Dan Chadwick (202) 564-7054, for NSPS Subpart Db; Joyce Chandler at (202) 564-7073, for NSPS Subpart Ea; Gregory R. Waldrip, (202) 564-7024, or via e-mail (waldrip>gregory@epamail.epa.gov), for NSPS Subpart EE; Tracy Back, (202) 564-7076, facsimile number (202) 564-0009, for NSPS Subpart H; Marcia Mia at (202) 564-7042, for NSPS Subpart VV, facsimile number (202) 564-0037; Maria Malave at (202) 564-7027 or via e-mail (malave.maria@epamail.epa.gov), for NESHAP Subpart L; Rafael Sanchez at (202) 564-7028 or via e-mail (sanchez.rafael@epamail.epa.gov) for NESHAP Subpart Y; and Ted Coopwood at (202) 564-7058, for NESHAP Subparts L and Y. Unless otherwise indicated above, the facsimile number for all contacts is (202) 564-0050.

NSPS Subpart Db Supplementary Information

Affected entities: Entities potentially affected by this action are those which are subject to NSPS Subpart Db, or each steam generating unit that commences construction, modification or reconstruction after June 19, 1984, and that has a heat input capacity from fuels combusted in the steam generating unit of greater than 29 MW (100 million BTU/hour).

Title: NSPS Subpart Db: Standards of Performance for Industrial-Commercial-Institutional Steam Generating Units, OMB number 2060-0072, expires April 30, 1996.

Abstract: Owners and operators of the affected facilities described must make the following one-time-only reports: notification of the date of construction or reconstruction; notification of the anticipated and actual dates of startup;

notification of any physical or operational change to an existing facility which may increase the regulated pollutant emission rate; notification of demonstration of the continuous monitoring system (CMS); notification of the date of the initial performance test; and the results of the initial performance test. Owners or operators are also required to maintain records of the occurrence and duration of any startup, shutdown, or malfunction in the operation of an affected facility, or any period during which the monitoring system is inoperative. These notifications, reports and records are required, in general, of all sources subject to NSPS.

An owner or operator subject to the NO_x standard who seeks to demonstrate compliance with these standards through the monitoring of steam generating unit operating conditions under the provisions of § 60.48b(g)(2) shall submit to the Administrator for approval a plan that identifies the operating conditions to be monitored under § 60.48b(g)(2) and the records to be maintained under § 60.49b(j). The owner or operator of an affected facility shall record and maintain records of the amounts of each fuel combusted during each day, and calculate the annual capacity factor individually for coal, distillate oil, residual oil, natural gas, wood, and municipal-type solid waste for each calendar quarter. For affected facilities that combust residual oil, the owner or operator shall maintain records of the nitrogen content of the residual oil combusted in the affected facility and calculate the average fuel nitrogen content on a per calendar quarter.

For facilities subject to the opacity standard of the regulation, the owner or operator shall maintain records of opacity. The owner or operator subject to the NO_x standards of the regulation shall maintain records for each steam generating unit operating day. The owner or operator of selected facilities are required to submit excess emission reports for any calendar quarter during which there are excess emissions from the affected facility. In periods where there are no excess emission reports, a semiannual report must be submitted stating that no excess emissions occurred during the semiannual period. The owner or operator of any affected facility subject to the continuous monitoring requirements for nitrogen oxides under § 60.48(b) shall submit a quarterly report containing information recorded in accordance with § 60.49b(i). The owner or operator of any affected facility subject to the sulfur dioxide standards under § 60.42b shall submit

written reports to the Administrator for every calendar quarter in accordance with § 60.49b(j). For each affected facility subject to the compliance and performance testing requirements of § 60.45b, certain information must be reported to the Administrator. Quarterly reporting of emission data is appropriate for Subpart Db sources due to their large emissions of sulfur dioxide, nitrogen oxides, and particulates.

For each affected facility subject to the sulfur dioxide standards under § 60.42b for which the minimum amount of data required under § 60.47b(f) were not obtained during a calendar quarter, certain information must be reported to the Administrator. If a percent removal efficiency by fuel pretreatment is used to determine the overall percent reduction under § 60.45b, the owner or operator of the affected facility shall submit a signed statement with the quarterly report containing certain information.

The owner or operator of an affected facility described in § 60.44b(j) or § 60.44b(k) shall submit to the Administrator selected information regarding fuel nitrogen content and emission tests on a quarterly basis. The owner or operator of an affected facility who elects to demonstrate that the affected facility combusts only very low sulfur oil under § 60.42b(j)(2) shall obtain and maintain at the affected facility fuel receipts from the fuel supplier which certify that the oil meets the definition of distillate oil as defined in § 60.41b.

All reports are sent to the delegated State or local authority. In the event that there is no such delegated authority, the reports are sent directly to the EPA Regional Office. Notifications are used to inform the Agency or delegated authority when a source becomes subject to the standard. The reviewing authority may then inspect the source to check if the standard is being met. Performance test reports are needed as these are the Agency's record of a source's initial capability to comply with the emission standard. Both the quarterly reports and semiannual reports (where appropriate) are used for problem identification, as a check on source operation and maintenance, and for compliance determinations.

An Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR Part 9.

The EPA would like to solicit comments to:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(ii) evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(iii) enhance the quality, utility, and clarity of the information to be collected; and

(iv) minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Burden Statement: The Agency computed the burden for each of the recordkeeping and reporting requirements applicable to the industry for the currently approved 1992 Information Collection Request (ICR). Where appropriate, the Agency identified specific tasks and made assumptions, while being consistent with the concept of burden under the Paper Reduction Act.

This estimate is based on the assumption that there would be 58 new affected facilities each year and that there were approximately 464 sources in existence for the three years covered by the ICR. The annual burden of reporting and recordkeeping requirements for facilities subject to Subpart Db are summarized by the following information. The reporting requirements are as follows: Read Instructions (1 person-hour), Initial performance test (330 person-hours), 24-hour test for gas units (250 person-hours). It is assumed that 20% of tests are repeated due to failure. The burden for demonstration of continuous emission monitoring system (CEMS) is: 150 person-hours for SO₂, 100 person-hours for PM, 350 person-hours for NO_x. Repeat demonstration of CEMS is: 150 person-hours for SO₂, 100 person-hours for PM, 350 person-hours for NO_x. Annual compliance tests for NO_x are estimated at 250 person-hours. Appendix F annual accuracy test estimates are: 146 person-hours for SO₂, and 146 person-hours for NO_x. Appendix F quarterly audit estimates for SO₂ are: 125 person-hours for in situ, 36 person-hours for extractive, and for Appendix F quarterly audit, NO_x: for in situ (125 person-hours), for extractive (36 person-hours) (*Assume that 25% of units have an in situ CEMS*). Estimates for report writing are: Notification of construction/reconstruction (2 person-

hours), Notification of anticipated startup (2 person-hours), Notification of actual startup (2 person-hours), Monitoring plan (4 person-hours), Notification of initial performance test: for SO₂ (2 person-hours), for PM (2 person-hours), for NO_x (2 person-hours), Report of initial performance test: for SO₂ (16 person-hours), for NO_x (16 person-hours), Notification of CMS demonstration: for SO₂ (2 person-hours), for PM (2 person-hours), for NO_x (2 person-hours), Quarterly reports for SO₂ (16 person-hours), Quarterly reports for PM: excess (16 person-hours), no excess (8 person-hours), Quarterly reports for NO_x: CEMS compliance (16 person-hours), excess (16 person-hours), no excess (8 person-hours), Appendix F quarterly reports: for SO₂ (11 person-hours), for NO_x (11 person-hours). Recordkeeping requirements include the following: Maintaining records of startup, shutdown, malfunction (1.5 person-hours), Maintaining records of all measurements (1.5 person-hours). Records must be kept for a period of two years.

This estimate includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

NSPS Subpart Ea Supplementary Information

Affected entities: Entities potentially affected by this action are those which are subject to the NSPS Subpart Ea, Municipal Waste Combustors (MWCs) with the exceptions listed in 40 CFR Part 60.50a (c), (d) and (g). The Subpart Ea standards of 40 CFR Part 60 apply to MWC's units with a capacity greater than 225 megagrams per day (250 tons/day) of municipal solid waste or refuse-derived fuel, for which construction, modification, or reconstruction commenced between December 20, 1989 and September 20, 1994. MWC's that are constructed, modified, or reconstructed after September 20, 1994 will be subject to the NSPS Subpart Eb.

Title: NSPS Subpart Ea, Municipal Waste Combustors, OMB number 2060-0210, expires May 31, 1996.

Abstract: This ICR contains recordkeeping and reporting

requirements that are mandatory for compliance with 40 CFR Part 60.50a, Subpart Ea, New Source Performance Standards for Municipal Waste Combustors. Owners or operators of units subject to Subpart Ea must provide the EPA, or the delegated State regulatory authority, with one-time notifications and reports, and must keep records, as required of all facilities subject to the general NSPS requirements. In addition, facilities subject to this Subpart must install continuous monitoring systems (CMS) to monitor specified operating parameters to ensure that good combustion practices are implemented on a continuous basis. Owners or operators must submit quarterly and annual compliance reports. The notifications and reports enable the EPA or the delegated State regulatory authority to determine that best demonstrated technology is installed and properly operated and maintained, and to schedule inspections. This information notifies the Agency when a source becomes subject to the regulations and informs the Agency of the source's compliance status when it begins operation. Later the quarterly and annual reports apprise the Agency of the sources' compliance status. The operating parameters specified for the continuous monitoring systems (CMS) ensure that good combustion practices are implemented on a continuous basis.

In the Administrator's judgement, emissions of the MWC metals, the MWC organics, the MWC acid gases, and nitrogen oxides cause or contribute to air pollution that may reasonably be anticipated to endanger public health or welfare. Therefore, New Source Performance Standards have been promulgated for this source category as required under Section 111.

The control of emissions of MWC metals, MWC organics, MWC acid gases and nitrogen oxides requires not only the correct installation, operation, and maintenance of the equipment, but also properly trained supervisors and equipment operators.

An Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR Part 9.

The EPA would like to solicit comments to:

(i) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(ii) evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(iii) enhance the quality, utility, and clarity of the information to be collected; and

(iv) minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Burden Statement: The Agency computed the burden for each to the recordkeeping and reporting requirements applicable to the industry for the currently approved 1993 Information Collection Request (ICR). Where appropriate, the Agency identified specific tasks and made assumptions, while being consistent with the concept of burden under the Paperwork Reduction Act.

The estimate was based on the assumption that there would be no new facilities since any MWC's constructed, modified, or reconstruction after September 20, 1994 would be subject to Subpart Eb not Subpart Ea and that there are an average of 70 sources in existence for the three years covered by the ICR. It is estimated that take: 51,352 person-hours to fill out quarterly and annual reports (assuming 20% of the sources will have at least one quarter with excess emissions) and 22,424 person-hours to enter information for records, for employee review of operation manual, and reading reporting requirements.

The average burden to industry over the next three years from these recordkeeping and reporting requirements is estimated at 73,776 person hours. The respondent costs have been calculated on the basis of \$14.50 per hour plus 110 percent overhead. The average burden to industry over the next three years of the ICR is estimated to be \$2,253,119.

This estimate includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of

information; and transmit or otherwise disclose the information.

NSPS Subpart EE Supplementary Information

Affected entities: Entities potentially affected by this action are each metal furniture surface coating operation in which organic coatings are applied and for which construction, modification or reconstruction commenced after the date of proposal, November 28, 1980. A surface coating operation includes the coating application station(s), flash-off area, and curing oven.

Title: NSPS for Metal Furniture Surface Coating (Subpart EE)—Information Requirements; OMB No.: 2060-1006; Expiration date: April 30, 1996.

Abstract: The EPA is charged under Section 111 of the Clean Air Act, as amended, to establish standards of performance for new stationary sources that reflect:

* * * application of the best technological system of continuous emissions reduction which (taking into consideration the cost of achieving such emissions reduction, of any nonair quality health and environmental impact and energy requirements) the Administrator determines has been adequately demonstrated [Section 111(a)(1)].

The Agency refers to this charge as selecting the best demonstrated technology (BDT). Section 111 also requires that the Administrator review, and, if appropriate revise such standards every four years. In addition, Section 114(a) states that:

* * * the Administrator may require any owner or operator subject to any requirement of this Act to (A) establish and maintain such records, (B) make such reports, install, use and maintain such monitoring equipment or methods (in accordance with such methods at such locations, at such intervals, and in such manner as the Administrator shall prescribe), and (D) provide such other information, as he may reasonably require.

In the Administrator's judgment, VOC emissions from the metal furniture surface coating industry cause or contribute to air pollution that may reasonably be anticipated to endanger public health or welfare. Therefore, NSPS were promulgated for this source category.

The control of VOC emissions from metal furniture surface coating operations requires not only the installation of properly designed equipment, but also the operation and maintenance of that equipment. VOC emissions from the coating of metal furniture surfaces result from the application and curing or drying of organic coatings on the surface of each metal furniture part or product. These

standards rely on the reduction of VOC emissions through either a capture system and incinerator or a capture system and solvent recovery system.

Information is recorded in sufficient detail to enable owners or operators to demonstrate compliance with the standards. This information is used to monitor effective operation of the capture system and control devices, thus ensuring continuous compliance with the standards. The semiannual reporting requirement for no exceedances of the monitoring parameters provides a good indication of a source's compliance status.

The information collected from record keeping and reporting requirements is also used for targeting inspections, and is of sufficient quality to be used as evidence in court. An Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR Part 9. In order to ensure compliance with these standards, adequate record keeping is necessary. In the absence of such information, enforcement personnel would be unable to determine whether the standards are being met on a continuous basis, as required by the Clean Air Act.

Owners/operators of affected facilities must report excess emissions and deviations in operating parameters on a quarterly basis. Where no exceedances have occurred during a particular quarter, a report stating this shall be submitted semi-annually.

Notification of construction and startup indicates to enforcement personnel when a new affected facility has been constructed and therefore is subject to the standards. The information generated by the monitoring, record keeping and reporting requirements described above is used by the Agency to ensure facilities affected by the NSPS continue to operate the control equipment used to achieve compliance with the NSPS.

The following table documents the computation of individual burdens for each of the record keeping and reporting requirements applicable to the industry. The individual burdens are expressed under standardized headings believed to be consistent with the concept of burden under the Paperwork Reduction Act. Where appropriate, specific tasks and major assumptions have been identified.

Source Data and Information Requirements—Surface Coating of Metal Furniture (NSPS Subpart EE)

Requirement

Notification of construction or reconstruction
Notification of anticipated data of initial startup
Notification of actual date of initial startup
Notification of physical or operational change
Notification of date of demonstration of continuous monitoring system (N/A)
Maintain records of startups, shutdowns, malfunctions, periods where continuous monitoring system is inoperative
Maintain continuous monitoring system and performance test records
Report of initial performance test
Install, calibrate, maintain, and operate temperature monitoring device
Install equipment necessary to determine volume of VOC solvent recovered
Identify and record periods of low incinerator temperature
Identify and record excess emissions
Maintain daily records of incinerator combustion temperature, or amounts of solvent recovered

Regulatory Reference

40 CFR 60.7(a)(1)
40 CFR 60.7(a)(2)
40 CFR 60.7(a)(3)
40 CFR 60.7(a)(4)
40 CFR 60.7(a)(5)
40 CFR 60.7(b)
40 CFR 60.7(d)
40 CFR 60.8(a), 60.315(a)
40 CFR 60.314(a)
40 CFR 60.314(b)
40 CFR 60.315(b)(2), (b)(3)
40 CFR 60.315(b)(1)
40 CFR 60.315

The EPA would like to solicit comments to:

(i) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(ii) evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(iii) enhance the quality, utility, and clarity of the information to be collected; and

(iv) minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated electronic,

mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

The burden has been estimated at 60 hours for performance testing. Notification of construction/modification, anticipated start-up, initial performance test, actual performance test date, no excess emissions, size cut offs exceeded are estimated to take two hours. Reports of monitoring exceedances and periods of noncompliance are estimated to require 16 hours. Notification of actual start-up is estimated to require one hour. An hourly wage of \$14.50 plus 110 percent overhead costs, which equals \$30.45 has been used in the previous ICR. Other assumptions include; total of 30 lines constructed per year, 20 percent of initial performance tests must be repeated due to failure, 80 percent of lines report no excess emission semiannually ($.8 \times 705 = 564$), no lines projecting application of less than 3,842 liters of coating are expected to exceed the cutoff in the next three years, one occurrence of startup, shutdown or malfunction per week (50 weeks per year), and operating parameters are recorded 350 days per year.

Burden Statement: The individual burdens for each of the record keeping and reporting requirements applicable to the industry are consistent with the concept of burden under the Paperwork Reduction Act. The only type of industry costs associated with the information collection activity in the standards are labor costs. The labor estimates in the table were derived from standard estimates based on EPA's experience with other standards. The average annual burden to industry over the next three years from these record keeping and reporting requirements is estimated at 128,213 person-hours. The respondent costs have been calculated on the basis of \$14.50 per hour plus 110 percent overhead. The average annual burden to industry over the next three years of the ICR is estimated to be \$3,904,086. This estimate includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

NSPS Subpart H Supplementary Information

Affected entities: are those plants that produce sulfuric acid by the contact process by burning elemental sulfur, alkylation acid, hydrogen sulfide, organic sulfides and mercaptans, or acid sludge, but does not include facilities where conversion to sulfuric acid is utilized primarily as a means of preventing emissions to the atmosphere of sulfur dioxide or other sulfur compounds.

Title: NSPS Subpart H, Sulfuric Acid Plants, OMB number 2060-0041, expires June 31, 1996.

Abstract: This ICR contains recordkeeping and reporting requirements that are mandatory for compliance with 40 CFR Part 60.80, Subpart H, New Source Performance Standards for Sulfuric Acid Plants. This information notifies the Agency when a source becomes subject to the regulations, and informs the Agency that the source is in compliance when it begins operation. The Agency is informed of the sources' compliance status by semiannual reports. The calibration and maintenance requirements aid in a source remaining in compliance.

In the Administrator's judgement, SO₂ and acid mist emissions from the manufacture of sulfuric acid cause or contribute to air pollution that may reasonably be anticipated to endanger public health or welfare. Therefore, New Source Performance Standards have been promulgated for this source category as required under Section 111 of the Clean Air Act.

The control of SO₂ and acid mist requires not only the installation of properly designed equipment, but also the proper operation and maintenance of that equipment. Sulfur dioxide and acid mist emissions from sulfuric acid plants result from the burning of sulfur or sulfur-bearing feedstocks to form SO₂, catalytic oxidation of SO₂ to SO₃, and absorption of SO₂ in a strong acid stream. These standards rely on the capture of SO₂ and acid mist by venting to a control device.

Owners or operators of Sulfuric Acid Plants subject to NSPS are required to make the following one-time-only reports: notification of the date of construction or reconstruction; notification of the anticipated and actual dates of startup; notification of any physical or operational change to an existing facility which may increase the regulated pollutant emission rate; notification of demonstration of the continuous emission monitoring system (CEMS); notification of the date of the

initial performance test; and the results of the initial performance test. After the initial recordkeeping and reporting requirements, semiannual reports are required if there has been an exceedance of control device operating parameters.

Owners or operators are also required to maintain records of the occurrence and duration of any startup, shutdown, or malfunction in the operation of an affected facility, or any period during which the monitoring system is inoperative. These notification, reports and records are required, in general, of all sources subject to NSPS.

Four new facilities are estimated to become subject to NSPS Subpart H annually.

An Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR Part 9.

The EPA would like to solicit comments to:

(i) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(ii) evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(iii) enhance the quality, utility, and clarity of the information to be collected; and

(iv) minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Burden Statement: The current ICR estimates the total annual burden to industry to be \$675,478.44. This is based on a total average annual burden of 22,183.2 person hours for 94 respondents with an average wage of \$14.55 per hour and 110% overhead. The burden is greatest for facilities in their first year of operation. The burden in the first year for reporting requirements is estimated to be 455.80 hours per facility. The burden for future years is greatly reduced because the initial notifications and initial performance tests are not required in subsequent years. The estimated burden for record keeping requirements for subsequent years per respondent is 140 person hours. This estimate includes the time to enter information regarding

records of operating parameters and calculations/record of conversion factors.

The following is a breakdown of burden used in the ICR. The estimated burden is calculated as two hours for respondents to write the reports for; notification of construction or reconstruction, notification of physical or operation changes, notification of anticipated startup, notification of actual startup, notification of initial performance test, notification of demonstration of CMS. The ICR uses 300 burden hours for the initial performance test. It is assumed that 20% of all affected facilities will have to repeat performance tests. The ICR uses four hours for performing the Reference Method 9 Test. It is estimated that performance of Reference Method 9 Test will occur 1.2 times per facility a year. The ICR uses 40 hours to write an excess emission reports—it is assumed this will take place twice a year.

The recordkeeping burden is estimated to be 0.25 hours to enter information regarding records of operating parameters. It is assumed this will take place 350 times a year per facility. The burden to enter information regarding calculation/record of conversion factors is 0.5 hours. It is assumed this will take place 1,050 times a year per facility.

NSPS Subpart VV Supplementary Information

Affected entities: Entities potentially affected by this action are those which are subject to Subpart VV, VOC Equipment Leaks in the Synthetic Organic Chemicals Manufacturing Industry with the exceptions listed in 40 CFR Part 60.480(d).

Title: NSPS Subpart VV, VOC Equipment Leaks in the SOCM, OMB number 2060-0012, expires May 31, 1996.

Abstract: This ICR contains recordkeeping and reporting requirements that are mandatory for compliance with 40 CFR Part 60.480, Subpart VV, VOC Equipment Leaks in the SOCM. This information is used by the Agency to identify sources subject to the standards and to insure that the best demonstrated technology is being properly applied. The standards require periodic recordkeeping to document process information relating to the sources ability to identify and eliminate leaking equipment. The standards apply to specific pieces of equipment contained within a process unit in the SOCM, including pumps in light liquid service, compressors, pressure relief devices in gas/vapor, light or heavy liquid service, sampling connection

systems, open-ended valves or lines, valves in gas/vapor and light liquid service, pumps and valves in heavy liquid service, and flanges and other connectors.

In the Administrator's judgement, VOC emissions from equipment leaks in the SOCM cause or contribute to air pollution that may reasonably be anticipated to endanger public health or welfare. Therefore, New Source Performance Standards have been promulgated for this source category as required under section 11 of the Clean Air Act.

The owners or operators of the affected facilities described must make the following one time only reports: notification of the date of construction or reconstruction, notification of the anticipated and actual date of startup, notification of any physical or operational change to an existing facility which may increase the emission rate of any air pollutant to which the standard applies (in this case, VOC), notification of the initial performance test, and the results of the performance test. The only regular report required by this Subpart is a semiannual excess emissions summary.

Owners or operator are also required to maintain records of the occurrence and duration of any startup, shutdown or malfunction in the operation of an affected facility, or malfunctions of the air pollution control device. These notifications, reports and records are required, in general, of all sources subject to the NSPS.

Recordkeeping requirements specific to equipment leaks in the SOCM support the facility's leak detection and repair program and include identification of leaking equipment; a log of leaking equipment; a log of information relating to the closed vent systems and control devices; a log identifying all equipment subject to the standards; a log of valves designated as difficult-to-monitor or unsafe-to-monitor; a log of valves complying with skip period leak detection and repair alternative standard; a log of criterion established which indicates a failure of the seal system, barrier system, or both for each barrier fluid system; dates of compliance tests and results; and for determining exemptions, an analysis of design capacity of affected sources or demonstration that the equipment is not in VOC service and a statement listing the feed or raw materials and products.

Reporting requirements specific to equipment leaks in the SOCM consist of an initial semiannual report including process unit identification and number of valves, pumps and compressors subject to the standards.

All semiannual reports are to include process unit identification, number of components leaking and not repaired, dates of process unit shutdowns, and revisions to items submitted in initial semiannual report. The source is also required to notify the Administrator of the election to use an alternative standard for valves ninety days before implementing the provision.

An Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR Part 9.

The EPA would like to solicit comments to:

(i) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(ii) evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(iii) enhance the quality, utility, and clarity of the information to be collected; and

(iv) minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Burden Statement: The Agency computed the burden for each of the recordkeeping and reporting requirements applicable to the industry for the currently approved ICR. Where appropriate, the Agency identified specific tasks and made assumptions, while being consistent with the concept of burden under the Paperwork Reduction Act.

The estimate was based on the assumption that there would be 166 new affected facilities each year and that there would be an annual average of 1909 affected facilities over each of the next three years covered by the ICR. For the new sources, it was estimated that it would take: 166 person hours to read the instructions, 9562 person hours to conduct the initial performance tests (assuming that 20% of the tests must be repeated), and 1394 person hours to gather the information and write the initial reports. For all sources, it was estimated that it would take: 15,272 person hours to fill out semiannual reports and 152,720 person hours to

enter information for records of operating parameters.

The annual average burden to industry for the three year period covered by this ICR from recordkeeping and reporting requirements has been estimated at 179,104 person hours. The respondents costs were calculated on the basis of \$14.50 per hour plus 100% overhead. The total annual burden to industry is estimated at \$5,453,716.

This estimate includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information. No additional third party burden is associated with this ICR.

NESHAP Subparts L and Y Supplementary Information

Affected entities: Entities potentially affected by this action are coke by-product recovery plants (NESHAP Subpart L) and storage vessels that store benzene having a specific gravity within the range of specific gravities specified in ASTM D 836-84 for Industrial Grade Benzene, ASTM D 835-85 for Refined Benzene-535 and ASTM D 4734-87 for Refined Benzene-545 (NESHAP Subpart Y), which are codified as separate subparts under 40 CFR, Part 61.

Title: National Emission Standards for Hazardous Air Pollutants, Benzene Emissions from Benzene Storage Vessels, and Coke Byproduct Recovery Plants; OMB No. 2060-0185, expiration date: 6/30/96.

Abstract: The EPA is charged under Section 112 of the Clean Air Act, as amended, with establishing emission standards for hazardous air pollutants. These standards are to be set at a level which provides an ample margin of safety to protect the public health. On June 8, 1977, EPA determined that benzene presents a significant carcinogenic risk to human health and is, therefore, a hazardous air pollutant requiring regulation. In addition, Section 114(a) states that:

* * * the Administrator may require any owner or operator subject to any requirement of this act to: (1) Establish and maintain such records, (2) make such reports, (3) install, use and maintain such monitoring equipment or methods (in accordance with such methods

at such locations, at such intervals, and in such manner as the Administrator shall prescribe), and (4) provide such other, information, as he may reasonably be required.

National Emission Standards for Benzene Emissions from Coke By-product Recovery Plants were proposed by EPA on June 6, 1984 (49 FR 23522). At that time, an information collection request was submitted (ICR number 1080). The proposed standards were reconsidered by EPA in light of the U.S. Court of Appeals vinyl chloride decision [*Natural Resources Defense Council, Inc. v. EPA*, 824 F.2d 1146, D.C. (1987)]. Other benzene-related actions including maleic anhydride, ethylbenzene/styrene, benzene storage vessels, and equipment leaks were also reviewed by EPA following the vinyl chloride court decision. The Agency proposed four different approaches to regulating these benzene source categories in a manner consistent with the vinyl chloride court decision (53 FR 28496, July 28, 1988). Regulations proposed for maleic anhydride and ethylbenzene/styrene were not promulgated and therefore have been dropped from this information collection statement. The coke by-product recovery plants rule was promulgated September 14, 1989 (54 FR 38044) and amended September 19, 1991 (56 FR 47406).

National Emission Standards for Hazardous Air Pollutants (NESHAP) for Benzene Emissions from Benzene Storage Vessels were proposed in 1980 and withdrawn by EPA on June 6, 1984 (49 FR 23558). On August 3, 1984, the Natural Resources Defense Council (NRDC) filed a petition in the U.S. Court of Appeals, seeking review of the EPA's storage withdrawal and other benzene rulemakings. (*Natural Resources Defense Council Inc. v. Thomas*, No. 84-1387) (referred to as Benzene). In light of the U. S. Court of Appeals Vinyl Chloride decision (*Natural Resources Defense Council. Inc. v. EPA*, 824 F.2d 1146, D.C. Cir., July 28, 1987), EPA requested a voluntary remand in Benzene to reconsider its June 6, 1984, rulemakings. In an order dated December 8, 1987, the court approved the EPA's voluntary remand and established a schedule under which EPA must propose its action on reconsideration within 180 days of the order. In June 1988, EPA received a 45-day extension. The benzene storage vessels rule was promulgated on September 14, 1989 (54 FR 38077) as 40 CFR Part 61 Subpart Y.

Subpart L: Coke By-Product Recovery Plants

A national emission standard for hazardous air pollutants (NESHAP) was proposed under Section 112 for coke by-product recovery plants, a benzene source category, on June 6, 1984 (49 FR 23522), republished on July 28, 1988 (53 FR 28496), and was promulgated on September 14, 1989.

The control requirements for coke by-product recovery plants require that organic vapors be recovered and routed via closedvent system (no detectable emissions) to a control device that achieves a 95 percent or greater destruction efficiency. The affected equipment must not exceed a specified level of equipment leaks, either through a concentration standard, or in the case of valves, a percent of total valves standard is optional. The control of emissions of benzene from recovery plants requires not only the installation of properly designed equipment, but also the operation and maintenance of that equipment. Emissions of benzene from recovery plants covered by this regulation are the result of leaking equipment.

The standards require initial notification reports with respect to construction, emissions tests, and startup. The standards also require reports on initial performance tests and emissions tests results.

Notifications are used to inform the Agency or delegated authority when a source becomes subject to the standard. The reviewing authority may then inspect the source to check that pollution control devices are properly installed and operated and the standards are being met. Performance test reports are needed as these are the Agency's record of a source's initial capability to comply with the emission standard, and note the operating conditions under which compliance was achieved. The regular reports are used for problem identification, as a check on source operation and maintenance, and for compliance determinations. The information generated by the monitoring, recordkeeping and reporting requirements described above is used by the Agency to ensure that facilities affected by the NESHAP continue to operate the control equipment used to achieve compliance. Effective enforcement of the standard is particularly necessary in light of the hazardous nature of benzene. Information is recorded in such sufficient detail to enable owners or operators to demonstrate compliance with the standards. This information is

used to monitor fugitive emissions directly, and to ensure effective operation of the vapor-collection system and control device, thus ensuring continuous compliance with the indications of a source's continuing compliance status. The information collected from recordkeeping and reporting requirements is also used for targeting inspections, and is of sufficient quality to be used as evidence in court. Records and reports also are necessary to enable EPA to identify plants that may not understand the workings of the standard or that may not be in compliance with the standard. Based on reported information, EPA can decide how many plant inspections would be needed, which plants should be inspected, and what records or processes should be inspected at the plant. In the absence of such information enforcement personnel would be unable to determine whether the standards are being met on a continuous basis, as required by the Clean Air Act, owners or operators of the affected facilities described must make the following one-time-only notices or reports: notification of anticipated startup, notification of actual startup, notification of construction or modification, initial compliance report, notification of emission test, report following an emission test, notification of a monitoring system performance test, and report following a monitoring system performance test. These notifications and reports are general provisions and required of all sources subject to any NESHAP.

Reporting requirements specific to benzene coke by-product recovery plants, Subpart L, include a semiannual report by affected facilities. The semiannual reports include results of leak monitoring and performance tests. Respondents also are required to submit semiannual reports of measurements for sources subject to a no detectable emissions limit and semiannual reports summarizing the results of the leak detection and repair program implemented at the plant. One report would incorporate information for both process equipment and fugitive sources. These reports would include information such as number of leaks that occurred, the number that could not be repaired, the general reasons for unsuccessful or delay of repair, and the results of performance tests conducted during the reporting period.

Monitoring, recordkeeping and reporting requirements specific to benzene coke by-product recovery plants for leak detection and repair of fugitive emission sources are those

provisions specified under 40 CFR 61, NESHAP Subpart V. The Subpart V regulations for equipment leaks were approved by the Office of Management and Budget (OMB) under control number 2060-0068. The only difference in the equipment leak requirements of Subpart V and this regulation relates to exhausters. Exhausters are subject to quarterly monitoring requirements. However, quarterly monitoring is not required if the exhauster is equipped with a seal system that has a barrier fluid, the exhauster seal is loaded and vented to a control device, or a leakless exhauster is used. Exhausters are subject to the same recordkeeping and reporting provisions as other equipment subject to Subpart V.

The added control amendment to the coke-by-product plant benzene NESHAP is based on a settlement agreement pursuant to a petition to review the benzene NESHAP by the American Coke and Coal Chemicals Institute (ACCCI). The recordkeeping and reporting requirements contained in this rule are consistent with those described in the agreement.

The owner or operator choosing to use one of the alternative control technologies (i.e., a carbon absorber or a vapor incinerator) would be required to record for the life of the control device, the design of the control device, the sources which it is intended to control, and a plan for the operation, maintenance and action needed to correct problems. Such a record would assist the owner or operator to operate the device properly throughout its life and would also assist the enforcement personnel in determining, when reviewing records that indicate problems with the control device, whether the device had been properly maintained and appropriate corrective action had been taken. The owner or operator would be required to record the results of each test for determining compliance with the standard. Also required to be recorded would be any data that provide reference values for parameters that are important to monitoring, such as temperature of the firebox in a vapor incinerator and the benzene concentration at the inlet to a carbon adsorber. Some of these data are gathered during the compliance test, others separately (e.g., the demonstrated bed life of a carbon adsorber).

These records would be required to be kept for at least two years, or until the next compliance test (or time that the parameter reference value is determined), whichever is longer. Finally, the results of monitoring the control device would be required to be recorded for at least 2 years. The records

would include any periods when the boundaries established for the monitored parameters were exceeded and the action taken to correct the problem that led to the exceedance.

The alternative control options require reporting in addition to recordkeeping. The General Provisions require reporting of compliance tests. This would be submitted each time a compliance test is performed. The rule requires compliance tests to be done initially and at the request of EPA (not at predetermined intervals). In addition, the rule requires reporting of exceedances of the monitored parameters, with a brief description of the corrective action taken. Included would be exceedances of the operating requirements such as if the source were not vented to a fresh carbon bed before the maximum concentration point was exceeded on the spent bed. The reports are required quarterly. When semiannual reports under Subpart L are due, the information for the quarterly report should be submitted as part of the semiannual report. If there were no exceedances during a quarter in which no semiannual report was due, reporting for that quarter could be skipped and a notation to that effect included in the next report. The reason that quarterly reports are required for these control devices is because the monitoring is generally continuous and therefore provides a continuous record of problems with operation and maintenance of the device. Because of the hazardous nature of benzene, it is important that enforcement personnel are alerted to plants that are having problems with their control device and are potentially in violation of the standards. The enforcement personnel can then move quickly to make sure the problem area is corrected.

Any owner or operator subject to the provisions of this part shall maintain an up-to-date file of monitoring and recordings, and retain them for at least two years following. Records of equipment and process design are kept permanently.

These data would include information necessary to administer the program (such as source identification number, percent by weight benzene in the process fluid, type of fugitive emission source) as well as data gathered relating directly to leak detection and repair (such as leak dates and repair methods). Respondents using gas-blanketing systems, closed-vent systems, and control devices are required to maintain records of schematics, design specifications, piping and instrumentation diagrams, and other information related to changes in design

or operation. Other records are required for sources which may be designated for no detectable emissions or as unsafe or difficult to monitor.

All reports are sent to the delegated State or Local authority. If there is no such delegated authority, the reports are sent directly to the EPA Regional Office.

Data obtained by Agency personnel from records maintained by the respondents during periodic visits are tabulated and published for internal Agency use in compliance and enforcement programs.

Information contained in the report is entered into the Aerometric Information Retrieval System (AIRS) Facility Subsystem (AFS) which is operated and maintained by EPA's Office of Air Quality Planning and Standards. The AFS is EPA's database for the collection, maintenance and retrieval of compliance data and annual emission inventory data for over 100,000 industrial and government facilities. EPA uses AFS for tracking compliance and enforcement by Local and State regulatory agencies, EPA Regional Offices and Headquarters. EPA personnel can edit, store, retrieve and analyze the data via personal computer terminals.

Burden Statement: For Subpart L, the Agency computed the burden for each of the recordkeeping and reporting requirements applicable to the industry for the currently approved 1993 Information Collection Request (ICR). Where it was appropriate, the Agency identified specific tasks and made assumptions, while being consistent with the concept of burden under the Paper Reduction Act. The 1993 ICR review was the first since promulgation of the rule and consolidated the added control options promulgated in September 1991.

For Subpart L, the majority of industry costs associated with the information collection activity in the standards are labor costs. The labor estimates were derived from standard estimates based on EPA's experience with other standards. For the purpose of the 1993 ICR burden analysis it was assumed that no sources choose to comply with the percent-allowable leaks nor skip period reporting. Thus, the burden analysis was based on a most burdensome case scenario for reporting and recordkeeping.

Recordkeeping and reporting requirements are an ongoing burden associated with this ICR. The 1993 ICR estimated a nationwide annualized cost to respondents for recordkeeping and reporting requirements of \$215,678 over a 3-year period. The respondent burden was estimated at 7,083 person-hours per

year. This estimate was based upon a cost of \$14.50 per hour plus an overhead rate of 110 percent, for a total cost of \$30.45 per hour.

The following is a breakdown of burden used in the 1993 ICR for Subpart L. It was assumed that 36 sources were subject to the standard and no additional sources per year will become subject to the standard over the past three years. The ICR allocated 224.5 hours *per respondent* for implementing the activities required to meet the recordkeeping and reporting requirements. Specifically, 132 hours were allocated for filing and maintaining records, 4 hours for conducting Method 21 tests during the year, 57.5 hours for creating the information for reporting and 31 hours for writing the report.

Subpart Y: Benzene Storage Vessels

Respondents are all owners or operators of benzene storage vessels. It is estimated that 126 existing plants are subject to the standard. All owners and operators of new or reconstructed plants would also have to respond.

In the General Provisions of 40 CFR Part 61 applicable to storage vessels, require up to four separate one time-only reports for each owner or operator: notification of construction or reconstruction, initial source report, notification of physical/operational changes, notification of anticipated and actual startup. The initial source report is the only one of these reports that would be required from existing sources under the standard.

Certain records and reports are necessary to assist EPA and State agencies to which enforcement has been delegated in determining compliance with the standard.

An initial emissions test is not required because conducting an emission test is not feasible. Therefore, the format of the standard is that of an equipment standard. Owners or operators of vessels equipped with the specified controls are required to submit, along with the notifications required by the General Provisions, a report that describes the control equipment used to comply with the regulation. Thereafter, an annual visual inspection is required of the primary seal of internal floating roof vessels (IFR's) (in cases where no secondary seal is present). An annual seal gap measurement of the secondary seal system on external floating roof vessels (EFR's) is required. The following inspections are required every five years: (1) internal inspection of seal system on IFR's equipped with primary and secondary seals in situations where

the owner or operator has decided to forego the annual visual inspection; and (2) measurement of gaps between the tank wall and primary seal on EFR's. An internal inspection in which the tank is emptied and degassed is required at least every 10 years for IFR's.

Another control option allowed is for owners or operators to equip vessels with closed-vent systems and 95-percent efficient control devices. It is expected that very few, if any, vessels will be equipped with these systems; however, owners or operators of vessels with such systems are required to submit, for the Administrator's approval, an operating plan describing system design specifications and an operation, maintenance, and inspection plan for the system. In the event the owner or operator has installed a flare, a report showing compliance with visible emission provisions shall be furnished to the Administrator. For closed-vent systems with control devices, quarterly reports are required informing the Administrator of each occurrence that results in excess emissions. Annual reports of the results of these inspections and seal gap measurements are required. These reports shall identify each storage vessel that is determined to be out of compliance with the standard, the nature of the defects, and the date the vessel was emptied or the repair was made. The owner or operator shall keep copies of all reports and records resulting from these inspections for two years.

The owner or operator of each benzene storage vessel shall, for the life of the source, keep readily accessible records showing the dimension of the vessel and an analysis showing the capacity of the storage vessel. For each vessel with a closed vent system and 95-percent efficient control device, records of the operating plan shall be kept for the life of the control device. Records of monitored parameters and maintenance shall be kept for two years.

Burden Statement: For Subpart Y, EPA estimated the nationwide annualized cost to respondents at a \$47,045/yr over a 3-year period. The respondent burden is estimated at 1,545 person-hours/yr. Respondent costs are estimated based on a cost of \$14.50 per hour, and on an overhead rate of 110 percent (for a total cost per hour of \$30.45). The annual reporting burden is estimated at a \$39,372/yr over a 3-year period. The number of responses per year is estimated to be 162. The number of responses per respondent is estimated to be five. The total annual responses are estimated to be 810. The number of hours per response per year is estimated

to be four. These estimates include the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

* * * * *

An Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR Part 9. The EPA would like to solicit comments to:

(i) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(ii) evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(iii) enhance the quality, utility, and clarity of the information to be collected; and

(iv) minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Send comments regarding these matters, or any other aspect of the information collection, including suggestions for reducing the burden, to the contacts listed above.

Dated: November 24, 1995.

Rick Colbert,

Acting Director, Office of Compliance.

[FR Doc. 95-29739 Filed 12-7-95; 8:45 am]

BILLING CODE 6560-50-P

[ER-FRL-5231-1]

Environmental Impact Statements; Notice of Availability

Responsible Agency: Office of Federal Activities, General Information (202) 260-5076 OR (202) 260-5075. Weekly receipt of Environmental Impact Statements Filed November 27, 1995

Through December 01, 1995 Pursuant to 40 CFR 1506.9.

EIS No. 950552, FINAL EIS, USA, MA, Army Material Technology Laboratory Reuse and Disposal, Implementation, Town of Watertown, Middlesex, Norfolk, Suffolk and Essex Counties, MA, Due: January 08, 1996, Contact: James Davidson (703) 274-5510

EIS No. 950553, DRAFT EIS, NAS, International Space Station, Assembly and Operation, Space Station Freedom (SSF), Due: January 22, 1996, Contact: David F. Ruszczky (713) 244-7756.

EIS No. 950554, DRAFT EIS, DOE, WA, Plutonium Finishing Plant (PFP) Stabilization, To Safely Reduced Radiation Exposure to Workers and the Environment, Hanford Site, Richland, Benton County, WA, Due: January 23, 1996, Contact: Ben F. Burton (509) 946-3609.

EIS No. 950555, DRAFT EIS, FRC, WA, Condit Hydroelectric Project (FERC No. 2342-005), Relicensing, White Salmon River, Klickitat and Skamania Counties, WA, Due: January 22, 1996, Contact: John Blair (202) 219-2845.

EIS No. 950556, DRAFT EIS, AFS, WA, Snoqualmie Pass Adaptive Management Area Plan, Implementation, Wenatchee and Mt. Baker-Snoqualmie National Forests, Cle Elum and North Bend Ranger Districts, Kittitas and King Counties, WA, Due: January 31, 1996, Contact: Floyd Rogalski (509) 674-4411.

EIS No. 950557, DRAFT EIS, FRC, ME, Lower Androscoggin River Basin Hydroelectric Project, Gulf Island Deer Rips Project (FERC No. 2283-005) and Marcal Project (FERC No. 11482-000) Relicensing and Licensing, Androscoggin County, ME, Due: January 22, 1996, Contact: Alan Creamer (202) 219-0635.

EIS No. 950558, DRAFT EIS, GSA, CO, National Oceanic and Atmospheric Administration (NOAA) Consolidation of Facilities; National Institute of Standards and Technology (NIST) to Upgrade Facilities and National Telecommunications and Information Administration (NITA) to Implement Master Site Development Plan, Site Specific, 325 Broadway Campus, Boulder County, CO, Due: January 22, 1996, Contact: Sharon Malloy (303) 236-7131.

EIS No. 950559, FINAL EIS, MMS, AL, TX, MS, LA, 1996 Central and Western Gulf of Mexico Outer Continental Shelf (OSC) Oil and Gas Lease Sales No. 157 (March 1996) and No. 161 (August 1996), Lease Offerings, Offshore coastal counties and parishes of AL, MS, LA and TX,

Due: January 08, 1996, Contact:

Archie P. Melancon (703) 787-5471.

EIS No. 950560, DRAFT EIS, FRC, WI, Flambeau River Hydroelectric Projects, Big Falls (FERC No. 2930), Thornapple (FERC No. 2475), Upper (FERC No. 2640), Lower (FERC No. 2421), Pixley (FERC No. 2395) and Crowley (FERC No. 2473), Relicensing, WI, Due: January 22, 1996, Contact: Frank Karwoski (202) 219-2782.

EIS No. 950561, FINAL EIS, NOA, Atlantic Mackerel, Squid and Butterfish Fisheries, Fishery Management Plan, Amendment No. 5, Implementation, Exclusive Economic Zone (EEZ) off the US Atlantic Coast, Due: January 23, 1996, Contact: Rolland A. Schmitten (301) 713-2239.

EIS No. 950562, DRAFT EIS, FHW, WI, US 10 Highway Improvements, WI-13 and US 10 in Marshfield to WI-54 and US 10 in Waupaca, Funding and COE Section 404 Permit, Wood, Portage and Waupaca Counties, WI, Due: January 22, 1996, Contact: Wesley Shemwell (608) 829-7500.

EIS No. 950563, DRAFT EIS, FHW, CA, CA-101/Cuesta Grade Highway Improvements, 1.1 Miles north of Reservoir Canyon Road to the Cuesta Grade Overhead, Funding and Permit Issuance, San Luis Obispo County, CA, Due: March 08, 1996, Contact: John R. Schultz (916) 498-5041.

EIS No. 950564, DRAFT EIS, COE, WA, Resource Investments Landfill Facility Construction, COE Section 404 Permit Issuance, Pierce County, WA, Due: January 22, 1996, Contact: Jim Green (206) 764-6906.

Dated: December 04, 1995.

B. Katherine Biggs,

Associate Director, NEPA Compliance Division, Office of Federal Activities.

[FR Doc. 95-29983 Filed 12-7-95; 8:45 am]

BILLING CODE 6560-50-U

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collections Submitted to OMB for Review and Approval

December 4, 1995.

SUMMARY: The Federal Communications, as part of its continuing effort to reduce paperwork burden invites the general public and other Federal agencies to take this opportunity to comment on the following proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104-13. Comments are requested concerning (a) whether the

proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commissions burden estimates; (c) ways to enhance the quality, utility, and clarity of the information collected and (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology.

DATES: Written comments should be submitted on or before January 8, 1996. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESS: Direct all comments to Dorothy Conway, Federal Communications, Room 234, 1919 M St., NW., Washington, DC 20554 or via internet to dconway@fcc.gov and Timothy Fain, OMB Desk Officer, 10236 NEOB 725 17th Street, NW., Washington, DC 20503 or fain_t@a1.eop.gov.

FOR FURTHER INFORMATION CONTACT: For additional information or copies of the information collections contact Dorothy Conway at 202-418-0217 or via internet at dconway@fcc.gov.

SUPPLEMENTARY INFORMATION:

OMB Approval No.: 3060-0028.

Title: Application for Authorization of the Auxiliary Broadcast Services.

Form No.: FCC 313.

Type of Review: Reinstatement without change of previously approved collection for which approval has expired.

Respondents: Businesses or other for-profit; State, Local or Tribal Governments.

Number of Respondents: 1,500.

Estimated Time Per Response: 5.166 hours.

Total Annual Burden: 7,749 hours.

Needs and Uses: FCC Form 313 is used by permittees or licensees of AM, FM and TV Broadcast Stations and eligible networks when applying for remote pickup, aural microwave, television microwave, and other auxiliary broadcast stations. Data is used by FCC staff to determine if proposal meets statutory requirements and to ensure that interference will not occur.

OMB Approval No.: 3060-0298.

Title: Section 76.601.

Form No.: N/A.

Type of Review: Revision of currently approved collection.

Respondents: Business or other for-profit; State, Local or Tribal Governments.

Number of Respondents: 14,673.

Estimated Time Per Response: 19.4 hours.

Total Annual Burden: 285,084 hours.

Needs and Uses: Section 76.601 requires that every cable system operator maintain a current listing of the cable television channels which that system delivers to its subscribers. Section 76.601(c) and (d) require cable systems with over 1,000 subscribers to conduct semi-annual proof of performance tests and triennial proof of performance tests for color testing. This collection is being revised to request approval for the third party disclosure in section 76.601(d) requiring local franchise authorities to notify the cable operators who will be alerted third days to come in compliance with any preceived signal quality problems which need to be corrected.

OMB Approval No.: 3060-0520.

Title: Section 90.127(e) Submission and filing of applications.

Form No.: N/A.

Type of Review: Extension of an existing collection.

Respondents: Business or other for-profit; Not-for-profit-institutions; State, Local or Tribal Governments.

Number of Respondents: 109,200.

Estimated Time Per Response: 5 minutes.

Total Annual Burden: 9,100 hours.

Needs and Uses: Section 90.127(e) requires licensees to report the number of mobiles and pagers when license is modified or renewed. This information is used for frequency coordination and licensing.

Federal Communications Commission.

William F. Caton,

Acting Secretary.

[FR Doc. 95-29899 Filed 12-7-95; 8:45 am]

BILLING CODE 6712-01-F

FEDERAL DEPOSIT INSURANCE CORPORATION

Determination of Insufficiency of Assets To Satisfy All Claims of Certain Financial Institutions in Receivership

AGENCY: Federal Deposit Insurance Corporation.

ACTION: Notice.

SUMMARY: In accordance with the authorities contained in 12 U.S.C. 1821(c), the Federal Deposit Insurance Corporation (FDIC) was duly appointed receiver for the financial institution specified in **SUPPLEMENTARY**

INFORMATION. The FDIC has determined that the proceeds which can be realized from the liquidation of the assets of the below listed receivership estate are insufficient to wholly satisfy the priority claims of depositors against the receivership estates. Therefore, upon satisfaction of secured claims, depositor claims and claims which have priority over depositors under applicable law, no amount will remain or will be recovered sufficient to allow a dividend, distribution or payment to any creditor of lessor priority, including but not limited to, claims of general creditors. Any such claims are hereby determined to be worthless.

FOR FURTHER INFORMATION CONTACT:

Tina A. Lamoreaux, Counsel, Legal Division, FDIC, 550 17th Street, NW., Room H-11027, Washington, DC 20429. Telephone: (202) 736-3134.

SUPPLEMENTARY INFORMATION: Financial Institution in Receivership Determined to Have Insufficient Assets to Satisfy All Claims.

Citytrust, #4382

Bridgeport, Connecticut

Dated: December 4, 1995.

Federal Deposit Insurance Corporation.

Jerry L. Langley,

Executive Secretary.

[FR Doc. 95-29979 Filed 12-7-95; 8:45 am]

BILLING CODE 6714-01-M

FEDERAL LABOR RELATIONS AUTHORITY

Notice of Proposed Agency Information Collection Activity; Request for Public Comment

AGENCY: Federal Labor Relations Authority.

ACTION: Notice.

SUMMARY: The Authority is soliciting public comments on the proposed information collection requirement described below, prior to submission of the proposal to the Office of Management and Budget (OMB) for review as required by the Paperwork Reduction Act.

DATES: Comments due: February 6, 1996.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and should be sent to: Solly Thomas, Executive Director, Federal Labor Relations Authority, 607 14th St., NW., Room 420, Washington, DC 20424.

FOR FURTHER INFORMATION CONTACT:

Nancy Anderson Speight, Director of

Program Development, Office of the General Counsel, 202-482-6680 ext. 205. A copy of the proposed information collection requirement can be examined at the Office of the General Counsel, 607 14th St., NW., Suite 210, Washington, DC 20424.

SUPPLEMENTARY INFORMATION: The Authority will submit the proposed information collection to OMB for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. Chap. 35 as amended).

This Notice solicits comments from members of the public and affected agencies concerning the proposed collection of information. The comments will be used to: (1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Authority, including whether the information will have practical utility; (2) evaluate the accuracy of the Authority's estimate of the burden of the proposed collection of information; (3) enhance the quality, utility, and clarity of the information to be collected; and (4) minimize the burden of the collection of information on those who are to respond.

This Notice also lists the following information:

Title of Proposal: Petition Form.

Description of the Need for the Information and Proposed Use: The information to be collected by the petition form is required for the Authority to be able to process and decide representation issues arising under the Federal Service Labor-Management Relations Statute, 5 U.S.C. §§ 7101 to 7135. The information collected on the petition form is to be used to enable Authority staff employees to contact affected parties in representation case proceedings, and to enable staff employees to take the necessary steps to begin the processing of the petition. The petition form will be provided to members of the public who request the form from the Authority's regional offices, to enable those members of the public to initiate a representation case proceeding before the Authority. The petition form is filed with an appropriate Authority regional office.

The petition form includes questions to the filer concerning the issues raised by the petition and the results the petitioner seeks as a consequence of filing the petition; a description of the collective bargaining unit affected by the petition, including employees who would be included or excluded from the unit; the showing of employee interest expressed as a per cent of the unit

affected that supports the petition; the names, addresses, and telephone numbers of the representatives of the union(s), agency(ies), and activity(ies) affected by the petition; the date of recognition or certification of the exclusive bargaining representative, if any, of any unit affected by the petition; and a declaration by the filer of the petition as to the truth of the statements made in the petition.

Members of the Affected Public: Federal employees representing Federal agencies in their capacity as employer, Federal employees and employees of labor organizations that are representing those labor organizations, and Federal employees in their individual capacities, are the members of the public who may file the representation form.

Estimation of the Total Numbers of Hours Needed to Prepare the Information Collection: It should normally take a party no longer than one hour to complete a petition form for filing with the Authority. In FY 1995, 496 representation forms were filed with the Authority.

Authority: Section 3506 of the Paperwork Reduction Act of 1995, 44 U.S.C. Chap. 35, as amended.

Dated: December 5, 1995.

Solly Thomas,

Executive Director, Federal Labor Relations Authority.

FR Doc. No. 95-29997 Filed 12-7-95; 8:45am

BILLING CODE 6727-01-P

FEDERAL MARITIME COMMISSION

Notice of Agreement(s) Filed

The Federal Maritime Commission hereby gives notice of the filing of the following agreement(s) pursuant to section 5 of the Shipping Act of 1984.

Interested parties may inspect and obtain a copy of each agreement at the Washington, D.C. Office of the Federal Maritime Commission, 800 North Capitol Street, N.W., 9th Floor. Interested parties may submit comments on each agreement to the Secretary, Federal Maritime Commission, Washington, D.C. 20573, within 10 days after the date of the Federal Register in which this notice appears. The requirements for comments are found in section 572.603 of Title 46 of the Code of Federal Regulations. Interested persons should consult this section before communicating with the Commission regarding a pending agreement.

Agreement No.: 203-011223-011.

Title: Transpacific Stabilization Agreement.

Parties: A.P. Moller-Maersk Line, American President Lines, Ltd., Evergreen Marine Corp. (Taiwan) Ltd., Hapag-Lloyd Aktiengesellschaft, Hanjin Shipping Co., Ltd., Hyundai Merchant Marine Co., Ltd., Kawasaki Kisen Kaisha, Ltd., Mitsui O.S.K. Lines, Ltd., Nedlloyd Lines B.V., Neptune Orient Lines, Ltd., Nippon Yusen Kaisha, Orient Overseas Container Line, Inc., Sea-Land Service, Inc., Yangming Marine Transport Corp.

Synopsis: The proposed amendment clarifies Article 5—Agreement Authority to state that the members have the authority to discuss and agree upon charges and conditions, rates, and rate levels concerning cargo or service contracts. It also makes other nonsubstantive changes to the Agreement.

Agreement No.: 202-011375-022.

Title: Trans-Atlantic Conference Agreement.

Parties: Atlantic Container Line AB, P&O Containers Limited, Sea-Land Service, Inc., Hapag-Lloyd AG, Nedlloyd Lijnen BV, A.P. Moller-Maersk Line, Cho Yang Shipping Co. Ltd., Mediterranean Shipping Company, S.A., DSR-Senator Lines, Polish Ocean Lines, Orient Overseas Container Line (UK) Ltd., Transportacion Maritima Mexicana, S.A., de C.V., Neptune Orient Lines Ltd., Nippon Yusen Kaisha, Tecomar S.A. de C.V., Hanjin Shipping Co., Ltd, Hyundai Merchant Marine Co., Ltd.

Synopsis: The proposed amendment permits the parties to establish the terms of an arrangement to promote and facilitate the interchange of empty containers between them and to establish a computerized reporting system on container imbalances.

Dated: December 5, 1995.

By Order of the Federal Maritime Commission.

Joseph C. Polking,

Secretary.

[FR Doc. 95-29963 Filed 12-7-95; 8:45 am]

BILLING CODE 6730-01-M

Ocean Freight Forwarder License Revocations

The Federal Maritime Commission hereby gives notice that the following freight forwarder licenses are revoked pursuant to section 19 of the Shipping Act of 1984 (46 U.S.C. app. 1718) and the regulations of the Commission pertaining to the licensing of ocean freight forwarders, effective on the corresponding revocation dates shown below:

License Number: 657

Name: Spartan Overseas Shipping Corp.
Address: 181 South Franklin Ave.,
Valley Stream, NY 11581
Date Revoked: November 1, 1995
Reason: Surrendered license
voluntarily.

License Number: 3382
Name: W.I.D.E. Corporation
Address: 850 Center Drive, Elizabeth, NJ
07201

Date Revoked: November 5, 1995
Reason: Failed to maintain a valid
surety bond.

License Number: 2097
Name: Concept Cargo, Inc.
Address: 8269-8287 N.W. 54th Street,
Miami, FL 33166

Date Revoked: November 20, 1995
Reason: Surrendered license
voluntarily.

License Number: 2825
Name: Henry L. Rosich dba Rosich
Forwarding Company
Address: 409 Warren Boulevard,
Broomall, PA 19008

Date Revoked: November 20, 1995
Reason: Surrendered license
voluntarily.

Bryant L. VanBrakle,
*Director, Bureau of Tariffs, Certification and
Licensing.*

[FR Doc. 95-29928 Filed 12-7-95; 8:45 am]

BILLING CODE 6730-01-M

FEDERAL RESERVE SYSTEM

Scotland Bancorp, Inc., et al.; Formations of; Acquisitions by; and Mergers of Bank Holding Companies

The companies listed in this notice have applied for the Board's approval under section 3 of the Bank Holding Company Act (12 U.S.C. 1842) and § 225.14 of the Board's Regulation Y (12 CFR 225.14) to become a bank holding company or to acquire a bank or bank holding company. The factors that are considered in acting on the applications are set forth in section 3(c) of the Act (12 U.S.C. 1842(c)).

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank or to the offices of the Board of Governors. Any comment on an application that requests a hearing must include a statement of why a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute and summarizing the

evidence that would be presented at a hearing.

Unless otherwise noted, comments regarding each of these applications must be received not later than January 2, 1996.

A. Federal Reserve Bank of Richmond (Lloyd W. Bostian, Jr., Senior Vice President) 701 East Byrd Street, Richmond, Virginia 23261:

1. *Scotland Bancorp, Inc.*, Laurinburg, North Carolina; to become a bank holding company by acquiring 100 percent of the voting shares of Scotland Savings Bank, SSB, Laurinburg, North Carolina.

B. Federal Reserve Bank of Atlanta (Zane R. Kelley, Vice President) 104 Marietta Street, N.W., Atlanta, Georgia 30303:

1. *Republic Bancshares, Inc.*, St. Petersburg, Florida; to become a bank holding company by acquiring 100 percent of the voting shares of Republic Bank, St. Petersburg, Florida. Comments regarding this notice should be received not later than December 22, 1995.

Board of Governors of the Federal Reserve System, December 4, 1995.

William W. Wiles,

Secretary of the Board.

[FR Doc. 95-29931 Filed 12-07-95; 8:45 am]

BILLING CODE 6210-01-F

Southern National Corporation, et al.; Notice of Applications to Engage de novo in Permissible Nonbanking Activities

The companies listed in this notice have filed an application under § 225.23(a)(1) of the Board's Regulation Y (12 CFR 225.23(a)(1)) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to commence or to engage *de novo*, either directly or through a subsidiary, in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that

outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than December 22, 1995.

A. Federal Reserve Bank of Richmond (Lloyd W. Bostian, Jr., Senior Vice President) 701 East Byrd Street, Richmond, Virginia 23261:

1. *Southern National Corporation*, Winston-Salem, North Carolina; to engage *de novo* in making, acquiring, or servicing loans or other extensions of credit pursuant to § 225.25(b)(1) of the Board's Regulation Y.

B. Federal Reserve Bank of Dallas (Genie D. Short, Vice President) 2200 North Pearl Street, Dallas, Texas 75201-2272:

1. *South Plains Financial, Inc.*, Lubbock, Texas; to engage *de novo* through its subsidiary, South Plains Financial Services, Inc., Lubbock, Texas, in providing for others, data processing and data transmission services, facilities (including data processing and data transmission hardware, software, documentation or operating personnel), pursuant to § 225.25(b)(7) of the Board's Regulation Y, and in performing real estate and personal property appraisals, including tangible and intangible personal property, pursuant to § 225.25(b)(13) of the Board's Regulation Y. These activities will take place in the state of Texas.

Board of Governors of the Federal Reserve System, December 4, 1995.

William W. Wiles,

Secretary of the Board.

[FR Doc. 95-29932 Filed 12-8-95; 8:45 am]

BILLING CODE 6210-01-F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration (SAMHSA) Notice of Meeting

Pursuant to Public Law 92-463, notice is hereby given of the meeting of

the Substance Abuse and Mental Health Services Administration (SAMHSA) National Advisory Council in January 1996.

The meeting of the SAMHSA National Advisory Council will include discussions concerning SAMHSA's Reauthorization; update on SAMHSA's demonstration program; SAMHSA's Managed Care Initiative, including the role of SAMHSA in developing mental health and substance abuse standards for managed care facilities; report on the Performance Partnership Development Process and Regional Meetings; and a report on the Co-Occurring Meeting. In addition various constituency organizations will be describing their collaborative efforts around the development of performance measures and outcomes monitoring, and exemplary community based programs will be describing their efforts to prevent and treat mental and addictive disorders. Finally, there will be status reports by the Council's work groups on Health Care Reform and Children's Services. Attendance by the public will be limited to space available.

The meeting will also include the review, discussion and evaluation of contract proposals. Therefore a portion of the meeting will be closed to the public as determined by the Administrator, SAMHSA, in accordance with Title 5 U.S.C. 552b(c) (3), (4) and (6) and 5 U.S.C. app. 2 10(d).

A summary of the meeting and a roster of Council members may be obtained from: Ms. Susan E. Day, Program Assistant, SAMHSA National Advisory Council, 5600 Fishers Lane, Room 12C-15, Rockville, Maryland 20857. Telephone: (301) 443-4640.

Substantive program information may be obtained from the contact whose name and telephone number is listed below.

Committee Name: Substance Abuse and Mental Health Services Administration, National Advisory Council.

Meeting Date: January 22, 1996.

Place: Omni-Shoreham Hotel, 2500 Calvert Street, N.W., Washington, DC 20008.

Open: January 22, 1996, 9:00 a.m. to 4:30 p.m.

Closed: January 22, 1996, 5:00 p.m. to 6:00 p.m.

Contact: Toian Vaughn, Room 12C-15, Parklawn Building, telephone (301) 443-4640 and FAX (301) 443-1450.

Dated: December 4, 1995.

Jeri Lipov,

Committee Management Officer, Substance Abuse and Mental Health Services Administration.

[FR Doc. 95-29934 Filed 12-7-95; 8:45 am]

BILLING CODE 4162-20-P

Food and Drug Administration

[Docket No. 95N-0371]

Interim Definition and Elimination of Lot-by-Lot Release For Well-Characterized Therapeutic Recombinant DNA-Derived and Monoclonal Antibody Biotechnology Products

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing an interim definition for well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology products. FDA is also announcing that FDA is eliminating lot-by-lot release for licensed well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology products. After approval, manufacturers of such products are no longer requested to submit samples and protocols for individual lots of products to the Center for Biologics Evaluation and Research (CBER) for routine lot-by-lot release. Manufacturers may begin distributing products affected by this policy after notification by CBER and without awaiting approval of a supplement to their product license applications. This notice is intended to reduce unnecessary burdens for industry without diminishing public health protection.

ADDRESSES: Submit written comments to the Dockets Management Branch (HFA-305), Food and Drug Administration, 12420 Parklawn Dr., rm. 1-23, Rockville, MD 20857. Comments should be identified with the docket number found in brackets in the heading of this document. Two copies of any comments are to be submitted, except that individuals may submit one copy. Received comments are available for public examination in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

FOR FURTHER INFORMATION CONTACT:

Regarding lot release: Jerome A. Donlon, Center for Biologics Evaluation and Research (HFM-200), Food and Drug Administration, 1401 Rockville Pike, Rockville, MD 20852-1448, 301-594-2200.

Regarding the definition of a well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology product: Jean M. Olson, Center for Biologics Evaluation and Research (HFM-630), Food and Drug

Administration, 1401 Rockville Pike, Rockville, MD 20852-1448, 301-594-3074.

SUPPLEMENTARY INFORMATION: This notice is being issued in accordance with the principles set forth in Executive Order 12866. Executive Order 12866 directs Federal agencies to implement measures that will reform and streamline the regulatory process to avoid unnecessary regulatory burdens. In the November 1995 "Reinventing the Regulation of Drugs Made from Biotechnology" report, the President and Vice President announced a series of regulatory reform initiatives, including FDA's intention to issue a notice eliminating lot-by-lot release for licensed well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology products. FDA made a commitment to issue the notice within 30 days of the report.

Elimination of Lot-by-Lot Release

Biologics have traditionally been complex mixtures of substances produced primarily from living organisms, and have been difficult to characterize by precise tests. They include vaccines, products made from human or animal blood, and other products made from a variety of materials. Because of the inherent variability of these products, each individual lot of most biological products has been subject to evaluation and testing by CBER prior to release.

Under § 610.2 (21 CFR 610.2), the Director of CBER may require, at any time, that samples of a licensed product, protocols, and test results be submitted to CBER for official release. FDA has invoked lot-by-lot release to help ensure that products continue to meet established standards before they are distributed.

Historically, lot-by-lot release has served an important role in the regulation of biotechnology products and has prevented the distribution of unacceptable lots. However, greater control has been achieved by manufacturers over the production of biotechnology products through in-process controls, process validation, and advances in analytical techniques. For well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology products, as defined below, FDA has found that once a company has demonstrated its ability to consistently produce acceptable lots, and has procedures in place that will prevent the release of lots that do not meet release specifications, it is not necessary for FDA to verify that each

manufactured lot is acceptable for release.

Accordingly, as provided under § 610.2, the Director of CBER is no longer requiring that manufacturers of well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology products submit samples and protocols to CBER. FDA will continue to monitor companies' compliance with the requirement in § 610.1 (21 CFR 610.1) that they assay each lot and release only those lots that meet release specifications.

FDA intends to revise the guidance entitled, "Guidance on Alternatives to Lot Release for Licensed Biological Products," (58 FR 38771, July 20, 1993) to reflect the new procedures. Manufacturers who do not receive a letter, but think that one of their licensed products meets the interim definition, may contact Jerome A. Donlon (address above).

Eliminating FDA lot-by-lot release should not compromise the safety, purity, or potency of licensed well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology products. Because of process validation and current in-process controls and testing for these products, identity, purity, and potency can be controlled and measured. In addition, the in-process and end-product release specifications can be validated for these products. Therefore, submission of lot release samples and protocols are no longer viewed by FDA as essential to the ongoing assurance of safety for these products.

Eliminating lot-by-lot release for these products furthers FDA's harmonization of its regulation of well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology products between CBER and the Center for Drug Evaluation and Research.

Manufacturers are still required under § 610.1 to test each lot and release only those that meet release specifications. During inspections, FDA will monitor compliance with those requirements. Manufacturers continue to be required to maintain adequate records and retention samples under 21 CFR 211.170 and 211.180.

Interim Definition

FDA has prepared the following interim definition for a well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology product:

A chemical entity(ies) whose identity, purity, impurities, potency, and quantity can be determined and controlled.

Identity:

a. Recombinant DNA Biotechnology Products

The primary structure is known (i.e., amino acid sequence), and

The secondary structure is known (e.g., disulfide linkage), and

Post-translational modifications are known (e.g., glycosylation), or

b. Monoclonal Antibodies

The identity can be determined by rigorous physicochemical and immunochemical characterization without fully knowing its chemical structure.

Purity and impurities:

The purity is quantifiable.

The impurities are quantifiable, and identified if feasible.

Potency and quantity:

The biological activity is measurable.

The quantity is measurable.

Well-characterized therapeutic recombinant DNA-derived or monoclonal antibody biotechnology products require proper raw material controls, process validation and controls, and sensitive and validated test methods and specifications. FDA intends to use the definition to determine which products may be exempted from lot-by-lot release and to help determine which products may be eligible for other regulatory initiatives directed at well-characterized biotechnology products.

FDA invites comments on its proposed definition for well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology products. In particular, FDA invites comments on whether the proposed definition for well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology products should be expanded to include other categories of products that would be considered to be well-characterized and should be categorically exempted from lot-by-lot release.

In the Federal Register of October 25, 1995 (60 FR 54695), FDA announced that it is sponsoring a public scientific workshop on December 11 through 13, 1995. At the workshop participants will be asked to refine the definition of a well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology product as set forth above. After considering the information presented at the workshop, FDA may modify the interim definition given above.

Manufacturers of well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology products affected by this change in policy will be notified by letter.

CBER does not intend for this notice to be comprehensive. If a manufacturer has questions concerning application of this policy to one of its licensed

products or the interim definition, it can discuss the matter with CBER. Although the interim definition for well-characterized therapeutic recombinant DNA-derived and monoclonal antibody biotechnology products in this notice is not binding on either FDA or manufacturers of biological products and does not create or confer any rights for or on any person, it does represent the agency's current thinking on that definition.

Dated: December 4, 1995.

William B. Schultz,

Deputy Commissioner for Policy.

[FR Doc. 95-29960 Filed 12-5-95; 2:43 pm]

BILLING CODE 4160-01-F

[Docket No. 93N-371W]

Prescription Drug Product Labeling; Public Patient Education Workshop

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice of a public workshop.

SUMMARY: The Food and Drug Administration (FDA) is announcing a public patient education workshop to discuss methods and criteria for developing and evaluating prescription drug information for patients. The purpose of this workshop is to obtain views and opinions concerning the criteria for useful patient information, and is part of FDA's ongoing initiative to improve the distribution of adequate and useful prescription drug information to patients. FDA encourages health professionals, consumer groups, industry, academicians, other experts in the field, and interested parties to participate in the workshop. FDA also invites the designers of primary information systems, which produce either written information or computer programs that generate prescription drug patient information, to display their systems for educational purposes.

DATES: The public patient education workshop will be held on January 9 and 10, 1996, from 8:30 a.m. to 5 p.m. Submit registration notices for participants by December 26, 1995. Submit registration notices for designers of information systems by December 19, 1995. Submit written comments by January 31, 1996.

ADDRESSES: The public patient education workshop will be held at the National Institutes of Health, Natcher Auditorium, 9000 Rockville Pike, Rockville, MD. Pre-registration for workshop participants is encouraged, although not required, in order to facilitate logistical planning of the

breakout discussion groups. There is no registration fee for this workshop. Registration forms can be obtained by calling 301-443-5470 or writing to the Office of Health Affairs, ATTN: Patient Education Workshop, Food and Drug Administration (HFY-40), 5600 Fishers Lane, Rockville, MD 20857. Submit written views or comments to the Dockets Management Branch (HFA-305), Food and Drug Administration, 12420 Parklawn Dr., rm. 1-23, Rockville, MD 20857. The designers of information systems should call the contact person (address below) for registration information. A more detailed agenda and written presentations will be placed in the docket, identified with the docket number found in brackets in the heading of this document, at the Dockets Management Branch, and will be available for review between 9 a.m. and 4 p.m., Monday through Friday. A transcript of the general sessions of the workshop will be available for review or purchase (10 cents per page) at the Dockets Management Branch approximately 5 business days after the meeting. The breakout sessions will not be transcribed.

FOR FURTHER INFORMATION CONTACT: Thomas J. McGinnis, Office of Health Affairs (HFY-40), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-443-5470.

SUPPLEMENTARY INFORMATION: In the Federal Register of August 24, 1995 (60 FR 44182), FDA published a proposed rule which, if finalized, is intended to increase the dissemination of useful written prescription drug information to patients who receive prescription drugs on an outpatient basis. The agency believes that such information must be widely distributed and be of sufficient quality to promote the proper use of prescription drugs. The agency proposed goals (performance standards) that would define acceptable levels of information distribution and quality. To meet the performance standard for distribution of patient information, the agency proposed that by the year 2000, at least 75 percent of people receiving new prescriptions receive useful written information. This goal was adapted from the Public Health Service's "Healthy People 2000" report. In addition, the agency proposed that by the year 2006, at least 95 percent of the people who receive new prescriptions receive useful written information.

FDA proposed to periodically evaluate and report on the achievement of the goals. If the goals are not met in the specified timeframes, FDA proposed to either: (1) Implement a mandatory

comprehensive medication guide program, or (2) seek public comment on whether the comprehensive program should be implemented, or whether, and what, other steps should be taken to meet the patient information goals.

In the Federal Register of August 24, 1995, the agency proposed the following seven specific components for determining whether patient information is useful: Scientific accuracy, consistency with a standard format, nonpromotional tone and content, specificity, comprehensiveness, understandable language, and legibility. The agency defined these components of usefulness, as well as criteria that could be used to judge these components, and invited comments on their appropriateness. The agency also stated that it would hold a public meeting for interested parties to provide recommendations and rationale for evaluating usefulness of written information.

The agency will hold a public patient education workshop to discuss the methods and criteria for developing and evaluating the usefulness of written information. The patient education workshop will be designed to obtain recommendations from the public about the criteria that should be applied to help ensure that written information provided to patients is "useful."

The patient education workshop will be comprised of both formal presentations and open breakout discussion periods. Any interested person may attend and participate in the discussions. The workshop will include general sessions with presentations from FDA, health professional groups, consumer groups, the pharmaceutical industry, academicians, and parties with legal and regulatory expertise. The agency also intends to hold breakout sessions throughout the 2-day workshop to obtain broad participation and input from workshop attendees.

FDA believes that it would be helpful for workshop participants (including FDA staff) to learn about the design of current patient information systems, in particular, programs that generate drug-specific patient information. The agency invites the designers of primary information systems (not the customizers of systems for retail outlets) to display their systems at the workshop for educational purposes only. No sales or solicitations may be made by exhibitors at the workshop site. Due to space limitations, FDA may be forced to limit the number of systems on display. In doing so, FDA would seek to permit display of the most representative/comprehensive systems available for patient information. However, the

agency invites all interested persons to submit their views, comments, and descriptions of computer programs to the Dockets Management Branch (address above).

The agency notes that the comment period for the proposed rule that published in the Federal Register of August 24, 1995, has recently been extended until December 22, 1995 (60 FR 58025, November 24, 1995). Because this workshop will occur after the comment period has closed, the agency will accept additional comments to the proposed rule on the specific issues raised at the workshop. These comments will be considered as part of the agency's deliberations regarding further action on this rulemaking. For this limited purpose, written comments may be submitted to the Dockets Management Branch (address above) until January 31, 1996. Comments are to be identified with the docket number found in brackets in the heading of this document.

A summary of the workshop will be included in a subsequent Federal Register notice related to this prescription drug labeling initiative.

Dated: December 1, 1995.

William K. Hubbard,

Associate Commissioner for Policy.

[FR Doc. 95-29903 Filed 12-7-95; 8:45 am]

BILLING CODE 4160-01-F

National Institutes of Health

National Institute of Mental Health; Notice of Closed Meeting

Pursuant to Section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting of the National Institute of Mental Health Special Emphasis Panel:

Agenda/Purpose: To review and evaluate grant applications.

Committee Name: National Institute of Mental Health Special Emphasis Panel.

Date: December 11, 1995.

Time: 11 a.m.

Place: Parklawn Building, Room 9C-18, 5600 Fishers Lane, Rockville, MD 20857.

Contact Person: Michael D. Hirsch, Parklawn Building, Room 9C-18, 5600 Fishers Lane, Rockville, MD 20857, Telephone: (301) 443-1000.

The meeting will be closed in accordance with the provisions set forth in secs. 552b(c)(4) and 552b(c)(6), Title 5, U.S.C. Applications and/or proposals and the discussions could reveal confidential trade secrets or commercial property such as patentable material and personal information concerning individuals associated with the applications and/or proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

This notice is being published less than fifteen days prior to the meeting due to the urgent need to meet timing limitations imposed by the review and funding cycle. (Catalog of Federal Domestic Assistance Program Numbers 93.242, 93.281, 93.282)

Dated: December 4, 1995.

Susan K. Feldman,

Committee Management Officer, NIH.

[FR Doc. 95-3000 Filed 12-7-95; 8:45 am]

BILLING CODE 4140-01-M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of the Assistant Secretary for Policy Development and Research

[Docket No. FR-3917-N-35]

Notice of Proposed Information Collection for Public Comment

AGENCY: Office of the Assistant Secretary for Policy Development and Research, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

DATES: Comments due: February 6, 1996.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name or OMB Control Number and should be sent to: Reports Liaison Officer, Office of Policy Development and Research, Department of Housing and Urban Development, 451 7th Street SW., Room 8226, Washington, DC 20410.

FOR FURTHER INFORMATION CONTACT: Jean Lin, Social Science Analyst, Office of Policy Development and Research—telephone (202) 708-0574 (this is not a toll-free number).

SUPPLEMENTARY INFORMATION: The Department will submit the proposed information collection to OMB for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended).

This Notice is soliciting comments from members of the public and affected agencies concerning the proposed collection of information to: (1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (3) Enhance the quality, utility, and clarity of the information to be collected; and (4) Minimize the burden of the collection of information on those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, e.g. permitting electronic submission of responses.

This notice also lists the following information:

Title of Proposal: The Survey of Habitat for Humanity Homebuyers and Affiliates

Description of the need for the information and proposed use: The information is being collected to examine the homeownership process and homeownership impacts on the individuals and community participating in the Habitat for Humanity International program. This study will: (1) describe the role of Habitat in assisting low-income families achieve homeownership; (2) describe the program experience of homeowners; (3) examine the changes in the quality of life of participants as a result of homeownership; and (4) assess the benefits of homeownership for low-income families.

This is being done to assist the Department in formulating its national homeownership strategy for expanding homeownership opportunities and improving the quality of life for low-income families.

Members of affected public: Homeowners of the Habitat for Humanity program: 100 homeowners will be individually surveyed and 200 homeowners will be participating in exit surveys from focus groups.

Estimation of the total number of hours needed to prepare the information collection including number of respondents, frequency of response, and hours of response: Information will be collected by one-time in-person interviews with 100 homeowners. These interviews will last an average of one hour. Two hundred homeowners will participate in exit interviews from focus groups. Exit surveys will last an average of ten minutes. This means a total of 134 hours of response for the information collection.

Status of the proposed information collection: Pending OMB approval.

Authority: Section 3506 of the Paperwork Reduction Act of 1995, 44 U.S.C. Chapter 35, as amended.

Dated: November 29, 1995.

Michael A. Stegman,

Assistant Secretary, Office of Policy Development and Research.

[FR Doc. 95-29981 Filed 12-7-95; 8:45 am]

BILLING CODE 4210-62-M

Office of the Assistant Secretary for Community Planning and Development

[Docket No. FR-3778-N-65]

Federal Property Suitable as Facilities to Assist the Homeless

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: This Notice identifies unutilized, underutilized, excess, and surplus Federal property reviewed by HUD for suitability for possible use to assist the homeless.

FOR FURTHER INFORMATION CONTACT:

Mark Johnson, room 7256, Department of Housing and Urban Development, 451 Seventh Street SW., Washington, DC 20410; telephone (202) 708-1226; TDD number for the hearing and speech-impaired (202) 708-2565 (these telephone numbers are not toll-free), or call the toll-free Title V information line at 1-800-927-7588.

SUPPLEMENTARY INFORMATION: In accordance with 56 FR 23789 (May 24, 1991) and section 501 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11411), as amended, HUD is publishing this Notice to identify Federal buildings and other real property that HUD has reviewed for suitability for use to assist the homeless. The properties were reviewed using information provided to HUD by Federal landholding agencies regarding unutilized and underutilized buildings and real property controlled by such agencies or by GSA regarding its inventory of excess or surplus Federal property. This Notice is also published in order to comply with the December 12, 1988 Court Order in *National Coalition for the Homeless v. Veterans Administration*, No. 88-2503-OG (D.D.C.).

Properties reviewed are listed in this Notice according to the following categories: Suitable/available, suitable/unavailable, suitable/to be excess, and unsuitable. The properties listed in the three suitable categories have been reviewed by the landholding agencies, and each agency has transmitted to HUD: (1) Its intention to make the property available for use to assist the

homeless, (2) its intention to declare the property excess to the agency's needs, or (3) a statement of the reasons that the property cannot be declared excess or made available for use as facilities to assist the homeless.

Properties listed as suitable/available will be available exclusively for homeless use for a period of 60 days from the date of this Notice. Homeless assistance providers interested in any such property should send a written expression of interest to HHS, addressed to Brian Rooney, Division of Health Facilities Planning, U.S. Public Health Service, HHS, room 17A-10, 5600 Fishers Lane, Rockville, MD 20857; (301) 443-2265. (This is not a toll-free number.) HHS will mail to the interested provider an application packet, which will include instructions for completing the application. In order to maximize the opportunity to utilize a suitable property, providers should submit their written expressions of interest as soon as possible. For complete details concerning the processing of applications, the reader is encouraged to refer to the interim rule governing this program, 56 FR 24789 (May 24, 1991).

For properties listed as suitable/to be excess, that property may, if subsequently accepted as excess by GSA, be made available for use by the homeless in accordance with applicable law, subject to screening for other Federal use. At the appropriate time, HUD will publish the property in a Notice showing it as either suitable/available or suitable/unavailable.

For properties listed as suitable/unavailable, the landholding agency has decided that the property cannot be declared excess or made available for use to assist the homeless, and the property will not be available.

Properties listed as unsuitable will not be made available for any other purpose for 20 days from the date of this Notice. Homeless assistance providers interested in a review by HUD of the determination of unsuitability should call the toll free information line at 1-800-927-7588 for detailed instructions or write a letter to Mark Johnston at the address listed at the beginning of this Notice. Included in the request for review should be the property address (including zip code), the date of publication in the Federal Register, the landholding agency, and the property number.

For more information regarding particular properties identified in this Notice (i.e., acreage, floor plan, existing sanitary facilities, exact street address), providers should contact the appropriate landholding agencies at the

following addresses: U.S. Army: Elaine Sims, CECPW-FP, U.S. Army Center for Public Works, 7701 Telegraph Road, Alexandria, VA 22310-3862; (703) 355-3475; Dept. of Energy: Tom Knox, Realty Specialist, AD223.1, 1000 Independence Avenue SW., Washington, DC 20585; (202) 586-1191; (These are not toll-free numbers).

Dated: December 1, 1995.

Jacque M. Lawing,
Deputy Assistant Secretary for Economic Development.

Title V, Federal Surplus Property Program
Federal Register Report for 12/08/95

Suitable/Available Properties

Buildings (by State)

Virginia

Bristol U.S. Army Reserve Ctr.
100 Piedmont Avenue
Bristol Co: Washington VA 24201-
Landholding Agency: Army
Property Number: 219440317
Status: Underutilized
Comment: 13,460 sq. ft., 2-story plus
basement, brick structure, presence of
asbestos, needs some rehab. (Property was
published incorrectly on 10/13/95)

Unsuitable Properties

Buildings (by State)

Connecticut

9 Bldgs.
Knolls Atomic Power Lab, Windsor Site
Windsor Co: Hartford CT 06095-
Landholding Agency: Energy
Property Number: 419540004
Status: Excess
Reason: Secured Area

Ohio

Fernald Env. Mgmt. Project
7400 Willey Road
Fernald Co: Hamilton OH 45030-
Landholding Agency: Energy
Property Number: 419540005
Status: Unutilized
Reason: Other
Comment: contamination
Mound—Guard Post
Mound Road
Miamisburg Co: Montgomery OH 45343-
Landholding Agency: Energy
Property Number: 419540006
Status: Unutilized
Reason: Within 2,000 ft. of flammable or
explosive material.

[FR Doc. 95-29803 Filed 12-7-95; 8:45 am]

BILLING CODE 4210-29-M

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Extension of the Public Comment Period—Availability of an Environmental Assessment and Receipt of an Application for a Residential Project Called Pineda Crossing/Windover Farms, Located in Brevard County, FL

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of extension of the public comment period.

SUMMARY: The Fish and Wildlife Service gives notice that the public comment period on the environmental assessment/habitat conservation plan for the Pineda Crossing/Windover Farms projects (Applicant) application for an incidental take permit pursuant to Section 10(a) of the Endangered Species Act (Act) is being extended. The Applicant has been assigned permit number PRT-808474. The original 30-day comment period was to end on/about December 15, 1995 (FR 60:57247-48). In the intervening period, the Fish and Wildlife Service was forced to cease operations due to the lapse in Congressional appropriations during the period of November 14 through 19. The Fish and Wildlife Service was unable to expeditiously respond to the public requesting the documentation announced in the original Federal Register notice. The Fish and Wildlife Service is therefore extending the formal public comment period to allow opportunity for public review and submittal of comments.

DATES: The public comment period for this proposal, which originally closed on December 15, 1995, is now extended until December 26, 1995.

ADDRESSES: Persons wishing to review the application, HCP, and EA may obtain a copy by writing the Service's Southeast Regional Office, Atlanta, Georgia. Documents will also be available for public inspection by appointment during normal business hours at the Regional Office, or the Jacksonville, Florida, Field Office. Written data or comments concerning the application, EA, or HCP should be submitted to the Regional Office. Please reference permit under PRT-808474 in such comments.

Regional Permit Coordinator, U.S. Fish and Wildlife Service, 1875 Century Boulevard, Suite 200, Atlanta, Georgia 30345, (telephone 404/679-7110, fax 404/679-7081).

Field Supervisor, U.S. Fish and Wildlife Service, 6620 Southpoint Drive,

South, Suite 310, Jacksonville, Florida 32216-0912, (telephone 904/232-2580, fax 904/232-2404).

FOR FURTHER INFORMATION CONTACT:

Dawn Zattau at the Jacksonville, Florida, Field Office, or Rick G. Gooch at the Atlanta, Georgia, Regional Office.

SUPPLEMENTARY INFORMATION: The red-cockaded woodpecker (RCW) is a territorial, non-migratory cooperative breeding bird species. RCWs live in social units called groups which generally consist of a breeding pair, the current year's offspring, and one or more helpers (normally adult male offspring of the breeding pair from previous years). Groups maintain year-round territories near their roost and nest trees. The RCW is unique among North American woodpeckers in that it is the only woodpecker that excavates its roost and nest cavities in living pine trees. Each group member has its own cavity, although there may be multiple cavities in a single pine tree. The aggregate of cavity trees used by a breeding group is called a cluster. RCWs forage almost exclusively on pine trees and they generally prefer pines greater than 10 inches diameter at breast height. Foraging habitat is contiguous with the cluster. The number of acres required to supply adequate foraging habitat depends on the quantity and quality of the pine stems available.

The RCW is endemic to the pine forests of the Southeastern United States and was once widely distributed across 16 States. The species evolved in a mature, fire-maintained, ecosystem. The RCW has declined primarily due to the conversion of mature pine forests to young pine plantations, agricultural fields, residential and commercial developments, and to hardwood encroachment in existing pine forests due to fire suppression. The species is still widely distributed (presently occurs in 13 southeastern States), but remaining populations are highly fragmented and isolated. Presently, the largest populations occur on federally owned lands such as military installations and national forests. Continued development of the two tracts may result in death of, or harm to, any remaining RCWs through the loss of nesting and foraging habitat. The Service's EA outlines two alternatives in response to this application. The first alternative is a no-action alternative, which would result in the Service's denial of the request for incidental take. The second alternative is to accept the application as sufficient and issue an incidental take permit. Under Alternative 2, the applicants' HCP proposes to offset the anticipated level

of incidental take, by implementing the following mitigation/minimization measures, including providing adequate funding to ensure their success:

1. For Pineda Crossing, temporary restrictions on construction activities at the project site will continue during the proposed period of 3 to 5 years of reproductive monitoring and translocations. This will provide temporary foraging, nesting, and roosting habitat. Construction within RCW habitat will not occur until translocations success is noted at the mitigation site or for 3 years, whichever comes first. If young birds are not available for 3 years, the HCP period will be extended to 5 years.
2. Three new cluster sites will be created at the Hal Scott Preserve in Orange County. Each cluster site will consist of three completed cavities and two start holes. New cavities will be caged and inspected for 6 months for sap leakage. Any trees leaking sap will not be opened for use by RCW.
3. Annual monitoring of nesting and roosting activity will be conducted at the project sites. During nesting season, weekly visits to occupied cavity trees will be conducted.
4. At Windover Farms, the single male RCW will be relocated to the newly created clusters at Hal Scott Preserve, along with a young female from Pineda Crossing (if available), or from the Big Econlockhatchee population, of which the RCWs occupying Hal Scott are a part.
5. The young birds from Pineda Crossing will be translocated to the newly created clusters at Hal Scott Preserve. Weekly visits will be conducted to the mitigation site once a week for 1 month after translocation to inspect the cavity and the surrounding area for the presence of these birds. Checks of the cluster sites will also be made four times during the following nesting season to monitor reproductive status and success.
6. Young birds from the surrounding population in the Big Econ River area will be used, if necessary, to augment these created cluster sites during years of no reproduction on the Pineda Crossing site.
7. At the mitigation site, inspections will be conducted in the fall and winter to locate the roost sites.

Dated: December 1, 1995.

Noreen K. Clough,
Regional Director.

[FR Doc. 95-29941 Filed 12-7-95; 8:45 am]

BILLING CODE 4310-55-P

Availability of an Environmental Assessment/Habitat Conservation Plan and Receipt of Application for Incidental Take Permit for Construction and Operation of a Residential and Commercial Development in Wimberely, Hays County, Texas

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice.

SUMMARY: Douglas J. Barclay (Applicant) has applied to the Fish and Wildlife Service (Service) for an incidental take permit pursuant to section 10(a) of the Endangered Species Act (Act). The Applicant has been assigned permit number PRT-808691. The requested permit, which is for a period of 30 years, would authorize the incidental take of the endangered golden-cheeked warbler (*Dendroica chrysoparia*). The proposed take would occur as a result of the construction and operation of 164 acres of residential and commercial development in Wimberely, Hays County, Texas.

The Service has prepared the Environmental Assessment/Habitat Conservation Plan (EA/HCP) for the incidental take applications. A determination of jeopardy to the species or a Finding of No Significant Impact (FONSI) will not be made before 30 days from the date of publication of this notice. This notice is provided pursuant to section 10(c) of the Act and National Environmental Policy Act regulations (40 CFR 1506.6).

DATES: Written comments on the application should be received on or before January 8, 1996.

ADDRESSES: Persons wishing to review the application and EA/HCP may obtain a copy by contacting Joseph E. Johnston or Sybil Vosler, Ecological Services Field Office, 10711 Burnet Road, suite 200, Austin, Texas 78758 (512/490-0063). Documents will be available for public inspection during normal business hours (9 to 4:30) U.S. Fish and Wildlife Service, Austin, Texas. Written data or comments concerning the application(s) and EA/HCPs should be submitted to the Acting Field Supervisor, Ecological Field Office, Austin, Texas (see **ADDRESS** above). Please refer to permit number PRT-808691 when submitting comments.

FOR FURTHER INFORMATION CONTACT: Joseph E. Johnston or Sybil Vosler at the above Austin Ecological Service Field Office.

SUPPLEMENTARY INFORMATION: Section 9 of the Act prohibits the "taking" of endangered species such as the golden-cheeked warbler. However, the Service, under limited circumstances, may issue permits to take endangered wildlife species incidental to, and not the purpose of, otherwise lawful activities. Regulations governing permits for endangered species are at 50 CFR 17.22.

APPLICANT: Douglas J. Barclay plans to construct and operate residential and commercial development on 164 acres in Wimberely, Hays County, Texas. This action will eliminate the habitat for one to two pairs of golden-cheeked warblers.

The applicant proposes to compensate for this incidental take of golden-cheeked warbler habitat by purchasing 20 acres of mitigation credit from the Nature Conservancy of Texas, Inc. to acquire/manage lands for the conservation of the golden-cheeked warbler.

Alternatives to this action were rejected because selling or not developing the subject property with federally listed species present was not economically feasible.

Nancy M. Kaufman,
Regional Director, Region 2, Albuquerque,
New Mexico.

[FR Doc. 95-29944 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-55-M

Availability of an Environmental Assessment and Receipt of an Application for an Incidental Take Permit for the American Burying Beetle by Weyerhaeuser Company for Timber Harvesting and Management in Little River County, AR, and McCurtain County, OK

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice.

SUMMARY: Weyerhaeuser Company (Applicant) is seeking an incidental take permit from the Fish and Wildlife Service (Service), pursuant to Section 10(a)(1)(B) of the Endangered Species Act (Act), as amended. The permit would authorize the take of the American Burying Beetle (*Nicrophorus americanus*), an endangered species, in Little River County, Arkansas, and McCurtain County, Oklahoma, for a period of 35 years. The proposed incidental take would result from normal forestry and other operational and management practices performed on the Applicant's lands.

The Service also announces the availability of a habitat conservation plan (HCP) and environmental assessment (EA). The Applicant's HCP describes conservation measures that will be taken to minimize and mitigate coincidentally with incidental take of the American burying beetle (ABB) by undertaking a research program into the long-term conservation needs of the affected species and by limiting certain ground-disturbing activities. Reporting and amendment procedures are included to ensure that the Applicant's management activities may continue to consider the latest scientific information pertaining to distribution and habitat requirements of the ABB and to address unforeseen circumstances. The EA prepared by the Service describes the

environmental consequences of issuing or denying the incidental take permit. As stated in the EA, the Service proposes to issue the requested permit. This proposal is based on a preliminary determination that the Applicant has satisfied the requirements for permit issuance and that the HCP provides conservation benefits to the ABB that exceed the impact of the expected level of incidental take. Copies of the EA and HCP may be obtained by making a written request to the Regional Office [See **ADDRESSES** below]. This notice is provided pursuant to Section 10(c) of the Act and National Environmental Policy Act Regulations (40 CFR 1506.6).

DATES: Written comments on the permit application, EA, and HCP should be received on or before January 8, 1996.

ADDRESSES: Persons wishing to review the application, HCP, and EA may obtain a copy by writing the Service's Southeast Regional Office, Atlanta, Georgia. Requests for the documents must be in writing to be processed. Documents will also be available for public inspection by appointment during normal business hours at the Regional Office, or the Jackson, Mississippi, Field Office. Written data or comments concerning the application, EA, or HCP should be submitted to the Regional Office. Please reference permit under PRT-809072 in such comments:

Regional Permit Coordinator, U.S. Fish and Wildlife Service, 1875 Century Boulevard, Suite 200, Atlanta, Georgia (404-679-7110, fax 404-679-7081)
Field Supervisor, U.S. Fish and Wildlife Service, 6578 Dogwood View Parkway, Suite A, Jackson, Mississippi 39213 (601-965-4900, fax 601-965-4340)

FOR FURTHER INFORMATION CONTACT: Will McDearman, Jackson, Mississippi Field Office or Rick Gooch at the Atlanta, Georgia Regional Office.

SUPPLEMENTARY INFORMATION: Section 9 of the Act, and implementing regulations, prohibits the take of RCWs. Take, in part, is defined as an activity that kills, injures, harms, or harasses a listed endangered or threatened species. Section 10(a)(1)(B) of the Act provides an exemption, under certain circumstances, to the Section 9 prohibition if the taking is incidental to, and not the purpose of an otherwise lawful activity.

This application for incidental taking is associated with a three-way land exchange proposed in Arkansas and Oklahoma. It involves the Applicant, the Service, and the Forest Service. The proposed exchange was formulated in consultation with State and local

interests. The Applicant's openness to the proposal is based on its interest in consolidating ownership and obtaining land and timber more strategically located to its sawmills. Additionally, some of its existing lands with their associated non-timber values are better suited for public ownership and management. The Applicant and the two Federal agencies believe the proposed exchange satisfies the desire to place these lands in public ownership and better aligns the highest and best land uses with landowner interest and objectives.

The land exchange is approximately a 4 to 1 ratio, with the Applicant contributing the larger share. The Applicant will transfer approximately 150,000 acres to the Federal government. About 100,000 acres of this lies in southeast Oklahoma around Broken Bow Lake and near the McCurtain County Wilderness Area, a site operated by the Oklahoma Department of Wildlife Conservation. Other acreage consists of sites totalling approximately 25,000 acres near areas of strong public interest including Lake Ouachita, Little Missouri Wild and Scenic River, Glover River, Lower Mountain Fork River, Flatside Wilderness Area and other parts of the Ouachita National Forest. The Applicant will also transfer some 25,000 acres of nationally significant wetland habitat to the Service to be incorporated into the existing Cossatot National Wildlife Refuge to be managed for public benefits associated with wetland flora and fauna.

The Applicant will acquire approximately 40,000 acres from the Federal government, including 27,000 acres of the Tiak Ranger District of the Ouachita National Forest in McCurtain County, Oklahoma. The remaining acreage is in smaller, scattered tracts in Garland, Yell and Perry Counties, Arkansas. As a result of the land exchange described above, the Applicant will obtain ownership of land with known populations of ABB. The ABB is known to occur on or near the Tiak Ranger District, a substantial portion of which is to be received by the Applicant in the land exchange. This species is a carrion beetle, family Silphidae, and is also called the giant carrion beetle. It is the largest member of a guild of beetles that breed and rear their young on vertebrate carcasses. Like other burying beetles, the ABB is a highly social species that provides biparental care to its young. Once widely distributed throughout Eastern North America, this species is believed to have disappeared from most of its historic range. Very little is known

about the life history of the species, including how forest structures affect population dynamics.

Potential taking incidental to the Applicant's proposed land management activities is largely associated with forest management in the permit area. There are, however, a variety of other potential effects associated with ownership and management which could also result in an incidental taking of the ABB. The following forest and land management activities are included for permit coverage: (1) Timber harvest, logging decks and pushout roads for access; (2) Site preparation activities; (3) tree planting; (4) thinning and pruning of trees; (5) pesticide use and prescribed burning; (6) food plot creation and other wildlife management activities; (7) leasing, exploration, and mining of minerals, oils, gas, and other natural resources; (8) right of way, road easements, and pipelines; (9) livestock grazing and fencing; (10) pond construction and maintenance; (11) road construction and maintenance; (12) fire lanes and helicopter pads; (13) hunting/recreational use activities; and, (14) miscellaneous activities which may cause minor ground disturbances. To address the effects of these activities on the ABB, the Applicant proposes to initiate a strategy which focuses on addressing research and management needs of the ABB on a landscape scale. This includes a baseline survey of ABB abundance and distribution, a research and monitoring program, restrictions on pesticide use, limiting ground disturbance activities during certain periods of the year, and an adaptive management approach to forest practices that incorporates new information on the ABB's needs and requirements as elucidated by the aforementioned research/monitoring plan. The Applicant will provide funding for the HCP over its 35-year life.

The EA considers the environmental consequences of several alternatives; issue the requested permit as conditioned by the HCP, issue a permit predicated on a different mitigation/minimization strategy for the ABB, or take no action (deny permit). The Service finds the greatest conservation benefits accompany the HCP and proposed permit. The Service's proposed alternative is to issue the requested incidental take permit, based upon the submitted HCP. The principal environmental consequence of permit issuance, in the Service's assessment, is to sustain or enhance the status of the ABB, via implementation and funding the mitigation and minimization measures as outlined above.

Dated: December 1, 1995.

Noreen K. Clough,

Regional Director.

[FR Doc. 95-29942 Filed 12-7-95; 8:45 am]

BILLING CODE 4310-55-P

Availability of an Environmental Assessment/Habitat Conservation Plan and Receipt of Application for Incidental Take Permit for Construction and Operation of a Mixed Use and Residential Development in Austin, Travis County, TX

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice.

SUMMARY: P-WB Joint Venture (Applicant) has applied to the Fish and Wildlife Service for an incidental take permit pursuant to Section 10(a) of the Endangered Species Act. The Applicant has been assigned permit number PRT-808694. The requested permit, which is for a period of 10 years, would authorize the incidental take of the endangered golden-cheeked warbler (*Dendroica chrysoparia*), Tooth Cave ground beetle (*Rhadine persephone*), and Bone Cave harvestman (*Texella reyesi*). The proposed take would occur as a result of the construction and operation of 138 acres of mixed use and residential development in Austin, Travis County, Texas.

The Service has prepared the Environmental Assessment/Habitat Conservation Plan for the incidental take applications. A determination of jeopardy to the species or a Finding of No Significant Impact will not be made before 30 days from the date of publication of this notice. This notice is provided pursuant to Section 10(c) of the Act and National Environmental Policy Act regulations (40 CFR 1506.6).

DATES: Written comments on the application should be received by January 8, 1996.

ADDRESS: Persons wishing to review the application or the EA/HCP may obtain a copy by contacting Joseph E. Johnston or Sybil Vosler, Ecological Services Field Office, 10711 Burnet Road, Suite 200, Austin, Texas 78758 (512/490-0063). Documents will be available for public inspection during normal business hours (9 to 4:30) U.S. Fish and Wildlife Service, Austin, Texas. Written data or comments concerning the application(s) and EA/HCPs should be submitted to the Acting Field Supervisor, Ecological Field Office, Texas (see **ADDRESS** above). Please refer to permit number PRT-808694 when submitting comments.

FOR FURTHER INFORMATION CONTACT:

Joseph E. Johnston or Sybil Vosler at the above Austin Ecological Service Field Office.

SUPPLEMENTARY INFORMATION: Section 9 of the Act prohibits the "taking" of endangered species such as the golden-cheeked warbler and cave invertebrates. However, the Service, under limited circumstances, may issue permits to take endangered wildlife species incidental to, and not the purpose of, otherwise lawful activities. Regulations governing permits for endangered species are at 50 CFR 17.22.

APPLICANT: P-WB Joint Venture plans to construct and operate 138 acres of mixed use and residential development on 333 acres in Austin, Travis County, Texas. This action will eliminate the habitat for 13 pairs of golden-cheeked warblers. The applicant proposes to compensate for this incidental take of golden-cheeked warbler habitat by preserving 135 acres of golden-cheeked warbler habitat and the preservation and maintenance of 52 acres with 5 caves containing the Tooth Cave ground beetle and the Bone Cave harvestman for the conservation of the golden-cheeked warbler and the cave invertebrates.

Alternatives to this action were rejected because selling or not developing the subject property with federally listed species present was not economically feasible.

Nancy M. Kaufman,

Regional Director, Region 2, Albuquerque, New Mexico.

[FR Doc. 95-29943 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-55-M

Bureau of Land Management

[UT-912-06-0777-52]

Meeting of the Utah Resource Advisory Council

AGENCY: Bureau of Land Management, Utah.

SUMMARY: The Utah Resource Advisory Council will meet on January 5-6, 1996 at the Howard Johnson Hotel, Salt Lake Conference Room, 122 West South Temple, Salt Lake City, Utah. Council members will meet from 9 a.m. to 5 p.m. on Friday, January 5. The entire first day will be devoted to a training session on rangeland ecology. The Council will reconvene at 8 a.m. on Saturday, January 6. A discussion of the planning process to develop standards and guidelines will be the primary topic the second day. A public comment, period where members of the public may address the Council, is scheduled for 12:00 noon on the 6th. The meeting will conclude at 1 p.m. All sessions of the

Utah Resource Advisory Council meeting are open to the public.

FOR FURTHER INFORMATION CONTACT: Don Banks, Utah State Office, Bureau of Land Management, 324 S. State St., Suite 300, Salt Lake City, UT 84111; phone (801) 539-4021.

Dated: December 1, 1995.

G. William Lamb,
Utah BLM State Director.

FR Doc. 95-29940 Filed 12-7-95; 8:45 am]

BILLING CODE 4310-DQ-M

[UT-04-1430-01; U-74782]

Leasing of Public Land Washington County, Utah

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of realty action.

SUMMARY: This notice involves a long term lease on public land in Utah. The lease is intended to resolve a long-standing agriculture trespass and would be offered non-competitively to the current user.

DATE: Comments should be received by January 8, 1996.

ADDRESS: Comments should be sent to the Area Manager, Dixie Resource Area, 345 East Riverside Drive, St. George, Utah 84770.

FOR FURTHER INFORMATION CONTACT: Randy Massey, Realty Specialist, (801) 673-4654 ext. 274.

SUPPLEMENTARY INFORMATION: The following described public land is being proposed for a long term agriculture lease:

Salt Lake Meridian

T. 40 S., R. 17 W.,

Sec. 29, SE $\frac{1}{4}$ NE $\frac{1}{4}$; (portion of)
containing approximately 6.7 acres.

The area is currently being used as irrigated pasture and has been used as such for a number of years. The issuance of the lease would terminate a long-standing trespass. The proposed lease would be issued non-competitively to the adjacent land owner. Application for the lease will be accepted upon completion of the comment period. The lease would be issued for not less than fair market rental, and the lessee shall reimburse the United States for reasonable administrative and other costs incurred by the United States in processing the lease and for monitoring operation, maintenance, and rehabilitation of the facilities authorized. The reimbursement of costs shall be in accordance with 43 CFR 2920.6.

For a period of 30 days from the date of this notice, interested parties may

submit comments to the Area Manager, Dixie Resource Area, address noted above. Any adverse comments will be evaluated by the Area Manager who may vacate or modify this Realty Action and issue a final determination. In the absence of any objections, this Notice of Realty Action will become the final determination of the Bureau of Land Management.

James D. Crisp,
Area Manager.

[FR Doc. 95-29911 Filed 12-7-95; 8:45 am]

BILLING CODE 4310-DQ-M

INTERSTATE COMMERCE COMMISSION

[Docket No. AB-32 (Sub-No. 70X)]

Boston and Maine Corporation— Abandonment Exemption—in Middlesex County, MA

Boston and Maine Corporation (B&M) has filed a notice of exemption under 49 CFR part 1152, Subpart F—*Exempt Abandonments* to abandon a portion of railroad known as the Tewksbury Branch line, between milepost 0.75 and milepost 1.92, a distance of approximately 1.17 miles, in Tewksbury, Middlesex County, MA. The proposed consummation date of the abandonment is January 8, 1996.

B&M has certified that: (1) no local traffic has moved over the line for at least 2 years; (2) overhead traffic has been rerouted over other lines; (3) no formal complaint filed by a user of rail service on the line (or by a State or local government entity acting on behalf of such user) regarding cessation of service over the line either is pending with the Commission or with any U.S. District Court or has been decided in favor of the complainant within the 2-year period; and (4) the requirements at 49 CFR 1105.7 (environmental reports), 49 CFR 1105.8 (historic reports), 49 CFR 1105.11 (transmittal letter), 49 CFR 1105.12 (newspaper publication), and 49 CFR 1152.50(d)(1) (notice to governmental agencies) have been met.

As a condition to use of this exemption, any employee adversely affected by the abandonment shall be protected under *Oregon Short Line R. Co.—Abandonment—Goshen*, 360 I.C.C. 91 (1979). To address whether this condition adequately protects affected employees, a petition for partial revocation under 49 U.S.C. 10505(d) must be filed.

Provided no formal expression of intent to file an offer of financial assistance (OFA) has been received, this exemption will be effective on January

6, 1996, unless stayed pending reconsideration. Petitions to stay that do not involve environmental issues,¹ formal expressions of intent to file an OFA under 49 CFR 1152.27(c)(2),² and trail use/rail banking requests under 49 CFR 1152.29³ must be filed by December 18, 1995. Petitions to reopen or requests for public use conditions under 49 CFR 1152.28 must be filed by December 27, 1995, with: Office of the Secretary, Case Control Branch, Interstate Commerce Commission, Washington, DC 20423.

A copy of any pleading filed with the Commission should be sent to applicant's representative: John R. Nadolny, Iron Horse Park, North Billerica, MA 01862.

If the notice of exemption contains false or misleading information, the exemption is void *ab initio*.

B&M has filed an environmental report which addresses the abandonment's effects, if any, on the environmental and historic resources. The Section of Environmental Analysis (SEA) will issue an environmental assessment (EA) by December 12, 1995. Interested persons may obtain a copy of the EA by writing to SEA (Room 3219, Interstate Commerce Commission, Washington, DC 20423) or by calling Elaine Kaiser, Chief of SEA, at (202) 927-6248. Comments on environmental and historic preservation matters must be filed within 15 days after the EA is available to the public.

Environmental, historic preservation, public use, or trail use/rail banking conditions will be imposed, where appropriate, in a subsequent decision.

Decided: November 29, 1995.

By the Commission, David M. Konschnik,
Director, Office of Proceedings.

Vernon A. Williams,

Secretary.

[FR Doc. 95-30007 Filed 12-7-95; 8:45 am]

BILLING CODE 7035-01-P

¹ A stay will be issued routinely by the Commission in those proceedings where an informed decision on environmental issues (whether raised by a party or by the Commission's Section of Environmental Analysis in its independent investigation) cannot be made prior to the effective date of the notice of exemption. See *Exemption of Out-of-Service Rail Lines*, 5 I.C.C.2d 377 (1989). Any entity seeking a stay on environmental concerns is encouraged to file its request as soon as possible in order to permit the Commission to review and act on the request before the effective date of this exemption.

² See *Exempt. of Rail Abandonment—Offers of Finan. Assist.*, 4 I.C.C.2d 164 (1987).

³ The Commission will accept a late-filed trail use request as long as it retains jurisdiction to do so.

DEPARTMENT OF JUSTICE**Drug Enforcement Administration****Manufacturer of Controlled Substances; Notice of Registration**

By Notice dated August 10, 1995, and published in the Federal Register on August 17, 1995, (60 FR 42905), Dupont Pharmaceuticals, The Dupont Merck Pharmaceutical Company, 1000 Stewart Avenue, Garden City, New York 11530, made application to the Drug Enforcement Administration (DEA) to be registered as a bulk manufacturer of the basic classes of controlled substances listed below:

Drug	Schedule
Oxycodone (9143)	II
Hydrocodone (9193)	II
Oxymorphone (9652)	II

No comments or objections have been received. DEA has determined that the registration of Dupont Pharmaceuticals to manufacture the listed controlled substances is consistent with the public interest at this time. Therefore, pursuant to Section 303 of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and Title 21, Code of Federal Regulations, Section 1301.54(e), the Deputy Assistant Administrator, Office of Diversion Control, hereby orders that the application submitted by the above firm for registration as a bulk manufacturer of the basic classes of controlled substances listed above is granted.

Dated: November 29, 1995.

Gene R. Haislip,
Deputy Assistant Administrator, Office of
Diversion Control Drug Enforcement
Administration.

[FR Doc. 95-29961 Filed 12-7-95; 8:45 am]

BILLING CODE 4410-09-M

Manufacturer of Controlled Substances; Notice of Registration

By Notice dated August 10, 1995, and published in the Federal Register on August 17, 1995, (60 FR 42905), Noramco of Delaware, Inc., Division of McNeilab, Inc., 500 Old Swedes Landing Road, Wilmington, Delaware 19801, made application to the Drug Enforcement Administration (DEA) to be registered as a bulk manufacturer of the basic classes of controlled substances listed below:

Drug	Schedule
Codeine (9050)	II
Oxycodone (9143)	II

Drug	Schedule
Hydrocodone (9193)	II
Morphine (9300)	II
Thebaine (9333)	II
Alfentanil (9737)	II
Fentanyl (9801)	II

No comments or objections have been reached. DEA has determined that the registration of Noramco of Delaware, Inc. to manufacture the listed controlled substances is consistent with the public interest at this time. Therefore, pursuant to Section 303 of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and Title 21, Code of Federal Regulations, Section 1301.54(e), the Deputy Assistant Administrator, Office of Diversion Control, hereby orders that the application submitted by the above firm for registration as a bulk manufacturer of the basic classes of controlled substances listed above is granted.

Dated: November 29, 1995.

Gene R. Haislip,
Deputy Assistant Administrator, Office of
Diversion Control, Drug Enforcement
Administration.

[FR Doc. 95-29962 Filed 12-7-95; 8:45 am]

BILLING CODE 4410-09-M

DEPARTMENT OF LABOR**Employment Standards Administration****Wage and Hour Division****Minimum Wages for Federal and Federally Assisted Construction; General Wage Determination Decisions**

General wage determination decisions of the Secretary of Labor are issued in accordance with applicable law and are based on the information obtained by the Department of Labor from its study of local wage conditions and data made available from other sources. They specify the basic hourly wage rates and fringe benefits which are determined to be prevailing for the described classes of laborers and mechanics employed on construction projects of a similar character and in the localities specified therein.

The determinations in these decisions of prevailing rates and fringe benefits have been made in accordance with 29 CFR Part 1, by authority of the Secretary of Labor pursuant to the provisions of the Davis-Bacon Act of March 3, 1931, as amended (46 Stat. 1494, as amended, 40 U.S.C. 276a) and of other Federal statutes referred to in 29 CFR Part 1, Appendix, as well as such additional statutes as may from time to time be enacted containing provisions for the

payment of wages determined to be prevailing by the Secretary of Labor in accordance with the Davis-Bacon Act. The prevailing rates and fringe benefits determined in these decisions shall, in accordance with the provisions of the foregoing statutes, constitute the minimum wages payable on Federal and federally assisted construction projects to laborers and mechanics of the specified classes engaged on contract work of the character and in the localities described therein.

Good cause is hereby found for not utilizing notice and public comment procedure thereon prior to the issuance of these determinations as prescribed in 5 U.S.C. 553 and not providing for delay in the effective date as prescribed in that section, because the necessity to issue current construction industry wage determinations frequently and in large volume causes procedures to be impractical and contrary to the public interest.

General wage determination decisions, and modifications and supersedeas decisions thereto, contain no expiration dates and are effective from their date of notice in the Federal Register, or on the date written notice is received by the agency, whichever is earlier. These decisions are to be used in accordance with the provisions of 29 CFR Parts 1 and 5. Accordingly, the applicable decision, together with any modifications issued, must be made a part of every contract for performance of the described work within the geographic area indicated as required by an applicable Federal prevailing wage law and 29 CFR Part 5. The wage rates and fringe benefits, notice of which is published herein, and which are contained in the Government Printing Office (GPO) document entitled "General Wage Determinations Issued Under The Davis-Bacon And Related Acts," shall be the minimum paid by contractors and subcontractors to laborers and mechanics.

Any person, organization, or governmental agency having an interest in the rates determined as prevailing is encouraged to submit wage rate and fringe benefit information for consideration by the Department. Further information and self-explanatory forms for the purpose of submitting this data may be obtained by writing to the U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, of Wage Determinations, 200 Constitution Avenue, N.W., Room S-3014, Washington, D.C. 20210.

Modifications to General Wage Determination Decisions

The number of decisions listed in the Government Printing Office document entitled "General Wage Determinations Issued Under the Davis-Bacon and Related Acts" being modified are listed by Volume and State. Dates of publication in the Federal Register are in parentheses following the decisions being modified.

Volume I

Connecticut

CT950001 (Feb. 10, 1995)

CT950004 (Feb. 10, 1995)

New York

NY950033 (Feb. 10, 1995)

Volume II

Maryland

MD950001 (Feb. 10, 1995)

MD950002 (Feb. 10, 1995)

MD950006 (Feb. 10, 1995)

MD950012 (Feb. 10, 1995)

MD950013 (Feb. 10, 1995)

MD950015 (Feb. 10, 1995)

MD950021 (Feb. 10, 1995)

MD950023 (Feb. 10, 1995)

MD950031 (Feb. 10, 1995)

MD950039 (Feb. 10, 1995)

MD950040 (Feb. 10, 1995)

MD950043 (Feb. 10, 1995)

MD950046 (Feb. 10, 1995)

MD950055 (Sept. 29, 1995)

Pennsylvania

PA950004 (Feb. 10, 1995)

PA950008 (Feb. 10, 1995)

PA950032 (Feb. 10, 1995)

Volume III

Florida

FL950002 (Feb. 10, 1995)

Volume IV

Minnesota

MN950005 (Feb. 10, 1995)

MN950007 (Feb. 10, 1995)

MN950008 (Feb. 10, 1995)

MN950012 (Feb. 10, 1995)

MN950015 (Feb. 10, 1995)

MN950027 (Feb. 10, 1995)

MN950031 (Feb. 10, 1995)

MN950035 (Feb. 10, 1995)

MN950039 (Feb. 10, 1995)

MN950049 (Feb. 10, 1995)

MN950058 (Feb. 10, 1995)

MN950061 (Feb. 10, 1995)

Wisconsin

WI950001 (Feb. 10, 1995)

WI950002 (Feb. 10, 1995)

WI950003 (Feb. 10, 1995)

WI950004 (Feb. 10, 1995)

WI950006 (Feb. 10, 1995)

WI950007 (Feb. 10, 1995)

WI950008 (Feb. 10, 1995)

WI950009 (Feb. 10, 1995)

WI950010 (Feb. 10, 1995)

WI950011 (Feb. 10, 1995)

WI950012 (Feb. 10, 1995)

WI950014 (Feb. 10, 1995)

WI950015 (Feb. 10, 1995)

WI950016 (Feb. 10, 1995)

WI950017 (Feb. 10, 1995)

WI950018 (Feb. 10, 1995)

WI950019 (Feb. 10, 1995)

WI950020 (Feb. 10, 1995)

WI950024 (Feb. 10, 1995)

WI950025 (Feb. 10, 1995)

WI950026 (Feb. 10, 1995)

WI950027 (Feb. 10, 1995)

WI950028 (Feb. 10, 1995)

WI950029 (Feb. 10, 1995)

WI950030 (Feb. 10, 1995)

WI950031 (Feb. 10, 1995)

WI950032 (Feb. 10, 1995)

WI950033 (Feb. 10, 1995)

WI950035 (Feb. 10, 1995)

Volume V

Arkansas

AR950003 (Feb. 10, 1995)

AR950008 (Feb. 10, 1995)

Texas

TX950003 (Feb. 10, 1995)

TX950011 (Feb. 10, 1995)

TX950012 (Feb. 10, 1995)

TX950013 (Feb. 10, 1995)

TX950015 (Feb. 10, 1995)

TX950018 (Feb. 10, 1995)

TX950060 (Feb. 10, 1995)

TX950081 (Feb. 10, 1995)

Volume VI

Alaska

AK950002 (Feb. 10, 1995)

North Dakota

ND950002 (Feb. 10, 1995)

General Wage Determination Publication

General wage determinations issued under the Davis-Bacon and related Acts, including those noted above, may be found in the Government Printing Office (GPO) document entitled "General Wage Determinations Issued Under The Davis-Bacon and Related Acts". This publication is available at each of the 50 Regional Government Depository Libraries and many of the 1,400 Government Depository Libraries across the country.

The general wage determinations issued under the Davis-Bacon and related Acts are available electronically by subscription to the FedWorld Bulletin Board System of the National Technical Information Service (NTIS) of the U.S. Department of Commerce at (703) 487-4630.

Hard-copy subscriptions may be purchased from: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, (202) 512-1800.

When ordering hard-copy subscription(s), be sure to specify the State(s) of interest, since subscriptions may be ordered for any or all of the six separate volumes, arranged by State. Subscriptions include an annual edition (issued in January or February) which includes all current general wage determinations for the States covered by each volume. Throughout the remainder of the year, regular weekly updates are distributed to subscribers.

Signed at Washington, D.C. this 1st day of December 1995.

Philip J. Gloss,

Chief, Branch of Construction Wage Determinations.

[FR Doc. 95-29649 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-27-M

Employment and Training Administration

[TA-W-31,317; TA-W-31,317A; TA-W-31,317B]

Barrow Manufacturing Corporation, Dahlonga, Georgia, et al.; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with Section 223 of the Trade Act of 1974 (19 USC 2273) the Department of Labor issued a Certification Regarding Eligibility to Apply for Worker Adjustment Assistance on October 6, 1995, applicable to all workers of Barrow Manufacturing Corporation located in Dahlonga, Georgia. The notice was published in the Federal Register on October 27, 1995 (60 FR 55064).

At the request of the company, the Department reviewed the certification for workers of the subject firm. Based on new information received by the company, the Department is amending the certification to cover the workers at the subject firm's Satham and Winder, Georgia locations. The workers at Barrow's Satham, Georgia location, scheduled to close before January 1, 1996, produce men's and boys' dress and casual slacks and men's and boys' jeans. The Barrow's workers located in Winder, Georgia perform cutting, shipping, and administrative functions for Barrow's Georgia manufacturing operations.

The intent of the Department's certification is to include all workers of Barrow Manufacturing Corporation who were adversely affected by increased imports of apparel.

The amended notice applicable to TA-W-31,317 is hereby issued as follows:

"All workers of Barrow Manufacturing Corporation, Dahlonga, Georgia (TA-W-31,317); Satham, Georgia (TA-W-31,317A); and Winder, Georgia (TA-W-31,317B) who became totally or partially separated from employment on or after July 27, 1994 are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974."

Signed at Washington, DC this 22nd day of November 1995.

Russell T. Kile,

Acting Program Manager, Policy and Reemployment Services, Office of Trade Adjustment Assistance.

[FR Doc. 95-29973 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-30-M

[TA-W-31,075 and 075A]

Gentek Building Products, Incorporated, Woodbridge, NJ, and Gentek Building Products, Incorporated; Franklin Park, IL; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with Section 223 of the Trade Act of 1974 (19 U.S.C. 2273) the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance on May 30, 1995, applicable to all workers of Gentek Building Products, Incorporated, located in Woodbridge, New Jersey. The notice was published in the Federal Register on June 21, 1995 (60 FR 32346).

The Department reviewed the certification for workers at the subject firm. New information received from the company shows that worker separations will occur at Gentek's Franklin Park, Illinois production facility. The workers produce aluminum and vinyl siding. Based on this new information, the Department is amending the certification to cover workers of the subject firm in Franklin Park, Illinois.

The intent of the Department's certification is to include all workers of Gentek Building Products, Incorporated who were adversely affected by increased imports.

The amended notice applicable to TA-W-31,075 is hereby issued as follows:

"All workers of Gentek Building Products, Incorporated, Woodbridge, New Jersey (TA-W-31,075), and Franklin Park, Illinois (TA-W-31,075A) who became totally or partially separated from employment on or after March 24, 1994 are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974."

Signed at Washington, D.C. this 22nd day of November 1995.

Russell T. Kile,

Acting Program Manager, Policy and Reemployment Services, Office of Trade Adjustment Assistance.

[FR Doc. 95-29971 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-30-M

[TA-W-31,454; TA-W-31,454A]

Oxford Industries, Inc., Oxford Shirtings Division, Alamo, Georgia, et al.; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with Section 223 of the Trade Act of 1974 (19 U.S.C. 2273) the Department of Labor issued a Certification Regarding Eligibility to Apply for Worker Adjustment Assistance on October 13, 1995, applicable to all workers of Oxford Industries, Inc., Oxford Shirtings Division located in Alamo, Georgia. The notice was published in the Federal Register on October 27, 1995 (60 FR 55064).

At the request of the company, the Department reviewed the subject certification. Based on new information received by the company, the Department is amending the certification to cover the workers at the subject firm's Lanier Clothes production facility in Bowman, Georgia. Shutdown operations will begin in December 1995. The workers produce men's pants.

The intent of the Department's certification is to include all workers of Oxford Industries, Inc. who were adversely affected by increase imports of apparel.

The amended notice applicable to TA-W-31,454 is hereby issued as follows:

"All workers of Oxford Industries, Inc., Oxford Shirtings Division, Alamo, Georgia (TA-W-31,454) engaged in employment related to the production of men's dress shirts, and all workers of Oxford Industries, Inc., Lanier Clothes, Bowman, Georgia (TA-W-31,454A) who became totally or partially separated from employment on or after September 7, 1994 are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974."

Signed at Washington, D.C. this 22nd day of November 1995.

Russell T. Kile,

Acting Program Manager, Policy and Reemployment Services, Office of Trade Adjustment Assistance.

[FR Doc. 95-29974 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-30-M

[TA-W-31,079]

Picker International, Inc., Cleveland, OH; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with section 223 of the Trade Act of 1974 (19 U.S.C. 2273) the Department of Labor issued a Notice of Certification Regarding Eligibility to Apply for Worker Adjustment

Assistance on June 30, 1995, applicable to all workers of Picker International, Inc., engaged in employment related to the production of medical imaging equipment in Cleveland, Ohio. The notice was published in the Federal Register on July 19, 1995 (60 FR 37083).

At the request of the State Agency, the Department reviewed the certification for workers of the subject firm. The workers produce medical imaging equipment. New findings show that the support workers (sales, service and administrative) of the subject firm, located in various States, should have been included. The intent of the Department's certification is to include all workers of Picker International, Inc. who were adversely affected by increased imports.

The amended notice applicable to TA-W-31,079 is hereby issued as follows:

"All workers of Picker International, Inc., Cleveland, Ohio, and at various field offices listed below, engaged in employment related to the production of medical imaging equipment who became totally or partially separated from employment on or after May 13, 1994 are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974:

TA-W-31,079A	Alabama
TA-W-31,079B	Arizona
TA-W-31,079C	California
TA-W-31,079D	Colorado
TA-W-31,079E	Florida
TA-W-31,079F	Georgia
TA-W-31,079G	Illinois
TA-W-31,079H	Indiana
TA-W-31,079I	Iowa
TA-W-31,079J	Kansas
TA-W-31,079K	Louisiana
TA-W-31,079L	Maryland
TA-W-31,079M	Massachusetts
TA-W-31,079N	Michigan
TA-W-31,079O	Missouri
TA-W-31,079P	Montana
TA-W-31,079Q	New Jersey
TA-W-31,079R	New York
TA-W-31,079S	North Carolina
TA-W-31,079T	Oregon
TA-W-31,079U	South Carolina
TA-W-31,079V	Texas
TA-W-31,079W	Virginia
TA-W-31,079X	Washington
TA-W-31,079Y	West Virginia
TA-W-31,079Z	Wyoming."

Signed at Washington, DC this 27th day of November 1995.

Russell T. Kile,

Acting Program Manager, Policy and Reemployment Services, Office of Trade Adjustment Assistance.

[FR Doc. 95-29976 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-30-M

[TA-W-31,267 and 267A]**Woolrich, Incorporated, Alliance, NE; and Woolrich, Incorporated, Ailey, GA; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance**

In accordance with Section 223 of the Trade Act of 1974 (19 U.S.C. 2273) the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance on August 10, 1995, applicable to all workers of Woolrich, Incorporated located in Alliance, Nebraska. The notice was published in the Federal Register on August 24, 1995 (60 FR 44079).

The Department reviewed the certification for workers at the subject firm. New information received from the company shows that worker separations will occur at Woolrich's Ailey, Georgia sewing facility. The workers produce ladies' and men's outerwear and sportswear. Based on this new information, the Department is amending the certification to cover workers of the subject firm in Ailey, Georgia.

The intent of the Department's certification is to include all workers of Woolrich, Incorporated who were adversely affected by increased imports of apparel.

The amended notice applicable to TA-W-31,267 is hereby issued as follows:

"All workers of Woolrich, Incorporated, Alliance, Nebraska (TA-W-31,267), and Ailey, Georgia (TA-W-31,267A) who became totally or partially separated from employment on or after July 12, 1994 are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974."

Signed at Washington, D.C. this 27th day of November 1995.

Russell T. Kile,
Acting Program Manager, Policy and Reemployment Services, Office of Trade Adjustment Assistance.

[FR Doc. 95-29975 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-30-M

[NAFTA-00659]**Gentek Building Products, Inc., Franklin Park, Illinois; Notice of Termination of Investigation**

Pursuant to Title V of the North American Free Trade Agreement Implementation Act (P.L. 103-182) concerning transitional adjustment assistance, hereinafter called (NAFTA-TAA), and in accordance with Section 250(a), Subchapter D, Chapter 2, Title II, of the Trade Act of 1974, as amended

(19 USC 2273), an investigation was initiated on October 25, 1995 in response to a petition filed by a company representative on behalf of workers at Gentek Building Products, Inc. located in Franklin Park, Illinois. The investigation revealed that on May 9, 1995, workers of Gentek Building Products, Inc. located in Woodbridge, New Jersey were certified eligible to apply for NAFTA-TAA under Section 250 of the Trade Act of 1974. On November 28, 1995 an amendment was made to NAFTA-00414 to include all workers of Gentek Building Products, Inc. located in Franklin Park, Illinois. Because the subject workers have been included in the amendment certification of NAFTA-00414, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, D.C., this 1st day of February 1995.

Russell T. Kile,
Acting Program Manager, Policy and Reemployment Services, Office of Trade Adjustment Assistance.

[FR Doc. 95-29969 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-30-M

[NAFTA-00414 and 00414A]**Gentek Building Products, Inc., Woodbridge, NJ and Gentek Building Products, Inc., Franklin Park, IL; Amended Certification Regarding Eligibility To Apply for NAFTA Transitional Adjustment Assistance**

In accordance with Section 250(a), Subchapter D, Chapter 2, Title II, of the Trade Act of 1974, as amended (19 U.S.C. 2273), the Department of Labor issued a Certification for NAFTA Transitional Adjustment Assistance on May 9, 1995, applicable to all workers at Gentek Building Products, Inc. located in Woodbridge, New Jersey.

New information received from the company shows that worker separations will take place at Gentek's Franklin Park, Illinois production facility. The layoffs are the result of a shift in production to the subject firm's Canadian plant. The Department is amending the certification to include the Franklin Park workers.

The intent of the Department's certification is to include all workers of Gentek Building Products, Inc. who are adversely affected by increased imports.

The amended notice applicable to NAFTA-00414 is hereby issued as follows:

"All workers of Gentek Building Products, Inc., Woodbridge, New Jersey (NAFTA-00414), and Franklin Park, Illinois (NAFTA-

00414A) who became totally or partially separated from employment on or after March 29, 1994 are eligible to apply for NAFTA-TAA under Section 250 of the Trade Act of 1974."

Signed at Washington, DC this 28th day of November 1995.

Russell T. Kile,
Acting Program Manager, Policy and Reemployment Services, Office of Trade Adjustment Assistance.

[FR Doc. 95-29970 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-30-M

[NAFTA-00622; NAFTA-00622C]**Samax II, Inc., Eggleston, Virginia, et al.; Amended Certification Regarding Eligibility To Apply for NAFTA Transitional Adjustment Assistance**

In accordance with Section 250(a), Subchapter D, Chapter 2, Title II, of the Trade Act of 1974, as amended (19 U.S.C. 2273), the Department of Labor issued a Certification for NAFTA Transitional Adjustment Assistance on October 25, 1995, applicable to all workers of Samax II, Inc. located in Eggleston, Virginia. The notice was published in the Federal Register on November 9, 1995 (60 FR 56620).

New information received from petitioners shows that worker separations have occurred at Pacemaker Togs, Inc., in New York, New York, the parent company of Samax. The workers at Pacemaker Togs provide support services for the Samax plants.

The intent of the Department's certification is to include all workers of the subject firm who were adversely affected by increased imports of apparel. Accordingly, the Department is amending the certification to include the workers of the parent company, Pacemaker Togs, Inc., New York, New York.

The amended notice applicable to NAFTA-00622 is hereby issued as follows:

"All workers of Samax II, Eggleston, Virginia (NAFTA-00622); and Pacemaker Togs, Inc., New York, New York (NAFTA-00622C) who became totally or partially separated from employment on or after September 21, 1994 are eligible to apply for NAFTA-TAA Section 250 of the Trade Act of 1974."

Signed at Washington, DC this 22nd day of November 1995.

Russell T. Kile,
Acting Program Manager, Policy and Reemployment Services, Office of Trade Adjustment Assistance.

[FR Doc. 95-29972 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-30-M

Office of Federal Contract Compliance Programs**Construction Contractors—Affirmative Action Requirements: Rescission of Reporting Requirements**

AGENCY: Office of Federal Contract Compliance Programs, Labor.

ACTION: Notice.

SUMMARY: As part of its regulatory reform efforts, the Department of Labor is reviewing reporting requirements placed on the public. The Office of Federal Contract Compliance Programs (OFCCP) has determined, as part of its review, that the present routine submission by covered construction contractors of the Monthly Employment Utilization Report (CC-257) is no longer necessary.

EFFECTIVE DATE: December 8, 1995.

FOR FURTHER INFORMATION CONTACT: Annie A. Blackwell, Director, Division of Policy, Planning and Program Development, OFCCP, 202-219-9430 (voice), 1-800-326-2577 (TDD). Copies of this Notice, including copies in alternative formats, may be obtained by calling OFCCP at 202-219-9430 (voice) or 1-800-326-2577 (TDD). The alternative formats available are: Large print, electronic file on computer disk, and audio-tape.

SUPPLEMENTARY INFORMATION: In accordance with Executive Order 11246 (Sections 202, 203, and 301), the equal opportunity clause included in non-exempt Government contracts and federally assisted construction contracts requires contractors to furnish all information and reports required by Executive Order 11246 and by the rules, regulations, and orders of the Secretary of Labor (41 CFR 60-1.4(a)(5), (b)(5)). Also, non-exempt Federal construction contracts and subcontracts, and federally assisted construction contracts and subcontracts include the Standard Federal Equal Employment Opportunity Construction Contract Specifications (41 CFR 60-4.3). These specifications require construction contractors and subcontractors to submit any reports relating to the provisions of the regulations as may be required by the Government (41 CFR 60-4.3(a)(14)).

For many years, the reports routinely required of construction contractors by OFCCP have taken the form of the Monthly Employment Utilization Report (CC-257). Covered construction contractors have been required to record on this form the total hours worked by all construction employees and the number of hours worked by minority and female employees by construction trade, on construction projects in a

specific area. The CC-257s are sent monthly to the OFCCP Area Office with jurisdiction over the location where the contractor's payroll records are kept.

The requirement to file the CC-257, however, has had only limited application. The report has been required only of approximately one-third of the covered construction contractors every month. Briefly, only construction work performed in geographic areas covered by minority goals under a hometown or imposed plan, as listed in the Federal Register in 1978, are required to report. (45 FR 85750; 43 FR 19473, App. B) Approximately 35,000 reports are filed each month.

The ongoing review of regulatory requirements and the identification of existing paperwork requirements which can be eliminated without significantly affecting compliance with the Executive Order has resulted in the decision to no longer require the routine preparation and submission of the CC-257. Eliminating these monthly reports will relieve the affected construction contractors of an estimated 419,000 burden hours per year currently calculated under the Paperwork Reduction Act (44 U.S.C. 3501) (OMB control number 1215-0163). Also, ending this collection of information will permit OFCCP to utilize its limited resources more efficiently.

It is important to note, however, that the Executive Order and regulations cited above continue to authorize the Secretary of Labor to require reporting from contractors subject to the regulations. It is anticipated that such reporting, generally, will be associated with instances involving the resolution of violations of the regulations and as otherwise deemed appropriate to further the purposes of the Executive Order. (For example, during the term of a construction mega project.)

Therefore, upon publication of this Notice, the routine monthly compilation and submission of the form CC-257 is no longer required from construction contractors: *Provided*, that any contractor or subcontractor required to submit such reports pursuant to an extant agreement with OFCCP shall continue to do so for the duration of the agreement.

Signed at Washington, D.C., this 17th day of November 1995.

Bernard E. Anderson,
Assistant Secretary for Employment Standards.

Shirley J. Wilcher,
Deputy Assistant Secretary for Federal Contract Compliance.

[FR Doc. 95-29978 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-27-M

Bureau of Labor Statistics**Proposed Information Collection Request Submitted for Public Comment and Recommendations; Multiple Worksite Report and Report of Federal Employment and Wages**

ACTION: Notice.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995. This program helps to ensure that requested data can be provided in the desired format, reporting burden is minimized, reporting forms are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Bureau of Labor Statistics (BLS) is soliciting comments concerning the proposed extension of the "Multiple Worksite Report." A copy of the proposed information collection request (ICR) can be obtained by contacting the individual listed below in the address section of this notice.

DATES: Written comments must be submitted on or before February 6, 1996.

ADDRESSES: Send comments to Karin G. Kurz, BLS Clearance Officer, Division of Management Systems, Bureau of Labor Statistics, Room 3255, 2 Massachusetts Avenue, N.E., Washington, D.C. 20212.

FOR FURTHER INFORMATION CONTACT: Ms. Kurz on 202-606-7628 (this is not a toll free number).

SUPPLEMENTARY INFORMATION:**I. Background**

The ES-202 Program is a Federal/State cooperative effort which compiles monthly employment and quarterly wage data. These data are collected from State Quarterly Contribution Reports submitted to State Employment Security Agencies (SESAs) by employers subject to State Unemployment Insurance (UI) laws. The ES-202 Report, produced for

each calendar quarter, is a summary of these employer (micro-level) data by industry at the county level. Similar data for Federal Government employees covered by the Unemployment Compensation for Federal Employees (UCFE) Program are also included in each State report. These data are submitted by all 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands to the Bureau of Labor Statistics (BLS) which then summarizes these macro-level data to produce totals for the States and the Nation. The ES-202 Report provides a virtual census of nonagricultural employees and their wages, with about 47 percent of the workers in agriculture covered as well.

As part of the ES-202 Program, the States also send micro-level employment and wages data, supplemented with the names and addresses of employers, to BLS. These States' data are used to create a BLS sampling frame, known as the Business Establishment List. This file represents one of the best sources of detailed industrial and geographical data on employers and is used as the sampling frame for most BLS surveys. The Business Establishment List includes the individual employer employment and wages data along with associated business identification information that is maintained by each State to administer the UI program as well as the UCFE program.

For employers having only a single physical location (worksite) in the State and, thus, operating under a single assigned industrial and geographical code, the data from the States' UI accounting file are sufficient for statistical purposes. Such data, however, are inadequate for statistical purposes for those employers having multiple establishments or engaged in different industrial activities within the State. In such cases, the employer's Quarterly Contributions Report may reflect only Statewide employment and wages and is not disaggregated by establishment or worksite. Although this level of data is sufficient for many purposes of the UI Program, more detailed information is required to create a sampling frame and meet the needs of several ongoing Federal/State statistical programs. As a result of the Multiple Worksite Report, improved establishment business identification data elements have been incorporated into and maintained on the Business Establishment List. Establishment identification data elements in the Business Establishment List include a physical location address, secondary name (division, trade name, subsidiary, etc.), and reporting unit description

(store number, plant name or number, etc.) for each worksite of multi-establishment employers.

Employers with more than one establishment reporting under the same U.I. account number within a State are requested to complete the Multiple Worksite Report if the sum of the employment in all of their secondary establishments is 10 or greater. The primary worksite is defined as the establishment with the greatest number of employees. Upon receipt of the first Multiple Worksite Report form, each employer is requested to supply business location identification information. Thereafter, this reported information is computer-printed on the Multiple Worksite Report each quarter. The employer is requested to verify the accuracy of this business identification information and provide only the employment and wages for each worksite for that quarter. By using a standardized form, the reporting burden on many large employers, especially those engaged in multiple economic activities at various locations across numerous States, has been reduced.

Comparable to the Multiple Worksite Report, the function of the Report of Federal Employment and Wages is to collect employment and wage data for each installation of a federal agency. The Report of Federal Employment and Wage aids in the development and maintenance of business identification information by installation. The Report of Federal Employment and Wages was modeled after the Multiple Worksite Report and is used only to collect data from Federal agencies covered by the UCFE program.

II. Current Actions

No other standardized report is available to collect current establishment-level employment and wages data by SESAs for statistical purposes each quarter. Also, no other standardized report currently is available to collect installation-level Federal employment and wages data by SESAs for statistical purposes.

The Bureau of Labor Statistics has taken steps to help reduce employer reporting burden by developing a standardized format for employers to use to send these data to the States in an electronic medium. The Bureau also established an Electronic Data Interchange (EDI) Collection Center to improve and expedite the Multiple Worksite Report collection process. Employers who complete the Multiple Worksite Report for multi-location businesses can now submit employment and wages information on any electronic medium (tape, cartridge,

diskette, or computer-to-computer) directly to the data collection center, in lieu of each State agency. The data collection center then distributes the appropriate data to each State.

Type of Review: Extension of currently approved collection.

Agency: Bureau of Labor Statistics.

Title: Multiple Worksite Report (MWR) and Report of Federal Employment and Wages (RFEW).

OMB Number: 1220-0134.

Frequency: Quarterly.

Affected Public: Business or other for-profit institutions, not for-profit institutions, Federal Government, and State, local or tribunal government.

Number of Respondents: 117,911.

Estimated Time Per Response: 22.2 minutes.

Total Burden Hours: 174,508 hours.

Comments submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget approval of the ICR; they also will become a matter of public record.

Signed at Washington, DC, this 5th day of December, 1995.

W. Stuart Rust, Jr.,

Acting Chief, Division of Management Systems, Bureau of Labor Statistics.

[FR Doc. 95-29977 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-24-M

Pension and Welfare Benefits Administration

[Prohibited Transaction Exemption 95-108, Exemption Application No. D-09973, et al.]

Grant of Individual Exemptions; Kay Alden, Inc. Money Purchase Plan (the Plan), et al.

AGENCY: Pension and Welfare Benefits Administration, Labor.

ACTION: Grant of individual exemptions.

SUMMARY: This document contains exemptions issued by the Department of Labor (the Department) from certain of the prohibited transaction restrictions of the Employee Retirement Income Security Act of 1974 (the Act) and/or the Internal Revenue Code of 1986 (the Code).

Notices were published in the Federal Register of the pendency before the Department of proposals to grant such exemptions. The notices set forth a summary of facts and representations contained in each application for exemption and referred interested persons to the respective applications for a complete statement of the facts and representations. The applications have been available for public inspection at the Department in Washington, D.C. The

notices also invited interested persons to submit comments on the requested exemptions to the Department. In addition the notices stated that any interested person might submit a written request that a public hearing be held (where appropriate). The applicants have represented that they have complied with the requirements of the notification to interested persons. No public comments and no requests for a hearing, unless otherwise stated, were received by the Department.

The notices of proposed exemption were issued and the exemptions are being granted solely by the Department because, effective December 31, 1978, section 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978) transferred the authority of the Secretary of the Treasury to issue exemptions of the type proposed to the Secretary of Labor.

Statutory Findings

In accordance with section 408(a) of the Act and/or section 4975(c)(2) of the Code and the procedures set forth in 29 CFR Part 2570, Subpart B (55 FR 32836, 32847, August 10, 1990) and based upon the entire record, the Department makes the following findings:

- (a) The exemptions are administratively feasible;
- (b) They are in the interests of the plans and their participants and beneficiaries; and
- (c) They are protective of the rights of the participants and beneficiaries of the plans.

Kay Alden, Inc. Money Purchase Plan (the Plan), Located in Chicago, Illinois; Exemption

[Prohibited Transaction Exemption 95-108; Exemption Application No. D-09973]

The restrictions of sections 406(a), 406(b)(1) and 406(b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code shall not apply to the purchase of real property (the Purchase) by the Plan from Mr. Vernon Nelson (Nelson), a party in interest with respect to the Plan provided that: (a) The Purchase is a one time transaction for cash; (b) the Plan will pay no more than fair market value for the Property, as determined by an independent qualified real estate appraiser at the time of the transaction; (c) the fair market value of the Property represents no more than 25% of the value of the Plan's assets; (d) the Plan's interests with respect to the Purchase are represented by two independent fiduciaries; (e) the Plan will pay no fees or commissions associated with the

Purchase; and (f) all terms and conditions of the Purchase are at least as favorable to the Plan as those obtainable in an arm's length transaction with an unrelated party.

For a more complete statement of the facts and representations supporting the Department's decision to grant this exemption, refer to the notice of proposed exemption published on October 17, 1995 at 60 FR 53805.

FOR FURTHER INFORMATION CONTACT:

Allison Padams of the Department, telephone (202) 219-8971. (This is not a toll-free number.)

Rea Magnet Wire Company, Inc. Employees' Retirement Savings Plan and Rea Magnet Wire Company, Inc. Union Employees' Retirement Savings Plan (together, the Plans) Located in Fort Wayne, Indiana; Exemption

[Prohibited Transaction Exemption 95-109; Exemption Application Nos. D-10075 and D-10076]

The restrictions of sections 406(a), 406(b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to the proposed sale by the Plans of two guaranteed investment contracts (the GICs) of Confederation Life Insurance Company (CL) to Rea Magnet Wire Company, Inc. (Rea), a party in interest with respect to the Plans, provided the following conditions are satisfied: a) the sale is a one-time transaction for cash; b) the Plans will receive no less than the fair market value of the GICs as of the date of the sale; and c) the purchase price will be not less than the GICs' accumulated book values at their maturity date (defined as total deposits plus interest accrued but unpaid at the GICs' stated rates of interest through the date of maturity, less withdrawals) plus interest from the date of maturity through the date of the sale at the rate then being earned under the Plans' "GIC/Stable Value Fund".

For a more complete statement of the facts and representations supporting the Department's decision to grant this exemption, refer to the notice of proposed exemption published on September 25, 1995 at 60 FR 49426.

FOR FURTHER INFORMATION CONTACT: Gary H. Lefkowitz of the Department, telephone (202) 219-8881. (This is not a toll-free number.)

Profit Sharing Plan of NEBCO, Inc. Located in Lincoln, Nebraska; Exemption

[Prohibited Transaction Exemption 95-110; Exemption Application No. D-10096]

The restrictions of sections 406(a) and 406(b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to (1) the extensions of credit in the form of guarantees and advances of funds (the Advances) to the Plan by NEBCO, Inc. (the Employer), the sponsor of the Plan, with respect to the Guaranteed Investment Contract No. 64238 (the GIC) issued by Confederation Life Insurance Company of Canada (Confederation); and (2) the repayment of the Advances by the Plan to the Employer; provided that the following conditions are satisfied: (a) All terms and conditions of the transactions are no less favorable to the Plan than those which the Plan would receive in arm's length transactions; (b) No interest payments or expenses will be incurred by the Plan with respect to the transactions; (c) Repayment of the Advances will be restricted to proceeds from the GIC (GIC Proceeds); (d) Repayment of Advances will be waived by the Employer to the Extent that Advances exceed the GIC Proceeds; and (e) All unpaid principal and earned interest of the GIC will be completely paid by the Advances to the Plan by March 15, 2000.

For a more complete statement of the facts and representations supporting the Department's decision to grant this exemption refer to the notice of proposed exemption published on October 6, 1995, at 60 FR 52419.

FOR FURTHER INFORMATION CONTACT: Mr. C.E. Beaver of the Department, telephone (202) 219-8881. (This is not a toll-free number.)

Profit Sharing Plan of Constructors, Inc. (the Plan) Located in Lincoln, Nebraska; Exemption

[Prohibited Transaction Exemption 95-111; Exemption Application No. D-10097]

The restrictions of sections 406(a) and 406(b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to (1) the extensions of credit in the form of guarantees and advances of funds (the Advances) to the Plan by Constructors, Inc. (the Employer), the sponsor of the Plan, with respect to the Guaranteed Investment Contract No. 64238 (the GIC) issued by Confederation Life Insurance Company of Canada (Confederation); and (2) the repayment of the Advances by the Plan to the Employer; provided that the following conditions are satisfied: (a) All terms and conditions of the transactions are no less favorable to

the Plan than those which the Plan would receive in arm's length transactions; (b) No interest payments or expenses will be incurred by the Plan with respect to the transactions; (c) Repayment of the Advances will be restricted to proceeds from the GIC (GIC Proceeds); (d) Repayment of Advances will be waived by the Employer to the Extent that Advances exceed the GIC Proceeds; and (e) All unpaid principal and earned interest of the GIC will be completely paid by the Advances to the Plan by March 15, 2000.

For a more complete statement of the facts and representations supporting the Department's decision to grant this exemption refer to the notice of proposed exemption published on October 6, 1995, at 60 FR 52421.

FOR FURTHER INFORMATION CONTACT: Mr. C. E. Beaver of the Department, telephone (202) 219-8881. (This is not a toll-free number.)

Universal Surety Company Profit Sharing Plan (the Plan) Located in Lincoln, Nebraska; Exemption

[Prohibited Transaction Exemption 95-112; Exemption Application No. D-10098]

The restrictions of sections 406(a) and 406(b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to (1) the extensions of credit in the form of guarantees and advances of funds (the Advances) to the Plan by Universal Surety Company (the Employer), the sponsor of the Plan, with respect to the Guaranteed Investment Contract No. 64238 (the GIC) issued by Confederation Life Insurance Company of Canada (Confederation); and (2) the repayment of the Advances by the Plan to the Employer; provided that the following conditions are satisfied: (a) All terms and conditions of the transactions are no less favorable to the Plan than those which the Plan would receive in arm's length transactions; (b) No interest payments or expenses will be incurred by the Plan with respect to the transactions; (c) Repayment of the Advances will be restricted to proceeds from the GIC (GIC Proceeds); (d) Repayment of Advances will be waived by the Employer to the Extent that Advances exceed the GIC Proceeds; and (e) All unpaid principal and earned interest of the GIC will be completely paid by the Advances to the Plan by March 15, 2000.

For a more complete statement of the facts and representations supporting the Department's decision to grant this exemption refer to the notice of

proposed exemption published on October 6, 1995, at 60 FR 52422.

FOR FURTHER INFORMATION CONTACT: Mr. C. E. Beaver of the Department, telephone (202) 219-8881. (This is not a toll-free number.)

Constructors, Inc. 401(k) Plan (the Plan) Located in Lincoln, Nebraska; Exemption

[Prohibited Transaction Exemption 95-113; Exemption Application No. D-10099]

The restrictions of sections 406(a) and 406(b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to (1) the extensions of credit in the form of guarantees and advances of funds (the Advances) to the Plan by Constructors, Inc. (the Employer), the sponsor of the Plan, with respect to the Guaranteed Investment Contract No. 64238 (the GIC) issued by Confederation Life Insurance Company of Canada (Confederation); and (2) the repayment of the Advances by the Plan to the Employer; provided that the following conditions are satisfied: (a) All terms and conditions of the transactions are no less favorable to the Plan than those which the Plan would receive in arm's length transactions; (b) No interest payments or expenses will be incurred by the Plan with respect to the transactions; (c) Repayment of the Advances will be restricted to proceeds from the GIC (GIC Proceeds); (d) Repayment of Advances will be waived by the Employer to the Extent that Advances exceed the GIC Proceeds; and (e) All unpaid principal and earned interest of the GIC will be completely paid by the Advances to the Plan by March 15, 2000.

For a more complete statement of the facts and representations supporting the Department's decision to grant this exemption refer to the notice of proposed exemption published on October 6, 1995, at 60 FR 52424.

FOR FURTHER INFORMATION CONTACT: Mr. C.E. Beaver of the Department, telephone (202) 219-8881. (This is not a toll-free number.)

General Information

The attention of interested persons is directed to the following:

(1) The fact that a transaction is the subject of an exemption under section 408(a) of the Act and/or section 4975(c)(2) of the Code does not relieve a fiduciary or other party in interest or disqualified person from certain other provisions to which the exemptions does not apply and the general fiduciary responsibility provisions of section 404

of the Act, which among other things require a fiduciary to discharge his duties respecting the plan solely in the interest of the participants and beneficiaries of the plan and in a prudent fashion in accordance with section 404(a)(1)(B) of the Act; nor does it affect the requirement of section 401(a) of the Code that the plan must operate for the exclusive benefit of the employees of the employer maintaining the plan and their beneficiaries;

(2) These exemptions are supplemental to and not in derogation of, any other provisions of the Act and/or the Code, including statutory or administrative exemptions and transactional rules. Furthermore, the fact that a transaction is subject to an administrative or statutory exemption is not dispositive of whether the transaction is in fact a prohibited transaction; and

(3) The availability of these exemptions is subject to the express condition that the material facts and representations contained in each application are true and complete and accurately describe all material terms of the transaction which is the subject of the exemption. In the case of continuing exemption transactions, if any of the material facts or representations described in the application change after the exemption is granted, the exemption will cease to apply as of the date of such change. In the event of any such change, application for a new exemption may be made to the Department.

Signed at Washington, D.C., this 5th day of December, 1995.

Ivan Strasfeld,

*Director of Exemption Determinations,
Pension and Welfare Benefits Administration,
U.S. Department of Labor.*

[FR Doc. 95-29985 Filed 12-7-95; 8:45 am]

BILLING CODE 4510-29-P

[Application Nos. D-09969 and D-09970]

Proposed Exemptions; Timberland Investment Group, Inc. (Timberland) and Wachovia Bank of Georgia, N.A. (the Investment Manager)

AGENCY: Pension and Welfare Benefits Administration, Labor.

ACTION: Notice of proposed exemptions.

SUMMARY: This document contains notices of pendency before the Department of Labor (the Department) of proposed exemptions from certain of the prohibited transaction restriction of the Employee Retirement Income Security Act of 1974 (the Act) and/or the Internal Revenue Code of 1986 (the Code).

Written Comments and Hearing Requests

Unless otherwise stated in the Notice of Proposed Exemption, all interested persons are invited to submit written comments, and with respect to exemptions involving the fiduciary prohibitions of section 406(b) of the Act, requests for hearing within 45 days from the date of publication of this Federal Register Notice. Comments and request for a hearing should state: (1) The name, address, and telephone number of the person making the comment or request, and (2) the nature of the person's interest in the exemption and the manner in which the person would be adversely affected by the exemption. A request for a hearing must also state the issues to be addressed and include a general description of the evidence to be presented at the hearing. A request for a hearing must also state the issues to be addressed and include a general description of the evidence to be presented at the hearing.

ADDRESSES: All written comments and request for a hearing (at least three copies) should be sent to the Pension and Welfare Benefits Administration, Office of Exemption Determinations, Room N-5649, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Attention: Application No. stated in each Notice of Proposed Exemption. The applications for exemption and the comments received will be available for public inspection in the Public Documents Room of Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-5507, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Notice to Interested Persons

Notice of the proposed exemptions will be provided to all interested persons in the manner agreed upon by the applicant and the Department within 15 days of the date of publication in the Federal Register. Such notice shall include a copy of the notice of proposed exemption as published in the Federal Register and shall inform interested persons of their right to comment and to request a hearing (where appropriate).

SUPPLEMENTARY INFORMATION: The proposed exemptions were requested in applications filed pursuant to section 408(a) of the Act and/or section 4975(c)(2) of the Code, and in accordance with procedures set forth in 29 CFR Part 2570, Subpart B (55 FR 32836, 32847, August 10, 1990). Effective December 31, 1978, section 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978)

transferred the authority of the Secretary of the Treasury to issue exemptions of the type requested to the Secretary of Labor. Therefore, these notices of proposed exemption are issued solely by the Department.

The applications contain representations with regard to the proposed exemptions which are summarized below. Interested persons are referred to the applications on file with the Department for a complete statement of the facts and representations.

Timberland Investment Group, Inc. (Timberland) and Wachovia Bank of Georgia, N.A. (the Investment Manager) Located in Atlanta, GA; Proposed Exemption

[Application Nos. D-09969 and D-09970]

Based on the facts and representations set forth in the application, the Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in 29 CFR Part 2570, Subpart B (55 FR 32836, 32847, August 10, 1990).¹

Section I. Covered Transaction

If the exemption is granted, the restrictions of section 406(b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1)(E) of the Code, shall not apply to the payment of an incentive fee (the Incentive Fee) by Timberland, a special purpose corporation which holds plan assets from the American Telephone and Telegraph Master Trust (the AT&T Trust) and the BellSouth Master Pension Trust (the BellSouth Trust; collectively, the Trusts), to the Investment Manager of Timberland, a party in interest with respect to the Trusts.

This proposed exemption is conditioned upon the requirements set forth below in Section II.

Section II. General Conditions

(a) The investment of the assets of each Trust in Timberland, including the terms and payment of the Incentive Fee, is approved in writing by a Trust fiduciary who is independent of the Investment Manager and its affiliates (the Independent Fiduciary).

(b) Each Trust participating in Timberland has total assets that are in excess of \$50 million and no Trust has

invested more than one percent of its assets in Timberland.

(c) The terms of the Trusts' investment management agreements for Timberland, including the Incentive Fee, are at least as favorable to the Trusts as those obtainable in an arm's length transaction with an unrelated party.

(d) Prior to investing in Timberland, each Independent Fiduciary entered into an agreement with the Investment Manager disclosing all material facts concerning the purpose, structure and operation of Timberland including the fee arrangements.

(e) With respect to its ongoing participation in Timberland, each Trust receives the following written documentation from the Investment Manager:

(1) Audited financial statements of Timberland prepared by independent, qualified public accountants on an annual basis, which disclose the fees that are paid to the Investment Manager and its affiliates.

(2) Quarterly valuations, transmitted routinely to the Trusts, which indicate the fair market value of Timberland's assets as established by appraisers who are independent of the Investment Manager and its affiliates.

(3) Upon request, valuations performed by independent appraisers at three year intervals which determine the underlying land value of Timberland.

(4) Upon request, a timber inventory valuation of Timberland performed every five years by independent, registered consulting foresters in order to determine timber volume and growth rates.

(f) The total fees paid to the Investment Manager constitute no more than reasonable compensation.

(g) The Incentive Fee is payable to the Investment Manager upon the complete liquidation of the Trusts' account in Timberland (the Timberland Account) and only if the Trusts recover distributions equal to their initial investments in Timberland.

(h) In the event that the Investment Manager resigns or is removed prior to the complete liquidation of the Timberland Account,

(1) The Trusts will appoint a successor Investment Manager to effect the liquidation of such account.

(2) The Incentive Fee will not be paid to the former Investment Manager until the complete liquidation of the Timberland Account takes place.

(3) The Incentive Fee will only be paid to the former Investment Manager if it represents the lowest of three fee amounts.

¹ For purposes of this exemption, reference to provisions of Title I of the Act, unless otherwise specified, refer also to the corresponding provisions of the Code.

(i) The Investment Manager maintains, for a period of six years, the records necessary to enable the persons described in paragraph (i) of this Section to determine whether the conditions of this exemption have been met, except that (1) a prohibited transaction will not be considered to have occurred if, due to circumstances beyond the control of the Investment Manager and/or its affiliates, the records are lost or destroyed prior to the end of the six year period, and (2) no party in interest other than the Investment Manager shall be subject to the civil penalty that may be assessed under section 502(i) of the Act, or to the taxes imposed by section 4975 (a) and (b) of the Code, if the records are not maintained, or are not available for examination as required by paragraph (i) below.

(i)(1) Except as provided in section (2) of this paragraph and notwithstanding any provisions of subsections (a)(2) and (b) of section 504 of the Act, the records referred to in paragraph (i) of this Section shall be unconditionally available at their customary location during normal business hours by:

(A) Any duly authorized employee or representative of the Department or the Internal Revenue Service (the Service);

(B) Any fiduciary of a plan (the Plan) participating in the Trusts or any duly authorized representative of such fiduciary;

(C) Any contributing employer to any Plan participating in the Trusts or any duly authorized employee representative of such employer; and

(D) Any participant or beneficiary of any Plan participating in the Trusts, or any duly authorized representative of such participant or beneficiary.

(2) None of the persons described above in subparagraphs (B)–(D) of this paragraph (i) shall be authorized to examine the trade secrets of the Investment Manager or commercial or financial information which is privileged or confidential.

Section IV. Definitions

For purposes of this exemption:

(a) An “affiliate” of the Investment Manager includes—

(1) Any person directly or indirectly through one or more intermediaries, controlling, controlled by, or under common control with the Investment Manager. (For purposes of this subsection, the term “control” means the power to exercise a controlling influence over the management or policies of a person other than an individual.)

(2) Any officer, director, employee, relative of, or partner of any such person, and

(3) Any corporation or partnership of which such person is an officer, director, partner or employee.

(b) The term “control” means the power to exercise a controlling influence over the management or policies of a person other than an individual.

(c) An “Independent Fiduciary” is a Trust fiduciary which is independent of the Investment Manager and its affiliates.

Summary of Facts and Representations

1. Wachovia Corporation (Wachovia) is a Southeastern interstate bank holding company maintaining dual headquarters in Winston-Salem, North Carolina and Atlanta, Georgia. The Investment Manager is one of Wachovia’s principal banking subsidiaries. As of December 31, 1994, the Investment Manager had 493 branches in 206 cities and 3 states.

2. The American Telephone & Telegraph Company (AT&T), a New York corporation, and BellSouth Corporation (BellSouth), a Georgia corporation, provide telecommunication services. AT&T, whose headquarters are in New York, New York, primarily provides long distance telephone communication services. BellSouth, one of the seven regional telephone companies that was divested from AT&T in 1984 as part of the Department of Justice’s antitrust settlement with AT&T, is located in Atlanta, Georgia and provides a wide array of telecommunication services, including mobile communications and advertising services.

3. The AT&T Trust covers active management and nonmanagement employees of AT&T as well as retirees throughout the United States. The AT&T Trust is comprised of the AT&T Management Pension Plan (the AT&T Management Plan) and the AT&T Nonmanagement Pension Plan (the AT&T Nonmanagement Plan). As of December 31, 1993, the participant and asset breakdown of these Plans were as follows:

AT&T Trust	Partici- pants	Net ssset value
Manage- ment Plan	180,491	\$20,024,695,000
Nonmanag- ement Plan	262,237	18,210,547,000
Totals	442,728	\$38,235,242,000

The AT&T Trust has six trustees. They are Citibank, N.A.; Chase Manhattan Bank, N.A.; Northern Trust Company; Bankers Trust Company; Mellon Bank, N.A.; and State Street Bank & Trust Company.

4. The BellSouth Trust covers active employees and retirees of BellSouth. The BellSouth Trust is comprised of the BellSouth Personal Retirement Account Pension Plan (the BellSouth PRA Plan), which covers management employees, the BellSouth Corporation Pension Plan (the BellSouth Pension Plan), which covers union employees, and the Retirement Pension Plan of Stephens Graphics, Inc. (the Stephens Plan), which covers management employees. In addition to covering active employees of BellSouth, all three plans include retirees. The retirees reside in all states comprising the United States. The active employees reside in Florida, Georgia, Alabama, Mississippi, Louisiana, Tennessee, Kentucky, North Carolina and South Carolina.

As of December 31, 1993, the participant and asset breakdown of the BellSouth Trust were as follows:

BellSouth Trust	Partici- pants	Net asset value
PRA Plan ..	43,669	\$6,064,663,690
Pension Plan	91,797	7,065,931,097
Stephens Plan	248	24,011,213
Totals	135,714	\$13,154,606,000

The Investment Manager serves as the trustee of the BellSouth Trust.

5. On January 1, 1985, AT&T and the First National Bank of Atlanta, predecessor in interest to the Investment Manager, entered into an investment management agreement (the AT&T Agreement) whereby the Investment Manager agreed to serve as investment manager with respect to a portion of the assets held in the AT&T Trust. Similarly, on September 20, 1990, BellSouth Corporation entered into an investment management agreement (the BellSouth Agreement) whereby the Investment Manager agreed to serve as investment manager with respect to a portion of the assets held in the BellSouth Trust. The decision by AT&T and BellSouth to enter into the Agreements with the Investment Manager was made by fiduciaries of the Trusts who are independent of the Investment Manager following written disclosure of all of the relevant facts and information concerning the purpose, structure and operation of Timberland including the proposed fee arrangements described herein and their

probable effect on the management of the assets of the Trusts.²

6. As contemplated by both the AT&T Agreement and the BellSouth Agreement, Timberland is a special purpose corporation with a projected duration of 7 years.³ Timberland was formed in 1990 for the purpose of holding title to timberland investments made on behalf of the AT&T Trust and the BellSouth Trust. The stock of Timberland is owned in equal shares by the Trusts. The assets of the Trusts that are invested in Timberland have been placed in an account which is referred to herein as the "Timberland Account."⁴ As of June 21, 1994, the Timberland Account had total assets of \$100,000,000.

7. Timberland holds title to the underlying land and timber on properties located in the States of Arkansas, Mississippi, Florida, Georgia, North Carolina, South Carolina, Michigan, Alabama and Louisiana. Such forest properties are primarily "mature" in that they predominately consist of sawtimber-sized trees that can be converted into lumber. Timberland also holds a fewer number of acres on which smaller trees are grown. Some of these smaller trees are merchantable as pulpwood while the remainder are

premerchantable in that they have not yet attained sufficient size to have any marketable value.

8. Effective October 15, 1990, Timberland entered into an investment management agreement with the Investment Manager (the Timberland Agreement). The Timberland Agreement was contemplated by both the BellSouth Agreement and the AT&T Agreement and is intended to ensure that the Timberland would bear directly on the investment management fees for the Investment Manager's services to the corporation. The Timberland Agreement is designed to reflect the operative provisions of the BellSouth and AT&T Agreements as they pertain to timberland investments.

9. Pursuant to the Timberland Agreement, the Investment Manager has full discretion and authority to purchase, sell convey or transfer timberland properties. To date, the Investment Manager has not incurred any debt in connection with the timberland properties. According to the applicants, it is not contemplated that such debt will ever be incurred.

The Investment Manager is also empowered to establish an overall plan for the management of timberland properties. In this regard, day-to-day management of the timber is performed by independent consulting foresters or their subcontractors who are retained on a per diem basis by the Investment Manager. Some of the duties performed by the consulting foresters include the construction and maintenance of firelines, timber stand improvement, inspection for and control of forest insects and disease, site preparation and planting, boundary line marking and maintenance and estimation of forest inventory.

10. Prior to the purchase of a property, the Investment Manager has the underlying bare land value and timber value independently appraised, along with an inventory of the volume of timber on the property, including estimates of the growth rates of the various species and timber products present on the property. At the end of each calendar quarter, the Investment Manager determines the closing market valuation of the timberland assets (excluding any then pending trades, accruals and cash) as of the end of that period. The Investment Manager derives the current volume of timber, net of growth and removals (sales and harvests), based on the independently arrived at growth rates. The Investment Manager retains the services of the independent consulting foresters licensed to do business in states in which the timber in question is located

to provide estimates of the per unit value of the various timber species and products on each tract of timberland in which Timberland has an interest.

As an additional method of valuation, the Investment Manager utilizes the services of Timber Mart South, a price reporting service which regularly quotes per unit market prices for timber products in conjunction with the information provided by the consulting foresters to establish a range of unit values of those areas. The Investment Manager may also use its own judgment to determine the appropriate unit values applicable to current volumes, employing the independently established ranges of values and thus arriving at closing market values for each timberland property in which Timberland has an interest.

In addition to quarterly valuations, the Investment Manager will have the underlying land value (bare land value) reappraised every three years by independent, state-certified appraisers. The purpose of these appraisals is to assist the Investment Manager in deciding whether to liquidate a tract of timberland. Further, the Investment Manager will have the timber inventory of Timberland appraised every five years by independent, registered consulting foresters to determine timber volume and growth rates.

The Investment Manager will select the independent, registered foresters referred to above based upon their prior satisfactory performance or their professional reputations as ascertained from knowledgeable sources within the industry. The consultants on timber value will be chosen on the basis of their reputations for reliability within the timber industry.

11. As compensation for its services under the Timberland Agreement, the Investment Manager is entitled to receive an investment management fee (the Management Fee). Initially, the Management Fee was paid quarterly in arrears at the annual rate of \$600,000. The first payment was made at the conclusion of the calendar quarter which included October 2, 1990. Over the next 11 quarters, Management Fee payments continued to be calculated at this rate until September 30, 1993 when a final payment was made to the Investment Manager.

Commencing in December 1993, the twelfth full quarter, the Management Fee is being paid quarterly in arrears in accordance with the following Annual Fee Schedule:

Annual fee schedule	
First \$100 Million	0.60%

² With respect to the proposed Incentive Fee, section 404 of the Act requires, among other things, that a plan fiduciary act prudently and solely in the interest of the plan's participants and beneficiaries. Thus, the Department expects a plan fiduciary, prior to entering into any performance-based compensation arrangement with an investment manager, to fully understand the risks and benefits associated with the compensation formula following disclosure by the investment manager of all relevant information pertaining to the proposed arrangement. In addition, a plan fiduciary must be capable of periodically monitoring the actions taken by the investment manager in the performance of its duties and must consider, prior to entering into the arrangement, whether such plan fiduciary is able to provide adequate oversight of the investment manager during the course of the arrangement.

³ Although Timberland is currently structured as a corporation, the parties may, for tax reasons, decide to change that form to, or make additional timberland investments through, a partnership. The ownership interest in the partnership would be unchanged, i.e., BellSouth and AT&T would each retain a 50 percent ownership interest in the new entity. Furthermore, any change in the form of ownership would only occur if agreed to by BellSouth, AT&T and the Investment Manager.

⁴ The applicants are assuming, for purposes of this exemption, that the assets of the Trusts that have been invested in Timberland are "plan assets" within the meaning of 29 CFR 2510.3-101. Although the applicants represent that they have considered whether Timberland qualifies as a "real estate operating company" within the meaning of 29 CFR 2510.3-101(e), they are unable to conclude that Timberland can qualify primarily due to the absence of direct authority on whether the activities associated with timberland management are real estate management activities as contemplated by the regulatory definition of "real estate operating company."

Annual fee schedule	
Next \$200 Million	0.50%
Next \$300 Million	0.40%
Balance	0.30%

Such fee is being computed on the basis of the closing market value of timberland assets as of the end of each calendar quarter based on independent appraisals of timber volume and bare land.⁵

12. In addition to the Management Fee, the Investment Manager is entitled to receive an Incentive Fee upon the complete liquidation of the Trusts' Timberland Account provided the Trusts recover distributions equal to their initial investments. Liquidation of the Trusts' Timberland Account is to be completed by October 2, 1997. This is also the "termination date" for Timberland.⁶

The intent of the Incentive Fee is to induce the Investment Manager to liquidate the assets of the Timberland Account in a manner that maximizes the return to the Trusts. However, market conditions at the time of the liquidation will dictate the pattern governing the sale of assets in the Timberland Account as well as the sales price of such assets. To the extent that the Investment Manager can exercise discretion regarding the timing or the amount of the Incentive Fee, the applicants recognize that a violation of the prohibited transaction rules may occur. Accordingly, the applicants request an administrative exemption from the Department.

The Incentive Fee is a one-time fee that will be based on the annual, real internal rate of return (the IRR) achieved on the assets of Timberland. The IRR is the periodic rate at which an investment of a given size grows to a terminal value of a given size. The IRR is determined by the interaction of three variables—(a) the percentage gain in net asset value of the Timberland Account, (b) the time

over which the gain is achieved, and (c) the rate of inflation.⁷

13. The proposed Incentive Fee payment would be based upon the IRR achieved on Timberland's assets consisting of a capital commitment (the Capital Commitment) of \$100 million or other amount as mutually agreed to by the Trusts and the Investment Manager. Such amount will be net of all fees, expenses, income taxes and debt and calculated in accordance with the Timberland Account Incentive Fee Payment Schedule which sets forth various IRRs (which begin at 1 percent and have no limit) and Incentive Fee payments (which are capped at \$10.5 million) applicable to the IRRs.

Basically, the Incentive Fee Payment Schedule provides that for each 0.1 percent increase in the IRR, the Incentive Fee is increased by the dollar amount of the prior increment plus \$500. For example, to determine the Incentive Fee earned with respect to an IRR of 3 percent, the incremental difference between the Incentive Fee earned with respect to an IRR of 2.8 and 2.9 percent must be determined initially. This difference, as reflected in the Incentive Fee Payment Schedule, is \$11,750 (\$137,750 minus \$126,000). Thus, the Incentive Fee for achieving an IRR of 3 percent would be \$150,000 according to the Incentive Fee Payment Schedule (\$137,750 plus \$11,750 plus \$500).

According to the applicant, the parties agreed to this formula for determining the Incentive Fee after considerable negotiation based on the understanding that each 0.1 percent increase in the IRR would be more difficult to achieve. In other words, increasing the IRR from 2.8 percent to 2.9 percent is more difficult than increasing it from 1.8 percent to 1.9 percent. Therefore, the Incentive Fee is designed to encourage this extra effort.

14. For purposes of computing the Incentive Fee, when calculating the IRR, any distributions made from the Timberland Account by the Investment Manager prior to October 2, 1994 and not recalled to fund additional timberland investments, will be subtracted from the cash flow used to determine the IRR. Also, any portion of the Capital Commitment not called prior to October 1, 1994 will cause the Incentive Fee payment amounts to be reduced by the same proportion as the ratio of uncalled capital to the Capital Commitment. All capital distributed to the Trusts from which said capital is

contributed must be recalled prior to any additional portion of the Capital Commitment being called.⁸

15. The Incentive Fee is payable to the Investment Manager upon the termination of Timberland (i.e., October 2, 1997). However, if the Investment Manager resigns or is removed for any reason prior to October 2, 1997 by either AT&T, BellSouth or by both Trusts, the Trusts may appoint a successor Investment Manager to complete the liquidation of the Timberland Account. In this event, the Incentive Fee will be calculated, but it will not be paid to the former Investment Manager until the Timberland Account is completely liquidated (i.e., by October 2, 1997). The actual fee that is paid to the former Investment Manager will be the *lesser* of:

(a) An amount based on the IRR achieved from the inception of the Timberland Account to completion of the liquidation of such account;

(b) An amount based on the IRR achieved from the inception of the Timberland Account to the effective date of the former Investment Manager's removal or resignation, which shall be determined based upon the assumption that the liquidation proceeds are distributed to the Trusts on the termination date of the former Investment Manager in an amount equal to the independently appraised value of the property of Timberland as of such termination date (net of all fees, expenses and taxes); or

(c) An amount based upon the Alternative Fee described in the preceding footnote. Under such circumstances, the Alternative Fee will be computed through the date of the Investment Manager's resignation or removal.

For purposes of calculating the Incentive Fee, if the Investment Manager is removed or resigns prior to the complete liquidation of the Timberland Account, any required appraisal will be performed by an independent appraiser approved by both the Trusts and the Investment Manager. The independent appraiser will determine the fair market value of

⁵The applicants represent that the Management Fee is statutorily exempt under section 408(b)(2) of the Act. However, the Department expresses no opinion herein on whether such fee is statutorily exempt under section 408(b)(2) of the Act.

⁶Initially, October 2, 1997 was the expected "termination date" for Timberland, subject to an extension for two additional years. However, no reinvestments in Timberland are currently being made and proceeds from the disposition of properties are being distributed to the Trusts as the proceeds are collected. It is not anticipated that further reinvestments will occur. Thus, absent agreement by the parties that changes in the investment climate warrant further investment, Timberland will cease to operate when its present holdings have been disposed of. Although the rate of disposition of these holdings will depend on prevailing market conditions, the current expectation is that liquidation will be completed by October 2, 1997.

⁷For purposes of calculating the IRR, the rate of inflation used will be defined as the "Consumer Price Index-U, United States, all items (1982-84 = 100)" (the CPI) currently prepared and published by the Department's Bureau of Labor Statistics.

⁸If the requested exemption is not granted, the Timberland Agreement provides for the payment, to the Investment Manager, of an alternative fee (the Alternative Fee) (in addition to the Management Fee) upon the termination of Timberland. The Alternative Fee is based upon the value of the assets that are under the control of the Investment Manager. The Alternative Fee consists of (a) the payment of \$100,000 for each of the first twelve quarters of the Timberland investment and (b) for the remaining period prior to complete liquidation of Timberland removal, an amount equal to a fixed percentage of the closing market value of timberland assets as of the end of each calendar quarter. The applicants represent that the Alternative Fee would be covered by section 408(b)(2) of the Act and the regulations promulgated thereunder (see 29 CFR 2550.408b-2). However, the Department expresses no opinion herein on whether the payment of such fee would satisfy the conditions of section 408(b)(2) of the Act.

the properties in the Timberland Account by assuming the orderly liquidation of said properties, normal expenses of liquidation and income tax liabilities based on an estimate prepared by an independent certified public accounting firm approved by both the Trusts and the Investment Manager.

16. The following examples illustrate the manner in which the Incentive Fee would be calculated in four hypothetical situations:

• *Example 1.*

Assume that Timberland has a life of 7 years and that the Trusts invest a total of \$100 million in Timberland. At the end of year 7, the sales price of timber plus land, net of all expenses, is \$207,620,000. Assume also that the rate of inflation is 0%. The IRR for this investment can be calculated directly because there is a single cash outflow of \$100,000,000 and a single cash inflow of \$207,620,000. The calculation is as follows: $[(\$207,620,000 / \$100,000,000)^{1/7} - 1] \times 100 = 11\%$

Once the IRR is calculated, the Incentive Fee that will be paid by the Trusts can be determined from the Incentive Fee Payment Schedule which has been reproduced, in part, as follows:

Annual real IRR (> or =)	Incentive fee payment
10.8%	\$2,646,000
10.9%	2,697,750
11.0%	2,750,000

Thus, the total Incentive Fee that will be paid by the Trusts to the Investment Manager based upon an IRR of 11% is \$2,750,000.

The above IRR is both a *nominal* and a *real* rate because inflation was assumed to be 0%. If inflation is positive, however, the nominal IRR will be greater than the real IRR. With positive inflation as measured by the CPI, the nominal IRR must be adjusted for inflation and the Incentive Fee calculated on the basis of the adjusted or real IRR. This is done in Example 2.

• *Example 2.*

Same as Example 1, except now assume inflation occurred at a 4% annual rate over the life of the Trusts' investment in Timberland.

To determine the real IRR, the 11% nominal IRR must be adjusted for 4% inflation. This figure is calculated by dividing the nominal IRR by the CPI: $1.11 / 1.04 = 1.0673 = 6.73\%$.

Once the real IRR is computed, the Incentive Fee that will be paid by Trusts can be determined by referring to the Incentive Fee Payment Schedule which has been reproduced, in part, as follows:

Annual real IRR (> or =)	Incentive fee payment
6.6%	\$924,000
6.7%	954,750
6.8%	986,000

Thus, the total Incentive Fee that will be paid by the Trusts to the Investment Manager based upon a real IRR of 6.73% is \$954,750.

• *Example 3.*

Assume the Trusts give the Investment Manager \$100 million to invest in Timberland and that the Investment Manager increases the investment amount to \$170 million (which is the fair market value determined by independent appraisals), net of expenses, by the end of 4 years. Assume also that the Investment Manager resigns and is replaced by a new Investment Manager. Assume further that the rate of inflation over the 4 year period is 4% annually.

The nominal IRR can be computed directly because there is one cash inflow and one cash outflow: $[(\$170,000,000 / \$100,000,000)^{1/4} - 1] \times 100 = 14.19\%$. To determine the real IRR, the 14.19% nominal IRR must be adjusted for 4% inflation. This figure is calculated by dividing the nominal IRR by the CPI: $1.1419 / 1.04 = 1.0979 = 9.79\%$.

From the Incentive Fee Payment Schedule, the Trusts would pay the former Investment Manager an Incentive Fee of \$2,109,750 based upon a real IRR of 9.79%.

Annual real IRR (> or =)	Incentive fee payment
9.6%	\$2,064,000
9.7%	2,109,750
9.8%	2,156,000

However, the actual fee paid to the former Investment Manager would be the lowest of (a) \$2,109,750, (b) the Alternative Fee or (c) an Incentive Fee determined by reference to the IRR achieved through the complete liquidation of Timberland (including investment results achieved by the successor Investment Manager).

Example 4 demonstrates how poor performance by a successor Investment Manager can reduce the actual payment made to the former Investment Manager.

• *Example 4.*

Same as Example 3, assuming further that the successor Investment Manager continues for a year and that all of Timberland's assets are liquidated in one transaction at the end of that period. During the extra year, the fair market value of Timberland remains at \$170 million and the rate of inflation remains at 4 percent.

The nominal IRR can be computed as follows: $[(\$170,000,000 / \$100,000,000)^{1/5} - 1] \times 100 = 11.20\%$.

To determine the real IRR, the 11.20% nominal IRR must be adjusted for 4% inflation. This figure is calculated by dividing the nominal IRR by the CPI: $1.112 / 1.04 = 6.92\%$.

From the Incentive Fee Payment Schedule, shown in part below, the former Investment Manager would be entitled to an Incentive Fee of \$1,017,750 based on a real IRR of 6.92 percent.

Annual real IRR (> or =)	Incentive fee payment
6.8%	\$986,000
6.9%	1,017,750
7.0%	1,050,000

Since this Incentive Fee is lower than the Incentive Fee based on independent appraisals (see Example 3), the Trusts would pay the former Investment Manager the lower of this fee or the Alternative Fee.

17. The Investment Manager will provide the Trusts with quarterly unaudited financial statements prepared by Price Waterhouse & Company (Price Waterhouse). In addition, the Investment Manager will provide the Trusts with annual audited financial statements, also prepared by Price Waterhouse. These documents will generally be issued within thirty days following their preparation.

18. In summary, it is represented that the proposed transaction will satisfy the statutory criteria for an exemption under section 408(a) of the Act because:

(a) The investment of the assets of each Trust in Timberland, including the terms and payment of the Incentive Fee, has been approved in writing by a fiduciary who is independent of the Investment Manager and its affiliates.

(b) Each Trust participating in Timberland has total assets that are in excess of \$50 million and no Trust may invest more than one percent of its assets in Timberland.

(c) The terms of the Trusts' investment management agreements for Timberland, including the Incentive Fee, will remain at least as favorable to the Trusts as those obtainable in an arm's length transaction with an unrelated party.

(d) Prior to investing in Timberland, each Independent Fiduciary received offering materials which disclose all material facts concerning the purpose, structure and operation of Timberland including the fee arrangements.

(e) The Investment Manager will make periodic written disclosures to the Trusts with respect to the financial condition of Timberland and the fees paid to the Investment Manager.

(f) The total fees paid to the Investment Manager will constitute no more than reasonable compensation.

(g) The Incentive Fee will be payable to the Investment Manager upon the complete liquidation of the Timberland Account and only if the Trusts recover distributions equal to their initial investments in Timberland.

(h) In the event that the Investment Manager resigns or is removed prior to the complete liquidation of the Timberland Account, the Trusts will appoint a successor Investment Manager to effect the liquidation of such account. Under such circumstances, the Incentive Fee will not be paid to the former Investment Manager until the Timberland Account is fully liquidated and if paid, such Incentive Fee must be

represent the lowest of three fee amounts.

Notice to Interested Persons

Notice of the proposed exemption will be provided to all interested persons within 30 days of the publication of the notice of pendency in the Federal Register. The notice will include a copy of the notice of proposed exemption as published in the Federal Register and a statement informing interested persons of their right to comment on and/or to request a hearing with respect thereto. The notice will be provided to all active employees of AT&T and BellSouth by posting. Mailed notice will be given to AT&T and BellSouth union representatives, plan administrators and representatives of retirees. Comments to the Department are due within 60 days of the publication of the proposed exemption in the Federal Register.

FOR FURTHER INFORMATION CONTACT: Ms. Jan D. Broady of the Department, telephone (202) 219-8881. (This is not a toll-free number.)

General Information

The attention of interested persons is directed to the following:

(1) The fact that a transaction is the subject of an exemption under section 408(a) of the Act and/or section 4975(c)(2) of the Code does not relieve a fiduciary or other party in interest of disqualified person from certain other provisions of the Act and/or the Code, including any prohibited transaction provisions to which the exemption does not apply and the general fiduciary responsibility provisions of section 404 of the Act, which among other things require a fiduciary to discharge his duties respecting the plan solely in the interest of the participants and beneficiaries of the plan and in a prudent fashion in accordance with section 404(a)(1)(b) of the act; nor does it affect the requirement of section 401(a) of the Code that the plan must operate for the exclusive benefit of the employees of the employer maintaining the plan and their beneficiaries;

(2) Before an exemption may be granted under section 408(a) of the Act and/or section 4975(c)(2) of the Code, the Department must find that the exemption is administratively feasible, in the interests of the plan and of its participants and beneficiaries and protective of the rights of participants and beneficiaries of the plan;

(3) The proposed exemptions, if granted, will be supplemental to, and not in derogation of, any other provisions of the Act and/or the Code, including statutory or administrative

exemptions and transitional rules. Furthermore, the fact that a transaction is subject to an administrative or statutory exemption is not dispositive of whether the transaction is in fact a prohibited transaction; and

(4) The proposed exemptions, if granted, will be subject to the express condition that the material facts and representations contained in each application are true and complete and accurately describe all material terms of the transaction which is the subject of the exemption. In the case of continuing exemption transactions, if any of the material facts or representations described in the application change after the exemption is granted, the exemption will cease to apply as of the date of such change. In the event of any such change, application for a new exemption may be made to the Department.

Signed at Washington, DC, this 5th day of December, 1995.

Ivan Strasfeld,

*Director of Exemption Determinations,
Pension and Welfare Benefits Administration,
U.S. Department of Labor.*

[FR Doc. 95-29984 Filed 12-07-95; 8:45 am]

BILLING CODE 4510-29-P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice 95-111]

Notice of Prospective Patent License

ACTION: Notice of Prospective Patent License.

SUMMARY: NASA hereby gives notice that MicroMed Systems Ltd., Co., Houston, TX 77019, has requested an exclusive license to practice the inventions protected by U.S. Patent Application Numbers 08/153,595 entitled "ROTARY BLOOD PUMP" and U.S. Patent Application No. 08/451,709 entitled "ROTARY BLOOD PUMP," which were respectively filed November 10, 1993 and May 26, 1995, by the United States of America as represented by the Administrator of the National Aeronautics and Space Administration. Written objections to the prospective grant of a license should be sent to Mr. Hardie R. Barr, Patent Attorney, NASA Johnson Space Center.

DATES: Responses to this Notice must be received by February 6, 1996.

FOR FURTHER INFORMATION CONTACT: Mr. Hardie R. Barr, NASA Johnson Space Center, Mail Code HA, Houston, TX 77058; telephone number (713) 483-1003.

Dated: December 1, 1995.

Edward A. Frankle,
General Counsel.

[FR Doc. 95-29939 Filed 12-7-95; 8:45 am]

BILLING CODE 7510-01-M

NUCLEAR REGULATORY COMMISSION

[Docket No. 50-289]

GPU Nuclear Corporation; Notice of Withdrawal of Application for Amendment to Facility Operating License

The U.S. Nuclear Regulatory Commission (the Commission) has granted a request by GPU Nuclear Corporation (the licensee) to withdraw its May 20, 1994, application for an amendment to Facility Operating License No. DPR-50, issued to the licensee for operation of the Three Mile Island Nuclear Station, Unit No. 2, located in Dauphin County, Pennsylvania. Notice of Consideration of Issuance of this amendment was published in the Federal Register on June 14, 1994 (59 FR 30621).

The purpose of the licensee's amendment request was to revise the Technical Specifications to raise the limit on maximum control rod drop time and was requested only for the duration of operating cycle 10, which was concluded on September 8, 1995.

Subsequently the licensee informed the staff that the amendment is no longer required. Thus, the amendment application is considered to be withdrawn by the licensee.

For further details with respect to this action, see (1) the application for amendment dated May 20, 1994, and (2) the staff's letter dated November 14, 1995.

These documents are available for public inspection at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC and at the Law/Government Publications Section, State Library of Pennsylvania, (REGIONAL DEPOSITORY) Walnut Street and Commonwealth Avenue, Box 1601, Harrisburg, PA 17105.

Dated at Rockville, Maryland, this 30th day of November 1995.

For the Nuclear Regulatory Commission.
Ronald W. Hernan,
*Project Manager, Project Directorate I-3,
Division of Reactor Projects—I/II, Office of
Nuclear Reactor Regulation.*

[FR Doc. 95-29938 Filed 12-7-95; 8:45 am]

BILLING CODE 7590-01-P

[Docket No. 50-244]

**R. E. Ginna Nuclear Power Plant;
Notice of Consideration of Issuance of
Amendment to Facility Operating
License, Proposed No Significant
Hazards Consideration Determination,
and Opportunity for a Hearing**

The U.S. Nuclear Regulatory Commission (the Commission) is considering issuance of an amendment to Facility Operating License No. DPR-18, issued to Rochester Gas and Electric Corporation (the licensee) for operation of the R. E. Ginna Nuclear Power Plant located in Wayne County, New York.

The proposed amendment would revise the Ginna Station Technical Specifications (TSs) to implement the amended regulation 10 CFR Part 50; Appendix J, Option B (new rule), to provide a performance based option for leakage-rate testing of containment.

The proposed amendment would revise the current TSs (CTSS) and License, Item 2.D, which contains four exemptions to 10 CFR Part 50, Appendix J, Option A, which are proposed to be removed:

- a. Exemption from Section III.A.4(a) with respect to the maximum allowable leakage rate for reduced pressure tests;
- b. Exemption from Section III.B.1 with respect to the acceptable technique for performing local Type B leakage rate tests;
- c. Exemption from Section III.D.1 for scheduling of containment integrated leakage rate tests with respect to the 10-year inservice inspection (ISI); and
- d. Exemption from Section III.D.2 with respect to the testing interval of containment airlocks.

The proposed amendment would implement Option B as part of the implementation of the improved standard TSs (ISTSS) which are currently undergoing NRC staff review (submittal of May 26, 1995).

The amendment proposes to add a specific reference to Regulatory Guide 1.163, "Performance-Based Containment Leak-Test Program" in the Administrative Controls section of the Ginna Station TSs. No exceptions to the regulatory guide, nor the documents which are endorsed by the regulatory guide, are being requested. The licensee does not propose to deviate from methods approved by the Commission and endorsed in a regulatory guide.

The amendment proposes that a detailed performance-based leakage-test program will be available for NRC inspection upon implementation of the ISTSS for the Ginna Station.

Before issuance of the proposed license amendment, the Commission

will have made findings required by the Atomic Energy Act of 1954, as amended (the Act) and the Commission's regulations.

The Commission has made a proposed determination that the amendment request involves no significant hazards consideration. Under the Commission's regulations in 10 CFR 50.92, this means that operation of the facility in accordance with the proposed amendment would not (1) involve a significant increase in the probability or consequences of an accident previously evaluated; or (2) create the possibility of a new or different kind of accident from any accident previously evaluated; or (3) involve a significant reduction in a margin of safety. As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

The proposed changes to the Ginna Station Technical Specifications [* * *] have been evaluated with respect to 10 CFR 50.92(c) and shown to not involve a significant hazards consideration as described below. This evaluation is organized into the 4 categories [* * *].

C.1 Evaluation of More Restrictive Changes

The more restrictive changes [* * *] do not involve a significant hazards consideration as discussed below:

1. Operation of Ginna Station in accordance with the proposed changes does not involve a significant increase in the probability or consequences of an accident previously evaluated. The proposed changes provide more stringent requirements for operation of the facility. These more stringent requirements do not result in operation that will increase the probability of initiating an analyzed event and do not alter assumptions relative to mitigation of an accident or transient event. The more restrictive requirements continue to ensure that process variables, structures, systems, and components are maintained consistent with the safety analyses and licensing basis. Therefore, this change does not involve a significant increase in the probability or consequences of an accident previously analyzed.

2. Operation of Ginna Station in accordance with the proposed changes does not create the possibility of a new or different kind of accident from any accident previously evaluated. The proposed changes do not involve a physical alteration of the plant (i.e., no new or different type of equipment will be installed) or changes in the methods governing normal plant operation. The proposed changes do impose different requirements. However, these changes are consistent with assumptions made in the safety analysis and licensing basis. Thus, this change does not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Operation of Ginna Station in accordance with the proposed changes does

not involve a significant reduction in a margin of safety. The imposition of more restrictive requirements either has no impact or increases the margin of plant safety. Each change in this category is, by definition, providing additional restrictions to enhance plant safety. The change maintains requirements within safety analyses and licensing bases. Therefore, this change does not involve a significant reduction in a margin of safety.

Based upon the above information, it has been determined that the proposed administrative changes to the Ginna Station Technical Specifications do not involve a significant increase in the probability or consequences of an accident previously evaluated, does not create the possibility of a new or different kind of accident previously evaluated, and does not involve a significant reduction in a margin of safety. Therefore, it is concluded that the proposed changes meet the requirements of 10 CFR 50.92(c) and do not involve a significant hazards consideration.

C.2 Evaluation of Less Restrictive Changes

The less restrictive changes [* * *] do not involve a significant hazards consideration as discussed below:

1. Operation of Ginna Station in accordance with the proposed changes does not involve a significant increase in the probability or consequences of an accident previously evaluated. The proposed changes are all consistent with NRC requirements and guidance for implementation of Option B. Based on industry and NRC evaluations performed in support of developing Option B, these changes potentially result in a minor increase in the consequences of an accident previously evaluated due to the increased testing intervals. However, the proposed changes do not result in an increase in the core damage frequency since the containment system is used for mitigation purposes only. The changes are also expected to result in increased attention on components with poor leakage test history as part of the performance-based nature of Option B such that the marginally increased consequences from the expanded testing intervals may be further reduced or negated. Therefore, these changes do not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Operation of Ginna Station in accordance with the proposed changes does not create the possibility of a new or different kind of accident from any accident previously evaluated. The proposed changes do not involve a physical alteration of the plant (i.e., no new or different type of equipment will be installed) nor alter the function of the containment system. The changes only provide for additional time between tests and revised acceptance and testing criteria for leakage tests which remain consistent with the accident analysis bases. Thus, these changes do not create the possibility of a new or different kind of accident from any previously evaluated.

3. Operation of Ginna Station in accordance with the proposed changes does not involve a significant reduction in a margin of safety. The proposed changes do

not alter the manner in which safety limits, limiting safety system setpoints, or limiting conditions for operation are determined. Instead, the changes are expected to result in an increased focus on components demonstrating poor leakage test history without excessive testing of components which continue to demonstrate good test history. Therefore, these changes do not involve a significant reduction in a margin of safety.

Based upon the above, it has been determined that the proposed less restrictive changes to the Ginna Station Technical Specifications do not involve a significant increase in the probability or consequences of an accident previously evaluated, does not create the possibility of a new or different kind of accident previously evaluated, and does not involve a significant reduction in a margin of safety. Therefore, it is concluded that the proposed changes meet the requirements of 10 CFR 50.92(c) and do not involve a significant hazards consideration.

C.3 Evaluation of Administrative Changes

The administrative changes [* * *] do not involve a significant hazards consideration as discussed below:

1. Operation of Ginna Station in accordance with the proposed changes does not involve a significant increase in the probability or consequences of an accident previously evaluated. The proposed changes involve either: (1) the relocation of requirements within the Technical Specifications to support consolidation of similar requirements, (2) the reformatting or rewording of the existing Technical Specifications to provide consistency with 10 CFR [Part] 50, Appendix J, Option B or NRC implementing guidance, or (3) minor changes to the Technical Specifications such that the changes do not involve any technical nature. As such, these changes are administrative in nature and does not impact initiators or analyzed events or assumed mitigation of accident or transient events. Therefore, these changes do not involve a significant increase in the probability or consequences of an accident previously analyzed.

2. Operation of Ginna Station in accordance with the proposed changes does not create the possibility of a new or different kind of accident from any accident previously evaluated. The proposed changes do not involve a physical alteration of the plant (i.e., no new or different type of equipment will be installed) or changes in the methods governing normal plant operation. The proposed changes will not impose any new or different requirements. Thus, this change does not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Operation of Ginna Station in accordance with the proposed changes does not involve a significant reduction in a margin of safety. The proposed changes will not reduce a margin of plant safety because the changes do not impact any safety analysis assumptions. These changes are administrative in nature. As such, no question of safety is involved, and the change does not involve a significant reduction in a margin of safety.

Based upon the above information, it has been determined that the proposed administrative changes to the Ginna Station Technical Specifications do not involve a significant increase in the probability or consequences of an accident previously evaluated, does not create the possibility of a new or different kind of accident previously evaluated, and does not involve a significant reduction in a margin of safety. Therefore, it is concluded that the proposed changes meet the requirements of 10 CFR 50.92(c) and do not involve a significant hazards consideration.

C.4 Evaluation of Removed or Deleted Requirements

The removed or deleted requirements discussed in Section B.4 do not involve a significant hazards consideration as discussed below:

1. Operation of Ginna Station in accordance with the proposed changes does not involve a significant increase in the probability or consequences of an accident previously evaluated. The proposed changes only involve the removal or deletion of requirements which are duplicated in 10 CFR [Part] 50, Appendix J, Option B, Regulatory Guide [RG] 1.163 as referenced in the Technical Specifications, or NEI [Nuclear Energy Institute] 94-01 and ANSI/ANS 56.8-1994 (as endorsed by RG 1.163). As such, this change is not technical in nature and does not impact initiators or analyzed events or assumed mitigation of accident or transient events. Therefore, this change does not involve a significant increase in the probability or consequences of an accident previously analyzed.

2. Operation of Ginna Station in accordance with the proposed changes does not create the possibility of a new or different kind of accident from any accident previously evaluated. The proposed changes do not involve a physical alteration of the plant (i.e., no new or different type of equipment will be installed) or changes in the methods governing normal plant operation. The proposed changes will not impose any new or different requirements. Thus, this change does not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Operation of Ginna Station in accordance with the proposed changes does not involve a significant reduction in a margin of safety. The proposed changes will not reduce a margin of plant safety because the deleted requirements are still retained in other regulatory documents that cannot be changed without prior NRC review and approval. As such, no question of safety is involved, and the change does not involve a significant reduction in a margin of safety.

Based upon the above information, it has been determined that the proposed changes to the Ginna Station Technical Specifications do not involve a significant increase in the probability or consequences of an accident previously evaluated, does not create the possibility of a new or different kind of accident previously evaluated, and does not involve a significant reduction in a margin of safety. Therefore, it is concluded that the

proposed changes meet the requirements of 10 CFR 50.92(c) and do not involve a significant hazards consideration.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

The Commission is seeking public comments on this proposed determination. Any comments received within 30 days after the date of publication of this notice will be considered in making any final determination.

Normally, the Commission will not issue the amendment until the expiration of the 30-day notice period. However, should circumstances change during the notice period such that failure to act in a timely way would result, for example, in derating or shutdown of the facility, the Commission may issue the license amendment before the expiration of the 30-day notice period, provided that its final determination is that the amendment involves no significant hazards consideration. The final determination will consider all public and State comments received. Should the Commission take this action, it will publish in the Federal Register a notice of issuance and provide for opportunity for a hearing after issuance. The Commission expects that the need to take this action will occur very infrequently.

Written comments may be submitted by mail to the Rules Review and Directives Branch, Division of Freedom of Information and Publications Services, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC 20555, and should cite the publication date and page number of this Federal Register notice. Written comments may also be delivered to Room 6D22, Two White Flint North, 11545 Rockville Pike, Rockville, Maryland, from 7:30 a.m. to 4:15 p.m. Federal workdays. Copies of written comments received may be examined at the NRC Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC.

The filing of requests for hearing and petitions for leave to intervene is discussed below.

By January 8, 1996, the licensee may file a request for a hearing with respect to issuance of the amendment to the subject facility operating license and any person whose interest may be affected by this proceeding and who wishes to participate as a party in the

proceeding must file a written request for a hearing and a petition for leave to intervene. Requests for a hearing and a petition for leave to intervene shall be filed in accordance with the Commission's "Rules of Practice for Domestic Licensing Proceedings" in 10 CFR Part 2. Interested persons should consult a current copy of 10 CFR 2.714 which is available at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, and at the local public document room located at the Rochester Public Library, 115 South Avenue, Rochester, NY 14610. If a request for a hearing or petition for leave to intervene is filed by the above date, the Commission or an Atomic Safety and Licensing Board, designated by the Commission or by the Chairman of the Atomic Safety and Licensing Board Panel, will rule on the request and/or petition; and the Secretary or the designated Atomic Safety and Licensing Board will issue a notice of hearing or an appropriate order.

As required by 10 CFR 2.714, a petition for leave to intervene shall set forth with particularity the interest of the petitioner in the proceeding, and how that interest may be affected by the results of the proceeding. The petition should specifically explain the reasons why intervention should be permitted with particular reference to the following factors: (1) The nature of the petitioner's right under the Act to be made party to the proceeding; (2) the nature and extent of the petitioner's property, financial, or other interest in the proceeding; and (3) the possible effect of any order which may be entered in the proceeding on the petitioner's interest. The petition should also identify the specific aspect(s) of the subject matter of the proceeding as to which petitioner wishes to intervene. Any person who has filed a petition for leave to intervene or who has been admitted as a party may amend the petition without requesting leave of the Board up to 15 days prior to the first prehearing conference scheduled in the proceeding, but such an amended petition must satisfy the specificity requirements described above.

Not later than 15 days prior to the first prehearing conference scheduled in the proceeding, a petitioner shall file a supplement to the petition to intervene which must include a list of the contentions which are sought to be litigated in the matter. Each contention must consist of a specific statement of the issue of law or fact to be raised or controverted. In addition, the petitioner shall provide a brief explanation of the bases of the contention and a concise

statement of the alleged facts or expert opinion which support the contention and on which the petitioner intends to rely in proving the contention at the hearing. The petitioner must also provide references to those specific sources and documents of which the petitioner is aware and on which the petitioner intends to rely to establish those facts or expert opinion. Petitioner must provide sufficient information to show that a genuine dispute exists with the applicant on a material issue of law or fact. Contentions shall be limited to matters within the scope of the amendment under consideration. The contention must be one which, if proven, would entitle the petitioner to relief. A petitioner who fails to file such a supplement which satisfies these requirements with respect to at least one contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene, and have the opportunity to participate fully in the conduct of the hearing, including the opportunity to present evidence and cross-examine witnesses.

If a hearing is requested, the Commission will make a final determination on the issue of no significant hazards consideration. The final determination will serve to decide when the hearing is held.

If the final determination is that the amendment request involves no significant hazards consideration, the Commission may issue the amendment and make it immediately effective, notwithstanding the request for a hearing. Any hearing held would take place after issuance of the amendment.

If the final determination is that the amendment request involves a significant hazards consideration, any hearing held would take place before the issuance of any amendment.

A request for a hearing or a petition for leave to intervene must be filed with the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Docketing and Services Branch, or may be delivered to the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, by the above date. Where petitions are filed during the last 10 days of the notice period, it is requested that the petitioner promptly so inform the Commission by a toll-free telephone call to Western Union at 1-(800) 248-5100 (in Missouri 1-(800) 342-6700). The Western Union operator should be given Datagram Identification Number N1023 and the following message addressed to Ledyard

B. Marsh, Director, Project Directorate I-1: petitioner's name and telephone number, date petition was mailed, plant name, and publication date and page number of this Federal Register notice. A copy of the petition should also be sent to the Office of the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555, and to Nicholas S. Reynolds, Winston and Strawn, 1400 L St. NW., Washington, DC 20005, attorney for the licensee.

Nontimely filings of petitions for leave to intervene, amended petitions, supplemental petitions and/or requests for hearing will not be entertained absent a determination by the Commission, the presiding officer or the presiding Atomic Safety and Licensing Board that the petition and/or request should be granted based upon a balancing of the factors specified in 10 CFR 2.714(a)(1) (i)-(v) and 2.714(d).

For further details with respect to this action, see the application for amendment dated November 27, 1995, which is available for public inspection at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, and at the local public document room located at the Rochester Public Library, 115 South Avenue, Rochester, NY 14610.

Dated at Rockville, Maryland, this 1st day of December 1995.

For the Nuclear Regulatory Commission.
Allen R. Johnson,
*Project Manager, Project Directorate I-1,
Division of Reactor Projects—I/II, Office of
Nuclear Reactor Regulation.*

[FR Doc. 95-29937 Filed 12-7-95; 8:45 am]

BILLING CODE 7590-01-P

[Docket Nos. 50-277 AND 50-278]

PECO Energy Company; Notice of Consideration of Issuance of Amendments to Facility Operating License, Proposed No Significant Hazards Consideration Determination, and Opportunity for a Hearing

The U.S. Nuclear Regulatory Commission (the Commission) is considering issuance of an amendment to Facility Operating License Nos. DPR-44 and DPR-56 issued to the PECO Energy Company (the licensee) for operation of the Peach Bottom Atomic Power Station, Units 2 and 3, located in York County, Pennsylvania.

The proposed amendments would revise the minimum allowable control rod scram accumulator pressure and charging water header pressure from a value of 955 psig to a value of 940 psig.

Before issuance of the proposed license amendments, the Commission will have made findings required by the Atomic Energy Act of 1954, as amended (the Act) and the Commission's regulations.

The Commission has made a proposed determination that the amendment request involves no significant hazards consideration. Under the Commission's regulations in 10 CFR 50.92, this means that operation of the facility in accordance with the proposed amendment would not (1) involve a significant increase in the probability or consequences of an accident previously evaluated; or (2) create the possibility of a new or different kind of accident from any accident previously evaluated; or (3) involve a significant reduction in a margin of safety. As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

(1) The proposed changes do not involve a significant increase in the probability or consequences of an accident previously evaluated because control rod scram accumulator pressure and charging water header pressure ≥ 940 psig has been determined to be adequate to ensure a complete reactor scram occurs within the time limits assumed in the safety analyses. Therefore, the proposed changes will not involve a significant increase in the probability or consequences of an accident previously evaluated.

(2) The proposed changes do not create the possibility of a new or different kind of accident from any accident previously evaluated because the proposed changes do not alter the plant configuration (no new or different type of equipment will be installed or removed) and will not alter the method used by any system to perform its design function. The CRD hydraulic system will continue to be operated within its design basis parameters. The proposed changes do not allow plant operation in any mode that is not already evaluated in the SAR. Therefore, these changes will not create the possibility of a new or different kind of accident from any accident previously evaluated.

(3) The proposed changes do not involve a significant reduction in a margin of safety. The proposed changes do not impact safety analysis assumptions or the ability of the CRD hydraulic system to perform its design function. The proposed minimum allowable control rod scram accumulator pressure is consistent with the pressure recommended in SIL 429R1. The proposed changes assure that a complete reactor scram occurs within the time limits assumed in the safety analyses. Therefore, these changes will not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are

satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

The Commission is seeking public comments on this proposed determination. Any comments received within 30 days after the date of publication of this notice will be considered in making any final determination.

Normally, the Commission will not issue the amendment until the expiration of the 30-day notice period. However, should circumstances change during the notice period such that failure to act in a timely way would result, for example, in derating or shutdown of the facility, the Commission may issue the license amendment before the expiration of the 30-day notice period, provided that its final determination is that the amendment involves no significant hazards consideration. The final determination will consider all public and State comments received. Should the Commission take this action, it will publish in the Federal Register a notice of issuance and provide for opportunity for a hearing after issuance. The Commission expects that the need to take this action will occur very infrequently.

Written comments may be submitted by mail to the Rules Review and Directives Branch, Division of Freedom of Information and Publications Services, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC 20555, and should cite the publication date and page number of this Federal Register notice. Written comments may also be delivered to Room 6D22, Two White Flint North, 11545 Rockville Pike, Rockville, Maryland, from 7:30 a.m. to 4:15 p.m. Federal workdays. Copies of written comments received may be examined at the NRC Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC 20555.

The filing of requests for hearing and petitions for leave to intervene is discussed below.

By January 8, 1996, the licensee may file a request for a hearing with respect to issuance of the amendment to the subject facility operating license and any person whose interest may be affected by this proceeding and who wishes to participate as a party in the proceeding must file a written request for a hearing and a petition for leave to intervene. Requests for a hearing and a petition for leave to intervene shall be filed in accordance with the Commission's "Rules of Practice for Domestic Licensing Proceedings" in 10

CFR Part 2. Interested persons should consult a current copy of 10 CFR 2.714 which is available at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, and at the local public document room located at the Government Publications Section, State Library of Pennsylvania, (REGIONAL DEPOSITORY) Education Building, Walnut Street and Commonwealth Avenue, Box 1601, Harrisburg, Pennsylvania 17105. If a request for a hearing or petition for leave to intervene is filed by the above date, the Commission or an Atomic Safety and Licensing Board, designated by the Commission or by the Chairman of the Atomic Safety and Licensing Board Panel, will rule on the request and/or petition; and the Secretary or the designated Atomic Safety and Licensing Board will issue a notice of hearing or an appropriate order.

As required by 10 CFR 2.714, a petition for leave to intervene shall set forth with particularity the interest of the petitioner in the proceeding, and how that interest may be affected by the results of the proceeding. The petition should specifically explain the reasons why intervention should be permitted with particular reference to the following factors: (1) the nature of the petitioner's right under the Act to be made party to the proceeding; (2) the nature and extent of the petitioner's property, financial, or other interest in the proceeding; and (3) the possible effect of any order which may be entered in the proceeding on the petitioner's interest. The petition should also identify the specific aspect(s) of the subject matter of the proceeding as to which petitioner wishes to intervene. Any person who has filed a petition for leave to intervene or who has been admitted as a party may amend the petition without requesting leave of the Board up to 15 days prior to the first prehearing conference scheduled in the proceeding, but such an amended petition must satisfy the specificity requirements described above.

Not later than 15 days prior to the first prehearing conference scheduled in the proceeding, a petitioner shall file a supplement to the petition to intervene which must include a list of the contentions which are sought to be litigated in the matter. Each contention must consist of a specific statement of the issue of law or fact to be raised or controverted. In addition, the petitioner shall provide a brief explanation of the bases of the contention and a concise statement of the alleged facts or expert opinion which support the contention and on which the petitioner intends to

rely in proving the contention at the hearing. The petitioner must also provide references to those specific sources and documents of which the petitioner is aware and on which the petitioner intends to rely to establish those facts or expert opinion. Petitioner must provide sufficient information to show that a genuine dispute exists with the applicant on a material issue of law or fact. Contentions shall be limited to matters within the scope of the amendment under consideration. The contention must be one which, if proven, would entitle the petitioner to relief. A petitioner who fails to file such a supplement which satisfies these requirements with respect to at least one contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene, and have the opportunity to participate fully in the conduct of the hearing, including the opportunity to present evidence and cross-examine witnesses.

If a hearing is requested, the Commission will make a final determination on the issue of no significant hazards consideration. The final determination will serve to decide when the hearing is held.

If the final determination is that the amendment request involves no significant hazards consideration, the Commission may issue the amendment and make it immediately effective, notwithstanding the request for a hearing. Any hearing held would take place after issuance of the amendment.

If the final determination is that the amendment request involves a significant hazards consideration, any hearing held would take place before the issuance of any amendment.

A request for a hearing or a petition for leave to intervene must be filed with the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Docketing and Services Branch, or may be delivered to the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, by the above date. Where petitions are filed during the last 10 days of the notice period, it is requested that the petitioner promptly so inform the Commission by a toll-free telephone call to Western Union at 1-(800) 248-5100 (in Missouri 1-(800) 342-6700). The Western Union operator should be given Datagram Identification Number N1023 and the following message addressed to John F. Stolz, Director, Project Directorate I-2: petitioner's name and telephone number, date petition was mailed, plant

name, and publication date and page number of this Federal Register notice. A copy of the petition should also be sent to the Office of the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555, and to J. W. Durham, Sr., Esquire, Sr. V.P. and General Counsel, PECO Energy Company, 2301 Market Street, Philadelphia, Pennsylvania 19101, attorney for the licensee.

Nontimely filings of petitions for leave to intervene, amended petitions, supplemental petitions and/or requests for hearing will not be entertained absent a determination by the Commission, the presiding officer or the presiding Atomic Safety and Licensing Board that the petition and/or request should be granted based upon a balancing of the factors specified in 10 CFR 2.714(a)(1)(i)-(v) and 2.714(d).

For further details with respect to this action, see the application for amendment dated November 30, 1995, which is available for public inspection at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, and at the local public document room located at the Government Publications Section, State Library of Pennsylvania, (REGIONAL DEPOSITORY) Education Building, Walnut Street and Commonwealth Avenue, Box 1601, Harrisburg, Pennsylvania 17105.

Dated at Rockville, Maryland, this 4th day of December 1995.

For the Nuclear Regulatory Commission,
Joseph W. Shea,
*Project Manager, Project Directorate I-2,
Division of Reactor Projects—I/II, Office of
Nuclear Reactor Regulation.*
[FR Doc. 95-29936 Filed 12-7-95; 8:45 am]
BILLING CODE 7590-01-P

OFFICE OF PERSONNEL MANAGEMENT

[RI 25-49]

Notice of Intention to Request Review of a Revised Information Collection

AGENCY: Office of Personnel Management.

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 (Public Law 104-13, May 22, 1995), this notice announces that the Office of Personnel Management intends to submit to the Office of Management and Budget a request for clearance of a revised information collection, RI 25-49, Verification of Adult Student Enrollment Status, is used to verify that

adult students are entitled to payments, OPM needs to know that a full-time enrollment has been maintained.

We estimate 10,000 RI 25-49 forms are completed annually. Each form takes approximately 60 minutes to complete. The annual estimated burden is 10,000 hours.

For copies of this proposal, contact Jim Farron on (202) 418-3208, or E-mail to jmfarron@mail.opm.gov

DATES: Comments on this proposal should be received on or before February 6, 1996.

ADDRESSES: Send or deliver comments to—Lorraine E. Dettman, Chief, Retirement and Insurance Service, Operations Support Division, U.S. Office of Personnel Management, 1900 E Street, NW., Room 3349, Washington, DC 20415.

FOR FURTHER INFORMATION REGARDING ADMINISTRATIVE COORDINATION—CONTACT: Mary Beth Smith-Toomey, Management Services Division, (202) 606-0623.

Office of Personnel Management.

Lorraine A. Green,

Deputy Director.

[FR Doc. 95-29880 Filed 12-7-95; 8:45 am]

BILLING CODE 6325-01-M

Privacy Act of 1974; Update of Existing Notices of Systems of Records

AGENCY: Office of Personnel Management (OPM).

ACTION: Notice of updated system notices.

SUMMARY: The Office of Personnel Management (OPM) has conducted a comprehensive review of all Internal and Central Privacy Act systems of records. This notice publishes updates to the Internal and Central systems of records, last published in complete form in April 1993. This notice proposes the adoption of a "Prefatory Statement of Routine Uses for OPM's Internal and Central Systems of Records."

DATES: The proposed non-substantive changes will be effective without further notice on January 8, 1996. The proposed substantive changes will be effective January 17, 1996, unless comments are received that result in a contrary determination.

ADDRESSES: Send written comments to Office of Personnel Management, ATTN: Mr. Robert Huley, Office of Information Technology, 1900 E Street NW., Room 5415, Washington, DC 20415-0001.

FOR FURTHER INFORMATION CONTACT: Mr. Robert Huley at (202) 418-3200.

SUPPLEMENTARY INFORMATION: OPM last published its Internal and Central

system notices in complete form April 12, 1993 (58 FR 19153). Since that time there have been two new Internal and one new Central system notices published: OPM/Internal-12, Telephone Call Record Detail Records (58 FR 47002, effective 11/2/93); OPM/Internal-13, Parking Program Records (59 FR 64439, effective 1/13/95); and OPM/Central-14, Debarment or Suspension Records of Federal Employees Health Benefits Program (FEHBP) (60 FR 39194, effective 8/31/95).

This update is meant to conform to the review requirements as set by the Office of Management and Budget Circular A-130, Appendix I, for system notices. Changes have been made to several notices to more accurately describe the contents of the system of records. Due to OPM's recent reorganization, the system location, manager, and address information has been changed for each system notice.

The adoption of a "Prefatory Statement" format will allow OPM to publish certain established repetitive routine uses for Internal and Central systems of records only once, in the interests of simplicity, economy, and to avoid redundancy. Each Internal and Central system notice will make reference to the routine uses of the prefatory statement applicable to that notice, and will print in full any routine uses unique to that specific system of records. Each system notice has been revised as necessary to reflect the use of the Prefatory Statement.

Following is a brief description of changes to system notices:

- OPM/INTERNAL-1, Defense Mobilization Emergency Cadre Records—changed to reflect adoption of Prefatory Statement and agency reorganization.
- OPM/INTERNAL-2, Negotiated Grievance Procedure Records—changed to reflect adoption of Prefatory Statement and agency reorganization. Records are no longer maintained in regional offices, so references to regional locations have been deleted.
- OPM/INTERNAL-3, Security Officer Control Files—changed to reflect adoption of Prefatory Statement and agency reorganization.
- OPM/INTERNAL-4, Health Program Records—changed to reflect adoption of Prefatory Statement and agency reorganization.
- OPM/INTERNAL-5, Pay, Leave and Travel Records—changed to reflect adoption of Prefatory Statement and agency reorganization.
- OPM/INTERNAL-6, Appeal and Administrative Review Records—

changed to reflect adoption of Prefatory Statement and agency reorganization. Records are no longer maintained in regional offices, so references to regional locations have been deleted.

- OPM/INTERNAL-7, Complaints and Inquiries Records—changed to reflect adoption of Prefatory Statement and agency reorganization. Records are no longer maintained in regional offices, so references to regional locations have been deleted.
- OPM/INTERNAL-8, Employee Counseling Services Program Records—changed to reflect adoption of Prefatory Statement and agency reorganization.
- OPM/INTERNAL-9, Employee Locator Card Files. Location of records has been updated to indicate records are also maintained in service centers.
- OPM/INTERNAL-10, Motor Vehicle Operator and Accident Report Records—changed to reflect adoption of Prefatory Statement and agency reorganization. The title has been changed to specify the maintenance of Motor Vehicle Operator "Authorization" records, and changes have been made throughout the system notice to clarify what authorization and report records are maintained where, for what purpose, and how to access them.
- OPM/INTERNAL-11, Administrative Grievance Records—changed to reflect adoption of Prefatory Statement and agency reorganization. Records are no longer maintained in regional offices, so references to regional locations have been deleted.
- OPM/INTERNAL-12, Telephone Call Detail Records—changed to reflect adoption of Prefatory Statement and agency reorganization. The category of individuals covered has been expanded to cover individuals who make as well as receive calls. The storage entry has been updated to reflect that data may be stored on optical media.
- OPM/INTERNAL-13, Parking Program Records—changed to reflect adoption of Prefatory Statement and agency reorganization.
- OPM/CENTRAL-1, Civil Service Retirement and Insurance Records—changed to reflect adoption of Prefatory Statement and agency reorganization. Routine uses that duplicate conditions of disclosure specified in the Privacy Act have been removed (no new routine uses have been added), organizational titles updated, and the routine uses covering release of data from the Retirement Master Annuity File to

Federal and State government agencies have been combined.

- OPM/CENTRAL-2, Complaints and Inquiries Records—changed to reflect adoption of Prefatory Statement and agency reorganization.
- OPM/CENTRAL-3, Reserved—no action.
- OPM/CENTRAL-4, Inspector General Investigations Case Files—changed to reflect adoption of Prefatory Statement and agency reorganization.
- OPM/CENTRAL-5, Intergovernmental Personnel Act Assignment Records—changed to reflect adoption of Prefatory Statement and agency reorganization.
- OPM/CENTRAL-6, Administrative Law Judge Application Records—changed to reflect adoption of Prefatory Statement and agency reorganization.
- OPM/CENTRAL-7, Litigation and Claims Records—changed to reflect adoption of Prefatory Statement and agency reorganization. The description of categories of records included in the system has been expanded to include garnishment documents. The purpose has been amended to note that the records are maintained to settle administrative claims brought against OPM employees as well as OPM (the agency).
- OPM/CENTRAL-8, Privacy Act/Freedom of Information Act (PA/FOIA) Case Records—changed to reflect adoption of Prefatory Statement and agency reorganization.
- OPM/CENTRAL-9, Personnel Investigations Records—changed to reflect adoption of Prefatory Statement and agency reorganization. The listing of authorities has been updated to delete Title 22, U.S.C., section 1434, which has been repealed. Disposal information has been updated to indicate that records are shredded or recycled instead of being burned.
- OPM/CENTRAL-10, Directory of Federal Executive Institute Alumni—changed to reflect adoption of Prefatory Statement and agency reorganization. This system of records is being renamed "Federal Executive Institute Program Participant Records," and the categories of records, purpose, and record source entries are being updated to reflect this change in emphasis. The policies and practices of storage entries have been updated to be more accurate.
- OPM/CENTRAL-11, Presidential Management Intern Program Records—changed to reflect adoption of Prefatory Statement and agency reorganization. The entry on records

retention is being revised to be more specific about retention periods.
OPM/CENTRAL-12, Reserved—no action.

OPM/CENTRAL-13, Executive Personnel Records—changed to reflect adoption of Prefatory Statement and agency reorganization. The system notice has been revised throughout to be more accurate in terms of individuals covered, information included, and purpose of the system. The listing of authorities has been updated. The retention entry is revised to conform to indicate National Archives and Records Administration is reviewing a proposed disposition schedule change.

OPM/CENTRAL-14, Debarment or Suspension Records for Federal Employees Health Benefits Program (FEHBP)—changed to reflect adoption of Prefatory Statement. The required altered system report has been submitted to the Office of Management and Budget and Congress.

Office of Personnel Management.

Lorraine A. Green,

Deputy Director.

Prefatory Statement of Routine Uses for OPM's Internal and Central Systems of Records

Certain established routine uses have been found to be applicable to the majority of OPM's Internal and Central systems of records. These repetitive routine uses will be published in their entirety once, in this Prefatory Statement. Each Internal and Central system notice will note which of these routine uses are applicable to that notice, and will also include the full text of any routine uses unique to that system of records.

1. For Law Enforcement Purposes—To disclose pertinent information to the appropriate Federal, State, or local agency responsible for investigating, prosecuting, enforcing, or implementing a statute, rule, regulation, or order, where OPM becomes aware of an indication of a violation or potential violation of civil or criminal law or regulation.

2. For Certain Disclosures to Other Federal Agencies—To disclose information to a Federal agency, in response to its request in connection with the hiring or retention of an employee, the issuance of a security clearance, the conducting of a suitability or security investigation of an individual, the classifying of jobs, the letting of a contract, or the issuance of a license, grant, or other benefit by the

requesting agency, to the extent that the information is relevant and necessary to the requesting agency's decision on the matter.

3. For Congressional Inquiry—To provide information to a congressional office from the record of an individual in response to an inquiry from that congressional office made at the request of that individual.

4. For Judicial/Administrative Proceedings—To disclose information to another Federal agency, to a court, or a party in litigation before a court or in an administrative proceeding being conducted by a Federal agency, when the Government is a party to the judicial or administrative proceeding. In those cases where the Government is not a party to the proceeding, records may be disclosed if a subpoena has been signed by a judge.

5. For National Archives and Records Administration—To disclose information to the National Archives and Records Administration for use in records management inspections.

6. Within OPM for Statistical/Analytical Studies—By OPM in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies. While published studies do not contain individual identifiers, in some instances the selection of elements of data included in the study may be structured in such a way as to make the data individually identifiable by inference.

7. For Litigation—To disclose information to the Department of Justice, or in a proceeding before a court, adjudicative body, or other administrative body before which OPM is authorized to appear, when:

(1) OPM, or any component thereof; or

(2) Any employee of OPM in his or her official capacity; or

(3) Any employee of OPM in his or her individual capacity where the Department of Justice or OPM has agreed to represent the employee; or

(4) The United States, when OPM determines that litigation is likely to affect OPM or any of its components; is a party to litigation or has an interest in such litigation, and the use of such records by the Department of Justice or OPM is deemed by OPM to be relevant and necessary to the litigation provided, however, that the disclosure is compatible with the purpose for which records were collected.

8. For the Merit Systems Protection Board—To disclose information to officials of the Merit Systems Protection Board or the Office of the Special

Counsel, when requested in connection with appeals, special studies of the civil service and other merit systems, review of OPM rules and regulations, investigations of alleged or possible prohibited personnel practices, and such other functions, e.g., as promulgated in 5 U.S.C. 1205 and 1206, or as may be authorized by law.

9. For the Equal Employment Opportunity Commission—To disclose information to the Equal Employment Opportunity Commission when requested in connection with investigations into alleged or possible discrimination practices in the Federal sector, compliance by Federal agencies with the Uniform Guidelines on Employee Selection Procedures or other functions vested in the Commission and to otherwise ensure compliance with the provisions of 5 U.S.C. 7201.

10. For the Federal Labor Relations Authority—To disclose information to the Federal Labor Relations Authority or its General Counsel when requested in connection with investigations of allegations of unfair labor practices or matters before the Federal Service Impasses Panel.

11. For Non-Federal Personnel—To disclose information to contractors, grantees, or volunteers performing or working on a contract, service, grant, cooperative agreement, or job for the Federal Government.

OPM/INTERNAL-1

SYSTEM LOCATION:

Change "Administration Group" to read "Office of Contracting and Administrative Services."

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS, AND THE PURPOSES OF SUCH USES:

Delete current entry (introduction and subparagraphs), insert: Routine uses 1, and 3 through 8, of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. There are no system unique routine uses.

SYSTEM MANAGER(S) AND ADDRESS:

Change "Administration Group" to read "Office of Contracting and Administrative Services."

OPM/INTERNAL-2

SYSTEM LOCATION:

Delete current entry, insert: Office of Human Resources and EEO, Office of Personnel Management, 1900 E Street NW., Washington, DC 20415-0001.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS, AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 1 through 11 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

a. By the Department of Labor in carrying out its function regarding labor-management relations in the Federal service.

b. To disclose information to officials of labor organizations recognized under 5 U.S.C. Chapter 71 when relevant and necessary to their duties of exclusive representation concerning personnel policies, practices, and matters affecting working conditions.

c. To disclose information to any source from which additional information is requested in the course of resolving a grievance, to the extent necessary to identify the individual, inform the source of the purpose(s) of the request, and to identify the type of information requested.

SYSTEM MANAGER(S) AND ADDRESS:

Change "Assistant Director for Personnel, Administration Group" to read "Director, Office of Human Resources and EEO."

NOTIFICATION PROCEDURE:

Delete first paragraph, insert:

Individuals who file a grievance under a negotiated procedure are aware of that fact and have been provided access to the record. They may, however, contact the indicated system manager regarding the existence of such records about them. Individuals must furnish the following information for their records to be located and identified:

RECORDS ACCESS PROCEDURE:

Delete first paragraph, insert:

Individuals who file a grievance under a negotiated procedure are aware of that fact and have been provided access to the record. However, after the grievance has been closed, an individual may request access to the official copy of the grievance records by writing the indicated system manager. Individuals must furnish the following information for their records to be located and identified:

CONTESTING RECORD PROCEDURE:

Delete second paragraph, insert:

Individuals wishing to request amendment of their records to correct factual errors should contact the indicated system manager. Individuals must furnish the following information for their records to be located and identified:

OPM/INTERNAL-3

SYSTEM LOCATION:

Change "Administration Group" to read "Office of Contracting and Administrative Services." Change "regional" to read "field service."

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS, AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 1, 3, 5, and 6 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

a. To disclose information to an agency in the executive, legislative, or judicial branch, or the District of Columbia Government, in response to its request in connection with the issuance of a security clearance or the conducting of a security or suitability investigation of an individual, to the extent that the information is relevant and necessary to the requesting agency's decision on the matter.

b. To disclose information to the security office of an agency in the executive, legislative, or judicial branch, or the District of Columbia Government, in response to its request for verification of security clearance, to enable OPM employees to have access to classified data or areas where their official duties require such access.

SYSTEM MANAGER AND ADDRESS:

Delete current entry, insert: Chief, Security Services, Office of Contracting and Administrative Services, Office of Personnel Management, 1900 E Street, NW., Washington, DC 20415-0001, for central office employees. Field Service Office Directors for field service office employees.

OPM/INTERNAL-4

SYSTEM LOCATION:

Change "Associate Director for Administration" to read "Health Unit, Office of Contracting and Administrative Services."

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS, AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 3, 4, and 7 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

a. To refer information required by applicable law to be disclosed to a Federal, State, or local public health service agency, concerning individuals

who have contracted certain communicable diseases or conditions. Such information is used to prevent further outbreak of the disease or condition.

b. To disclose information to the appropriate Federal, State, or local agency responsible for investigation of an accident, disease, medical condition, or injury as required by pertinent legal authority.

c. To disclose to the Office of Workers' Compensation Programs in connection with a claim for benefits filed by an employee.

Note: Disclosure of these records beyond officials of OPM having a bona fide need for them or to the person to whom they pertain, is rarely made, as disclosures of information pertaining to an individual with a history of alcohol or drug abuse must be limited in compliance with the restriction of the Confidentiality of Alcohol and Drug Abuse Patient Records regulations 42 CFR part 2. Records pertaining to the physical and mental fitness of employees are, as a matter of OPM policy, afforded the same degree of confidentiality and are generally not disclosed.

SYSTEM MANAGER(S) AND LOCATION:

Change "Administration Group" to read "Office of Contracting and Administrative Services."

OPM/INTERNAL-5

SYSTEM LOCATION:

Change "Office of Procurement and Administrative Services, Administration Group" to read "Office of Contracting and Administrative Services."

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS, AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 1 through 10 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

a. By the Department of Labor in connection with a claim filed by an employee for compensation due to a job-connected injury or illness.

b. By the Department of the Treasury to issue checks and U.S. Savings Bonds.

c. By State offices of unemployment compensation with survivor annuity or health benefits claims or records reconciliations.

d. By Federal Employee's Group Life Insurance or Health Benefits carriers in connection with survivor annuity or health benefits claims or records reconciliations.

e. To disclose information to the Internal Revenue Service and State and local tax authorities.

f. To provide officials of labor organizations recognized under 5 U.S.C. Chapter 71 with information as to the identity of OPM employees contributing union dues each pay period and the amount of dues withheld from each contributor.

g. To disclose information to officials of labor organizations recognized under 5 U.S.C. Chapter 71 when relevant and necessary to their duties of exclusive representation concerning personnel policies, practices, and matters affecting working conditions.

h. To disclose information to any source from which additional information is requested relevant to an OPM determination concerning an individual's pay, leave, or travel expenses, to the extent necessary to identify the individual, inform the source of the purpose(s) of the request, and to identify the type of information requested.

i. To disclose information to the Office of Management and Budget at any stage in the legislative coordination and clearance process in connection with private relief legislation as set forth in OMB Circular No. A-19.

j. To disclose, annually, pay data to the Social Security Administration and the Department of the Treasury as required.

k. To disclose information to a Federal agency or Congressional inquiry from which additional or statistical information is requested relevant to the OPM Fare Subsidy Program.

SYSTEM MANAGER(S) AND ADDRESS:

Change "Assistant Director of Procurement and Administrative Services, Administration Group" to read "Director, Office of Contracting and Administrative Services."

OPM/INTERNAL-6

SYSTEM LOCATION:

Delete current entry, insert: Office of Human Resources and EEO, Office of Personnel Management, 1900 E Street NW., Washington, DC 20415-0001.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS, AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:
Routine uses 1 through 11 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

a. To provide information to officials of labor organizations recognized under 5 U.S.C. Chapter 71, when relevant and necessary to their duties of exclusive representation concerning personnel

policies, practices, and matters affecting working conditions.

b. To disclose information to any source from which additional information is requested in the course of processing an appeal or administrative review procedure, to the extent necessary to identify the individual, inform the source of the purpose(s) of the request, and identify the type of information requested.

SYSTEM MANAGER(S) AND ADDRESSES:

Change "Assistant Director, Office of Personnel, Administration Group" to read "Director, Office of Human Resources and EEO."

NOTIFICATION PROCEDURE:

Delete first paragraph, insert:
Individuals involved in appeals and administrative review procedures are aware of that fact and have been provided access to the records. They may, however, contact the system manager indicated regarding the existence of such records about them. They must furnish the following information for their records to be located and identified:

RECORD ACCESS PROCEDURE:

Delete first paragraph, insert:
Individuals involved in appeals and administrative review procedures are aware of that fact and have been provided access to the records. After the action has been closed, however, an individual may request access to the official copy of an appeal or administrative review procedure by contacting the system manager indicated. Individuals must provide the following information for their records to be located and identified:

CONTESTING RECORD PROCEDURE:

Delete second paragraph, insert:
Individuals wishing to request amendment of their records to correct factual errors should contact the system manager indicated. Individuals must furnish the following information for their records to be located and identified:

OPM/INTERNAL-7

SYSTEM LOCATION:

Delete current entry, insert: Office of Human Resources and EEO, Office of Personnel Management, 1900 E Street NW., Washington, DC 20415-0001.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS, AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:
Routine uses 1 through 11 of the Prefatory Statement at the beginning of

OPM's system notices apply to the records maintained within this system. The routine use listed below is specific to this system of records only:

To disclose information to any source from which additional information is requested (to the extent necessary to identify the individual, inform the source of the purpose of the request, and identify the type of information requested), where necessary to obtain information relevant to an OPM decision concerning the individual employee, e.g., on the issuance of a security clearance, the conducting of a security or suitability investigation of an individual, the issuance of a license, grant, or other benefit.

SYSTEM MANAGER(S) AND ADDRESS:

Change "Assistant Director for Personnel, Administration Group" to read "Director, Office of Human Resources and EEO."

NOTIFICATION PROCEDURE:

Delete first paragraph, insert:
Individuals wishing to inquire whether this system contains information about them should contact the system manager. Individuals must furnish the following information for their records to be located and identified:

RECORD ACCESS PROCEDURE:

Delete first paragraph, insert:
OPM employees wishing to request access to their records should contact the system manager. Individuals must furnish the following information for their records to be located and identified:

CONTESTING RECORD PROCEDURE:

Delete first paragraph, insert:
OPM employees wishing to request amendment of their records should contact the system manager indicated. Individuals must furnish the following information for their records to be located and identified:

OPM/INTERNAL-8

SYSTEM LOCATION:

Change "Office of Personnel, Administration Group" to read "Office of Human Resources and EEO."

SYSTEM MANAGER(S) AND ADDRESS:

Change "Assistant Director for Personnel, Administration Group" to read "Director, Office of Human Resources and EEO."

OPM/INTERNAL-9

SYSTEM LOCATION:

Delete current entry, insert: Personnel and administrative offices of the Office

of Personnel Management, 1900 E Street NW., Washington, DC 20415-0001, and OPM field service offices.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS, AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 1 through 11 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. There are no routine uses unique to this system of records.

SYSTEM MANAGER(S) AND ADDRESS:

Change "Assistant Director for Personnel, Administration Group" to read "Director, Office of Human Resources and EEO."

NOTIFICATION PROCEDURE:

Delete first paragraph, insert:

OPM employees wishing to inquire whether this system contains information about them should contact the appropriate management official where employed. Individuals must furnish the following information for their records to be located and identified:

RECORD ACCESS PROCEDURE:

Delete first paragraph, insert:

OPM employees wishing to request access to their records should contact the appropriate OPM management official where employed. Individuals must furnish the following information for their records to be located and identified:

CONTESTING RECORD PROCEDURE:

Delete first paragraph, insert:

OPM employees may amend information in these records at any time by resubmitting updating information. Individuals wishing to request amendment of their records under the provisions of the Privacy Act should contact the appropriate management official where employed. Individuals must furnish the following information for their records to be located and identified:

OPM/INTERNAL-10

SYSTEM LOCATION:

Delete current entry, insert: Office of Contracting and Administrative Services; Investigations Service; and the Office of the General Counsel; Office of Personnel Management, 1900 E Street NW., Washington, DC 20415-0001.

CATEGORIES OF RECORDS IN THE SYSTEM:

Delete current entry, insert:

The system contains document related to the authorization of an individual to operate a Government

motor vehicle; and reports, correspondence, and fiscal documents concerning automobile accidents occurring in a Government-owned, leased, or rented vehicle or in a privately-owned vehicle while on official business.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM INCLUDES THE FOLLOWING WITH ANY REVISIONS AND AMENDMENTS:

Revise current entry by adding "chapter." 28 U.S.C. Chapter 171.

PURPOSE:

Delete current entry, insert:

These records serve to document supervisor's verification of employee's license to operate a Government motor vehicle; authorization to use Government-owned, leased, or rented motor vehicle or privately-owned vehicle to conduct official business; and information regarding motor vehicle accidents, including reports and related documents that may be used in settlement of claims and litigation resulting from an accident involving a Government-owned, leased, or rented motor vehicle or privately-owned vehicle used by employees to conduct official business.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routines uses 1, and 3 through 7, of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

a. To disclose information any source from which additional information is requested (to extent necessary to identify the individual, inform the source of the purpose of the request, and identify the type of information requested), when necessary to obtain information relevant to an office decision concerning the hiring or retention of an employee, the issuance of a security clearance, the conducting of a security or suitability investigation of an individual, the classifying of jobs, the letting of a contract, or the issuance of a grant or other benefit.

b. To disclose accident report record information to officials of labor organizations recognized under the Chapter 71, title 5, U.S.C. when relevant and necessary to their duties of exclusive representation concerning personnel policies, practices, and matters affecting working conditions.

c. To disclose information to a Federal agency, in response to its request, in connection with the hiring or retention of an employee, the issuance of a

security clearance, the conducting of a security or suitability investigation, the classifying of jobs, or the award of a contract, license, grant, or other benefit.

d. To disclose information to the General Services Administration about accidents involving Government owned or leased automobiles.

e. To disclose information to insurance carriers about accidents involving privately-owned vehicles.

RETENTION AND DISPOSAL:

In first sentence change "Motor vehicle operator records" to read "Motor vehicle operator authorization records."

SYSTEM MANAGER(S) AND ADDRESS:

Delete current entry, insert:

Motor vehicle operator authorization records:

Director, Office of Contracting and Administrative Services, Office of Personnel Management, 1900 E Street NW., Washington, DC 20415-0001, or the Director of the appropriate field service office.

Accident report records: For reports involving employees of the Investigations Service with judgements under \$2,500: Associate Director, Investigations Service, Office of Personnel Management, 1900 E Street NW., Washington, DC 20415-0001.

For reports involving employees of Field Service Offices with no personal injury, and judgements under \$2,500: Appropriate Field Service Office Director.

For reports involving other OPM employees, or of employees of the Investigations Service involving judgements over \$2,500: Office of the General Counsel, Office of Personnel Management, 1900 E Street NW., Washington, DC 20415-0001.

NOTIFICATION PROCEDURE

Delete first paragraph, insert:

Individuals wishing to inquire whether this system of records contains information about them should contact the appropriate system manager as indicated under SYSTEM MANAGER AND ADDRESS.

RECORD ACCESS PROCEDURE:

Delete first paragraph, insert:

Individuals wishing to request access to records about them should contact the appropriate system manager as indicated under SYSTEM MANAGER AND ADDRESS.

CONTESTING RECORD PROCEDURE:

Delete first paragraph, insert:

Individuals wishing to request amendment of their records should contact the appropriate system manager

as indicated under SYSTEM MANAGER AND ADDRESS.

RECORD SOURCE CATEGORIES:

Delete current subparagraph e, insert:
e. Officials of OPM.

OPM/INTERNAL-11

SYSTEM LOCATION:

Delete current entry, insert:
Office of Human Resources and EEO, Office of Personnel Management, 1900 E Street NW., Washington, DC 20415-0001.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS, AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:
Routine uses 1 through 11 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine use listed below is specific to this system of records only:

To disclose information to any source from which additional information is required in the course of processing a grievance, to the extent necessary to identify the individual, inform the source of the purpose(s) of the request, and identify the type of information requested.

SYSTEM MANAGER(S) AND ADDRESSES:

Change "Assistant Director for Personnel, Administration Group" to read "Director, Office of Human Resources and EEO."

NOTIFICATION PROCEDURE:

Delete first paragraph, insert:
It is required that individuals submitting grievances be provided a copy of the record under the grievance process. They may, however, contact the personnel office regarding the existence of such records on them. They must furnish the following information for their records to be located and identified:

RECORDS ACCESS PROCEDURE:

Delete first paragraph, insert:
It is required that individuals submitting grievances be provided a copy of the record under the grievance process. After the action has been closed, however, an individuals may request access to the official copy of the grievance file by contacting the personnel office. Individuals must furnish the following information for their records to be located and identified:

CONTESTING RECORD PROCEDURE:

Delete second paragraph, insert:
Individuals wishing to request amendment of their records to correct

factual errors should contact the personnel office. Individuals must furnish the following information for their records to be located and identified:

OPM/INTERNAL-12

SYSTEM LOCATION:

Change "Office of Information Resources Management, Administration Group" to read "Office of Information Technology."

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Persons who are assigned OPM telephone numbers or are authorized to use OPM telephone services, and persons who make or receive calls billed to OPM.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS, AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:
Routine uses 1 through 7, and 11, of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

- a. By OPM employees or other persons to determine their individual responsibility for telephone calls.
- b. By another Federal agency or a telecommunications company providing telephone services to permit servicing the account.
- c. By appropriate OPM employees to assist in the planning and effective management of OPM telephone services, and to determine that OPM telephone services are being used in an efficient and economical manner.
- d. By auditors, investigators, and other employees authorized by the Inspector General, pursuant to sections 4 and 6 of the Inspector General Act of 1978.

STORAGE:

OPM stores records on magnetic media, optical media, and on paper.

SYSTEM MANAGER(S) AND ADDRESSES:

Delete current entry, insert:
Chief, Plans and Policies Division, Office of Information Technology, Office of Personnel Management, 1900 E Street, NW., Washington, DC 20415-0001.

OPM/INTERNAL-13

SYSTEM LOCATION:

Change "Office of Procurement and Administrative Services, Administration Group" to read "Office of Contracting and Administrative Services."

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS, AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:
Routine uses 1, 3 through 7, and 11, of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

- a. To disclose information to the Internal Revenue Service and State and local tax authorities.
- b. To disclose information to officials of labor organizations recognized under 5 U.S.C. Chapter 71 when relevant and necessary to their duties of exclusive representation concerning personnel policies, practices, and matters affecting working conditions.
- c. To disclose information in computer matching activities, including comparison of parking records with other Federal agencies, and for the purpose of assigning tax liabilities related to the fringe benefit accrual value of parking.

SYSTEM MANAGER(S) AND ADDRESS:

Change "Assistant Director of Procurement and Administrative Services, Administration Group" to read "Director, Office of Contracting and Administrative Services."

OPM/CENTRAL-1

SYSTEM LOCATION:

Change "Associate Director for Retirement and Insurance" to read "Associate Director, Retirement and Insurance Service."

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:
Routine uses 1 through 10 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

- a. To disclose, to the following recipients, information needed to adjudicate a claim for benefits under OPM's or the recipients's benefits program(s), or information needed to conduct an analytical study of benefits being paid under such programs: Office of Workers' Compensation Programs; Department of Veterans Affairs Pension Benefit Program; Social Security Administration's Old Age, Survivor and Disability Insurance and Medical Programs, Health Care Financing Administration, and Supplemental Security Income Program; military retired pay programs; Federal civilian

employee retirement programs (other than the CSR or FER system); or other national, State, county, municipal, or other publicly recognized charitable or social security administrative agency;

b. To disclose to the Federal Employees Group Life Insurance Office information necessary to verify the election, declination, or waiver of regular and/or optional life insurance coverage or eligibility for payment of a claim for life insurance.

c. To disclose to health insurance carriers contracting with OPM to provide a health benefits plan under the Federal Employees Health Benefits Program, Social Security Numbers and other information necessary to identify enrollment in a plan, to verify eligibility for payment of a claim for health benefits, or to carry out the coordination for benefits provisions of such contracts.

d. To disclose to any inquirer, if sufficient information is provided to assure positive identification of an individual on whom a department or agency maintains retirement or insurance records, the fact that an individual is or is not on the retirement rolls, and, if so, the type of annuity (employment or survivor, but not retirement on disability) being paid, or if not, whether a refund has been paid.

e. When an individual to whom a record pertains dies, to disclose to any person possibly entitled in the order of precedence for lump-sum benefits, information in the individual's record that might properly be disclosed to the individual, and the name and relationship of any other person whose claim for benefits takes precedence or who is entitled to share the benefits payable. When a representative of the estate has not been appointed, the individual's next of kin may be recognized as the representative of the estate.

f. To disclose to the Internal Revenue Service, Department of the Treasury, information as required by the Internal Revenue Code of 1954, as amended.

g. To disclose to the Department of the Treasury information necessary to issue benefit checks.

h. To disclose information to any person who is responsible for the care of the individual to whom a record pertains, and who is found by a court or OPM Medical Officers to be incompetent or under other legal disability, information necessary to assure payment of benefits to which the individual is entitled.

i. To disclose to the Parent Locator Service of the Department of Health and Human Services, upon its request, the present address of an annuitant, or former employee, for enforcing child

support obligations against such individual.

j. In connection with an examination ordered by the agency under

(1) Medical examination procedures; or

(2) Agency-filed disability retirement procedures.

To disclose to the agency-appointed representative of an employee all notices, decisions, other written communications, or any pertinent medical evidence other than medical evidence that a prudent physician would hesitate to inform the individual of; such medical evidence will be disclosed only to a licensed physician, designated in writing for that purpose by the individual or his or her representative.

k. To disclose information to any source from which additional information is requested relevant to OPM determination on an individual's eligibility for or entitlement to coverage under the retirement, life insurance, and health benefits program, to the extent necessary to identify the individual and the type of information requested.

l. To disclose information to the Office of Management and Budget at any stage of the legislative coordination and clearance process in connection with private relief legislation as set forth in OMB Circular NO. A-19.

m. To provide an official of another Federal agency information needed in the performance of official duties related to reconciling or reconstructing data files, compiling descriptive statistics, and making analytical studies to support the function for which the records were collected and maintained.

n. To disclose to a Federal agency, in response to its request, the address of any annuitant or applicant for refund of retirement deductions, if the agency requires that information to provide consideration in connection with the collection of a debt due the United States.

o. To disclose to an allottee, as defined in 5 CFR 831.1501, the name, address, and the amount withheld from an annuitant's benefits, pursuant to 5 CFR 831.1501 et seq. as an allotment to that allottee to implement the program of voluntary allotments authorized by 5 U.S.C. 8345(h) or 8465.

p. To disclose to a Federal agency, in response to its request, information in connection with the hiring, retention, separation, or retirement of an employee; the issuance of a security clearance; the reporting of an investigation of an employee; the letting of a contract; the classification of a job; or the issuance of a license, grant, or other benefit by the requesting agency,

to the extent that OPM determines that the information is relevant and necessary to the requesting party's decision on the matter.

q. To disclose to a State agency responsible for the collection of State income taxes the information required by an Agreement to Implement State Income Tax Withholdings from Civil Service Annuities entered pursuant to section 1705 of Pub. L. 97-35 or 5 U.S.C. 8469 to implement the program of voluntary State income tax withholding required by 5 U.S.C. 8345(k) or 8469.

r. To disclose to the Social Security Administration the Social Security Numbers of civil service annuitants to determine (1) their vital status as shown in the Social Security Master Records; (2) whether recipients of the minimum annuity are receiving at least the Special Primary Insurance Amount benefit from the Social Security Administration; and (3) whether civil service retirees with post-1956 military service credit are receiving benefits from the Social Security Administration.

s. To disclose information contained in the Retirement Annuity Master File; including the name, Social Security Number, date of birth, sex, OPM's claim number, health benefit enrollment code, retirement date, retirement code (type of retirement), annuity rate, pay status of case, correspondence address, and ZIP code, of all Federal retirees and their survivors to requesting Federal agencies and States to help eliminate fraud and abuse in the benefit programs administered by the Federal agencies and States (and those States to local governments) and to collect debts and overpayments owed to the Federal Government, and to State governments and their components.

t. To disclose to a Federal agency, a person or an organization contracting with a Federal agency for rendering collection services within the purview of section 13 of the Debt Collection Act of 1982, in response to a written request from the head of the agency or his or her designee, or from the debt collection contractor, the following data concerning an individual owing a debt to the Federal Government: (1) The debtor's name, address, Social Security Number, and other information necessary to establish the identity of the individual; (2) the amount, status, and history of the claim; and (3) the agency or program under which the claim arose.

u. To disclose information contained in the Retirement Annuity Master File, upon written request, to state tax administration agencies, for the express purpose of ensuring compliance with

state tax obligations by persons receiving benefits under the Civil Retirement System or the Federal Employees Retirement System, and to prevent fraud and abuse, but only the following data elements: Name, correspondence address, date of birth, sex, Social Security Account Number, annuity rate, commencing date of benefits, and retirement code (type of retirement).

v. To disclose information to a State court or administrative agency in connection with a garnishment, attachment, or similar proceeding to enforce an alimony or child support obligation.

w. To disclose to a former spouse when necessary to explain how that former spouse's benefit under 5 U.S.C. 8341(h), 8345 (j), 8445, or 8467 was computed.

x. To disclose to a Federal or State agency (or its agent) when necessary to locate individuals who are owed money or property either by a Federal agency, state or local agency, or by a financial institution or similar institution.

y. To disclose to a health plan participating in the Federal Employees Health Benefits Program (FEHBP) and to an FEHBP enrollee or covered family member or an enrollee or covered family member's authorized representative, in connection with the review of a disputed claim for health benefits, from information maintained within this system of records, the decision of OPM regarding the disputed claim review.

z. To disclose to a State or local government, or private individual or association engaged in volunteer work, identifying and address information and other pertinent facts, for the purpose of developing an application as representative payee for an annuitant or survivor annuitant who is mentally incompetent or under other legal disability.

aa. To disclose on request to a spouse or dependent child (or court-appointed guardian thereof) of a CSR or FER system annuitant or an annuitant of any other Federal retirement system enrolled in the Federal Employees Health Benefits Program whether the annuitant has changed from a self-and-family to a self-only health benefits enrollment.

bb. To the Defense Manpower Data Center, Department of Defense, and the U.S. Postal Service to conduct computer matching programs for the purpose of identifying and locating individuals who are receiving Federal salaries or benefit payments and are delinquent in their repayment of debts owed to the U.S. Government under certain programs administered by the Office of

Personnel Management in order to collect the debts under the provisions of the Debt Collection Act of 1982 (Pub. L. 97-365) by voluntary repayment, or by administrative or salary offset procedures.

cc. To any other Federal agency for the purpose of effecting administrative or salary offset procedures against a person employed by that agency or receiving or eligible to receive some benefit payments from the agency when the Office of Personnel Management as a creditor has a claim against that person.

SYSTEM MANAGER(S) AND ADDRESS:

Change "Associate Director for Retirement and Insurance" to read "Associate Director, Retirement and Insurance Service."

OPM/CENTRAL-2

SYSTEM LOCATION:

Change "Agency Compliance and Evaluation, Personnel Systems and Oversight Group" to read "Office of Merit Systems Oversight and Effectiveness."

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 1, 3 through 5, and 7 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

a. To disclose information to the Office of Management and Budget at any stage in the legislative coordination and clearance process in connection with private relief legislation as set forth in OMB Circular No. A-19.

b. To disclose information to any source from which additional information is requested in the course of adjudicating an appeal or complaint, to the extent necessary to identify the individual, inform the source of the purpose(s) of the request, and to identify the type of information requested.

SYSTEM MANAGER(S) AND ADDRESS:

Delete entry, insert: Associate Director, Office of Merit Systems Oversight and Effectiveness, Office of Personnel Management, 1900 E Street, NW., Washington, DC 20415-0001.

NOTIFICATION PROCEDURES:

In first paragraph change "regional office" to read "field service office" wherever it appears.

RECORD ACCESS PROCEDURE:

In first paragraph change "regional office" to read "field service office."

OPM/CENTRAL-4

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 1, 3 through 5, and 7 through 10, of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

a. To designated officers and employees of agencies, offices, and other establishments in the executive, legislative, and judicial branches of the Federal Government having an interest in the individual for employment purposes, including a security clearance or access determination, and the need to evaluate qualifications, suitability, and loyalty to the United States Government.

b. To designated officers and employees of agencies, offices, and judicial branches of the Federal Government when such agency, office, or establishment conducts an investigation of the individual for granting a security clearance, or for making a determination of qualifications, suitability, or loyalty to the United States Government, or access to classified information or restricted areas.

c. To any source from which information is requested in the course of an investigation, to the extent necessary to identify the individual, inform the source of the nature and purpose of the investigation, and to identify the type of information requested.

d. To the Office of Management and Budget at any stage in the legislative coordination and clearance process in connection with private relief legislation as set forth in OMB Circular No. A-19.

OPM/CENTRAL-5

SYSTEM LOCATION:

Change "Human Resources Development Group" to read "Office of Merit Systems Oversight and Effectiveness." In second sentence change "regional offices" to read "field service offices."

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 1 through 6 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine use listed below is specific to this system of records only:

To disclose information to any source from which additional information is requested (to the extent necessary to identify the individual, inform the source of the purpose(s) of the request, and to identify the type of information requested), where necessary to obtain information relevant to an OPM decision regarding possible termination of assignment.

SYSTEM MANAGER(S) AND ADDRESS:

Change "Human Resources Development Group" to read "Office of Merit Systems Oversight and Effectiveness."

OPM/CENTRAL-6

SYSTEM LOCATION:

Change "Assistant Director, Office of Administrative Law Judges, Career Entry Group" to read "Administrative Law Judges Office, Employment Service."

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 1 through 10 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

- a. To refer applicants to Federal agencies for employment consideration for Administrative Law Judge positions.
- b. To refer current and former Administrative Law Judges to Federal agencies for consideration for detail, transfer, reassignment, reinstatement, or reemployment, as applicable.

- c. To disclose information to any source (e.g., references, employers, educational institutions or applicant/appellant review panel members) from which additional information is requested (to the extent necessary to identify the individual, inform the source of the purpose(s) of the request, and to identify the type of information requested), when necessary to obtain information relevant to an agency decision concerning the hiring or retention of an employee, the issuance of a security clearance, the conducting of security or suitability investigation of an individual, the classifying of jobs, the letting of a contract, or the issuance of a license, grant, or other benefit.

SYSTEM MANAGER(S) AND ADDRESS:

Change "Assistant Director, Office of Administrative Law Judges, Career Entry Group" to read "Director, Administrative Law Judges Office, Employment Service."

OPM/CENTRAL-7

CATEGORIES OF RECORDS IN THE SYSTEM:

Delete current entry; insert:

This system includes the following kinds of records: Garnishment documents; administrative appeals; investigative reports; retirement records; official personnel records; documentation of litigation including complaints, answers, motions, briefs, orders, and decisions; claims and supporting documentation submitted under the Federal Tort Claims Act and the Military Personnel and Civilian Employees Claims Act, together with correspondence and records of settlement; and final administrative and judicial determinations.

PURPOSE:

Delete current entry; insert:

These records are maintained to defend OPM against lawsuits and to settle administrative claims brought against OPM or OPM employees.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 1 through 10 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

- a. To any source where necessary to obtain information relevant to an OPM decision or action involved in one of the purposes for maintenance of the system.
- b. To the insurance carrier of an employee, or a claimant against OPM under the Federal Tort Claims Act or the Military Personnel and Civilian Employees Claims Act in order to determine the proper assignment of any liability.

OPM/CENTRAL-8

SYSTEM LOCATION:

Change "regional and area offices" to read "field service offices."

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 1, and 3 through 10, of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

- a. To disclose information to the Office of Management and Budget at any stage in the legislative coordination and clearance process in connection with private relief legislation as set forth in OMB Circular No. A-19.

- b. To disclose information to an agency, subject to law, rule, or regulation enforced by OPM, having been found in violation of such law, rule or regulation, in order to achieve compliance with OPM instructions.

- c. To disclose information to Federal agencies (e.g., Department of Justice) in order to obtain advice and recommendations concerning matters on which the agency has specialized experience or particular competence, for use by OPM in making required determinations under the Freedom of Information Act of the Privacy Act of 1974.

- d. To disclose information to any source from which additional information is requested (to the extent necessary to identify the individual, inform the source of the purpose of the request, and to identify the type of information requested), where necessary to obtain information relevant to an OPM decision concerning a Privacy or Freedom of Information Act request.

- e. To disclose to the Federal agency involved, an OPM decision on an appeal from an initial denial of a request involving OPM-controlled records.

SYSTEM MANAGER(S) AND ADDRESS:

Change "appropriate Regional Director" to read "appropriate Field Service Office Director."

OPM/CENTRAL-9

SYSTEM LOCATION:

In subparagraph a., change "Investigations Group" to read "Investigations Service."

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Delete current subparagraph c, insert:
c. Title 22, U.S.C., sections 2519 and 2585.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 4 through 10 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

- a. To designated officers and employees of agencies, offices, and other establishments in the executive, legislative, and judicial branches of the Federal Government, having a need to evaluate qualifications, suitability, and loyalty to the United States Government and/or a security clearance or access determination.

- b. To designated officers and employees of agencies, offices, and other establishments in the executive,

legislative, and judicial branches of the Federal Government, when such agency, office, or establishment conducts an investigation of the individual for purposes of granting a security clearance, or for the purpose of making a determination of qualifications, suitability, or loyalty to the United States Government, or access to classified information or restricted areas.

c. To designated officers and employees of agencies, offices, and other establishments in the executive, judicial, or legislative branches of the Federal Government, having the responsibility to grant clearances to make a determination regarding access to classified information or restricted areas, or to evaluate qualifications, suitability, or loyalty to the United States Government, in connection with performance of a service to the Federal Government under a contract or other agreement.

d. To the intelligence agencies of the Department of Defense, the National Security Agency, the Central Intelligence Agency, and the Federal Bureau of Investigation for use in intelligence activities.

e. To any source from which information is requested in the course of an investigation, to the extent necessary to identify the individual, inform the source of the nature and purpose of the investigation, and to identify the type of information requested.

f. To the appropriate Federal, State, local, tribal, foreign, or other public authority responsible for investigating, prosecuting, enforcing, or implementing a statute, rule, regulation, or order where OPM becomes aware of an indication of a violation or potential violation of civil or criminal law or regulation.

g. To an agency, office, or other establishment in the executive, legislative, or judicial branches of the Federal Government, in response to its request, in connection with the hiring or retention of an employee, the issuance of a security clearance, the conducting of a security or suitability investigation of an individual, the classifying of jobs, the letting of a contract, or the issuance of a license, grant, or other benefit by the requesting agency, to the extent that the information is relevant and necessary to the requesting agency's decision on the matter.

h. To provide information to a congressional office from the records of an individual in response to an inquiry from the congressional office made at the request of that individual. However, the investigative file, or parts thereof, will only be released to a congressional

office if OPM receives a notarized authorization or signed statement under 28 U.S.C. 1746 from the subject of the investigation.

i. To the Office of Management and Budget at any stage in the legislative coordination and clearance process in connection with private relief legislation as set forth in OMB Circular No. A-19.

j. To disclose information to contractors, grantees, experts, consultants, or volunteers performing or working on a contract, service, or job for the Federal Government.

RETENTION AND DISPOSAL:

Delete current subparagraph b, insert:

b. Hard copy records are destroyed by shredding and recycling, and computerized records are destroyed by electronic erasure.

SYSTEM MANAGER(S) AND ADDRESSES:

Delete current entry, insert: Associate Director Investigations Service, Office of Personnel Management, PO Box 886, Washington, DC 20044-0886.

OPM/CENTRAL-10

SYSTEM NAME:

Delete current entry, insert: Federal Executive Institute Program Participant Records.

SYSTEM LOCATION:

Change zip code from 22901 to 22903-4899.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Change "attended long term programs" to read "attended programs."

CATEGORIES OF RECORDS IN THE SYSTEM:

Delete current entry; insert:

This system contains information supplied by the sponsoring agency and the program participant, including application and consent forms, supporting correspondence, class rosters and directories. The records contain the name, position title, office address and telephone number, FEI program attended, and, with the approval of the individual, home address and telephone number of program participants.

PURPOSE:

Delete current entry; insert:

The records are used by FEI staff to administer the program, to promote program participant interaction, and by FEI program participants to maintain contact with other participants. These records may be used to locate individuals for personnel research.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Delete current entry, insert:

Routine uses 1 through 10 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

a. To disclose information to Federal agencies to assist them in planning for executive development programs.

b. To provide information to the FEI Alumni Association for the purpose of mailing association materials to an alumni's home or business address.

POLICIES AND PRACTICES OF STORING, RETRIEVING, SAFEGUARDING, RETAINING AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Delete current entry, insert:

Records are maintained in hard copy and automated form.

SAFEGUARDS:

Delete current entry; insert:

Records kept by FEI officials are maintained in a secured area with access limited to those authorized personnel at FEI whose duties require access. Distribution of information is limited to FEI program participants and specified recipients. In addition:

a. At the request of the individual, his or her home address and telephone number will not be released; and

b. At the request of the employing agency, information relating to the individual's status (i.e., position title) will not be released.

RETENTION AND DISPOSAL:

Delete current entry; insert:

A new records schedule is in the process of being approved by the National Archives and Records Administration, to provide for destruction of application files after a maximum of 3 years, and the destruction of consent forms after five years. The automated data base of participant information will be destroyed when no longer needed for administrative purposes.

SYSTEM MANAGER(S) AND ADDRESSES:

Change "Registrar" to read "Director, Office of Executive Resources." Change zip code from "22901" to "22903-4899."

NOTIFICATION PROCEDURE:

Delete current entry; insert:

Individuals wishing to inquire whether this system contains information about them should contact the system manager. Individuals must furnish the following for their records to be located and identified:

- a. Name.
- b. Agency.
- c. FEI program attended and dates.

RECORD ACCESS PROCEDURES:

Delete current entry; insert:

Individuals wishing to request access to their records should contact the system manager. Individuals must furnish the following for their records to be located and identified:

- a. Name.
- b. Agency.
- c. FEI program attended and dates.

RECORD SOURCE CATEGORIES:

- Add new subparagraph b as follows:
- b. Employing agency.

OPM/CENTRAL-11**SYSTEM LOCATION:**

Change "Human Resources Development Group" to read "Workforce Training Service."

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Delete current entry; insert:

Routine uses 1, 3, 4, and 7 through 10 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

- a. To refer candidates to Federal agencies for employment consideration.
- b. To refer candidates to State and local governments, congressional offices, international organizations, and other public offices with permission of the candidates, for the purpose of employment consideration.
- c. To refer interns for consideration for reassignment and promotion within the employing agencies.
- d. As a data source for management information of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related personnel research functions or manpower studies, or to locate individuals for personnel research.
- e. To request information from a Federal, State, or local agency maintaining civil, criminal, or other information relevant to an agency decision concerning the hiring or retention of a candidate.
- f. To provide an educational institution with information on an appointment of a recent graduate to a Federal position at a certain grade level.

SYSTEM MANAGER(S) AND ADDRESSES:

Change "Director, Human Resources Development Group" to read "Associate Director, Workforce Training Service."

OPM/CENTRAL-12 [Reserved]**OPM/CENTRAL-13****SYSTEM LOCATION:**

Delete current entry; insert: Office of Executive Resources, Office of Personnel Management, 1900 E Street, NW., Washington, DC 20415-0001.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Delete current entry; insert:

Current and former appointees in the Senior Executive Service; current and former incumbents of Executive Schedule, Scientific and Professional research and development, Senior Level, Board of Contract Appeals, and similar positions; former incumbents of General Schedule 16-18 positions; and participants in and graduates of OPM-approved agency Senior Executive candidate development programs.

CATEGORIES OF RECORDS IN THE SYSTEM:

- a. Delete current entry; insert:
 - a. Demographic, appointment, and assignment information (e.g., name, office address, date of birth, Social Security Number, sex, race and ethnic designation, titles of positions, pay rates, and types of appointments).
 - c. Delete current entry; insert:
 - d. Determinations on nominees for Meritorious and Distinguished Presidential Rank awards.
 - e. Delete current entry; insert:
 - e. Information on performance of executives (e.g., performance ratings, performance awards, and incentive awards).
 - h. Delete current entry; insert:
 - h. Information concerning the reason(s) why an individual leaves an executive position (e.g., retired, resigned, to enter private industry, to work for a State government, or removed during probation or after because of performance).
 - i. Delete current entry; insert:
 - i. Information about the recruitment of individuals for executive positions (e.g., recruited from another Federal agency or from outside the Federal service).

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Delete current entry; insert:

5 U.S.C. Sections 2101 through 2103; 3104; 3131 through 3136; 3324; 3325; 3391 through 3397; 3591 through 3596; 4311 through 4315; 4507; 5108; 5381 through 5385; 5407; 5752 through 5754; and 7541 through 7543.

PURPOSE:

- a. Delete current entry; insert:
 - a. Assist OPM in carrying out its responsibilities under title 5, U.S. Code, and OPM rules and regulations

promulgated thereunder, including the allocation and establishment of SES, Senior Level, and Scientific and Professional research and development positions; development of qualification standards for SES positions, establishment and operation of one or more qualifications review boards, establishment of programs to develop candidates for and incumbents of executive positions, and development of performance appraisal systems.

c. Delete entry; insert:

c. Provide data used in policy formulation, program planning and administration, research studies, and required reports regarding the Governmentwide executive program.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Routine uses 1 through 5, and 7 through 11, of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

- a. To identify and refer qualified current or former Federal employees to Federal agencies for executive vacancies.
- b. To refer qualified current or former Federal employees or retirees to State and local governments and international organizations for employment considerations.
- c. To provide an employing agency with extracts from the records of that agency's employees in the system.
- d. To provide information required in the annual report to Congress mandated by 5 U.S.C. 3135 and elsewhere, regarding positions in the SES and the incumbents of these positions.
- e. By OPM to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the functions for which the records are collected and maintained, or for related work force studies. While published studies do not contain individual identifiers, in some instances the selection of elements of data included in the study may be structured in such a way as to make the data individually identifiable by inference.
- f. To disclose information to any member of an agency's Performance Review Board or other board or panel (e.g., one convened to select or review nominees for awards of merit pay increases), when the member is not an official of the employing agency; information would then be used for the purposes of approving or recommending

selection of candidates for executive development programs, issuing a performance appraisal rating, issuing performance awards, nominating for Meritorious and Distinguished Executive ranks, and removal, reduction-in-grade, and other personnel actions based on performance.

g. To provide information to the White House on executives with noncareer appointments in the Senior Executive Service, in positions formerly in the General Schedule filled by noncareer executive assignments, in excepted positions paid at Executive Schedule pay rates, and in positions in the Senior Level pay system or other pay systems equivalent to those described which are filled by Presidential appointment or excepted from the competitive service because they are of a confidential or policy-determining character.

RETENTION AND DISPOSAL:

Delete current entry; insert:

Records are retained for varying lengths of time, in accordance with disposition schedules approved by NARA. Disposal of manual records is by shredding or burning, electronic databases are erased.

SYSTEM MANAGER(S) AND ADDRESSES:

Delete current entry, insert: Director, Office of Executive Resources, Office of Personnel Management, 1900 E Street, NW., Washington, DC 20415-0001.

OPM/CENTRAL-14

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Routine uses 1 through 11 of the Prefatory Statement at the beginning of OPM's system notices apply to the records maintained within this system. The routine uses listed below are specific to this system of records only:

- a. To disclose records to appropriate Federal, State and local agencies if necessary and relevant to administering Federal financial or nonfinancial assistance programs or benefits.
- b. To disclose records for performance of a Federal duty to a State or local agency, or financial institution.
- c. To disclose information on excluded health care providers to other persons involved in or affected by the action.
- d. To disclose information to agencies or organizations that license, certify, regulate, investigate, or prosecute persons or organizations that provide health-related services or items to

determine possible disqualifying actions, practices, or conditions.

[FR Doc. 95-29879 Filed 12-7-95; 8:45 am]

BILLING CODE 6325-01-P

POSTAL RATE COMMISSION

[Order No. 1093; Docket No. A96-8]

Sedan, Minnesota 56380 (Robert C. Hawm, Petitioner); Notice and Order Accepting Appeal and Establishing Procedural Schedule Under 39 U.S.C. § 404(b)(5)

Issued December 4, 1995.

Docket Number: A96-8.

Name of Affected Post Office: Sedan, Minnesota 56380.

Name(s) of Petitioner(s): Robert C. Hawm.

Type of Determination: Closing.

Date of Filing of Appeal Papers: November 29, 1995.

Categories of Issues Apparently Raised:

1. Effect on postal services [39 U.S.C. § 404(b)(2)(C)].
2. Effect on the community [39 U.S.C. § 404(b)(2)(A)].

After the Postal Service files the administrative record and the Commission reviews it, the Commission may find that there are more legal issues than those set forth above. Or, the Commission may find that the Postal Service's determination disposes of one or more of those issues.

The Postal Reorganization Act requires that the Commission issue its decision within 120 days from the date this appeal was filed (39 U.S.C. § 404(b)(5)). In the interest of expedition, in light of the 120-day decision schedule, the Commission may request the Postal Service to submit memoranda of law on any appropriate issue. If requested, such memoranda will be due 20 days from the issuance of the request and the Postal Service shall serve a copy of its memoranda on the petitioners. The Postal Service may incorporate by reference in its briefs or motions, any arguments presented in memoranda it previously filed in this docket. If necessary, the Commission also may ask petitioners or the Postal Service for more information.

The Commission orders:

(a) The Postal Service shall file the record in this appeal by December 14, 1995.

(b) The Secretary of the Postal Rate Commission shall publish this Notice and Order and Procedural Schedule in the Federal Register.

By the Commission.
Margaret P. Crenshaw,
Secretary.

Appendix

November 29 1995—Filing of Appeal letter
December 4, 1995—Commission Notice and Order of Filing of Appeal

December 26, 1995—Last day of filing of petitions to intervene [see 39 CFR § 3001.111(b)]

January 3, 1995—Petitioner's Participant Statement or Initial Brief [see 39 C.F.R. § 3001.115 (a) and (b)]

January 23, 1996—Postal Service's Answering Brief [see 39 CFR § 3001.115(c)]

February 7, 1996—Petitioner's Reply Brief should Petitioner choose to file one [see 39 C.F.R. § 3001.115(d)]

February 14, 1996—Deadline for motions by any party requesting oral argument. The Commission will schedule oral argument only when it is a necessary addition to the written filings [see 39 CFR § 3001.116]

March 28, 1996—Expiration of the Commission's 120-day decisional schedule [see 39 U.S.C. § 404(b)(5)]

[FR Doc. 95-29926 Filed 12-7-95; 8:45 am]

BILLING CODE 7710-FW-P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34-36543; File No. SR-CSE-95-09]

Self-Regulatory Organizations; Notice of Filing of Proposed Rule Change by the Cincinnati Stock Exchange, Inc., Relating to Including Within the Exchange's Minor Rule Plan 4.2 Which Deals with the Furnishing of Records to the Exchange

November 30, 1995.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"), 15 U.S.C. 78s(b)(1), notice is hereby given that on November 16, 1995, the Cincinnati Stock Exchange, Inc. ("CSE" or "Exchange") filed with the Securities and Exchange Commission ("Commission") a proposed rule change to amend its Minor Rule Violation Plan¹ as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

¹ Rule 19d-1(c)(2) under the Act, 17 CFR 240.19d-1(c)(2), authorizes national securities exchanges to adopt minor rule violation plans for the summary discipline and abbreviated reporting of minor rule violations by exchange members and member organizations.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange hereby amends Rule 8.14 regarding the imposition of fines for minor violations. The text of the proposed rule change is as follows (new text is italicized; deleted text is bracketed):

Rule 8.14 Imposition of Fines for Minor Violation(s) of Rule Interpretations and Policies: .01

(d) Rule 4.1, *Rule 4.2* and Interpretation, thereunder, requiring the submission of responses to Exchange requests for trading data within specified time period.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the CSE included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The CSE has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

Rule 8.14² authorizes the Exchange, in lieu of commencing a disciplinary proceeding before a hearing panel, to impose a fine not to exceed \$2,500, on any member, member organizations, or registered or non-registered employee of a member organization for a minor violation of certain specified Exchange rules.³

The purpose of the Rule 8.14 procedure is to improve the Exchange's ability to efficiently meet its statutory enforcement responsibilities by

establishing a program for the imposition of fines for minor violations of Exchange Rules and by designating certain specified Rule violations as minor Rule violations.⁴ In File No. SR-CSE-88-1,⁵ which initially set forth the provisions and procedures of Rule 8.14, the Exchange indicated that it would periodically prepare and announce to its members and member organizations a revised list of Exchange Rules for violation of which the Exchange may impose fines pursuant to Rule 8.14, as well as the fines that may be imposed for such violation.

The Exchange is presently adding Rule 4.2⁶ to the list of rules subject to possible imposition of fines under Rule 8.14 procedures. The purpose of the proposed Rule Change is to clarify that Exchange Rule 4.2 is a part of the Exchange's Minor Rule Violation Rule. Exchange Rule 4.2 deals with the furnishing of information to the Exchange upon request. Rule 4.2 is not currently included in the specific list of Rules to which the Minor Rule Plan applies, however, the text listed under Rule 4.1 which is noted therein, addresses the requirements of Rule 4.2 as well as Rule 4.1. The Exchange believes that the specific inclusion of Rule 4.2 will make it clear to members that the Minor Rule Plan provisions apply to it.

2. Statutory Basis

The proposed rule change is consistent with Section 6(b)(6) of the Act⁷ in that it will provide a procedure whereby member organizations can be "appropriately disciplined" in those instances when a rule violation is minor in nature, but a sanction more serious than a warning or cautionary letter is appropriate. The rule change provides a fair procedure for imposing such sanctions, in accordance with the requirements of Sections 6(b)(7) and 6(d)(1) of the Act.⁸

B. Self-Regulatory Organization's Statement on Burden on Competition

The CSE does not believe that the proposed rule change will impose any inappropriate burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the publication of this notice in the Federal Register or within such other period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

- (A) by order approve the proposed rule change, or
- (B) institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street NW., Washington, D.C. 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. § 552, will be available for inspection and copying at the Commission's Public Reference Section, 450 Fifth Street NW., Washington, D.C. 20549. Copies of such filing will also be available for inspection and copying at the principal office of the Exchange. All submissions should refer to File No. SR-CSE-95-09 and should be submitted by December 29, 1995.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Margaret H. McFarland,
Deputy Secretary.

[FR Doc. 95-29922 Filed 12-7-95; 8:45 am]

BILLING CODE 8010-01-M

² Rule 8.14 was approved by the Commission on September 1, 1988. See Securities Exchange Act Release No. 26053 (September 1, 1988), 53 FR 34851 (September 8, 1988) (order approving File No. SR-CSE-88-1). A subsequent addition of a rule to the Rule 8.14 Violations List was made in Securities Exchange Act Release No. 27609 (January 11, 1990), 55 FR 1758 (January 18, 1990) (order approving File No. SR-CSE-89-6).

³ CSE Rule 8.14, entitled Imposition of Fines for Minor Violation(s) of Rules, contains a list of minor rule violations as to which the Exchange may impose such fines. Although the CSE's Board of Trustees makes the initial determination of whether a CSE rule violation is "minor" for purposes of CSE Rule 8.14, this determination is subject to Commission approval pursuant to Section 19(d)(1) of the Act and paragraph (c)(2) of Rule 19d-1 under the Act. See Release No. 26053 n.5, *supra* note 2.

⁴ *Id.*

⁵ *Id.*

⁶ CSE rule 4.2 provides that "every member shall furnish to the Exchange, upon request and in a time and manner required by the Exchange, current copies of any financial information filed with the Commission, as well as any records, files or financial information pertaining to transactions executed on or through the Exchange. Further, the Exchange shall be allowed access, at any time, to the books and records of the member in order to obtain or verify information related to transactions executed on or through the Exchange or activities relating to the Exchange."

⁷ 15 U.S.C. 78f(b)(6).

⁸ 15 U.S.C. 78f(b)(7) and 78f(d)(1).

[Release No. 34-36540; File No. SR-MBS-95-09]

Self-Regulatory Organizations; MBS Clearing Corporation; Notice of Filing and Order Granting Accelerated Approval of Proposed Rule Change Requesting Permanent Approval of the Electronic Pool Notification Service

November 30, 1995.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),¹ notice is hereby given that on November 3, 1995, the MBS Clearing Corporation ("MBS") filed with the Securities and Exchange Commission ("Commission") the proposed rule change (File No. SR-MBS-95-09) as described in Items I and II below, which Items have been prepared primarily by MBS. The Commission is publishing this notice and order to solicit comments from interested persons and to grant accelerated approval of the proposed rule change.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The proposed rule change requests permanent approval of the rules that set forth and establish the Electronic Pool Notification ("EPN") service. The Commission previously approved on a temporary basis through November 30, 1995, a proposed rule change that added Articles VI, VII, VIII, IX, and X to MBS's rules to establish the EPN service.²

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, MBS included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. Summaries of the most significant aspects of such statements are set forth in sections A, B, and C below.³

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

The purpose of the proposed rule change is to request permanent approval of the rules that set forth and establish

the EPN service. EPN was developed by MBS in response to a Public Securities Association ("PSA") initiative to automate the pool notification process with the ultimate goal of supplementing and/or replacing the manually intensive telephone and fax environment. EPN is an electronic, post-trade communication system for mortgage-backed securities.⁴ EPN provides an electronic communications network through which EPN users can quickly and efficiently transmit mortgage-backed securities pool allocation information regarding deliveries of securities for settlement. EPN was designed for use by organizations actively engaged in the allocation and notification process associated with mortgage-backed securities and derivative securities. EPN user firms may be acting as principal to the underlying trade activity or as agent on behalf of another EPN user in a fully disclosed capacity.⁵

An EPN message will be required to contain (1) the lot sequence of "good delivery millions" (i.e., the number of million dollar lots delivered in accordance with PSA guidelines), (2) a pool number that references a specific pool of mortgages, (3) the principal amount at date of issue, (4) the coupon rate, and (5) a termination code. In addition, an EPN message may contain, among other things, additional information such as the maturity date, CUSIP number, current outstanding principal amount, an MBS trade number, internal control number, and interest accrued.

MBS decided that a complete stand-alone set of rules for EPN was preferable to trying to integrate the EPN rules into existing MBS rules. As a result, many of the EPN rules mirror the language of existing MBS rules in order to make the provisions of those rules applicable to the EPN service. There has been an attempt to use the same terms and definitions that MBS uses in its current rules wherever possible. However, the EPN rules do differ from existing MBS rules in several respects. The EPN rules define new terms specifically related to EPN. Another change from existing MBS

rules concerns who can become an EPN user. Because EPN is essentially a sophisticated e-mail/database system that does not involve traditional clearance or settlement functions, the risk to MBS from defaulting EPN users is limited to nonpayment of fees. As a result, the standards for applicants to become EPN users are significantly less demanding than the standards for applicants that wish to become full participants of MBS. It is anticipated that some applicants that do not qualify as full participants of MBS will still qualify to become EPN users. The EPN rules also provide for an EPN user fund. The EPN user fund will be similar in purpose to the existing MBS participants fund, but because the risk to MBS is limited to nonpayment of fees, the EPN user fund will be smaller.

MBS believes that the proposed rule change is consistent with Section 17A(b)(3)(F) of the Act⁶ and the rules and regulations thereunder because it facilitates the prompt and accurate clearance and settlement of securities transactions.

B. Self-Regulatory Organization's Statement on Burden on Competition

MBS does not believe that the proposed rule change will have an impact or impose any burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Other

No written comments relating to the proposed rule change have been solicited or received. MBS will notify the Commission of any written comments received by MBS.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Section 17A(b)(3)(F) of the Act⁷ requires that the rules of a clearing agency be designed to promote the prompt and accurate clearance and settlement of securities transactions. The Commission believes that MBS's proposal to establish the EPN service on a permanent basis is consistent with this obligation.

One reason the Commission previously approved the EPN service only on a temporary basis was EPN's lack of a disaster recovery program. During the temporary approval period, MBS established and thoroughly tested the EPN service's disaster recovery program. Because the EPN disaster

¹ 15 U.S.C. § 78s(b)(1) (1988).

² Securities Exchange Act Release No. 35009 (November 25, 1994), 59 FR 61913 [File No. SR-MBS-94-02] (order temporarily approving proposed rule change).

³ The Commission has modified the text of the summaries prepared by MBS.

⁴ The number of securities eligible for the EPN service will be greater than those eligible for the comparison and clearing service at MBS. All mortgage-backed securities eligible for comparison and clearing at MBS will be eligible for the EPN service. In addition, securities which are not eligible for comparison and clearing because of lack of volume or inability to be valued will be eligible for the EPN service.

⁵ MBS commenced the EPN service on a pilot basis in February 1995. During September 1995, EPN users processed 6,936 messages comprised of 56,224 pools with a current face value of approximately \$58 billion. Currently there are fourteen EPN users.

⁶ 15 U.S.C. § 78q-1(b)(3)(F) (1988).

⁷ 15 U.S.C. 78q-1(b)(3)(F) (1988).

recovery program has operated successfully during its testing, MBS has decided to request permanent approval of the EPN service.

Prior to the establishment of the EPN service, participants in the mortgage-backed securities market had to manually telephone or fax pool information to other participants. Historically, billions of dollars of fails occurred because sellers were not able to communicate with buyers because of telephone and fax limitations (*e.g.*, busy signals preventing the exchange of information). The Commission is permanently approving the rules for the EPN service because it believes that replacing a manually intensive communication system with an electronic communication system should help to significantly reduce the number of fails in the mortgage-backed securities market by making the notification process more efficient and more reliable. Furthermore, MBS has demonstrated that the disaster recovery program for the EPN service is capable of ensuring the continuity of critical EPN business operations in the event the primary computer operations become unavailable to EPN users.⁸

MBS has requested that the Commission find good cause for approving the proposed rule change prior to the thirtieth day after the date of publication of notice of the filing. The temporary approval period for the EPN service will expire on November 30, 1995. The Commission finds good cause to grant accelerated approval of the proposal because the EPN service has operated successfully since its implementation and because the Commission did not receive any comment letters during the comment period before it granted temporary approval or during the temporary approval period and because the Commission does not expect to receive any during the current comment period. Furthermore, accelerated approval will allow the EPN service to continue operating without interruption.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange

Commission, 450 Fifth Street NW., Washington, D.C. 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street NW., Washington, D.C. 20549. Copies of such filing will also be available for inspection and copying at the principal office of MBS. All submissions should refer to file number SR-MBS-95-09 and should be submitted by December 29, 1995.

It is therefore ordered, pursuant to Section 19(b)(2) of the Act, that the proposed rule change (File No. SR-MBS-95-09) be and hereby is approved on an accelerated basis.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.⁹

Margaret H. McFarland,
Deputy Secretary.

[FR Doc. 95-29921 Filed 12-7-95; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-36547; File No. SR-NSCC-95-15]

Self-Regulatory Organizations; National Securities Clearing Corporation; Notice of Filing of a Proposed Rule Change Regarding Arrangements Between the National Securities Clearing Corporation and Chicago Stock Exchange, Incorporated Relating to a Decision by Chicago Stock Exchange, Incorporated to Withdraw From the Clearance and Settlement, Securities Depository, and Branch Receive Businesses

December 1, 1995.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),¹ notice is hereby given that on November 24, 1995, the National Securities Clearing Corporation ("NSCC") filed with the Securities and Exchange Commission ("Commission") the proposed rule change (File No. SR-NSCC-95-15) as described in Items I, II, and III below, which items have been prepared primarily by NSCC. The Commission is publishing this notice to

solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The proposed rule change involves proposed arrangements relating to a decision by the Chicago Stock Exchange, Incorporated ("CHX") to withdraw from the clearance and settlement, securities depository, and branch receive businesses. Parties to the proposed arrangements are The Depository Trust Company ("DTC"), CHX, Midwest Securities Trust Company ("MSTC"), NSCC, Midwest Clearing Corporation ("MCC") and Securities Trust Company of New Jersey ("STC/NJ").²

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, NSCC included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. NSCC has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of such statements.³

(A) Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

CHX has announced that it is closing its clearance and settlement and securities depository facilities in order to focus its resources on the operations of the exchange. CHX has determined to take this step in response to recommendations by industry users to eliminate redundant facilities and thereby reduce the costs of processing securities transactions. The proposed arrangements will assist in achieving these objectives while affording qualified sole MCC participants an opportunity to become NSCC participants and transfer their continuous net settlement positions to NSCC. NSCC's primary purpose for entering into the proposed arrangements at this time is to facilitate the industry's planned conversion to same-day funds

⁸ On September 27, 1995, staff of the Division of Market Regulation met with MBS to discuss the disaster recovery program developed for the EPN service. The staff also reviewed and assessed documentation related to the management and operation of the disaster recovery system and conducted an examination of the primary data center.

⁹ 17 CFR 200.30-3(a)(12) (1994).

¹ 15 U.S.C. 78s(b)(1) (1988).

² STC/NJ is a subsidiary of CHX that currently provides certain services, including a securities custody service. STC/NJ is not a clearing agency as defined in the Act and therefore is not required to register with the Commission.

³ The Commission has modified the text of the summaries prepared by NSCC.

settlement.⁴ Additionally, the proposal will result in substantial savings for NSCC participants and the securities industry as a whole.

Currently, transactions in equities, corporate debt, and municipal debt are settled in next-day funds.⁵ Transactions in commercial paper and other money market instruments are settled in same-day funds. As the Commission is aware, DTC and NSCC have been working with the industry over the last few years to develop a system that will provide for the settlement of virtually all securities transactions in same-day funds. DTC's and NSCC's efforts have been encouraged by the Commission, the Board of Governors of the Federal Reserve System, and the Federal Reserve Bank of New York, and NSCC's plans have been monitored by the staffs of these regulatory bodies.⁶ Under the conversion plan, all issues currently settling in next-day funds will be converted to settlement in same-day funds settlement on a single day. Several months ago, a consensus was reached that the conversion date will be February 22, 1996.

Where there are interfaces among the securities clearing corporations, same-day funds settlement exposes each clearing corporation, same-day funds settlement exposes each clearing corporation to settle its net payment obligation because of a failure by one of the participants of such other clearing corporation to settle with it or because such other clearing corporation is experiencing a major systems problem. These risks cannot be entirely avoided with existing and available risk management controls. CHX's withdrawal from the securities clearing corporation business will eliminate the exposure of NSCC and its participants to the payment system risks associated with the NSCC-MCC interface. Also, the interests of MCC participants can be provided for in an orderly manner that will help assure their successful

integration in the process of converting to same-day funds settlement.

The proposed arrangement should result in substantial savings for NSCC participants and the securities industry. In connection with this proposal, former sole MCC participants may become NSCC participants if they qualify. An increase in the number of NSCC participants will result in higher NSCC transaction volumes thereby reducing the per-unit service costs that must be recovered through participant service fees. Moreover, interclearing corporation interfaces involve the maintenance of substantial facilities, communications networks, and account and inventory reconciliation mechanisms. As a result of the proposal, the substantial costs incurred by both NSCC and MCC in operating an interface would be eliminated.

NSCC believes the proposed rule change is consistent with the requirements of Section 17A of the Act and the rules and regulations thereunder applicable to NSCC because the proposed arrangements will facilitate the industry's conversion to same-day funds settlement for virtually all securities transactions and thereby facilitate the prompt and accurate clearance and settlement of such transactions. The proposal will provide qualified sole MCC participants. The proposal will provide qualified sole MCC participants with access to NSCC's facilities and will be implemented consistently with the safeguarding of securities and funds in NSCC's custody and control.

(B) Self-Regulatory Organization's Statement on Burden on Competition

NSCC believes the proposed arrangements would impose no burden on competition. Securities clearing corporations registered under Section 17A of the Act are utilities created to serve members of the securities industry for the purpose of providing certain services that are ancillary to the business in which industry members compete with one another. Operating a securities clearing corporation requires a substantial and continuing investment in infrastructure, including telecommunications links with users, data centers, and disaster recovery facilities, in order to meet the increasing needs of participants and to respond to regulatory requirements.

After consummation of the proposed arrangements, securities industry members will continue to have access to high-quality, low-cost clearance services provided under the mandate of the Act. The overall cost to the industry of having such services available will be

reduced, thereby permitting a more efficient and productive allocation of industry resources. Furthermore, because most interface costs must be mutualized, thereby requiring some participants to subsidize costs incurred by others, CHX's withdrawal participants and thereby remove impediments to competition. Finally, CHX's ability to focus its resources on the operations of its exchange should help enhance competition among securities markets.

(C) Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received from Members, Participants, or Others

No written comments have been solicited or received. NSCC will notify the Commission of any written comments received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within thirty-five days of the date of publication of this notice in the Federal Register or within such longer period (i) as the Commission may designate up to ninety days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which NSCC consents, the Commission will:

- (a) By order approve such proposed rule change or
- (b) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, N.W., Washington, D.C. 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. § 552, will be available for inspection and copying in the Commission's Public Reference Room, 450 Fifth Street, N.W., Washington, D.C. 20549. Copies of such filing will also be available for inspection and copying at the principal office of NSCC. All submissions should refer to the file number SR-NSCC-95-

⁴ The term "same-day funds" refers to payment in funds that are immediately available and generally are transferred by electronic means.

⁵ The term "next-day funds" refers to payment by means of certified check that is for value on the following day.

⁶ In approving certain modifications of DTC's existing system in order to accommodate the overall conversion to same-day funds settlement, the Commission stated that it believes that the overall conversion to a same-day funds settlement system will help reduce systemic risk by eliminating overnight credit risk. The same-day funds settlement system also will reduce risk by achieving closer conformity with the payment methods used in the derivatives markets, government securities markets, and other markets. Securities Exchange Act Release No. 35720 (May 16, 1995), 60 FR 27360 [File No. SR-DTC-95-06] (order granting accelerated approval to proposed rule change modifying the same-day funds settlement system).

15 and should be submitted by December 29, 1995.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.⁷

Margaret H. McFarland,
Deputy Secretary.

[FR Doc. 95-29917 Filed 12-7-95; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-36548; File No. SR-NASD-95-42]

Self-Regulatory Organizations; Notice of Filing of Proposed Rule Change by National Association of Securities Dealers, Inc. Relating to NAqcess System and Accompanying Rules of Fair Practice

December 1, 1995.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),¹ notice is hereby given that on November 9, 1995, the National Association of Securities Dealers, Inc. ("NASD" or "Association") filed with the Securities and Exchange Commission ("SEC" or "Commission") the proposed rule change as described in Items I, II and III below, which Items have been prepared by the NASD. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

Pursuant to Section 19(b)(1) of the Act, attached as Exhibit A is the full text of a series of proposed rule changes by the NASD and The Nasdaq Stock Market, Inc. ("Nasdaq") regarding the operation of The Nasdaq Stock Market's NAqcess system, a new system that offers nationwide limit order protection and price improvement² over the dealer

quotation of small-sized customer orders. The "Rules of Operation and Procedures for NAqcess" ("NAqcess Rules") will replace in its entirety the "Rules of Practice and Procedures for the Small Order Execution System" ("SOES Rules"), which the NASD proposes to withdraw simultaneously with the new system becoming operational. The NAqcess system rules package attached in Exhibit A is new and accordingly has not been italicized. The NASD is also proposing several new Interpretations and a new Rule in its Rules of Fair Practice to afford individual investors the opportunity to determine whether their orders are to be handled in NAqcess and to provide customer limit orders held in NAqcess or elsewhere with enhanced price protection (Exhibit B). The NASD is also proposing conforming modifications to the NASD Manual, including the Rules of Practice and Procedure for the Automated Confirmation Transaction Service ("ACT Rules") and Schedule D to the NASD By-Laws (and all other places in the Manual that refer to SOES) to delete references to SOES and/or the SOES Rules and to replace those references with NAqcess and/or the NAqcess Rules, as appropriate. These references may be found in the ACT Rules, Section (c)(2); in Schedule D, Part V, Section (1)(f), Section (7)(a), Section (8)(c), and Section (9); and Schedule D, Part XI, Section (2)(e)(1).

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the NASD included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The NASD has prepared summaries, set forth in Sections (A), (B), and (C) below, of the most significant aspects of such statements.

(A) Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Introduction

The NASD and The Nasdaq Stock Market, Inc. are proposing rules of operation and procedure and companion rules for a new service that provides investors market-wide price protection of their limit orders, the

opportunity to obtain price improvement over the dealer quotation in buying and selling Nasdaq stocks, and increased access to the Nasdaq market. The new facility, to be named NAqcess and operated by The Nasdaq Stock Market, will permit significant opportunity for investors in Nasdaq securities to enter limit orders inside the Nasdaq dealer quotation and enhance the opportunity for such investors to receive executions between the best dealer bid and offer without such orders interacting with market makers. The limit orders at the top of the NAqcess limit order file that are the same as or better than the best dealer quotations will be included in the inside market for The Nasdaq Stock Market, thereby providing new levels of transparency, increased price efficiency, and greater investor protection. Further, the companion rule and Interpretations accompanying the new system will provide retail customers with enhanced price protection of their limit orders, a significant expansion over current limit order protection afforded to customers in the Nasdaq market. Finally, NAqcess will provide customers that choose to enter market orders into the system with the opportunity to obtain price improvement over the dealer quotation through interaction with customer limit orders in the NAqcess file and will provide a prompt, cost-effective execution at the best price available in the market at any particular point in time.

NAqcess and the accompanying new Rules of Fair Practice provide multiple benefits to retail investors that were heretofore unavailable to such investors. A key feature of NAqcess that is a significant enhancement over current practices in Nasdaq is the ability of investors to have limit orders placed in a central file where they can interact directly with other customer limit orders and market orders entered into the system. Under a proposed new Interpretation to Article III, Section 1 of the Rules of Fair Practice, a customer may instruct its broker-dealer to enter the customer's limit order or market order into NAqcess. Moreover, NAqcess will provide increased transparency of the best priced limit orders in NAqcess because Nasdaq will incorporate into the Nasdaq inside market limit orders that are priced the same as or better than the best dealer bid and offer displayed in Nasdaq, and their aggregate sizes in a particular security. This increased transparency will enhance the Nasdaq price discovery process. NAqcess will match incoming limit and market orders against limit orders resident in the

⁷ 17 CFR 200.30-3(a)(12) (1994).

¹ 15 U.S.C. 78s(b)(1) (1988).

² Commission Note: The NASD's use of the term "price improvement" in this proposal differs from the use of the term in recent Commission releases. Specifically, the Commission has used the term when referring to the opportunity to receive a price that is superior to best bid or offer. See, e.g., 17 CFR 11Ac1-3(a)(2); Securities Exchange Act Release No. 34902 (Oct. 27, 1994), 59 FR 55006 (Nov. 2, 1994) at text accompanying n. 32. The NASD's use of the term in this proposal, on the other hand, refers to the opportunity to receive a price that is better than the best market maker quotation, which may not be the best bid or offer to the extent NAqcess limit orders are included. In its recent rule proposal concerning the obligations of market makers executing customer orders, the Commission asked for comment on whether automated systems that include the possibility of the interaction of market orders with limit orders should be deemed to satisfy the proposal's requirement that market orders be provided with an opportunity for price

improvement. Securities Exchange Act Release No. 36310 (Sept. 29, 1995), 60 FR 52792 (Oct. 10, 1995).

NAqcess file so as to permit customer orders to interact directly with each other without the participation of a market maker. The interaction of customer orders offers such orders an opportunity for price improvement over the dealer quotation and increases the likelihood that public limit orders will be executed on a more timely basis.

The companion rules and Interpretations regarding price protection in Nasdaq will also significantly enhance the protection of customer limit orders whether they are held in NAqcess or stored in a member firm's limit order file. Under a newly proposed rule, NASD member firms, whether acting as principal or agent, will not be permitted to execute an order at a price inferior to any limit order(s) in the NAqcess limit order file that the member firm is able to view, without satisfying the viewable limit order(s). An "inferior price" means an execution price that is lower than a buy limit order or higher than a sell limit order. In addition, if a member firm holds a customer limit order outside of NAqcess, a new Interpretation to Article III, Section 1 of the Rules of Fair Practice would require the member firm that holds the limit order to provide the customer with price protection that is equivalent to that which the limit order would have received if it had been entered into the NAqcess file. The concept of equivalent price protection is further explained below.

Aside from these major regulatory enhancements that provide for major changes in order handling and protection in The Nasdaq Stock Market, the NAqcess system itself represents a significant improvement over the current methodology for the handling of small investor orders. NAqcess, as noted, will permit interaction of small customer limit and market orders within the dealer spread and thus permit such orders to obtain significant opportunities for price improvement over the dealer quotation.

This new order delivery and execution system will replace SOES, the NASD's current system for the handling of small customer orders. Because SOES is an automated, quote-based execution system, it does not offer the opportunity for price improvement over the dealer quotation of small customer orders. Moreover, the proposed NAqcess system addresses the queuing concerns that were raised in connection with the previously proposed N—Prove system. NAqcess will distribute non-directed market orders that can not be immediately matched against NAqcess limit orders to available market makers at the inside market as the orders are

presented. A market maker will provide such order an automated execution at the inside if the market maker presented with the order does not manually decline the order within a 20-second period because the market maker (consistent with SEC Rule 11Ac1-1)³ has already effected, or is in the process of effecting an execution in the security and is in the process of updating its quotation. This approach eliminates the single-threaded distribution mechanism proposed in Notice To Members 95-20 and permits rapid distribution of orders to market makers as the orders are received.⁴

³ 17 CFR 240.11Ac1-1 (1995).

⁴ The NASD believes that significant queues in excess of those currently experienced under SOES today will not occur under the new proposal. First, if the limit order file for a security has depth, market orders will immediately execute against limit orders without any delay. Because each order when received is immediately distributed to the next available market maker, the large majority of orders will be executed within 20 seconds of distribution. Even if an order is declined by a market maker at one price level, an event that the NASD believes will not be frequent, the declined order will be automatically executed without the possibility of rejection immediately upon presentation at the next price level. All of these techniques mean that it will be rare for an order not to be executed within a 20 to 40-second period after processing.

For example, assume that five market orders are entered into NAqcess at one second apart from each other and there are five market makers in the stock at the inside. Each order when received will be immediately distributed to the next market maker. Thus, order one at second one is distributed immediately to market maker one, while order two at second two is sent to market maker two immediately, and so on through order five. In most circumstances, each market maker will not decline the order within 20 seconds, and thus, each order would be executed within 20 seconds of processing. If any one of these orders were declined, the order would wait for the next available market maker for re-presentation. If that market maker remained at the same price level as that when the order was originally presented, the order would be subject to a further 20-second reaction period. In the unlikely event it was declined again, the order would be presented again for execution. If that presentation occurred at a new price level, it would be immediately executed at the new price level.

If order entry firms enter more orders than there are market makers at the inside, the queue for such orders would be the same as today in SOES when orders must be queued while waiting for a market maker to update its quotation after a SOES execution. Consequently, the NASD believes that queuing under this proposal does not represent a significant threat to prompt market order execution much different from current queuing. It should be noted as well, that market orders of eligible size entered into NAqcess are guaranteed an execution. Such execution may be effected against a customer order or a dealer's quote. Thus, in response to concerns raised in some comment letters the NASD received in response to Notice to Members 95-20 and 95-60, NAqcess will provide guaranteed executions to investors entering eligible market orders. Accordingly, the NASD believes that those comment letters from individual investors that allege that NAqcess will deprive them of an automatic execution are mistaken. Of course, it should be noted that not even in SOES is a market order guaranteed an execution at the price observed

NAqcess and its companion rules represent a significant enhancement to the treatment of investor orders in The Nasdaq Stock Market. The entire proposal, when taken together with other recent enhancements to the Nasdaq trading environment, such as the Limit Order Protection Interpretation⁵ and the Short Sale Rule,⁶ demonstrates the significant strides that the NASD and The Nasdaq Stock Market have taken to provide increased protection of investors while continuing to preserve the benefits that its competitive dealer market structure currently provides. Individual investors seeking price improvement over the dealer quotation will be afforded a transparent mechanism to obtain greater opportunities for price improvement over the dealer quotation without market maker interaction. Moreover, through the accompanying rules, NAqcess will provide such limit orders with increased market-wide price protection. Individual investors seeking rapid execution of small market orders at the best available price will continue to be able to obtain executions promptly, while Nasdaq market makers will be permitted the opportunity to interact with such orders in a manner consistent with SEC rules and in a manner similar to market order handling in exchange markets. By permitting market makers to continue the operation of their own internal execution systems, the NASD will maintain the ability of dealers to provide liquidity and competitive mechanisms to handle customer orders.

2. NAqcess Operations

The proposed NAqcess system will provide the following:

A. Scope of System. NAqcess will be available for all Nasdaq issues. It will completely replace SOES which will operate until the effective date for operation of NAqcess and will be discontinued as of that date. NAqcess participation will be mandatory for market makers in all National Market securities. NAqcess participation for SmallCap market makers will be voluntary, as is SOES participation today for such market makers.

B. Order Entry Requirements. Agency orders may be entered into NAqcess only by member firms on behalf of customers. "Customers" are defined to

at the time the order was entered. Similarly, under NAqcess no such guarantee is extended to an investor.

⁵ Securities Exchange Act Release Nos. 35751 (May 22, 1995), 60 FR 27997 (May 26, 1995) and 34279 (June 29, 1994), 59 FR 34883 (July 7, 1994).

⁶ Securities Exchange Act Release No. 34277 (June 29, 1994), 59 FR 34885 (July 7, 1994).

exclude any broker, dealer, person associated with a member, or a member of the immediate family of a person associated with a member. Because the purpose of the system is to provide small retail customers with access to The Nasdaq Stock Market, member firms, with one limited exception,⁷ are not permitted to enter proprietary orders.⁸ As explained in more detail below, customers may request that appropriately sized limit and market orders be entered into NAqcess, and if so requested, member firms must honor the customer's request.⁹

Customers may request the entry of limit orders up to 1,000 shares in National Market and SmallCap issues, except for the Nasdaq 100 issues, in which case limit orders up to 3,000 shares may be entered. This represents a difference from the original proposal¹⁰ of 3,000 shares for all National Market issues.¹¹ The issue of size eligibility for limit orders generated significant comment in response to the two Notices.¹² Many commenters believed that because NAqcess is intended to provide small retail customers with limit order protection, the initial

approach should reflect more closely that the average retail order size is well under 1,000 shares. For example, the Security Traders Association ("STA") noted that the experience of STA members was that the typical retail customer order size averaged well-less than 1,000.¹³ It was also noted by commenters that it could reduce the potential for investor confusion if NAqcess established a standard for limit orders that was consistent with market order size, 1,000 shares. Commenters also noted that NAqcess could potentially significantly impact market maker participation, particularly in less active securities. As a result, they suggested that the NAqcess order size should be set at lower levels at least until the NASD had thoroughly evaluated the impact of the system on market liquidity.

While the NASD believes that NAqcess will have overall a positive effect on market quality, we believe that it is prudent in this start-up period to commence NAqcess limit order size eligibility at 1,000 shares for most securities. However, limit orders up to 3,000 shares would be eligible for NAqcess for those securities that comprise the Nasdaq 100 Index. The NASD believes that this higher eligibility level is appropriate because the securities comprising the Nasdaq 100 have high levels of volume, greater market maker participation and significant market liquidity and therefore are less likely to be adversely impacted by the proposal. Because of the significant changes that NAqcess may bring to The Nasdaq Stock Market, the NASD believes that it is appropriate to commence the operation of the system with a smaller limit order size than originally proposed to permit market makers and investors to adjust to the new trading environment. The NASD proposes to monitor the limit order size requirement carefully in the initial eighteen months of NAqcess operation and may choose to expand the eligible size of limit orders, if experience demonstrates such expansion to have merit.

Market orders in National Market issues may be 1,000, 500 or 200 shares depending upon tier size determination to be made in the same manner as done in SOES today.¹⁴ Similarly, market

orders in SmallCap issues will be tiered at 500 shares or less as done in SOES today.¹⁵

Customers may choose to enter "marketable limit orders." A marketable limit order is a limit order that is priced at the time of entry at the current inside market or better on the opposite side of the market, i.e., a marketable limit order to buy is equal to or higher than the current inside offer, while a marketable limit order to sell is equal to or lower than the inside bid. For example, if the current inside market is 20 bid and 20¼ asked, the entry of limit orders to sell priced at 20 or 19⅞ would be considered marketable limit orders. Marketable limit orders will be treated as market orders. Thus, if a firm enters a customer limit order to sell at 20 at the time the inside bid is 20, the limit order will be passed over the limit order file and if no match occurs, it will be treated as a market order and executed as discussed above in the market order handling section. If such marketable limit order, however, is greater than 1,000 shares in a Nasdaq 100 security, the marketable limit order will be returned to the order entry firm for handling outside of NAqcess, without matching against the inside market whether the inside consists of a dealer quote, limit order(s), or an aggregation thereof.

Neither a limit order nor a market order may be split up to meet the size parameters of NAqcess. The NASD will examine order handling practices of

The same concept will apply with respect to NAqcess maximum market order sizes, except that the NASD has determined to use a slightly higher average daily non-block volume of 6,000 shares. The NASD has chosen this higher level because it better reflects trading patterns consistent with the increased overall volume in Nasdaq securities.

¹⁵ The NASD will permit market makers to establish minimum exposure limits that are equal to the maximum market order size. In addition, NAqcess will contain an automated update feature that will automatically change the market maker's quotation by a minimum increment set by the market maker after the market maker has executed a trade at a price level and has exhausted its minimum exposure limit through system executions. The NASD believes that these aspects of NAqcess are critical to an effective operation that permits a market maker to manage its risk capital, and is consistent with the SEC firm quote rule as applied to all other registered markets. The minimum exposure limit is set at the same size as the minimum quote size in Nasdaq. Under the SEC Firm Quote Rule (Rule 11Ac1-1(c)), a broker-dealer is entitled to change its quotation within a reasonable period of time after it has completed a trade at its published price. Accordingly, the NASD believes that these aspects of NAqcess are consistent with SEC and NASD rules and provide retail investors with the same access to dealer quotations as are available in any other registered marketplace.

⁷ The only exception to the proprietary order prohibition is an order designated by a market maker as a "marker order." A marker order is a principal order entered by a market maker in a transaction that is functionally the equivalent of a riskless principal transaction. The firm may place a principal account limit order in the NAqcess file, and if an execution is obtained, immediately pass along the benefit of such execution to a retail customer order it holds in its own file. Because the order is part of a principal transaction for the benefit of the retail customer, the NASD believes that it is appropriate to permit this limited exception to the prohibition of proprietary orders in NAqcess. The NASD will require member firms entering such orders to mark their order tickets accordingly, and will examine a firm's trading activities carefully to determine that such proprietary orders are being effected for the purposes of engaging in a riskless principal-like transaction. Marker orders, however, may not be placed with respect to customer limit orders held by the firm that exceed the permitted maximum limit order size.

⁸ Member firms will be permitted, however, to enter so-called "takeout" orders for their own account or on behalf of a customer. A takeout order is an order that results in an immediate automatic execution of a limit order or orders in the NAqcess limit order file at the limit order price(s). There is no size limitation on the takeout order. Thus, if the NAqcess file displays limit orders at a price with an aggregate size of 15,000 shares, a single takeout order of 15,000 shares may be entered and executed. Similarly, a firm may enter a takeout order to immediately execute multiple limit orders at multiple prices in the NAqcess file. When there are multiple limit orders being taken out, each limit order will execute at each limit order's price.

⁹ See *infra* Section II(A)3.A of this proposal.

¹⁰ NASD Special Notice to Members 95-20 (Mar. 21, 1995).

¹¹ All SmallCap issues have a limit order size of 1,000 shares.

¹² NASD Special Notice to Members 95-20 (Mar. 21, 1995) and 95-60 (July 27, 1995).

¹³ See letter from John Giese, Chairman, and John Watson, President, STA (Apr. 28, 1995).

¹⁴ Under SOES Rules, the tier sizes of 1,000, 500 and 200 shares were determined by reference to the average daily non-block volume of a security, among other things. Thus, for example, if an issue had an average daily non-block volume of 3,000 or more shares, it could qualify for a tier size of 1,000 shares.

order entry firms to determine compliance with this requirement.¹⁶

C. *Display of Limit Orders.* To enhance the transparency of The Nasdaq Stock Market and to assist in the price discovery process, the NASD will provide for the display of limit orders entered into NAQcess. There will be two separate approaches to the display: a consolidated inside market display and the Full File Display.

1. *Inside Market Display.* In a significant revision to Nasdaq's methodology for calculating the inside market for Nasdaq securities, The Nasdaq Stock Market will include in the Nasdaq inside market NAQcess limit orders, and their aggregate sizes, that are priced the same as or better than the best dealer bid and offer.¹⁷ Thus, in Nasdaq the inside market will consist of a single display of the best priced quotes or limit orders, as the case may be. The inside market will be calculated in the following manner. If the best limit order(s) to buy (sell) in NAQcess is (are) better than the best Nasdaq market maker bid (offer) displayed in Nasdaq and such limit order(s) is (are) 100 shares or more, it (they) will be included in the Nasdaq inside market and disseminated as the inside bid (offer), together with the aggregate size of such order(s) and a unique indicator to denote that the inside market is represented by a NAQcess limit order or orders, rather than a quotation of a Nasdaq market maker or UTP exchange quotation. If there are multiple limit orders at the best price, aggregate size will be displayed and execution of such

orders will occur on a time priority basis as explained below.

If the best-priced NAQcess limit order(s) is (are) equal to the inside dealer quotation, the limit order size will be reflected in the aggregate size of the quotation. That is, if there is a limit order to buy 500 shares at the same price as a 1,000 share dealer bid quotation, and both are the best bids reflected in Nasdaq, the aggregated size displayed as the best Nasdaq bid will reflect a size of 1,500 shares with a special indicator to denote that such size is an aggregation of a dealer quote and any limit order(s) at that price. Priority for execution will depend upon the general limit order priority rules, i.e., if the limit order is received prior to the market maker quotation, it will be entitled to priority for execution purposes.¹⁸

The inclusion of NAQcess limit orders in the Nasdaq inside market represents a significant enhancement to The Nasdaq Stock Market. Consolidation of NAQcess orders into the Nasdaq inside quotation is the best means to communicate clearly to all investors in Nasdaq the true market for such securities at any particular point in time. The consolidation of best-priced limit orders with the best dealer bid and offer in Nasdaq provides the best level of transparency and aids in the price discovery process.

Although this represents a change from the original NAQcess proposal,¹⁹ the NASD believes that the display of this consolidated information maintains the advantages of a competing dealer market while permitting an expansion in information available to investors.²⁰ The new inside quotation display will clearly identify when aggregated customer limit orders are represented in the inside market display. Accordingly, market participants will be able to ascertain when the inside quotation represents a customer limit order and when it represents a market maker whose quotation may signify that it is

available to effect a significantly larger sized transaction. In this way, the NASD believes that transparency of customer orders may be enhanced while the integrity of the dealer quotation is preserved.

2. *Full File Display.* The full file display for a particular security will be made available on a query basis over Nasdaq Workstations only to Nasdaq market makers in that security. The NASD believes that, as with other U.S. market centers, display of the entire limit order file should be reserved to market makers in a particular security to assist in price discovery and to provide the market maker with an incentive to provide liquidity by risking its capital. In fact, no U.S. exchange registered with the SEC publicly disseminates any display (full or partial) of a limit order book maintained by an exchange specialist. Because of the accompanying rules described below that the NASD has proposed, customer limit orders in the file will be protected to a large extent, from inferior executions.

D. *Order Processing.* The NAQcess system will provide significant improvements over the current SOES system in the way that customer limit orders and market orders will be handled. NAQcess will attempt to match all incoming orders, limit or market, directed or non-directed, against limit orders already resident in NAQcess on a price and time priority basis.²¹ If a match is found, the orders will be automatically executed against each other without the participation of a market maker. For example, assume the current inside market for a security is 20-20½ and customers enter into NAQcess a 1,000 share limit order to buy at 20⅞ and a 1,000 share limit order to sell at 20¾. The new inside market will become 20⅞-20¾. If a customer thereafter enters a 1,000 share limit order to sell at 20⅞, the incoming limit order to sell will match against the 1,000 share limit order to buy on the NAQcess file at 20⅞ and will be executed against that order. If a

¹⁶In this regard, the NASD notes that order entry firms may enter agency orders only. The rules continue in effect the definition of agency orders as found in the current SOES Rules and the new rules carry forward the existing principles regarding the aggregation of orders based on a single investment decision entered by an order entry firm. Orders entered by an order entry firm within any five minute period in accounts controlled by associated person or public customers, acting alone or in concert with other associated persons or public customers are presumed to be based on a single investment decision. In connection with this rule, the NASD notes that it will examine carefully the entry of computer-generated orders to determine whether such orders are based upon a single investment decision.

¹⁷This is a change from the approach originally proposed in Special Notice To Members 95-20 and 95-60. In the original NAQcess approach to the display of NAQcess limit orders, the NASD proposed to provide two separate displays of prices: the inside dealer quotation (i.e., the best-priced bids and offers of Nasdaq market makers and UTP exchanges displayed in the Nasdaq market) and the top of the NAQcess limit order file (i.e., the best-priced limit orders to buy and sell and their aggregate sizes). Such displays would have been separate and side-by-side. Under this new proposal, the NASD will maintain a Top of the File display on its Nasdaq Workstations, as well as include the best priced limit orders to buy and sell in the Nasdaq inside market display.

¹⁸Rules regarding calculation of the excess spread will not include NAQcess limit orders for purposes of determining compliance with those Rules. See *NASD Manual*, Schedules to the By-Laws, Schedule D, Part V, Sec. 2(d), CCH ¶ 1819.

¹⁹NASD Special Notice to Members 95-60 (July 27, 1995).

²⁰One commenter specifically noted that a consolidated display of the best priced limit orders in the Nasdaq inside market was a better approach than maintaining separate displays, especially since member best execution obligations would be determined by reference to the best prices displayed by Nasdaq, whether such prices were dealer quotes or limit orders in NAQcess. See Lehman Bros. (Sept. 12, 1995). In addition, several vendors expressed technological concerns regarding separate displays. See letters from ADP (Aug. 16, 1995) and Telekurs (Aug. 14, 1995).

²¹NAQcess will match only round lots and round lot portions of mixed lot orders. Odd lot limit orders will not be matched. Odd lots are orders less than 100 shares. Odd lot limit orders will not be displayed in the inside quotation; however, odd lot limit orders will be displayed in the full file display. If an odd-lot order is executable i.e., if it is a market order or an executable limit order, it will be automatically executed at the applicable inside dealer quotation. If it is a directed order, it is executed against the directed market maker. If it is a non-directed order, it will be executed automatically without any decline capability against the next available market maker at the inside dealer quotation. If the odd-lot order is a limit order that is not executable at time of entry, it will remain in the file until the inside dealer quotation moves to match the odd-lot price.

customer next sends in a market order to buy in NAqcess, the market order will match against the limit order to sell at $20\frac{3}{8}$, rather than the dealer offer of $20\frac{1}{2}$, and thus, the market order will be automatically executed immediately at $20\frac{3}{8}$. In both cases, the orders received price improvement over the dealer quotation and immediate execution without the participation of a market maker.

If, in the scenario set forth above, the second limit order to sell is priced at 20 instead of $20\frac{3}{8}$, the execution price would be $20\frac{1}{8}$, the price of the limit order to buy because such order was entered into the system earlier than the second limit order to sell.

The system will only execute such matches when the execution prices would be equal to or better than the inside market. Nevertheless, limit orders priced away from the inside market, *i.e.*, limit orders to sell priced higher than the inside offer and limit orders to buy priced lower than the inside bid, will be stored in the NAqcess file. When the inside market moves to a price so that the limit order is equal to or better than the inside dealer quotation, such limit orders will be consolidated into the Nasdaq inside market and the limit order will become eligible for matching as described in this section.

When a limit order in the NAqcess file is priced the same as the inside market, the time priority of the limit order compared with the best dealer quotation will govern which price interacts first with incoming orders in NAqcess. The NASD believes that this approach is a well-understood and reasonable means for determining the interaction of such orders and provides a further incentive to market makers to provide liquidity and narrow spreads.

If no limit orders reside in the NAqcess file, market orders will be immediately assigned and distributed to market makers at the inside market. This rapid distribution should minimize the potential for queues that the original proposal found in Notice To Members 95-20 could have caused. After an order is distributed to a market maker, the market maker will be permitted a 20-second period within which it may decline a non-directed order if such action is consistent with the exceptions to the SEC's firm quote rule, Rule 11Ac1-1.²² In other words, the market

maker is permitted to decline the NAqcess order if the market maker, immediately before the presentation of the NAqcess order: (a) effected or was in the process of effecting a trade, and (b) was in the process of updating its quotation to reflect that previous transaction. When a NAqcess order is declined by a market maker, the declined order is presented to the next available market maker. If that market maker is at the same price as the market maker that originally declined the order, the second market maker also has a 20-second period to react to the order. If the second time the order would be presented, the inside market has moved to a different price level, it is automatically executed without any decline capability. For example, four market makers are at the inside bid of 20. Three market orders to sell are entered into NAqcess when there are no limit orders to buy at 20 or better. Each market order is immediately distributed to one of the three market makers. Because the first market maker had completed a trade by telephone and was about to change its quotation, the first market order is declined by the first market maker. That order is redistributed to the fourth market maker still quoting a price of 20. The fourth market maker has 20 seconds to interact with the order. If, however, there were only three market makers at 20, and all market makers had updated their quotations to reflect a price of $19\frac{7}{8}$, the declined order would be immediately executed at $19\frac{7}{8}$ against the first available market maker without any decline capability.

The NASD is developing an automated surveillance capability to monitor on a real-time basis whether an order was properly declined. The NASD believes that this capability is crucial to engendering investor confidence in the

systems and the market maker. Thus, the NASD has purposefully designed a 5-second period to accommodate the transmission of messages between the NASD host computer and member firm presentation devices. This five-second period addresses the potential delays of 3.75 seconds that may occur in broadcasting a message from the host to a workstation, and the .775 seconds that could occur in transmitting a decline message from the presentation device to the host. (It should be noted that such time periods arise in the context of the current configuration of the proposed system. Development of alternative methods of processing could increase the total time delays.) In examining the potential length of time that a message could consume in transmission from the host to the presentation device and back again, the NASD determined that market makers would be at a significant time disadvantage in that a market maker could lose up to 33% of its already limited reaction period. In this context, then, the NASD believes that it is appropriate to recognize the inherent delays of computer-to-computer data exchange, and provide additional time to account for such delays.

firmness of Nasdaq market maker quotations and should alleviate any concerns regarding "backing away" questions. The NASD notes that the 15-second decline feature was criticized in the context of the N•Prove proposal.²³ The NASD believes that this proposal to develop a real-time automated surveillance capability should alleviate any concerns about the "decline" capability. The NASD will undertake strong disciplinary measures against any firm that displays a pattern and practice of improper order declines.

Order entry firms have two alternatives in entering NAqcess orders—they may direct the order to a particular market maker with whom they have established a direct order arrangement, or they may enter a non-directed order. In either circumstance, market orders and marketable limit orders will first pass over the limit order file to obtain a match before execution against a market maker. If an order is directed pursuant to a valid agreement between the order entry firm and the market maker, the market maker may not decline the order.

E. Opening Procedures. NAqcess will have special opening procedures that are consistent with the opportunities for order matching and price improvement over the dealer quotation provided intra-day by NAqcess.

NAqcess's operating hours are from 9:30 a.m. to 4:00 p.m. (EST). However, limit orders may be entered and stored in NAqcess from 4:00 p.m. to 6:00 p.m. and limit and market orders may be entered from 8:30 a.m. to 9:28 a.m. At 9:28 a.m., no further orders for opening purposes will be accepted.²⁴ At 9:30 a.m., Nasdaq will rank all limit orders stored as of 9:28 a.m. according to price and time of entry. To the extent orders are available, the system will then match the best-priced sell limit orders against the best-priced buy limit orders in the file that are within the best dealer bid and offer as determined at 9:30 a.m. When all available limit order matches are effected, any remaining limit orders within the inside dealer quote at 9:30 a.m. will be matched against market orders stored as of 9:28 a.m. and will be executed at such limit order prices. Any remaining orders will be subject to the normal intra-day, order distribution and execution procedures. It should be noted that this opening procedure will not create a single, unitary price for all orders in NAqcess. The individual

²² While the total time period between order entry and Nasdaq receipt of the decline is 20 seconds, the system has been designed to provide market makers with a full 15-second period in which to react to an order. The rule itself references a 15-second period in which the market maker must react. Five seconds of the 20-second period is designed to accommodate communications between Nasdaq

²³ See Securities Exchange Act Release No. 35275 (Jan. 25, 1995), 60 FR 6327 (Feb. 1, 1995).

²⁴ Orders entered from 9:28 a.m. to 9:30 a.m. will be stored and handled after the opening in line with ordinary matching and handling procedures described above.

prices of each match will be reported. Thus, assuming the dealer quotation is 20–20½, if the file contains two limit orders to buy at 20⅛, each for 1,000 shares, and there are also three 1,000 share limit orders to sell at 20⅛, two 1,000 share limit orders to sell at 20¼, and 4,000 shares to buy at the market, the system will execute as follows: the first two in time priority of the three 1,000 shares sell limit orders at 20⅛ will be matched against the two 20⅛ 1,000 share buy limit orders. The first 3,000 shares to buy at the market will be matched against the remaining limit orders to sell, with the first market order in time receiving an execution of 20⅛ and two 1,000 share market orders next in time receiving executions of 20¼. The remaining 1,000 share market order will be executed against the dealer quote according to the normal post-opening execution algorithm.

3. Rules of Fair Practice

The NASD is also proposing in conjunction with NAqcess three major changes to the Rules of Fair Practice. Under the proposed new rule and Interpretations, the treatment of limit orders will be significantly changed to promote price protection of such orders throughout The Nasdaq Stock Market. These proposed rule changes provide greatly enhanced limit order treatment over current practices. Together with existing limit order protections already in place (*i.e.*, the so-called “Manning” rule), the new proposals provide investors placing limit orders with significantly enhanced protections against limit order trade-throughs throughout The Nasdaq Stock Market.

A. Customer Order Handling. The NASD is proposing a new Interpretation under Article III, Section 1 of the Rules of Fair Practice. Under the proposal, if a customer requests that his or her order be entered into NAqcess, the member firm must do so. While the Interpretation permits a firm to charge for such services and to recommend the use of its own execution system, the member is not permitted to discriminate against customers that choose NAqcess over an internal system by imposing unfair commissions or charges. The proposed Interpretation covers both market and limit orders.

B. Price Protection. The NASD is also proposing a new rule in the Rules of Fair Practice that would prohibit a member firm, whether acting as a principal or as an agent, from executing any order at a price inferior to any limit orders that the firm is able to see in the

NAqcess limit order file.²⁵ An inferior price means an execution price that is lower than a buy limit order or higher than a sell limit order that a member firm is able to see in the NAqcess limit order file. This prohibition means that limit orders in the NAqcess file will not be traded through elsewhere in Nasdaq in most circumstances. A member firm's activity with respect to protecting NAqcess limit orders must be consistent with its best execution obligations to its own customers. When a firm acts as principal in filling a NAqcess limit order when it is in possession of an executable customer market order on the other side of the market, it should pass on the benefit of the NAqcess trade to the customer order. If the firm in receipt of the market order is acting as agent for its own customer's order, its best execution obligation would mean that it should select the appropriate market for execution, which could be NAqcess.

The price protection obligation is related to the ability of the firm to view the orders in the limit order file. Thus, under the proposal's current configuration, limit orders at the top of the file and included in the inside market calculation must be protected by all member firms. Under NAqcess system rules, limit orders ranked below the top of the file are viewable only by market makers in the particular security. Accordingly, market makers in a particular security would be obligated to protect all limit orders in that security in the NAqcess file from inferior executions that they may engage in.²⁶ Thus, if a market maker in a security sought to execute a 1,000 share trade at 20, when the NAqcess file displayed limit orders to buy at 20⅛ and 20¼, the market maker would be required to

either execute the limit orders first or contemporaneously, depending on the size of the limit orders in NAqcess.²⁷

The NASD believes it important to explain for the purposes of the price protection rule and the Interpretation regarding equivalent price protection for limit orders held outside of NAqcess, that the protectible price that generates a firm's obligation to provide price protection is the price reported for last sale reporting purposes. Some confusion has occurred regarding limit orders trading at an “inferior price,” especially in the context of internal sales credits. If the execution price reported via ACT for Schedule D transaction reporting purposes includes an internal sales credit that will be provided to a sales representative at the firm, the price that triggers the member firm's obligation to protect a limit order is the reported price. The internal sales credit included in the reported price has no effect on the obligation to protect the NAqcess limit order.²⁸

C. Equivalent Price Protection. As noted earlier, the NASD, to encourage competition and to enhance the liquidity of The Nasdaq Stock Market, has determined that market makers should continue to be permitted to operate their own internal execution systems and to handle limit orders outside of NAqcess. However, the NASD also believes it is important to provide limit orders held outside of NAqcess with price protection substantially equivalent to that which NAqcess orders would have. Accordingly, the NASD has proposed an Interpretation to Article III, Section 1 of the Rules of Fair Practice

²⁷ The NASD will interpret the price protection rule to not apply to member firms that operate passively-priced crossing systems, such as POSIT and Instinet's Crossing Network. Generally speaking, such systems execute prices at the dealer quotation spread midpoint and would not likely trade through a NAqcess order. Members that believe that they operate systems that could qualify for this exemption should submit a request for exemption to the NASD.

The proposed rule would apply, however, to ordinary broker-dealer trading systems such as Instinet's regular trading session. Because many such trades could occur at prices that could be inferior to limit orders in NAqcess, the NASD believes it appropriate that such NASD member firms should protect NAqcess customer limit orders as would any other registered broker-dealer member firm. Orders placed in SelectNet that trade through NAqcess are also subject to the price protection rule.

²⁸ See NASD Special Notices To Members 95–43 (July 27, 1995) and 95–67 (Mar. 21, 1995) for a more detailed discussion of the proper means for protecting customer limit orders when firms are dealing at net prices. The same concepts apply in the context of protecting system limit orders.

²⁵ It should be noted that placement of a customer limit order in the NAqcess file does not relieve a member firm of its obligation under the Limit Order Protection Interpretation of Article III, Section 1 of the Rules of Fair Practice that prohibits a member firm from trading ahead of a customer limit order it has been entrusted with. Under the so-called “Manning” Interpretation, if a member firm holding a customer limit order, whether from its own customer or as a result of a member-to-member order, places that order into NAqcess, the member firm is nevertheless prohibited from trading at the same price or at an inferior price to the customer order. Thus, while the newly proposed price protection rules speak in terms of protecting NAqcess orders from inferior priced transactions, if the NAqcess order is the firm's customer's order or a member-to-member order it placed in NAqcess, the firm may not trade at the same price without protecting that order.

²⁶ In today's environment, market makers are involved in approximately 83% of all Nasdaq trades. Consequently, it is likely that in a large majority of trades when NAqcess is operational, a market maker will be involved, and thus, orders away from the top of the file typically will be protected as well as the top of the file.

that provides substance to the term equivalent price protection.²⁹

First, a member firm holding a protectible customer limit order³⁰ outside of NAqcess must provide such order with print protection, if any transaction at a price inferior to the customer limit order occurs.³¹ Thus, any firm holding a protectible customer limit order is required to contemporaneously execute, up to the size of the reported transaction, the customer limit order at the limit order price if an inferior-priced execution is reported in that security.

“Contemporaneously” means within approximately 60 seconds of the trade report. For example, firms A and B each hold 1,000 share customer limit orders to buy priced at 20⅞. A 1,000 share trade is reported at 20. Both firms A and B are obligated to execute their limit orders at 20⅞ within 60 seconds of the trade report. If the triggering trade report had been 500 shares at 20, each firm owed its customers executions of at least 500 shares at 20⅞.

Next, if the firm holds a protectible customer limit order at a price that would match a limit order in the NAqcess file, the firm must either execute its limit order or send its limit order to NAqcess for matching. “Matching” means that the NAqcess limit order is the same price or lower than the firm’s customer’s limit order to buy or higher than the limit order to sell.

The same matching would be required if the firm holds offsetting limit orders within its own file. If the firm holds a limit order to sell at 20¼ and accepts

a limit order to buy at 20¼ or higher, the firm must execute the two orders against each other. Finally, if the firm holds a limit order that is priced equal to or better than the inside market in Nasdaq, and if the firm accepts a customer market order for automated execution at the inside market, the firm must first match the market order against the limit order before it can execute the market order for its own account.

4. NAqcess Proposal—Consistent With Securities Exchange Act

The proposed NAqcess system and the accompanying proposed rule changes in the Rules of Fair Practice propose significant structural changes in The Nasdaq Stock Market that greatly benefit investors in their handling of limit orders, price improvement over the dealer quotation, and rapid execution of orders. It is important to note that no previous proposal for a Nasdaq order handling and execution system has been so interrelated with such significant changes to rules that provide price protection across the Nasdaq market. The two developments—a new system with advanced order matching features and greater transparency along with the dramatic changes to price protection of orders in and outside the system—must be considered as a part of a fully integrated approach to the handling of retail customer orders. Together, they permit retail investors greater opportunity to participate directly in the market through the use of limit orders and substantially increase their ability to receive executions between the best dealer bid and offer. Further, the NASD believes that the approach to changes in The Nasdaq Stock Market proposed in this rule filing helps to guarantee investor protection and fairness to all market participants, while still allowing the market makers to operate in a competitive dealer market. The enhanced price discovery features, the transparency of limit orders, and the interaction of limit orders and market orders should add to the liquidity, efficiency and immediacy of Nasdaq’s competing dealer market structure.

Accordingly, the NASD believes that the proposed rule change is consistent with Sections 15A(b)(6), 15A(b)(9), 15A(b)(11) and 11A(a)(1)(C) of the Act. Section 15A(b)(6) requires that the rules of a national securities association be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing

information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system and in general to protect investors and the public interest. Section 15A(b)(9) requires that rules of an Association not impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. Section 15A(b)(11) requires the NASD to formulate rules governing the quality of fair and informative quotations. Section 11A(a)(1)(C) finds that it is in the public interest to, among other things, assure economically efficient execution of securities transactions. The fundamental purpose of NAqcess is to assist investors in achieving prompt, efficient executions of their small orders and to provide an opportunity for price improvement over the dealer quotation within an automated execution environment. The integrity and efficiency of Nasdaq for public investors and market-making participants is critical and the NASD believes that NAqcess will provide benefits to both constituencies. The design of NAqcess is not anti-competitive as it treats all non-directed orders uniformly; to the extent that directed orders are distinguished, by entering into such arrangements with known customers, market makers effectively waive the protections offered by the system.

The new proposals are also fully consistent with the significant national market system objectives contained in Section 11A of the Act. The NAqcess national limit order facility would advance these objectives by offering efficient execution of investors’ small orders, by maintaining market maker participation through the automated delivery of orders with the ability to reject those orders if trades have already occurred, and by offering the opportunity for price improvement over the dealer quotation to orders both inside and outside of the NAqcess system. The system’s functionality will more accurately reflect market makers’ affirmative obligations to provide liquidity to the market, without depriving market makers of legitimate exceptions from the firmness requirements contained in Rule 11Ac1–1. In sum, the NASD believes that the entire proposal set forth herein significantly advances the goals of investor protection and greater access to The Nasdaq Stock Market.

(B) Self-Regulatory Organization’s Statement on Burden on Competition

The NASD does not believe that the proposed rule change will result in any

²⁹ The equivalent price protection Interpretation would not apply to continuous trading systems, such as that operated by Instinet, because such customers are generally sophisticated and have deliberately opted to trade in an alternative trading system. Such customers are institutions and broker-dealers that seek other advantages in trading in these alternative systems. Because of their sophistication, these customers believe they do not need the broker-dealer operating the system to provide equivalent price protection. Accordingly, the NASD will provide an exemption from the Interpretation to brokers operating such systems if they seek an exemption.

³⁰ A “protectible” order is a customer order of a size that would be eligible for entry into NAqcess. Accordingly, the Interpretation requirements do not extend to customer limit orders that are larger than 1,000 shares (or larger than 3,000 shares for Nasdaq 100 securities).

³¹ A member’s obligation to provide print protection will not be triggered by a trade report that has a special modifier, such as .SLD or otherwise, appended to it. Because such modifiers indicate the trade being reported is out of sequence or was executed under special conditions, such trade reports should not require an execution of a limit order. The NASD will closely monitor member’s usage of special trade reporting modifiers to ensure that firms do not use such modifiers as a vehicle to avoid print protection obligations under the new rule.

burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act, as amended.

(C) Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received from Members, Participants, or Others

Written comments are discussed above.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the Federal Register or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

A. By order approve such proposed rule change, or

B. Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing. In particular, the Commission requests general comments concerning the NASD's proposal and whether it is consistent with the Act. In addition, the Commission invites interested persons to address the following specific issues:

(1) The Commission recently proposed rules concerning order execution obligations.³² Among other things, the Commission's proposal generally would: (a) require Nasdaq market makers to display in their quotations (1) customer limit orders priced better than the market maker's current quotation, or (2) the size of a customer limit order that equals the current inside bid or offer; and (b) require that market makers offer market orders for certain securities an opportunity for price improvement over the current national best bid or offer. The Commission seeks comment on whether the NASD's proposal is consistent with the Commission's proposal and with the goals set forth in the Commission's release;

(2) The NASD's proposal would eliminate SOES and does not include the immediate automatic execution feature for market orders currently available in SOES. In light of historical concern about the accessibility of

market maker quotations,³³ the Commission seeks comment on the possible effects this change could have on the Nasdaq market and retail investors;

(3) The SOES Rules provide a market maker a five-minute period within which to update its quotation or reestablish its exposure limit after its exposure limit has been exhausted. Further, the current operation of SOES allows for a market maker to elect to use an automated quotation update feature which, generally, changes, by a prespecified increment, the market maker's quotation after its SOES exposure limit is exhausted. The NASD's NAQcess proposal would continue both of these features. In light of the automated quotation update feature and the lack of immediate automatic execution that would occur under NAQcess, the Commission seeks comment on whether there is a continuing need for the five-minute grace period;

(4) The NASD proposes to modify the methodology for calculating the inside Nasdaq market to include both dealer quotations and NAQcess limit orders. If a NAQcess limit order equals or improves the best market maker quotation, it will be included in the Nasdaq inside market and disseminated as the inside quotation, including the aggregate size of all orders at that price. Further, the NASD proposes to use a unique indicator to denote when the inside market is represented by a NAQcess limit order, rather than a dealer or UTP exchange quotation. The Commission requests comment on whether using an indicator for a NAQcess limit order is appropriate;

(5) As discussed above in the NASD's proposal, priority of NAQcess executions when the best bid or offer consists of both a market maker quotation and a NAQcess limit order would be based on time priority. For example, if the inside bid consists of two market makers' bids and a NAQcess limit order, and the market makers' bids were received before the NAQcess limit order, the first two incoming market orders would be delivered to the market makers and subject to potential rejection within 20 seconds, rather than delivered to the limit order for immediate automatic execution. The Commission seeks comment on whether limit orders priced equal to the inside dealer quote should be given priority over market maker quotations, the implications of such a rule, and the relative costs and benefits of such a rule, particularly

given that orders against market makers are delayed for 20 seconds but are executed immediately if matched with NAQcess limit orders;

(6) The proposal would limit the maximum order size for market orders to 1,000 shares (depending on certain trading characteristics of the security). For limit orders, the maximum order size would be 1,000 shares for all securities, except for limit orders in Nasdaq 100 securities for which the maximum limit order size would be 3,000 shares. The Commission seeks comment on the appropriate maximum order size for NAQcess limit orders, and whether different thresholds should be established for different Nasdaq securities. Further, the Commission notes that the Commission's recent proposal concerning order execution obligations generally would require display of limit orders of 10,000 shares or less; the Commission requests comment on the interaction between this aspect of the Commission's proposal and the NASD's proposal;

(7) The proposed NAQcess rules would limit access to the system to agency orders entered by member firms on behalf of public customers. Generally, the proposal would exclude: (a) accounts of persons associated with any member firm, and (b) the immediate family of any person associated with a member. The Commission is interested in commenters' views on the appropriateness of these exclusions. Specifically, the Commission requests comment on: (a) whether proprietary market and limit orders should be allowed or, alternatively, whether only proprietary limit orders should be allowed; (b) whether orders from the immediate family of members should be permitted; and (c) whether orders from non-member broker-dealers (e.g., options market makers and UTP specialists) to member broker-dealers should be permitted;

(8) Under the proposal, any firm holding a protectible customer limit order would be required to execute contemporaneously (i.e., within 60 seconds of the trade report), up to the size of the reported transaction, the customer limit order at the limit order price if an inferior-priced execution is reported in that security. The Commission requests comment on the appropriateness of this time period;

(9) The NASD's proposal includes Rules of Fair Practice that generally would prohibit a member from trading at a price inferior to a viewable NAQcess limit order and require that orders held outside of NAQcess be provided price protection substantially equivalent to that which NAQcess orders would have.

³² Securities Exchange Act Release No. 36310 (Sept. 29, 1995), 60 FR 52791 (Oct. 10, 1995).

³³ Division of Market Regulation, SEC, The October 1987 Market Break 9-19 (1988).

Under the proposal, for each security, only market makers in that security will be able to see the full limit order file; all other members are limited to viewing the top of the file. The Commission requests comment on whether there should be an exception to the NASD's price protection rule for block trades. In addition, the Commission requests comment on whether full file display of the NAQcess limit order file should be broadened and, if so, to what extent; and

(10) The Commission requests comment on whether the NASD's proposal, and in particular the amendments to the Rules of Fair Practice, would result in any burdens on competition, and if so, the extent of such burdens and whether they are necessary and appropriate in furtherance of the Act.

Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, N.W., Washington, D.C. 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. § 552, will be available for inspection and copying in the Commission's Public Reference Room. Copies of the filing will also be available for inspection and copying at the principal office of the NASD. All submissions should refer to the file number SR-NASD-95-42 and should be submitted by January 16, 1996.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.³⁴

Margaret H. McFarland,
Secretary.

Exhibit A—Rules of Operation and Procedures for the NAQcess System

I. Definitions

The terms used in this Section shall have the same meaning as those defined in the Association's By-Laws and Rules of Fair Practice, unless otherwise specified.

A. The term "NAQcess" shall mean the limit order and market order delivery and execution system owned and operated by The Nasdaq Stock Market, Inc. (a wholly owned subsidiary

of the National Association of Securities Dealers, Inc.).

B. The term "NAQcess participant" shall mean either a market maker or order entry firm registered for participation in NAQcess.

C. The term "NAQcess eligible security" shall mean any Nasdaq National Market or Nasdaq SmallCap equity security.

D. The term "open quote" shall mean a market maker's quotation price and size (up to its designated exposure limit) in an eligible security against which orders may be executed through the NAQcess system during normal market hours, as specified by the NASD. For the purposes of these Rules, a market maker has a "closed quote" when its exposure limit in NAQcess has been exhausted or it has been deemed "closed" pursuant to Section IV. A. 9 below.

E. The term "NAQcess market maker" shall mean a member of the Association that is registered as a Nasdaq market maker pursuant to the requirements of Schedule D to the NASD By-Laws and as a market maker in one or more NAQcess eligible securities.

F. The term "NAQcess order entry firm" shall mean a member of the Association that is registered as an order entry firm for participating in NAQcess which permits the firm to enter agency orders of limited size for delivery to and execution against NAQcess market makers and customer limit orders in NAQcess that are included in the inside market.

G. The term "agency order" shall mean an order from a public customer that is entered by the NAQcess order entry firm or NAQcess market maker on an agency basis.

An order will not be considered an agency order if it is for any account of a person associated with any member firm or any account controlled by such an associated person. An order will not be considered an agency order if it is for any account of a member of the "immediate family" (as that term is defined in the NASD Free-Riding and Withholding Interpretation, Article III, Section 1 of the Rules of Fair Practice) of an associated person who has physical access to a terminal capable of entering orders into NAQcess.

H. The term "directed order" shall mean an order entered into NAQcess and directed to a particular NAQcess market maker or an order entered by a NAQcess market maker that is self-directed. Each market maker has the ability to select order entry firms from which it will accept directed orders.

I. The term "non-directed order" shall mean an order entered into NAQcess and not directed to any particular

market maker, or a directed order that has been directed to a market maker that has not identified the order entry firm as one from which it will accept directed orders, or a directed order sent to a firm that is not registered as a market maker in that security.

J. The term "limit order" shall mean an order entered into NAQcess that is a priced order.

K. The term "marketable limit order" shall mean a limit order that, at the time it is entered into NAQcess, if it is a limit order to buy, is priced at the current inside offer or higher, or if it is a limit order to sell, is priced at the inside bid or lower.

L. The term "executable limit order" shall mean a limit order that, at the time a limit order, market order, or marketable limit order on the opposite side of the market is entered, is either included in the inside market or is equal in price to the inside market and has time priority over other limit orders or dealer quotations included in the inside market.

M. The term "marker order" shall mean a limit order for a market maker's principal account that is a part of a contemporaneously executed transaction that the firm is engaged in for the benefit of one or more customers.

N. The term "takeout order" shall mean an order entered by an NASD member firm, acting as principal or as agent, that executes against NAQcess limit orders viewable by that firm.

O. The term "inside market" shall mean the best dealer bid, UTP exchange bid, or NAQcess limit order(s) to buy and the best dealer offer, UTP exchange offer or NAQcess limit order(s) to sell, as the case may be, displayed by Nasdaq.

P. The term "UTP exchange" shall mean any registered national securities exchange that has unlisted trading privileges in Nasdaq securities.

Q. The term "matched or crossed file" shall mean the entry of: (1) a bid quotation by a market maker equal to or greater than a limit order to sell resident in the NAQcess file in the same security; or (2) an offer quotation by a market maker equal to or less than a limit order to buy resident in the NAQcess file in the same security.

R. The term "maximum market order size" shall mean the maximum size of individual market orders for a NAQcess eligible security that may be entered into or executed through NAQcess. The maximum market order size for each security shall be advertised in the system and published from time to time by the Association. In establishing the maximum market order size for each Nasdaq National Market security, the Association generally will give

³⁴ 17 CFR 200.30-3(a)(12).

consideration to the average daily non-block volume, bid price, and number of market makers for each security. Maximum market order size for Nasdaq National Market securities shall be 200, 500 or 1,000 shares, depending upon the trading characteristics of the securities.¹ These sizes may be adjusted on an issue by issue basis, depending upon trading characteristics of the issue and other relevant factors as determined by the Association. Maximum market order size for Nasdaq SmallCap securities shall be 500 shares.

S. The term "maximum limit order size" shall mean the maximum size of a limit order for a security that may be entered into or matched through NAQcess. The maximum limit order size for Nasdaq National Market securities shall be 1,000 shares for each tier of Nasdaq National Market securities, except for the securities that comprise the Nasdaq 100 Index,² which shall have a maximum limit order size of 3,000 shares. Maximum limit order size for Nasdaq SmallCap securities shall be 1,000 shares.

T. The term "exposure limit" shall mean the number of shares of a NAQcess eligible security specified by a NAQcess market maker that it is willing to have executed for its account by orders entered into NAQcess on either side of the market.

U. The term "minimum exposure limit" for a security shall mean an exposure limit equal to the maximum market order size for that security.

V. The term "automated quotation update facility" shall mean the facility in the NAQcess system that allows the system to automatically refresh a market maker's quotation in any security that the market maker designates when the market maker's exposure limit has been exhausted. The facility will update: (1) either the bid or the offer side of the

quote using a quotation interval designated by the market maker, depending upon the side of the market on which the execution has occurred and refresh the market maker's exposure limit; or (2) close the market maker's quote for five minutes, within which time the market maker shall update its quote or be placed in a suspended state for 20 days.

W. The term "Automated Confirmation Transaction service" ("ACT"), for purposes of the NAQcess rules, shall mean the automated system owned and operated by The Nasdaq Stock Market, Inc. which accommodates trade reporting of transactions executed through NAQcess and submits locked-in trades to clearing.

II. NAQcess Participant Registration

A. All members participating in NAQcess shall register and be authorized as NAQcess market makers and/or order entry firms. Registration as a NAQcess participant shall be conditioned upon the member's initial and continuing compliance with the following requirements: (1) membership in a clearing agency registered with the Securities and Exchange Commission which maintains facilities through which NAQcess compared trades may be settled; or entry into a correspondent clearing arrangement with another member that clears trades through such clearing agency; (2) registration as a market maker (if applicable) in Nasdaq pursuant to Schedule D of the NASD By-Laws and compliance with all applicable rules and operating procedures of the Association and the Securities and Exchange Commission; (3) maintenance of the physical security of the equipment located on the premises of the member to prevent the unauthorized entry of orders or other data into NAQcess or Nasdaq; and (4) acceptance and settlement of each trade for which it is responsible that is executed through the facilities of the NAQcess service, or if settlement is to be made through another clearing member, guarantee of the acceptance and settlement of such identified NAQcess trades by the clearing member on the regularly scheduled settlement date.

B. Upon effectiveness of the member's registration to participate in NAQcess, participants may commence activity within NAQcess for entry and/or execution of orders, as applicable, and their obligations as established in this rule will commence.

C. Pursuant to Schedule D to the NASD By-Laws, participation as a NAQcess market maker is required for any Nasdaq market maker registered to make a market in a Nasdaq National

Market security. A market maker in a Nasdaq SmallCap security may withdraw from and reenter NAQcess at any time, and without limitations, during the operating hours of the service.

D. Each NAQcess participant shall be under a continuing obligation to inform the Association of noncompliance with any of the registration requirements set forth above.

III. Operating Hours of NAQcess

The operating hours of NAQcess will be the normal market hours specified for The Nasdaq Stock Market.

IV. Participant Obligations in NAQcess

A. Market Makers

1. A NAQcess market maker shall commence participation in NAQcess by initially contacting the Market Operation Center to obtain authorization for market making in particular Nasdaq securities and identifying those terminals on which the NAQcess trade information is to be displayed. Thereafter, on-line registration on a security-by-security basis is permissible, consistent with the requirements of Schedule D to the NASD By-Laws.

2. Participation as a NAQcess market maker obligates the firm, upon presentation of a market order or marketable limit order through the service, to execute such order as provided in Section V. A. 5. below. NAQcess market makers are not permitted to decline orders directed to the firm pursuant to a directed order arrangement acknowledged by the market maker. The system will transmit to the market maker on the Nasdaq Workstation screen and printer, if requested, or through a computer interface, as applicable, an execution report generated following each execution.

3. For each NAQcess eligible security in which a market maker is registered, the market maker shall enter into NAQcess its exposure limit. For a Nasdaq National Market security, that limit shall be any amount equal to or larger than the minimum exposure limit for the particular security. If no exposure limit is entered for a Nasdaq National Market security, the firm's exposure limit will be either the default size selected by the particular market maker or the minimum exposure limit. "Default size" shall mean an exposure limit greater than the minimum exposure limit that may be selected by a market maker for individual securities or for all securities in which it makes a market.

4. A NAQcess market maker may elect to use the automated quotation update

¹ The applicable maximum market order size for each Nasdaq National Market security is determined generally by the following criteria:

(i) a 1,000 share maximum market order size shall apply to Nasdaq National Market securities with an average daily non-block volume of 6,000 shares or more a day, a bid price of less than or equal to \$100, and three or more market makers;

(ii) a 500 share maximum market order size shall apply to Nasdaq National Market securities with an average daily non-block volume of 2,000 shares or more a day, a bid price of less than or equal to \$150, and two or more market makers; and

(iii) a 200 share maximum market order size shall apply to Nasdaq National Market securities with an average daily non-block volume of less than 2,000 shares a day, a bid price of less than or equal to \$250, and that have two or more market makers.

² The Nasdaq 100 Index is an index comprised of many of the largest capitalized issues quoted in the Nasdaq National Market. The securities that make up the Nasdaq 100 are changed from time to time and The Nasdaq Stock Market publishes notice of such changes as they occur.

facility in one or more securities in which it is registered. The facility will update the market maker's quotation automatically by a quotation interval designated by the market maker, once its exposure limit in the security has been exhausted. The facility will update the market maker's quotation in either the bid or the offer side of the market by the interval designated and will reestablish the market maker's displayed size and either the default size or the minimum exposure limit; or the facility will close the market maker quote for five minutes.

5. Matched or crossed file. If a market maker's quotation change matches or crosses a limit order residing in the NAQcess limit order file, the system will automatically provide a notification to the market maker that informs the market maker of its obligation to protect all limit orders residing in the NAQcess file that would be affected by the quotation change. If the market maker enters the matching or crossing quotation change after this notification, limit orders in the file for the particular security will be automatically executed against the matching or crossing market maker, provided however, that if the number of shares in the limit order file that would be matched or crossed is greater than five times the maximum market order size for that particular security, or if the quotation change matches and crosses multiple price levels, the quotation change will be rejected. To effect such quotation change, the market maker first must manually enter a takeout order for the affected orders in the file prior to reentering its quotation update.

6. The market maker may terminate its obligation by keyboard withdrawal from NAQcess at any time. However, the market maker has the specific obligation to monitor its status in NAQcess to assure that a withdrawal has in fact occurred. Except as otherwise permitted by Section 70 of the Uniform Practice Code regarding the Association's authority to declare clearly erroneous transactions void, ("UPC Section 70"), any transaction occurring prior to the effectiveness of the withdrawal may remain the responsibility of the market maker. In the case of a Nasdaq SmallCap security, a market maker whose exposure limit is exhausted will be deemed to have withdrawn from NAQcess and may reenter at any time. In the case of a Nasdaq National Market security, a market maker whose exposure limit is exhausted will have a closed quote in Nasdaq and NAQcess and will be permitted a standard grace period of five minutes within which to take action to restore its exposure limit,

if the market maker has not authorized use of the automated quotation update facility. A market maker that fails to renew its exposure limit in a Nasdaq National Market security within the allotted time will be deemed to have withdrawn as a market maker. Except as provided in subsection 7 below, a market maker that withdraws from a Nasdaq National Market security may not re-register in NAQcess as a market maker in that security for twenty (20) business days.

7. Notwithstanding the provisions of subsection 6 above, (i) a market maker that obtains an excused withdrawal pursuant to Part V of Schedule D to the NASD By-Laws prior to withdrawing from NAQcess may reenter NAQcess according to the conditions of its withdrawal; and (ii) a market maker that fails to maintain a clearing arrangement with a registered clearing agency or with a member of such an agency, and is thereby withdrawn from participation in ACT and NAQcess for Nasdaq National Market securities, may reenter NAQcess after a clearing arrangement has been reestablished and the market maker has complied with ACT participant requirements, provided however, that if the Association finds that the ACT market maker's failure to maintain a clearing arrangement is voluntary, the withdrawal of quotations will be considered voluntary and unexcused pursuant to Schedule D and these rules.

8. In the event that a malfunction in the market maker's equipment occurs rendering on-line communications with the NAQcess service inoperable, the NAQcess market maker is obligated to immediately contact the Market Operations Center by telephone to request a closed quote status from NAQcess. For Nasdaq securities, such request must be made pursuant to the requirements of Part V, Schedule D to the NASD By-Laws. If the closed quote status is granted, Market Operations personnel will enter such status notification into NAQcess from a supervisory terminal. Such manual intervention, however, will take a certain period of time for completion and, unless otherwise permitted by the Association pursuant to its authority under UPC Section 70, the NAQcess market maker may continue to be obligated for any transaction executed prior to the effectiveness of its closed quote.

B. Order Entry

1. Only market and limit agency orders may be entered in NAQcess by the NAQcess order entry firm through either its Nasdaq Workstation or computer interface. The system will

transmit to the order entry firm on the Nasdaq Workstation screen and printer, if requested, or through a computer interface, as applicable, an execution report generated following each execution. NAQcess market makers may enter limit agency orders in NAQcess for any NAQcess eligible security, but may not enter agency market orders or marketable limit orders in securities in which they make markets, unless such orders are self-directed. As a limited exception to the prohibition of the entry of proprietary orders into NAQcess, NAQcess market makers may place marker orders into NAQcess. The benefit of any such marker order execution must be passed immediately to one or more customer limit orders held by the firm placing the marker order. Marker orders may not be placed with respect to customer limit orders held by the firm that exceed the maximum limit order size permitted by these rules.

2. NAQcess will accept both market and limit agency orders of appropriate size for execution. Agency orders may be directed to a specific NAQcess market maker, self-directed by the NAQcess market maker, or may be non-directed, thereby resulting in execution against the next available NAQcess market maker. If an order is directed to a market maker by an order entry firm from which it has not agreed to accept direct orders, the order will be executed on a non-directed basis.

3. Only agency orders no larger than the maximum market and limit order sizes may be entered by a NAQcess order entry firm into NAQcess for execution against an NAQcess market maker or against an executable limit order. Orders in excess of the maximum order sizes may not be divided into smaller parts for purposes of meeting the size requirements for orders entered into NAQcess. All orders based on a single investment decision that are entered by a NAQcess order entry firm for accounts under the control of associated persons or public customers, whether acting alone or in concert with other associated persons or public customers, shall be deemed to constitute a single order and shall be aggregated for determining compliance with the maximum order size limits. Orders entered by the NAQcess order entry firm within any five-minute period in accounts controlled by associated persons or public customers, acting alone or in concert with other associated persons or public customers, shall be presumed to be based on a single investment decision. An associated person or customer shall be deemed to control an account if the account is his or her personal account or an account in

which he or she has a beneficial interest; the person exercises discretion over the account; the person has been granted a power of attorney over the account; or the account is the account of an immediate family member as that term is defined in the Board of Governors Interpretation on Free-Riding and Withholding, Article III, Section 1 of the NASD Rules of Fair Practice.

4. No order will be considered an agency order from a public customer if it is for any account of a person associated with any member firm or any account controlled by such an associated person. No order will be considered an agency order from a public customer if it is for any account of a member of the "immediate family" (as that term is defined in the NASD Free-Riding and Withholding Interpretation, Article III, Section 1 of the Rules of Fair Practice) of an associated person who has physical access to a terminal capable of entering orders into NAqcess.

5. No member or person associated with a member shall utilize NAqcess for the execution of agency orders in a SmallCap security in which the member is a Nasdaq market maker but is not a NAqcess market maker.

6. NAqcess will accept the following types of agency orders during normal market hours: (a) day orders; (b) good-till-canceled ("GTC"); and (c) good till date ("GTD").

V. Execution of NAqcess Orders

A. General Execution Procedures: Orders in Nasdaq equity securities entered into NAqcess may be directed or non-directed. Non-directed market orders and non-directed marketable limit orders will be processed according to the procedures established below. Non-directed odd-lot orders that are market orders or marketable limit orders will be automatically executed in NAqcess against the next available market maker at the inside market and execution reports will be delivered to the order entry firm and the market maker.

1. *Entry of Limit Orders:* Limit orders may be entered into NAqcess by order entry firms and by market makers up to the maximum limit order size allowed for a particular security. Limit orders priced away from the Nasdaq inside bid or offer (as the case may be) as well as limit orders consolidated in the inside market will be stored in the NAqcess limit order file. Limit orders in securities priced at \$10 or more shall be priced in increments of an eighth or more; limit orders in securities that are priced at under \$10 may be placed in increments of a sixteenth or less

depending upon the dealer quotation increments permitted.

2. *Display of NAqcess Limit Orders:* (a) *Consolidated Display of Limit Orders In Inside Market:* If a NAqcess limit order to buy or sell for 100 shares or more is better than the best dealer bid or offer, the limit order to buy or sell will be displayed in the Nasdaq inside market. Such display will contain the limit order price, size (which shall be aggregated if two or more limit orders are at the same best price) and an indicator to note that the inside market consists of a limit order rather than a market maker or UTP exchange quotation. If a NAqcess limit order of 100 shares or more is at the same price as the best dealer bid or offer, the size displayed in the inside market will be an aggregation of any same-priced limit orders and a single dealer quote at the best price.

(b) *Full Limit Order File Display:* All Nasdaq market makers in a particular security may request via Nasdaq Workstations a display of all limit orders in such security entered in the NAqcess limit order file. Such displays will be available on a query basis only to a registered market maker in a particular security.

3. *Execution of Limit Orders:* A limit order that matches or crosses a limit order on the opposite side of the market will be automatically executed against the matching or crossing order when such orders are at the inside market or better, and have priority over the dealer quotation. The priority rules for limit order interaction shall be that orders that are best in price shall be executed against each other first. If two or more orders are at the same price on the same side of the market, then the order that was received first in time shall be accorded priority over other orders at the same price. Limit orders that cross each other in price shall be executed at the price of the order that entered the file first. A limit order matches a limit order on the file when: the limit orders are consolidated in the inside market on Nasdaq; are on opposite sides of the market; and are equal in price. A limit order crosses a limit order on the file when: both limit orders are either consolidated in the inside market or better than the inside market; are on opposite sides of the market from each other; and the subsequent limit order is at a superior price to the existing limit order (i.e., the sell (buy) limit order is priced below (above) a limit order to buy (sell)). Execution of limit orders will occur up to the size of the initial limit order or the subsequent limit order, whichever is smaller, and without the participation of a market

maker. The unexecuted balance of a limit order is entered into the NAqcess file for subsequent matching, unless such balance is less than 100 shares, in which case the balance is automatically executed against the next available market maker, if equal to the inside quotation. If there is a limit order at the same price as the best dealer quotation (i.e., if a limit order to buy is the same as the best dealer bid, or a limit order to sell is the same as the best dealer offer), the order or quote that has time priority shall be matched against the incoming limit order.

4. *Takeouts of Limit Orders:* Any NASD member firm, acting as principal or as agent, may enter into NAqcess an order or orders that execute(s) any limit order(s) consolidated in the inside market or otherwise displayed in the NAqcess limit order file. Such orders shall be known as "takeout" orders. A takeout order may be for any size up to the aggregate amount of shares displayed in the NAqcess limit order file at a particular price. Takeout orders must be executed against limit orders on the opposite side of the market in order of price and time. A firm entering a takeout order for limit orders at multiple prices may enter a single takeout order at a price either at or above or below the NAqcess limit orders, as the case may be, and each limit order will be executed at each such price. Takeout orders do not reduce a firm's exposure limit.

5. *Entry and Execution of Market Orders:* (a) Market orders up to the maximum market order size for NAqcess eligible security may be entered into NAqcess. If at the time a market order is entered into NAqcess there is a limit order on the opposite side of the market that resides in the NAqcess limit order file and is reflected in the inside market as the best bid or offer, the incoming market order will be automatically executed against the limit order at the limit order price without the participation of a market maker. If a market order is not fully executed against the limit order file, the balance of such market order will be treated as any other market order as set forth in subparagraph (b) below, provided that if the balance of the market order is odd-lot size, the balance will be automatically executed against the next available market maker at the inside quotation. If there is a limit order consolidated in the inside market at the same price as a dealer bid or offer (i.e., if a limit order to buy is the same as the best dealer bid, or a limit order to sell is the same as the best dealer offer), the order or quote that has time priority

shall be matched against the incoming market order.

(b) If there is no limit order residing in NAqcess that has been consolidated in the inside market on the opposite side of the market from the market order, each market order will be assigned to a market maker at the inside market and will be executed against the next available market maker at the current inside market after a display period of 15-seconds. The market maker to which a market order is displayed may decline the market order within the 15-second period if the market maker has contemporaneously executed another transaction and is in the process of updating its quotation pursuant to SEC Rule 11Ac1-1. If a market order or a marketable limit order is declined by a market maker, the order is returned to the system for distribution to the next available market maker. If that market maker is at the same price level as the first market maker who declined the order, the second market maker has 15 seconds to react to the order. If the originally declined order is re-presented to a market maker at a price level different from its original presentation(s), the order is automatically executed at that price level without any market maker ability to decline.

(c) If the NAqcess limit order file does not have any executable limit orders at the time a directed market order is entered, directed market orders will be automatically executed against the directed order market maker without a 15-second decline capability. Directed limit orders that are not matched by incoming limit or market orders will be automatically executed against the directed order market maker when the inside market is changed to match the directed limit order price. Directed odd-lot orders (orders of less than 100 shares) that are market orders or marketable limit orders also will be automatically executed against the directed order market maker. Non-directed odd-lot orders that are market orders or marketable limit orders will be automatically executed against the next available market maker at the current inside market. An odd-lot limit orders that is not executable at time of entry will be stored and executed against the best dealer bid or offer, as the case may be, when such quotation reaches the limit order price.

6. Entry and Execution of A Marketable Limit Order: Marketable limit orders that meet the maximum market order size requirements will be accepted and treated as market orders. Marketable limit orders greater than the maximum market order size will be

returned to the order entry firm for handling outside of NAqcess.

7. NAqcess Opening Procedures: NAqcess will permit the entry of limit orders and market orders outside of normal market hours, except that market orders will not be accepted between 4:00 and 6:00 p.m. Orders entered at such times will not be executed but will be stored for matching and execution at the next market opening. NAqcess permits the entry of such orders between 4:01 p.m. to 6:00 p.m. and 8:00 a.m. to 9:28 a.m. (Orders entered from 9:28 to 9:30 will be stored and handled according to normal market procedures after the opening procedures are concluded.)

Matching and execution at the NAqcess opening will occur according to the following procedures:

At 9:28 a.m., NAqcess will stop accepting orders for execution in the NAqcess file for opening purposes. At 9:30 a.m., NAqcess will commence execution procedures for opening orders in NAqcess by first ranking and matching limit orders in NAqcess in sequence of the highest price buy order against the lowest price sell order. When all available limit orders are matched and executed, market orders on a time priority basis will be matched and executed against any remaining limit orders in the NAqcess file within the inside quotation at the limit order price(s). Any remaining market limit orders will be stored in the NAqcess file. Any remaining orders will be subject to normal order execution processes.

VI. Clearance and Settlement

All transactions executed in NAqcess shall be transmitted to the National Securities Clearing Corporation to be cleared and settled through a registered clearing agency using a continuous net settlement system.

VII. Obligation to Honor System Trades

If a trade reported by a NAqcess participant, or clearing member acting on its behalf, is reported by NAqcess to clearing at the close of any trading day, or shown by the activity reports generated by NAqcess as constituting a side of a NAqcess trade, such NAqcess participant, or clearing member acting on its behalf, shall honor such trade on the scheduled settlement date.

VIII. Compliance With Procedures and Rules

Failure of a NAqcess participant or person associated with a NAqcess participant to comply with any of the rules or requirements of NAqcess may be considered conduct inconsistent with

high standards of commercial honor and just and equitable principles of trade, in violation of Article III, Section 1 of the Rules of Fair Practice. No member shall effect a NAqcess transaction for the account of a customer, or for its own account, indirectly or through the offices of a third party, for the purpose of avoiding the application of these rules. Members are precluded from doing indirectly what is directly prohibited by these rules. All entries in NAqcess shall be made in accordance with the procedures and requirements set forth in the NAqcess User Guide. Failure by a NAqcess participant to comply with any of the rules or requirements applicable to NAqcess shall subject such NAqcess participant to censure, fine, suspension or revocation of its registration as a NAqcess market maker and/or order entry firm or any other fitting penalty under the Rules of Fair Practice of the Association.

IX. Termination of NAqcess Service

The Association may, upon notice, terminate NAqcess service to a participant in the event that a participant fails to abide by any of the rules or operating procedures of the NAqcess service or the Association, or fails to pay promptly for services rendered.

Exhibit B—Interpretations Related to Member Firm Responsibilities Regarding Orders in NAqcess

In its efforts to maximize the protection of investors and to enhance the quality of the marketplace, the NASD and The Nasdaq Stock Market, Inc. have developed a nationwide limit order protection, price improvement, and market order handling facility of The Nasdaq Stock Market. This nationwide facility is herein referred to as "NAqcess".

The NASD Board of Governors is issuing these Interpretations to the Rules of Fair Practice to provide: (1) Customers the right to have their orders entered and protected in NAqcess; and (2) member firm provision of equivalent protection for limit orders held in a member firm's proprietary limit order system. These Interpretations are based upon a member firm's obligation to provide best execution to customer orders under Article III, Section 1 of the Rules of Fair Practice and a member firm's obligations in dealing with customers as principal or agent to buy and sell at fair prices and charge reasonable commissions or service charges under Article III, Section 4 of the Rules of Fair Practice. Accordingly, it shall be deemed a violation of Article

III, Section 1 of the Rules of Fair Practice for a member or a person associated with a member to violate the following provisions:

1. Member Firm Obligation Regarding Investors' Directions on Order Handling

NAqcess will provide individual investors with significant opportunities to achieve limit order protection and price improvement. The NASD recognizes that member firms operating as market makers also operate trading systems which offer significant protection and execution opportunities for customer limit orders. Accordingly, nothing herein is intended to limit a member's ability to recommend use of its own or another member firm's proprietary system for handling limit and market orders where equivalent protection is afforded. In light of the significant benefits offered to customers by the NAqcess system, however, members must abide by the directions of its customers who request that the firm enter their orders in NAqcess.

Further, nothing in this Interpretation requires a member firm to accept any or all customer limit orders. Member firms accepting limit orders that are placed in NAqcess or otherwise may charge fair and reasonable commissions, commission equivalents, or service charges for such handling, provided that such commissions, commission equivalents, or service charges do not violate Article III, Section 4 of the Rules of Fair Practice. In no event, however, shall a member impose any fee or charge that effectively operates as a disincentive to the entry of orders in the nationwide facility and thereby interferes with the investor's ability to choose order handling alternatives.

2. Equivalent Protection for Orders Held Outside of NAqcess

As a further adjunct to a member firm's best execution obligations, the NASD Board of Governors has interpreted Article III, Section 1 of the Rules of Fair Practice to require member firms that do not enter customer limit orders into NAqcess, but hold such protectible orders in their own proprietary system, to provide such orders with price protection at least equivalent in substance to that which the order would have received had the order been entered into NAqcess. For the purposes of this Interpretation, a "protectible limit order" shall mean a limit order that meets the maximum limit-order size criteria as set forth in the Rules of Operation and Procedure for NAqcess at Section I.S. For the

purposes of this Interpretation, equivalent price protection shall mean:

A. Print Protection

If a transaction in a Nasdaq security is reported via the Automated Confirmation Transaction Service ("ACT") at a price inferior to the price of customer limit order(s) that the firm is holding (i.e., if the reported price is a price lower than a buy limit order or higher than a sell limit order being held by the firm), the firm holding the limit order(s) is required on a contemporaneous basis to execute the limit order(s) at the limit price(s) up to the size of the reported transaction.

B. Matching Limit Orders

If the firm holds a customer buy (sell) limit order in its proprietary limit order file and that limit order matches a sell (buy) limit order in NAqcess, the firm holding the limit order must either provide its customer with an immediate execution at the limit order price or must immediately direct the order to NAqcess. A limit order held by a firm would match a limit order in NAqcess when the limit order in NAqcess is at the same price or is priced lower than the firm's customer's limit order to buy or higher than the firm's customer limit order to sell ("offsetting limit orders").

C. Matching Limit Order Interaction Within A Firm's File

If the firm holds two or more offsetting customer limit orders within its own proprietary file, the firm must execute the offsetting limit orders.

D. Interaction Between Limit and Market Orders Held Within A Firm's File

While holding a customer limit order that is priced equal to or better than the best bid or offer in the security disseminated in Nasdaq, if a firm accepts customer market orders for automated execution against the best bid or offer in the security disseminated in Nasdaq, the firm, pursuant to its obligation set forth in the Interpretation to the Rules of Fair Practice, Article III, Section 1, (the so-called "Manning Interpretation"), must first permit the market orders to execute against any applicable limit orders it holds before the firm may execute the market orders for its own account.

E. Examples of Equivalent Protection

The NASD Board of Governors has provided the following examples to further explain a member firm's equivalent protection obligation for orders held outside of NAqcess:

Print Protection The best dealer bid and offer in Nasdaq ("the inside price")

is 20 bid-20¼ offer. Firm ABCD holds a customer limit order of 1,000 shares to buy at 20⅞ in its own proprietary file. Firm MNOP reports a transaction in the subject security via ACT, disseminating a price of 20¼₁₆ for 500 shares. Contemporaneous with the dissemination of the trade report, firm ABCD is required to provide an execution of its customer limit order for at least 500 shares at 20⅞.

Matching Limit Orders The inside price is 20 bid-20¼ offer. NAqcess is displaying a 1,000 share customer limit order to buy at 20⅞ for customer X. Firm ABCD thereafter receives from customer Y a 1,000 share limit order to sell at 20⅞ that the firm ABCD retains for handling outside of NAqcess. Upon receipt of the limit order, firm ABCD must execute customer Y's limit order for 1,000 shares at 20⅞.

Matching Limit Order Interaction Within A Firm's File. The inside price is the same as above. Firm ABCD holds a customer limit order to buy 1,000 shares at 20⅞. Firm ABCD thereafter receives a customer limit order to sell 1,000 shares at 20⅞. Firm ABCD must match the orders and execute the trade.

Interaction Between Limit and Market Orders Held Within A Firm's File. The inside price is the same as above. Firm ABCD holds a customer limit order to buy 1,000 shares at 20⅞. Firm ABCD thereafter receives a customer market order to sell 1,000 shares. Firm ABCD must match the two orders and execute the trade at 20⅞. Similarly, if the limit order to buy were priced at 20, the firm would have to execute the market order against the limit order at 20.

Price Protection for NAqcess Limit Orders, Rules of Fair Practice, Article III, Section [XX]

No member firm shall execute an order as principal or as agent at a price inferior to any limit order(s) viewable in NAqcess to the member firm, provided however, that a member firm executing a transaction that is larger than the limit order(s) viewable in NAqcess at an inferior price must contemporaneously satisfy the limit order(s) viewable in NAqcess. An "inferior price" means an execution price that is lower than a buy limit order or higher than a sell limit order that is viewable in NAqcess. The term "limit orders viewable in NAqcess" shall mean those orders that the member firm is able to view either as consolidated in the Nasdaq inside market or as reflected in the Full Limit Order File Display as the firm is

authorized to view under the Rules of Operation and Procedure.

[FR Doc. 95-29950 Filed 12-7-95; 8:45 am]

BILLING CODE 8010-01-P

[Rel. No. IC-21561; File No. 812-9588]

American Skandia Life Assurance Corporation, et al.

December 1, 1995.

AGENCY: U.S. Securities and Exchange Commission ("SEC" or "Commission").

ACTION: Notice of Application for Exemption Under the Investment Company Act of 1940 (the "1940 Act").

APPLICANTS: American Skandia Life Assurance Corporation ("ASLAC"), American Skandia Life Assurance Corporation Variable Account B (Class 1) ("Account B—Class 1"), American Skandia Life Assurance Corporation Variable Account B (Class 2) ("Account B—Class 2"), and American Skandia Marketing, Inc. ("ASM").

RELEVANT 1940 ACT SECTIONS: Sections 6(c), 17(a), 17(b), 17(d) and 26(b) of the 1940 Act and Rule 17d-1 thereunder.

SUMMARY OF APPLICATION: Applicants seek an order of approval under Section 26(b) of the 1940 Act and exemptions from Sections 6(c), 17(a), 17(b), 17(d) of the 1940 Act and Rule 17d-1 thereunder. The requested order would exempt Applicants from those Sections of the 1940 Act and the Rule set out above to the extent necessary to permit certain underlying mutual funds of the separate account to be substituted for certain other underlying mutual funds.

FILING DATE: The application was filed on May 2, 1995 and amended on November 17, 1995.

HEARING OR NOTIFICATION OF HEARING: An order granting the application will be issued unless the SEC orders a hearing. Interested persons may request a hearing by writing to the Secretary of the SEC and serving Applicants with a copy of the request, personally or by mail. Hearing requests should be received by the SEC by 5:30 p.m. on December 26, 1995, and should be accompanied by proof of service on Applicants in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the Secretary of the SEC.

ADDRESSES: SEC, Secretary, 450 Fifth Street, NW., Washington, DC 20549. Applicants: John T. Buckley, Esq., Werner & Kennedy 1633 Broadway,

New York, New York 10019 and American Skandia Life Assurance Corporation, c/o Jeffrey M. Ulness, Esq., One Corporate Drive, Shelton, CT 06484.

FOR FURTHER INFORMATION CONTACT:

Edward P. Macdonald, Staff Attorney, or Brenda D. Sneed, Chief (Office of Insurance Products), Division of Investment Management, at (202) 942-0670.

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained for a fee from the Public Reference Branch of the SEC.

Applicants' Representations

1. ASLAC, the depositor of both Account B—Class 1 and Account B—Class 2 (collectively, the "Separate Account"), is a stock life insurance company organized under the laws of the State of Connecticut and wholly-owned by American Skandia Investment Holding Corporation ("ASIH"), which is an indirect wholly-owned subsidiary of Skandia Insurance Company Ltd., a corporation organized under the laws of the Kingdom of Sweden.

2. ASM, the underwriter of variable annuity contracts issued through the Separate Account and offered by ASLAC, is registered with the SEC and is a member of the NASD. ASM is 100% owned by ASIH.

3. The Separate Account is a separate account of ASLAC, and is registered under the 1940 Act as a unit investment trust. ASLAC established the Separate Account to the purpose of funding certain flexible purchase payment deferred variable annuity contracts (the "Contracts"). Account B—Class 1 subaccounts each invest exclusively in one of the corresponding portfolios of six open-end management investment companies. The following five Contracts are funded, through the sub-accounts of Account B—Class 1: American Skandia Advisors Plan ("ASAP") [32];¹ ASAP II [21];² the LifeVest Personal Security Annuity ("PSA") [32]; the Alliance Capital Navigator Annuity ("Alliance Navigator") [15]; and the StageCoach Variable Annuity ("StageCoach") [8] (collectively, the "Class 1 Contracts").

Account B—Class 2 sub-accounts each invest exclusively in one of the corresponding portfolios of six open-end management investment companies. ASLAC currently offers two

Contracts that invest in Account B—Class 2: the Wrap Fee Contracts ("Wrap Fee") [42].

4. Under the Contracts affected by the proposed substitutions, six open-end management investment companies currently offer shares of several of their portfolios to the Separate Account: The Alger American Fund ("Alger Fund"); Alliance Variable Products Series Fund, Inc. ("AVP"); Neuberger & Berman Advisers Management Trust ("AMT"); American Skandia Trust ("AST"); and Scudder Variable Life Investment Fund ("Scudder"). In addition, six portfolios of the Janus Aspen Series ("Janus") are offered to Account B—Class 2 but not Account B—Class 1. All such investment companies in which the Separate Account invest are collectively referred to as "Underlying Funds."

5. The proposed substitutions would result in a reduction in variable investment options and corresponding portfolios available as follows. ASAP and PSA would be reduced to 21 (a reduction of 11 each) and Wrap Fee would be reduced to 21 (a reduction of 21). Applicants state that funding such varied products through a consolidated fund structure will aid in the growth of the Underlying Funds resulting in lower operating costs through economies of scale. Applicants further state that regardless of whether one Contract achieves more popularity or appeal, or is no longer marketed by ASLAC, the interests of Contract owners will be protected by like underlying portfolios of all ASLAC nonproprietary variable annuities.

6. Of the Underlying Funds, only AST is affiliated with ASLAC or the Separate Account. None of the Underlying Funds, their investment managers, or underwriters are affiliated with ASLAC, the Separate Account or AST through any corporate ownership.

7. Applicants state that in the registration statements filed by the Separate Account, ASLAC expressly reserved the right both on its own behalf and on behalf of the Separate Account to eliminate sub-accounts, combine two or more sub-accounts, or substitute one or more Underlying Funds for others in which its sub-accounts are invested.

8. ASLAC, on its own behalf and on behalf of the Separate Account, proposes to effect the following substitutions of shares of the following portfolios (the "Transferee Portfolios") for shares of other portfolios (the "Transferor Portfolios") (collectively, the "Substitution(s)"): (i) the AST Phoenix Balanced Asset Portfolio will be substituted for the Alger Balanced, Alliance Total Return, AMT Balanced, Scudder Balanced, and Janus Aspen

¹ The numbers in brackets denote the number of portfolios which are currently available under the Contracts.

² ASAP II, the Alliance Navigator and the StageCoach Contracts will not be subject to the proposed substitutions.

Balanced Portfolios; (ii) The Lord Abbett Growth & Income Portfolio (AST) will be substituted for the Alger Income & Growth and Alliance Growth & Income Portfolios; (iii) the Seligman Henderson International Equity Portfolio (AST) will be substituted for the Alliance International, Scudder International, and Janus Aspen Worldwide Growth Portfolios; (iv) the Alger Growth Portfolio will be substituted for the Alliance Premier Growth, AST Phoenix Capital Growth, AST Eagle Growth Equity, Scudder Capital Growth, and the Janus Aspen Aggressive Growth Portfolios; (v) the PIMCO Limited Maturity Bond Portfolio (AST) will be substituted for the Alliance Short-Term Multi-Market, Alliance U.S. Government/High Grade Securities, AMT Limited Maturity Bond, and Janus Short-Term Bond Portfolios; (vi) the AMT Partners Portfolio will be substituted for the AMT Growth Portfolio; (vii) the PIMCO Total Return Bond Portfolio (AST) will be substituted for the Scudder Bond and Janus Aspen Flexible Income Portfolios; and, (viii) the JanCap Growth Portfolio (AST) will be substituted for the Janus Aspen Growth Portfolio. Applicants note that allocations to the Alliance Fund Transferor Portfolios available under Separate Account Contracts will be substituted, except for those amounts allocated under the Alliance Navigator Contract (Account B—Class 1). Allocations under the Alliance Navigator Contract will remain unaffected by the Substitutions.

9. The Substitution process will include two periods during which Contract owners may make cost free transfers to the remaining portfolios of their choice. The first free transfer period will start prior to the "Automatic Selection Date." The Automatic Selection Date is the date ASLAC will schedule the Substitutions to occur. Such date will be as soon as practicable following the issuance of an order by the SEC. Moreover, any transfers of account value from any of the Transferor Portfolios from May 1, 1995 (the date the relevant Contract prospectuses reflected the proposed Substitutions), will not be counted toward the twelve free transfers permitted under relevant Contracts.

10. For several months prior to the Automatic Selection Date, and in all cases since May 1, 1995, relevant Contract prospectuses reflected the Substitutions. Such registration statements as in effect as of May 1, 1995 for ASAP, PSA and Wrap Fee also contain information of the investment policies of the Transferee Portfolios.

11. The first free transfer period will start before the Automatic Selection Date. Within approximately five days after the Applicant's notice of application appearing in the Federal Register, ASLAC will mail a written notice to all Contract owners who, as of the date the notice of application appears in the Federal Register, have allocations in any Transferor Portfolio. The notice will contain information as to the Substitutions and will provide instructions regarding the ability of Contract owners to make transfers of account value out of any Transferor Portfolio without transfer fees or similar charges, and without such transfer being counted as a free transfer. After notice is mailed and up until the Automatic Selection Date, any Contract owner making an allocation or transfer (*i.e.*, new money) to any Transferor Portfolio during the first free transfer period will be sent a similar notice with their confirmation statement (the "Affected Contract owners").

12. As of the Automatic Selection Date, allocations or transfers to a Transferor Portfolio will automatically be allocated to the corresponding Transferee Portfolio. No Transferor portfolio will accept additional premium payments (*i.e.*, new money) on or after the Automatic Selection Date.

3. On the Automatic Selection Date, all account values allocated to each Transferor Portfolio, if any, will be transferred to the corresponding Transferee Portfolio ("Automatic Selection Option"). Applicants state that the Automatic Selection Options (which may only occur if Contract owners do not give timely instructions during the first free transfer period) are temporary in character because Contract owners can always exercise their own judgment as to the most appropriate alternative investment. Applicants also state that Affected Contract owners will have an additional free transfer period after the Automatic Selection Date. No sales load deductions will be made in connection with any transfers among the portfolios because of the Substitutions or otherwise. Contract owners who have not annuitized may at any time, before or after the Substitutions, transfer their account value to any of the other portfolios offered under their respective Contracts.

14. The second free transfer period will start after the Automatic Selection Date. For thirty (30) calendar days, or if the thirtieth day is not a business day then the following business day after the Automatic Selection Date, Affected Contract owners may transfer account values out of the Transferee Portfolios to any other available portfolios without

transfer fees or similar charges and without transfer being counted as a free transfer. Within five (5) days of the Automatic Selection Date, ASLAC will send Affected Contract owners written notice of the Substitution identifying units of the Transferee Portfolios. ASLAC will include in this notice information regarding the second free transfer period. Applicants state that if Affected Contract owners have telephone transfer privileges, telephone instructions will be accepted during both free transfer periods.

15. Applicants anticipate that some or all Substitutions may be effected partly for cash and partly for securities as a partial redemption "in-kind" at the net asset values of the portfolios (such transfer will be in conformity with Sections 22(c) and 22(g) of the 1940 Act and Rule 22c-1 thereunder). The transfers will be effected by selling the securities of the applicable Transferor Portfolios and applying the proceeds to the purchase price of securities issued by the Transferee Portfolios selected by Contract owners. At all times all contract values will remain unchanged, no fees or charges will be incurred, all Contract owner rights will be unaffected, and ASLAC's obligations under any Contract will not be altered in any way because of the Substitutions.

16. To the extent "in-kind" redemptions are not utilized, Applicants anticipate that Transferor Portfolios will incur brokerage fees and expenses to the extent not assumed by Applicants, or the adviser or sub-adviser of the Transferee Portfolios in connection with the redemption of shares of the affected Transferor Portfolios.

Applicants state that they will effect the redemptions "in-kind" to the extent consistent with investment objectives and applicable diversification requirements. ASLAC states that it will establish procedures to ensure that "in-kind" redemptions will be effected in a fair and equitable manner from the perspective of the Separate Account, the Transferor Portfolios, and other separate accounts which currently invest in the Transferor Portfolios, and other separate accounts which currently invest in the Transferor Portfolios. These procedures will provide that: (i) the Transferor Portfolio investment adviser identify prior to the effective date of the Substitutions the securities to be included in the "in-kind" transfer; and (ii) the investment adviser to the Transferee Portfolio reviews and agrees to accept the securities so identified as payment for the purchase of Transferee Portfolio shares. The valuation of "in-kind" transfers will be on a basis consistent with the valuation

procedures of the applicable Transferor and Transferee Portfolios.

17. ASLAC or the investment adviser of the Transferee Portfolio will assume the transfer and custodial expenses and legal and accounting fees of the Substitutions, and Contract owners will not incur any fees or charges as a result of the transfer of account value from any portfolio. The Substitutions will not increase Contract and Separate Account fees and charges after the Substitutions. In addition, Applicants state that the Substitutions have been designed to avoid any adverse federal income tax impact on Contract owners.

18. Following the Substitutions, the sub-accounts which invest in the Transferor Portfolios will be terminated.

Applicants' Legal Analysis

Request for an Order Pursuant to Section 26(b) of the 1940 Act

1. Section 26(b) of the 1940 Act provides that it shall be unlawful for any depositor or trustee of a registered unit investment trust holding the security of a single issuer to substitute another security for such security unless the Commission shall have approved such substitution; and the Commission shall issue an order approving such substitution if the evidence establishes that it is consistent with the protection of investors and the purpose fairly intended by the policy and provisions of the 1940 Act.

2. Section 26(b) protects the expectation of investors in a UIT that the UIT will accumulate shares of a particular issuer. The Section also prevents unscrutinized security to redeem their shares, thereby incurring either a loss of the sales load deducted from initial proceeds, an additional sales load upon reinvestment of the redemption proceeds, or both. Section 26(b) affords protection to investors by preventing a depositor or trustee of a unit investment trust (holding the shares of one issuer) from substituting the shares of another issuer for those shares, unless the Commission approves the Substitutions.

3. Applicants represent that the purposes, terms, and conditions of the Substitutions will not entail any of the abuses that Section 26(b) is designed to prevent for the following reasons:

a. The proposed Substitutions are for shares of the Transferee Portfolios with investment objectives of the corresponding Transferor Portfolios so as to provide a means for Contract owners to continue their current investment goals and risk expectations.

b. The proposed Automatic Selection Options will be only temporary because

Contract owners may always exercise their own judgment as to the most appropriate alternative investment vehicles. No sales load deductions will be made in connection with any transfers among the portfolios by reason of the Substitutions. After the Substitutions, the Affected Contracts would still offer a broad array of variable investment options and Contract owners who have not annuitized may at any time transfer their account value to any of the other portfolios offered under their respective Contracts.

c. the transactions effecting the proposed Substitutions including the redemption of Transferor Portfolio shares and the purchase of Transferee Portfolio shares will be effected at net asset value in conformity with Section 22(c) of the 1940 Act and Rule 22c-1 thereunder.

d. The anticipated utilization of "in-kind" redemptions by the Transferor Portfolios for the purchase by the Separate Account of Transferee Portfolio shares, in conformity with Section 22(g) of the 1940 Act, may reduce transaction costs of the Substitutions.

e. ASLAC or the Transferee Portfolio investment adviser will assume various expenses and transaction costs relating to the Substitutions, including custodial and transfer fees incurred by use of any "in kind" redemptions, and legal and accounting fees.

f. The Substitutions will not alter or affect the insurance benefits provided by ASLAC to Contract owners or the terms or obligations under the terms of the Contracts.

g. The Substitutions are designed to avoid any adverse effects upon the tax benefits available to Contract owners; the Substitutions are designed not to give rise to any current federal income tax to Contract owners.

h. The Substitutions are expected to confer economic benefits by virtue of the enhanced asset size of the Transferee Portfolios.

4. Applicants state that under the circumstances it is in the best interest of Contract owners to proceed with the Substitutions. The Substitutions are appropriate because the overall investment objectives of the Transferee Portfolios are similar and their investment objectives are compatible to the Transferor Portfolios.

5. Applicants also represent that total fees and expenses as a percentage of net assets for the Transferee Portfolios are expected to decrease through economies of scale caused by the anticipated increase in asset size and the increased similarity of available portfolios in

applicable Contracts as a result of the Substitutions.

Request for Order Pursuant to Section 6(c) and 17(b) of the 1940 Act

6. Applicants seek an exemption from Section 17(a) through both Sections 17(b) and 6(c) of the 1940 Act because Section 17(b) permits the Commission to exempt a single "proposed transaction" whereas Section 6(c) enables the Commission to exempt a series of transactions.

7. Under certain circumstances, Section 17(a)(1) of the 1940 Act prohibits any affiliated person of a registered investment company, or an affiliated person of an affiliated person, from selling any security or other property to such registered investment company. Section 17(a)(2) of the 1940 Act prohibits any affiliated person of the persons described above from purchasing any security or other property from such registered investment company.

8. Applicants state that since the Substitutions may be deemed to involve one or more purchases or sales of securities between and among affiliated persons, the Substitutions may involve transactions prohibited by Section 17(a) of the 1940 Act. Applicants also state that the Substitutions may not be exempt from Section 17 of the 1940 Act pursuant to Rule 17a-7 thereunder, since the affiliations among some of the parties do not arise solely through having common investment advisers, common directors and/or common officers.

9. Section 17(b) authorizes the SEC to issue an order exempting a proposed transaction from Section 17(a) if evidence establishes that: (1) the proposed transaction is fair and reasonable and does not involve overreaching on the part of any person concerned; (2) the proposed transaction is consistent with the policy of each registered investment company concerned; and (3) the proposed transaction is consistent with the general purposes of the 1940 Act. Applicant represent that the terms of the Substitutions are consistent with the standard for relief described in Section 17(b) of the 1940 Act.

10. The Substitutions will be effected at the net asset value of the securities involved. ASLAC or the adviser of the Transferee Portfolios will bear those expenses associated with the transfers. The Substitutions and transfers of securities are consistent with the policies of each investment company involved and of the 1940 Act.

11. As a condition to the granting of an order of exemption under Section

17(b), Applicants represent that they will comply with the conditions set forth in Rule 17a-7 except for subparagraph (a), which requires that the transaction be "for no consideration other than cash payment." Although the consideration in some cases will be "securities" and not cash, Applicants state that these transactions are in substance the type of transactions currently exempted by Rule 17a-7.

12. Applicants further state that the terms of the Substitutions and the transfer of the securities meet all the requirements of Section 17(b) and represent that for the terms of the Substitutions and transfers of securities are reasonable and fair and do not involve overreaching on the part of any person concerned.

13. Applicants also represent that with respect to the "in-kind" portion of the Substitutions established procedures will guard against inappropriate or unfair exchanges.

14. Since Applicants may be deemed to be affiliated persons of each other or affiliated persons of an affiliated person under Section 2(a)(3) of the 1940 Act the Substitutions may be deemed to entail one or more purchases or sales of securities or property between Applicants. Accordingly, Applicants believe that the Substitutions may require an order exempting the transactions prohibited under Sections 17(a)(1) and 17(a)(2) of the 1940 Act, pursuant to Section 17(b) of the 1940 Act.

15. Rule 17a-7 under the 1940 Act exempts from the prohibitions of Section 17(a) a purchase or sale transaction between registered investment companies or separate series of registered investment companies which may be affiliated persons, or affiliated persons of affiliated persons, solely by reason of having a common investment adviser or investment advisers which are affiliated persons of each other, common directors and/or common officers, subject to certain specified conditions. As the affiliation among the Applicants, however, does not arise solely by reason of having common investment advisers, directors, and/or officers, and redemption by the Transferor Portfolios may involve redemptions of securities "in-kind" rather than for cash, the Substitutions likely would not satisfy the technical requirements of Rule 17a-7.

Nonetheless, Applicants represent that the Substitutions will comply with the underlying intent of Rule 17a-7 in all respects for the following reasons. First, although the Substitutions would involve partial redemption of securities "in-kind" rather than the "all-cash," as

required under subsection (a) of Rule 17a-7, such transactions likely would be less amenable to self-dealing than corresponding "all-cash" transactions. Moreover, redemptions in kind would reduce brokerage commissions or other remuneration ordinarily paid in connection with securities transactions. Second, because the Substitutions will be effected at the independent current market price and are consistent with the policies of each of the Transferor and the Transferee Portfolios, the Substitutions would comply with both the technical requirements and underlying intent of subsections (b) and (c) of the Rule. Third, to the extent consistent with investment objectives and applicable diversification requirements, Applicants will effect redemption "in-kind" to reduce any brokerage commissions or other remuneration usually paid in connection with securities transactions, as contemplated by subsection (d) of the Rule. Finally, because the Substitutions would occur only once, the formal written compliance procedure required under subsections (e) and (f) of the Rule would prove inapplicable.

Request for Order Pursuant to Section 6(c) and Rule 17d-1 of the 1940 Act

16. Section 17(d) of the 1940 Act prohibits any affiliated person of a registered investment company, or any affiliated person of such affiliated person, acting as principal, from effecting any transaction in which such registered investment company, or a company controlled by such registered investment company, is a joint participant with such person, in contravention of Commission rules designed to limit or prevent participation by the registered investment company "on a basis different from or less advantageous than" that of the affiliated person. Rule 17d-1(a) prohibits any of the persons described above, acting as principal, from participating in, or effecting "any transaction in connection with, any joint enterprise or other joint arrangement or profit-sharing plan in which any such registered investment company, or a company controlled by such registered company, is a participant" unless the Commission has approved the joint enterprise, arrangement or plan.

17. Applicants state that they may be deemed to be affiliated persons of each other under Section 2(a)(3) of the 1940 Act, and that the Substitutions will involve transactions that may be deemed to implicate Section 17(d) of the 1940 Act and Rule 17d-1 thereunder.

18. The simultaneous purchase and sale transactions involve a number of registered investment companies, and each such purchase and sale transaction is dependent on the other. Each transaction therefore may be deemed to be in connection with a joint arrangement within the contemplation of Section 17(d) of the 1940 Act and Rule 17d-1 thereunder. Applicants request an order pursuant to Section 6(c) and Rule 17d-1 to eliminate any question of compliance with Section 17(d) and Rule 17d-1.

19. Rule 17d-1 provides for the Commission to grant an order upon request. In passing upon such request, the Commission is to consider whether the participation of the management investment companies is consistent with the provisions, policies and purposes of the 1940 Act and the extent to which such participation is on a basis different from or less advantageous than that of other participants.

20. Section 6(c) of the 1940 Act provides that the Commission may grant an order exempting persons and transactions from any provision or provisions of the 1940 Act as may be necessary or appropriate in the public interest and consistent with the protection of investors and the purposes fairly intended by the policy and provisions of the 1940 Act. For all the reasons stated herein, Applicants submit that the Substitutions are consistent with the provisions, policies and purposes of the 1940 Act and that the participation of each of the parties to the Substitutions will be on an equal basis and consistent with their respective participation in the Substitutions, and is consistent with the provisions, policies and purposes of the 1940 Act.

21. Based on the foregoing, Applicants represent that the Substitutions and the related transactions meet all the requirements of Section 6(c) of the 1940 Act and Rule 17d-1 thereunder, and are consistent with applicable precedent, and request that an order of exemption from Section 17(d) and approval pursuant to Section 6(c) and Rule 17d-1 be granted.

Conclusion

For the reasons set forth above, Applicants represent that the exemptions requested are necessary and appropriate in the public interest and consistent with the protection of investors and purposes fairly intended by the policy and provisions of the 1940 Act.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Margaret H. McFarland,
Deputy Secretary.

[FR Doc. 95-29920 Filed 12-7-95; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 35-26423]

Filing Under the Public Utility Holding Company Act of 1935, as Amended ("Act")

December 1, 1995.

Notice is hereby given that the following filing(s) has/have been made with the Commission pursuant to provisions of the Act and rules promulgated thereunder. All interested persons are referred to the application(s) and/or declaration(s) for complete statements of the proposed transaction(s) summarized below. The application(s) and/or declaration(s) and any amendments thereto is/are available for public inspection through the Commission's Office of Public Reference.

Interested persons wishing to comment or request a hearing on the application(s) and/or declaration(s) should submit their views in writing by December 26, 1995, to the Secretary, Securities and Exchange Commission, Washington, D.C. 20549, and serve a copy on the relevant applicant(s) and/or declarant(s) at the address(es) specified below. Proof of service (by affidavit or, in case of an attorney at law, by certificate) should be filed with the request. Any request for hearing shall identify specifically the issues of fact or law that are disputed. A person who so requests will be notified of any hearing, if ordered, and will receive a copy of any notice or order issued in the matter. After said date, the application(s) and/or declaration(s), as filed or as amended, may be granted and/or permitted to become effective.

Eastern Utilities Associates, et al. (70-7287)

Eastern Utilities Associates ("EUA"), a registered holding, and its wholly owned nonutility subsidiary company, EUA Cogenex, Corp. ("Cogenex"), both at P.O. 2333, Boston, Massachusetts 02107, have filed a post-effective amendment under sections 9(a) and 10 of the Act to their application-declaration previously filed under sections 6(a), 7, 9(a), 10, 12(c), 12(f), and 13(b) of the Act and rules 42, 45, 87, 90, and 91 thereunder.

By prior order in this proceeding dated December 19, 1986, the Commission authorized EUA to acquire

Cogenex (HCAR Release No. 24273). Subsequent orders of the Commission authorized Cogenex to engage in additional activities and removed restrictions on the amount of revenues Cogenex could receive from customers outside New England (*see, e.g.*, HCAR Release Nos. 26232 (Feb. 15, 1995), 26135 (Sept. 30, 1994), 25982 (Jan. 28, 1994), and 25636 (Sept. 17, 1992)).¹

Cogenex designs, finances, installs and maintains energy conservation systems. Cogenex provides energy management services ("EMS") directly to institutional commercial, industrial and governmental customers to reduce their energy costs and consumption. Cogenex employs energy efficiency technology and equipment in its EMS program through building automation, lighting modifications, boiler replacement, and other heat recovery methods to reduce electrical energy and fuel consumption and related energy costs of its customers. Cogenex earns fees for these services primarily through shared savings agreements under which Cogenex is paid a portion of the customers' energy savings.

Cogenex also participates in demand side management ("DSM") programs sponsored by electric utilities as a means to decrease base load and peak demand on the utilities' systems. In DSM programs, Cogenex provides EMS services to the utility's customers to reduce their energy demands. The utility pays Cogenex based on the reduction in demand, and Cogenex may also receive a portion of the customer's savings.

Cogenex now proposes to provide services relating to the furnishing and conservation of water to the types of customers to whom it furnishes EMS services. Cogenex proposes to provide such water services packaged with its EMS services or on a stand alone basis.

American Electric Power Company, Inc., et al. (70-8307)

American Electric Power Company, Inc. ("AEP"), a registered holding company, and its nonutility subsidiary company, AEP Energy Services, Inc. ("AEPES") (collectively, "Applicants"), both at 1 Riverside Plaza, Columbus, Ohio 43215, have filed a post-effective amendment to their application-declaration filed under sections 6(a), 7, 9(a), 10, 12(b), and 13(b) of the Act and rules 45, 54, 87, 90, and 91 thereunder.

AEPES is engaged in the business of selling management, technical and training expertise both to certain AEP

affiliates and to non-affiliates. AEPES requests authorization to make financial and/or technical contributions to assist research and development efforts of non-affiliated entities. As a result of such contributions, AEPES may receive a license to use and/or a right to sublicense intellectual property developed by those entities ("Non-Affiliate Intellectual Property"). If AEPES became entitled to receive an equity interest in a non-affiliated entity to which such contributions were made, AEPES would sell the interest to an affiliate, AEP Investments, Inc., at its fair market value, subject to the receipt of any required regulatory approvals.

AEPES is also engaged in, among other things, the business of selling or otherwise providing access to intellectual property developed by AEP affiliates for their own use. Currently, AEPES pays to any such affiliate in perpetuity a certain portion of the revenues realized from any disposition of such intellectual property. Specifically, AEPES pays the affiliate (a) 70% of the revenues from the intellectual property until the affiliate recovers its direct costs of making the property available and (b) 20% of such revenues thereafter. Additionally, AEPES makes intellectual property it develops available to AEP affiliates without charge, except for actual expenses incurred by AEPES in connection with making such intellectual property so available.

AEP and AEPES propose that, if AEPES disposes of intellectual property developed by an affiliate for its own use and which such affiliate retains a right to use, AEPES would pay that affiliate an amount equal to the costs the affiliate directly incurred in making the property available to AEPES. For dispositions by AEPES of intellectual property developed by an AEP affiliate for its own use, but which that affiliate no longer would be able to use, AEPES would continue to reimburse that affiliate an amount equal to the affiliate's development costs. If an AEP affiliate developed intellectual property not for its own use but for use by AEPES, AEPES would also pay that affiliate an amount equal to the affiliate's development costs. AEPES additionally proposes that any disposition on Non-Affiliate Intellectual Property to an AEP affiliate would be at cost. Any intellectual property developed by AEPES would be made available to AEP affiliates at the direct cost of making such property available.

Also, AEPES requests authority to provide or broker financing to customers in connection with and to support the sale of goods or provision of

¹ Cogenex announced on September 28, 1995, that it was discontinuing one of its principal business segments involving small self-generation projects.

services through direct loan, installment purchase, operating or finance lease arrangements (including sublease arrangements) or loan guarantees. Interest on loans and imputed interest on lease payments will be at prevailing market rates. The obligations will have terms of one to thirty years and be secured or unsecured. AEPES also may assign obligations acquired from customers to banks or other financial institutions with or without recourse.

In addition, AEP is authorized through December 31, 1995 to guarantee debt of AEPES to third parties in an amount not to exceed a total of \$51,000,000. AEP proposes to extend this authority through December 31, 1998.

Public Service Company of Oklahoma (70-8711)

Public Service Company of Oklahoma ("PSOK"), located at 212 East 6th Street, Tulsa, Oklahoma 74119-1212, a wholly-owned public-utility subsidiary company of Central and South West Corporation, a registered holding company, has filed an application under sections 9(a) and 10 of the Act and rule 54 thereunder.

PSOK requests authorization to make equity and debt investments totaling \$3,500,000 in four Oklahoma limited liability companies, RIKA Management Company, L.L.C ("RIKA"), Universal Power Products Company, L.L.C ("Universal"), Automated Substation Development Company, L.L.C ("Automated") and RC Training, L.L.C, (Training") (collectively, the "RIKA Companies"), engaged in the development and commercialization of computer automation technology for the electric power industry.

The predecessor to the RIKA Companies, Relay Concepts, Inc. ("Relay"), reorganized its corporate structure into the four limited liability RIKA Companies referred to above on July 17, 1995. As a consequence of this reorganization, the RIKA Companies will acquire Relay's three existing lines of business:

(1) relay testing software,² (2) electrical substation automation systems,³ and (3) personnel training

² Relay developed a protective relay testing software package, known as Ultratest, which is the first automated relay testing software capable of communicating with and controlling the testing instruments made by most major relay manufacturers.

³ Relay had begun the definition phase of a substation automation project that will combine off-the-shelf hardware with specially developed software to provide improved substation communications, maintenance support and testing.

services.⁴ The RIKA Companies will derive substantially all of their revenues from the development and commercialization of software that enhances the efficiency of substation operation and maintenance, and from the sale of training courses relating to all phases of automated testing and maintenance systems as well as on-site training and consulting services. Universal will be the primary marketing and sales arm of the RIKA Companies. Automated will be a research and development company, with no sales or support function, and will license Universal to market and sell the products it develops. Training will develop, market and operate training programs as a separate business. RIFA will provide management oversight and administrative support and control of the RIKA Operating Companies. RIKA will charge each of the RIKA Operating Companies for all direct and allocated costs plus a management fee equal to 5% of all cost billings.

On July 17, 1995, PSOK and RIKA entered into a Software Application Development Agreement ("Development Agreement") pursuant to which the RIKA Companies will develop certain substation automation software applications for PSOK ("Software").⁵ Under the Development Agreement, PSOK and RIKA each have, with certain limitations, a perpetual, non-exclusive and unrestricted license to use, modify, sublicense, sell or otherwise transfer the Software. Notwithstanding its rights under the Development Agreement, PSOK states that it does not intend to license the Software to non-affiliates and is not requesting authority from this Commission to engage in such activity. PSOK further states that its right to license the Software to third parties will be terminated upon consummation of the transactions, described below, for which it is seeking authorization (see footnote 5). In consideration for RIKA's services under the Development Agreement, PSOK has agreed to pay RIKA up to \$3,050,000 to be made

⁴ Relay established a training facility named Power Industry Learning Center ("PILC"). Located in Phoenix, Arizona, PILC will provide training to electric utility personnel relating to automated systems for relays, substations and other electric utility facilities as well as certain basic courses in electric generating and distribution systems. At present, all of the formal training programs developed by PILC relate to products developed by the RIKA companies.

⁵ PSOK notes that PSOK or a device manufacturer could develop the Software independently, but states that development by RIKA assures a more widely acceptable product. It suggests that software developed by PSOK would only be suitable for the devices currently in use in the CSW system and that a device manufacturer would have difficulty getting the proprietary protocols of a competitor.

available to RIKA in periodic installments, commencing upon the execution of the Development Agreement and continuing through March 31, 1996. As of October 30, 1995, PSOK had paid RIKA \$1,500,000 of this amount.

Subject to approval of the investments by the Commission, the Development Agreement calls for PSOK and RIKA to execute a Member Agreement ("Member Agreement") in accordance with which the \$3,050,000 payable to RIKA under the Development Agreement to fund development of the Software would be converted into a \$750,000 capital contribution to Automated and a loan to RIKA of up to \$2,300,000. PSOK would also make a \$450,000 capital contribution to Universal.⁶ Like the original \$3,050,000, the money for this additional \$450,000 investment would come from internally generated funds. In return, PSOK would receive RIKA's promissory note ("Promissory Note"), 50% of RIKA's outstanding units of membership,⁷ 71% of Automated's outstanding units of membership,⁸ 48% of Universal's outstanding units of membership, and 48% of Training's outstanding units of membership.

Absent an event of default ("Event of Default") as defined in the Member Agreement, PSOK would hold 4% of the voting rights of each of the RIKA Companies and have the right to designate one of the two managers of RIKA.⁹ Upon the occurrence of an Event of Default, RIKA would hold one hundred percent (100%) of the voting rights of Universal, Automated and Training, the holder of a majority of the

⁶ The Member Agreement would also memorialize the respective rights and obligations of PSOK and the RIKA Companies regarding the development of the Software and the management of the businesses in which the RIKA Companies are engaged or intend to engage. Among other things, it would assure PSOK of the right to purchase a non-exclusive license to use the Software under the same terms and conditions as the license RIKA will offer to non-affiliated utilities. Such license would be a perpetual, unrestricted license to use and modify the Software at a fee no greater than the fee RIKA will pay Automated for the right to market the Software to non-affiliated utilities, and would result in the termination of PSOK's right to license the Software to third parties.

⁷ Equity in a limited liability company is represented by units of membership rather than shares of company stock, and holders of the units are referred to as members rather than shareholders. An Oklahoma limited liability company is controlled by managers rather than by a board of directors.

⁸ After payment in full of the Promissory Note, PSOK's membership interest in Automated will be reduced from 71% to 48%.

⁹ Management of each of the RIKA Companies would be vested in two managers, who, in the case of the RIKA Companies other than RIKA, would be elected by majority vote of the voting rights of the members of such RIKA Company at an annual or special meeting called for that purpose.

voting rights of RIKA would be entitled to designate both managers of RIKA, and the voting rights of RIKA would be apportioned among the members of RIKA so that the voting rights held by PSOK on the one hand, and the other RIKA members on the other hand, would be in proportion to the amounts of principal and interest then outstanding under the Promissory Note and any RIKA promissory notes held by the other RIKA members, respectively.¹⁰

Mississippi Power Company (70-8737)

Mississippi Power Company ("Mississippi"), 2992 West Beach, Gulfport, Mississippi 39501, a wholly owned electric public-utility subsidiary company of The Southern Company, a registered holding company, has filed an application-declaration under sections 6(a), 7, 9(a), 10, and 12(d) of the Act and rules 44, 53, and 54 thereunder.

Mississippi proposes to incur obligations, from time to time on or before December 31, 2002, in connection with the issuance and sale by public instrumentalities of one or more series of pollution control revenue bonds ("Revenue Bonds") in an aggregate principal amount of up to \$75 million.

The Revenue Bonds will be issued for the financing or refinancing of the costs of certain air and water pollution control facilities and sewage and solid waste disposal facilities at one or more of Mississippi's electric generating plants or other facilities located in various counties. It is proposed that each such county or appropriate public body or instrumentality ("County") will issue its Revenue Bonds to finance or refinance the costs of the acquisitions, construction, installation and equipping of said facilities at the plant or other facility located in its jurisdiction ("Project").

The Revenue Bonds will mature from one to 40 years from the first day of the month in which they are initially issued and may, if it is deemed advisable for purposes of the marketability of the Revenue Bonds, be entitled to the benefit of a mandatory redemption sinking fund calculated to retire a portion of the aggregate principal amount of the Revenue Bonds prior to maturity.

Mississippi proposes to enter into a Loan or Installment Sale Agreement with the County ("Agreement") pursuant to each issue of the Revenue Bonds, and Mississippi may issue a

Note therefor, or the County will undertake to purchase and sell the related Project to Mississippi. The proceeds from the sale of the Revenue Bonds will be deposited with a trustee ("Trustee") under an indenture to be entered into between the County and such Trustee ("Trust Indenture"), pursuant to which such Revenue Bonds are to be issued and secured, and will be applied by Mississippi to payment of the cost of construction of the Project or to refund outstanding pollution control revenue obligations.

The Trust Indenture and the Agreement may give the holders of the Revenue Bonds the right, during such time as the Revenue Bonds bear interest at a fluctuating rate, to require Mississippi to purchase the Revenue Bonds from time-to-time, and arrangements may be made for the remarketing of any such Revenue Bonds through a remarketing agent.

Mississippi also may be required to purchase the Revenue Bonds, or the Revenue Bonds may be subject to mandatory redemption, at any time if the interest thereon is determined to be subject to federal income tax. Also in the event of taxability, interest on the Revenue Bonds may be effectively converted to a higher variable or fixed rate, and Mississippi also may be required to indemnify the bondholders against any other additions to interest, penalties and additions to tax.

In order to obtain the benefit of ratings for the Revenue Bonds equivalent to the rating of Mississippi's first mortgage bonds outstanding under the indenture dated as of September 1, 1941 between Mississippi and Bankers Trust Company, as successor trustee, as supplemented and amended ("Mortgage"), Mississippi may determine to secure its obligations under the Note and/or Agreement by delivering to the Trustee, to be held as collateral, a series of its first mortgage bonds ("Collateral Bonds"). The aggregate principal amount of the Collateral Bonds would be equal to either: (1) the principal amount of the Revenue Bonds; or (2) the sum of such principal amount of the Revenue Bonds plus interest payments thereon for a specified period.

As a further alternative to, or in conjunction with, securing its obligations through the issuance of the Collateral Bonds, Mississippi may: (1) cause an irrevocable letter of credit ("Letter of Credit") to be delivered to the Trustee; and/or (2) cause an insurance company to issue a policy ("Policy") guaranteeing the payment of the Revenue Bonds. In the event that either the Letter of Credit is delivered to

the Trustee or the Policy is issued, Mississippi may also convey to the County a subordinated security interest in the Project or other property of Mississippi as further security for Mississippi's obligations under the Agreement and/or the Note. However, in the event that Mississippi is unable or determines not to issue the Collateral Bonds, deliver the Letter of Credit to the Trustee or cause the Policy to be issued, it proposes that it may guarantee the payment of the principal of, premium, if any, and interest on the Revenue Bonds.

Mississippi also proposes to issue and sell, at any time on or before December 31, 2002: (1) one or more series of its (a) first mortgage bonds ("Bonds"), having a maturity of more than 40 years and (b) one or more series of preferred stock ("Preferred") in an aggregate of up to \$400 million in any combination thereof.

The Bonds will be issued pursuant to the Mortgage, as to be further supplemented, and sold for the best price obtainable, but for a price to Mississippi of not less than 98% nor more than 101¾% of the principal amount thereof, plus accrued interest (if any), which may be an adjustable interest rate determined on a periodic basis, or a fixed interest rate. The Bonds and/or the Preferred may be subject to a mandatory or optional cash sinking fund. Mississippi may enhance the marketability of the Bonds by purchasing an insurance policy to guarantee the payment when due of the Bonds.

Mississippi seeks authority to deviate from the provisions of the Commission's Statement of Policy Regarding First Mortgage Bonds and Preferred Stock (HCAR Nos. 13105 and 13106, February 16, 1956, as amended by HCAR Nos. 16369 and 16758, May 8, 1969 and June 22, 1970, respectively) with respect to the issuance of the Bonds and Preferred.

Indiana Michigan Power Company et al. (70-8747)

Indiana Michigan Power Company ("I&M"), One Summit Square, P.O. Box 60, Fort Wayne, Indiana 46801, an electric public utility subsidiary company of American Electric Power Company, Inc. ("AEP"), a registered holding company, and Blackhawk Coal Company ("Blackhawk"), c/o American Electric Power Service Corporation, 161 West Main Street, Lancaster, Ohio 43130, a coal-mining subsidiary of I&M, have filed an application under sections 9(a) and 10 of the Act and rule 54 thereunder.

By order dated September 20, 1985 (HCAR No. 23834), the Commission

¹⁰ PSOK states that, under certain circumstances following an Event of Default, PSOK could possibly obtain a majority of the voting rights of RIKA and/or be in a position to direct the management and affairs of one or more of the RIKA Companies.

authorized I&M and Blackhawk to enter into transactions to implement a settlement agreement, executed on January 9, 1985 by AEP, its associate companies and the staff of the Federal Energy Regulatory Commission ("FERC") ("Settlement Agreement"), concerning certain coal mining properties located in Carbon County, Utah, including coal reserves located west of the Price River, together with existing surface facilities located east of the Price River for processing, handling and shipping coal ("Western Reserves"). The Settlement Agreement was intended to dispose of all issues remaining to be resolved in an investigation by FERC of the coal procurement and pricing policies of AEP and its associate companies.

By subsequent order dated May 1, 1986 (HCAR No. 24080), the Commission authorized Blackhawk to transfer its coal mining operations with respect to the Western Reserves to Castle Gate Coal Company ("Castle Gate") and Meadowlark, Utah, Inc. ("Meadowlark"), subsidiaries of AMAX, Inc. ("AMAX"). This transfer was accomplished by means of a set of transactions involving leases, subleases, conveyances and assignments with respect to the various surface interests, fee coal, coal preparation facilities, federal and state leases, structures, equipment, permits and water rights associated with the Western Reserves.

Subsequent to May 30, 1986, Castle Gate merged into its affiliate, Amax Coal Company ("Amax Coal"); Meadowlark changed its name to Amax Land Company ("Amax Land"); and AMAX merged into Cyprus Amax Minerals Company ("CyprusAmax").

Blackhawk, Amax Land and Amax Coal now propose to amend the Lease Transaction Agreement to provide for the exercise by Amax Land and Amax Coal of the purchase options for four of the leases entered into pursuant to this authority prior to the end of the initial terms of the leases. The four leases will be terminated, Amax Land and/or Amax Coal will take title to all of the properties and/or equipment being leased under the four leases. In lieu of the obligation to make the remaining quarterly lease payments, as partial consideration for the purchase, Amax Land and Amax Coal will execute promissory notes in the same amounts and at the same dates as the remaining lease payments under the four leases. The notes will be guaranteed by CyprusAmax. Payment of the consideration for the purchase of the properties will be in the form of \$5,700,000 in cash at closing and four promissory notes, totalling approximately \$31.4 million. The

promissory notes will be secured initially by a mortgage and security interest in the properties transferred.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 95-29918 Filed 12-7-95; 8:45 am]

BILLING CODE 8010-01-M

[Rel. No. IC-21563; 811-6432]

Smith Breeden Institutional Short Duration U.S. Government Fund; Notice of Application

December 1, 1995.

AGENCY: Securities and Exchange Commission ("SEC").

ACTION: Notice of application for deregistration under the Investment Company Act of 1940 (the "Act").

APPLICANT: Smith Breeden Institutional Short Duration U.S. Government Fund.

RELEVANT ACT SECTION: Order requested under section 8(f).

FILING DATES: The application was filed on August 22, 1995 and amended on November 2, 1995.

SUMMARY OF APPLICATION: Applicant requests an order declaring that it has ceased to be an investment company.

HEARING OR NOTIFICATION OF HEARING: An order granting the application will be issued unless the SEC orders a hearing. Interested persons may request a hearing by writing to the SEC's Secretary and serving applicant with a copy of the request, personally or by mail. Hearing requests should be received by the SEC by 5:30 p.m. on December 26, 1995, and should be accompanied by proof of service on applicant, in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons may request notification of a hearing by writing to the SEC's Secretary.

ADDRESSES: Secretary, SEC, 450 5th Street NW., Washington, D.C. 20549. Applicant, 100 Europa Drive, Suite 200, Chapel Hill, North Carolina, 27514.

FOR FURTHER INFORMATION CONTACT: David W. Grim, Law Clerk, at (202) 942-0571, or Robert A. Robertson, Branch Chief, at (202) 942-0564 (Division of Investment Management, Office of Investment Company Regulation).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application

may be obtained for a fee at the SEC's Public Reference Branch.

Applicant's Representations

1. Applicant is a registered open-end management investment company organized as a business trust under the laws of the Commonwealth of Massachusetts. On October 8, 1991, applicant filed a Notification of Registration on Form N-8A pursuant to section 8(a) of the Act and a registration statement on Form N-1A under section 8(b) of the Act and under the Securities Act of 1933. The registration statement became effective on February 24, 1992, and the initial public offering commenced on February 25, 1992.

2. On March 1, 1995, applicant's Board of Trustees (the "Board") unanimously determined through a consent action that the continuation of applicant was no longer in the best interest of applicant or its shareholders. The Board determined that applicant's shareholders would be better served by a liquidation of applicant's assets. Applicant is the master fund in a master-feeder arrangement. The master-feeder arrangement was chosen initially to allow flexibility in distribution. The structure allowed applicant to be sold to institutional investors while the Smith Breeden Short Duration U.S. Government Series (the "Short Series"), the feeder fund, was sold to retail investors. This two-tier structure created redundancies in expenses. As a result, the Board concluded that the master-feeder structure was no longer the most economically viable alternative over the long term. The Board consented to a plan of liquidation whereby the assets of applicant would be distributed in cash or in-kind to applicant's shareholders in complete liquidation of applicant. Shareholder approval of the liquidation was not required under the terms of applicant's declaration of trust, and thus no shareholder authorization was obtained in connection with the liquidation. Applicant did notify shareholders of the plan of liquidation in the form of a letter signed by a majority of the Board and sent to the shareholders March 15, 1995.

3. On March 31, 1995, immediately prior to the liquidation, applicant had a total of 22,190,030 shares of beneficial interest outstanding. At such time, applicant's net asset value was \$221,304,914.56 in the aggregate and \$9.97 per share.

4. On March 31, 1995, applicant liquidated all of its assets. Applicant transferred cash in the amount of \$2,905,338.41 to its minority shareholders, who held 291,315.48 shares immediately prior to the

liquidation. Each minority shareholder received \$9.97 per share, which was equivalent to the per share net asset value of such shares on such date. Also on March 31, 1995, applicant transferred all of its other assets to its majority shareholder, the Short Series, which held 21,898,714.52 shares immediately prior to the liquidation. The fair market value of the assets received by the Short Series was \$218,399,576.24. The Short Series received \$9.97 per share, which was equivalent to the per share net asset value of such shares on such date.

5. The Short Series assumed all liabilities of applicant, an amount equal to \$121,844,321. All expenses incurred in connection with the liquidation, which amounted to approximately \$5,000 in legal fees, were paid by the Short Series. Smith Breeden Associates, Inc., applicant's investment adviser, paid applicant the balance of unamortized organizational expenses as of March 31, 1995, an amount equal to \$17,869.24.

6. As of the date of the application, applicant had no assets, liabilities, or shareholders. Applicant is not a party to any litigation or administrative proceeding.

7. Applicant is neither engaged nor proposes to engage in any business activities other than those necessary for the winding-up of its affairs. Applicant will file appropriate certificates of liquidation with the Commonwealth of Massachusetts.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Margaret H. McFarland,
Deputy Secretary.

[FR Doc. 95-29919 Filed 12-7-95; 8:45 am]

BILLING CODE 8010-01-M

(Call the SSA Reports Clearance Officer on (410) 965-4142 for a copy of the form(s) or package(s), or write to her at the address listed below.) SSA Reports Clearance Officer: Charlotte S. Whitenight.

1. *Inquiry to File An SSI Child's Application—0960-NEW.* The information collected on the form will be used by the Social Security Administration to document the earliest possible filing date and to determine potential eligibility for SSI child's benefits. The respondents are claimants for SSI benefits.

Number of Respondents: 2,100.

Frequency of Response: 1.

Average Burden Per Response: 10 minutes.

Estimated Annual Burden: 350 hours.

Written comments and recommendations regarding these information collections should be sent within 60 days from the date of this publication, directly to the SSA Reports Clearance Officer at the following address: Social Security Administration, DCFAM, Attn: Charlotte S. Whitenight, 6401 Security Blvd., 1-A-21 Operations Bldg., Baltimore, MD 21235.

In addition to your comments on the accuracy of the agency's burden estimate, we are soliciting comments on the need for the information; its practical utility; ways to enhance its quality, utility and clarity; and on ways to minimize burden on respondents, including the use of automated collection techniques or other forms of information technology.

Dated: December 1, 1995.

Charlotte Whitenight,
Reports Clearance Officer Social Security Administration.

[FR Doc. 95-29935 Filed 12-7-95; 8:45 am]

BILLING CODE 4190-29-P

DATES: The meeting will be held from 10 a.m. to approximately 1 p.m. on Thursday, January 18, 1996.

ADDRESSES: The meeting will be held in the conference room of the Houston Pilots Office, 8150 South Loop East, Houston, Texas.

FOR FURTHER INFORMATION CONTACT:

Mr. M.M. Ledet, Recording Secretary, Commander, Eighth Coast Guard District (oan), Room 1211, Hale Boggs Federal Building, 501 Magazine Street, New Orleans, LA 70130-3396, telephone (504) 589-4686.

SUPPLEMENTARY INFORMATION: Notice of this meeting is given pursuant to the Federal Advisory Committee Act, 5 U.S.C. App. 2 § 1 et seq. The meeting is open to the public. Members of the public may present written or oral statements at the meeting.

The tentative agenda for the meeting will consist of the following items:

(1) Review of the Houston Ship Channel 2000 report.

(2) Report from the Waterways Subcommittee.

(3) Report from the Navigation Subcommittee.

(4) Various Coast Guard aid to navigation improvement initiatives and waterway analysis studies.

(5) Updates from the U.S. Army Corps on various waterway improvement projects.

Dated: November 22, 1995.

R.C. North,

Rear Admiral, U.S. Coast Guard, Commander, Eighth Coast Guard District.

[FR Doc. 95-29968 Filed 12-7-95; 8:45 am]

BILLING CODE 4910-14-M

[CGD08-95-022]

Houston/Galveston Navigation Safety Advisory Committee; Navigation Subcommittee Meeting

AGENCY: Coast Guard, DOT.

ACTION: Notice of meeting.

SUMMARY: The Navigation Subcommittee of the Houston/Galveston Navigation Safety Advisory Committee will meet to discuss various navigation safety matters affecting navigation in the Houston/Galveston port area.

DATES: The meeting will be held from 9:30 a.m. to 11 a.m., on Thursday, January 4, 1996.

ADDRESSES: The meeting will be held at the Blackthorn Memorial, U.S. Coast Guard Base Galveston, 1 Ferry Road, Galveston, TX 77553.

FOR FURTHER INFORMATION CONTACT:

Mr. M.M. Ledet, Recording Secretary, Commander, Eighth Coast Guard

SOCIAL SECURITY ADMINISTRATION

Agency Forms Submitted to the Office of Management and Budget for Clearance

Normally on Fridays, the Social Security Administration publishes a list of information collection packages that will require submission to the Office of Management and Budget (OMB) for clearance in compliance with P.L. 96-511, as amended (P.L. 104-13 effective October 1, 1995), The Paperwork Reduction Act. Since the last list was published in the Federal Register on December 1, 1995, the following information collections have been proposed or will require extension of the current OMB approvals:

DEPARTMENT OF TRANSPORTATION

Coast Guard

[CGD08-95-021]

Houston/Galveston Navigation Safety Advisory Committee Meeting

AGENCY: Coast Guard, DOT.

ACTION: Notice of meeting.

SUMMARY: The Houston/Galveston Navigation Safety Advisory Committee (HOGANSAC) will meet to discuss waterway improvements, aids to navigation, current meters, and various other navigation safety matters affecting the Houston/Galveston area. The meeting will be open to the public.

District (oan), Room 1211, Hale Boggs Federal Building, 501 Magazine Street, New Orleans, LA 70130-3396, telephone (504) 589-4686.

SUPPLEMENTARY INFORMATION: Notice of this meeting is given pursuant to the Federal Advisory Committee Act, 5 U.S.C. App. 2 § 1 et seq. The meeting is open to the public. Members of the public may present written or oral statements at the meeting. The agenda for the meeting will consist of discussion of previous recommendations and presentation of new items for consideration.

Dated: November 22, 1995.

R.C. North,

Rear Admiral U.S. Coast Guard Commander, Eighth Coast Guard District.

[FR Doc. 95-29966 Filed 12-7-95; 8:45 am]

BILLING CODE 4910-14-M

[CGD08-95-023]

Houston/Galveston Navigation Safety Advisory Committee; Waterways Subcommittee Meeting

AGENCY: Coast Guard, DOT.

ACTION: Notice of meeting.

SUMMARY: The Waterways Subcommittee of the Houston/Galveston Navigation Safety Advisory Committee will meet to discuss various navigation safety matters affecting the waterways of the Houston/Galveston area.

DATES: The meeting will be held from 11 a.m. to 1 p.m., on Thursday, January 4, 1996.

ADDRESSES: The meeting will be held at the Blackthorn Memorial, U.S. Coast Guard Base Galveston, 1 Ferry Road, Galveston, TX, 77553.

FOR FURTHER INFORMATION CONTACT: Mr. M.M. Ledet, Recording Secretary, Commander, Eighth Coast Guard District (oan), room 1211, Hale Boggs Federal Building, 501 Magazine Street, New Orleans, LA 70130-3396, telephone (504) 589-4686.

SUPPLEMENTARY INFORMATION: Notice of this meeting is given pursuant to the Federal Advisory Committee Act, 5 U.S.C. App. 2 § 1 et seq. The meeting is open to the public. Members of the public may present written or oral statements at the meeting. The agenda for the meeting will consist of discussion of previous recommendations and presentation of new items for consideration.

Dated: November 22, 1995.

R.C. North,

Rear Admiral, U.S. Coast Guard Commander, Eighth Coast Guard District.

[FR Doc. 95-29967 Filed 12-7-95; 8:45 am]

BILLING CODE 4910-14-M

Federal Aviation Administration

RTCA, Inc., Special Committee 185; Aeronautical Spectrum Planning Issues

Pursuant to section 10(a) (2) of the Federal Advisory Committee Act (P.L. 92-463, 5 U.S.C., Appendix 2), notice is hereby given for a Special Committee 185 meeting to be held on January 3-4, 1996, starting at 9:00 a.m. The meeting will be held at RTCA, 1140 Connecticut Avenue, N.W., Suite 1020, Washington, DC, 20036.

The agenda will be as follows: (1) Administrative Remarks; (2) Introductions; (3) Review and Approval of the Agenda; (4) Review and Approval of the Summary of the Previous Meeting; (5) Review Rewrite of Changes Made at Last Plenary Meeting; (6) Assignment of Tasks; (7) Other Business; (8) Date and Place of Next Meeting.

Attendance is open to the interested public but limited to space availability. With the approval of the chairman, members of the public may present oral statements at the meeting. Persons wishing to present statements or obtain information should contact the RTCA Secretariat, 1140 Connecticut Avenue NW., Suite 1020, Washington, D.C. 20036; (202) 833-9339 (phone) or (202) 833-9434 (fax). Members of the public may present a written statement to the committee at any time.

Issued in Washington, D.C., on December 4, 1995.

Janice L. Peters,

Designated Official.

[FR Doc. 95-29964 Filed 12-7-95; 8:45 am]

BILLING CODE 4810-13-M

Federal Railroad Administration

Petition for Exemption or Waiver of Compliance

In accordance with Title 49 CFR Sections 211.9 and 211.41, notice is hereby given that the Federal Railroad Administration (FRA) has received requests for exemptions from or waivers of compliance with a requirement of its safety standards. The individual petitions are described below, including the party seeking relief, the regulatory

provisions involved, and the nature of the relief being requested.

Interested parties are invited to participate in these proceedings by submitting written views, data, or comments. FRA does not anticipate scheduling a public hearing in connection with these proceedings since the facts do not appear to warrant a hearing. If any interested party desires an opportunity for oral comment, they should notify FRA, in writing, before the end of the comment period and specify the basis for their request.

All communications concerning these proceedings should identify the appropriate docket number (e.g., Waiver Petition Docket Number RSGM-95-9) and must be submitted in triplicate to the Docket Clerk, Office of Chief Counsel, FRA, Nassif Building, 400 Seventh Street SW., Washington, DC 20590. Communications received within 45 days of the date of publication of this notice, will be considered by FRA before final action is taken. Comments received after that date will be considered as far as practicable. All written communications concerning these proceedings are available for examination during regular business hours (9:00 a.m.-5:00 p.m.) in Room 8201, Nassif Building, 400 Seventh Street SW., Washington, DC 20590.

The individual petitions seeking an exemption or waiver of compliance are as follows:

Tioga Central Railroad (TIOC)

(Waiver Petition Docket Number RSGM-95-9)

The TIOC seeks a permanent waiver of compliance with certain provisions of the Safety Glazing Standards (Title 49 CFR Part 223) for five locomotives and seven passenger cars. The TIOC has relocated their tourist passenger operation from Owego, New York, to Wellsboro, Pennsylvania. The train operates on the former Consolidated Rail Corporation Corning Secondary line from Wellsboro, Pennsylvania, to a point south of the Gang Mills Yard in New York. The railroad states the route is very rural with a few small hamlets along the way. Vandalism has been minimal since relocating.

Anthracite Railroads Historical Society, Incorporated (ATRW)

(Waiver Petition Docket Number RSGM-95-10)

The ATRW seeks a permanent waiver of compliance with certain provisions of the Safety Glazing Standards (Title 49 CFR Part 223) for two locomotives. Locomotives CRP 56 and 57 were built by EMD in 1948. The railroad states that

the locomotives are equipped with FRA glazing in the windshields but the original safety glass has been retained in other locations for historical purposes. The locomotives are used primarily in excursion passenger service but will be used in very limited freight service. The ATRW operates on the Southern Railroad of New Jersey.

West Jersey Railroad (WJ)

(Waiver Petition Docket Number RSGM-95-11)

The WJ seeks a permanent waiver of compliance with certain provisions of the Safety Glazing Standards (Title 49 CFR Part 223) for one locomotive. The locomotive, WJ 7803, an ALCO model RS-3 road switcher built in 1952, will be operated on 15 miles of track between Hartford and Paw Paw, Michigan. The area is very rural and not subject to vandalism.

Decatur Junction Railway Company (DT)

(Waiver Petition Docket Number RSGM-95-12)

The DT seeks a permanent waiver of compliance with certain provisions of the Safety Glazing Standards (Title 49 CFR Part 223) for one locomotive. The locomotive, WJ 7804, an ALCO model RS-3 road switcher built in 1952, was formerly used on the West Jersey Railroad in Salem, New Jersey. The locomotive will be operated on 15.4 miles of track between Cisco and Green's Switch, Decatur, Illinois, and 16.6 miles between Elwin and Assumption, Illinois. The area is rural farm country. The DT has trackage rights on the Illinois Central Railroad between Elwin and Green's Switch and operate over this area no more than one or two times per week.

Vandalia Railroad Company (VRR)

(Waiver Petition Docket Number RSGM-95-13)

The VRR seeks a permanent waiver of compliance with certain provisions of the Safety Glazing Standards (Title 49 CFR Part 223) for one locomotive. The locomotive, number 56, is an ALCO Model T-6 switcher. Waiver RSGM 94-21 was recently granted to the West Jersey Railroad for operation of this locomotive at Salem, New Jersey. The locomotive has now been moved to the affiliated VRR. The locomotive will be operated over approximately 2.54 miles of track at Vandalia, Illinois. This is a small rural farming community with very little vandalism.

Massachusetts Central Railroad Corporation (MCER)

(Waiver Petition Docket Number RSGM-95-14)

The MCER seeks a permanent waiver of compliance with certain provisions of the Safety Glazing Standards (Title 49 CFR Part 223) for one locomotive. The locomotive, number 4243, is an ALCO road switcher. The MCER operates on approximately 24.8 miles of track between Palmer and South Barre, Massachusetts, and 2.6 miles on the Bondsville Branch between Forest Lake Junction and Bondsville, Massachusetts. The railroad states there have been no incidents of broken glass due to vandalism.

Florida Central Railroad (FCEN)

(Waiver Petition Docket Number RSGM-95-15)

The FCEN seeks a permanent waiver of compliance with certain provisions of the Safety Glazing Standards (Title 49 CFR Part 223) for four passenger cars. The cars were recently acquired from the New Georgia Railroad. The cars will be operated four to five times per week in excursion or dinner train service.

Southeastern Pennsylvania Transportation Authority (SEPTA)

(Waiver Petition Docket Number H-95-5)

The SEPTA is seeking a five year test waiver of compliance from Section 229.29(a) of the Railroad Locomotive Safety Standards, (Title 49 CFR Part 229) for 33 electric MU locomotives. SEPTA is requesting that it be permitted to extend the clean, oil, test and stencil (COT&S) period from 24 months to 60 months on 8 test cars equipped with 26-R Brake Equipment and 25 test cars with PS-68 Brake Equipment. The test cars represent approximately 10 percent of their fleet of 304 electric MU locomotives. SEPTA states that the condition of the brake equipment at the two year overhaul indicates the maintenance cycle could be increased.

The test locomotives would be selected from those due COT&S at the inception of the test. Each test car will be so identified and its computer work report will show the test status. Major valvular components will be sealed so that tampering or changes can be detected. Monitoring will consist of a weekly check of road failure reports and computer work order records as well as any special failure reports, and a check at each periodic inspection to ensure that the original test components are intact. The test locomotives will be run beyond their two year COT&S cycle

with one 26-R and two PS-68 locomotives being overhauled at three and four year intervals after their last overhaul. Each valve will be tested prior to a tear down inspection which will be witnessed by SEPTA's project manager, manufacturer's representatives and FRA. Failed components will be analyzed to determine if the failure could have been prevented by a two year COT&S period. Final analysis of the data will be used to determine if the COT&S cycle can be extended.

Issued in Washington, DC on December 4, 1995.

Phil Olekszyk,

Deputy Associate Administrator for Safety Compliance and Program Implementation.

[FR Doc. 95-29929 Filed 12-7-95; 8:45 am]

BILLING CODE 4910-06-P

Notice of Application for Approval of Discontinuance or Modification of a Railroad Signal System or Relief From the Requirements of Title 49 CFR Part 236

Pursuant to Title 49 CFR Part 235 and 49 U.S.C. App. 26, the following railroads have petitioned the Federal Railroad Administration (FRA) seeking approval for the discontinuance or modification of the signal system or relief from the requirements of Title 49 CFR Part 236 as detailed below.

Block Signal Application (BS-AP)-No. 3367

Applicant: Burlington Northern Railroad Company, Mr. William G. Peterson, Director Signal Engineering, 1900 Continental Plaza, Fort Worth, Texas 76102-5304.

The Burlington Northern Railroad Company seeks approval of the proposed modification of the traffic control system, on the two main tracks, between milepost 337.1, near Chariton, Iowa, and milepost 310.0, near Halpin, Iowa, on the Northern Corridor, Galesburg Division, Ottumwa Subdivision; consisting of the discontinuance and removal of 18 automatic signals and installation of 34 automatic signals.

The reason given for the proposed changes is to respace signals associated with the installation of electronic coded track circuits.

BS-AP-No. 3368

Applicant: CSX Transportation, Incorporated, Mr. D. G. Orr, Chief Engineer—Train Control, 500 Water Street (S/C J-350), Jacksonville, Florida 32202.

CSX Transportation, Incorporated seeks approval of the proposed discontinuance and removal of the

traffic control system, on the single siding, between Demmler, milepost PLY11.6 and Riverton, milepost PLY14.3, Pennsylvania, Cumberland Division, Pittsburgh Subdivision; consisting of the discontinuance and removal of the electric locks from four hand-operated switches, and establish Rule 105 for the method of operation on the siding.

The reason given for the proposed changes is to eliminate signal system no longer needed for present day operation. BS-AP-No. 3369

Applicant: Burlington Northern Railroad Company, Mr. William G. Peterson, Director Signal Engineering, 1900 Continental Plaza, Fort Worth, Texas 76102-5304.

The Burlington Northern Railroad Company seeks approval of the proposed modification of the traffic control system on the single main track, between milepost 310.0, near Neosho, Missouri, and milepost 345.0 near Afton, Oklahoma, on the Southern Corridor, Springfield Division, Monett Subdivision, consisting of the discontinuance and removal of 15 automatic signals, the discontinuance and removal of 2 absolute signals, and the installation of 20 automatic signals.

The reason given for the proposed changes is to respace signals associated with the installation of electronic coded track circuits.

Rules Standards & Instructions

Application (RS&I-AP)-No. 1098
Applicants: Union Pacific Railroad Company, Chicago and NorthWestern Transportation Company, Mr. A.L. Shoener, Executive Vice President Operations, 1416 Dodge Street, Room 1206, Omaha, Nebraska 68179.

The Union Pacific Railroad Company and Chicago and NorthWestern Transportation Company (CNW) jointly seek relief from the requirements of Section 236.566 (49 CFR, 236.566) of the Rules, Standard and Instructions to the extent that they be allowed to operate non-equipped automatic cab signal/automatic train stop (ACS/ATS) locomotives, in unit coal train service, between Lake Bluff, milepost 30.2 and Waukegan, milepost 35.9, Wisconsin, on the Kenosha Subdivision of the former CNW, in ACS/ATS territory.

Applicant's justification for relief: To eliminate train delay, additional operating costs, and reduced locomotive utilization on the limited fleet of ATS equipped locomotives.

Any interested party desiring to protest the granting of an application shall set forth specifically the grounds upon which the protest is made, and contain a concise statement of the

interest of the protestant in the proceeding. The original and two copies of the protest shall be filed with the Associate Administrator for Safety, FRA, 400 Seventh Street, S.W., Washington, D.C. 20590 within 45 calendar days of the date of issuance of this notice. Additionally, one copy of the protest shall be furnished to the applicant at the address listed above.

FRA expects to be able to determine these matters without oral hearing. However, if a specific request for an oral hearing is accompanied by a showing that the party is unable to adequately present his or her position by written statements, an application may be set for public hearing.

Issued in Washington, D.C. on December 4, 1995.

Phil Olekszyk,

Deputy Associate Administrator for Safety Compliance and Program Implementation.

[FR Doc. 95-29930 Filed 12-7-95; 8:45 am]

BILLING CODE 4910-06-P

National Highway Traffic Safety Administration

[Docket No. 95-64; Notice 2]

Decision That Nonconforming 1993 Mercedes-Benz 500SL and 1994 and 1995 SL500 Passenger Cars Are Eligible for Importation

AGENCY: National Highway Traffic Safety Administration (NHTSA), DOT.

ACTION: Notice of decision by NHTSA that nonconforming 1993 Mercedes-Benz 500SL and 1994 and 1995 SL500 passenger cars are eligible for importation.

SUMMARY: This notice announces the decision by NHTSA that 1993 Mercedes-Benz 500SL and 1994 and 1995 SL500 passenger cars not originally manufactured to comply with all applicable Federal motor vehicle safety standards are eligible for importation into the United States because they are substantially similar to vehicles originally manufactured for importation into and sale in the United States and certified by their manufacturer as complying with the safety standards (the U.S.-certified versions of the 1993 Mercedes-Benz 500SL and 1994 and 1995 SL500), and they are capable of being readily altered to conform to the standards.

DATES: This decision is effective December 8, 1995.

FOR FURTHER INFORMATION CONTACT: George Entwistle, Office of Vehicle Safety Compliance, NHTSA (202-366-5306).

SUPPLEMENTARY INFORMATION:

Background

Under 49 U.S.C. 30141(a)(1)(A) (formerly section 108(c)(3)(A)(i) of the National Traffic and Motor Vehicle Safety Act (the Act)), a motor vehicle that was not originally manufactured to conform to all applicable Federal motor vehicle safety standards shall be refused admission into the United States unless NHTSA has decided that the motor vehicle is substantially similar to a motor vehicle originally manufactured for importation into and sale in the United States, certified under 49 U.S.C. 30115 (formerly section 114 of the Act), and of the same model year as the model of the motor vehicle to be compared, and is capable of being readily altered to conform to all applicable Federal motor vehicle safety standards.

Petitions for eligibility decisions may be submitted by either manufacturers or importers who have registered with NHTSA pursuant to 49 CFR Part 592. As specified in 49 CFR 593.7, NHTSA publishes notice in the Federal Register of each petition that it receives, and affords interested persons an opportunity to comment on the petition. At the close of the comment period, NHTSA decides, on the basis of the petition and any comments that it has received, whether the vehicle is eligible for importation. The agency then publishes this decision in the Federal Register.

G&K Automotive Conversion, Inc. of Santa Ana, California (Registered Importer R-90-007) petitioned NHTSA to decide whether 1993 Mercedes-Benz 500SL and 1994 and 1995 SL500 passenger cars are eligible for importation into the United States. NHTSA published notice of the petition on September 26, 1995 (60 FR 49661) to afford an opportunity for public comment. The reader is referred to that notice for a thorough description of the petition. No comments were received in response to the notice. Based on its review of the information submitted by the petitioner, NHTSA has decided to grant the petition.

Vehicle Eligibility Number for Subject Vehicles

The importer of a vehicle admissible under any final decision must indicate on the form HS-7 accompanying entry the appropriate vehicle eligibility number indicating that the vehicle is eligible for entry. VSP-140 is the vehicle eligibility number assigned to vehicles admissible under this decision.

Final Decision

Accordingly, on the basis of the foregoing, NHTSA hereby decides that 1993 Mercedes-Benz 500SL and 1994 and 1995 SL500 (Model ID 129.067) passenger cars not originally manufactured to comply with all applicable Federal motor vehicle safety standards are substantially similar to 1993 Mercedes-Benz 500SL and 1994 and 1995 SL500 passenger cars originally manufactured for importation into and sale in the United States and certified under 49 U.S.C. 30115, and are capable of being readily altered to conform to all applicable Federal motor vehicle safety standards.

Authority: 49 U.S.C. 30141 (a)(1)(A) and (b)(1); 49 CFR 593.8; delegations of authority at 49 CFR 1.50 and 501.8.

Issued on: December 4, 1995.

Marilynne Jacobs,

Director, Office of Vehicle Safety Compliance.
[FR Doc. 95-29900 Filed 12-7-95; 8:45 am]

BILLING CODE 4910-59-M

[Docket No. 95-78; Notice 2]

Decision That Nonconforming 1990 Mercedes-Benz 560SEC Passenger Cars Are Eligible for Importation

AGENCY: National Highway Traffic Safety Administration (NHTSA), DOT.

ACTION: Notice of decision by NHTSA that nonconforming 1,990 Mercedes-Benz 560SEC passenger cars are eligible for importation.

SUMMARY: This notice announces the decision by NHTSA that 1990 Mercedes-Benz 560SEC passenger cars not originally manufactured to comply with all applicable Federal motor vehicle safety standards are eligible for importation into the United States because they are substantially similar to a vehicle originally manufactured for importation into and sale in the United States and certified by its manufacturer as complying with the safety standards (the U.S.-certified version of the 1990 Mercedes-Benz 560SEC), and they are capable of being readily altered to conform to the standards.

DATES: This decision is effective December 8, 1995.

FOR FURTHER INFORMATION CONTACT: George Entwistle, Office of Vehicle Safety Compliance, NHTSA (202-366-5306).

SUPPLEMENTARY INFORMATION:

Background

Under 49 U.S.C. § 30141(a)(1)(A) (formerly section 108(c)(3)(A)(i) of the National Traffic and Motor Vehicle

Safety Act (the Act)), a motor vehicle that was not originally manufactured to conform to all applicable Federal motor vehicle safety standards shall be refused admission into the United States unless NHTSA has decided that the motor vehicle is substantially similar to a motor vehicle originally manufactured for importation into and sale in the United States, certified under 49 U.S.C. § 30115 (formerly section 114 of the Act), and of the same model year as the model of the motor vehicle to be compared, and is capable of being readily altered to conform to all applicable Federal motor vehicle safety standards.

Petitions for eligibility decisions may be submitted by either manufacturers or importers who have registered with NHTSA pursuant to 49 CFR Part 592. As specified in 49 CFR 593.7, NHTSA publishes notice in the Federal Register of each petition that it receives, and affords interested persons an opportunity to comment on the petition. At the close of the comment period, NHTSA decides, on the basis of the petition and any comments that it has received, whether the vehicle is eligible for importation. The agency then publishes this decision in the Federal Register.

Champagne Imports, Inc. of Lansdale, Pennsylvania (Registered Importer R-90-007) petitioned NHTSA to decide whether 1990 Mercedes-Benz 560SEC passenger cars are eligible for importation into the United States. NHTSA published notice of the petition on September 26, 1995 (60 FR 49663) to afford an opportunity for public comment. The reader is referred to that notice for a thorough description of the petition. No comments were received in response to the notice. Based on its review of the information submitted by the petitioner, NHTSA has decided to grant the petition.

Vehicle Eligibility Number for Subject Vehicles

The importer of a vehicle admissible under any final decision must indicate on the form HS-7 accompanying entry the appropriate vehicle eligibility number indicating that the vehicle is eligible for entry. VSP-141 is the vehicle eligibility number assigned to vehicles admissible under this decision.

Final Decision

Accordingly, on the basis of the foregoing, NHTSA hereby decides that a 1990 Mercedes-Benz 560SEC (Model ID 126.045) not originally manufactured to comply with all applicable Federal motor vehicle safety standards is substantially similar to a 1990

Mercedes-Benz 560SEC originally manufactured for importation into and sale in the United States and certified under 49 U.S.C. § 30115, and is capable of being readily altered to conform to all applicable Federal motor vehicle safety standards.

Authority: 49 U.S.C. 30141 (a)(1)(A) and (b)(1); 49 CFR 593.8; delegations of authority at 49 CFR 1.50 and 501.8.

Issued on: December 4, 1995.

Marilynne Jacobs,

Director, Office of Vehicle Safety Compliance.
[FR Doc. 95-29902 Filed 12-7-95; 8:45 am]

BILLING CODE 4910-59-M

[Docket No. 95-75; Notice 2]

Decision That Nonconforming 1989 Nissan Maxima Passenger Cars Are Eligible for Importation

AGENCY: National Highway Traffic Safety Administration (NHTSA), DOT.

ACTION: Notice of decision by NHTSA that decision that nonconforming 1989 Nissan Maxima passenger cars are eligible for importation.

SUMMARY: This notice announces the decision by NHTSA that 1989 Nissan Maxima passenger cars not originally manufactured to comply with all applicable Federal motor vehicle safety standards are eligible for importation into the United States because they are substantially similar to a vehicle originally manufactured for importation into and sale in the United States and certified by its manufacturer as comply with the safety standards (the U.S.-certified version of the 1989 Nissan Maxima), and they are capable of being readily altered to conform to the standards.

DATE: This decision is effective December 8, 1995.

FOR FURTHER INFORMATION CONTACT: George Entwistle, Office of Vehicle Safety Compliance, NHTSA (202-366-5306).

SUPPLEMENTARY INFORMATION:

Background

Under 49 U.S.C. 30141(a)(1)(A) (formerly section 108(c)(3)(A)(i) of the National Traffic and Motor Vehicle Safety Act (the Act)), a motor vehicle that was not originally manufactured to conform to all applicable Federal motor vehicle safety standards shall be refused admission into the United States unless NHTSA has decided that the motor vehicle is substantially similar to a motor vehicle originally manufactured for importation into the sale in the United States, certified under 49 U.S.C.

30115 (formerly section 114 of the Act), and of the same model year as the model of the motor vehicle to be compared, and is capable of being readily altered to conform to all applicable Federal motor vehicle safety standards.

Petitions for eligibility decisions may be submitted by either manufacturers or importers who have registered with NHTSA pursuant to 49 CFR part 592. As specified in 49 CFR 593.7, NHTSA publishes notice in the Federal Register of each petition that it receives, and affords interested persons an opportunity to comment on the petition. At the close of the comment period, NHTSA decides, on the basis of the petition and any comments that it has received, whether the vehicle is eligible for importation. The agency then publishes this decision in the Federal Register.

Liphardt & Associates of Ronkonkoma, New York (Registered Importer R-90-004) petitioned NHTSA to decide whether 1989 Nissan Maxima passenger cars are eligible for importation into the United States. NHTSA published notice of the petition on September 12, 1995 (60 FR 47426) to afford an opportunity for public comment. The reader is referred to that notice for a thorough description of the petition. No comments were received in response to the notice. Based on its review of the information submitted by the petitioner, NHTSA has decided to grant the petition.

Vehicle Eligibility Number for Subject Vehicles

The importer of a vehicle admissible under any final decision must indicate on the form HS-7 accompanying entry the appropriate vehicle eligibility number indicating that the vehicle is eligible for entry. VSP-138 is the vehicle eligibility number assigned to vehicles admissible under this decision.

Final Decision

Accordingly, on the basis of the foregoing, NHTSA hereby decides that a 1989 Nissan Maxima not originally manufactured to comply with all applicable Federal motor vehicle safety standards is substantially similar to a 1989 Nissan Maxima originally manufactured for importation into and sale in the United States and certified under 49 U.S.C. § 30115, and is capable of being readily altered to conform to all applicable Federal motor vehicle safety standards.

Authority: 49 U.S.C. 30141 (a)(1)(A) and (b)(1); 49 CFR 593.8; delegations of authority at 49 CFR 1.50 and 501.8.

Issued on: December 4, 1995.

Marilynne Jacobs,
Director, Office of Vehicle Safety,
Compliance.

[FR Doc. 95-29901 Filed 12-7-95; 8:45 am]

BILLING CODE 4910-59-M

Maritime Administration

[Docket S-929]

Mormac Marine Transport, Inc.; Notice of Application for Written Permission Under Section 805(a) of the Merchant Marine Act, 1936, as Amended

Mormac Marine Transport, Inc. (Transport) by letter of November 22, 1995, requests, pursuant to section 805(a) of the Merchant Marine Act, 1936, as amended (Act) and Article II-13 of Operating-Differential Subsidy Agreements (ODSA) MA/MSB-295(a), (b), and (c), written permission to expand the scope of domestic operations permitted under the ODSA Contract MA/MSB-295 to include the management and operation of the vessels POTOMAC TRADER, DELAWARE TRADER, and CHESAPEAKE TRADER (Vessels) for Attranco, Inc. (Attranco), pursuant to a management agreement to be entered into between Mormac Marine Enterprises (Mormac) and Attranco.

Mormac and Transport are owned by Mormac Marine Group, Inc. (Parent). Transport, Mormac and the Parent have common ownership as well as common directors and officers.

Transport states that pursuant to a management agreement to be entered into between Attranco and Mormac, Mormac will become the manager of the Vessels. The Vessels, Transport continues, will be used in the Jones Act trade in essentially the same manner as is currently the case. Transport explains that since the Vessels will essentially continue their current services as they have been used by Attranco, the management of the Vessels by Mormac will not result in any change in competitive conditions for U.S.-flag vessels providing service in the Jones Act trade. Transport further explains that it and Mormac are entirely separate corporate entities that will maintain separate and discreet accounts so there will be no issue of subsidy leakage. Furthermore, Transport continues, the only benefit which Mormac will receive in respect of the operation of the Vessels will be a management fee, and all other benefits of operations will redound to Attranco.

In Transport's views, no U.S.-flag competitor of the Vessels will be subject to any changed circumstances or unfair

competition as a result of the change in management of the Vessels, nor will the operation of the Vessels by an affiliate of Transport be prejudicial to the purposes and policies of the Act.

In summary, Transport requests that the scope of domestic operations permitted under ODSA Contracts MA/MSB-295 (a), (b), and (c) be modified to incorporate the management and operation of the Vessels and requests approval for common ownership, officers and directors of Mormac and Transport.

Finally, Transport advises that Mormac will assume management responsibilities of the Vessels on January 1, 1996.

The application may be inspected in the Office of the Secretary, Maritime Administration. Any person, firm or corporation having any interest (within the meaning of section 805(a)) in Transport's request and desiring to submit comments concerning the request must by 5:00 pm on December 15, 1995, file written comments in triplicate with the Secretary, Maritime Administration, together with a petition for leave to intervene. The petition shall state clearly and concisely the grounds of interest, and the alleged facts relied on for relief.

If no petition for leave to intervene is received within the specified time or if it is determined that petitions filed do not demonstrate sufficient interest to warrant a hearing, the Maritime Administration will take such action as may be deemed appropriate.

In the event petitions regarding the relevant section 805(a) issues are received from parties with standing to be heard, a hearing will be held, the purpose of which will be to receive evidence under section 805(a) relative to whether the proposed operations (a) would result in unfair competition to any person, firm, or corporation operating exclusively in the coastwise or intercoastal service, or (b) would be prejudicial to the objects and policy of the Act relative to domestic trade operations.

(Catalog of Federal Domestic Assistance Program No. 20.805 (Operating-Differential Subsidies)).

By Order of the Maritime Administrator.

Dated: December 6, 1995.

Joel C. Richard,

Secretary.

[FR Doc. 95-30031 Filed 12-7-95; 8:45 am]

BILLING CODE 4910-81-P

DEPARTMENT OF THE TREASURY**Community Development Financial Institutions Fund; Notice of Extension of Due Dates and Availability of Supplemental Information for Notices of Funds Availability (NOFA) Inviting Applications for the Community Development Financial Institutions Program and the Bank Enterprise Award Program**

AGENCY: Community Development Financial Institutions Fund, Department of the Treasury.

ACTION: Notice of extension of due dates and availability of supplemental information for notices of funds availability inviting applications.

SUMMARY: This notice extends the application due date for the Bank Enterprise Award ("BEA") Program to January 16, 1996 and for the Community Development Financial Institutions ("CDFI") Program to January 22, 1996 from the dates indicated in the NOFAs published on October 19, 1995 inviting applications for the CDFI or BEA programs. This notice also announces the availability and distribution of supplemental information to assist potential applicants in completing the applications for these two programs.

DATES: This notice extends the application due date from December 15, 1995 to January 16, 1996 for the BEA Program and from December 22, 1995 to January 22, 1996 for the CDFI Program. The deadline for receipt of an application is 4 p.m. Eastern Standard Time on the respective due date. An application received after the specified date and time will not be accepted and

will be returned to the sender. Applications sent by FAX will not be accepted.

ADDRESSES: An application and supplemental information may be obtained from the office of the Community Development Financial Institutions Fund (the "Fund") listed below or by telephone at (202) 622-8662. (This is not a toll free number.) An application must be sent to: The Community Development Financial Institutions Fund, U.S. Department of the Treasury, 1500 Pennsylvania Avenue, N.W., Room 5116, Washington, DC 20220.

FOR FURTHER INFORMATION CONTACT: The Community Development Financial Institutions Fund, U.S. Department of the Treasury, 1500 Pennsylvania Avenue, N.W., Room 5116, Washington, DC 20220, (202) 622-8662. (This is not a toll free number.)

SUPPLEMENTARY INFORMATION: On October 19, 1995 the Department of the Treasury published a NOFA for the CDFI Program (60 FR 54136) and a separate NOFA for the BEA Program (60 FR 54140). The CDFI Program NOFA announced the availability of up to \$31 million for program awards and gave an application deadline of December 22, 1995. The BEA Program NOFA announced the availability of up to \$15.5 million for program awards and gave an application due date of December 15, 1995. In response to numerous requests by potential applicants, this notice extends the application due dates to January 16, 1996 for the BEA Program and January 22, 1996 for the CDFI Program. In addition, the Fund has prepared

supplemental information to assist potential applicants in completing the required application materials. This information will be mailed to all those who attended a workshop announced in the NOFAs published on October 19, 1995 and to those on the Fund's mailing list, which includes those who have requested an application from the Fund. Others may request a copy of this information by contacting the Fund.

Authority: 12 U.S.C. 4703, 4717; Chapter X, Pub.L. 104-19, 109 Stat. 237; 12 CFR 1805.700.

Dated: December 5, 1995.

Kirsten S. Moy,

Director, Community Development Financial Institutions Fund.

[FR Doc. 95-29982 Filed 12-7-95; 8:45 am]

BILLING CODE 4810-70-P

DEPARTMENT OF VETERANS AFFAIRS**Special Medical Advisory Group, Notice of Charter Renewal**

This gives notice under the Federal Advisory Committee Act, as amended (Public Law 92-463; 5 U.S.C. App.), that the Department of Veterans Affairs' Special Medical Advisory Group has been renewed for a 2-year period beginning November 9, 1995, through November 9, 1997.

Dated: November 29, 1995.

By Direction of the Secretary:

Heyward Bannister,

Committee Management Officer.

[FR Doc. 95-29924 Filed 12-7-95; 8:45 am]

BILLING CODE 8320-01-M

Sunshine Act Meetings

Federal Register

Vol. 60, No. 236

Friday, December 8, 1995

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

AFRICAN DEVELOPMENT FOUNDATION

Board of Directors Meeting

TIME: 11:30 a.m.—2:00 p.m.

PLACE: ADF Headquarters.

DATES: Tuesday, December 12, 1995.

STATUS: Open.

Agenda

11:30 a.m.—Lunch

12:00 noon—Chairman's Report

12:15 p.m.—President's Report

1:00 p.m.—Other

If you have any questions or comments, please direct them to Ms. Janis McCollim, Executive Assistant to the President, who can be reached at (202) 673-3916.

William R. Ford,

President.

[FR Doc. 95-30077 Filed 12-6-95; 1:42 pm]

BILLING CODE 6116-01-P

BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM

TIME AND DATE: Approximately 11:30 a.m., Wednesday, December 13, 1995, following a recess at the conclusion of the open meeting.

PLACE: Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, N.W., Washington, D.C. 20551.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Proposed recommendations regarding the Federal Reserve Board's affirmative action policy. (This item was originally announced for a closed meeting on December 6, 1995.)

2. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.

3. Any items carried forward from a previously announced meeting.

CONTACT PERSON FOR MORE INFORMATION: Mr. Joseph R. Coyne, Assistant to the

Board; (202) 452-3204. You may call (202) 452-3207, beginning at approximately 5 p.m. two business days before this meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Dated: December 6, 1995.

Jennifer J. Johnson,

Deputy Secretary of the Board.

[FR Doc. 95-30044 Filed 12-6-95; 10:39 am]

BILLING CODE 6210-01-P

BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM

TIME AND DATE: 10:00 a.m., Wednesday, December 13, 1995.

PLACE: Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, N.W., Washington, D.C. 20551.

STATUS: Open.

MATTERS TO BE CONSIDERED:

Summary Agenda

Because of its routine nature, no substantive discussion of the following item is anticipated. This matter will be voted on without discussion unless a member of the Board requests that the item be moved to the discussion agenda.

1. Publication for comment of proposed amendments to Subpart A of Regulation S (Reimbursement for Providing Financial Records; Recordkeeping Requirements for Certain Financial Records) regarding reimbursement of certain costs incurred by financial institutions.

Discussion Agenda

2. Proposed policy statement describing how interest rate risk will be measured and evaluated for supervisory purposes (proposed earlier for public comment; Docket No. R-0802).

3. Proposed 1996 Federal Reserve Bank budgets.

4. Cost of Federal Reserve notes in 1996.

5. Any items carried forward from a previously announced meeting.

Note: This meeting will be recorded for the benefit of those unable to attend. Cassettes will be available for listening in the Board's Freedom of Information Office, and copies may be ordered for \$5 per cassette by calling (202) 452-3684 or by writing to:

Freedom of Information Office, Board of Governors of the Federal Reserve System, Washington, D.C. 20551.

CONTACT PERSON FOR MORE INFORMATION:

Mr. Joseph R. Coyne, Assistant to the Board; (202) 452-3204.

Dated: December 6, 1995.

Jennifer J. Johnson,

Deputy Secretary of the Board.

[FR Doc. 95-30045 Filed 12-6-95; 10:39 am]

BILLING CODE 6210-01-P

U.S. NATIONAL COMMISSION ON LIBRARIES AND INFORMATION SCIENCE

STATUS: Open.

MEETING: Meeting of the U.S. National Commission on Libraries and Information Science (NCLIS).

DATE AND TIME:

December 14, 1995—10:10 a.m.—4:45 p.m.

December 15, 1995—9:00 a.m.—2:30 p.m.

PLACE: Room SH-708, Hart Senate Office Building (HSOB), Second St. and Constitution Ave., N.E., Washington, DC.

MATTERS TO BE DISCUSSED:

Administrative matters
Status reports on FY 1996 appropriations and continuing resolution(s)
Status report and discussion of NCLIS involvement with Library Services and Technology Act
Status report on other Congressional initiatives related to libraries and information services
Status report on NCLIS projects, FY 1995
Strategic planning mini-retreat led by NCLIS Committee on Information Policies

To request further information or to make special arrangements for physically challenged persons, contact Barbara Whiteleather (202-606-9200) no later than one week in advance of the meeting.

Dated: November 30, 1995.

Peter R. Young,

NCLIS Executive Director.

[FR Doc. 95-30029 Filed 12-6-95; 8:45 am]

BILLING CODE 7527-01-M

Registered
for
Federal

Friday
December 8, 1995

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 400, et al.

Medicare Program; Physician Fee
Schedule for Calendar Year 1996;
Payment Policies and Relative Value Unit
Adjustments; Final Rule and Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Health Care Financing Administration****42 CFR Parts 400, 405, 410, 411, 412, 413, 414, 415, 417, and 489****[BPD-827-FC]****RIN 0938-AG96****Medicare Program; Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1996****AGENCY:** Health Care Financing Administration (HCFA), HHS.**ACTION:** Final rule with comment period.

SUMMARY: This final rule revises various policies affecting payment for physician services including Medicare payment for physician services in teaching settings, the relative value units (RVUs) for certain existing procedure codes, and establishes interim RVUs for new and revised procedure codes. The rule also includes the final revised 1996 geographic practice cost indices.

The rule redesignates current regulations on teaching hospitals, on the services of physicians to providers, on the services of physicians in providers, and on the services of interns and residents. This redesignation consolidates related rules affecting a specific audience in a separate part and, thereby, makes them easier to use.

DATES: *Effective Date:* This final rule is effective January 1, 1996, except part 415 which is effective July 1, 1996.

Comment Date: We will accept comments on interim RVUs for new or revised procedure codes identified in Addendum C. Comments will be considered if we receive them at the appropriate addresses, as provided below, no later than 5 p.m., February 6, 1996.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD-827-FC, P.O. Box 7519, Baltimore, MD 21207-0519.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or
Room C5-09-26, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code BPD-827-FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690-7890).

For comments that relate to information collection requirements, mail a copy of comments to: Allison Herron Eydt, HCFA Desk Officer, Office of Information and Regulatory Affairs, Rm. 10235, New Executive Office Bldg., Washington, DC 20530.

Copies: To order copies of the Federal Register containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify stock number 069-001-00090-4 and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or MasterCard number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each copy is \$8. As an alternative, you can view and photocopy the Federal Register document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the Federal Register.

Copies of the source files for this document can also be purchased on high density 3.5 inch personal computer diskettes for \$20.00. Send your request to: Superintendent of Documents, Attention: Electronic Products, P.O. Box 37082, Washington, DC 20013-7082. Enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or MasterCard number and expiration date. Credit card orders for the diskettes can also be placed by calling (202) 512-1530 or by faxing to (202) 512-1262. The file format on the diskettes is comma delimited ASCII, Lotus 123, and WordPerfect 5.1.

FOR FURTHER INFORMATION CONTACT: Shana Olshan, (410) 786-5714 (for all issues except those related to physician services in teaching settings). William Morse, (410) 786-4520 (for issues related to physician services in teaching settings).

SUPPLEMENTARY INFORMATION: In this final rule, we provide background on

the statutory authority for and development of the physician fee schedule. We also explain in detail the process by which certain interim work RVUs are reviewed and, in some cases, revised.

Section 1848(c)(2)(B) of the Social Security Act (the Act) provides that adjustments in RVUs resulting from an annual review of those RVUs may not cause total physician fee schedule payments to differ by more than \$20 million from what they would have been had the adjustments not been made. Thus, the statute allows a \$20 million tolerance for increasing or reducing total expenditures under the physician fee schedule. We have determined that net increases because of changes in RVUs for codes reviewed as part of a refinement process, the addition of new codes to the fee schedule, and the revisions in payment policies would have added to projected expenditures in calendar year 1996 by approximately \$140 million. Therefore, it is necessary to adjust the physician fee schedule conversion factors (CFs). We have made the adjustments in such a manner as to achieve budget neutrality as we were best able to estimate. As a result, the total projected expenditures from the revised fee schedule are estimated to be the same as they would have been had we not changed the RVUs for any individual codes or added new codes to the fee schedule. We have adjusted all CFs by a uniform adjustment factor of 0.9964, which results in a uniform reduction of 0.36 percent to the CFs for all services.

The CF is a national value that converts RVUs into payment amounts. There are three separate CFs: one for surgical services, one for primary care services, and one for nonsurgical services other than primary care. The CFs are updated annually.

Anesthesia services are paid differently from other physicians' services under the fee schedule. Payment for anesthesia services is based on base unit RVUs that are assigned to each service and on time units that can vary by procedure. The base and time units are multiplied by an anesthesia-specific CF, not the CFs used for surgical, nonsurgical, or primary care services.

This final rule also contains the second half of the revisions to the geographic practice cost indices (GPCIs). Section 1848(e)(1)(c) of the Act requires that the GPCIs be reviewed and, if necessary, revised at least every 3 years. The first review was required by 1995. The first-half of the revision was implemented in 1995. The second half,

published in Addendum D, is effective January 1, 1996.

Addenda to this rule provide the following information:

Addendum A—Explanation and Use of Addenda B through E.

Addendum B—1996 Relative Value Units and Related Information Used in Determining Medicare Payments for 1996.

Addendum C—Codes with Interim Relative Value Units.

Addendum D—1996 Geographic Practice Cost Indices by Medicare Carrier and Locality.

Addendum E—Procedure Codes Subject to the Site-of-Service Differential.

The RVUs and revisions to payment policies in this final rule apply to physicians' services furnished on or after January 1, 1996.

For those codes identified in Addendum C of this final rule as new or revised codes, the RVUs and update indicators are considered to be interim as they have not been published before this final rule. Therefore, we will accept comments on these interim RVUs and update indicators if they are received no later than 5 p.m. February 6, 1996. The RVUs for the remaining codes are final.

To assist readers in referencing sections contained in this final rule, we are providing the following table of contents. Some of the issues discussed in this final rule affect the payment policies but do not require changes to the regulations in the Code of Federal Regulations.

Table of Contents

I. Background

- A. Legislative Requirements
- B. Published Changes to the Fee Schedule
- C. Components of the Fee Schedule Payment Amounts
- D. Summary of the Development of the Relative Value Units
 1. Work Relative Value Units
 2. Practice Expense and Malpractice Expense Relative Value Units
- II. Specific Proposals for Calendar Year 1996 and Responses to Public Comments
 - A. Budget-Neutrality Adjustments for Relative Value Units
 - B. Bundled Services
 1. Hydration Therapy and Chemotherapy
 2. Evaluation of Psychiatric Records and Reports and Family Counseling Services
 3. Fitting of Spectacles
 - C. X-Rays and Electrocardiograms Taken in the Emergency Room
 - D. Extension of Site-of-Service Payment Differential to Services in Ambulatory Surgical Centers
 - E. Services of Teaching Physicians
 1. General Background
 2. Payment for Physician Services Furnished in Teaching Settings
 3. Payments for Supervising Physicians in Teaching Settings and for Residents in Certain Settings

4. Public Comments on the Teaching Physician Proposal in the Proposed Rule and Our Responses

F. Unspecified Physical and Occupational Therapy Services (HCFA Common Procedure Coding System Codes M0005 Through M0008 and H5300)

G. Transportation in Connection With Furnishing Diagnostic Tests

H. Maxillofacial Prosthetic Services

I. Coverage of Mammography Services

III. Anesthesia Issues

A. Modifier Units for Anesthesia Services

B. Issue for Change in Calendar Year 1998—Two Anesthesia Providers Involved in One Procedure

IV. Refinement of Relative Value Units for Calendar Year 1996 and Responses to Public Comments on Interim Relative Value Units for 1995

A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units

B. Process for Establishing Work Relative Value Units for the 1996 Fee Schedule

1. Work Relative Value Unit Refinements of Interim and Related Relative Value Units
2. Establishment of Interim Work Relative Value Units for New and Revised Codes for 1996

V. Issues for Discussion

- A. Five-Year Refinement of Relative Value Units
- B. Resource-Based Practice Expense Relative Value Units
- C. Case Management in a Fee-for-Service System

VI. Provisions of the Final Rule

VII. Collection of Information Requirements

VIII. Response to Comments

IX. Regulatory Impact Analysis

- A. Regulatory Flexibility Act
 - B. Budget-Neutrality Adjustments
 - C. Bundled Services
 1. Hydration Therapy and Chemotherapy
 2. Evaluation of Psychiatric Records and Reports and Family Counseling Services
 3. Fitting of Spectacles
 - D. X-Rays and Electrocardiograms Taken in the Emergency Room
 - E. Extension of Site-of-Service Payment Differential to Services in Ambulatory Surgical Centers
 - F. Services of Teaching Physicians
 - G. Unspecified Physical and Occupational Therapy Services (HCFA Common Procedure Coding System Codes M0005 Through M0008 and H5300)
 - H. Transportation in Connection With Furnishing Diagnostic Tests
 - I. Maxillofacial Prosthetic Services
 - J. Coverage of Mammography Services
 - K. Two Anesthesia Providers Involved in One Procedure
 - L. Rural Hospital Impact Statement
- Text of the Final Regulations

Addenda
Addendum A—Explanation and Use of Addenda B through E

Addendum B—1996 Relative Value Units and Related Information Used in Determining Medicare Payments for 1996

Addendum C—Codes with Interim Relative Value Units

Addendum D—1996 Geographic Practice Cost Indices by Medicare Carrier and Locality

Addendum E—Procedure Codes Subject to the Site-of-Service Differential

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

ASC Ambulatory surgical center

CF Conversion factor

CFR Code of Federal Regulations

CPT [Physicians'] Current Procedural Terminology [4th Edition, 1994, copyrighted by the American Medical Association] DEFRA Deficit Reduction Act

EKG Electrocardiogram

GPCI Geographic Practice Cost Index

GME Graduate Medical Education

HCFA Health Care Financing Administration

HCPCS HCFA Common Procedure Coding System

OBRA Omnibus Budget Reconciliation Act

ORA Omnibus Reconciliation Act

RUC [American Medical Association Specialty Society] Relative [Value] Update Committee

RVU Relative Value Unit

TEFRA Tax Equity and Fiscal Responsibility Act

I. Background

A. Legislative Requirements

The Medicare program was established in 1965 by the addition of title XVIII to the Social Security Act (the Act). Since January 1, 1992, Medicare pays for physician services under section 1848 of the Act, "Payment for Physicians' Services." This section contains three major elements: (1) A fee schedule for the payment of physician services; (2) a Medicare volume performance standard for the rates of increase in Medicare expenditures for physician services; and (3) limits on the amounts that nonparticipating physicians can charge beneficiaries. The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) based on the resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense, and malpractice expense.

Section 1848(e)(1)(c) of the Act requires us to review and, if necessary, adjust the geographic practice cost indices at least every 3 years. This section of the Act also requires us to phase in the adjustment over 2 years and implement only one half of any

adjustment if more than 1 year has elapsed since the last geographic practice cost index revision. The geographic practice cost indices were first implemented in 1992 and were not reviewed until 1994. We implemented one half of the adjustment in 1995 and will implement the second half of the adjustment in 1996.

The Act requires that payments vary among fee schedule areas according to geographic indices. In general, the fee schedule areas that existed under the prior reasonable charge system were retained under the fee schedule. A detailed discussion of fee schedule areas can be found in the June 5, 1991 proposed rule (56 FR 25832) and in the November 25, 1991 final rule (56 FR 59514). We are required by section 1848(e)(1)(A) of the Act to develop separate indices to measure relative cost differences among fee schedule areas compared to the national average for each of the three fee schedule components. While requiring that the practice expense geographic practice cost indices and malpractice geographic practice cost indices reflect the full relative cost differences, the Act requires that the work indices reflect only one-quarter of the relative cost differences compared to the national average.

B. Published Changes to the Fee Schedule

We published a final rule on November 25, 1991, (56 FR 59502) to implement section 1848 of the Act by establishing a fee schedule for physician services furnished on or after January 1, 1992. In the November 1991 final rule (56 FR 59511), we stated our intention to update RVUs for new and revised codes in the American Medical Association's Physicians' Current Procedural Terminology (CPT) through an "interim RVU" process every year. The updates to the RVUs and fee schedule policies follow:

- November 25, 1992, as a final notice with comment period on new and revised RVUs only (57 FR 55914).
- December 2, 1993, as a final rule with comment period (58 FR 63626) announcing revised payment policies and RVUs for 1994. (We solicited comments on new and revised RVUs only.)
- December 8, 1994, as a final rule with comment period (59 FR 63410) to revise the geographic adjustment factor values, fee schedule payment areas, and payment policies and RVUs for 1995. The final rule also discussed the process for periodic review and adjustment of RVUs not less frequently than every 5

years as required by section 1848(c)(2)(B)(I) of the Act.

Prior Federal Register Documents

The information in this final rule with comment period updates information in the following Federal Register documents:

- June 5, 1991, proposed rule entitled "Fee Schedule for Physicians' Services" (56 FR 25792).
 - November 25, 1991, final rule entitled "Fee Schedule for Physicians' Services" (56 FR 59502).
 - September 15, 1992, correction notice for the 1992 fee schedule (57 FR 42491).
 - November 25, 1992, final notice with comment period entitled "Fee Schedule for Physicians' Services for CY 1993" (57 FR 55914).
 - June 7, 1993, correction notice for the 1993 fee schedule (58 FR 31964).
 - July 14, 1993, proposed rule entitled "Revisions to Payment Policies Under the Physician Fee Schedule" (58 FR 37994).
 - December 2, 1993, final rule with comment period entitled "Revisions to Payment Policies and Adjustments to the Relative Value Units under the Physician Fee Schedule for Calendar Year 1994" (58 FR 63626). (There were two correction notices published for the 1994 physician fee schedule (July 15, 1994, 59 FR 36069) and (August 4, 1994, 59 FR 39828).)
 - June 24, 1994, proposed rule entitled "Refinements to Geographic Adjustment Factor Values and Other Policies Under the Physician Fee Schedule" (58 FR 32754).
 - December 8, 1994, final rule with comment period entitled "Refinements to Geographic Adjustment Factor Values, Revisions to Payment Policies, Adjustments to the Relative Value Units (RVUs) Under the Physician Fee Schedule for Calendar Year 1995, and the 5-Year Refinement of RVUs" (59 FR 63410). (There were two correction notices published for the 1995 physician fee schedule (January 3, 1995, 60 FR 46) and (July 18, 1995, 60 FR 36733).)
 - July 26, 1995, proposed rule entitled "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 1996 (60 FR 38400).
- This final rule would affect the regulations set forth at 42 CFR part 400, which consists of an introduction to, and definitions for, the Medicare and Medicaid programs; part 405, which encompasses regulations on Federal health insurance for the aged and disabled; part 410, which consists of regulations on supplementary medical insurance benefits; part 414, which

covers regulations on payment for Part B medical and other health services; and new part 415, which contains regulations on services of physicians in teaching settings, and residents in certain settings. We are making technical and conforming amendments to parts 411, 412, 413, 417, and 489.

C. Components of the Fee Schedule Payment Amounts

Under the formula set forth in section 1848(b)(1) of the Act, the payment amount for each service paid for under the physician fee schedule is the product of three factors: (1) A nationally uniform relative value for the service; (2) a geographic adjustment factor for each physician fee schedule area; and (3) a nationally uniform conversion factor for the service. There are three conversion factors (CFs)—one for surgical services, one for nonsurgical services, and one for primary care services. The conversion factors convert the relative values into payment amounts.

For each physician fee schedule service, there are three relative values: (1) An RVU for physician work; (2) an RVU for practice expense; and (3) an RVU for malpractice expense. For each of these components of the fee schedule there is a geographic practice cost index for each fee schedule area. The geographic practice cost indices reflect the relative costs of practice expenses, malpractice insurance, and physician work in an area compared to the national average.

The general formula for calculating the Medicare fee schedule amount for a given service in a given fee schedule area can be expressed as:

$$\text{Payment} = [(\text{RVU}_{\text{work}} \times \text{GPCI}_{\text{work}}) + (\text{RVU}_{\text{practice expense}} \times \text{GPCI}_{\text{practice expense}}) + (\text{RVU}_{\text{malpractice}} \times \text{GPCI}_{\text{malpractice}})] \times \text{CF}$$

The conversion factors for calendar year 1996 appear in Addendum A. The RVUs for calendar year 1996 are in Addendum B. The GPCIs are in Addendum D.

Section 1848(e) of the Act requires the Secretary to develop geographic adjustment factors for all physician fee schedule areas. The total geographic adjustment factor for a fee schedule area is equal to a weighted average of the individual GPCIs for each of the three components of the service. Thus, the geographic practice cost indices reflect the relative costs of practice expenses, malpractice insurance, and physician work in an area compared to the national average. In accordance with the law, however, the geographic adjustment factor for the physician's

work reflects one-quarter of the relative cost of physician's work compared to the national average.

For the first year of the fee schedule, the law required a base-year CF that was budget-neutral relative to 1991 estimated expenditures. The Secretary is required to recommend to the Congress updates to the CFs by April 15 of each year as part of the Medicare volume performance standards and annual fee schedule update process. The Congress may choose to enact the Secretary's recommendation, enact another update amount, or not act at all. If the Congress does not act, the annual fee schedule update is set according to a "default" mechanism in the law. Under this mechanism, the update will equal the Medicare Economic Index adjusted by the amount actual expenditures for the second previous fiscal year (FY) were greater or less than the performance standard rate of increase for that FY. (The Medicare Economic Index is a physician input price index, in which the annual percent changes for the direct-labor price component are adjusted by an annual percent change in a 10-year moving average index of labor productivity in the nonfarm business sector.) The Medicare volume performance standard for FY 1996 and the physician fee schedule update for CY 1996 are published elsewhere in this Federal Register issue as a final notice (BPD-828-FN).

D. Summary of the Development of the Relative Value Units

1. Work Relative Value Units

Approximately 7,500 codes represent services included in the physician fee schedule. The work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. The original work RVUs for most codes were developed by a research team at the Harvard School of Public Health in a cooperative agreement with us. In constructing the vignettes for the original RVUs, Harvard worked with panels of expert physicians and obtained input from physicians from numerous specialties.

The RVUs for radiology services are based on the American College of Radiology (ACR) relative value scale, which we integrated into the overall physician fee schedule. The RVUs for anesthesia services are based on RVUs from a uniform relative value guide. We established a separate CF for anesthesia services because we continue to recognize time as a factor in determining payment for these services.

Proposed RVUs for services were published in a proposed rule in the Federal Register on June 5, 1991 (56 FR 25792). We responded to the comments in the November 1991 final rule. Since many of the RVUs were published for the first time in the final rule, we considered the RVUs to be interim during the first year of the fee schedule and gave the public 120 days to comment on all work RVUs. In response to the final rule, we received comments on approximately 1,000 services. We responded to those comments and listed the new RVUs in the November 1992 notice for the 1993 fee schedule for physicians' services. We considered these RVUs to be final and did not request comments on them.

The November 1992 notice (57 FR 55914) also discussed the process used to establish work RVUs for codes that were new or revised in 1993. The RVUs for these codes, which were listed in Addendum C of the November 1992 notice, were considered interim in 1993 and open to comment through January 26, 1993.

We responded to comments received on RVUs listed in Addendum C of the November 1992 notice (57 FR 56152) in the December 1993 final rule (58 FR 63647) for the 1994 physician fee schedule. The December 1993 final rule discussed the process used to establish RVUs for codes that were new or revised for 1994. The RVUs for these codes, which are listed in Addendum C of the December 1993 final rule (58 FR 63842), were considered interim in 1994 and open to comment through January 31, 1994. We proposed RVUs for some non-Medicare and carrier-priced codes in our June 1994 proposed rule (59 FR 32760). Codes listed in Table 1 of the June 1994 proposed rule were open to comment. These comments, in addition to comments on RVUs published as interim in the December 1993 final rule were addressed in the December 1994 final rule (59 FR 63432). In addition, the December 1994 final rule discussed the process used to establish RVUs for codes that were new or revised for 1995. Interim RVUs for new or revised procedure codes were open to comment. Comments were also accepted on all RVUs considered under the 5-year refinement process. The comment period closed on February 6, 1995.

2. Practice Expense and Malpractice Expense Relative Value Units

Section 1848(c)(2)(C) of the Act requires that the practice expense and malpractice expense RVUs equal the product of the base allowed charges and the practice expense and malpractice percentages for the service. Base

allowed charges are defined as the national average allowed charges for the service furnished during 1991, as estimated using the most recent data available. For most services, we used 1989 charge data "aged" to reflect the 1991 payment rules, since those were the most recent data available for the 1992 fee schedule.

If charge data were unavailable or insufficient, we imputed the practice expense and malpractice expense RVUs from the work RVUs. For example, if a procedure has work RVUs of 6.00, and the specialty practice cost percentages for the specialty furnishing the service is 60 percent work, 30 percent practice expense, and 10 percent malpractice expense, then the total RVUs would be 10.00 (6.00/.60), the practice expense RVUs would be 3.00 (10 × .30), and the malpractice expense RVUs would be 1.00 (10 × .10).

II. Specific Proposals for Calendar Year 1996 and Responses to Public Comments

In response to the publication of the July 26, 1995 proposed rule, we received approximately 9,500 comments. We received comments from individual physicians and health care workers and professional associations and societies. The majority of the comments addressed two proposals: (1) Revising Medicare payment for physician services in teaching settings; and (2) paying for only one interpretation of an electrocardiogram or an x-ray procedure furnished to an emergency room patient except in unusual circumstances.

The proposed rule discussed policies that affect the number of RVUs on which payment for certain services would be based. Any changes implemented through this final rule are subject to the \$20 million limitation on annual adjustments as contained in section 1848(c)(2)(B) of the Act.

After reviewing the comments and determining the policies we will implement, we have estimated the costs and savings of these policies and added those costs and savings to the estimated costs associated with any other changes in RVUs for 1996, including RVU changes necessitated by the 1995 CPT coding changes. We discuss in detail the effects of these changes in the Regulatory Impact Analysis (section IX).

In the July 1995 proposed rule (60 FR 38416), we invited public comments on a proposal to calculate the Medicare volume performance standard for fiscal year 1996 and all future years based on estimates of the average volume and intensity growth specific to each category of physician service. We are

responding to the comments we received on this issue in the final notice entitled "Physician Fee Schedule Update for Calendar Year 1996 and Physician Volume Performance Standard Rates of Increase for Federal Fiscal Year 1996 (BPD-828-FN) published elsewhere in this Federal Register issue.

For the convenience of the reader, the headings for the policy issues in sections II, III, and IV, for the most part, correspond to the headings used in the July 1995 proposed rule. More detailed background information for each issue can be found in the July 1995 proposed rule (60 FR 38400).

A. Budget-Neutrality Adjustments for Relative Value Units

We make annual adjustments to RVUs for the physician fee schedule to reflect changes in CPT codes and changes in estimated physician work. The statute requires that these revisions may not change physician expenditures by more than \$20 million compared to estimated expenditures that would have occurred if the RVU adjustments had not been made. In the past, we have made an adjustment across all RVUs in the physician fee schedule to maintain this statutorily-mandated budget neutrality.

We recognize that many other payers, including several Medicaid programs, use the Medicare physician fee schedule. To reduce the number of system changes required by the annual revisions to the physician fee schedule, we proposed to apply these budget-neutrality adjustments to the physician fee schedule conversion factors (CFs) rather than across all RVUs.

The impact of this proposal on payment amounts would be minimal (slight differences could be caused by rounding). This alternative approach would be administratively simpler for Medicare and other payers that base payment on the Medicare RVUs, including many State Medicaid programs. In addition, this change would provide for consistent RVUs from year to year (for those codes with no other changes), thus making it easier to analyze payment and policy changes.

Comment: An overwhelming majority of commenters strongly supported our decision to apply the annual budget-neutrality adjustments to the physician fee schedule CFs rather than across all RVUs, beginning with the publication of this final rule in the Federal Register; however, a few commenters suggested that we apply this change retroactively by converting all RVUs, which were altered for budget-neutrality reasons, back to their original 1992 levels.

Response: For the sake of administrative simplicity, we will not readjust RVUs from periods before the current period. In addition, we believe that retroactively adjusting the RVUs would cause unnecessary programming costs for those who electronically maintain systems containing the RVU data.

Comment: A few commenters suggested the use of a separate budget-neutrality factor rather than the adjustment of the physician fee schedule CFs to achieve budget neutrality. They stated that private payers who use the Medicare fee schedule CFs would then be able to decide whether to apply the budget neutrality adjustment. This particularly could be an issue for any adjustments needed for the five-year review of all work RVUs, depending on the magnitude of the adjustments.

Response: We prefer to adjust the existing CFs rather than add an additional factor to adjust for budget neutrality. Because we explicitly identify the magnitude of the annual budget-neutrality adjustment, other payers can decide whether to apply the adjustment to their CFs. However, we may reconsider this issue in the future for issues such as the 5-year review of RVUs or congressional action.

Final Decision: Beginning with the publication of this final rule, we will apply annual budget-neutrality adjustments to physician fee schedule CFs rather than across all RVUs. However, if the Congress explicitly sets a conversion factor at a fixed dollar amount for a given year, we will consider establishing a separate budget-neutrality adjustor.

B. Bundled Services

1. Hydration Therapy and Chemotherapy

We proposed not paying separately for hydration therapy infusion (CPT codes 90780 and 90781) when billed on the same day as chemotherapy infusion, CPT codes (96410, 96412, and 96414). Frequently, hydration therapy and chemotherapy are performed at the same time. We believe paying for both would be duplicative. We would continue to pay separately for both the hydration therapy solution and the chemotherapy drug. This reflects a policy change that is not explicitly addressed in our regulations.

Comment: Commenters objected to our proposal stating that the administration of saline for hydration therapy infusion at the same time as chemotherapy infusion requires

significant additional work and supplies.

Response: We disagree. The saline and the chemotherapy drug are usually administered through the same port or site. In some cases, the solutions may even be mixed. We see no significant additional work or expense involved in these cases, and we believe that paying separately for hydration therapy infusion administered at the same time as chemotherapy infusion represents duplicate payment.

Comment: A commenter agreed with our proposal stating that the same access port or site is used for administering the chemotherapy drug and the hydration therapy solution. The commenter requested clarification as to whether the policy would apply to other drugs, such as antiemetics and corticosteroids, which are often administered with chemotherapy and, like hydration therapy, billed using CPT codes 90780 and 90781. The commenter suggested that a logical extension of our proposal is to cover the administration of these drugs as well as hydration therapy.

Response: We agree with this comment. CPT codes 90780 and 90781 for the administration of saline or drugs such as antiemetics and corticosteroids will not be paid separately when furnished at the same time as CPT codes 96410, 96412, and 96414 for chemotherapy infusion. However, we will pay separately for the drugs.

Comment: Most commenters agreed that for any given segment of time it would be duplicative to pay for both chemotherapy infusion and hydration therapy infusion. These commenters noted that the course of treatment for many chemotherapy drugs, for example, cisplatin, ifosfamide, and methotrexate, require hydration therapy or the infusion of an antiemetic on the same day, but either before or after the chemotherapy. The commenters believed that in these cases, the work is not duplicative, and they should be allowed to bill for the infusion of the saline or antiemetic.

Response: We agree. We are revising our proposal to allow payment for hydration therapy or the infusion of an antiemetic or other nonchemotherapy drug on the same day as chemotherapy infusion when the nonchemotherapy drug is administered sequentially rather than at the same time as the chemotherapy infusion.

Final Decision: We will not pay for the infusion of saline, an antiemetic, or any other nonchemotherapy drug under CPT codes 90780 and 90781 when these drugs are administered at the same time as chemotherapy infusion (CPT codes

96410, 96412, or 96414). However, we will pay for the infusion of saline, antiemetics, or any other nonchemotherapy drug under CPT codes 90780 and 90781 when these drugs are administered on the same day but sequentially to rather than at the same time as chemotherapy infusion, under CPT codes 96410, 96412, and 96414. Physicians should use the new modifier “-GB” to indicate when CPT codes 90780 and 90781 are provided sequentially rather than contemporaneously with CPT codes 96410, 96412, and 96414.

This policy change is not explicitly addressed in our regulations.

2. Evaluation of Psychiatric Records and Reports and Family Counseling Services

At present, we allow separate payment for CPT codes 90825 and 90887. However, we believe that the activities described by these codes are generally performed as part of the prework and postwork of other physician services. The RVUs for psychiatric services (CPT codes 90801 and 90835 through 90857) include the prework and postwork activities described by CPT codes 90825 and 90887. Thus, continuing to allow separate payment for these codes, in addition to payment for other psychiatric services, results in duplicate payments and is inconsistent with our policy for other services.

Counseling of the family is part of the work of all other evaluation and management services. Medicare has a long-standing policy of covering these services if they relate to the management of the beneficiary's problems and not to the problems of the family member. We believe it is appropriate to bundle covered family counseling procedures into the other psychiatric codes so that our policy is consistent with our policy on services furnished by other physician specialties.

Therefore, we proposed to change the status indicator for CPT codes 90825 and 90887 to “B” to show that payment for these codes is bundled into the payment for another service, and separate payment would not be allowed. We proposed to implement this change in a budget-neutral manner by redistributing the RVUs for CPT codes 90825 and 90887 across the following psychiatric codes: 90801, 90820, 90835, 90842 through 90847, and 90853 through 90857.

Comment: Several commenters questioned our claim that the work involved in CPT codes 90825 and 90887 is a fundamental element of the pre- and postwork of other physician or other psychiatric services, stating that medical

psychotherapy is a specific procedure, distinct from evaluation and management, and that these procedures (CPT codes 90825 and 90887) are characteristically excluded from psychotherapy. Some commenters believed this payment change would be inherently unfair to providers who furnish services under CPT codes 90825 and 90887.

Response: In addressing the concern that CPT codes 90825 and 90887 are excluded from psychotherapy and represent distinct and different services, we note that in the CPT chapter on Psychiatry, General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures, CPT code 90801 (Psychiatric Interview) refers to both communication with family or other sources, as well as the ordering and medical interpretation of laboratory or other medical diagnostic studies. Further, the definition includes the history and the exchange of information with family members and other informants. Additionally, the final report by Harvard researchers (“Refinement of the Development of a Resource-Based Relative Value Scale for Psychiatrist Services; National Institute of Mental Health Contract No. 278-87-0024”) defines physician work as encompassing work while with the patient and work before and after the service, defined as reviewing records as well as communicating with the patient, the patient's family, and other professionals. We believe these definitions clearly indicate that the evaluation of other records and family counseling fall within the scope of medical psychotherapy and, thus, do not represent distinct services. Therefore, we believe it is appropriate to bundle payment for these services.

Comment: Several commenters specifically addressed CPT code 90887. One commenter agreed that the services encompassed by CPT code 90825 are usually performed as part of the pre- and postwork for other physician services, but expressed concern this was not true for CPT code 90887, which is typically the exclusive service being furnished. Another commenter questioned the redistribution of the RVUs for CPT code 90887. The commenter believed that if, as stated, family counseling is part of the postwork of evaluation and management services, the RVUs for this service should be distributed across all evaluation and management codes, not just the psychiatric codes.

Response: Family counseling must be related to the patient. The fact that this service occurs on different days or times does not preclude it from being part of

the pre- and postwork. Although we recognize that the services described by CPT code 90887 may be provided on different dates of service from when the patient received psychiatric service, they are still considered part of the postwork service associated with that code. We note, also, that the evaluation and management services cannot be billed by clinical psychologists and, thus, have been included in other service codes.

If the RVUs for CPT code 90887 were distributed across all evaluation and management codes as well as the psychiatric codes for this service, the impact would be negligible. That is, the amount to be distributed is not of sufficient magnitude to have any noticeable effect.

Comment: One commenter requested that we also consider changing the status indicator for CPT code 90862 (Pharmacologic management) to “B” because, according to the commenter, pharmacological management is part of evaluation and management services.

Response: Separate payment for pharmacological management is not permitted on the same day as psychotherapy as this service is already included in the codes for psychotherapy. To distinguish services to Medicare beneficiaries for the sole purpose of drug management from those that include some psychotherapy, HCFA developed HCPCS code M0064. This code is defined as a brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders.

Comment: According to one commenter, since the original survey of psychiatric work conducted by Harvard researchers, managed care has increased. With the rise in managed care, there is a decrease in mental health benefits. Therefore, the patients that psychiatrists treat, especially in the fee-for-service setting, are much more complex. The commenter believed this additional work is not currently included in the RVUs for psychiatric services. In addition, this commenter has found that psychiatrists are spending a greater amount of time responding to review requests, developing treatment plans for managed care, managing and supervising nonphysician mental health providers, and documenting and coding work.

Response: Section 1848(c)(2)(B) of the Act requires that all RVUs be reviewed not less frequently than every 5 years to account for changes in medical practice, coding changes, new data, and new procedures. Thus, the issues of psychiatric work time, as well as the

issue of psychiatric services delivered in a managed care setting, will be addressed as part of the 5-year review process.

Final Decision: We will bundle the payment for CPT codes 90825 and 90887 into the payment for other psychiatric services. Therefore, separate payment for CPT codes 90825 and 90887 is not allowed.

This policy change is not explicitly addressed in our regulations.

3. Fitting of Spectacles

We proposed to cease paying separately for the fitting of glasses and low vision systems. The payment for the fitting of spectacles is included in the payment for the spectacles in the same way that payment for other prosthetic fitting services is included in the payment for the prosthetic device.

We proposed to assign a "B" status indicator to CPT codes 92352, 92353, 92354, 92355, 92358, and 92371 to indicate that the services are covered under Medicare but that payment for them is bundled into the payment for the spectacles. We proposed to implement this in a budget-neutral manner by redistributing the current RVUs for these services across all RVUs.

This reflects a policy change that is not explicitly addressed in our regulations.

Comment: A commenter believed that these fitting services should continue to be paid separately because of the time and expertise required to fit glasses for aphakic patients and low vision aids.

Response: The fitting of spectacles is covered under section 1861(s)(8) of the Act. Services under this section are not included in the definition of physician services as defined in section 1848(j)(3) of the Act and are not payable under the physician fee schedule. Although we have been allowing payment, the fitting of spectacles is included in the payment for the spectacles in the same way that payment for other prosthetic fitting services are included in the payment for the device. Under the current system, duplicate payment has been made for the aforementioned procedure codes.

Final Decision: We will no longer pay separately for CPT codes 92352, 92353, 92354, 92355, 92358, and 92371. Beginning January 1, 1996, these codes will be assigned a "B" status indicator to indicate that the services are covered under Medicare, but payment for them is bundled into the payment for the spectacles.

This policy change is not explicitly addressed in our regulations.

C. X-Rays and Electrocardiograms Taken in the Emergency Room

We proposed to pay for the x-ray and/or electrocardiogram (EKG) interpretation that contributes to the diagnosis or treatment of the patient in the emergency room. We will pay for only one x-ray and/or EKG interpretation except under unusual circumstances.

Comment: The comments from radiologists opposed every aspect of the proposal. The primary point raised by virtually all of these commenters was that, by training and experience, they were more qualified than emergency physicians or other nonradiologists to furnish these interpretations. Some radiologists commented that we should require board certification as a requirement to bill for the interpretation of x-rays.

Response: In paying for physicians' services under the Act, we are charged with determining the following:

- Is the service covered under Medicare?
- Is the service reasonable and necessary for the individual beneficiary?
- Is the physician licensed to perform the service in the State in which it is furnished?

In the case of a licensed physician who has furnished a covered service (that is not payable through another code) to a Medicare beneficiary in an emergency room, it is not readily apparent to us upon what basis the claim can be denied. There is no portion of the Act upon which to base a decision that only board-certified radiologists can furnish x-ray interpretations or board-certified cardiologists can furnish EKG interpretations. (Where the Congress has determined that there should be special qualifications in order to furnish a service, as in the case of mammography, a provision was made in the statute.) Our proposed policy for x-ray and EKG interpretation is consistent with how we generally treat other physician services.

Comment: Emergency room physicians supported the direction of the proposal but requested clarification of the proposal including its effect on payments for second interpretations. Many commended us for proposing to change the existing policy but criticized the agency for not going far enough. Several emergency physicians commented that it was unethical for us to withhold compensation from physicians who make life-saving decisions every day based on x-ray and EKG interpretations.

Response: Our proposal addressed situations in which both the emergency

physician and the radiologist/cardiologist billed for the same interpretation. It is that situation in which a determination needs to be made of which interpretation contributed to the diagnosis and treatment of the individual patient. If an emergency physician does not bill for the interpretation, there would be no change from existing policy. We would like to stress that if the only bill received is from the radiologist or cardiologist, it is paid on the same basis as current claims.

Comment: We received relatively few comments from physicians and other entities specializing in cardiology procedures. Their comments focused on the cardiologists' greater qualifications to interpret EKGs based on their training and experience.

Response: The discussion above about the qualifications of the interpreting radiologist would also apply here. The situation with EKGs is somewhat different than with x-rays because section 13514 of OBRA 1993, Public Law 103-66, enacted August 10, 1993, requires us to make separate payment for EKG interpretations and to exclude the RVUs for EKG interpretations from the RVUs for visits and consultations, making the EKG portion of the current policy as set forth in section 2020G of the Medicare Carriers Manual obsolete.

Comment: We proposed that the radiologist or cardiologist should be paid for the interpretation when it is performed contemporaneously with the diagnosis and treatment of the emergency room patient. This standard would be met if an interpretation were initially conveyed to the treating physician verbally. Nearly all commenters seemed to be troubled by the use of the term "contemporaneous" and requested clarification of the term. Some radiologists indicated that their interpretation is furnished contemporaneously if it is provided timely, which commenters variously defined as 12-24 hours. Other radiologists indicated that there are teleradiology hook-ups to radiologists, homes which should satisfy the need for contemporaneous interpretations. Several emergency room specialists indicated that the circumstances under which a radiologist or cardiologist furnishes a contemporaneous interpretation as discussed in the proposal should be clarified. They expressed concern that the provision of a verbal interpretation by the specialist to the emergency room physician could be used to circumvent the stated intention to pay for the interpretation used in the diagnosis and treatment of the beneficiary.

Response: When we used the term contemporaneous, we meant that the interpretation of the procedure by the radiologist or cardiologist and the diagnosis and treatment of the beneficiary by the physician in the emergency room occur at the same time, as opposed to an interpretation performed hours or days after the beneficiary is sent home. While the argument that the carrier should pay for any interpretation furnished timely sounds reasonable, it does not reflect the realities of claims processing. It would be impossible for a reviewer to make an assessment in every individual case as to whether the second interpretation was furnished "timely." In situations in which both physicians bill for the interpretation, the question to be resolved is whether the radiologist or cardiologist performed the interpretation in time to be used in the diagnosis and treatment of the patient. As set forth in the proposal, we believe that in any case in which the radiologist or cardiologist furnishes the interpretation (a written interpretation or a verbal interpretation that will be written later), the emergency room physician should not bill for the interpretation, and the carrier should pay for the claim submitted by the radiologist or cardiologist. The comments we received from the emergency room physicians did not seem to be requesting payment for interpretations furnished under these conditions. We agree that an interpretation furnished via teleradiology meets the requirement when the interpretation is used in the diagnosis and treatment of the patient.

Comment: Several commenters indicated that emergency room physicians without formal training in interpreting computerized axial tomography (CT) scans will miss subtle changes which could lead to permanent injuries to patients. They also stated that there were problems with the application of the proposal to other diagnostic procedures such as mammography, ultrasound, and upper and lower gastrointestinal series.

Response: This proposal applies only to x-ray procedures and EKGs furnished in emergency rooms.

Comment: Many radiologists indicated that the proposal will increase the Medicare program costs "tremendously" because of the potential for self-referral abuse. The commenters believed that physicians who see patients in the emergency room will order unnecessary tests if they know that they will be able to bill for the interpretations of these tests.

Response: We would be interested in reviewing any evidence the radiologists have that emergency room physicians order additional tests that are not medically necessary when they are permitted to bill for x-ray and EKG interpretations. We are also interested in any suggestions we might offer to the carriers on how to identify such unnecessary testing. We will address any self-referral prohibitions within our Stark regulations.

Comment: Several radiologists pointed out that a proper interpretation does not really mean a "check" or a few words on the chart, but requires a full written report.

Response: We agree completely. The requirement for a written report of the interpretation of an x-ray or EKG is an integral part of our proposal. We would point out that less extensive "reviews" by emergency room physicians are not separately billable because payment for such reviews is included in the payment for the evaluation and management services rendered in an emergency room.

Comment: Many radiologists commented that, while some emergency medicine specialists are very proficient at reading trauma films, they lack the necessary training to identify subtle changes. For example, a patient is brought into the emergency room with chest trauma. The commenter indicated that the emergency physician would identify the broken ribs but miss a lung tumor. Several other commenters were concerned that a missed early diagnosis could result from an interpretation performed by a nonradiologist emergency room physician while a radiologist would review the total film rather than just the area of clinical concern.

Response: It seems to us that the major purpose of the emergency room x-ray in this instance would be to diagnose the degree of chest trauma. However, in this circumstance, if the emergency physician billed for the interpretation and a radiologist made an additional finding of a lung tumor, it would be appropriate for the carrier to pay for both interpretations.

Comment: One radiologist indicated that all too often the emergency room preliminary interpretation is made by a nurse or medical student and the films are never reviewed by a staff emergency room physician.

Response: It is difficult to see how such an observation relates to our proposal. A physician could not provide a written interpretation of an x-ray unless he or she personally viewed it. A written report of interpretation is an integral part of our proposal.

Comment: Many commenters objected to the hospital playing a role in determining which physician should bill for the interpretation of these procedures. The following comments were received:

- Hospitals are not capable of making such determinations.
- It would be in the financial interest of the hospital for the interpretation to be paid to those physicians who order the most tests.
- The medical staff is usually a legally separate and independent body from the hospital, and hospitals have no authority to become involved in such matters.
- Such decisions should be left to peer review.

• Hospitals should be encouraged to ensure that the billed interpretation is the one upon which treatment is based.

• The concept of a hospital making a policy decision as to which physician should get paid for interpretations will be a regulatory nightmare and the time and money carriers will have to expend to monitor the situations will be enormous. However, one emergency room physician commented that he hoped the proposal would encourage radiologists and cardiologists to furnish these interpretations in a more timely fashion.

Response: In developing our proposal, we considered requiring hospitals to notify their local carrier of the identity of the physician who would be performing these interpretations for their patients. We determined that such a requirement would have had an effect as indicated by one of the commenters and that our authority to impose such a requirement was questionable. However, under our proposal, we suggested that hospitals act to ensure that only one interpretation is billed. (Hospitals could do this now; we are not mandating an additional duty.) If a carrier receives only one claim, there will be no problem. The problem will arise when hospitals do not take action and the carrier receives two claims for each interpretation and then must make a determination about which claim to pay. It seems reasonable to us for hospitals to work with their medical staffs to establish guidelines for the billing of x-ray and EKG interpretations for emergency room patients.

Comment: Some commenters expressed concern about the effect of the proposal on small, rural hospitals in which there are an insufficient number of radiologists to cover the emergency room 24 hours a day. It was pointed out that many of these hospitals either go without any service at all and ship films to radiologists for interpretation or

receive direct radiologist's services on an infrequent basis each week. One commenter indicated that consideration should be given to the size of the hospital, the definition of what constitutes an emergency room, and the availability of radiologic services.

Response: Since our proposal is limited to emergency room services, if a hospital does not have an emergency room and no claims with a place of service indicator of emergency room are received, there does not appear to be a problem. Likewise, if there is an emergency room in a hospital but no emergency room physician bills for an interpretation of the test, there is also no problem. We indicated in our proposal that if a carrier receives only one claim for a reasonable and necessary interpretation of an x-ray or EKG, it would pay the claim, generally without further development.

Comment: One commenter indicated that the proposal was inappropriate because emergency room physicians are thankful that radiologists will interpret the overnight x-rays the next morning in view of the harried circumstances under which services are furnished in the emergency room.

Response: Our proposal does not require emergency room physicians to bill for these interpretations. If the emergency room physicians do not bill for these interpretations, the radiologist and cardiologist may continue to be paid for the interpretations. Our proposal has no effect on situations in which the emergency physician does not wish to bill for the interpretation.

Comment: A carrier medical director expressed concern that it will be impossible to determine from a claim whether the emergency physician has submitted written documentation of the x-ray or EKG interpretation for the medical record. The carrier medical director went on to indicate that encouraging hospitals to exercise their authority to ensure that only one claim for interpretation is received will not work and recommended that the current policy should be maintained.

Response: By submitting a claim for the interpretation of an x-ray or EKG, the emergency room physician is stating that he or she has prepared a written interpretation of the procedure for inclusion in the patient's medical record. We do not agree that the current manual policy works well since it became partially obsolete by the physician fee schedule.

Comment: Another carrier medical director indicated that the requirement for a written report be strengthened to indicate that Medicare is requiring a separately written report which meets

the hospital's requirement for an official report.

Response: We agree and will include such a written report requirement in the revised manual instructions.

Comment: Some emergency room physicians commented that they should be paid for the x-ray and EKG interpretation in almost every case since it is they who furnish the real-time service.

Response: We believe that our proposal is a better approach. There is no question that the cardiologist or radiologist should be paid for the interpretation when that physician furnishes the service in time to be used in the diagnosis and treatment of the patient. Further, we believe that there are physicians who work in emergency rooms who prefer to defer to a cardiologist or radiologist for the final interpretation and do not wish to prepare written reports or bill for interpretations. However, our proposal provides for payment when the emergency room physician provides a written interpretation that contributed to the diagnosis and treatment of the patient.

Comment: One commenter indicated that, in their community hospital, the radiologist is summoned at the time of the initial diagnosis and treatment for the most serious cases, whereas, for less urgent examinations, the formal interpretation is made the following morning. The commenter went on to say that the issue should be the responsiveness of the radiologist when his or her input will affect care, and that having x-rays read by nonradiologists is moving in the wrong direction.

Response: As indicated previously, interpretations by radiologists used for the diagnosis and treatment of the patient would be payable.

Comment: A few commenters suggested that the appropriate approach is to split the fee for the interpretation between the radiologist and the ER physician.

Response: We do not believe that this would be a workable approach since the carrier would not know when or if it would receive the second claim.

Comment: Radiologists made the following additional comments:

- The majority of carrier medical directors do not support the proposal.
- The changes do not reflect the findings of the July 1993 report of the Department of Health and Human Services, Office of Inspector General, entitled "Medicare's Reimbursement for Interpretations of Hospital Emergency Room X-Rays."

Response: We did present the proposal to a committee of carrier

medical directors during a monthly conference call on operational issues and the views were mixed. The major impression we drew from their comments was that they were most concerned with enforcement issues. We will continue to seek the guidance of the carrier medical directors and other interested parties in developing instructions to implement this policy.

The recommendation of the OIG report was to pay for reinterpretations of x-rays only when attending physicians specifically request a second physician's interpretation in order to render appropriate medical care before the patient is discharged. Any other reinterpretation of the attending physician's original interpretation should be treated and reimbursed as part of the hospital's quality assurance program.

Using 1990 data, the OIG projected savings of \$20.4 million based on a cessation on payments for radiologists' interpretations of x-rays if its recommendation were implemented. We believe that the OIG recommendation would result in no payment for interpretations of these services in many cases; therefore, we reject that portion of the recommendation. In other words, we believe that one physician should be paid for the interpretation of an x-ray.

Comment: One commenter suggested that the solution to this problem be developed through the CPT system. The commenter suggested that we propose separate codes for the emergent reading of the test and a second, different code for the over-read. This commenter and some others indicated that payment for these interpretations be evenly divided between the two codes.

Response: The commenter may want to refer this proposal to the CPT Editorial Panel.

Final Decision: We are adopting the policy as set forth in the proposed rule for services furnished on or after January 1, 1996.

Listed below are the elements of our policy.

- The carrier will pay separately for only one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. However, there is a provision for payment of second interpretation under unusual circumstances such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.

- The professional component of a diagnostic procedure furnished to a beneficiary in a hospital includes an interpretation and written report for

inclusion in the beneficiary's medical record maintained by the hospital. We have placed this requirement in the radiology section of the regulations on services of physicians in providers at § 405.554(a). (Under the recodification, this section becomes 415.120(a)).

- We distinguish between an "interpretation and report" of an x-ray or an EKG procedure and a "review" of the procedure. An interpretation and report of the procedure is separately payable by the carrier. A review of the findings of these procedures, without a written report, does not meet the conditions for separate payment of the service since the review is already included in the emergency room visit payment.

- In the case of multiple bills for the same interpretation and report, we will instruct the carriers to adopt the following procedures:

- + Cease consideration of physician specialty in deciding which interpretation and report to pay regardless of when the service is performed.

- + Pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient.

- + Pay for the interpretation billed by the cardiologist or radiologist if the interpretation of the procedure is performed at the same time as the diagnosis and treatment of the beneficiary. (This interpretation may be a verbal report conveyed to the treating physician that will be written in a report at a later time.)

- We will minimize the carrier's need to make decisions about which claim to pay when multiple claims for the interpretation and report of the same procedure are received by—

- + Encouraging hospitals to work with their medical staffs to ensure that only one claim per interpretation is submitted;

- + Advising hospitals that if they allow a physician to perform and bill for a medically necessary service (the interpretation and report) in an emergency room and permit another physician to perform and bill for the same service, the Medicare carrier will not pay two claims;

- + Advising hospitals that the Medicare carrier may determine that the hospital's "official interpretation" is for quality control and liability purposes only and is a service to the hospital rather than to an individual beneficiary; and

- + Advising hospitals that Medicare fiscal intermediaries consider costs incurred for quality control activities in determining payments to hospitals.

- When the Medicare carrier receives only one claim for an interpretation and the procedure is reasonable and necessary, the carrier will pay the claim. We will presume that the one service billed was a service to the individual beneficiary and not a quality control measure.

Manual instructions to the carriers will be issued as soon as possible.

This policy change is not explicitly addressed in our regulations.

D. Extension of Site-of-Service Payment Differential to Services in Ambulatory Surgical Centers

We proposed extending the site-of-service payment differential to services on the ambulatory surgical center (ASC) covered list of procedures that are predominantly performed in an office setting. We see no reason for exempting these procedures from the site-of-service payment differential. The practice expense RVUs duplicate many of the overhead expenses included in the ASC facility and hospital payment rates. As such, when a service is provided in an ASC or a hospital, the physician does not bear the same level of practice costs as when the same service is furnished in the office. Therefore, in § 414.32 ("Determining payments for certain physician services furnished in facility settings"), we proposed to modify in paragraph (d) ("Services excluded from the reduction") the subordinate paragraph (d)(2), which would have the effect of applying the site-of-service payment differential to ASC services. The payment differential does not apply to procedures performed in an ASC that are not on the ASC list because no facility payment is made.

Comment: Many commenters stated that the Act provides that procedures included on the ASC list, by definition, are not office-based procedures. Commenters indicated that we had concluded in previously published regulations on ASCs that certain procedures, such as cystoscopies, prostate biopsies, and skin lesion excisions, are not office-based procedures.

Response: Historically, the ASC list included only procedures that were performed less than half of the time in an office setting. Consequently, the ASC list and the site-of-service payment differential lists were mutually exclusive. Over time, many procedures shifted from being performed predominately in ASCs to being performed predominately in offices. However, in many cases the procedures were retained on the ASC list because we were persuaded by arguments that while the procedure may usually be

done in an office, there were circumstances justifying using an ASC. Therefore, the two lists are no longer mutually exclusive. Retention of certain procedures on the ASC list does not imply that they cannot appropriately be performed in an office. In fact, the only procedures proposed for addition to the site-of-service differential payment list are those that are performed in an office setting the majority of the time.

Comment: Several commenters questioned the accuracy of data or indicated that they could not fully evaluate the proposals because we did not publish data on which the site-of-service list is based. Some stated we should use clinically-based criteria instead of purely objective, arithmetic data.

Many commenters indicated that many of the procedures added to the site-of-service differential list were inappropriate and unlikely to be office-based procedures because they are extraordinarily complicated procedures, require anesthesia or sophisticated equipment, or need to be evaluated on a case by case basis. Several commenters believed the list to be arbitrary and unfair. Others indicated that physicians should not be punished for selecting the medically appropriate site for certain procedures on the list. One commenter agreed that we should encourage physicians to perform procedures in an office when it is safe and effective.

Another commenter stated that we should pay urologists for supplies and a small facility fee to shift procedures to the less costly office setting.

Some commenters stated that because nasal/sinus endoscopy codes were added to the ASC list effective January 1, 1994 the site-of-service data are likely to be skewed toward the physician's office setting. Other commenters stated the CPT description for breast biopsy (CPT code 19100) was recently changed to include only core needle aspiration while fine needle aspiration is now reported using code CPT code 88170. One commenter agreed that breast biopsy should be on the list. Other commenters argued that the data do not distinguish between techniques employed. Many commenters indicated that the policy does not account for gender differences. For example, cystoscopies performed on males are more difficult and painful and are inappropriate for an office setting.

Response: According to our data, the procedures on the site-of-service payment differential list are performed in a physician's office more than 50 percent of the time. Inclusion of procedures on the list is not intended to

reflect a judgment regarding the appropriateness of the site where the service is performed or to encourage performance of procedures in the less costly office setting or to create a financial disincentive for the physician to select the most appropriate site. Inclusion on this list merely recognizes where the service is being furnished the majority of the time. We recognize that although the majority of the procedures we proposed to add to the site-of-service list are performed in a physician's office, the ASC setting is sometimes appropriate. That is the reason they remain on the ASC list. It is not the purpose of this policy to dictate where a physician should perform the service. The policy reflects the lower practice costs incurred by physicians when these services are performed in an ASC or a hospital.

Comment: One commenter objected to including urodynamic evaluation CPT codes 51725, 51726, and 51772 on the site-of-service payment differential list. Another commenter provided information demonstrating that 21 other proposed procedures should not be on the list because more recent data indicate that the procedures are not performed in the office more than 50 percent of the time.

Response: We agree with the comment that urodynamic evaluation codes do not belong on the list and have removed CPT codes 51725, 51726, 51772, and 51785 from the list. We also agree with the comment that some of the proposed procedures are not performed in the office setting more than 50 percent of the time based on the most current data available. Therefore, we have removed the following CPT codes from the list: 13150, 14020, 14060, 15740, 21208, 21440, 23066, 26645, 28030, 28043, 28092, 28261, 40510, 41805, 42408, 46220, 46610, 63600, 64420, 65270, and 67921.

Comment: Some commenters stated that the site-of-service payment differential should not apply to services furnished in an ASC for which no facility payment is made. Another commenter said that many ASCs are considered extensions of a physician's office, not a free-standing facility, and physicians are responsible for ASC overhead.

Response: We agree with these comments. Therefore, we have clarified the proposal to state that when a service that is not on the ASC list is performed in an ASC, the site-of-service payment differential does not apply. In this case, we view the ASC as an extension of the physician's office and, for purposes of this provision, view this as an office service.

Comment: Some commenters said that there is no difference in practice costs between the office setting and the ASC. In some cases, costs may be higher in the ASC because of more complicated cases, the delivery of anesthesia services, and physician travel costs. Other commenters said it is unjustified to conclude that there is no office overhead for physicians performing procedures in another setting.

Some commenters recommended that we make no changes to the site-of-service payment differential before the implementation of resource-based practice expense RVUs in 1998. One commenter requested that we suspend the site-of-service payment differential altogether. Others recommended increasing practice expense payments for procedures performed in the office to discourage physicians from using hospital ASCs. Other commenters said we should exempt codes that are reduced by the interim practice expense reduction of OBRA 1993.

Response: The site-of-service payment differential is a long established policy that aims to avoid duplicate payments for overhead while, at the same time, recognizes that some office overhead is incurred when physicians perform procedures outside the office setting. For this reason, the practice expense RVUs are reduced by only 50 percent. While we will implement resource-based practice expense RVUs in 1998, we see no reason to postpone applying the payment differential to ASCs until then. The site-of-service policy currently applies to both inpatient and outpatient hospital settings. We see no justification for continuing to exempt services provided in ASCs.

Section 13513 of OBRA 1993 provided for reductions in practice expense RVUs for services for which practice expense RVUs exceeded 128 percent of the work RVUs and that are performed less than 75 percent of the time in an office setting. This reduction was based on the Congress' determination that practice expense RVUs were too high for some procedures. This reduction is independent of the long standing site-of-service payment differential.

Comment: Many commenters stated that the proposal would result in reduced quality of care. Other commenters said it did not encourage placement of patients in the most appropriate and cost-effective setting to address the patient's medical needs. Several commenters indicated that since we have determined that the proposed procedures are appropriate for ASCs based on medical review and patient safety outcome data, it would be

inconsistent to apply the site-of-service payment differential.

Some commenters indicated that many of the proposed procedures cannot be performed safely in an office. They indicated that offices are not certified to meet the same standards of care or health care outcomes as ASCs, which are generally safer places to perform procedures. They believed the proposal creates a disincentive for physicians to use ASCs even when it is in the patient's best interest to do so. Other commenters said procedures are performed in an ASC because of patient choice or for a patient's safety and comfort. They believed that paying less for the most complicated cases will discourage doctors from doing such cases, thereby creating serious access problems for patients.

Response: We disagree that application of the site-of-service payment differential will penalize a physician who has valid clinical reasons for performing a procedure in an ASC. Rather, we believe the payment differential will appropriately reflect that the physician incurs fewer costs when furnishing service in an ASC. We believe that physicians consider the welfare of the beneficiary in selecting the appropriate site to perform the service. We do not believe that physicians will make inappropriate decisions regarding the health and well being of their patients because of a reduction in their payment.

Comment: Many commenters said that the proposal will encourage physicians to buy costly equipment for their offices, such as that required for urologic and arthroscopic procedures, which most do not have.

Response: We believe the payment differential is incentive neutral with regard to selecting a practice site. That is, we do not believe that the payment differential will induce physicians to purchase additional equipment to enable them to furnish services in the office.

Comment: One commenter stated that a large number of procedures proposed for addition to the site-of-service list were originally exempt from the list because they were performed less than 50 percent of the time in a physician's office. Therefore, the practice expense values already reflect the costs of furnishing the procedures outside the office setting.

Response: Physicians shift the place of service for procedures from the hospital setting to the office setting for various reasons. Two reasons are (1) that advances in technology, technique, or other factors make it now feasible to do many services in the office setting that

historically were furnished in a hospital setting; and (2) physicians believe that it is cost-effective and efficient to shift the place of service. We believe that the direct costs of providing the service (staff, supplies, equipment, and space) are reflected in the practice expense relative values based on the predominant place of service. Therefore, we believe it is appropriate to apply the site-of-service reduction to these services when they are performed in a setting where we make a payment for the direct costs of providing the service; for example, hospitals and ASCs. However, this issue will be further examined as part of the development of practice expense RVUs for 1998.

Comment: Several commenters misunderstood the proposal. Some implied that we were proposing a reduction in the ASC facility payment rate or reducing payments for office based procedures. One objected to applying the site-of-service payment differential to the hospital setting. One commenter was not convinced the proposal will save money.

Several comments concerned issues not covered under this proposal, for example, objections to removing certain codes from the ASC approved list and requests that particular codes be added or deleted from the ASC list. Another commenter suggested that new criteria are needed for procedures on the ASC list. Another thought we were proposing removing the codes from the ASC list.

Response: The proposal does not affect ASC facility payment rates or physician payments for procedures performed in an office setting. The site-of-service payment differential already applies to the hospital outpatient setting. The proposal is budget neutral and is not intended to reduce Medicare payments. The proposal does not revise procedures on the approved ASC list.

Final Decision: We will extend the site-of-service payment differential to office-based services on the ASC list if those services are performed in an ASC or in a hospital setting. However, when a service that is not on the ASC list is performed in an ASC, the site-of-service payment differential will not apply. The site-of-service list for 1996 appears in Addendum E of this final rule. All additions to the list are identified by an asterisk.

E. Services of Teaching Physicians

1. General Background

Our July 26, 1995 proposed rule (60 FR 38405) discussed Medicare payment for those services furnished under graduate medical education (GME) programs that are not payable through

the mechanisms established for direct GME costs by section 1886(h) of the Act. Section 1886(h) addresses Medicare payments to hospitals and hospital-based providers for the costs of approved GME programs in medicine, osteopathy, dentistry, and podiatry. Those costs include residents' salaries and fringe benefits, physician compensation costs for GME program activities that are not payable on a fee schedule basis, and other GME program costs.

Medicare intermediary expenditures under section 1886(h) of the Act for fiscal year 1996 are estimated to be approximately \$1.9 billion. In addition, under section 1886(d)(5)(B) of the Act, Medicare makes additional payments to teaching hospitals under the prospective payment system for the higher indirect operating costs hospitals incur by having GME programs. (These are costs other than direct GME costs.) Medicare indirect GME payments for fiscal year 1996 are estimated to be approximately \$4.9 billion. Medicare also supports GME programs in teaching hospitals through billings for the services of attending physicians who involve residents in the care of their patients. The amount of Medicare expenditures for these services is not known since attending physicians are not required to distinguish between services they personally furnish and those they furnish as attending physicians in claims submitted to the Part B carriers.

Our proposal addressed services of teaching physicians that are payable on a fee schedule basis, services of residents in settings that are not payable under section 1886(h), and services of moonlighting residents. In addition, the proposed rule addressed, but did not substantially change, existing rules on related issues on Medicare payments for the services of residents in approved GME programs furnished in certain freestanding skilled nursing facilities and home health agencies, and services of residents who are not in approved GME programs. We referred to the section 1886(h) mechanisms to distinguish between that payment methodology and other payment mechanisms.

Title XVIII of the Act provides separate coverage and payment bases for provider services and physician services. Under Medicare, provider services, such as inpatient hospital services and skilled nursing facility services, are covered under Hospital Insurance (Part A) and are paid from the Part A Trust Fund. Outpatient hospital services are covered under Supplementary Medical Insurance (Part B) and are paid from the Part B Trust

Fund. Provider services are paid on a prospective payment, reasonable cost, or other payment mechanism through Medicare contractors called "fiscal intermediaries." Physician services and other "medical and other health services," as defined in section 1861(s) of the Act, are generally paid under Part B through Medicare contractors called "carriers." To administer the Medicare program, we must distinguish clearly between provider services and physician services to determine the appropriate payment methodology and the appropriate Trust Fund that is liable for payment.

As discussed in the proposed rule, in part 405 ("Federal Health Insurance for the Aged and Disabled"), subpart D ("Principles of Reimbursement for Services by Hospital-Based Physicians"), current regulations beginning with § 405.480 set forth the basic principles regarding payment for services of physicians who practice in providers. Additional principles applicable to payment for physician services in teaching hospitals appeared in subpart E ("Criteria for Determination of Reasonable Charges; Payment for Services of Hospital Interns, Residents, and Supervising Physicians") in §§ 405.520 and 405.521. Principles applicable to services of interns and residents appeared in §§ 405.522 through 405.525. Sections 405.465 and 405.466 addressed the payment methodology for teaching hospitals that elect reasonable cost payments for physician services. (See sections 1832(a)(2)(B)(i)(II) and 1861(b)(7) of the Act.) Since the publication of those regulations, the Congress enacted a series of legislative changes that affected payments for these services, and we proposed to revise the regulations to conform to those statutory changes and to clarify current policy.

Section 948 of the Omnibus Reconciliation Act of 1980 (ORA 1980) (Pub. L. 96-499), enacted on December 5, 1980, as amended by section 2307 of the Deficit Reduction Act of 1984 (DEFRA 1984) (Pub. L. 98-369), enacted on July 18, 1984, addressed payments for physician services in teaching settings. (See section 1842(b)(7) of the Act.) Another pertinent legislative change, section 108 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA 1982) (Pub. L. 97-248), enacted on September 3, 1982, added a new section 1887 to the Act. That legislation dealt explicitly with distinguishing between the professional services physicians furnish to individual patients in a provider and services physicians furnish to the provider itself. While section 1887 of the Act does not

specifically address teaching physicians or GME issues, it is consistent with Medicare policy on classifying the activities in which physicians in teaching hospitals are engaged.

We published a final rule with comment period in the Federal Register on March 2, 1983 (48 FR 8902), which implemented the provisions of section 1887 of the Act. That final rule revised the regulations that govern Medicare payment for services of physicians who practice in providers such as hospitals, skilled nursing facilities, and comprehensive outpatient rehabilitation facilities. As a part of that final rule, we revised §§ 405.480 through 405.482, removed §§ 405.483 through 405.488, and added new §§ 405.550 through 405.557. Those regulations—

- Set forth basic criteria for distinguishing those physician services furnished in providers that are payable by Part B carriers as physician services to individual patients from those services that are payable by fiscal intermediaries as physician services to the provider itself;
- Set limits on the amounts payable on a reasonable cost basis to providers for physician services to the provider; and
- Established more specific criteria for determining the basis and amount of payment for physician services in the specialties of anesthesiology, radiology, and pathology.

In the preamble to the March 1983 final rule (48 FR 8906), we stated that because of problems related to applying portions of the revised regulations to teaching hospitals and to implement sections 1842(b)(6) and 1861(b)(7) of the Act for physician payment (as amended by section 948 of ORA 1980), we planned to publish, in a separate document, proposed regulations that would establish special rules governing payment for services of physicians in teaching hospitals. Those rules would have superseded §§ 405.520 and 405.521 if they became effective. Subsequently, however, the Congress passed DEFRA 1984, which further amended section 1842(b)(6) of the Act and redesignated it as section 1842(b)(7).

Another statutory change that affected payments to teaching hospitals was section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272), enacted on April 7, 1986, as amended by section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509), enacted on October 21, 1986, which added a new section 1886(h) to the Act. Section 1886(h) of the Act revised the method of calculating Medicare payment for the

direct costs of approved GME activities such as residents' salaries and fringe benefits, from reasonable cost payment to payments based on hospital-specific per-resident amounts multiplied by the number of full-time equivalent residents working in the hospital during a hospital's cost reporting period.

A major change in the Medicare payment rules for physician services in general was enacted as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) (Pub. L. 101-239), enacted on December 19, 1989, which added section 1848 to the Act. Section 1848 replaced the reasonable charge payment mechanism with a fee schedule for physician services. The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) (Pub. L. 101-508), enacted on November 5, 1990, contained several modifications and clarifications to the OBRA 1989 provisions that established the physician fee schedule.

2. Payment for Physician Services Furnished in Teaching Settings

a. Current Practices

In our proposed rule (60 FR 38406), we stated that of the nearly 7,000 hospitals that participate in Medicare, approximately 1,200 have GME programs that are approved for residency training by the appropriate accrediting organization. (We used the term "residents" in the preamble of the proposed rule to include residents, interns, and fellows who are in formally organized and approved GME programs.)

For hospital cost reporting periods beginning on or after July 1, 1985, the costs of residents' compensation (representing payment for the residents' services), certain physician compensation costs related to GME programs, and other GME program costs are payable based on hospital-specific per-resident amounts as described in § 413.86, in accordance with section 1886(h) of the Act. Physician compensation costs for administrative and supervisory services unrelated to the GME program or other approved educational activities are payable as operating costs through diagnosis-related group payments under the prospective payment system for inpatient services and on a reasonable cost basis for inpatient services in hospitals excluded from the prospective payment system and for outpatient services.

In the case of those few teaching hospitals that elect reasonable cost payments for physician direct medical and surgical services under section

1861(b)(7) of the Act instead of billing for services to Medicare beneficiaries on a fee-for-service basis, the election and payment mechanisms described in former §§ 405.465 and 405.466 were set forth in the proposed rule in new § 415.160 and in redesignated §§ 415.162 and 415.164.

Practices vary widely among and within teaching hospitals with respect to the degree of physician involvement in the care of patients. In some cases, teaching physicians personally direct residents in furnishing patient care services. In others, residents assume a greater degree of responsibility for the care patients receive, and the teaching physicians exercise only general control over the residents' activities.

b. Statutory and Other Developments Pertaining to Teaching Physician Services

(1) Original Medicare Law and Regulations

As originally enacted, title XVIII of the Act excluded the services of physicians, interns, and residents from the definition of "inpatient hospital services," except for the services of interns and residents in approved training programs. The services of residents in an approved program of a hospital with which a skilled nursing facility has a transfer agreement are included in the definition of "extended care services" and in the definition of "home health services" in the case of a home health agency that is affiliated with or under common control of a hospital having the program. These provisions established the costs of approved GME programs for provider services payable by intermediaries on a reasonable cost basis. The Act did not include special rules for payment of physician services in teaching hospitals.

At the time of the publication of the proposed rule, under §§ 405.520 and 405.521 for teaching physician services, and §§ 405.522 through 405.525 for residents' services, a physician in a teaching setting was considered the attending physician for a Medicare patient, and thereby qualified for Part B payment, only if he or she furnished "personal and identifiable direction" to the interns and residents who provided the actual services to the patient. Before January 1, 1992, Part B physician services were paid under the reasonable charge payment system. As of January 1, 1992, these physician services are paid under the physician fee schedule set forth in part 414 (56 FR 59502).

Although former § 405.521(b) listed examples that illustrated the types of responsibilities attending physicians

typically carry out, the list was not exhaustive. In individual cases, it might be difficult to determine, by referring to § 405.521, whether a physician in a teaching setting is the "attending physician" for a Medicare patient. It might be necessary for the carrier to review hospital charts to see if the attending physician requirements were met; however, the involvement of the teaching physician in individual services was often unclear from a review of the charts.

It became apparent, shortly after the former §§ 405.520 and 405.521 were issued, that some Medicare carriers were paying charges for physician services in some teaching hospitals, even though interns and residents were primarily responsible for the care of the patients. The physicians who were billing for these services were often assuming only limited responsibility for the medical management of the patients' treatment. It also became clear that some physicians were submitting charges for services furnished to Medicare patients even though non-Medicare patients were not billed for similar services, and patients generally were not obligated to pay for those physician services.

In April 1969, those problems led to the issuance of Intermediary Letter 372, which set forth specific conditions that physicians in teaching settings were required to meet to be considered attending physicians and, thus, qualify to charge the carrier for services in which they involved residents. It also specified how carriers were required to determine the reasonable charges for these services. Although Intermediary Letter 372, which was still in effect at the time of the publication of the proposed rule, provided guidance to Medicare carriers and intermediaries on payment for these services, it was not applied uniformly by all Medicare carriers.

(2) 1972 Amendments

On October 30, 1972, the Congress amended the Act to provide rules on payment for physician services (as distinguished from the services of interns and residents) furnished in teaching hospitals. Section 227 of the Social Security Amendments of 1972 (Pub. L. 92-603) amended section 1861(b) of the Act to require that Medicare treat those services as hospital services and pay for them on a reasonable cost basis, except under certain specific circumstances. Section 227 also made certain incentives available to hospitals that elected to be paid for physician services on a reasonable cost basis.

In subsequent legislation (section 15 of Pub. L. 93-233, enacted on December 31, 1973, and section 7 of the End-Stage Renal Disease Program Amendments of 1978 (Pub. L. 95-292), enacted on June 13, 1978), the Congress deferred implementation of all provisions of section 227 of the 1972 amendments except for the incentives to elect reasonable cost payment for physician direct medical and surgical services. The cost reimbursement provisions were implemented through former § 405.465, as published in a final rule on August 8, 1975 (40 FR 33440). The statutory provisions for which the Congress deferred implementation were eventually replaced by new provisions passed by the Congress in ORA 1980. ORA 1980 reaffirmed, but did not otherwise affect, the provisions of section 227 of the 1972 amendments authorizing cost reimbursement incentives.

(3) ORA 1980

Section 948 of ORA 1980 made several important changes in the sections of the Medicare statute that address payment for physician services in teaching hospitals. Specifically, section 948—

- Repealed the provisions of the 1972 Amendments that required Medicare to pay for those services (with certain exceptions) on a reasonable cost basis;
- Amended section 1861(b) of the Act to allow hospitals with approved teaching programs to elect to be paid on a reasonable cost basis for physician direct medical and surgical services furnished to their Medicare patients and for the supervision of interns and residents in the care of individual patients if all physicians in the hospital agree not to bill charges for their services furnished to Medicare patients; and
- Added section 1842(b)(6) of the Act (now section 1842(b)(7)) to specify the conditions that must be met to permit payment under Part B for physician services in teaching hospitals that do not elect cost reimbursement, and to provide special payment rules for determining the customary charges applicable in this situation.

In the Conference Report accompanying ORA 1980 (H.R. Rep. No. 1479, 96th Cong., 2d Sess. 145 (1980)), the Conference Committee stated that its intention was to permit payment for physician services in a teaching hospital on a reasonable charge basis only if the physician is the patient's "attending physician." The conferees also endorsed the attending physician criteria in Intermediary Letter 372.

The Conference Report further stated that "[t]he conferees intend (without precluding reasonable changes in the future) that in determining the amount payable on a charge basis under Medicare Part B for services of physicians in teaching hospitals, the policies contained in Intermediary Letter 372 should be generally followed where these are not inconsistent with the provisions of the conference agreement." *Ibid.* p. 146.

(4) DEFRA 1984

Subsequently, section 2307(a) of DEFRA 1984 further amended section 1842(b)(7) of the Act concerning conditions for payment for physician services furnished in teaching hospitals that do not elect cost reimbursement. Section 2307(a) was later amended by sections 3(b) (5) and (6) of the DEFRA Technical Amendments (Public Law 98-617), enacted on November 8, 1984. As revised, section 1842(b)(7) of the Act (which was redesignated from section 1842(b)(6) of the Act by section 2306 of DEFRA '84) provided that—

- The customary charge of a physician qualifying as a teaching physician is set no lower than 85 percent of the prevailing charge paid for similar services in the same locality; and
- If all the teaching physicians in a teaching hospital agree to accept assignment for all the services they furnish to Medicare patients in that hospital, the customary charge is set at 90 percent of the prevailing charge paid for similar services in the same locality.

(5) 1989 Proposed Rule

On February 7, 1989, we published a proposed rule that would have implemented the teaching physician payment provisions of both ORA 1980 and DEFRA 1984 (54 FR 5946). In that document, we proposed the following changes relating to teaching physicians:

- Revise the regulations governing the conditions under which Medicare payment is made for the services of physicians in teaching settings and implement a special methodology for determining customary charges for the services of teaching physicians.
- Revise the regulations governing Medicare payment to providers for compensation paid to physicians who furnish services that are of general benefit to patients in the provider.

That proposed rule was never published in final because legislation enacted in 1989 and 1990 that mandated the implementation of the Medicare physician fee schedule had the effect of replacing the payment methodology of the proposed rule.

3. Payments for Supervising Physicians in Teaching Settings and for Residents in Certain Settings

In our July 26, 1995 proposed rule, we proposed to revise the regulations because of the substantial changes that have taken place in the way Medicare payments for physician services are determined (that is, the replacement of the reasonable charge system with the physician fee schedule); the length of time since the publication of the February 1989 proposed rule; and our decision to propose to replace the attending physician criteria of the February 1989 proposed rule. The details of the attending physician policy had been set forth earlier in Intermediary Letter 372, published in April 1969.

We proposed to change the attending physician criteria from those of Intermediary Letter 372 to make the criteria more flexible in terms of the individual teaching physician who may serve as the responsible physician for a particular service while ensuring that a teaching physician is present during at least some portion of each service payable by the carrier. We also proposed rules based on other Medicare policies that had been in effect for years but had never been explicitly addressed in the regulations.

a. Distinction Between Teaching Hospital and Teaching Setting

We proposed to distinguish between "teaching hospital" and "teaching setting," because the former is more directly related to intermediary payments, and the latter (although defined in terms of intermediary payments) is more directly related to carrier payments. We proposed to define "teaching hospital" as a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry. We proposed to define "teaching setting" as a provider or freestanding setting for which Medicare payment for the services of residents is made under the direct GME payment provisions of § 413.86 (hospitals, hospital-based providers, and settings, including nonprovider settings, meeting the requirements for residents in § 413.86(f)(1)(iii)), or on a reasonable cost basis under the provisions of § 409.26 or § 409.40(f) for residents' services furnished in freestanding skilled nursing facilities or home health agencies, respectively.

b. Statutory Requirements for Payment in Teaching Hospitals Not Electing Reasonable Costs for Physician Services to Individual Patients

Section 1842(b)(7) of the Act is generally premised on the use of customary charges, that is, the reasonable charge system, as the basis for Medicare payments for the services of physicians in teaching hospitals. Section 1848 of the Act, however, established the physician fee schedule as the payment methodology for physician services furnished beginning January 1, 1992 without any exception for physician services furnished in teaching settings. Therefore, we based the policies in the July 26, 1995 proposed rule on principles established in legislation on payment for physician services generally under the physician fee schedule, on payment for physician services furnished in providers, and on payment to hospitals for GME programs. With regard to payment to hospitals for GME programs, the proposal addressed activities associated with GME programs that were not payable through fiscal intermediary payment mechanisms.

c. Intermediary Letter 372 Attending Physician Criteria

The Intermediary Letter 372 attending physician criteria and related policy were developed by Medicare in 1969 as a means of documenting the involvement of teaching physicians in patient care services furnished in teaching hospitals and have been controversial ever since. It was recognized then and now that residents must furnish patient care services to develop their skills as physicians or other types of practitioners. The "attending physician" policy was developed as a mechanism to make Part B fee schedule payments for services in which residents were involved. The main requirement of the policy was that there would be a single attending physician who personally examined the beneficiary within a reasonable time after admission, confirmed the diagnosis and course of treatment, and was continuously involved in the care of the beneficiary throughout the stay. The attending physician policy as set forth in Intermediary Letter 372 and related issuances specifically stated that the attending physician had to be present when a major surgical procedure or a complex or dangerous medical procedure was performed, but was vague, perhaps necessarily, on the matter of the presence of the physician during other occasions of inpatient service. There was less ambiguity with regard to hospital outpatients. Part A

Intermediary Letter No. 70-7/Part B Intermediary Letter No. 70-2 (issued in January 1970), a question-and-answer on Intermediary Letter 372, indicated that the supervising physician must either personally perform the service or function as the attending physician and be present while a service is being furnished (question 14).

Medicare carriers were directed to periodically review the hospital charts for verification of the establishment of attending physician relationships and their involvement in individual services. If the chart did not substantiate a sufficient level of involvement in the care furnished, the teaching physician role was seen as supervisory in nature, rather than as an attending physician, even though the teaching physician may have had legal responsibility for the care furnished to the patient. Consequently, the fiscal intermediary for the hospital would pay Medicare's share of the salary costs of the teaching physician attributable to the supervision of residents, but the Medicare carrier would not make payment for the physician services on the basis of reasonable charges.

We believe, after years of working experience with the Intermediary Letter 372 attending physician policy, that we should replace it. The amount of postpayment review necessary to verify the establishment and continuity of the attending physician relationship from patient charts had become impractical given reductions in contractor budgets and was inconsistent with more recent congressional action. While the Congress endorsed the attending physician policy in the Conference Report accompanying ORA 1980, the Intermediary Letter 372 policy might be viewed as not entirely consistent with the payment mechanism enacted in OBRA '86 under section 1886(h) of the Act for payment of direct GME costs in teaching hospitals. For example, Intermediary Letter 372 indicated that, if a physician was not an attending physician but supervised a resident who furnished a service, the costs of the physician services were payable by the intermediary. Under section 1886(h) of the Act, if a service was determined not to be an attending physician service billable under Part B, the service could not become a provider service for purposes of additional payments made under Part A since the GME payments were prospectively determined amounts that could not be adjusted based on the individual circumstances of the delivery of individual services. Further, allocation agreements between physicians and hospitals identifying the various activities in which the

physicians were involved for purposes of determining the appropriate payment amounts had no effect on GME payments in an individual hospital cost reporting period. The costs that were allocated during the GME base period were carried forward regardless of changes in the physician activities.

Moreover, the Intermediary Letter 372 policy left it to individual carriers to determine coverage of the services based on customary practices in the area or on the competence of individual residents. For example, a sentence in Intermediary Letter 372.A. reads as follows:

If the supervising physician was present at surgery, and the surgery was performed by a resident acting under his close supervision and instruction, he would not be the attending surgeon unless it were customary in the community for such services to be performed in a similar fashion to private patients who pay for services rendered by a private physician.

While this policy might have been appropriate 30 years ago in the early days of Medicare, we stated in our proposed rule (60 FR 38409) that we believe it is inappropriate to base the determination of whether a carrier will pay several thousand dollars or zero dollars for a surgical procedure on this standard, which could result in a wide disparity of policy from area to area regarding when payment is made.

Another problem with the Intermediary Letter 372 policy was reliance on a single physician to be the attending physician for the beneficiary throughout the inpatient stay. The only exception permitting an attending physician relationship for only a portion of a stay was if the portion was a distinct segment of the patient's course of treatment, such as the postoperative period. Another example from Intermediary Letter 372 reads as follows:

A group of physicians share the teaching and supervision of the house staff on a rotating basis. Each physician sees patients every third day as he makes rounds. No physician can be held to be one of these patients' attending physician for any portion of the hospital care although consultations and other services they personally perform for the patient might be covered.

We stated in our proposed rule (60 FR 38409) that we believe that this emphasis on a single teaching physician serving as the attending physician through the stay was no longer necessary, and that we should provide teaching hospitals and GME programs with flexibility in the determination of the responsible teaching physician in an individual case. We no longer believe the Intermediary Letter 372 requirement that a single physician be recognized by

the beneficiary as his or her personal physician through a period of hospitalization reflects current realities. Further, the existing attending physician regulation might operate at cross-purposes with managed care arrangements that often employ treatment teams.

The Intermediary Letter 372 requirements for continuity of care might be difficult for carriers to verify from reviews of medical records, might be interpreted in different ways by different carriers, and might be counterproductive and burdensome in the delivery of services to the patient. We believe the proposed policy would address potential sources of misunderstanding and abuse that have been longstanding Medicare program concerns. For example, Intermediary Letter 372 required the attending physician to personally examine the patient, review the history and record of test results, etc. From discussions with carrier medical directors, it is our understanding that some carriers considered the requirements to be met if the teaching physician first saw the patient 1 or 2 days after admission. In those situations, the carrier might pay for an admission history and physical performed by a resident on Saturday while the teaching physician did not actually see and examine the patient until Monday. Other carriers would maintain that, to pay for the admission history and physical as an attending physician, the teaching physician would have to see the patient on the day the service was performed.

We believe that the most important consideration should be the presence of the teaching physician during the key portion of the service or procedure being furnished by the resident, and that requiring both an attending physician relationship and the presence of that same physician during every billable service is no longer warranted. Thus, under our proposal, carriers would no longer pay for services such as admission evaluation and management services unless a teaching physician was present during the key portion of the service.

d. Carrier Payment for Services of Teaching Physicians—General

We proposed to eliminate the Intermediary Letter 372 attending physician criteria from the determination of whether payment should be made for the services of physicians in teaching settings. We recognize that the term "attending physician" is used in academic medicine to denote the responsible physician, and we believe that hospitals

and GME programs should be free to designate any physician to be the attending physician of the patients in the teaching setting. We proposed to require the following conditions for services of teaching physicians (physicians who involve residents in the care of their patients) in both inpatient and outpatient settings to be payable under the physician fee schedule:

- A teaching physician (a physician other than a resident or fellow in an approved program) must be present for a key portion of the time during the performance of the service for which payment is sought.
- In the case of surgery or a dangerous or complex procedure, the teaching physician must be present during all critical portions of the procedure and must be immediately available to furnish services during the entire service or procedure. We specified that the teaching physician presence requirement is not met when the presence of a teaching physician is required in two places for concurrent major surgeries. The operative notes must indicate when the teaching physician presence in individual procedures began and ended. In the case of procedures, such as an endoscopy, in which a body area, rather than a representation, is viewed, we would not make payment if the teaching physician was not present during the viewing. A discussion of the findings with a resident would not be sufficient. The situation is contrasted with a diagnostic procedure, such as an x-ray, in which the physician would not be expected to be present during the performance of a test and could bill for an interpretation by reviewing the film with the resident (or by performing an independent interpretation).
- In the case of services such as evaluation and management services (for example, visits and consultations), for which there are several levels of service available for reporting purposes, the appropriate payment level must reflect the extent and complexity of the service if the service had been fully furnished by the teaching physician. In other words, if the medical decision-making in an individual service is highly complex to an inexperienced resident, but straightforward to the teaching physician, payment is made at the lower payment level reflecting the involvement of the teaching physician in the service. We intend to promote flexibility and leave the decision to the teaching physician as to whether the teaching physician should perform hands-on care, in addition to the care furnished by the resident in the presence of the teaching physician.

However, in the case of both hospital inpatient and outpatient evaluation and management services, the teaching physician must be present during the key portion of the visit.

- The presence of the physician during the service or procedure must be documented in the medical records.

The proposal eliminated the Intermediary Letter 372 requirement that the attending physician personally examine the patient and left the decision to the teaching physician as to whether he or she should perform an examination in addition to the resident's examination based on medical and risk management considerations rather than Medicare payment rules. For example, a beneficiary might be admitted to the hospital on a Saturday and be examined by a resident in the presence of a teaching physician on duty at the time. On Monday, another teaching physician might be designated to be the attending physician in the case. Under the proposal to eliminate the Intermediary Letter 372 attending physician criteria, the services of both teaching physicians in this example would be payable (as long as distinct services are furnished).

Under our proposal, we clarified that services of teaching physicians that involve the supervision of residents in the care of individual patients are payable under the physician fee schedule only if the teaching physician is present during the key portion of the service. If a teaching physician is engaged in such activities as discussions of the patient's treatment with a resident but is not present during any portion of the session with the patient, we believe that the supervisory service furnished is a teaching service as distinguished from a physician service to an individual patient.

We believe that this clarification is consistent with existing policy. Part A Intermediary Letter No. 70-7/Part B Intermediary Letter No. 70-2, issued in January 1970, contained a series of questions and answers about the attending physician policy set forth in Intermediary Letter No. 372. Question 14 of that issuance addressed services furnished in emergency rooms and outpatient departments and states the following:

Q. Intermediary letter No. 372 states, "An emergency room supervising physician may not customarily be considered to be the attending physician of patients cared for by the house staff, etc." Is this also true in the hospital's outpatient department?

A. Yes, because an attending physician relationship is not normally established with anyone other than the

treating physician in an outpatient department. If the Part B bills are submitted for services performed by a physician in either the emergency room or in any part of the outpatient department, the hospital records should clearly indicate either that: the supervising physician *personally* performed the service; or he functioned as the patient's attending physician and was present at the furnishing of the service for which payment is claimed.

At the same time we were concerned about the integrity of the Medicare payment process, we recognized that application of this policy to the reimbursement of teaching physicians in family practice residency programs raised special concerns about the viability of these programs. Family practice residency programs are different from other programs because training occurs primarily in an outpatient setting, known as a family practice center. In these centers, residents are assigned a panel of patients for whom they will provide care throughout their 3 years of training. While teaching physicians supervise this care and, indeed, are present during the actual furnishing of services in some circumstances (most notably with first year residents and for more complex patient cases), a general requirement that teaching physicians be physically present during all visits to the family practice center would undermine the development of this physician/patient relationship. This requirement also would be incompatible with the way family practice centers are organized and staffed and could require the hiring of additional teaching physicians when the faculty are already in short supply.

We stated in our July 26, 1995 proposed rule (60 FR 38410) that we would be willing to develop a special rule for paying teaching family physicians that takes into account the unique nature of these training programs while clarifying the appropriate level of involvement of the teaching physician in patient care in family practice centers. We invited comments on the structure and content of such a rule, or a legislative proposal, along with any supportive data. We also invited comments on whether and how such a rule might be applied to other primary care training programs.

e. Special Treatment—Psychiatric Services

During the period in which we were developing the February 1989 proposed rule, we met with representatives of psychiatric GME programs who indicated that it was inappropriate for a physician other than the treating

resident to be viewed by psychiatric patients as their physician. In psychiatric programs, the teaching physician may observe a resident's treatment of patients only through one-way mirrors or video equipment. We accepted this position and proposed that, with respect to psychiatric services (including evaluation and management services) furnished under an approved psychiatric GME program, the teaching physician would be considered to be "present" during each visit for which payment is sought as long as the teaching physician observes the visit through visual devices and meets with the patient after the visit.

f. Physician Services Furnished to Renal Dialysis Patients in Teaching Hospitals

Effective for services furnished on or after August 1, 1983, Medicare pays for physician services to end-stage renal disease patients on the basis of the physician monthly capitation payment method described in § 414.314. This payment method generally applies to renal-related physician services furnished to outpatient maintenance dialysis patients, regardless of where the services are furnished (that is, in an independent end-stage renal disease facility, a hospital-based end-stage renal disease facility, or in the patient's home). Physician services furnished to end-stage renal disease patients on or after August 7, 1990 may also be paid on the basis of the initial method as described in § 414.313. We would continue application of these physician payment methods to teaching hospitals with end-stage renal disease facilities. We would not impose any special medical record documentation requirements solely because the end-stage renal disease facility is based in a teaching hospital.

Physician fee schedule payments for covered physician services furnished to inpatients in a hospital by a physician who elects not to continue to receive payment on a monthly capitation basis through the period of the inpatient stay, or who is paid based on the initial method, would be determined according to the rules described in proposed § 415.170. Physicians would have to either personally furnish the services, or furnish the services as a teaching physician as described in proposed § 415.172.

g. Special Criteria for Anesthesia Services and Interpretation of Diagnostic Tests

Special criteria for anesthesia services involving residents appear in § 415.178. In the case of diagnostic radiology and other diagnostic tests, we make payment

for the interpretation if the physician either personally performs the interpretation or reviews the resident's interpretation.

h. Services of Residents

We proposed to incorporate into the regulations longstanding Medicare coverage and payment policy regarding the circumstances under which the services of residents are payable as physician services. These policies are in operating instructions and other issuances.

Generally, the services of residents in approved GME programs furnished in hospitals and hospital-based providers are payable through the direct GME payment methodology in § 413.86. For hospital cost reporting periods beginning on or after July 1, 1985, a teaching hospital is entitled to include residents working in the hospital and hospital-based providers in the full-time equivalency count used to compute direct GME payments. These payments are based on per-resident amounts reflecting GME costs incurred during a base period and updated by the Consumer Price Index. Further, effective July 1, 1987, under the conditions set forth in § 413.86(f)(1)(iii), a teaching hospital may elect to enter into a written agreement with another entity for the purpose of including the time spent by residents in furnishing patient care services in a setting outside the hospital in the hospital's full-time equivalency count of residents for GME purposes. The agreement must specify that the hospital compensate the resident for the services in the nonhospital setting. When an agreement is in effect, the teaching setting guidelines of proposed §§ 415.170 through 415.184 would apply to services in which physicians involve residents in the nonhospital setting. The services of residents in these settings are payable as hospital services rather than physician services. We stated that proposed § 415.200 would replace current § 405.522.

Current § 405.523 addressed payment for the services of residents who are not in approved programs. The section was applicable to the services of a physician employed by a hospital who is authorized to practice only in a hospital setting and to residents in an unapproved program. We proposed to replace this rule with new § 415.202. The proposed rule incorporated the policy currently in section 404.1.B of the Provider Reimbursement Manual (HCFA Pub. 15-1), which provides that only the costs of the residents' services are allowable as Part B costs, and that other costs, such as teaching costs, of an unapproved program are not allowable.

Current § 405.524 ("Interns' and residents' services outside the hospital") provided for reasonable cost payments for the services of residents in freestanding skilled nursing facilities and home health agencies. We proposed to rename this section to clarify that its scope is limited to these types of providers and to include it with only minor changes into a new § 415.204.

We proposed to establish a new § 415.206 to address payment issues relating to the services of residents in nonprovider settings, such as freestanding clinics that are not part of a hospital. Paragraph (a) addresses situations when a teaching hospital and another entity have entered into a written agreement under which the time the residents spend in patient care activities in these nonhospital settings is included in the hospital's full-time equivalency count used to compute direct GME payments. If an agreement is in force, the carrier would make payments for teaching physician and other physician services under the rules in §§ 415.170 through 415.190.

If a nonprovider entity, such as a freestanding family practice or multispecialty clinic, does not enter into this type of agreement for residency training with a teaching hospital, the payment mechanism in proposed § 415.206(b) would apply in the case of services furnished by certain residents. We modified the policy on Part B billings for services furnished by licensed residents in the late 1970's in an action designed to enhance the ability of primary care residency programs to finance their training activities outside the teaching hospital setting. We revised the Medicare Carriers Manual (HCFA Pub. 14-3) to cover residents' services furnished in a setting that is not part of a hospital as physician services if the resident was fully licensed to practice by the State in which the service was performed. This policy applies whether or not the residents are functioning within the scope of their approved GME program. Under these circumstances, the resident is functioning in the capacity of a physician, and the teaching physician guidelines do not apply.

Additionally, the services of residents practicing in freestanding federally qualified health centers and rural health clinics who meet the requirements of proposed § 415.206(b) would be eligible for payment under the payment methodology for federally qualified health centers. (We would make payments for residents' services in a hospital-based entity under the provisions of § 413.86 for direct GME payments.) We proposed to allow

freestanding federally qualified health centers and rural health clinics to include the costs of a service performed by a resident meeting those requirements as an allowable cost on the entity's cost report. We proposed to amend § 405.2468(b)(1), which sets forth allowable costs for federally qualified health centers and rural health clinic services, to recognize these costs. Further, a resident is considered to be a physician as defined in revised § 405.2401(b) for the purpose of determining payments to the federally qualified health centers and rural health clinics. Consistent with the payment method for federally qualified health centers and rural health clinics, payments for services furnished by residents in federally qualified health centers and rural health clinics would be paid under § 405.2462 rather than under the physician fee schedule. In other words, services of the resident would be treated in exactly the same manner as services of other physicians who are not residents in the federally qualified health center or rural health clinic. We believe that recognizing the costs of these residents in federally qualified health centers and rural health clinic settings would create more uniformity in the way these costs are treated by the Medicare program.

We proposed to establish a new § 415.208 to address carrier payments for the services of "moonlighting" residents. Paragraph (a) defines these services as referring to services that licensed residents perform that are outside the scope of an approved GME program. Paragraph (b) reflects the policy set forth in section 2020.8.C. of the Medicare Carriers Manual under which carriers may pay under the physician fee schedule for the services of moonlighting residents in the outpatient department or emergency department of a hospital in which they have their training program if there is a contract between the resident and the hospital indicating that the following criteria are met:

- The services are identifiable physician services and meet the criteria in § 415.102(a) (formerly § 405.550(b)).
- The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry in the State in which the services are performed.
- The services can be separately identified from those services that are required as part of the approved GME program.

Paragraph (c) indicates that the moonlighting services of a resident furnished outside the scope of an approved GME program in a hospital or other setting that does not participate in

the GME program are payable as physician services under the physician fee schedule.

i. Redesignation of Regulations on Teaching Hospitals, Teaching Physicians, and Physicians Who Practice in Providers

As a part of this rulemaking process, we proposed to redesignate the regulations currently set forth in §§ 405.465 and 405.466, 405.480 through 405.482, 405.522 through 405.524, 405.550, 405.551, 405.554, 405.556, and 405.580 into a new part 415, along with the new regulations proposed in this rule. The redesignation is part of our continuing effort to improve the overall organization of title 42 of the Code of Federal Regulations and, in this case, specifically, the organization of the regulations on teaching hospitals, teaching physicians, and physicians who practice in providers.

Except as indicated below, we proposed only technical changes to conform cross-references, and no substantive changes were included. We proposed to remove §§ 405.520 and 405.521 because the applicable rules for payment of services are obsolete. We also proposed to remove the chart for payment to interns and residents in § 405.525 as obsolete. In addition, we proposed to remove § 405.552 because the applicable payment rules for anesthesia services are set forth in § 414.46. The proposed deletion of § 405.552 was an error; we are redesignating this section as § 415.110.

We intended the redesignation to make these regulations easier to use. Following is a distribution table that indicates the new section numbers that will result from the redesignation or the removal of the section:

DISTRIBUTION TABLE

Old section	New section
405.465	415.162
405.466	415.164
405.480	415.55
405.481	415.60
405.482	415.70
405.520	Removed.
405.521	Removed.
405.522	415.200
405.523	415.202
405.524	415.204
405.525	Removed.
405.550	415.100, 415.102
405.551	415.105
405.552	415.110
405.554	415.120
405.556	415.130
405.580	415.190

Following is a derivation table that shows the origin of each section of the new material:

DERIVATION TABLE

New section	Old section
415.1	
415.50	
415.55	405.480
415.60	405.481
415.70	405.482
415.100, 415.102	405.550
415.105	405.551
415.110	405.552
415.120	405.554
415.130	405.556
415.150	
415.152	
415.160	
415.162	405.465
415.164	405.466
415.170	
415.172	
415.174	
415.176	
415.178	
415.180	
415.184	
415.190	405.580
415.200	405.522
415.202	405.523
415.204	405.524
415.206	
415.208	

4. Public Comments on the Teaching Physician Proposal in the Proposed Rule and Our Responses

We received several thousand comments on the teaching physician proposal in our July 26, 1995 proposed rule. Almost all of the comments came from medical schools, residency programs, and other entities that bill for physicians' services in teaching hospitals and GME programs. The comments and our responses to them follow.

Comment: Most commenters argued that the requirement of teaching physician presence during individual services was a significant departure from the current practice, and that a teaching setting would need a great deal of time to implement the requirement. They requested a delay in the effective date of any new policy. They believed that January 1 would be a particular problem since it falls in the middle of the cost reporting period for most teaching hospitals.

Response: We do not believe that the physical presence requirement is a significant departure from current practice. Instead, as we have indicated in the proposed rule and in this final rule, the proposed rule requiring physical presence clarifies current policy. Under the criteria in

Intermediary Letter 372, Part B payment should be made only when a supervising physician either personally performed the service or functioned as the attending physician and was present while the service was furnished. It has always been our intent that, at a minimum, a teaching physician must be present during a service furnished by an intern or resident in order for the teaching physician to receive Part B payment.

We proposed to clarify our policy because it has not been enforced consistently across carriers. More specifically, we have learned that some teaching physicians are billing Medicare and receiving Part B payment for services even when the service is performed by an intern or resident outside the presence of the teaching physician and the teaching physician has minimal involvement, or no involvement, in the service. Under the physician fee schedule, payment amounts are intended to reflect the amount of resources required for a particular service, and we believe a teaching physician should not receive a resource-based fee schedule amount when the physician has expended little or no resources with respect to the service. It would be particularly inequitable to make a resource-based payment to some teaching physicians when other teaching physicians receive no payment because a carrier is properly applying the physical presence requirement in Intermediary Letter 372.

Thus, the proposed rule would clarify the physical presence requirement reflected in Intermediary Letter 372. At the same time, the proposed rule increases flexibility for billing. The criteria in Intermediary Letter 372 were premised in part on the notion that the same physician served as the attending physician throughout the entire inpatient stay; therefore, only that physician could bill Medicare Part B. Accordingly, under Intermediary Letter 372, if a patient receives a service from the attending physician soon after admission, and receives services from other physicians during the course of the inpatient stay, the other physicians cannot bill Medicare Part B for services furnished by a resident. The proposed rule deletes the requirement of a single attending physician, and allows more than one teaching physician to receive Medicare Part B payment with respect to a particular inpatient stay.

Although the physical presence requirement merely clarifies current policy, we are nevertheless willing to delay the effective date of the provisions of this final rule concerning teaching physicians until July 1, 1996 to give our

contractors adequate time to educate all affected parties. This delay will apply to all provisions of the regulation concerning teaching physicians, including those that state the new policies relating to the elimination of the single attending physician requirement and the exception for residency programs in certain centers.

Comment: One commenter stated that section 948 of the Omnibus Reconciliation Act of 1980, as amended by section 2307 of the Deficit Reduction Act of 1984, requires only that—

The physician renders sufficient personal and identifiable physicians' services to the patient and exercises full, personal control over the management of the portion of the case for which payment is sought.

The commenter believed that these legislative provisions contain no physician presence requirement and questioned our authority to change 25 years of policy without a Congressional mandate to do so.

Response: We believe that the physical presence requirement is entirely consistent with our statutory authority. Under section 1887 of the Act, we are authorized to establish criteria to distinguish between services furnished for an individual patient, which may be paid for by carriers as physician services, and services that are furnished for the general benefit to patients in a hospital, which are paid for by intermediaries.

In addition, we do not view the proposed policy as inconsistent with the statutory provision cited by the commenter. In the first place, we note that section 1842(b)(7) of the Act is largely premised on the use of charges as a basis for payment, and the charge-based system for physicians' services has been superseded by the enactment of the physician fee schedule. Nevertheless, the requirements stated in that section are not in conflict with the physical presence requirement. Section 1842(b)(7) provides that Part B payment may not be made for the services of teaching physicians unless, among other things, "The physician renders *sufficient personal and identifiable services to the patient* and exercises full personal control over the management of the portion of the case for which payment is sought." (Emphasis added.)

We believe we have ample authority under these provisions, as well as section 1848 of the Act, to determine the circumstances under which a teaching physician has performed a service for a patient, and thus has furnished a "physician's service" that warrants Part B payment under the physician fee schedule. Currently, despite the criteria

in Intermediary Letter 372, many teaching physicians are billing Medicare and receiving Part B payment in situations when they have minimal, if any, involvement in the care of an individual patient. For example, the teaching physician may have medical and legal responsibility for the care a resident furnishes to a patient but may never actually see the patient after admission to the hospital. We believe it is inappropriate to make Part B payment in these cases, particularly because the amount of payment is resource-based.

Of course, it is often difficult, and quite time-consuming, to determine when a physician is "sufficiently involved" in a particular patient care service so that Part B payment is warranted. As indicated in the proposed rule (60 FR 38409), the amount of postpayment review necessary to verify the involvement of teaching physicians in the care of individual patients would be enormous, and the use of scarce carrier resources in that effort would be impractical. Therefore, consistent with our authority to establish standards for determining when a service is furnished *for a patient*, as a general matter we believe the most appropriate and feasible manner to determine when Part B payment may be made is to require that the teaching physician must be present for the service for which payment is sought. The physical presence requirement identifies situations when the teaching physician is sufficiently involved in the service, and at the same time it provides a standard that can be readily documented and verified.

Comment: One commenter argued that, under the proposed rule, teaching physicians would not be reimbursed in any manner under Medicare for certain teaching activities that were previously paid for under Part B. According to the commenter, Part A payment reflects base year costs that include only teaching physician costs related to the administration of the teaching program, and "Teaching physician time was not allocable to Part A if attributable to patient care, whether the service was personally performed by the physician, or furnished in the context of the attending physician relationship." The commenter argued that teaching activities related to services to individual patients could not be included in base year costs and thus would never be reimbursed under Part A. The commenter concluded that, under the physical presence requirement, teaching activities related to the care of individual patients would not be reimbursed under either Part A or Part B.

Response: We believe the policies reflected in this final rule fairly reimburse hospitals and physicians for the activities of teaching physicians. As we have indicated, currently many teaching physicians are billing Medicare and receiving Part B payment even when they have little or no involvement in a service furnished by an intern or resident. We believe it is not appropriate for teaching physicians to receive physician fee schedule payment in these situations as if the teaching physician had personally performed the service, particularly since fee schedule payments are intended to reflect the amount of resources expended by the physician. In order to address this problem, and to ensure that Part B payment is made only when the situation warrants, this final rule clarifies the physical presence requirement reflected in Intermediary Letter 372. We believe the requirement is reasonable and necessary because it ensures that Part B payment is made only when a teaching physician is sufficiently involved in the service and does so in a manner that can be readily documented.

We recognize that there may be some inherent tension between policies for carrier payments under Part B and policies for intermediary payments under Part A or Part B. If a service or activity is payable under Medicare, and it is not payable under Part B, then presumably the service or activity is encompassed in the Part A payment. Therefore, any "change" in (or clarification of) Part B policy may, at least arguably, implicate Part A policy. The commenter argued that, despite this relationship between Part A and Part B, under the proposed policies, some services might not be reimbursed at all under Medicare.

We believe that the commenter's arguments are misguided. We note initially that, as a general matter, payment for the costs of direct GME under Part A, like any system that uses base year costs, necessarily reflects conditions in the base year, and any number of conditions might change after the base year (these changes might benefit or hurt the hospital). However, the use of base years for purposes of making these Part A payments is required by statute. We do not believe we should necessarily perpetuate inappropriate payments under Part B simply because payments under Part A cannot be adjusted.

Moreover, and more significantly, we believe that the policies reflected in this final rule taken as a whole reasonably reconcile any tension that there might be between Part A payment policies and

Part B payment policies. The commenter seemed to suggest that, in conducting the Part A base year audits, the agency excluded all costs associated with teaching activities that were related to patient care. This suggestion, however, is incorrect. Indeed, as the commenter acknowledged, time spent supervising residents in patient care was allocable to Part A under the audits if there was no attending physician relationship. Furthermore, although the commenter also asserted that 100 percent of a physician's time was allocable to Part B "in the absence of appropriate documentation," it follows that time spent supervising residents could have been allocated to Part A if the hospital or the physician provided appropriate documentation. Thus, contrary to the commenter's suggestion, teaching activities related to patient care were, or could have been, included in the Part A base year costs. We believe we should not perpetuate inappropriate Part B policies simply because hospitals and physicians failed to properly claim or document Part A costs in the base year.

The commenter also indicated that, under the proposed rule, certain teaching activities would not be reimbursed under Part B even though they were reimbursed under Part B previously (incorrectly or otherwise). This might relate to activities such as discussions about patient charts with a resident when the teaching physician was not present during the visit itself. The commenter stated that, in the proposed rule, we claimed incorrectly that lost Part B revenues could be collected through Part A. Contrary to the commenter's suggestion, we did not mean to suggest that services that were previously, but no longer, paid for under Part B would be paid for through increased payments under Part A. Rather, we meant to indicate that, at times in the past, improper payments may have been made.

We believe that our policies adequately reimburse hospitals and teaching physicians for the activities of teaching physicians. First, the services of the interns or residents themselves are payable under separate mechanisms. Thus, to the extent that services are provided by interns and residents who are largely unsupervised, Medicare pays for the direct costs of those services through GME payments. Second, consistent with the criteria in Intermediary Letter 372, the teaching physician may receive Part B payment as long as the physician is present for the service. Finally, we are providing further flexibility for billing in this final rule, so that services may now be paid

for under Part B even though the same services could *not* previously be properly billed to Part B; specifically, under this final rule, more than one teaching physician may bill Part B with respect to a particular hospital inpatient stay, whereas under Intermediary Letter 372, only a single attending physician could properly bill Part B.

In short, hospitals and physicians will not, as alleged, be systematically underreimbursed under the policies reflected in this final rule. The Part A payment encompasses costs of supervising residents that were (or could have been) properly allocated and substantiated for the base year. Teaching physicians may continue to receive Part B payment under the physical presence requirement reflected in Intermediary Letter 372. And Part B payment may now be made under circumstances in which payment could not properly be made under Intermediary Letter 372.

Comment: Many commenters believed that we developed the teaching physician proposal because we had concluded that beneficiaries in teaching hospitals receive substandard care when the teaching physician is not present during the service or procedure.

Response: The policy was not intended to specifically address quality concerns. Rather, the policy addresses payment issues, in particular, identifying when it is appropriate to make Medicare Part B payment to teaching physicians who oversee the services of interns and residents.

It is important to distinguish between the services of interns and residents and the services of teaching physicians. Medicare fiscal intermediaries pay teaching hospitals for the services of interns and residents. Those services are described in sections 1861(b) and 1832(a) of the Act and are paid under the methodology established by section 1886(h) of the Act. Thus, the fiscal intermediaries are already paying teaching hospitals for services furnished to beneficiaries by residents. The graduate medical education costs payable through the section 1886(h) methodology also encompass any costs associated with the supervisory services of teaching physicians that were appropriately allocated during the base period for that methodology (fiscal year 1984).

Particularly in light of these other payments, we believe that, if we are to pay a fee to another physician who is medically responsible for the services the resident is furnishing to the beneficiary, it is entirely appropriate to require as a condition of payment that the supervising physician furnish a direct, personal physician service to the

beneficiary. This is the basis for the payment of physician services under Medicare. If the resident has personally furnished the service to the beneficiary and the intermediary is paying the teaching hospital for Medicare's share of the services performed by the resident, we believe it is appropriate not to pay a full fee to a supervising physician who was not present when the service was furnished. Furthermore, the Medicare beneficiary is responsible for a 20 percent coinsurance amount for that physician's services as well as any deductible liability. We believe it is fully consistent with a resource-based fee schedule that the physician in whose name the service is billed furnishes a service to the beneficiary.

Comment: Many commenters stated that residency programs cannot afford to furnish services to Medicare beneficiaries without Medicare payment.

Response: Medicare fiscal intermediaries pay approximately \$7 billion annually in direct and indirect medical expenses to teaching hospitals for the costs associated with approved GME programs.

Comment: Some commenters expressed concern about the term "key portion" in determining when the teaching physician should be present. They stated that it is often difficult to define the key portion of a service or procedure. Many commenters expressed their concern with the lack of a clear definition of what constitutes the key portion of every service or procedure. Many other commenters contended that the key portion of the teaching physician's services takes place during the teaching physician's discussions of the case with the resident before and after a visit or procedures. This argument was made by physicians in both medical and surgical specialties.

Response: We proposed the concept of the key portion of a service or procedure to provide flexibility and to avoid requiring the presence of the teaching physician for the duration of every service or procedure billed in his or her name. Many of the commenters expressed the view that the key portion—and the most meaningful portion—of the teaching physician's service to the beneficiary actually takes place in the absence of the beneficiary. We do not agree with this interpretation of key portion because it blurs the distinction between teaching oversight and actually furnishing an identifiable service to the beneficiary.

While we recognize the concern that it may be difficult to determine the key portion for a particular service, this concept is necessarily general because it

is not feasible to define the key portion for each and every billable service. In order to provide guidance, we stated some general guidelines in the proposed rule. Thus, in the case of surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. In the case of surgery, the teaching physician's presence is not required during opening and closing of the surgical field. In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing.

In the case of evaluation and management services, the teaching physician must be present during the portion of the service that determines the level of service billed. The factors to be considered are complexity of medical decision-making, extent of history obtained, and extent of examination performed. We believe that the teaching physician should have considerable discretion in determining the key portion of the service, and we do not anticipate that carriers will deny claims submitted based on this discretion, as long as the claims are documented and in accord with our guidelines. If the teaching physician believes that a key portion of an entire evaluation and management service cannot be identified, the teaching physician should be present for the entire service.

We plan to address this matter further in carrier manual instructions.

Comment: Some commenters objected to the requirement of the proposed rule that the teaching physician be present during the viewing portion of a procedure such as an endoscopy. The commenters believed that the presence of the physician should be determined by the teaching physician based on the competence of the resident.

Response: In those situations, we believe that the carrier should pay for the interpretation of the viewed area by the teaching physician rather than by the resident. As indicated earlier, the viewing by the resident is not payable as a physician service; this service by the resident is paid under direct GME.

Comment: The majority of the commenters identified themselves as representatives of family practice residency programs. The commenters made the following points:

- Many appreciated the preamble language of the proposed rule indicating our willingness to consider adopting special rules for family practice programs.

- Many claimed that hospitals and health care delivery systems would cease residency training for family practice programs if the proposal went into effect without an exception.

- In a family practice program, the resident is the primary care-giver, and the faculty physician sees the patient only in a consultative role.

- It is beneficial for family practice residents to see patients alone in order to learn medical decision-making and to recognize their own limitations.

- A resident cannot be educated in the art and practice of medicine without unsupervised patient contact; the proposed policy would interfere with the development of a resident's bedside manner.

- One family practice resident objected to the low levels of fee payments for his services under Medicare and Medicaid.

- The teaching physician presence requirement intrudes upon the relationship between the resident and the patient and, in the view of some, would cause Medicare beneficiaries to lose confidence in the competence of their resident physician.

- The requirement would necessitate the hiring of more teaching physicians and inhibit the ability to finance family practice programs through patient care billings.

- In many cases, the presence of the teaching physician is superfluous.

- The proposal does not adequately recognize the way medicine is practiced in this country.

- The family practice teaching physician is responsible for supervising four or more residents and medical students who are seeing patients simultaneously. Since the teaching physician must remain with the medical students during patient care visits, he or she does not have time to be involved in services furnished by the residents.

- The family practice preceptors are responsible for signing the medical records after the residents have dictated their entries which, in the view of some, guarantees mandatory supervision for each and every visit.

- Some residents are experienced physicians who have been in private practice for years and are in the residency program only to obtain board certification. The proposal does not adequately address those residents.

- If the proposed policy is implemented, family practice clinics will refuse to treat Medicare beneficiaries. Thus, the beneficiaries will be forced to go to medical assistance clinics.

- The proposal would put the resident in the position of being a clerk rather than a physician.

- Care furnished in family practice programs is more cost-effective than care furnished in established practices; therefore, total Medicare costs are lower when services are provided by these programs.

- The physician presence requirement would inhibit the ability of family practice clinics to compete with managed care programs in the community.

In addition, the American Academy of Family Practice proposed a specific limited exception to the physician presence requirement that we have adopted in large part as set forth below.

Response: As we have discussed, we believe the physical presence requirement is necessary and appropriate as a general rule to ensure that Part B payment is not made when a teaching physician does not furnish a service for a patient; we also believe that hospitals and teaching physicians generally can, as a practical matter, reasonably meet the presence requirement and that Part B payment will be made as appropriate for the services and activities of teaching physicians. At the same time, we believe that, if the nature of a residency program is fundamentally incompatible with a physical presence requirement, it may be appropriate to make Part B payment if the teaching physicians satisfy certain conditions that demonstrate that they are sufficiently involved in the care of individual patients to warrant Medicare Part B payment. As reflected in the proposed rule, we believe a requirement of physical presence would be inherently incompatible with the nature of family practice residency programs, and thus unfairly deny reimbursement for the activities of teaching physicians in these programs and endanger the financial viability of these programs. Because of these considerations, we proposed a limited exception for family practice residency programs.

In light of the comments, we have concluded that an exception should not be limited to family practice programs, but instead should apply to any program that satisfies certain specified criteria. The criteria are designed to capture those residency programs with requirements that are incompatible with a physical presence requirement. Thus, in this final rule, we have decided to establish an exception to the physician presence requirement for certain evaluation and management services furnished in certain centers within the context of certain types of residency

training programs. The exception is set forth in a new § 415.174 of this final rule.

Under the exception, carriers may make physician fee schedule payment for reasonable and necessary low to mid-level evaluation and management services when furnished by a resident without the presence of a teaching physician if all of the following conditions are met:

- Services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining intermediary payments to a hospital under § 413.86.

- Any resident furnishing the service without the presence of a teaching physician must have completed more than 6 months of an approved residency program. The center is responsible for furnishing this information to the carrier. The family practice groups recommended the 6-month requirement, and we believe it is an appropriate safeguard.

- The teaching physician may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must—

- + Have no other responsibilities at the time of the service for which payment is sought;

- + Assume management responsibility for those beneficiaries seen by the residents;

- + Ensure that the services furnished are appropriate;

- + Review with each resident during or immediately after each visit, the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies; and

- + Document the extent of his or her own participation in the review and direction of the services furnished to each beneficiary.

- The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians. The residents must generally follow the same group of patients throughout the course of their residency program. We are not requiring that the teaching physicians remain the same over any period of time.

- The range of services furnished by residents includes:

- + Acute care for undifferentiated problems or chronic care for ongoing conditions.

- + Coordination of care furnished by other physicians and providers.

- + Comprehensive care not limited by organ system, diagnosis, or gender.

We believe that the types of GME programs most likely to qualify for this exception include: family practice and some programs in general internal medicine, geriatrics, and pediatrics.

- The center must be located in a setting in which the resident's time is included in the full-time equivalency count used by the intermediary to make direct GME payments to a hospital for services of residents in that setting. In a freestanding setting in which residents are not counted for the purpose of making these payments, the services of licensed residents are already covered as physician services.

This exception to the teaching physician presence applies only to specific low- and mid-level evaluation and management codes for office or other outpatient visits for both new and established patients. The established patient codes to which the exception applies are CPT codes 99211, 99212, and 99213 (and their successor codes). New patient codes to which the exception applies are CPT codes 99201, 99202, and 99203 (and their successor codes). The teaching physician must be present for higher level evaluation and management codes and all invasive procedures.

In paragraph (b) of new § 415.174, we clarify that the exception may not be construed as providing a basis for the coverage of otherwise noncovered services under Medicare, such as routine physical checkups. Further, this special treatment for certain training situations does not apply to services involving medical school students. A service furnished by a medical school student is a noncovered service under Medicare even if the teaching physician is in the room. We will publish further instructions on the new policy in the Medicare Carriers Manual.

Comment: Some commenters who represent physician specialty organizations stated that they were opposed to any exception to the physician presence requirement if it was limited to a particular specialty. They believed that the same rules on physician presence should apply to all specialties. Some commenters indicated that special treatment for family practice programs "devalued" the importance of residency training in other programs. Many commenters argued that any special treatment given to family practice programs should apply to their programs as well. These include psychiatry, physical medicine, internal medicine, and obstetrics-gynecology.

For example, several commenters believed that psychiatric residency programs should be given the same special treatment in the final rule as might be afforded to family practice programs. Some indicated that the costs of purchasing video equipment or one-way mirrors would be too great.

Response: The exception we are establishing at new § 415.174 is not limited to family practice programs; it applies to the indicated evaluation and management codes when furnished under the specified conditions. We are continuing to provide an additional, special exception for psychiatric programs in § 415.184 as originally proposed.

Comment: Some commenters indicated that their family practice clinics are not under the sponsorship of a hospital, and that their programs do not receive Medicare funds from a hospital for the time the resident is in the clinic.

Response: If the family practice clinic is freestanding (that is, not part of a hospital) and the residents are not included in any hospital's full-time equivalent count of residents, the services of licensed residents are payable under the physician fee schedule on the same basis as any other physician's services. This longstanding policy applies regardless of whether or not the resident's services are furnished within the scope of an approved GME training program.

Comment: Several commenters expressed concern that the same residents for whom we are requiring the presence of a teaching physician are not supervised by a teaching physician when they "moonlight" outside of their training programs.

Response: We recognize moonlighting situations and addressed the subject in the proposed rule. When licensed residents moonlight outside of their training program, Medicare pays for their services as physician services. Medicare does not pay a teaching hospital for these services through the direct GME payment mechanism or through the indirect medical education payment mechanism. In other words, in moonlighting situations, the Medicare program pays for the service only once.

Comment: One organization supported the proposed rule on "moonlighting residents" but sought clarification as to the impact of the proposal on inpatient services. Another commenter sought clarification of the policy when a licensed resident moonlights in another teaching hospital.

Response: The proposal reflects longstanding policy outlined in section 2020.8 of the Medicare Carriers Manual.

The policy does not encompass Medicare payment for moonlighting services furnished to inpatients in the hospital in which the resident has his or her program since we believe these services are virtually indistinguishable from the services the resident furnishes within the scope of the training program. However, when a licensed resident moonlights in another teaching hospital, the carrier must be furnished sufficient information to be sure that the moonlighting resident is not being included in the residency count (used to determine direct and indirect medical education payments) of either hospital for the period of time in question. Moreover, in this final rule, we are revising proposed § 415.202 ("Services of residents not in approved GME programs") (formerly § 405.523) to clarify that, when an intern or resident is in an approved GME program at one hospital and is concurrently furnishing moonlighting services in another hospital that lacks an approved GME program, the services in the second hospital may be reimbursed only pursuant to 42 CFR part 414 or section 2109 of the Provider Reimbursement Manual.

Comment: Some commenters suggested that we should discard the current proposal and implement the "philosophy" of teaching physician immediate availability rather than presence as proposed in the February 7, 1989 proposed rule.

Response: The exception that we have added to the policy we are adopting is consistent with the philosophy to which the commenters referred.

Comment: Some commenters stated that documentation of a teaching physician's presence during a procedure would add costs to an already burdensome, bureaucratic process.

Response: The policy we are adopting cannot be enforced without some documentation of the presence of the teaching physician during procedures and the personal involvement of the teaching physician in evaluation and management services.

Comment: A few physician specialty organizations supported the proposal. In addition, a few physicians stated that the physician presence requirements reflected their standard practice. Some commenters representing surgeons stated that, while they generally supported the physician presence proposal, they objected to the requirement that the surgeons have to indicate in their operative notes when their presence began and ended since the anesthesiologist and nurses already record this information. Many other commenters objected to any restriction

in the involvement of teaching surgeons in concurrent cases. Some commenters believed that third or fourth year residents were capable of performing surgical procedures with the teaching physician in the operating suite rather than in the operating room.

Response: As we stated in the proposed rule, the notation in the nurse's notes is sufficient documentation of the teaching physician's presence during surgical procedures. There is no requirement that the teaching physician personally record the information if it duplicates information available elsewhere. If the teaching physician believes the third or fourth year resident is capable of performing surgical procedures without supervision, the teaching physician should not bill Part B for the surgical services furnished by the resident.

Comment: One commenter recommended that the teaching physician be able to indicate the following general statement on all records:

I have interviewed and examined the patient, and I agree with the history and physical findings as recorded by Dr. (Resident) in his/her note of (date).

The commenter believed that this would clarify that the physician participated in the care of the patient, but not require that he or she spend valuable time repeating all of the documentation already present in the record.

Response: This statement, by itself, would not be sufficient for Part B payment if the physician was not present during the service. If the physician was present, it is not necessary for the teaching physician to repeat all of the documentation entered into the medical records by the resident. The teaching physician may countersign the resident's entries and enter additional notes as necessary to indicate his or her involvement in the service. We will address these matters in more detail in manual instructions.

Comment: One commenter believed that we should pay teaching physicians under case management CPT codes 99361 through 99373 and care plan oversight codes (CPT codes 99375 and 99376). These services include care team conferences and telephone calls for consultation or medical management with other health care professionals. In addition, the commenter suggested that we undertake a demonstration project to test the feasibility and cost-effectiveness of these payments with the goal of implementing a budget-neutral policy for the payments. The same commenter also suggested a policy under which the teaching physician could bill Medicare

for each visit if the physician were present to observe every third visit furnished by the resident to the patient.

Response: Medicare does not allow separate payment for the case management codes. We consider case management services to be included in the prework and postwork of the evaluation and management codes. The suggestion seems to be a way of removing the teaching physician further from the actual performance of the service, and we do not support this outcome.

Comment: Under current policy in § 414.46(c)(1)(iii), if a teaching anesthesiologist is involved in concurrent cases, the medical direction payment rules apply, and a reduced allowance is recognized for the physician service in each concurrent case. Commenters argued that this standard is inconsistent with the standard for teaching surgical services. They indicated their understanding that the teaching surgeon can be involved in concurrent procedures and receive a full allowance for each surgical procedure.

Response: We intend to apply the physician presence standard for both surgical and anesthesia teaching services and have revised § 415.178 ("Anesthesia services") accordingly. Under the policy we are adopting, while we require the teaching surgeon's presence during the critical portion of the service, we do not require the surgeon's presence during the opening and closing of the patient. However, during this period, the teaching surgeon may not be involved in surgical services for other patients since this would preclude his or her return to the original case. We believe that this policy is analogous to the teaching anesthesiologist policy under which, in order to receive an unreduced fee, the anesthesiologist must be present during all critical portions of the procedure and immediately available to furnish services during the entire procedure.

Comment: A carrier medical director commented that there should be a national standard on documentation of what the teaching physician actually does. The carrier medical director believed that physicians in nonteaching settings have to provide considerably more documentation than a counter-signature, and that the teaching physician should make a brief notation documenting his or her involvement in support of the level of evaluation and management code billed.

Response: We plan to address this matter in billing instructions to implement the new policy.

Final decision: We are going forward with the policy we proposed but have

included an exception to the teaching physician presence requirement for certain evaluation and management services furnished in certain centers within the context of certain types of residency training programs. The new exception is found in § 415.174 ("Exception: Evaluation and management services furnished in certain centers"). The effective date of the regulations concerning teaching physicians will be July 1, 1996.

F. Unspecified Physical and Occupational Therapy Services (HCFA Common Procedure Coding System Codes M0005 Through M0008 and H5300)

We proposed to eliminate HCFA Common Procedure Coding System (HCPCS) codes M0005 through M0008 and H5300 and to redistribute the RVUs to the codes in the physical medicine section of the CPT (CPT codes 97010 through 97799). This policy change requires a single way of reporting and paying for a service for which there are now two ways to report. We proposed no change regarding what services may be covered, only as to how covered services would be billed and paid.

Comment: All the comments we received expressed agreement with our proposal to eliminate the HCPCS codes M0005 through M0008 and H5300. The commenters stated that these services can be accurately reported using the new and revised physical medicine and rehabilitation codes in the CPT. They considered the decision to delete these codes to be appropriate and long overdue. The commenters cited the opportunity for unnecessary duplications of service codes and the misuse or overuse of the "M" codes in billing by physical therapists to support eliminating the HCPCS codes.

However, some commenters were concerned that carriers might be reluctant to follow billing rules under the CPT for occupational and physical therapists in the same manner as is accepted for physicians. One commenter had encountered problems in the past with carrier refusals to accept the range of codes allowed under the scope of practice, to allow payment for both physical therapy and occupational therapy services required by the same patient, or to reimburse for more than one code per visit. Another commenter questioned whether occupational therapists in independent practice could report the full range of codes or if some codes were appropriate only to physical therapists in independent practice. The commenter also observed that some procedures can be considered either a physical therapy

service or an occupational therapy service based solely on the specialty of the provider performing the service. Because of the coding flexibility, a beneficiary who has met his or her outpatient limit for physical therapy can continue to receive some of the same services under the occupational therapy outpatient limit if the service is furnished by an occupational therapist and vice versa.

Response: Physical therapy and occupational therapy services required by the same patient are permitted, as is payment for more than one code per visit, subject to statutory requirements and limitations. That is, the provider of a service must be qualified within the State's scope of practice to furnish the service. According to § 410.60 ("Outpatient physical therapy services: Conditions."), the services must be furnished under a written plan of treatment established by the physician or therapist caring for the patient. The services also must be medically necessary and reasonable for the diagnosis or treatment of an illness or injury, as mandated by section 1862(a) of the Act. Occupational and physical therapy services furnished to the same patient on the same day would necessitate two separate treatment plans, two separate physician orders, and both must be medically necessary.

The current Medicare coding limitations apply when both physical therapists and occupational therapists furnish services to the same patient. Specifically, we do not allow separate payment for CPT code 97250 (Myofascial release/soft tissue mobilization, one or more regions) for the same patient, on the same date of service as CPT codes 97265 (Joint mobilization), 97260 (Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure)), or 97261 (each additional area) because these services overlap. Because of the duplication of services represented by the codes for manual manipulation (CPT codes 97260 and 97261), soft tissue mobilization (CPT code 97250), joint mobilization (CPT code 97265), or osteopathic manipulation (CPT codes 98925 through 98929), we do not permit separate payment if any of these codes are reported for the same patient, on the same date of service. Aside from these limitations, there is nothing that precludes the payment for both physical therapy and occupational therapy services for the same patient on the same date of service.

The full range of CPT codes 97010 through 97799 may be reported by occupational therapists in independent

practice as well as by physical therapists in independent practice if the service is within the scope of practice. We have no national payment policy that prevents occupational therapists in independent practice from billing and being paid for any CPT code that describes a service they furnish that may be covered. We do not allow payment for evaluation and management services billed by physical therapists in independent practice and occupational therapists in independent practice because the work RVUs for these services include work that they are not trained to perform (for example, evaluation for and prescription of drug therapy and evaluation for and prescription of surgical or other therapy). Otherwise, occupational therapists in independent practice may bill using any CPT code the carrier determines describes the covered services, not just the codes in the physical medicine section of the CPT.

It follows, therefore, that the same procedure code may be used to bill for an occupational therapy service or a physical therapy service. The covered outpatient limit applies to both specialties individually.

Comment: We were requested to clarify whether carriers allow payment for therapists' bills submitted under the physician fee schedule in the same manner as physicians' bills for similar services.

Response: Section 1848(j)(3) of the Act defines physicians' services to include outpatient physical therapy and occupational therapy for physician fee schedule payment and, therefore, bills of physical therapists and occupational therapists in independent practice are treated in the same manner as bills of a physician for covered services.

Comment: We received one comment asking if RVUs will be established for CPT codes 97545 and 97546, which are currently carrier priced.

Response: We reviewed the RUC recommendations and decided to defer assigning RVUs for these codes until there is a better definition of the services. It is unclear whether the time specified in the codes (CPT 97545, work hardening/conditioning, initial 2 hours and CPT code 97546, each additional hour) describes the time of the patient or the practitioner. It is our belief that it is possible for physical therapists in independent practice to do work hardening for four patients simultaneously, rotating from patient to patient located within the same room. Moreover, we believe that there is more work (that is, higher intensity and one-on-one attention) in the first 2 or more hours of service, not the initial 2 hours

of care in a given day, as these codes are defined. We believe that the intensity and amount of work drops off quickly in the process and that it would be impossible to value the services correctly under its current definition.

Comment: As noted in the proposed rule, the Health Care Professional Advisory Committee will be considering the creation of evaluation and management codes for physical therapists in independent practice and occupational therapists in independent practice. One commenter expressed hope that these codes would be developed by 1997.

Response: We anticipate these codes will be developed for use in 1997.

Final Decision: We will eliminate HCPCS codes M0005 through M0008 and H5300 and redistribute the RVUs across CPT codes 97010 through 97799. This policy change is not explicitly addressed in our regulations.

G. Transportation in Connection with Furnishing Diagnostic Tests

The general physician fee schedule policy regarding additional payments for travel expenses is that travel is included in the practice expense RVUs for a service. However, we have not specifically applied that policy to the transportation of equipment used to perform diagnostic tests. In the absence of specific instructions from us, separate payment for the transportation of diagnostic equipment has been at the Medicare carriers' discretion. We proposed to standardize payment for transportation of diagnostic equipment by applying the general physician fee schedule policy regarding payment for travel expenses to transportation services except in some cases of transporting portable x-ray and EKG equipment.

The exceptions are based on longstanding specific instructions. In the case of x-ray services furnished by approved suppliers, section 1861(s)(3) of the Act establishes the coverage of diagnostic x-rays furnished in a place of residence used as the patient's home. Although the Congress did not explicitly so state, we determined that, because there were increased costs associated with transporting the x-ray equipment to the beneficiary, the Congress intended for us to pay an additional amount for the transportation service. Thus, we established codes for use in billing for a transportation component of these services. Nothing in our proposal affects the payment of a transportation component in connection with the x-ray procedures furnished by approved portable x-ray suppliers listed

in section 2070.4.C of the Medicare Carriers Manual.

We later added the taking of an EKG tracing to the list of services approved suppliers of portable x-ray services may furnish (section 2070.4.F of the Medicare Carriers Manual) and established HCPCS code R0076 to pay for the transportation of EKG equipment. Under our proposal, we would continue to pay for the transportation of EKG equipment by approved suppliers of portable x-ray equipment although we did clarify that the policy applied only to standard EKG procedures described by CPT code 93005 (or CPT code 93000 if the interpretation is billed with the tracing).

Many Medicare carriers have limited the use of HCPCS code R0076 to approved portable x-ray suppliers, but some Medicare carriers permit other types of entities, such as independent physiological laboratories to use the code. Section 2070.1.G of the Medicare Carriers Manual provides for the coverage of an EKG tracing by an independent laboratory in the following situations:

- In a home if the beneficiary is a homebound patient.
- In an institution used as a place of residence if the patient is confined to the facility and the facility does not have on-duty personnel qualified to perform the service.

Under our proposal, we would remove the requirement that the beneficiary be confined to his or her home or to an institution for the EKG tracing to be a covered service since this requirement does not apply to EKG tracings taken by portable x-ray suppliers.

For all other types of diagnostic tests payable under the physician fee schedule, Medicare carriers would pay for the transportation of equipment only on a "by report" basis under CPT code 99082 if a physician submits documentation to justify the "very unusual" travel set forth in section 15026 of the Medicare Carriers Manual.

Comment: One commenter, representing a mobile independent physiological laboratory, indicated that the laboratory currently furnished several types of diagnostic procedures to patients in various settings without any separate payment for transportation. The commenter appreciated the fact that, under the proposal, the laboratory would now receive a transportation payment for CPT code 93005 (a 12-lead EKG) and suggested that the exceptions to the transportation payment proposal be extended to include CPT code 93225 (holter monitoring) and HCPCS code G0005 (patient activated event recording

procedures). The commenter suggested that HCPCS code R0076 be revised to specifically include the transportation of holter monitoring and patient activated event recorder equipment to patients upon physician order.

Response: We were not seeking to expand the list of services independent physiological laboratories may furnish for which carriers will make separate transportation payments. Since the law does not provide for coverage of any diagnostic tests payable under the physician fee schedule furnished to beneficiaries in their place of residence other than x-ray services furnished under conditions we have approved, we will not provide for transportation payments in connection with other diagnostic tests furnished by independent physiological laboratories.

Under our proposal, Medicare carriers would make transportation payments under HCPCS code R0076 in connection with standard EKG procedures (CPT code 93005) furnished by an independent physiological laboratory when the coverage conditions of section 2070.5 of the Medicare Carriers Manual are met. We made this exception to the general policy on transportation of diagnostic equipment because of the longstanding nature of the Medicare Carriers Manual policy on furnishing EKGs to patients in their residences or in nursing homes by "independent" laboratories. We have some concerns about making this exception because it is our understanding that some Medicare carriers are not currently making such payments. However, we anticipate that this additional cost will be offset, to some degree, nationally by the discontinuation of transportation payments to independent physiological laboratories for other types of diagnostic tests that Medicare carriers may currently allow. In addition, we are maintaining our proposal in that we are maintaining section 2070.1.G of the Medicare Carriers Manual regarding the homebound status of the beneficiary receiving the service.

Comment: A carrier medical director questioned why the proposal did not address whether the diagnostic procedure itself was payable when furnished by an independent physiological laboratory in settings such as a nursing home and whether we were suggesting that such procedures should not be done in nursing homes. The commenter noted that it would be useful for us to establish a list of "physiological" tests that can be furnished by an independent physiological laboratory.

Response: Our proposal does not address the coverage for procedures

furnished by independent physiological laboratories. In the absence of a national policy on the payment for the services, the coverage for independent physiological laboratory services remains within the authority of the carrier and must be consistent with any applicable State or local laws.

Comment: A national organization of suppliers of portable x-ray services commented that portable x-ray suppliers should be the only entities paid under the physician fee schedule who may bill for transportation of diagnostic equipment under HCPCS codes R0070, R0075, and R0076.

Response: Under the policy we are adopting, approved suppliers of portable x-ray services are the only entities who may bill HCPCS codes R0070 and R0075 under the physician fee schedule. Portable x-ray suppliers and independent physiological laboratories may bill HCPCS code R0076 for the transportation of EKG equipment used to furnish standard EKGs (CPT codes 93000 and 93005).

Comment: A national organization whose membership includes primary care physicians opposed the proposal because it would adversely affect the availability of portable diagnostic equipment for small hospitals and for patients in home care and skilled nursing facilities. The commenter noted that it was not in the best interest of patient care to force patients to travel to medical facilities outside their communities to receive the testing and that Medicare carriers should ensure that transportation payments do not exceed transportation costs.

Response: We believe there is no problem with respect to the transportation of diagnostic equipment to small hospitals. The hospital must purchase the service "under arrangements" if the service is provided to its patients. When a hospital purchases services "under arrangement," it assumes responsibility for the service furnished, and Medicare intermediary payment is made for this service through one of several payment mechanisms applicable to payment for hospital services.

Comment: Several commenters indicated that home and facility bound patients would benefit from expanded coverage of portable ultrasound services. One commenter indicated that these services offer the patient a top quality examination while eliminating the trauma and expense of an ambulance ride and emergency room stay. The commenter requested a mobile ultrasound transport code and a mobile ultrasound set-up code.

Response: Our proposal does not affect the furnishing of these procedures in homes or facilities; it merely affects any additional payment for the transportation of the diagnostic equipment. We can find no basis in the statute to support separate payments for the transportation of the equipment used to furnish these services.

Comment: A national physicians' organization recommended we establish a list of diagnostic services for which transportation payment will be made. It suggested the list include transportation of diagnostic equipment used to perform the following:

- Frozen section diagnosis in hospitals and other facilities in which surgery is provided.
- Therapeutic apheresis furnished to patients in sites where the equipment is not available.

Response: The frozen section diagnostic equipment should be purchased "under arrangement" by the hospital and is payable through Medicare intermediary payment mechanisms. Therapeutic apheresis services are outside the scope of this proposal, which only relates to diagnostic tests.

Comment: We received several comments requesting the following:

- The definition of an independent physiological laboratory be extended to include diagnostic and screening mammograms furnished by certified facilities.
- Transportation payments be made to mobile facilities providing mammography services.
- Diagnostic and screening mammography services be added to the list of covered portable x-ray services.

Response: As indicated in an earlier response, the coverage of services furnished by independent physiological laboratories is beyond the scope of this proposal. Furthermore, the Congress has placed the authority for setting standards for entities furnishing both diagnostic and screening mammograms with the Food and Drug Administration. If an independent physiological laboratory were to receive certification from the Food and Drug Administration, it may furnish these services to Medicare beneficiaries.

Under the policy we are adopting, the only service furnished by an independent physiological laboratory for which a separate transportation payment may be made is a standard EKG.

Under our proposal, we were not planning to make any changes in the services an approved supplier of portable x-ray services may furnish; however, the commenter has made a

good point about mammography services. Under the changes made to section 1861(s)(3) of the Act by section 145(b) of the Social Security Act Amendments of 1994, Public Law 103-432, enacted on October 31, 1994, we believe that the Congress has added diagnostic mammography as part of the portable x-ray benefit. We will issue instructions to Medicare carriers regarding payments (including transportation payments) for mammograms furnished by approved portable x-ray suppliers.

Final Decision: We are adopting the proposal to preclude separate payment for the transportation of diagnostic equipment except under the following circumstances:

- Transportation services billed under HCPCS codes R0070, R0075, or R0076 in connection with services furnished by approved suppliers of portable x-ray services as set forth in section 2070.4 of the Medicare Carriers Manual.
- Transportation services billed by an independent physiological laboratory under HCPCS code R0076 in connection with the provision of the CPT codes 93000 or 93005 (a 12-lead EKG with interpretation and report or a 12-lead EKG, tracing only, without interpretation and report, respectively) furnished under the conditions set forth in section 2070.1.G. of the Medicare Carriers Manual.
- Transportation services billed on a "by report" basis under CPT code 99082 (unusual travel) if a physician submits documentation to justify "very unusual" travel as set forth in section 15026 of the Medicare Carriers Manual.

Payment for expenses associated with the transportation of diagnostic equipment under conditions that do not meet any of the above criteria is included in the practice expense RVUs assigned to the service or procedure and is not separately payable. In addition, we plan to develop a proposal related to the transportation of EKG equipment furnished by any supplier as part of next year's physician fee schedule regulation.

H. Maxillofacial Prosthetic Services

We proposed to eliminate the carrier-priced status and establish RVUs for maxillofacial prosthetic services effective for services performed on or after January 1, 1996. We proposed RVUs for CPT codes 21079 through 21087 and HCPCS codes G0020 and G0021.

The work RVUs that we proposed were developed by the American Academy of Maxillofacial Prosthetics. We believe they appropriately represent the work involved in these procedures.

Because the CPT codes were introduced in 1991 and the HCPCS codes in 1995, we have little or no charge data on which to base practice expense and malpractice expense RVUs in accordance with section 1848(c)(2)(C) of the Act. Therefore, we imputed the practice expense and malpractice expense RVUs from the work RVUs based on the practice cost shares provided by the American Association of Oral and Maxillofacial Surgeons. Those shares are 54.7 percent for practice expense and 4.4 percent for malpractice expense.

Comment: We received numerous comments in response to the RVUs assigned to maxillofacial prosthetic services. Although there was some support for eliminating the carrier-priced status of these services and at least one commenter expressed appreciation of the work RVUs, the commenters were unanimous in objecting to our use of the American Association of Oral and Maxillofacial Surgeons' practice cost shares. These commenters stated that the practice and malpractice expenses for the subspecialty of maxillofacial prosthetics differ substantially from those of maxillofacial surgery, primarily due to increased laboratory, supply, and maxillofacial material costs. The commenters believed that the RVUs imputed for practice expense are too low and should be between 65 and 70 percent to accurately reflect the practice expenses incurred by the prosthodontist. According to the commenters, the RVUs we proposed for malpractice expense are too high and should be in the range of 1 percent to 3.5 percent of the total RVUs.

Because maxillofacial prosthodontic practice expenses include laboratory charges (including precious metals and impression materials) that are rarely seen in oral and maxillofacial surgery and include significantly higher practice expenses, the commenters requested that we revise the RVUs for maxillofacial prosthetic procedures to account for the higher practice cost shares.

Response: In the absence of charge data, we use the best available data to impute practice expense and malpractice expense RVUs. Maxillofacial surgery represented the specialty for which we had available data that used comparable survey methods. We note, also, that we are currently working on a resource-based practice expense study and, as part of this effort, hope to have more definitive data in the future. At that time, we will reevaluate all maxillofacial practice expense RVUs.

Final Decision: We are recommending no additional modifications to the RVUs for maxillofacial codes at this time. The proposed RVUs for CPT codes 21079 through 21087 are accepted as final. HCPCS code G0020 has been replaced by new CPT code 21076, and G0021 has been replaced by new CPT code 21077. Because these new CPT codes describe the same services as the HCPCS codes, the assigned RVUs will not change. Therefore, the proposed relative values for G0020 and G0021 are accepted as final but are assigned to CPT codes 21076 and 21077, respectively. G0020 and G0021 are deleted effective January 1, 1996. All RVUs for oral maxillofacial prosthetic services are published in Addendum B.

I. Coverage of Mammography Services

Based on recommendations from the Food and Drug Administration, the National Cancer Institute, and a carrier medical directors' workgroup, we proposed to revise the definitions of "diagnostic" and "screening" mammography in § 410.34 to make them consistent with previous Medicare coverage policy regarding "diagnostic" mammography and with the way these terms are used in general clinical practice in the United States. Specifically, we proposed to expand the definition of "diagnostic" mammography in § 410.34(a)(1) to include as candidates for this service asymptomatic men or women who have a personal history of biopsy-proven breast disease. However, we proposed to retain the substance of the present definition of "screening" mammography in § 410.34(a)(2) so that patients with a personal history of breast disease can be considered candidates for the "screening" examination, if the woman's attending physician determines that this is appropriate.

Comment: One commenter indicated that, because of the overlap in the definitions for "screening" and "diagnostic" mammograms, the proposal would lead to allowing almost every mammogram furnished to a Medicare beneficiary to be covered as a diagnostic mammogram, thereby increasing Medicare costs for mammograms.

Response: We do not believe the revised definitions will significantly increase the total number of diagnostic mammography services furnished. Information from the Medicare carriers indicates that most asymptomatic patients with a personal history of biopsy-proven breast disease are already receiving diagnostic mammograms rather than screening mammograms. This final rule is consistent with general

clinical practice in the United States and falls within the parameters of Medicare statutory coverage for diagnostic and screening mammograms.

Comment: Two commenters recommended that we clarify the term "a personal history of biopsy-proven breast disease." One commenter assumed that both benign (for example, fibroadenomas) and malignant neoplasms would fall in that category. The other commenter suggested that we make a distinction between "a personal history of breast cancer" and "a personal history of biopsy-proven breast disease."

Response: We agree that this point needs to be clarified. The intent of the proposal was to include both benign and malignant neoplasms within the meaning of the term "a personal history of biopsy-proven breast disease." Breast diseases, including both benign and malignant neoplasms, that require a biopsy and subsequently demonstrate a pathologic process, establish a history of biopsy-proven breast disease. In the final rule, we are clarifying this by revising the term "a personal history of biopsy-proven breast disease" to read "a personal history of breast cancer or a personal history of biopsy-proven benign breast disease."

Comment: One commenter expressed the opinion that the term "fibrocystic disease" referred to in the preamble of the proposed rule should be more appropriately referenced as "fibrocystic changes."

Response: The terms "fibrocystic disease" and "fibrocystic changes" are often used synonymously. We agree that, in our discussion of this subject in the preamble to the proposed rule, the preferred term is "fibrocystic changes."

Comment: One commenter suggested that the proposal should be revised to include, as candidates for diagnostic mammography, women who have a family history of breast disease (within one generation).

Response: While there is a growing consensus among clinicians and mammography experts that family history is an important etiologic factor that places women at high risk of developing breast cancer, and thus eligible for screening mammography at frequent intervals, the data are not sufficiently definitive at present to consider these women to be candidates for diagnostic mammography.

Comment: One commenter suggested that we discuss whether women who have tested positive for any of the recently identified breast cancer genes, such as BRCA1, should be considered to have a personal history of breast cancer

within the meaning of this term in the regulations.

Response: As we stated in the final rule concerning Medicare coverage of screening mammography that was published in the Federal Register on September 30, 1994 (59 FR 49826), the term "a personal history of breast cancer" in § 410.34(b)(4) of the regulations was intended to mean that there is documented evidence in the woman's medical record that she has tested positive for breast cancer. While the development of screening tests in this area is promising, we do not believe that the inclusion of these tests as specific criteria for coverage of screening mammograms is warranted at this time. However, as new information becomes available, we will reconsider this issue.

Final Decision: We are adopting our proposal to revise the definitions of the terms diagnostic and screening mammography in § 410.34. As requested by several commenters, we are clarifying the final regulations text by revising the term "a personal history of biopsy-proven breast disease" to read "a personal history of breast cancer or a personal history of biopsy-proven benign breast disease."

III. Anesthesia Issues

A. Modifier Units for Anesthesia Services

In the January 26, 1989 proposed rule (54 FR 3794) and the August 7, 1990 final rule implementing the uniform relative value guide for physician anesthesia services, we stated our national policy that Medicare carriers cannot recognize payments for anesthesia modifiers. Anesthesia modifiers represent additional units charged by physicians because of the patient's advanced age, poor physical health status, or unusual circumstances including the performance of anesthesia under emergency circumstances or anesthesia complicated by the use of controlled hypotension.

For the 3 years preceding the physician fee schedule, Medicare carriers had uniformly implemented the policy of not allowing modifier units in determining payment for physician anesthesia services.

The physician fee schedule legislation required us to use the uniform relative value guide to the extent feasible and to make any necessary adjustments to the anesthesia CF. In the November 1991 final rule (56 FR 59509) to implement the physician fee schedule, we stated that we were continuing to use the uniform relative value guide to determine payment for physician

anesthesia services under the physician fee schedule. Since it was the established uniform practice for Medicare carriers not to recognize modifier units, we believed it was sufficient to write the regulations to explain only those elements that the Medicare carrier would recognize in calculating anesthesia payments, namely anesthesia base and time units. Thus, in the final rule to implement the physician fee schedule, we did not include specific regulatory language prohibiting anesthesia modifier units.

Some administrative law judges have interpreted the absence of language expressly prohibiting the use of modifier units under the physician fee schedule to mean that modifier units can be allowed. This is clearly an incorrect interpretation of our regulations, and we have chosen to clarify this matter by including a specific reference in the regulations stating that modifier units are not allowed. We have revised § 414.46 to reflect this policy. Because this clarification of the regulations is an interpretive change, the law does not require prior notice and comment. However, we will accept comments on this change in the regulations.

B. Issue for Change in Calendar Year 1998—Two Anesthesia Providers Involved in One Procedure

As a result of the revised payment methodology for the anesthesia care team established by section 13516 of OBRA 1993, we proposed to apply the medical direction payment policy to the single procedure involving both the physician and the certified registered nurse anesthetist. Thus, in § 414.46 we proposed to revise paragraphs (c) and (d) to state that, in this situation, the payment allowance for the medical direction service of the physician and the medically directed service of the certified registered nurse anesthetist or the anesthesiologist assistant is based on the specified percentage of the payment allowance in § 414.46(d)(3). In addition, we proposed that in 1998 and later years, this payment allowance is equal to 50 percent of the allowance for personally performed procedures.

We proposed to implement this policy on January 1, 1998. At that time, the change in policy will be done in a budget-neutral manner.

Comment: Commenters referred to those complicated anesthesia cases when it may be medically necessary for two anesthesia care providers to be involved. The anesthesia providers could be an anesthesiologist and a certified registered nurse anesthetist or two anesthesiologists. They asked

whether we would permit full payment for each of these providers or subject these providers to the new proposal in which case each provider would receive only 50 percent of the allowance recognized for the anesthesia case personally performed by a single anesthesiologist.

Response: We are not changing the current policy under which the Medicare carriers can, on the basis of medical necessity, recognize full payment for the services of each of two anesthesia providers if both providers are needed in a single anesthesia case. Thus, the Medicare carriers can continue, based on medical necessity, to allow full payment for the service furnished by each anesthesia provider in a single case.

Comment: A commenter offered an alternative proposal that would achieve budget neutrality but allow implementation beginning in 1996. Under the commenter's proposal, which would take effect in 1996, the payment allowance for both the certified registered nurse anesthetist and the anesthesiologist involved in the single case would be 50 percent of the allowance recognized for the single anesthesiologist.

Response: The law recognizes that an anesthesia service is either personally performed by a physician (or nonmedically directed certified registered nurse anesthetist) or the case is medically directed. We have implemented the medical direction policy as applying only to two, three, or four concurrent procedures. Therefore, we deemed the case involving both the anesthesiologist and the certified registered nurse anesthetist to be personally performed by the physician. In the July 26, 1995 proposed rule, we proposed to modify the definition of medical direction to include a single procedure in addition to concurrent procedures. The statutory provisions governing medical direction provide that, in 1996, the payment allowance for both the certified registered nurse anesthetist and the physician are equal to 55 percent of the single anesthesiologist payment allowance. Thus, there is no direct authority in the law to recognize a payment allowance that is 50 percent of the single anesthesiologist payment allowance for both the certified registered nurse anesthetist and the physician.

Final Decision: We will apply the medical direction payment policy to the single procedure involving both the physician and the certified registered nurse anesthetist. We will implement this policy on January 1, 1998. At that

time, the change in policy will be done in a budget-neutral manner.

IV. Refinement of Relative Value Units for Calendar Year 1996 and Responses to Public Comments on Interim Relative Value Units for 1995

A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units

Section IV.B. of this final rule describes the methodology used to review the comments received on the relative value units (RVUs) for physician work and the process used to establish RVUs for new and revised CPT codes. (The CPT, which is published annually by the American Medical Association, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.) Changes to codes on the physician fee schedule reflected in Addendum B are effective for services furnished beginning January 1, 1996.

B. Process for Establishing Work Relative Value Units for the 1996 Fee Schedule

Our December 8, 1994 final rule on the 1995 physician fee schedule (59 FR 63410) announced the final RVUs for Medicare payment for existing procedure codes under the physician fee schedule and interim RVUs for new and revised codes. The RVUs contained in the rule apply to physician services furnished beginning January 1, 1995. We announced that we would accept comments on interim RVUs for new or revised codes. We announced that we considered the RVUs for the remaining codes to be subject to public comment under the 5-year refinement process. In this section, we summarize the refinements to the interim work RVUs that have occurred since publication of the December 1994 final rule and our establishment of the work RVUs for new and revised codes for the 1996 fee schedule.

1. Work Relative Value Unit Refinements of Interim and Related Relative Value Units

a. Methodology (Includes Table 1—Work Relative Value Unit Refinements of Interim and Related Relative Value Units).

Although the RVUs in the December 1994 final rule were used to calculate 1995 payment amounts, we considered the RVUs for the new or revised codes to be interim. We accepted comments for a period of 60 days. We received approximately 100 substantive comments from 24 specialty societies on

approximately 83 CPT codes with interim RVUs.

Only comments received on codes listed in Addendum C of the December 1994 final rule were considered this year. We will consider comments we received on other codes under the 5-year refinement process. We convened a multispecialty panel of physicians to assist us in the review of the comments with certain exceptions. The comments that we did not submit to panel review are discussed at the end of this section. The panel was moderated by our medical staff and consisted of the following groups:

- A clinician representing each of the specialties most identified with the procedures in question. Each specialist on the panel was nominated by the specialty society that submitted the comments. Eleven specialty societies, including primary care, were represented on the panel.
- Primary care clinicians nominated by the American Academy of Family Physicians, the American Society of Internal Medicine, the American College of Physicians, and the American Academy of Pediatrics.
- Carrier medical directors.

After eliminating the codes with final RVUs and certain codes that are discussed at the end of this section, we submitted comments on 18 codes for evaluation by the panel. The panel discussed the work involved in each procedure under review in comparison to the work associated with other services on the fee schedule. We had assembled a set of reference services and asked specialty societies to compare clinical aspects of the work of services they believed were incorrectly valued to one or more of the reference services. In compiling the set, we attempted to include: (1) Services that are commonly performed whose work RVUs are not controversial; (2) services that span the entire spectrum from the easiest to the most difficult; and (3) at least three services performed by each of the major specialties so that each specialty would be represented. The set listed approximately 120 services. Panelists were encouraged to make comparisons to reference services.

The intent of the panel process was to capture each participant's independent judgment based on the discussion and his or her clinical experience. Following each discussion, each participant rated the work for the procedure. Ratings were individual and confidential, and there was no attempt to achieve consensus among the panel members.

We then analyzed the ratings based on a presumption that the final rule RVUs were correct. To overcome this

presumption, the inaccuracy of the interim RVUs had to be apparent to the broad range of physicians participating in each panel.

Ratings of work were analyzed for consistency among the groups represented on each panel. In general terms, we used statistical tests to determine whether there was enough agreement among the groups of the panel and whether the agreed-upon RVUs were significantly different from the interim RVUs published in Addendum C of the December 1994 final rule. We did not modify the RVUs unless there was clear indication for a change. If there was agreement across groups for change, but the groups did not agree on what the new RVUs should be, we eliminated the outlier group and looked for agreement among the two remaining groups as the basis for new RVUs. We used the same methodology in analyzing the ratings that we used in the refinement process for the 1993 fee schedule. The statistical tests were described in detail in the November 25, 1992 final notice (57 FR 55938).

Our decision to convene multispecialty panels of physicians and to apply the statistical tests described above was based on our need to balance the interests of those who commented on the work RVUs against the redistributive effects that would occur in other specialties, particularly the potential adverse effect on primary care services. Of the 18 codes reviewed by our multispecialty panel, all of the requests were for increased values.

We also received comments on RVUs that were interim for 1995 but which we did not submit to the panel for review for a variety of reasons. These comments and our decisions on those comments are discussed in further detail in section VI.B.1.c. of this final rule. Of the 44 interim work RVUs that were reviewed, approximately 41 percent were increased, and approximately 59 percent were not changed.

Table 1—Work Relative Value Unit Refinements of Interim Relative Value Units

Table 1 lists the interim and related codes reviewed during the 1995 refinement process described in this section. This table includes the following information:

- **CPT code.** This is the CPT code for a service.
- **Modifier.** A "26" in this column indicates that the RVUs are for the professional component of the code.
- **Description.** This is an abbreviated version of the narrative description of the code.

• *1995 work RVUs.* The work RVUs that appeared in the December 1994 rule are shown for each reviewed code.

• *Requested work RVUs.* This column identifies the work RVUs requested by commenters. We received more than one comment on some codes, and, in a few of these cases, the commenters requested different RVUs. The table lists the highest requested RVUs. For some codes, we received recommendations for an increase or decrease but no specific RVU recommendations.

• *1996 work RVUs.* This column contains the final RVUs for physician work.

• *Basis for decision.* This column indicates whether:

—The recommendations of the refinement panel were the basis upon which we determined that the interim work RVUs published in the December 1994 final rule should be retained (indicator 1);

—A new value emerged from our analysis of the refinement panel ratings (indicator 2); or

—A new or retained value emerged from some other source (indicator 3). Codes with an indicator of 3 are discussed following Table 1, in section VI.B.1.c.

—New or retained values emerged through a combination of the panel ratings and code descriptor interpretation (indicator 4). Codes with an indicator of 4 are discussed following Table 1, in section VI.B.1.b.

TABLE 1.—WORK RVU REFINEMENTS OF INTERIM AND RELATED RVUS

CPT*	Mod	Description	1995 work RVU	Re-requested work RVU	1996 work RVU	Basis for decision
11977		Removal/reinsert contra cap	2.52	3.30	3.30	3
19367		Breast reconstruction	24.73	26.50	24.73	3
20955		Microvascular fibula graft	37.58	43.00	37.58	3
25337		Reconstruct ulna/radioulna	9.10	9.50	9.50	3
25830		Fusion radioulnar jnt/ulna	9.10	9.50	9.50	3
26580		Repair hand deformity	15.81	17.71	17.71	3
29445		Apply rigid leg cast	1.78	0.57	1.78	3
31276		Sinus surgical endoscopy	7.42	8.85	8.85	3
37209		Exchange arterial catheter	1.48	3.66	2.27	2
41822		Excision of gum lesion	2.26	4.20	2.26	1
41823		Excision of gum lesion	3.15	4.60	3.15	1
41828		Excision of gum lesion	1.26	4.44	3.04	2
41830		Removal of gum tissue	1.12	5.00	3.30	2
43842		Gastroplasty for obesity	13.76	17.47	13.76	3
43843		Gastroplasty for obesity	13.76	17.47	13.76	3
43846		Gastric bypass for obesity	17.84	20.87	17.84	3
43847		Gastric bypass for obesity	19.87	23.24	19.87	3
43848		Revision gastroplasty	22.10	24.75	22.10	3
52647		Laser surgery of prostate	7.42	11.51	9.84	2
52648		Laser surgery of prostate	8.65	11.51	10.69	2
59855		Abortion	4.75	5.80	5.80	3
64820		Remove sympathetic nerves	9.10	10.00	10.00	3
76093	26	Magnetic image, breast	1.63	1.94	1.63	1
76094	26	Magnetic image, both breasts	1.63	1.94	1.63	1
76936	26	Echo guide for artery repair	1.31	2.64	1.99	2
90849		Special family therapy	0.59	0.78	0.59	3
90918		ESRD related services, month	9.77	13.27	11.18	4
90919		ESRD related services, month	7.13	9.13	8.54	4
90920		ESRD related services, month	5.86	6.64	7.27	4
90921		ESRD related services, month	3.06	5.06	4.47	4
92587	26	Evoked auditory test	0.13	1.40	0.13	3
92588	26	Evoked auditory test	0.36	1.70	0.36	3
93350	26	Echo exam of heart	0.78	Increase	0.78	3
93990	26	Doppler flow testing	0.25	1.18	0.25	1
95812	26	Electroencephalogram (EEG)	1.08	1.75	1.08	4
95813	26	Electroencephalogram (EEG)	1.73	2.50	1.73	4
96913		Photochemotherapy, UV-A or B	0.00	Increase	0.00	3
97124		Massage therapy	0.35	Decrease	0.35	3
97265		Joint mobilization	0.45	Decrease	0.45	3
99354		Prolonged service, office	1.51	2.33	1.51	3
99355		Prolonged service, office	1.51	1.20	1.51	3
99356		Prolonged service, inpatient	1.44	3.00	1.44	3
99357		Prolonged service, inpatient	1.44	1.50	1.44	3
99375		Care plan oversight/30-60	1.06	2.65	1.73	2

b. Discussion of codes reviewed by the panel for which clarification of the description of the service is required.

For several of the codes reviewed by the refinement panel, it was necessary to reach agreement on the meaning of

the codes before individual ratings of work could be provided. In the following paragraphs, we summarize the

panel's understanding of the nature and extent of the services included in the codes for which extensive discussion was required.

End-stage renal disease services, per full month (CPT codes 90918 through 90921).

Before rating the work of CPT codes 90918 through 90921, the refinement panel discussed the definition of the monthly capitation payment and the list of services included in and excluded from the monthly capitation payment that was developed by the Renal Physicians Association and presented to the RUC and the refinement panel. The refinement panel also reviewed HCFA regulations regarding the monthly capitation payment and agreed to rate the work of the codes based on the following definition and list of services included in and excluded from the monthly capitation payment.

The monthly capitation payment for maintenance dialysis is defined as a comprehensive monthly payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient.

The following physician services are included in the monthly capitation payment:

- Assessment and determination of the need for outpatient chronic dialysis therapy.

- Assessment of the need for a specified diet and the need for nutritional supplementation for the control of chronic renal failure. Specification of the quantity of total protein, high biologic protein, sodium, potassium, and amount of fluids to be allowed during a given time period. For diabetic patients with chronic renal failure, the prescription usually includes specification of the number of calories in the diet.

- Assessment of which mode(s) of chronic dialysis (types of hemodialysis or peritoneal dialysis) are suitable for a given patient and recommendation of the type(s) of therapy for a given patient.

- Assessment and determination of which type of dialysis access is best suited for a given patient and arrangement for creation of dialysis access.

- Assessment of whether the patient meets preliminary criteria as a renal transplant candidate and presentation of this assessment to the patient and family.

- Prescription of the parameters of intradialytic management. For chronic hemodialysis therapies, this includes

the type of dialysis access, the type and amount of anticoagulant to be employed, blood flow rates, dialysate flow rate, ultrafiltration rate, dialysate temperature, type of dialysate (acetate versus bicarbonate) and composition of the electrolytes in the dialysate, size of hemodialyzer (surface area) and composition of the dialyzer membrane (conventional versus high flux), duration and frequency of treatments, the type and frequency of measuring indices of clearance, and intradialytic medications to be administered. For chronic peritoneal dialysis therapies, this includes the type of peritoneal dialysis, the volume of dialysate, concentration of dextrose in the dialysate electrolyte composition of the dialysate, duration of each exchange, and addition of medication to the dialysate, such as heparin, and the type and frequency of measuring indices of clearance. For diabetics, the quantity of insulin to be added to each exchange is prescribed.

- Assessment of whether the patient has significant renal failure-related anemia, determination of the etiology(ies) for the anemia based on diagnostic tests, and prescription of therapy for correction of the anemia, such as vitamins, oral or parenteral iron, and hormonal therapy such as erythropoietin.

- Assessment of whether the patient has hyperparathyroidism and/or renal osteodystrophy secondary to chronic renal failure and prescription of appropriate therapy, such as calcium and phosphate binders for control of hyperphosphatemia. Based upon assessment of parathormone levels, serum calcium levels, and evaluation for the presence of metabolic bone disease, the physician determines whether oral or parenteral therapy with vitamin D or its analogs is indicated, and prescribes the appropriate therapy. Based upon assessment and diagnosis of aluminum bone disease, the physician may prescribe specific chelation therapy with deferoxamine and the use of hemoperfusion for removal of aluminum and the chelator.

- Assessment of whether the patient has dialysis-related arthropathy or neuropathy and adjustment of the patient's prescription accordingly. Referral of the patient for any additional needed specialist evaluation and management of these end-organ problems.

- Assessment of whether the patient has fluid overload resulting from renal failure and establishment of an

estimated "ideal (dry) weight." The physician determines the need for fluid removal independent of the dialysis prescription and implements these measures when indicated.

- Determination of the need for and prescription of anti-hypertensive medications and their timing relative to dialysis when the patient is hypertensive in spite of correction of fluid overload.

- Periodic review of the dialysis records to ascertain whether the patient is receiving the prescribed amount of dialysis and ordering of indices of clearance, such as urea kinetics, in order to ascertain whether the dialysis prescription is producing adequate dialysis. If the indices of clearance suggest that the prescription requires alteration, the physician orders changes in the hemodialysis prescription, such as blood flow rate, dialyzer surface area, dialysis frequency, and/or dialysis duration (length of treatment). For peritoneal dialysis patients, the physician may order changes in the volume of dialysate, dextrose concentration of the dialysate, and duration of the exchanges.

- Periodic visits to the patient during dialysis to ascertain whether the dialysis is working well and whether the patient is tolerating the procedure well (physiologically and psychologically). During these visits, the physician determines whether alteration in any aspect of a given patient's prescription is indicated, such as changes in the estimate of the patient's dry weight. Review of the treatment with the nurse or technician performing the therapy is also included. The frequency of these visits will vary depending upon the patient's medical status, complicating conditions, and other determinants.

- Performance of periodic physical assessments, based upon the patient's clinical stability, in order to determine the necessity for alterations in various aspects of the patient's prescription. Similarly, the physician reviews the results of periodic laboratory testing in order to determine the need for alterations in the patient's prescription, such as changes in the amount and timing of phosphate binders or dose of erythropoietin.

- Periodic assessment of the adequacy and function of the patient's dialysis access.

- Assessment of patients on peritoneal dialysis for evidence of peritonitis and the ordering of appropriate tests and antibiotic therapy.

- Periodic review and update of the patient's short-term and long-term care plans with staff.

- Coordination and direction of the care of patients by other professional staff, such as dietitians and social workers.

- Certification of the need for items and services such as durable medical equipment and home health care services. Care plan oversight services described by CPT code 99375 also are included in the monthly capitation payment and may not be separately reported.

The following physician services are excluded from the monthly capitation payment:

- Surgical services such as—
 - Temporary hemodialysis catheter placement.
 - Permanent hemodialysis catheter placement.
 - Temporary peritoneal dialysis catheter placement.
 - Permanent peritoneal dialysis catheter placement.
 - Repair of existing dialysis accesses.
 - Placement of catheter(s) for thrombolytic therapy.
 - Thrombolytic therapy (systemic, regional, or access catheter only; hemodialysis or peritoneal dialysis).
 - Thrombectomy of clotted cannula.
 - Arthrocentesis.
 - Bone marrow aspiration.
 - Bone marrow biopsy.
- Interpretation of tests that have a professional component such as:
 - Electrocardiograms (12 lead, Holter monitor, stress tests, etc.).
 - Echocardiograms.
 - 24-hour blood pressure monitor.
 - Nerve conduction velocity and electromyography studies.
 - Flow doppler studies.
 - Bone densitometry studies.
 - Biopsies.
 - Spirometry and complete pulmonary function tests.

- Complete evaluation for renal transplantation. While the physician assessment of whether the patient meets preliminary criteria as a renal transplant candidate is included under the monthly capitation payment, the complete evaluation for renal transplantation is excluded from the monthly capitation payment.

- Evaluation of potential living transplant donors.

- The training of patients to perform home hemodialysis, self hemodialysis, and the various forms of self peritoneal dialysis.

- Non-renal related physician's services. These services may be furnished by the physician providing renal care or by another physician. They may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition. For example, the medical management of diabetes mellitus that is not related to the dialysis or furnished during a dialysis session is excluded.

- Covered physician services furnished to hospital inpatients, including services related to inpatient dialysis, by a physician who elects not to continue to receive the monthly capitation payment during the period of inpatient stay. In these cases, the physician receives a prorated portion of the monthly capitation payment for that month.

- All physician services that antedate the initiation of outpatient dialysis.

While the refinement panel agreed to rate the work of the monthly capitation payment codes based on the above definitions, it was unable to reach consensus on whether the interpretation of all tests that have a professional component should be included in or excluded from the monthly capitation payment. Because the American Medical Association Specialty Society Relative Value Update Committee (RUC) recommendations were based on the Renal Physicians Association's definition, which excludes test interpretations from the monthly capitation payment, it was decided to rate the physician work based on an assumption that the physician work associated with test interpretations was excluded from the monthly capitation payment and included in other codes that would be reported separately. It was also agreed that the Renal Physicians Association and HCFA would examine current utilization data and that HCFA would consider bundling the work of test interpretations into the monthly capitation payment. This would lead to adding additional RVUs to the RVUs that emerged from the panel ratings. The RVUs that emerged from the statistical tests of the refinement panel were 4.45.

Subsequent to the refinement panel, we analyzed utilization data on test interpretations provided to end-stage renal disease patients by monthly capitation payment physicians. In general, most physicians who are paid under the monthly capitation payment method do not separately bill for test interpretations. Based on our analysis, we have bundled the work RVUs of the

test interpretations listed below into the monthly capitation payment:

- Bone mineral density studies (CPT codes 76070, 76075, 78350, and 78351).
- Non-invasive vascular diagnostic studies of hemodialysis access (CPT codes 93925, 93926, 93930, 93931, and 93990).
- Nerve conduction studies (CPT codes 95900, 95903, 95904, 95925, 95926, 95927, 95934, 95935, and 95936).
- Electromyography studies (CPT codes 95860, 95861, 95863, 95864, 95867, 95868, 95869, and 95872).

In performing our analysis, we took into account the fact that the coding for the four categories of services listed above has changed in the past 2 years. Thus, while we used all of the most current utilization data, the specific codes listed may be new, revised or deleted from CPT 1996. When the physician receiving the monthly capitation payment performs the services listed above, we will not make separate payment. However, these and other medically necessary services that are included or bundled into the monthly capitation payment are separately payable when furnished by physicians other than the monthly capitation payment physician.

The bundling of these services leads to the addition of 0.02 RVUs to the refinement panel rating of 4.45 RVUs to result in the assignment of 4.47 RVUs. Medically necessary services that are included or bundled into the monthly capitation payment are separately payable when furnished by physicians other than the monthly capitation payment physician.

We next increased the RVUs of the pediatric monthly capitation payment CPT codes (90918 through 90920) to maintain the relationship of adult to pediatric services that we established in last year's final rule. This led to the assignment of 11.18 RVUs to CPT code 90918, 8.54 RVUs to CPT code 90919, and 7.27 RVUs to CPT code 90920.

Electroencephalogram Codes

Before rating the work of CPT codes 95812 and 95813 (electroencephalogram (EEG) extended monitoring), the panel discussed extensively the work involved in EEG monitoring compared to other EEG and electrodiagnostic services on the fee schedule. Subsequent to the panel meeting, the American Academy of Neurology provided us with the following written definitions and clinical vignettes to clarify the types of services that should be coded using nine

common EEG diagnostic codes by comparing and contrasting them. The panel members discussed these definitions of the EEG services before they rated the work of extended EEG monitoring.

Extended EEG; up to one hour (CPT code 95812).

EEG recording is conducted for 45 to 60 minutes. Hyperventilation, photic stimulation and/or oral sedation may be used. The physician reviews in detail the entire 45-to-60 minute record (270 to 360 pages of standard EEG paper).

The following is a vignette for CPT code 95812: A 35-year-old woman experiences episodic loss of consciousness. Differential diagnosis includes syncope and several types of seizure disorder. The EEG is extended because the EEG technologist detected no epileptic abnormalities during the first 20 to 30 minutes of recording, and the physician had requested a longer recording if needed to find abnormalities. Bursts of epileptic abnormalities are finally detected at 55 minutes into the recording. This helps make the diagnosis of a seizure disorder. The type of epileptic abnormalities seen on the EEG guides the diagnosis and choice of medications.

Extended EEG; greater than one hour (CPT code 95813).

EEG recording is conducted continuously for more than 1 hour. Hyperventilation, photic stimulation and/or oral sedation may be used. The recording is continued until the events sought are obtained, if possible. Typical recording time is 2 to 3 hours. The physician reviews the entire recording in detail (typically equal to 360 to 1,000-plus pages of standard EEG paper). The entire continuous EEG recording is also interpreted for additional diagnostic information.

The following is a vignette for CPT code 95813: A 55-year-old woman is comatose in the intensive care unit with multiple medical problems and is having repeated episodes of movements possibly representing epileptic seizures. Continuous EEG recording is performed for 3 hours, including recording during two of her episodes. Four additional subclinical ictal events were also detected on the EEG beyond the two events noted by the nurses. Events are determined to be epileptic seizures, and a treatment plan is developed accordingly.

Awake EEG (CPT code 95816).

The test is conducted with the patient awake. The patient often becomes drowsy or may briefly fall asleep, but

the test is not run deliberately to obtain sleep. Hyperventilation and/or photic stimulation are usually obtained. The minimum recording time is 20 minutes. The typical recording time is 20 to 25 minutes. The physician reads in detail the entire 20-to-25 minute record (120 to 150 pages of standard EEG paper).

The following is a vignette for CPT code 95816: A 60-year-old man complains of memory and other cognitive impairment. Differential diagnosis includes dementia and depression. EEG seeks objective evidence of organic impairment supporting a diagnosis of a dementia.

EEG awake and asleep (CPT code 95819).

Sleep is deliberately sought during the EEG record to identify specific epileptic abnormalities. The patient may be sleep-deprived before the recording or given sedative medication to induce sleep. The recording continues until at least 5 minutes of Stage 2 sleep is obtained. During the awake portion of the recording, hyperventilation and/or photic stimulation are usually obtained. The minimum recording time is 20 minutes. The typical recording time is 30 to 35 minutes. The physician reads in detail the entire 30-to-35 minute record (180 to 210 pages of standard EEG paper).

The following is a vignette for CPT code 95819: A 25-year-old woman experiences recent onset of lapses of consciousness. The differential diagnosis includes syncope and several types of seizure disorders. A test is conducted to look for evidence of a seizure disorder and to help specify which type of seizure disorder.

EEG; sleep only (CPT code 95822).

The EEG is conducted with the patient asleep, stuporous, or comatose. Little or no awake EEG is recorded. Hyperventilation and photic stimulation are generally not performed. Stuporous or comatose patients may be stimulated by the technologist to attempt to induce state changes. The minimum recording time is 20 minutes. The typical recording time is 20 to 30 minutes. The physician reads in detail the entire 20 to 30 minute record (120 to 180 pages of standard EEG paper).

The following is a vignette for CPT code 95822: A 45-year-old man is comatose after a head injury. An EEG is performed to assess the depth of the coma, assist in assessing prognosis, and evaluate for epileptic discharges or focal cerebral abnormality.

EEG; all night sleep only (CPT code 95827).

Prolonged EEG recording is performed by leaving equipment at the hospital bedside. The recording may or may not be continuous. If not continuous, the recording is done periodically as needed. The minimum time the EEG is at the bedside is 8 hours. The physician scans the hours-long records, reading in detail selected or specific portions. The minimum amount of the EEG actually reviewed in detail is 20 minutes of recording (120 pages of standard EEG paper). The typical amount reviewed in detail is 30 to 40 minutes.

The following is a vignette for CPT code 95827: A 3-year-old boy is comatose from near-drowning. The patient is in a therapeutic barbiturate coma. The EEG is used to titrate the amount of barbiturate to keep the EEG in burst-suppression. Incidental observations are made of any epileptic discharges or focal features. The EEG is kept at the intensive care unit bedside for 3 days. Each day, 50 to 90 minutes of EEG are printed, of which 20 to 30 minutes (120 to 180 pages of standard EEG paper) are reviewed in detail, and other pages are scanned for relevant events.

Electrocorticography (CPT code 95829).

The EEG is recorded in the operating room from electrodes applied directly to the surgically exposed cerebral cortex. Many separate recording sites are used. While it is being recorded in the operating room, the EEG is interpreted by the EEG physician, who is present in the operating room for 60 minutes or more. The EEG physician uses the EEG features for determining the extent of surgical resection of the cerebral cortex. During this 60 minutes, 30 to 60 minutes of EEG recording (minimum 20 minutes) are made from various cortical recording sites.

The following is a vignette for CPT code 95829: A 25-year-old man, disabled by medically refractory epileptic seizures, undergoes a craniotomy to resect a portion of his temporal lobe. The EEG physician interprets the record in the operating room. Electrocorticography is used to define the extent of epileptic spiking and slowing, and the resection is tailored to include regions of electrically identified pathology. Follow-up recording is made to check for any remaining epileptic spiking after resection.

Ambulatory EEG monitoring (CPT code 95950).

The EEG is recorded onto a long-term storage medium such as magnetic disc

or tape, using a small portable recorder. The patient is free to take this home, returning to the laboratory one or several days later. The recording is continuous for 24 hours per day. The patient, family, and friends write notes about clinical events. The recorded EEG is scanned to find these or other events of clinical interest. Around the time of each clinical event of interest, 5 to 10 minutes of the EEG is reviewed in detail. The EEG is also surveyed for other EEG findings of clinical importance.

The following is a vignette for CPT code 95950: A 12-year-old boy has episodes of staring or daydreaming, possibly representing nonconvulsive seizures. Previous routine EEG recording was normal. Ambulatory EEG is conducted to search for signs of epileptic abnormality. During 2 days of ambulatory monitoring, 6 clinical daydreaming events are noted by the family. These demonstrate petit mal seizures, as do 10 additional events not noted by the family but found on EEG review. A treatment plan is developed accordingly.

Video EEG long-term monitoring (CPT code 95951).

This daily procedure is used when video and EEG are continuously recorded for several days. Continuous videotaping of the patient's behavior is made simultaneously with the EEG. Monitoring is usually conducted in a specialized inpatient epilepsy evaluation and monitoring unit, with the patient's antiepileptic medications reduced or withdrawn to induce epileptic seizures. The physician reviews the EEG and videotapes recorded before, during, and after each captured epileptic seizure. Typically, several seizures may occur each day. In some patients, no seizures may occur for several days, whereas other patients may have more than a dozen seizures per day. Randomly selected recorded segments are also chosen for review and comparison to look for subclinical seizures and isolated epileptic EEG discharges. Monitoring generally is continued until at least 5 seizures are captured to characterize and to localize the abnormality. The exact number of seizures needed varies with the specific clinical circumstances and the nature of EEG findings.

The following is vignette number one for CPT code 95951: A 25-year-old man has become totally disabled as a result of frequent medically refractory epileptic seizures. Long-term video EEG monitoring for 4 days captures 6

seizures and localizes the ictal onset sufficiently to refer the patient for surgical excision of the epileptic area. Localization for surgical excision is based primarily on this EEG localization. After eventual surgical excision, the patient becomes seizure-free, stops medication, and is no longer disabled.

The following is vignette number two for CPT code 95951: A 9-year-old boy has frequent seizures not controlled by medication, during some of which he abruptly falls to the ground. Because of the falls, he has lacerated his scalp on several occasions, requiring trips to the emergency room for x-rays, sutures, and antibiotic treatment. His physicians are considering corpus callosum section, but some of the clinical data suggest that the seizures may be originating from a more localized area of one frontal lobe. Forty seizures are recorded in 2 days, some of which appear to originate from this region. Analysis of the recordings indicates, however, that the majority do not, and he undergoes callosal section. Following callosal section, he no longer has "falling seizures" and no longer needs to wear a helmet for protection. He does continue to have focal seizures of one arm.

We have finalized the interim RVUs for the EEG CPT codes; we have not changed any of the interim RVUs for these codes. However, we have clarified the descriptors for the CPT codes for the services. We have assigned 1.08 RVUs to CPT code 95812, 1.73 RVUs to CPT code 95813, 1.08 RVUs to CPT code 95816, 1.08 RVUs to CPT code 95819, 1.08 RVUs to CPT code 95822, 1.08 RVUs to CPT code 95827, 6.21 RVUs to CPT code 95829, 1.51 RVUs to CPT code 95950, and 3.80 RVUs to CPT code 95951.

c. Discussion of codes not reviewed by the panel.

Codes listed in Table 1 with a basis of decision of "3" fall into several categories. For most of these codes, we received comments that were not considered by the multispecialty refinement panel for a variety of reasons. Those codes and our rationale for the final work RVUs we have established for the codes are discussed below.

Removal with reinsertion, implantable contraceptive capsules (CPT code 11977).

Comment: A commenter stated that we erred in rejecting the RUC recommendation of 3.30 RVUs for CPT code 11977. The commenter recommended that "Removal with reinsertion" should be assigned the full

value of both CPT code 11975 (Insertion, implantable contraceptive capsules) and CPT code 11976 (Removal, implantable contraceptive capsules). Typically, the new capsules are inserted at a different site than the one from which the old capsules were removed, thus requiring a second incision and closure. In addition, the amount of preservice and postservice work associated with reinsertion is similar to the preservice and postservice work for the original insertion. The physician must ascertain that the patient has not undergone changes in health status or experienced side effects that would make her an unsuitable candidate for this contraceptive method and must instruct her about follow-up care and potential complications.

Response: We agree with the comment and have assigned 3.30 RVUs to CPT code 11977, as recommended.

Breast reconstruction with a TRAM flap (CPT code 19367).

Comment: A commenter recommended that the RVUs of CPT code 19367 be increased from 24.73 to a minimum 26.50 RVUs. The commenter stated that breast reconstruction is similar to facial fracture surgeries and that in comparison to CPT code 21159 (Le Fort III), with 40.99 RVUs, a TRAM flap reconstruction is a much larger procedure.

Response: We disagree with this comment that we believe may have been based on a misunderstanding of CPT code 21159. This code is used to report reconstruction of the midface. It is not used to report the repair of facial fractures. When compared to the RVUs of codes for the open repair of a facial fracture, for example, CPT code 21432, which is assigned 8.05 RVUs, the RVUs of the breast reconstruction code are much higher. The 24.73 interim RVUs, which were based on a RUC recommendation, will be made final.

Microvascular fibula graft (CPT code 20955).

Comment: A commenter recommended 43.00 RVUs for this procedure, which was described as a very delicate, labor-intensive procedure particularly for mandible reconstruction, multiple osteotomies, and plate and wire fixation. The commenter stated that the work and postoperative care can be compared to twice that of a breast reconstruction with a TRAM flap (CPT code 19367), with 24.73 RVUs. Because of the nature of this delicate procedure, the risks for malpractice are greater than for any

other bone procedure. These risks include complications such as foot drop, sensory loss of the lower extremity, complications related to skin graft healing, chronic pain, and wound closure.

Response: We agree this is a complex procedure as confirmed by our acceptance of a RUC recommendation of 38.00 RVUs (see Table 4, "American Medical Association RUC Recommendations and HCFA's Decisions," in our December 8, 1994 final rule with comment period (60 FR 63441)). We do not believe, however, the arguments presented warrant an increase to 43.00 RVUs, which would be nearly 3.00 RVUs higher than the reference code for repair of a thoracoabdominal aortic aneurysm with graft (CPT code 33877) valued at 40.29 RVUs. We have retained 38.00 RVUs for CPT code 20955 (37.58 RVUs after adjustment for budget neutrality).

Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint (CPT code 25337).

Comment: A commenter disagreed with our decision to value new CPT code 25337 at 9.10 RVUs instead of 9.50 RVUs as the RUC recommended. The commenter stated that the preservice and postservice work is quite similar between the new code and the reference service, CPT code 25312. The commenter also stated the intraservice work requires more skill, effort, and time because the new code may involve a two-tendon transfer with two skin incisions, hence, a larger surgical exposure. The potential of injury to the ulnar nerve is high. Confirmation of an accurate reduction of the distal ulna requires an intraoperative x-ray, and, frequently, internal fixation with K-wires. Tunnels must be drilled into bone to allow passage of the tendons.

Response: We agree with the comment and have assigned 9.50 RVUs to CPT code 25337, as recommended.

Distal radioulnar joint arthrodesis and segmental resection of ulna (Sauve-Kapandji procedure) (CPT code 25830).

Comment: A commenter stated that the work of CPT code 25830 is equal to the work of CPT code 25337 (Distal radioulnar tenodesis) and recommended that 9.50 RVUs are the most appropriate RVUs for both codes. The commenter also stated that the RUC accepted CPT code 25390 (Osteoplasty, radius or ulna; shortening), with 9.96 RVUs, as a reference service for new CPT code 25830. This reference service involves excising a carefully measured segment of ulna followed by internal fixation

using a plate and screws. Preoperative work is somewhat greater than the work in new CPT code 25830. New CPT code 25830 is similar to the reference service in that a small segment of ulna is excised and then fused to the adjacent radius using pins or screws. Plates are not used and the amount of excised ulna is less critical. For these clinical reasons, the commenter recommended 9.50 RVUs for CPT code 25830.

Response: We agree with the comment and have assigned 9.50 RVUs to CPT code 25830, as recommended.

Repair of cleft hand (CPT code 26580).

Comment: A commenter disagreed with our decision to value CPT code 26580 at 15.99 RVUs (15.81 RVUs rescaled) instead of 17.71 RVUs, as the RUC recommended (see Table 4 of our December 8, 1994 final rule with comment period (60 FR 63441)). The commenter objected to the use of CPT code 28360 (Repair of a cleft foot) as the reference service. The commenter argued that the choice of this code as a reference service was inappropriate because of its clinical dissimilarity to the revised code. The commenter stated that CPT code 26590 (Repair macrodactylia), with 17.63 RVUs, is a more appropriate reference service. This code deals with a congenital anomaly of the digits of the hand requiring exacting microsurgical reconstruction of soft tissue, nerves, and bone in an infant. Revised CPT code 26580 requires metacarpal alignment by soft tissue dissection or metacarpal osteotomy requiring internal fixation, reconstruction of the deep transverse metacarpal ligament, and a thumb realignment to allow opposition. Mobilization of skin flaps may be necessary to achieve skin closure. This is a microsurgical procedure performed in infants, with an amount of work similar to the work involved in CPT code 26590. For these clinical reasons, the commenter recommended that revised CPT code 26580 should have 17.71 RVUs.

Response: We agree with the comment and have assigned 17.71 RVUs to CPT code 26580, as recommended.

Application of rigid total contact leg cast (CPT code 29445).

Comment: A commenter stated that this service is overvalued compared to the application of an Unna boot (CPT code 29580), with 0.57 RVUs.

Response: We disagree that this service is overvalued. The application of a rigid total contact leg cast (CPT code 29445) involves more work than the

application of an Unna boot because it requires the physician to custom make and fabricate the walking surface for each cast. The patient is usually diabetic with a grade 1 or 2 foot ulcer. The use of casts by these patients is risky because they are at risk of developing additional ulcers. Therefore, a great deal of time is spent ensuring that the cast will fit properly. Unlike Unna boots or other casts, total contact casts are always performed personally by a physician who must hold the foot in place while applying the cast.

Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus (CPT code 31276).

Comment: A commenter objected to the assigned 7.42 RVUs and requested an increase to 8.85 RVUs. The commenter presented the following description of the procedure. This procedure is performed around the middle turbinate anterior attachment in the frontal recess at 90 degrees to the line of sight. It requires the use of 70 and 30 degree telescopes, small-angled forceps, curettes, and hooks. It requires an exhaustive knowledge of frontal recess anatomy, very delicate technique, removal of tiny bone fragments, preservation of mucosa, and a dry field. It is very tedious and time-consuming. The commenter believed that the overall intensity and time is significantly greater for the endoscopic frontal sinusotomy than either a total ethmoidectomy (CPT code 31255), with 6.96 RVUs, or an external frontal sinusotomy (CPT code 31075), with 8.85 RVUs.

Response: We agree with the comment and have assigned 8.85 RVUs to CPT code 31276, as recommended.

Gastroplasties and gastric bypass for obesity (CPT codes 43842, 43843, 43846, 43847, and 43848).

Comment: A commenter requested a re-evaluation of the entire family of codes because of a lack of representation of bariatric surgeons in the original resource-based relative value scale process. The commenter stated that the modest increase in the RVUs we assigned to these procedures still left a deficit valuation of approximately 27 percent for CPT codes 43842 and 43843, 17 percent for CPT codes 43846 and 43847, and 12 percent for CPT code 43848.

Response: We have not revised the interim RVUs because we do not believe the commenter made a compelling argument for change. We also disagree that the increases in RVUs assigned to

these codes were modest. As we discussed in Table 4 of our December 8, 1994 final rule (59 FR 63444), the increases were as follows: CPT code 43842 from 11.99 RVUs to 13.91 RVUs; CPT code 43843 from 11.99 RVUs to 13.91 RVUs; CPT code 43846 from 12.90 RVUs to 18.04 RVUs; CPT code 43847 from 14.32 RVUs to 20.09 RVUs; and, CPT code 43848 from 15.00 RVUs to 22.35 RVUs. When the RVUs were adjusted for budget neutrality, the RVUs were as follows: CPT code 43842, assigned 13.76 RVUs; CPT code 43843, assigned 13.76 RVUs; CPT code 43846, assigned 17.84 RVUs; CPT code 43847, assigned 19.87 RVUs; and, CPT code 43848 assigned 22.10 RVUs. We believe that further increases would create rank order anomalies with other abdominal surgical procedures on the physician fee schedule.

Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits (CPT code 59855).

Comment: A commenter recommended that we assign the RUC-recommended 5.80 RVUs to CPT code 59855. The commenter believed that our rationale for lowering the work RVUs to 4.80 (4.75 rescaled) was "the physician work in placing suppositories is less than the work in an amniocentesis, regardless of the number of suppositories needed" and that CPT code 59855 requires less physician work than CPT code 59850 (Induced abortion by amniocentesis). The commenter stated that while it is true that the procedural work associated with placing suppositories is less than the procedural work associated with amniocentesis, placement of the suppositories or performance of the amniocentesis is only one element of the total work of each of these services. Use of prostaglandin suppositories typically results in more side effects that the physician must manage over a period of time that is longer than that associated with the amniocentesis, increasing the amount of evaluation and management work for CPT code 59855. Overall, CPT code 59855 requires a greater amount of physician work than CPT code 59850.

Response: We agree with the comment and have assigned 5.80 RVUs to CPT code 59855, as recommended.

Sympathectomy, digital arteries (CPT code 64820).

Comment: A commenter disagreed with our decision to value CPT code 64820 at 9.20 RVUs (9.10 RVUs

rescaled) instead of 10.00 RVUs as the RUC recommended. The commenter objected to our determination that the work involved in new CPT code 64820 is approximately the same as the repair of a blood vessel of the hand or finger (CPT code 35207). The commenter stated that the work on the two vessels involved in a digital sympathectomy is not similar to the anastomosis of a single vessel and offered the following explanation. CPT code 35207 involves the repair of a single injured vessel through an existing skin laceration. CPT code 35207 has less preservice and intraservice work than new CPT code 64820. Digital sympathectomy is performed in individuals with vasospastic disease of the hand and severe ischemic pain frequently with ulceration of the finger tip. Two vessels are always treated through an extensile palmar incision on the radial and ulnar side of a digit. Using an operating microscope and jeweler's forceps, a tedious removal of the adventitia is performed for a distance of 1.5 to 2.0 centimeters. Extraordinary care must be taken to avoid perforating the vessel. Damaging the vessel's media or intima will cause thrombosis and possible gangrene of the finger. Considering the clinical circumstances regarding the patient indications and actual intraservice work, digital sympathectomy represents a greater intensity of work than CPT code 35207, as measured by increased mental effort and judgment, greater technical skill, and considerably more psychological stress. Postservice work is similar for both codes, however, with an average of four office visits after the procedure. For these clinical reasons, the commenter recommended that new CPT code 64820 should have 10.00 RVUs.

Response: We agree with the comment and have assigned 10.00 RVUs to CPT code 64820, as recommended.

Multiple-family group medical psychotherapy (CPT code 90849).

Comment: A commenter recommended increases for all psychiatric services in response to our request for comments as part of the 5-year refinement of RVUs under the physician fee schedule. Included in that comment was a recommendation to increase the RVUs for CPT code 90849 from 0.59 to 0.78 to maintain the relative value with the recommended increases for the other psychiatric codes.

Response: The RVUs assigned to this code were based on a 1994 RUC recommendation that we accepted. We

have not increased the RVUs this year because we believe it is an issue for the 5-year refinement. We will consider the recommended RVUs as part of that process. In the meantime, we will maintain the assigned 0.59 RVUs.

Evoked otoacoustic emissions testing (CPT codes 92587 and 92588).

Comment: A commenter recommended that we provide a ten-fold increase in the RVUs for these audiology services to "properly compensate for the training, effort, and time necessary to diagnose hearing loss and related disorders."

Response: We have not accepted this comment because it did not provide enough clinical information about the nature of the work to warrant a reconsideration of the interim RVUs.

Stress echocardiography (CPT code 93350).

Comment: A commenter expressed concern about the decrease in RVUs for this service.

Response: The decrease in RVUs for stress echocardiography occurred as a result of a change in CPT reporting instructions that now direct the user to report the appropriate stress testing code from the 93015 through 93018 series in addition to CPT code 93350. The sum of the RVUs for these services is equal to the RVUs that were assigned to CPT code 93350 in the past when it was the only code used to report stress echocardiography.

Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least four to eight hours of care under direct supervision of the physician (includes application of medication and dressings) (CPT code 96913).

Comment: A commenter objected to our decision not to assign physician work RVUs to this service. The commenter stated that with the availability of psoriasis day treatment centers, much Goeckerman therapy is now practical in a day treatment program but that it is very different from a simple office visit. The commenter argued that there is considerable professional judgment involved and there is also an extraordinary quantity of nursing time involved since the patient is typically in a day treatment center for 6 hours or more a day. The treatment requires bathing, scale removal, twice daily application of tar over the total body surface, shampoos, scale removal from scalp, ultraviolet light, and typically anthralin as well. The treatment is extremely time-consuming because the medication must be put on

each individual spot while avoiding normal skin.

Response: We have not revised our decision regarding this code. We have not assigned any work RVUs to this service because the commenter did not persuade us that photochemotherapy requires any physician work beyond that already described by existing evaluation and management codes. We have assigned practice expense and malpractice expense RVUs based on historic charges for this code so that it will no longer be carrier-priced. We have categorized this service as an "incident to" code, which means that it is covered incident to a physician's service when it is furnished by auxiliary personnel employed by the physician and working under his or her direct supervision. Payment may not be made for this service when it is furnished to hospital inpatients or patients in a hospital outpatient department. Physicians may bill for evaluation and management services in those settings.

Joint mobilization and massage (CPT codes 97124 and 97265).

Comment: One commenter stated that these codes may be overvalued relative to osteopathic manipulative treatment (CPT codes 98925 through 98929) and evaluation and management services.

Response: The interim RVUs we proposed for these codes were based on our acceptance of recommendations we received from the RUC Health Care Professionals Advisory Committee Review Board last year. The history and functions of this board are described below.

In 1992 the American Medical Association recommended that a Health Care Professionals Advisory Committee be established to expand the CPT Editorial Panel and the RUC processes to all groups legally required to use the CPT to report their services. Organizations representing physician assistants, nurses, occupational and physical therapists, optometrists, podiatrists, psychologists, social workers, audiologists and speech pathologists were invited to nominate representatives to the CPT and RUC Health Care Professionals Advisory Committee. The CPT Health Care Professionals Advisory Committee was created to foster participation in and solicit comments from these professional organizations in coding changes affecting their members, while the RUC Health Care Professionals Advisory Committee was formed to allow participation in development of

RVUs for new and revised codes within their scope of practice.

To further facilitate the decision-making process on issues of concern to both medical doctors (MDs) and doctors of osteopathy (DOs) and non-MDs and non-DOs, CPT and RUC Health Care Professionals Advisory Committee Review Boards were also formed. The review boards bring MDs and DOs and non-MDs and non-DOs together to discuss coding issues and RVU proposals. The RUC Health Care Professionals Advisory Committee Review Board comprises all nine members of the current RUC Health Care Professionals Advisory Committee and three RUC members. For codes used only or predominantly by non-MDs and non-DOs, the RUC Health Care Professionals Advisory Committee Review Board replaces the RUC as the body responsible for developing recommendations for HCFA.

We have decided to maintain the RVUs for joint mobilization (CPT code 97265), with 0.45 RVUs, and massage (CPT code 97124), with 0.35 RVUs, as interim RVUs on the 1996 fee schedule so that we will have additional time to re-evaluate them. While we agree that these services appropriately are compared to other therapeutic procedures in the physical medicine section of CPT, our review of them in light of the comment causes us to believe that the interim RVUs we assigned to the therapeutic procedures services may have been too high relative to other services on the fee schedule, for example, osteopathic manipulative treatments and evaluation and management services.

While we acknowledge that we accepted last year's recommendations of the RUC Health Care Professionals Advisory Committee Review Board, we now plan to refer these and all other physical medicine and rehabilitation codes (CPT codes 97010 through 97770) back to the RUC Health Care Professionals Advisory Committee Review Board for its reconsideration. We also will notify the RUC of our concerns. In addition, we seek public comments on this issue.

Prolonged physician services (CPT codes 99354 through 99357).

Comment: A commenter provided extensive arguments for an increase in the RVUs of these codes based on the premise that we have underestimated the time involved in furnishing these services. Because the RVUs for evaluation and management services are related to the time specified in the CPT

codes, the commenter believed that the selection of the appropriate level of service should be based solely on the time spent providing the service. For example, a consultation (CPT code 99253) typically assumes a 55-minute time segment. The commenter stated that if less time is spent, the consultation would be coded at a lower level as CPT code 99252 or 99251. The commenter believed that the correct key references for these prolonged physician services are CPT codes 99245 (Office consultation) and 99255 (Hospital inpatient consultation) because the times specified in those codes correspond to the times specified in the prolonged services codes.

Response: We have decided not to accept this comment, which we believe is based, in part, on a misunderstanding of the relationship of the typical times associated with the evaluation and management codes and the RVUs assigned to the codes. While it is true that time is a key predictor of work, it is not true that physicians are required to report their evaluation and management services based solely on the amount of time spent furnishing the service. CPT codes 99354 and 99356 both describe the "first hour" of prolonged services. This terminology in the code does not require that an entire hour of service be furnished in order for the code to be used. In fact, the CPT directs the reader to use the code to report 30 to 74 minutes of prolonged services. In our discussion of these codes in the December 8, 1994 Federal Register (59 FR 63437 through 63440), we indicated that we did not expect that the typical use of the code would be to report an hour of service. We assigned RVUs that are equivalent to 40 minutes of face-to-face or floor time.

Finally, for those specialties with very prolonged encounters, we have assigned the same RVUS to the "each additional 30 minutes" codes (CPT codes 99355 and 99357) that we assigned to the "first hour" codes. This actually represents an increase above the recommended RVUs we received from the RUC for CPT codes 99355 and 99357. We believe the final RVUs for the prolonged service codes appropriately recognize the work associated with very prolonged services.

2. Establishment of Interim Work Relative Value Units for New and Revised Codes for 1996

a. Methodology (Includes Table 2—American Medical Association Specialty Society Relative Value Update

Committee Recommendations and HCFA's Decisions).

The major aspect of establishing work RVUs for 1996 was related to the assignment of interim RVUs for all new and revised CPT codes. As described in our November 1992 notice on the 1993 fee schedule (57 FR 55938), we established a process, based on recommendations received from the RUC, for establishing interim RVUs for new and revised codes.

The RUC was formed in November 1991 and grew out of a series of discussions between the American Medical Association and the major national medical specialty societies. The RUC is comprised of 26 members; 22 are representatives of major specialty societies. The remaining members represent the American Medical Association, the American Osteopathic Association, and the CPT Editorial Panel. The work of the RUC is supported by the RUC Advisory Committee made up of representatives of 65 specialty societies in the American Medical Association House of Delegates. The RUC used a small group survey method to produce work RVUs that were voted on by the RUC, with a two-thirds vote required for acceptance. The RUC then submitted to us those accepted RVUs as recommended values.

We received work RVU recommendations for approximately 140 new and revised codes from the RUC. We also received RUC recommendations for base units for two anesthesia codes, CPT codes 00520 (Anesthesia, closed chest procedures) and 00540 (Anesthesia, chest procedure) and have accepted the recommendations of 6.00 and 13.00 base units, respectively. Physician panels consisting of carrier medical directors and our staff reviewed the RUC recommendations by

comparing them to our reference set or to other comparable services on the fee schedule for which work RVUs had been established previously, or to both of these criteria. The panels also considered the relationships among the new and revised codes for which we received the RUC recommendations. We agreed with a majority of the relationships reflected in the RUC values. In some cases when we agreed with the RUC relationships, we revised the RVUs recommended by the RUC in order to achieve work neutrality within families of codes. For example, if CPT revised an existing code by splitting it into two or more new codes, we took into account the RVUs assigned to the existing code and the expected utilization of the split codes in such a way that the coding change would not lead to an overall increase in RVUs associated with services previously described by a single code. For approximately 90 percent of the RUC recommendations, proposed RVUs were accepted or increased, and for approximately 10 percent, RVUs were decreased.

We also received two recommendations from specialty societies and four recommendations from the Health Care Professionals Advisory Committee for new or revised codes for which the RUC did not provide a recommendation. The specialty society recommendations were also reviewed by the physician panels. All of the proposed RVUs of the specialty society recommendations were accepted. All of the proposed RVUs of the Health Care Professionals Advisory Committee recommendations were decreased.

Table 2 is a listing of those codes that will be new or revised in 1996 for which we received recommended work RVUs.

This table includes the following information:

- A “#” identifies a new code for 1996.
- *CPT code*. This is the CPT code for a service.
- *Modifier*. A “26” in this column indicates that the RVUs are for the professional component of the code.
- *Description*. This is an abbreviated version of the narrative description of the code.
- *RUC-recommended work RVUs*. This column identifies the work RVUs recommended by the RUC. If no recommendation was received from the RUC, this column shows “no rec.”
- *Health Care Professionals Advisory Committee (HCPAC) recommendations*. This column identifies work RVUs recommended by the Health Care Professionals Advisory Committee.
- *Specialty-recommended RVUs*. This column identifies work RVUs recommended by a specialty society.
- *HCFA decision*. This column indicates whether we agreed with the RUC recommendation (“agreed”); we established work RVUs that are higher than the RUC recommendation (“increased”); or we established work RVUs that were less than the RUC recommendation (“decreased”). Codes for which we did not accept the RUC recommendation are discussed in greater detail following Table 2. A discussion follows the table in section VI.B.2.b. An (a) in the column indicates that RVUs were not assigned.

- *HCFA value*. This column contains the 1996 RVUs for physician work.

This table includes only those codes that were reviewed by the full RUC or for which we received a recommendation from a specialty society or Health Care Professionals Advisory Committee.

TABLE 2.—AMA RUC RECOMMENDATIONS AND HCFA'S DECISIONS

CPT*	Mod	Description	RUC recommendations	HCPAC recommendations	Specialty recommendations	HCFA decision	1996 work RVUs
17110		Destruction of skin lesions	0.55	.....	.....	Agreed	0.55
#20100		Explore wound, neck	9.50	.....	.....	Agreed	9.50
#20101		Explore wound, chest	3.00	.....	.....	Agreed	3.00
#20102		Explore wound, abdomen	3.68	.....	.....	Agreed	3.68
#20103		Explore wound, extremity	4.95	.....	.....	Agreed	4.95
#20930		Spinal bone allograft	0.00	.....	.....	Agreed	0.00
#20931		Spinal bone allograft	1.81	.....	.....	Agreed	1.81
#20936		Spinal bone autograft	0.00	.....	.....	Agreed	0.00
#20937		Spinal bone autograft	2.79	.....	.....	Agreed	2.79
#20938		Spinal bone autograft	3.02	.....	.....	Agreed	3.02
#21076		Prepare face/oral prosthesis .....	.....	.....	12.54	Agreed	12.54
#21077		Prepare face/oral prosthesis .....	.....	.....	31.54	Agreed	31.54
#21141		Reconstruct midface, lefort	16.92	.....	.....	Agreed	16.92
#21142		Reconstruct midface, lefort	17.58	.....	.....	Agreed	17.58

* All CPT codes and descriptors copyright 1995 American Medical Association.

^a No work RVUs assumed.

TABLE 2.—AMA RUC RECOMMENDATIONS AND HCFA'S DECISIONS—Continued

CPT*	Mod	Description	RUC rec- ommendations	HCPAC rec- ommendations	Specialty rec- ommendations	HCFA decision	1996 work RVUs
#21143		Reconstruct midface, lefort	18.30	.....	.....	Agreed	18.30
21145		Reconstruct midface, lefort	18.92	.....	.....	Agreed	18.92
21146		Reconstruct midface, lefort	19.58	.....	.....	Agreed	19.58
21147		Reconstruct midface, lefort	20.30	.....	.....	Agreed	20.30
22100		Remove part of neck vertebra	9.05	.....	.....	Agreed	9.05
22101		Remove part, thorax vertebra	9.00	.....	.....	Agreed	9.00
22102		Remove part, lumbar vertebra	9.00	.....	.....	Agreed	9.00
#22103		Remove extra spine segment	2.34	.....	.....	Agreed	2.34
22110		Remove part of neck vertebra	11.59	.....	.....	Agreed	11.59
22112		Remove part, thorax vertebra	11.59	.....	.....	Agreed	11.59
22114		Remove part, lumbar vertebra	11.59	.....	.....	Agreed	11.59
#22116		Remove extra spine segment	2.32	.....	.....	Agreed	2.32
22210		Revision of neck spine	22.51	.....	.....	Agreed	22.51
22212		Revision of thorax spine	18.14	.....	.....	Agreed	18.14
22214		Revision of lumbar spine	18.14	.....	.....	Agreed	18.14
#22216		Revise, extra spine segment	6.04	.....	.....	Agreed	6.04
22220		Revision of neck spine	20.15	.....	.....	Agreed	20.15
22222		Revision of thorax spine	20.15	.....	.....	Agreed	20.15
22224		Revision of lumbar spine	20.15	.....	.....	Agreed	20.15
#22226		Revise, extra spine segment	6.04	.....	.....	Agreed	6.04
22305		Treat spine process fracture	1.86	.....	.....	Agreed	1.86
22310		Treat spine fracture	1.86	.....	.....	Agreed	1.86
22315		Treat spine fracture	8.36	.....	.....	Agreed	8.36
22325		Repair of spine fracture	17.19	.....	.....	Agreed	17.19
22326		Repair neck spine fracture	18.43	.....	.....	Agreed	18.43
22327		Repair thorax spine fracture	17.56	.....	.....	Agreed	17.56
#22328		Repair each add spine fx	4.61	.....	.....	Agreed	4.61
22548		Neck spine fusion	24.08	.....	.....	Agreed	24.08
22554		Neck spine fusion	17.24	.....	.....	Agreed	17.24
22556		Thorax spine fusion	22.27	.....	.....	Agreed	22.27
22558		Lumbar spine fusion	21.22	.....	.....	Agreed	21.22
22585		Additional spinal fusion	5.53	.....	.....	Agreed	5.53
22590		Spine & skull spinal fusion	19.50	.....	.....	Agreed	19.50
22595		Neck spinal fusion	18.19	.....	.....	Agreed	18.19
22600		Neck spine fusion	14.74	.....	.....	Agreed	14.74
22610		Thorax spine fusion	14.62	.....	.....	Agreed	14.62
22612		Lumbar spine fusion	20.19	.....	.....	Agreed	20.19
#22614		Spine fusion, extra segment	6.44	.....	.....	Agreed	6.44
22630		Lumbar spine fusion	20.03	.....	.....	Agreed	20.03
#22632		Spine fusion, extra segment	5.23	.....	.....	Agreed	5.23
22800		Fusion of spine	16.92	.....	.....	Agreed	16.92
22802		Fusion of spine	29.74	.....	.....	Agreed	29.74
#22804		Fusion of spine	35.00	.....	.....	Agreed	35.00
#22808		Fusion of spine	25.00	.....	.....	Agreed	25.00
22810		Fusion of spine	29.00	.....	.....	Agreed	29.00
22812		Fusion of spine	31.00	.....	.....	Agreed	31.00
22830		Exploration of spinal fusion	10.22	.....	.....	Agreed	10.22
22840		Insert spine fixation device	6.27	.....	.....	Agreed	6.27
#22841		Insert spine fixation device	0.00	.....	.....	Agreed	0.00
#22842		Insert spine fixation device	7.19	.....	.....	Agreed	7.19
#22843		Insert spine fixation device	8.97	.....	.....	Agreed	8.97
#22844		Insert spine fixation device	10.96	.....	.....	Agreed	10.96
22845		Insert spine fixation device	5.98	.....	.....	Agreed	5.98
#22846		Insert spine fixation device	8.28	.....	.....	Agreed	8.28
#22847		Insert spine fixation device	9.20	.....	.....	Agreed	9.20
#22848		Insert pelvic fixation device	6.00	.....	.....	Agreed	6.00
#22851		Apply spine prosth device	6.71	.....	.....	Agreed	6.71
32095		Biopsy through chest wall	7.13	.....	.....	Agreed	7.13
#32501		Repair bronchus (add-on)	4.69	.....	.....	Agreed	4.69
#33253		Reconstruct atria	30.00	.....	.....	Agreed	30.00
#33924		Remove pulmonary shunt	5.50	.....	.....	Agreed	5.50
#38231		Stem cell collection	1.74	.....	.....	Decreased ..	1.50
38240		Bone marrow/stem transplant	2.24	.....	.....	Agreed	2.24
38241		Bone marrow/stem transplant	2.24	.....	.....	Agreed	2.24
47350		Repair liver wound	11.29	.....	.....	Agreed	11.29
47360		Repair liver wound	15.34	.....	.....	Agreed	15.34
#47361		Repair liver wound	28.00	.....	.....	Agreed	28.00
#47362		Repair liver wound	10.00	.....	.....	Agreed	10.00

* All CPT codes and descriptors copyright 1995 American Medical Association.

a No work RVUs assumed.

TABLE 2.—AMA RUC RECOMMENDATIONS AND HCFA'S DECISIONS—Continued

CPT*	Mod	Description	RUC rec- ommendations	HCPAC rec- ommendations	Specialty rec- ommendations	HCFA decision	1996 work RVUs
49000		Exploration of abdomen	8.99	.....	.....	Agreed	8.99
49002		Reopening of abdomen	9.40	.....	.....	Agreed	9.40
49010		Exploration behind abdomen	11.19	.....	.....	Agreed	11.19
55859		Percut/needle insert, pros	14.00	.....	.....	Decreased ..	8.29
#56343		Laparoscopic salpingostomy	6.96	.....	.....	Agreed	6.96
#56344		Laparoscopic fimbrioplasty	7.16	.....	.....	Agreed	7.16
#57284		Repair paravaginal defect	12.10	.....	.....	Agreed	12.10
#59610		Vbac delivery	22.63	.....	.....	Decreased ..	22.55
#59612		Vbac delivery only	15.00	.....	.....	Decreased ..	14.84
#59614		Vbac care after delivery	16.00	.....	.....	Decreased ..	15.96
#59618		Attempted vbac delivery	25.03	.....	.....	Increased	25.23
#59620		Attempted vbac delivery only	16.75	.....	.....	Increased	16.95
#59622		Attempted vbac after care	17.94	.....	.....	Increased	18.11
62274		Inject spinal anesthetic	1.78	.....	.....	Agreed	1.78
62288		Injection into spinal canal	1.74	.....	.....	Agreed	1.74
#62350		Implant spinal catheter	6.25	.....	.....	Agreed	6.25
#62351		Implant spinal catheter	9.25	.....	.....	Agreed	9.25
#62355		Remove spinal canal catheter	4.80	.....	.....	Agreed	4.80
#62360		Insert spine infusion device	2.00	.....	.....	Agreed	2.00
#62361		Implant spine infusion pump	4.80	.....	.....	Agreed	4.80
#62362		Implant spine infusion pump	6.29	.....	.....	Agreed	6.29
#62365		Remove spine infusion device	4.77	.....	.....	Agreed	4.77
#62367	26	Analyze spine infusion pump	0.48	.....	.....	Agreed	0.48
#62368	26	Analyze spine infusion pump	0.75	.....	.....	Agreed	0.75
67107		Repair detached retina	13.99	.....	.....	Agreed	13.99
67108		Repair detached retina	19.90	.....	.....	Agreed	19.90
67112		Re-repair detached retina	16.15	.....	.....	Agreed	16.15
#76965	26	Echo guidance radiotherapy	1.34	.....	.....	Agreed	1.34
#78459	26	Heart muscle imaging (PET)	1.88	.....	.....	Agreed	1.88
#78810	26	Tumor imaging (PET)	1.93	.....	.....	Agreed	1.93
#90922		ESRD related services, day	0.44	.....	.....	Decreased ..	0.37
#90923		Esrd related services, day	0.30	.....	.....	Decreased ..	0.28
#90924		Esrd related services, day	0.22	.....	.....	Increased	0.24
#90925		Esrd related services, day	0.17	.....	.....	Decreased ..	0.15
92506		Speech & hearing evaluation	0.86	.....	.....	Agreed	0.86
92507		Speech/hearing therapy	0.52	.....	.....	Agreed	0.52
92508		Speech/hearing therapy	0.26	.....	.....	Agreed	0.26
#92510		Rehab for ear implant	1.50	.....	.....	Agreed	1.50
92516		Facial nerve function test	0.43	.....	.....	Agreed	0.43
#92525		Oral function evaluation	1.61	.....	.....	Decreased ..	1.13
#92526		Oral function therapy	0.64	.....	.....	Decreased ..	0.52
92546	26	Sinusoidal rotational test	0.29	.....	.....	Agreed	0.29
#92579		Visual audiometry (vra) .....	.....	.....	.....	(a) .....	.....
#92597		Oral speech device eval	1.50	.....	.....	Decreased ..	1.11
#92598		Modify oral speech device	0.99	.....	.....	Decreased ..	0.73
#92987		Revision of mitral valve	20.69	.....	.....	Agreed	20.69
95872	26	Muscle test, one fiber	1.50	.....	.....	Agreed	1.50
95900	26	Motor nerve conduction test	0.42	.....	.....	Agreed	0.42
#95903	26	Motor nerve conduction test	0.60	.....	.....	Agreed	0.60
95904	26	Sense nerve conduction test	0.34	.....	.....	Agreed	0.34
95925	26	Somatosensory testing	0.81	.....	.....	Decreased ..	0.54
#95926	26	Somatosensory testing	0.81	.....	.....	Decreased ..	0.54
#95927	26	Somatosensory testing	0.81	.....	.....	Decreased ..	0.54
#95930	26	Visual evoked potential test	0.35	.....	.....	Agreed	0.35
#95934	26	'H' reflex test	0.51	.....	.....	Agreed	0.51
#95936	26	'H' reflex test	0.55	.....	.....	Agreed	0.55
97116		Gait training therapy	0.40	.....	.....	Agreed	0.40
#97535		Self care mngmt training .....	.....	0.45	.....	Decreased ..	0.33
#97537		Community/work reintegration .....	.....	0.45	.....	Decreased ..	0.33
#97542		Wheelchair mngement training .....	.....	0.45	.....	Decreased ..	0.25
#97703		Prosthetic checkout .....	.....	0.45	.....	Decreased ..	0.25
99238		Hospital discharge day	1.06	.....	.....	Agreed	1.06
#99239		Hospital discharge day	1.75	.....	.....	Agreed	1.75
#99435		Hospital NB discharge day	1.50	.....	.....	Agreed	1.50

* All CPT codes and descriptors copyright 1995 American Medical Association.

a No work RVUs assumed.

b. Discussion of codes for which the recommendations were not accepted or for which clarification of the code is necessary.

The following is a summary of our rationale for not accepting particular recommendations. It is arranged by type of service in CPT code order. We have included in this section a clarification of the intended use of one family of codes for which we accepted the RUC recommendations. This summary refers only to work RVUs.

Exploration of penetrating wounds (CPT codes 20100 through 20103).

We accepted the RUC recommendations for these codes but are concerned that they could be inappropriately used to report the repair of wounds. Therefore, we are providing a clarification of the codes based on the language that will be included in CPT 1996.

These codes are used to report the treatment of wounds resulting from penetrating trauma that require surgical exploration and enlargement of the wound, extension of dissection (to determine penetration), debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s), of the subcutaneous tissue, muscle fascia, and/or muscle. If a repair is done to major blood vessel(s) requiring thoracotomy or laparotomy, those specific code(s) would supersede the use of CPT codes 20100 through 20103. These codes should not be used to report simple, intermediate, or complex repair of wound(s) that do not require enlargement of the wound, extension of dissection, etc., as stated above.

Blood-derived peripheral stem cell harvesting for transplantation, per collection (CPT code 38231).

The RUC recommended 1.74 RVUs based on its determination that the work is equivalent to the work of CPT code 36520 (Therapeutic apheresis). We believe that the work associated with this procedure is less than that for CPT code 36520 in that the patients are less ill and the risk of complications is much less. In addition, patients require less physician monitoring, and the procedure is more likely to be performed on an outpatient basis. We believe the work is comparable to a level-5 evaluation and management service (CPT code 99215), which is assigned 1.50 RVUs.

However, as with therapeutic apheresis, we do not permit payment for both harvesting and certain evaluation and management codes on the same

date. Specifically, we do not allow separate payment for CPT codes 99211 through 99215 (Established patient office or other outpatient visits), 99231 through 99233 (Subsequent hospital care), and 99261 through 99263 (Follow-up inpatient consultations) on the same date that CPT code 38231 (Stem cell harvesting) is furnished because it would allow duplicate payment for the evaluation and management service. Physicians furnishing stem cell harvesting services may choose to bill for the appropriate evaluation and management visit or consultation code indicating the level of services furnished rather than billing for the stem cell harvesting. This will permit physicians to be paid for the level of service furnished.

Separate payment will be allowed for physician services furnished to establish the required vascular access if performed by the physician and if the criteria for payment under the appropriate CPT code are satisfied. We will also allow separate billing for CPT codes 99221 through 99223 (Initial hospital visit), CPT codes 99241 through 99245 and 99251 through 99255 (Initial consultations), and CPT code 99238 (Hospital discharge service) when billed on the same date as CPT code 38231 (Stem cell harvesting) because the work associated with these evaluation and management services is not included in work RVUs assigned to the stem cell harvesting. These policies are consistent with the policies for therapeutic apheresis that were established for the 1995 fee schedule.

Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy (CPT code 55859).

We received a RUC recommendation of 14.00 RVUs based upon the use of CPT code 61770 (Stereotactic localization, any method, including burr hole(s) with insertion of catheter(s) for brachytherapy) as a reference procedure. We believe that these RVUs are too high and disagree with the RUC's use of CPT code 61770 as a reference procedure; we view that procedure as requiring greater technical skill, mental effort, and judgment. The recommended 14.00 RVUs are higher than the RVUs assigned to CPT code 55860 (Exposure of prostate, any approach, for insertion of radioactive substance), which is assigned 13.33 RVUs. This is an open surgical procedure with significantly more postprocedure work than CPT

code 55859, which can be performed on an outpatient basis.

The placement of needles or catheters into the prostate is performed under ultrasonic guidance, and the guidance is separately reported by new CPT code 76965 for which we accepted the RUC recommendation of 1.34 RVUs. In addition, CPT also directs separate reporting of the interstitial radioelement application (CPT codes 77776 through 77778). CPT code 77778 (Interstitial radioelement application, complex) is the code most likely to be reported. We assigned 10.46 RVUs to this code. Thus, a physician performing all aspects of this procedure would report all three codes with 25.80 total RVUs if we accepted the RUC recommendation of 14.00 for code 55859.

We believe it is possible that urologists responding to the surveyed vignette may have misunderstood that this code is used to report only the placement of the needles or catheters into the prostate and that they inadvertently included in their estimates of work the separately reported work of ultrasonic guidance and application of the radioelements.

We believe that a more appropriate reference procedure than a neurosurgical procedure would be another prostate procedure that can be performed on an outpatient basis. We selected CPT code 55700 (Biopsy, prostate; needle or punch, single or multiple, any approach), which is assigned 1.57 RVUs. Because of the increased intraoperative time and complexity as well as the increased surgical risk associated with CPT code 55859, we have increased the RVUs four-fold to 6.28 RVUs. In addition we added 2.01 RVUs, the RVUs assigned to CPT code 52000, to reflect the added work of the cystoscopy. This addition results in the assignment of 8.29 RVUs for CPT code 55859.

Vaginal birth after cesarean (CPT codes 59610, 59612, 59614, 59618, 59620, and 59622).

The CPT has added a new section to the 1996 edition for "delivery after previous cesarean delivery." Included in this section are six new codes that are used to report the services furnished to patients who have had a previous cesarean delivery and who present with the expectation of a vaginal delivery. If the patient has a successful vaginal delivery after a previous cesarean delivery (VBAC), then either CPT code 59610, 59612, or 59614 is reported. If the attempt is unsuccessful and another cesarean delivery is carried out, either

CPT code 59618, 59620, or 59622 is reported. The RUC-recommended RVUs for all six codes that added varying increments of work to the RVUs of the

six existing codes that are used to report routine vaginal and cesarean deliveries. The following table includes the RVUs for the six existing codes, the RUC

recommendations for the six new VBAC codes and the difference in RVUs for each of the six pairs.

Existing delivery code	RVUs of existing delivery code	Corresponding new VBAC code	RUC-Recommended RVUs for new VBAC code	RVU difference	HCFA RVUs
59400	20.99	59610	22.63	1.64	22.55
59409	13.28	59612	15.00	1.72	14.84
59410	14.44	59614	16.00	1.56	15.96
59510	23.67	59618	25.03	1.36	25.23
59514	15.39	59620	16.75	1.36	16.95
59515	16.55	59622	17.94	1.39	18.11

While we accept the RUC conclusion that VBAC services entail more physician work and that the existing delivery codes are appropriate reference points, we disagree with the variable and small differences in work from one code to the next. We believe the increased stress, mental effort, and judgment associated with VBAC is the same regardless of the particular delivery service furnished. Therefore, we are adding 1.56 RVUs (the median RVUs of the above differences) to each of the existing delivery codes. This results in the interim RVUs identified in the last column of the table as "HCFA RVUs."

End-stage renal disease services, per day (CPT codes 90922 through 90925).

CPT 1996 will include four codes for the reporting of end-stage renal disease services on a per day rather than per month basis. We did not accept the RUC recommendations for these codes that were based on the RUC's recommendations for the monthly codes (CPT codes 90918 through 90921). As discussed in section VI.B.1.b. of this final rule, new RVUs emerged from the refinement panel ratings for these codes. We calculated work RVUs for the four "per day" end-stage renal disease codes by dividing the RVUs of the "per full month" codes by 30. This led to the assignment of 0.37 RVUs to CPT code 90922, 0.28 RVUs to CPT code 90923, 0.24 RVUs to CPT code 90924, and 0.15 RVUs to CPT code 90925.

Evaluation of swallowing and oral function for feeding (CPT code 92525).

The RUC made its recommendation of 1.61 RVUs based on a clinical vignette of an inpatient whose evaluation included a barium swallow. The RUC lowered the specialty's recommendation to better account for the times when the barium swallow might not be done. We believe the RVUs recommended, which are between the RVUs of a level-3

inpatient consultation (CPT code 99253), with 1.56 RVUs, and a level-4 inpatient consultation (CPT code 99254) with 2.27 RVUs, are too high. While we believe that the intraservice work determined by the survey for the vignette may be reasonable, we do not believe that the surveyed vignette represented a typical patient.

Our data suggest that this procedure, which was formerly reported by CPT code 92506, is performed primarily in the physician's office. We took into consideration that the procedure is currently reported using CPT code 92506, which is assigned 0.86 RVUs. We then took into account that the barium swallow is probably included in at least 50 percent of the cases and that the evaluation of the barium swallow is an integral part of the procedure. Therefore, we added half the value of CPT code 74230 (Swallowing function, pharynx and/or esophagus, with cineradiography and/or video), which is assigned 0.54 RVUs to the 0.86 RVUs for CPT code 92506 resulting in an assignment of 1.13 RVUs to CPT code 92525. These RVUs are slightly higher than the RVUs of CPT code 99242, which is the code for a level-2 office consultation, the components of which include an expanded problem-focused history, an expanded problem-focused examination, and straightforward medical decision making.

Treatment of swallowing dysfunction and/or oral function for feeding (CPT code 92526).

The RUC recommended 0.64 RVUs based on a clinical vignette of an inpatient similar to the patient described in the vignette used for CPT code 92525 described above. Our data suggest that this procedure, which is currently reported using CPT code 92507, also is performed primarily in physicians' offices. Because we believe

the surveyed vignette does not describe a typical patient, we reduced the RUC recommendation for CPT code 92526 to 0.52 RVUs, which are the same RVUs as those for CPT code 92507 (Speech, language or hearing therapy, with continuing medical supervision; individual). These RVUs are slightly less than the RVUs assigned to a mid-level office visit (CPT code 99213), with 0.55 RVUs, which typically requires 15 minutes of face-to-face time with a physician.

Visual reinforcement audiometry (VRA) (CPT code 92579).

The RUC made no recommendation for RVUs for this procedure. As with most of the audiologic function tests, we do not believe this service requires performance by a physician. Consequently, we have not assigned physician work RVUs to this code. However, we have assigned 0.69 practice expense RVUs and 0.07 malpractice expense RVUs.

Evaluation for use and/or fitting of voice prosthetic or augmentative/alternative communication device to supplement oral speech (CPT code 92597).

The RUC recommended 1.50 RVUs. We believe the recommended RVUs are too high because they are comparable to the highest level established patient office visit, CPT code 99215, the components of which include a comprehensive history, a comprehensive examination, and medical decision-making of high complexity. We do not believe the work of these two services is comparable. Rather, we believe the work associated with CPT code 92597 is slightly less than the work associated with a level-3 new patient office visit (CPT code 99203) with 1.14 RVUs and a level-2 inpatient consultation (CPT code 99252) with 1.13 RVUs. Therefore, we have assigned 1.11 RVUs to CPT code 92597.

Modification of voice prosthetic or augmentative/alternative communication device to supplement oral speech (CPT code 92598).

The RUC recommended 0.99 RVUs, which are higher than the RVUs assigned to a level-4 established patient office visit (CPT code 99214), with 0.94 RVUs. We believe that the recommendation is too high. However, we believe that the relative relationship between this service and CPT code 92597, as established by the RUC, should be maintained. Thus, we calculated the interim RVUs by multiplying the recommended 0.99 RVUs by 74 percent ($0.99 \times 1.11/1.5$) representing the percentage of the RUC-recommended RVUs, which we accepted for the preceding code. This calculation results in 0.73 interim RVUs for CPT code 92598.

Short-latency somatosensory evoked potential studies, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system (CPT codes 95925 through 95927).

The existing code for the reporting of somatosensory testing is CPT code 95925. The descriptor in CPT 1995 is "Somatosensory testing (e.g., cerebral evoked potentials), one or more nerves." CPT revised existing CPT code 95925 by splitting it into three codes (95925, 95926, and 95927), which will be used to report testing of the upper limbs, lower limbs, and trunk or head, respectively. Currently, 0.81 RVUs are assigned to CPT code 95925. The RUC viewed the coding change as editorial and recommended 0.81 RVUs for each of these codes. While we agree that the same RVUs should be assigned to the three codes, we have not accepted the specific recommendation of 0.81 RVUs because we do not view it as an editorial change. We believe that the RUC failed to take account of the fact that some patients will require testing of both the upper and lower limbs during an encounter and that, under the existing code, only one unit of service can be reported regardless of the number of nerves tested because the descriptor specifies "one or more nerves." We estimate that the cases previously reported with CPT code 95925 will be reported under the new and revised codes as follows: About 50 percent will be reported with revised CPT code 95925; about 50 percent will be reported as new CPT code 95926; about 1 percent will be reported as CPT code 95927; and 50 percent of all testing will involve

both CPT codes 95925 and 95926 during the same encounter. Using these estimates, we adjusted the RVUs for the three codes so that the total number of RVUs under the new codes will be the same as the total number of RVUs under the old codes. This results in a decrease of the RUC's recommendation of 0.81 RVUs for each of the codes to 0.54 RVUs for each of the codes.

ADDITIONAL CODES

CPT code	Description
97535	Self care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes.
97537	Community/work reintegration, training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one on one contact by provider, each 15 minutes.
97542	Wheelchair management/propulsion training, each 15 minutes.
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes.

The RUC Health Care Professionals Advisory Committee Review Board recommended 0.45 RVUs for each of these services on the basis of their comparability to other physical medicine codes, for example, CPT code 97110 (Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility). While we agree that these new services appropriately are compared to other therapeutic procedures, our review of the new services causes us to believe that the interim RVUs we assigned to the therapeutic procedures services may have been too high relative to other services on the fee schedule, for example, evaluation and management services.

We have decided to maintain the interim RVUs for the physical medicine and rehabilitation codes (CPT codes 97010 through 97770) as interim RVUs on the 1996 fee schedule so that we will have additional time to re-evaluate them. While we acknowledge that we accepted last year's recommendations of the Health Care Professionals Advisory

Committee Review Board to assign 0.45 RVUs to CPT code 97110 and several other of the therapeutic procedures, we now plan to refer these codes back to the RUC Health Care Professionals Advisory Committee Review Board for its reconsideration, and we will notify the RUC of our concerns. In addition, we seek public comments on this issue.

For new CPT codes 97535 and 97537, we believe the recommended 0.45 RVUs are too high. Since they are currently reported using CPT code 97540 (Training in activities of daily living (self care skills and/or daily life management skills); initial 30 minutes, each visit), which has 0.44 RVUs, we divided the RVUs for CPT code 97540 by 2 to arrive at RVUs for 15 minutes and added 50 percent to account for the prework and postwork inherent in the service. This results in 0.33 RVUs for CPT codes 97535 and 97537.

For new CPT codes 97542 and 97703, we believe the recommended 0.45 RVUs are too high. We believe these services are comparable to attended modality services such as manual electrical stimulation (CPT code 97032), with 0.25 RVUs. Therefore, we have assigned 0.25 RVUs to both CPT codes 97542 and 97703.

CPT code	Description
99238	Hospital discharge day management; 30 minutes or less.
99239	Hospital discharge day management; more than 30 minutes.

We agreed with the RUC recommendation of 1.06 RVUs for CPT code 99238 and 1.75 RVUs for CPT code 99239. The reporting of CPT code 99239 must be supported by documentation in the patient's medical record of the time spent by the physician furnishing the service as well as documentation of the actual services furnished. Time spent by individuals other than the physician should not be considered in selecting the appropriate hospital discharge day management code.

CPT code	Description
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure): approximately 30 minutes.
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure): approximately 60 minutes.

We agreed with the RUC recommendations of 0.15 RVUs for CPT code 99411 and 0.25 RVUs for CPT code 99412. While these services are not covered by Medicare, we believe it is important to state the assumptions we made in agreeing with the RUC-recommended RVUs. The intent of the codes is to represent an interactive service between the patient and the physician. We expect that the interaction will be documented in each patient's individual medical record. In addition, since the RVUs are based on physician work, the codes should not be reported unless they are personally performed by a physician; they should not be used to report group preventive

medicine counseling furnished by anyone other than a physician. Nor is the service to be reported if it is furnished in a place of service other than the physician's office. Finally, the assigned RVUs are based on a group of two to five persons for CPT code 99411 and a group of two to six persons for CPT code 99412. Preventive medicine furnished to groups larger than these should be reported using code 99249 which is for the reporting of preventive medicine services not listed in CPT.

c. Temporary alpha-numeric HCFA Common Procedure Coding System codes.

For the 1996 Medicare fee schedule for physicians services, we have established several new alpha-numeric HCFA Common Procedure Coding System (HCPCS) codes for the reporting of certain new services that are not clearly described by existing CPT codes. In this section, we discuss our rationale for establishing the codes as well as the basis of the interim RVUs we have assigned to them. We view these codes as temporary since we will be referring them to the CPT Editorial Panel for possible inclusion in future editions of the CPT.

Measurement of post-voiding residual urine and/or bladder capacity by ultrasound (HCPCS code G0050).

Measurement of postvoiding residual (PVR) urine and/or bladder capacity can be done by simple diagnostic catheterization. It can also be done by ultrasound using either traditional sonographic equipment or smaller less expensive equipment whose capacity is limited only to bladder volume determination. When done by catheterization, CPT code 53670, with 0.74 RVUs, is reported. When done by ultrasound, CPT code 76857, pelvic echography, with 1.65 RVUs, is reported whether done using traditional equipment or the smaller bladder scan. There is presently no separate CPT code for a bladder scan only. Both individual carriers and a manufacturer of bladder scanning devices have recommended that we establish a separate code to distinguish bladder scans from general pelvic scans because they believe that payment for CPT code 76857 is too high for only a bladder scan to determine PVR. We agree with this recommendation and are issuing the new HCPCS code G0050.

HCPCS code	Work RVUs	Practice RVUs	Malpractice RVUs	Total RVUs
G0050	0.00	0.81	0.05	0.86

We believe that this bladder scan performs the same function as a simple diagnostic catheterization but without the risk of infection. To recognize the slightly higher equipment costs, we have established interim total RVUs for bladder scan of 0.86, or about 0.12 RVUs higher than for catheterization. We have not assigned physician work RVUs for a bladder scan. We expect that the scan will be performed after a physician has examined the patient and determined the medical necessity for a bladder scan. Physician interpretation of the scan is included in the associated evaluation and management service.

Lung volume reduction surgery (reduction pneumoplasty) eg, lung shaving, lung contouring, unilateral or bilateral (HCPCS code G0061).

Lung volume reduction surgery, also termed reduction pneumoplasty, lung shaving, or lung contouring is a procedure performed to improve pulmonary function in patients with severe emphysema. Medicare has not established that the procedure is

reasonable and necessary for the diagnosis or treatment of illness or injury. Therefore, we have excluded this procedure from coverage under the provisions of section 1862(a)(1)(A) of the Act.

Although we have assigned a noncoverage indicator of "N" to this code, we are providing interim RVUs for those who look to the Medicare fee schedule for information on the relative value of all physicians services including those not covered by Medicare.

We believe the procedure is most often being reported as wedge resection(s) of the lung using CPT code 32500, which has 13.10 work RVUs. Based on discussions with carrier medical directors, we believe that lung volume reduction surgery is more difficult than wedge resection(s). After considering existing CPT codes for other pulmonary procedures, we have assigned 17.62 RVUs on an interim basis to HCPCS code G0061. These are the same RVUs assigned to total pulmonary

decortication (CPT code 32220), which we believe is similar to lung reduction surgery in terms of physician work.

V. Issues for Discussion

A. Five-Year Refinement of Relative Value Units

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less often than every 5 years. Since we implemented the physician fee schedule effective for services furnished beginning January 1, 1992, we have initiated the 5-year refinement of RVUs that will be effective for services furnished beginning January 1, 1997.

All work RVUs included in the December 1994 final rule (59 FR 63617) were subject to comment. During the comment period, which closed on February 6, 1995, we received approximately 500 public comments on approximately 1,100 procedure codes. After review by our medical staff, we forwarded comments on approximately 700 CPT codes for consideration by the

American Medical Association/Specialty Society Relative Value Update Committee (RUC).

After a thorough review of the RUC recommendations, we will announce any proposed changes to the work RVUs in the Federal Register in early 1996 and provide an opportunity for the public to comment before we finalize the changes.

B. Resource-Based Practice Expense Relative Value Units

With the exception of anesthesia services, physician services and other diagnostic services paid under the physician fee schedule have practice expense and malpractice expense RVUs. Payments for practice expense RVUs account for approximately 42 percent of physician fee schedule payments.

The practice expense RVUs are derived from historical allowed charge data. The common criticism is that the practice expense RVUs are not truly resource-based because they are not based on resource costs.

Section 121 of the Social Security Act Amendments of 1994, Public Law 103-432, enacted on October 31, 1994, requires the Secretary to develop a methodology for a resource-based system for determining practice expense RVUs for each physician service. In developing the methodology, the Secretary must consider the staff, equipment, and supplies used in the provision of medical and surgical services in various settings. The Secretary must report to the Congress on the methodology by June 30, 1996. The new payment methodology is effective for services furnished in 1998. There is no transition provision for these services.

We awarded a contract to Abt Associates in March 1995. Abt will develop a uniform database that can be used to support a number of analytical methods (for example, microcosting or economic cost functions) to estimate practice expense per service. Abt will also provide us with both direct and indirect practice expense estimates for all services paid under the physician fee schedule. We expect that these estimates will vary based on the site where the service is furnished. For example, the practice expense for a physician service furnished in the hospital outpatient department will differ from the practice expense for the same service performed in the physician's office.

As we pointed out in our July 26, 1995 proposed rule (60 FR 38400), Abt

will use information from two separate processes to generate practice expense RVUs for physician services (60 FR 38417). Through the use of Clinical Practice Expert Panels, Abt will estimate the expenses, including the cost of clinical labor, supplies, and medical equipment for specific physician services. The Clinical Practice Expert Panels will also consider whether additional items, such as the cost of administrative services, can be directly assigned to individual services. The remaining expenses for physician services will be calculated from the information obtained through the practice expense survey.

Practice Expense Survey

Abt will obtain physician practice specific information through a practice expense survey. Abt expects to receive responses from approximately 3,000 practices.

The survey instrument was sent to the Office of the Secretary in the Department of Health and Human Services on August 7, 1995. Under current procedures, the Department has a 60-day period to review this survey. After Departmental clearance, the survey is sent to the Office of Management and Budget where it will undergo a 60-day clearance process. Under the current schedule, the earliest clearance on the survey will be in early December.

We expect that Abt will send the survey to individual practices starting in January 1996. Abt estimates that it will take approximately 7 months for its staff to mail the survey, to compile the completed responses, and to assemble the data into a database.

As we stated in the July 26, 1995 proposed rule, one of the main objectives of the practice expense survey will be to collect indirect practice expenses so that these expenses can be related to individual CPT procedure codes.

Clinical Practice Expert Panels

We furnished Abt with a list of all the codes in the Medicare physician fee schedule database for which practice expense RVUs are to be estimated. As a starting point, Abt used a classification system that is a hybrid of the Ambulatory Patient Groups system developed by 3M and the Berenson-Eggers-Holahan (Urban Institute) system to group the codes into similar families of codes. The objective was to sort the codes into families that are clinically related and have relatively comparable

direct costs. This system was reviewed by our medical staff, clinical consultants, and the Clinical Practice Expert Panel Technical Expert Group, the advisory group for the overall design of the project.

At a HCFA-sponsored public meeting on August 18, 1995, a draft copy of this classification system was provided to various specialty groups. These groups were given the opportunity to review the families of codes and the Clinical Practice Expert Panel to which the family was assigned and to suggest one or more reference codes for each family. Abt considered these comments in the development of the final classification system.

At this time, Abt has grouped the codes into 199 families. These families have been assigned to 15 Clinical Practice Expert Panels. Each Clinical Practice Expert Panel is generally assigned between 6 to 25 families. A goal is to keep the number of service families per Clinical Practice Expert Panel manageable.

Each Clinical Practice Expert Panel will be composed of up to 15 members. Clinical Practice Expert Panel membership is not restricted to practicing physicians. Clinical Practice Expert Panel members can be practice managers and nonphysician clinicians who are knowledgeable about physician practice expenses. There will be a primary care physician and surgeon on every Clinical Practice Expert Panel. The remainder of the Clinical Practice Expert Panel members will be composed of the primary providers of the services in the Clinical Practice Expert Panel families.

The Clinical Practice Expert Panel is to reach consensus on the detailed direct inputs for one reference procedure per family. The following four criteria were established to guide the selection process of the reference procedure:

- The service should be commonly performed.
- The service should have a mid-range level of resource usage relative to the other codes in the family.
- The service should be a code whose definition or coding application has not changed in the last several years.
- The variation across physicians in the way the service is performed should be minimal.

A Clinical Practice Expert Panel Technical Expert Group meeting was held on September 7 and 8, 1995. The Clinical Practice Expert Panel Technical Expert Group devoted its attention to

the following topics: service family composition including criteria; reference procedures per family; composition of the Clinical Practice Expert Panel; and the process for conducting the Clinical Practice Expert Panels, in particular, the worksheets to be completed.

Future Scheduled Activities

A mock Clinical Practice Expert Panel meeting will be held in January 1996. The purpose of the mock Clinical Practice Expert Panel meeting is to pre-test the Clinical Practice Expert Panel process and worksheets.

The first series of Clinical Practice Expert Panel meetings will be conducted beginning in late January 1996. Before the Clinical Practice Expert Panel meetings, each Clinical Practice Expert Panel member (and if it so chooses, specialty group) will complete the worksheets on the resource costs of reference procedures. Abt will compile these data and provide summary information to each Clinical Practice Expert Panel member. The Clinical Practice Expert Panel members will use a consensus approach to estimate the direct inputs for the reference services.

The second series of Clinical Practice Expert Panel meetings will be conducted in the spring of 1996. The Clinical Practice Expert Panel members will use an extrapolation process to estimate the direct costs of the other nonreference procedures in the same family.

Data collection on the practice expense survey will be completed by June 1996. Abt will deliver data files by August 1, 1996. We expect to award multiple contracts to analyze the data. Abt's report on the analysis of the data is due by September 1996.

We expect to publish the proposed rule in the Federal Register in the spring of 1997 and the final rule in the fall of 1997. We will implement the resource-based practice expense RVUs beginning January 1, 1998.

As we also stated in the July 26, 1995 proposed rule, this discussion of our efforts to implement the requirement in the statute to develop a resource-based relative value scale is for informational purposes and is not a formal proposal. We were not soliciting comments on the proposal. While we did receive several comments, we are not providing a summary of these comments nor responses to them because it was not a formal proposal. We will, however, consider the comments.

C. Case Management in a Fee-for-Service System

In the July 26, 1995 proposed rule, we solicited information, recommendations, and suggestions from the public on how we might apply case management to the Medicare fee-for-service system. While the comments we received addressed the issues we raised in the proposed rule, we are now seeking comments on some additional issues.

We are currently interested in paying physicians for the management of patients with specific diagnoses. We believe that physicians often provide extensive case management to patients with certain chronic conditions and that these management activities may maintain or improve health status. We are interested in learning more about which patients would benefit from this case management.

We are also exploring various managed care options within the Medicare fee-for-service system. We are interested in receiving public comment about the appropriateness and feasibility of creating periodic capitated payments for comprehensive management of medical cases.

Our intent at this time is to solicit information, recommendations, and suggestions from the public on how we might create a capitated payment for case management. We are particularly interested in the following:

- What types of patients would benefit from extensive case management? We are considering developing bundled payments for physician services furnished to patients with dementia and one or more comorbidities, diabetes, hypertension, or congestive heart failure. We are seeking comments on these and other types of patients who would benefit from case management. Any information about the types of services that should be included in a bundled payment for care of these patients and data on the prevalence of a given medical condition or combination of conditions in the Medicare population would be appreciated.

- What is an appropriate periodicity for a capitated payment? There is precedent in the Medicare program for monthly and weekly capitated payments. (Medicare pays on a monthly basis for physician services associated with the continuing medical management of a maintenance dialysis patient and has a weekly radiation therapy management payment.) Do

other schedules such as quarterly or semiannually make more sense for identifiable groups of patients?

VI. Provisions of the Final Rule

The provisions of this final rule, for the most part, restate the provisions of the July 1995 proposed rule. This section includes the following changes from the proposed rule:

- Adds a new statutory basis section in § 405.500 for subpart E ("Criteria for Determining Reasonable Charges") in part 405 and also revises the authority citation for subpart E.
- Redesignates § 405.552 ("Conditions for payment: Anesthesiology services") as § 415.110.
- Adds a statutory basis section in § 405.2400 for subpart X ("Health Clinic and Federally Qualified Health Center Services") of part 405 and also revises the authority citation for subpart X.
- Revises § 405.2468 ("Allowable costs") to expand the definition of physician services in rural health clinics and Federally qualified health centers to include services of residents as defined in § 415.152 ("Definitions") who meet the requirements in § 415.206(b) (concerning physician fee schedule payment for services of residents in nonprovider settings).
- Revises § 414.30 ("Conversion factor update") to incorporate a change regarding the downward adjustment to the conversion factor required by section 13511 of OBRA 1993.
- Revises § 414.32 ("Determining payments for certain physicians' services furnished in facility settings") to state that when a service which is not on the ASC list is performed in an ASC, the site-of-service payment differential does not apply.
- Removes the urodynamic evaluation CPT codes 51725, 51726, 51772, 51785 and CPT codes 13150, 14020, 14060, 15740, 21208, 21440, 23066, 26645, 28030, 28043, 28092, 28261, 40510, 41805, 42408, 46220, 46610, 63600, 64420, 65270, and 67921 from the site-of-service payment differential list as proposed.
- Revises § 414.46 ("Additional rules for payment of anesthesia services") to state that anesthesia CPT modifier units are not allowed for Medicare payment.
- Moves the "Scope" paragraph (a) in § 415.100 of subpart C ("Part B Carrier Payments for Physician Services to Beneficiaries in Providers") of part 415 in the proposed rule into a separate § 415.100. Redesignates the remaining paragraphs in proposed rule § 415.100 as § 415.102 ("Conditions for fee

schedule payment for physician services to beneficiaries in providers").

- Creates a limited exception to the teaching physician presence requirement for certain residency programs in new § 415.174 ("Exception: Evaluation and management services furnished in certain centers").

In addition, the final rule differs from the proposed rule in that we have revised our proposed payment policy related to hydration therapy and chemotherapy as a result of public comments. We will allow separate payment for hydration therapy or the infusion of antiemetics or other nonchemotherapy drug on the same date of service as chemotherapy infusion only when the nonchemotherapy drug is administered sequentially rather than at the same time as the chemotherapy infusion. However, as we proposed, we will not pay for hydration therapy when administered at the same time as chemotherapy infusion.

VII. Collection of Information Requirements

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

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirements discussed below.

The following sections of this document contain information collection requirements as described below:

The information collection requirements in § 415.60 ("Allocation of physician compensation costs"), in paragraph (f)(1), concern determination

and payment of allowable physician compensation costs. The requirements also concern the amounts of time the physician spends in furnishing physician services to the provider, physician services to patients, and services that are not paid under either Part A or Part B of Medicare; and assurance that the compensation is reasonable in terms of the time devoted to these services. The information collection requirements in § 415.60(g) concern recordkeeping requirements for allocation of physician compensation costs. They also concern time records used to allocate physician compensation, information on which the physician compensation allocation is based, and retention of this information for a 4-year period after the end of each cost reporting period to which the allocation applies. Respondents that will provide the information are 7,091 hospitals, 10,630 freestanding skilled nursing facilities, and 258 freestanding comprehensive outpatient rehabilitation facilities. The respondents will provide the information in Exhibits 2 through 4 on Form HCFA-339, "Provider Cost Report Reimbursement Questionnaire."

The information collection requirements in § 415.130 ("Conditions for payment: Physician pathology services"), paragraph (b)(3), concern a written narrative report included in the beneficiary's medical record for clinical consultation pathology services. The services must be requested by the beneficiary's attending physician, relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the beneficiary, and require the exercise of medical judgment by the consultant physicians. Respondents who will provide the information are physicians furnishing clinical consultation pathology services.

The information collection requirements in § 415.162 ("Determining payment for physician services furnished to beneficiaries in teaching hospitals") concern the apportionment of compensation in the case of teaching hospitals electing cost reimbursement for direct medical and surgical services furnished by physicians to beneficiaries and supervision of interns and residents furnishing care to beneficiaries in a teaching hospital. Respondents that will provide the information are 40 cost election teaching hospitals. The respondents will provide the

information on Supplemental Worksheet, Part I and Part II, of Form HCFA-2552-92.

The information collection requirements in § 415.172 ("Physician fee schedule payment for services of teaching physicians"), paragraph (b), concern documentation in the medical records that the teaching physician was present at the time the service was furnished, and, in the case of evaluation and management services, personal documentation by the teaching physician in the medical records of his or her participation in the service. The information collection requirements also concern, in the case of surgical, high-risk, or other complex procedures, the presence of the teaching physician during all critical portions of the procedure and immediate availability to furnish services during the entire service or procedure. In the case of surgery, the teaching physician's presence is not required during opening and closing of the surgical field. In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing. In the case of evaluation and management services, the teaching physician must be present during the portion of the service that determines the level of service billed. Respondents who will provide this information are physicians, residents, or nurses; however, in the case of evaluation and management services, the teaching physician must personally document in the medical records his or her participation in the service.

The information collection requirements in § 415.174 ("Exception: Evaluation and management services furnished in certain centers"), paragraph (a)(3)(v), concern documentation of the extent of the teaching physician's participation in the review and direction of the services furnished to each beneficiary in an outpatient department of a hospital or another ambulatory care entity. The information collection requirements concern the conditions under which carriers will make physician fee schedule payment for certain evaluation and management services of lower and mid-level complexity furnished by a resident without the presence of a teaching physician. Respondents who will provide this information are teaching physicians.

The information collection requirements in § 415.178 ("Anesthesia services"), paragraph (b), concern

documentation of the teaching physician's presence or participation in the administration of the anesthesia and a preoperative and postoperative visit by the teaching physician. The teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. The teaching physician cannot receive an unreduced fee if he or she performs services involving other patients during the period the

anesthesia resident is furnishing services in a single case. Respondents who will provide this information are teaching physicians.

The information collection requirements in § 415.180 ("Teaching setting requirements for the interpretation of diagnostic radiology and other diagnostic tests"), paragraph (b), concern documentation that the teaching physician personally performed the interpretation or reviewed the resident's interpretation

with the resident. Physician fee schedule payment will be made in those situations. Respondents who will provide this information are teaching physicians.

The table below indicates the annual number of responses for each regulation section in this final rule containing information collection requirements, the average burden per response in minutes or hours, and the total annual burden hours.

ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

CFR sections	Annual No. of responses	Annual frequency	Average burden per response	Annual burden hours
415.60	17,979	1	11 hours	197,769
415.130	9,273	1	3 minutes	464
415.162	40	1	2 hours	80
415.172	3,200,232	1	1 minute	53,337
415.174	1,237,516	1	1 minute	20,625
415.178	106,819	1	1 minute	1,780
415.180	1,000,107	1	1 minute	16,668

The information collection requirements were approved by OMB for §§ 415.60 and 415.162 as §§ 405.481 and 405.465, respectively, under OMB control number 0938-0301 and expire August 31, 1998.

We have submitted a copy of this final rule with comment period to OMB for its review of the information collection requirements in §§ 415.130, 415.172, 415.174, 415.178, and 415.180. These requirements are not effective until they have been approved by OMB. A document will be published in the Federal Register when OMB approval is obtained.

Organizations and individuals desiring to submit comments on the information collection and recordkeeping requirements should send them to the Health Care Financing Administration, Office of Financial and Human Resources, Management Planning and Analysis Staff, 7500 Security Boulevard, Baltimore, Maryland, 21244-1850 and to the Office of Management and Budget official whose name appears in the **ADDRESSES** section of this preamble.

VIII. Response to Comments

Because of the large number of items of correspondence we normally receive on Federal Register documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and

time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

IX. Regulatory Impact Analysis

A. Regulatory Flexibility Act

Consistent with the Regulatory Flexibility Act (5 U.S.C. 601 through 612), we prepare a regulatory flexibility analysis unless the Secretary certifies that a rule will not have a significant economic impact on a substantial number of small entities. For purposes of the Regulatory Flexibility Act, all physicians are considered to be small entities.

This final rule will not have a significant economic impact on a substantial number of small entities. Nevertheless, we are preparing a regulatory flexibility analysis because the provisions of this rule are expected to have varying effects on the distribution of Medicare physician payments across specialties and across geographic areas. We anticipate that virtually all of the approximately 500,000 physicians who furnish covered services to Medicare beneficiaries will be affected by one or more provisions of this rule. In addition, physicians who are paid by private insurers for non-Medicare services will be affected to the extent that they are paid by private insurers that choose to use the RVUs.

However, with few exceptions, we expect that the impact on individual medical practitioners will be limited.

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

B. Budget-Neutrality Adjustment

Section 1848(c)(2)(B) of the Act requires that adjustments to RVUs in a year may not cause the amount of expenditures for the year to differ by more than \$20 million from the amount of expenditures that would have been made if these adjustments had not been made. We refer to this as the budget-neutrality adjustment.

In past years, we have made this adjustment across all RVUs. This year, as we proposed, we are making this adjustment on the conversion factors instead of the RVUs. This alternative approach is administratively simpler, and it facilitates policy and data analysis of RVUs. It does not significantly affect the final payments that are made to physicians because any changes to payments will be the result of rounding and will be minimal.

The issues discussed in sections IX.C. through IX.K. will have no impact on Medicare program expenditures because the effects of these changes have been neutralized in the calculation of the conversion factors for 1996.

We have estimated the net increase in program costs in calendar year 1996

resulting from the adjustments to RVUs and revisions in payment policies to be approximately \$140 million. This is a net figure in that savings from the reductions in RVUs for some services partially offset the cost associated with increases in the RVUs for other services. This figure requires a reduction of 0.36 percent in the conversion factors for all services to comply with the statutory limitation on increases in expenditures. Although a \$20 million tolerance is permitted under the law, this 0.36 percent reduction to all conversion factors is designed to approximate budget neutrality as closely as possible, without creating any increase or decrease in expenditures as a result of RVU adjustments or revisions in payment policies.

C. Bundled Services

1. Hydration Therapy and Chemotherapy

Bundling of payment for CPT codes 90780 and 90781, (Therapeutic infusions except for chemotherapy) into CPT codes 96410, 96412, and 96414 (Chemotherapy infusion), when nonchemotherapy drugs are infused at the same time as chemotherapy drugs means that in some cases, physicians will no longer be paid for CPT codes 90780 and 90781. However, our policy will allow physicians to continue to be paid for CPT codes 90780 and 90781 when done on the same day as CPT codes 96410, 96412, and 96414 if the nonchemotherapy drugs are infused sequentially rather than contemporaneously with the chemotherapy drugs. We are unable to determine from our existing data which portion of billings for CPT codes 90780 and 90781 that are currently furnished on the same day as CPT codes 96410, 96412, and 96414 are for sequential or contemporaneous services. Therefore, at this time, we are unable to estimate the impact of this policy. We expect that the impact will be minor.

2. Evaluation of Psychiatric Records and Reports and Family Counseling Services

Bundling of payment for CPT codes 90825 and 90887 into the payment for other psychiatric codes means that physicians who are currently billing for, and receiving separate payment for, these services may no longer do so. Because we believe that the services described by CPT codes 90825 and 90887 are captured in the prework and postwork of other psychiatric services, we will implement this change in policy

by redistributing the RVUs for CPT codes 90825 and 90887 equally into the following psychiatric procedure codes: CPT codes 90801, 90820, 90835, 90842 through 90847, and 90853 through 90857. We estimate that this change will increase the RVUs for the latter codes by approximately 0.7 percent.

3. Fitting of Spectacles

We will cease making separate payment under the physician fee schedule for fitting of spectacles and low vision systems (CPT codes 92352 through 92358 and 92371) beginning January 1, 1996. Payment for these services is already included in the payment for the prosthetic device. We will redistribute the payment currently made for these CPT codes across all physician services, which is what would have occurred had we not included these fees when the fee schedule was created. Because the total payment for spectacle fitting services is relatively low (approximately \$2.5 million in calendar year 1994) compared to the total payment for all physician services, we believe the impact on RVUs for all physician services is negligible.

Virtually all of the providers who have been billing for the fitting of spectacles as a professional service have been optometrists. Under this revised policy, they are no longer able to bill separately for this service. The effect on individual optometrists will depend upon the amount of their income derived from billing for spectacle fitting services.

D. X-Rays and Electrocardiograms Taken in the Emergency Room

Under policy issued in 1981, the interpretation of an x-ray or EKG furnished to an emergency room patient by a radiologist or cardiologist, respectively, "almost always" constituted a covered Part B service payable by the carrier, regardless of whether the test results had been previously used in the diagnosis and treatment of the patient by a physician in the emergency room and regardless of when the specialist furnished the interpretation. A study completed by the Office of Inspector General of the Department of Health and Human Services, dated July 1993, recommended that we change this policy to indicate that the second interpretation is generally a quality control service to be taken into account by intermediaries in determining hospital reasonable costs. Further, we understand that some

carriers are currently paying both the emergency room physician and the radiologist or cardiologist for the interpretation of the same x-ray or EKG.

We will pay for only one interpretation of an x-ray or EKG furnished to an emergency room patient except under unusual circumstances. In situations in which both the emergency room physician and the radiologist or cardiologist bill for the interpretation, we will instruct the carriers to pay for the interpretation used in the diagnosis and treatment of the patient. We will consider the second interpretation to be a quality control service. Under this policy, we will reduce the incidence of carriers' paying twice for an interpretation, but we have no estimate of the number of duplicate payments that will be eliminated. We believe that the specialists will be affected primarily. If hospitals want to ensure that their specialists are paid for these interpretations, they can make arrangements to preclude the emergency room physician from billing for the same service.

E. Extension of Site-of-Service Payment Differential to Services in Ambulatory Surgical Centers

We are extending the site-of-service payment limit to office-based services if those services are performed in an ambulatory surgical center, effective for services furnished beginning January 1, 1996. We are adding 126 procedure codes to the list. Were it not for budget-neutrality adjustments, we estimate that these additions would result in a \$24.6 million reduction in 1996 Medicare payments.

F. Services of Teaching Physicians

This change removes the single attending physician criteria for hospital patients. It allows and promotes supervision of the care by physician group practices. We believe allowing for more than one teaching physician per beneficiary inpatient stay will result in negligible additional cost, but the lack of any data prevents us from quantifying the effects of this change. In addition, this rule will incorporate longstanding Medicare coverage and payment policy regarding the circumstances under which the services of residents are payable as physician services.

We will require the physical presence of a teaching physician during the key portion of the service in order for the teaching physician to receive Part B physician fee schedule payment for the service. Details regarding the physical

presence of a teaching physician during different types of services and procedures are discussed in section II.F. of this preamble. Although we lack specific data, we believe that the provisions of this part of the final rule have no budgetary effect because we believe that the potential costs are offset by the potential savings.

G. Unspecified Physical and Occupational Therapy Services (HCFA Common Procedure Coding System Codes M0005 Through M0008 and H5300)

We are eliminating HCPCS codes M0005 through M0008 and H5300 and redistributing the RVUs to codes in the physical medicine and rehabilitation section of the CPT (codes 97010 through 97799). The codes we are deleting are general codes that do not describe adequately the service being furnished. Their use precludes effective review necessary to ensure that the services being paid are covered by Medicare. In 1995, the American Medical Association revised the CPT codes in the Physical Medicine and Rehabilitation section of the CPT to better reflect the provision of physical and occupational therapy services.

We believe that each unit of service currently billed under the codes we are deleting will be billed under a CPT or HCPCS code and that the total amount of Medicare payment for physical medicine services will not change significantly as a result of the elimination of these codes. Therefore, we believe there will be no additional costs or savings as a result of this change in billing. Since the original codes were not descriptive, we had no way of comparing payments. However, we believe that we are eliminating potential manipulation of payment and are improving the data collected by requiring practitioners to use the more specific codes when billing for these services.

H. Transportation in Connection With Furnishing Diagnostic Tests

Under the policy adopted in this final rule, we are restricting the discretion of carriers to make separate payments for the transportation of diagnostic testing equipment. Effective for services furnished beginning January 1, 1996, the general policy is that separate transportation payments will be made only in connection with the following services:

- X-ray and standard EKG services furnished by an approved portable x-ray supplier; and
- Standard EKG services furnished by an independent physiological laboratory under special conditions.

For all other types of diagnostic tests payable under the physician fee schedule, travel expenses are considered to be "bundled" into the payment for the procedure, and Medicare carriers will pay for the transportation of equipment only on a "by report" basis under CPT code 99082 if a physician submits documentation to justify the "very unusual" travel as set forth in section 15026 of the Medicare Carriers' Manual.

We are unable to assess the impact of this new national policy because carriers have had such varying payment policies on this issue. We had thought that this might be a significant policy change since we had received many inquiries on the subject in recent years; however, we received fewer than 10 comments on this policy as set forth in the proposed rule, and we now conclude that the national impact of the new policy will not be significant. There will likely be an impact on payments to independent physiological laboratories in some areas in which transportation payments were made before January 1, but it is not possible to assess these reductions from the comments received.

I. Maxillofacial Prosthetic Services

We are establishing national RVUs for these services and, therefore, are discontinuing pricing by individual carriers, effective January 1, 1996. We estimate that total expenditures for CPT codes 21079 through 21087 and codes G0020 and G0021 (replaced by CPT codes 21076 and 21077 in 1996), based on the RVUs will be approximately \$2.4 million in calendar year 1996. The 1994 Medicare expenditures for these codes under the carrier pricing methodology were approximately \$1.5 million which, if updated for 1995, would be approximately \$1.6 million. Thus, we estimate an increase of approximately \$800,000 for these codes. However, total expenditures for physician services will not increase because we are implementing this change in a budget-neutral manner in accordance with section 1848(c)(2)(B)(ii) of the Act.

These services are furnished most frequently by oral surgeons (dentists only) and by maxillofacial surgeons. Because we estimate that the total expenditures for these services will increase slightly, we expect that, in

general, the physicians who perform and bill for these procedures will realize an increase in payment. However, in some areas, the payment amounts based on national RVUs may be lower than those calculated by the local carrier.

J. Coverage of Mammography Services

We are expanding the definition of "diagnostic" mammography to include as candidates for this service asymptomatic men or women who have a personal history of breast cancer or a personal history of biopsy-proven benign breast disease. We do not believe this change will result in a significant increase in the total number of mammography services because information from carriers indicates that most asymptomatic patients in these categories are already receiving diagnostic mammography services.

K. Two Anesthesia Providers Involved in One Procedure

We will apply the medical direction payment policy to the single procedure involving both the physician and the CRNA. We will not implement this policy until January 1, 1998, at which time the proposal will be budget-neutral. In 1998, the allowance for the medically-directed CRNA service and the medical-direction service of the anesthesiologist will be equivalent to 50 percent of the allowance recognized for the service personally performed by the anesthesiologist alone. Thus, payment for both services will be no different than what would be allowed for the anesthesia service personally performed by the anesthesiologist.

Although this proposal is budget-neutral, total payments to anesthesiologists will decrease slightly and payments to the CRNAs' employers will increase slightly. We cannot quantify the amount of the losses to the anesthesiologists or the gains to the CRNAs' employers. However, anesthesiologists can lessen their losses by actually personally performing as many of these services as possible and receiving the same allowance they would have in the absence of this new policy.

L. Rural Hospital Impact Statement

Section 1102(b) of the Act requires the Secretary 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. This analysis must conform to the provisions of section 604 of the Regulatory Flexibility Act. 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 50 beds.

This final rule will have little direct effect on payments to rural hospitals since this rule will change only payments made to physicians and certain other practitioners under Part B of the Medicare program and will not change payments to hospitals under Part A. We do not believe the changes will have a major, indirect effect on rural hospitals.

Therefore, we are not preparing an analysis for section 1102(b) of the Act since we have determined, and the Secretary certifies, that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

List of Subjects

42 CFR Part 400

Grant programs—health, Health facilities, Health maintenance organizations (HMO), Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 405

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

42 CFR Part 410

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

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Part 414

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

42 CFR Part 415

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

42 CFR Part 417

Administrative practice and procedure, Grant programs—health, Health care, Health facilities, Health insurance, Health maintenance organizations (HMO), Loan programs—health, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

Under the authority of 42 U.S.C. 1302 and 1395hh, 42 CFR chapter IV is amended as set forth below:

PART 400—INTRODUCTION; DEFINITIONS

A. Part 400 is amended as set forth below:

1. The authority citation for part 400 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. Chapter 35.

2. In § 400.202, the introductory text is republished and the definition of *GME* is added in alphabetical order to read as follows:

§ 400.202 Definitions specific to Medicare.

As used in connection with the Medicare program, unless the context indicates otherwise—

* * * * *

GME stands for graduate medical education.

* * * * *

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

B. Part 405 is amended as set forth below:

Subpart D—[Removed and Reserved]

1. Subpart D, consisting of §§ 405.465 through 405.482, is removed and reserved.

2. Subpart E is amended as set forth below:

a. The authority citation for subpart E is revised to read as follows:

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

b. The heading for subpart E is revised to read as follows:

Subpart E—Criteria for Determining Reasonable Charges

c. A new § 405.500 is added to read as follows:

§ 405.500 Basis.

Subpart E is based on the provisions of the following sections of the Act: Section 1814(b) provides for Part A payment on the basis of the lesser of a provider's reasonable costs or customary charges. Section 1832 establishes the scope of benefits provided under the Part B supplementary medical insurance program. Section 1833(a) sets forth the amounts of payment for supplementary medical insurance services on the basis of the lesser of a provider's reasonable costs or customary charges. Section 1834(a) specifies how payments are made for the purchase or rental of new and used durable medical equipment for Medicare beneficiaries. Section 1834(b) provides for payment for radiologist services on a fee schedule basis. Section 1834(c) provides for payments and standards for screening mammography. Section 1842(b) sets forth the provisions for a carrier to enter into a contract with the Secretary and to make determinations with respect to Part B claims. Section 1842(h) sets forth the requirements for a physician or supplier to voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. Section 1842(i) sets forth the provisions for the payment of Part B claims. Section 1848 establishes a fee schedule for payment of physician services. Section 1861(b) sets forth the inpatient hospital services covered by the Medicare program. Section 1861(s) sets forth medical and other health services covered by the Medicare program. Section 1861(v) sets forth the general authority under which HCFA may establish limits on provider costs recognized as reasonable in determining Medicare program payments. Section 1861(aa) sets forth the rural health clinic services and Federally qualified health center services covered by the Medicare program. Section 1861(jj) defines the term "covered osteoporosis drug." Section 1862(a)(14) lists services that are excluded from coverage. Section 1866(a) specifies the terms for provider agreements. Section 1881 authorizes special rules for the coverage of and payment for services furnished to patients with end-stage renal disease. Section 1886 sets forth the requirements for payment to hospitals for inpatient hospital services. Section 1887 sets forth

requirements for payment of provider-based physicians and payment under certain percentage arrangements. Section 1889 provides for Medicare and Medigap information by telephone.

§ 405.501 [Amended]

d. In § 405.501, the following changes are made:

i. Paragraphs (c) and (d) are removed, and paragraphs (e) and (f) are redesignated as paragraphs (c) and (d), respectively.

ii. In newly redesignated paragraph (c), the phrase “§§ 405.480 through 405.482 and §§ 405.550 through 405.557” is removed, and the phrase “§§ 415.55 through 415.70 and §§ 415.100 through 415.130 of this chapter” is added in its place.

iii. In newly redesignated paragraph (d), the words “For services furnished on or after January 1, 1989, payment” are removed, and the word “Payment” is added in their place.

§§ 405.520–405.525 [Removed]

e. Sections 405.520 through 405.525 are removed.

Subpart F—[Removed and Reserved]

3. Subpart F, consisting of §§ 405.550 through 405.580, is removed and reserved.

Subpart X—Rural Health Clinic and Federally Qualified Health Center Services

4. Subpart X is amended as set forth below:

a. The authority citation for subpart X is revised to read as follows:

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

b. A new § 405.2400 is added to read as follows:

§ 405.2400 Basis.

Subpart X is based on the provisions of the following sections of the Act: Section 1833 sets forth the amounts of payment for supplementary medical insurance services. Section 1861(aa) sets forth the rural health clinic services and Federally qualified health center services covered by the Medicare program.

c. In § 405.2401, paragraph (b), the introductory text is republished, and the definition for physician is revised to read as follows:

§ 405.2401 Scope and definitions.

* * * * *

(b) *Definitions.* As used in this subpart, unless the context indicates otherwise:

* * * * *

Physician means the following:

(1) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed.

(2) Within limitations as to the specific services furnished, a doctor of dentistry or dental or oral surgery, a doctor of optometry, a doctor of podiatry or surgical chiropody or a chiropractor. (See section 1861(r) of the Act for specific limitations.)

(3) A resident (including residents as defined in § 415.152 of this chapter who meet the requirements in § 415.206(b) of this chapter for payment under the physician fee schedule).

* * * * *

d. In § 405.2468, the introductory text of paragraph (b) is republished, and paragraph (b)(1) is revised to read as follows:

§ 405.2468 Allowable costs.

* * * * *

(b) *Typical rural health clinic and Federally qualified health center costs.* The following types and items of cost are included in allowable costs to the extent that they are covered and reasonable:

(1) Compensation for the services of physicians, (including residents as defined in § 415.152 of this chapter who meet the requirements in § 415.206(b) of this chapter for payment under the physician fee schedule), physician assistants, nurse practitioners, nurse midwives, specialized nurse practitioners, visiting nurses, qualified clinical psychologists, and clinical social workers employed by the clinic or center.

* * * * *

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

C. Part 410 is amended as set forth below:

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

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

2. Section 410.34 is amended by republishing the introductory text to paragraph (a) and revising paragraphs (a)(1), (a)(2), and (d) to read as follows:

§ 410.34 Mammography services: Conditions for and limitations on coverage.

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

(1) *Diagnostic mammography* means a radiologic procedure furnished to a man or woman with signs or symptoms of breast disease, or a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease, and includes a physician's interpretation of the results of the procedure.

(2) *Screening mammography* means a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure.

* * * * *

(d) *Limitations on coverage of screening mammography services.* The following limitations apply to coverage of screening mammography services as described in paragraph (a)(2) of this section:

(1) The service must be, at a minimum a two-view exposure (that is, a cranio-caudal and a medial lateral oblique view) of each breast.

(2) Payment may not be made for screening mammography performed on a woman under age 35.

(3) Payment may be made for only 1 screening mammography performed on a woman over age 34, but under age 40.

(4) For a woman over age 39, but under age 50, the following limitations apply:

(i) Payment may be made for a screening mammography performed after at least 11 months have passed following the month in which the last screening mammography was performed if the woman has—

(A) A personal history of breast cancer;

(B) A personal history of biopsy-proven benign breast disease;

(C) A mother, sister, or daughter who has had breast cancer; or

(D) Not given birth before age 30.

(ii) If the woman does not meet the conditions described in paragraph (d)(4)(i) of this section, payment may be made for a screening mammography performed after at least 23 months have passed following the month in which the last screening mammography was performed.

(5) For a woman over age 49, but under age 65, payment may be made for a screening mammography performed after at least 11 months have passed

following the month in which the last screening mammography was performed.

(6) For a woman over age 64, payment may be made for a screening mammography performed after at least 23 months have passed following the month in which the last screening mammography was performed.

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

D. Part 414 is amended as set forth below:

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

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

2. In § 414.2, the following definitions are added alphabetically:

§ 414.2 Definitions.

AA stands for anesthesiologist assistant.

* * * * *

CRNA stands for certified registered nurse anesthetist.

* * * * *

3. In § 414.28, the introductory text is republished, and paragraph (b) is revised to read as follows:

§ 414.28 Conversion factors.

HCFA establishes CFs in accordance with section 1848(d) of the Act.

* * * * *

(b) *Subsequent CFs.* For calendar years 1993 through 1995, the CF for each year is equal to the CF for the previous year, adjusted in accordance with § 414.30. Beginning January 1, 1996, the CF for each calendar year may be further adjusted so that adjustments to the fee schedule in accordance with section 1848(c)(2)(B)(ii) of the Act do not cause total expenditures under the fee schedule to differ by more than \$20 million from the amount that would have been spent if these adjustments had not been made.

4. In § 414.30, the introductory text to the section and the introductory text to paragraph (b) are republished, paragraph (b)(2) is revised, and paragraph (c) is added to read as follows:

§ 414.30 Conversion factor update.

Unless Congress acts in accordance with section 1848(d)(3) of the Act—

* * * * *

(b) *Downward adjustment.* The downward adjustment may not exceed the following:

* * * * *

(2) For CY 1994, 2.5 percentage points.

* * * * *

(c) For CYs 1995 and thereafter, 5 percentage points.

5. In § 414.32, the introductory text to paragraph (d) is republished and paragraph (d)(2) is revised to read as follows:

§ 414.32 Determining payments for certain physician services furnished in facility settings.

* * * * *

(d) *Services excluded from the reduction.* The reduction established under this section does not apply to the following:

* * * * *

(2) Surgical services not on the ambulatory surgical center covered list of procedures published under § 416.65(c) of this chapter when furnished in an ambulatory surgical center.

* * * * *

§ 414.46 [Amended]

6. In § 414.46, the following changes are made:

a. The word “procedure” in paragraph (g) is removed, and the word “service” is added in its place. The word “procedures” in paragraphs (a)(1), (e) and (g) is removed, and the word “services” is added in its place.

b. Paragraphs (b), (c), and (d) are revised to read as follows:

§ 414.46 Additional rules for payment of anesthesia services.

* * * * *

(b) *Determination of payment amount—Basic rule.* For anesthesia services performed, medically directed, or medically supervised by a physician, HCFA pays the lesser of the actual charge or the anesthesia fee schedule amount.

(1) The physician fee schedule amount for an anesthesia service is based on the product of the allowable base and time units and an anesthesia-specific CF.

(2) The allowable base units are determined by the uniform relative value guide based on the 1988 American Society of Anesthesiologists' Relative Value Guide except that the number of base units recognized for anesthesia services furnished during cataract or iridectomy surgery is four units. The

uniform base units are identified in program operating instructions.

(3) Modifier units are not allowed. Modifier units include additional units charged by a physician or a CRNA for patient health status, risk, age, or unusual circumstances.

(c) *Physician personally performs the anesthesia procedure.*

(1) HCFA considers an anesthesia service to be personally performed under any of the following circumstances:

(i) The physician performs the entire anesthesia service alone.

(ii) The physician establishes an attending physician relationship in one or two concurrent cases involving an intern or resident and the service was furnished before January 1, 1994.

(iii) The physician establishes an attending physician relationship in one case involving an intern or resident and the service was furnished on or after January 1, 1994 but prior to January 1, 1996. For services on or after January 1, 1996, the physician must be the teaching physician as defined in §§ 415.170 through 415.184 of this chapter.

(iv) The physician and the CRNA or AA are involved in a single case and the services of each are found to be medically necessary.

(v) The physician is continuously involved in a single case involving a student nurse anesthetist.

(vi) The physician is continuously involved in a single case involving a CRNA or AA and the service was furnished prior to January 1, 1998.

(2) HCFA determines the fee schedule amount for an anesthesia service personally performed by a physician on the basis of an anesthesia-specific fee schedule CF and unreduced base units and anesthesia time units. One anesthesia time unit is equivalent to 15 minutes of anesthesia time, and fractions of a 15-minute period are recognized as fractions of an anesthesia time unit.

(d) *Anesthesia services medically directed by a physician.* (1) HCFA considers an anesthesia service to be medically directed by a physician if:

(i) The physician performs the activities described in § 415.110 of this chapter.

(ii) The physician directs qualified individuals involved in two, three, or four concurrent cases.

(iii) Medical direction can occur for a single case furnished on or after January 1, 1998 if the physician performs the activities described in § 415.110 of this

chapter and medically directs a single CRNA or AA.

(2) The rules for medical direction differ for certain time periods depending on the nature of the qualified individual who is directed by the physician. If more than two procedures are directed on or after January 1, 1994, the qualified individuals could be AAs, CRNAs, interns, or residents. The medical direction rules apply to student nurse anesthetists only if the physician directs two concurrent cases, each of which involves a student nurse anesthetist or the physician directs one case involving a student nurse anesthetist and the other involving a CRNA, AA, intern, or resident.

(3) Payment for medical direction is based on a specific percentage of the payment allowance recognized for the anesthesia service personally performed by a physician alone. The following percentages apply for the years specified:

(i) CY 1994—60 percent of the payment allowance for personally performed procedures.

(ii) CY 1995—57.5 percent of the payment allowance for personally performed services.

(iii) CY 1996—55 percent of the payment allowance for personally performed services.

(iv) CY 1997—52.5 percent of the payment allowance for personally performed services.

(v) CY 1998 and thereafter—50 percent of the payment allowance for personally performed services.

* * * * *

7. Section 414.60 is revised to read as follows:

§ 414.60 Payment for the services of CRNAs.

(a) *Basis for payment.* Beginning with CY 1994—

(1) The allowance for an anesthesia service furnished by a medically directed CRNA is based on a fixed percentage of the allowance recognized for the anesthesia service personally performed by the physician alone, as specified in § 414.46(d)(3); and

(2) The CF for an anesthesia service furnished by a CRNA not directed by a physician may not exceed the CF for a service personally performed by a physician.

(b) *To whom payment may be made.* Payment for an anesthesia service furnished by a CRNA may be made to the CRNA or to any individual or entity (such as a hospital, rural primary care hospital, physician, group practice, or

ambulatory surgical center) with which the CRNA has an employment or contract relationship that provides for payment to be made to the individual or entity.

(c) *Condition for payment.* Payment for the services of a CRNA may be made only on an assignment related basis, and any assignment accepted by a CRNA is binding on any other person presenting a claim or request for payment for the service.

Subpart H—[Removed and Reserved]

8. Subpart H, consisting of §§ 414.450 through 414.453, is removed and reserved.

E. A new part 415 is added to read as follows:

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

Subpart A—General Provisions

Sec.

415.1 Basis and scope.

Subpart B—Fiscal Intermediary Payments to Providers for Physician Services

415.50 Scope.

415.55 General payment rules.

415.60 Allocation of physician compensation costs.

415.70 Limits on compensation for physician services in providers.

Subpart C—Part B Carrier Payments for Physician Services to Beneficiaries in Providers

415.100 Scope.

415.102 Conditions for fee schedule payment for physician services to beneficiaries in providers.

415.105 Amounts of payment for physician services to beneficiaries in providers.

415.110 Conditions for payment: Anesthesiology services.

415.120 Conditions for payment: Radiology services.

415.130 Conditions for payment: Physician pathology services.

Subpart D—Physician Services in Teaching Settings

415.150 Scope.

415.152 Definitions.

415.160 Election of reasonable cost payment for direct medical and surgical services of physicians in teaching hospitals: General provisions.

415.162 Determining payment for physician services furnished to beneficiaries in teaching hospitals.

415.164 Payment to a fund.

415.170 Conditions for payment on a fee schedule basis for physician services in a teaching setting.

415.172 Physician fee schedule payment for services of teaching physicians.

415.174 Exception: Evaluation and management services furnished in certain centers.

415.176 Renal dialysis services.

415.178 Anesthesia services.

415.180 Teaching setting requirements for the interpretation of diagnostic radiology and other diagnostic tests.

415.184 Psychiatric services.

415.190 Conditions of payment: Assistants at surgery in teaching hospitals.

Subpart E—Services of Residents

415.200 Services of residents in approved GME programs.

415.202 Services of residents not in approved GME programs.

415.204 Services of residents in skilled nursing facilities and home health agencies.

415.206 Services of residents in nonprovider settings.

415.208 Services of moonlighting residents.

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

Subpart A—General Provisions

§ 415.1 Basis and scope.

(a) *Basis.* This part is based on the provisions of the following sections of the Act: Section 1848 establishes a fee schedule for payment for physician services. Section 1861(q) specifies what is included in the term “physician services” covered under Medicare. Section 1862(a)(14) sets forth the exclusion of nonphysician services furnished to hospital patients under Part B of Medicare. Section 1886(d)(5)(B) provides for a payment adjustment under the prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983, to account for the indirect costs of medical education. Section 1886(h) establishes the methodology for Medicare payment of the cost of direct GME activities.

(b) *Scope.* This part sets forth rules for fiscal intermediary payments to providers for physician services, Part B carrier payments for physician services to beneficiaries in providers, physician services in teaching settings, and services of residents.

Subpart B—Fiscal Intermediary Payments to Providers for Physician Services

§ 415.50 Scope.

This subpart sets forth rules for payment by fiscal intermediaries to providers for services furnished by

physicians. Payment for covered services is made either under the prospective payment system (PPS) to PPS-participating providers in accordance with part 412 of this chapter or under the reasonable cost method to non-PPS participating providers in accordance with part 413 of this chapter.

§ 415.55 General payment rules.

(a) *Allowable costs.* Except as specified otherwise in §§ 413.102 of this chapter (concerning compensation of owners), 415.60 (concerning allocation of physician compensation costs), and 415.162 (concerning payment for physician services furnished to beneficiaries in teaching hospitals), costs a provider incurs for services of physicians are allowable only if the following conditions are met:

(1) The services do not meet the conditions in § 415.102(a) regarding fee schedule payment for services of physicians to a beneficiary in a provider.

(2) The services include a surgeon's supervision of services of a qualified anesthetist, but do not include physician availability services, except for reasonable availability services furnished for emergency rooms and the services of standby surgical team physicians.

(3) The provider has incurred a cost for salary or other compensation it furnished the physician for the services.

(4) The costs incurred by the provider for the services meet the requirements in § 413.9 of this chapter regarding costs related to patient care.

(5) The costs do not include supervision of interns and residents unless the provider elects reasonable cost payment as specified in § 415.160, or any other costs incurred in connection with an approved GME program that are payable under § 413.86 of this chapter.

(b) *Allocation of allowable costs.* The provider must follow the rules in § 415.60 regarding allocation of physician compensation costs to determine its costs of services.

(c) *Limits on allowable costs.* The intermediary must apply the limits on compensation set forth in § 415.70 to determine its payments to a provider for the costs of services.

§ 415.60 Allocation of physician compensation costs.

(a) *Definition.* For purposes of this subpart, *physician compensation costs* means monetary payments, fringe

benefits, deferred compensation, and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician services. Other organizations are entities related to the provider within the meaning of § 413.17 of this chapter or entities that furnish services for the provider under arrangements within the meaning of the Act.

(b) *General rule.* Except as provided in paragraph (d) of this section, each provider that incurs physician compensation costs must allocate those costs, in proportion to the percentage of total time that is spent in furnishing each category of services, among—

(1) Physician services to the provider (as described in § 415.55);

(2) Physician services to patients (as described in § 415.102); and

(3) Activities of the physician, such as funded research, that are not paid under either Part A or Part B of Medicare.

(c) *Allowable physician compensation costs.* Only costs allocated to payable physician services to the provider (as described in § 415.55) are allowable costs to the provider under this subpart.

(d) *Allocation of all compensation to services to the provider.* Generally, the total physician compensation received by a physician is allocated among all services furnished by the physician, unless—

(1) The provider certifies that the compensation is attributable solely to the physician services furnished to the provider; and

(2) The physician bills all patients for the physician services he or she furnishes to them and personally receives the payment from or on behalf of the patients. If returned directly or indirectly to the provider or an organization related to the provider within the meaning of § 413.17 of this chapter, these payments are not compensation for physician services furnished to the provider.

(e) *Assumed allocation of all compensation to beneficiary services.* If the provider and physician agree to accept the assumed allocation of all the physician services to direct services to beneficiaries as described under § 415.102(a), HCFA does not require a written allocation agreement between the physician and the provider.

(f) *Determination and payment of allowable physician compensation costs.* (1) Except as provided under paragraph (e) of this section, the

intermediary pays the provider for these costs only if—

(i) The provider submits to the intermediary a written allocation agreement between the provider and the physician that specifies the respective amounts of time the physician spends in furnishing physician services to the provider, physician services to patients, and services that are not payable under either Part A or Part B of Medicare; and

(ii) The compensation is reasonable in terms of the time devoted to these services.

(2) In the absence of a written allocation agreement, the intermediary assumes, for purposes of determining reasonable costs of the provider, that 100 percent of the physician compensation cost is allocated to services to beneficiaries as specified in paragraph (b)(2) of this section.

(g) *Recordkeeping requirements.*

Except for services furnished in accordance with the assumed allocation under paragraph (e) of this section, each provider that claims payment for services of physicians under this subpart must meet all of the following requirements:

(1) Maintain the time records or other information it used to allocate physician compensation in a form that permits the information to be validated by the intermediary or the carrier.

(2) Report the information on which the physician compensation allocation is based to the intermediary or the carrier on an annual basis and promptly notify the intermediary or carrier of any revisions to the compensation allocation.

(3) Retain each physician compensation allocation, and the information on which it is based, for at least 4 years after the end of each cost reporting period to which the allocation applies.

§ 415.70 Limits on compensation for physician services in providers.

(a) *Principle and scope.* (1) Except as provided in paragraphs (a)(2) and (a)(3) of this section, HCFA establishes reasonable compensation equivalency limits on the amount of compensation paid to physicians by providers. These limits are applied to a provider's costs incurred in compensating physicians for services to the provider, as described in § 415.55(a).

(2) Limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services that are paid for under the prospective

payment system implemented under part 412 of this chapter or to costs of physician compensation attributable to approved GME programs that are payable under § 413.86 of this chapter.

(3) Compensation that a physician receives for activities that may not be paid for under either Part A or Part B of Medicare is not considered in applying these limits.

(b) *Methodology for establishing limits.* HCFA establishes a methodology for determining annual reasonable compensation equivalency limits and, to the extent possible, considers average physician incomes by specialty and type of location using the best available data.

(c) *Application of limits.* If the level of compensation exceeds the limits established under paragraph (b) of this section, Medicare payment is based on the level established by the limits.

(d) *Adjustment of the limits.* The intermediary may adjust limits established under paragraph (b) of this section to account for costs incurred by the physician or the provider related to malpractice insurance, professional memberships, and continuing medical education.

(1) For the costs of membership in professional societies and continuing medical education, the intermediary may adjust the limit by the lesser of—

(i) The actual cost incurred by the provider or the physician for these activities; or

(ii) Five percent of the appropriate limit.

(2) For the cost of malpractice expenses incurred by either the provider or the physician, the intermediary may adjust the reasonable compensation equivalency limit by the cost of the malpractice insurance expense related to the physician service furnished to patients in providers.

(e) *Exception to limits.* An intermediary may grant a provider an exception to the limits established under paragraph (b) of this section only if the provider can demonstrate to the intermediary that it is unable to recruit or maintain an adequate number of physicians at a compensation level within these limits.

(f) *Notification of changes in methodologies and payment limits.* (1) Before the start of a cost reporting period to which limits established under this section will be applied, HCFA publishes a notice in the Federal Register that sets forth the amount of the limits and explains how it calculated the limits.

(2) If HCFA proposes to revise the methodology for establishing payment limits under this section, HCFA publishes a notice, with opportunity for public comment, in the Federal Register. The notice explains the proposed basis and methodology for setting limits, specifies the limits that would result, and states the date of implementation of the limits.

(3) If HCFA updates limits by applying the most recent economic index data without revising the limit methodology, HCFA publishes the revised limits in a notice in the Federal Register without prior publication of a proposal or public comment period.

Subpart C—Part B Carrier Payments for Physician Services to Beneficiaries in Providers

§ 415.100 Scope.

This subpart implements section 1887(a)(1)(A) of the Act by providing general conditions that must be met in order for services furnished by physicians to beneficiaries in providers to be paid for on the basis of the physician fee schedule under part 414 of this chapter. Section 415.102 sets forth the conditions for fee schedule payment for physician services to beneficiaries in providers. Section 415.105 sets forth general requirements for determining the amounts of payment for services that meet the conditions of this section. Sections 415.120 and 415.130 set forth additional conditions for payment for physician services in the specialties of radiology and pathology (laboratory services).

§ 415.102 Conditions for fee schedule payment for physician services to beneficiaries in providers.

(a) *General rule.* If the physician furnishes services to beneficiaries in providers, the carrier pays on a fee schedule basis provided the following requirements are met:

(1) The services are personally furnished for an individual beneficiary by a physician.

(2) The services contribute directly to the diagnosis or treatment of an individual beneficiary.

(3) The services ordinarily require performance by a physician.

(4) In the case of radiology or laboratory services, the additional requirements in § 415.120 or § 415.130, respectively, are met.

(b) *Exception.* If a physician furnishes services in a provider that do not meet the requirements in paragraph (a) of this

section, but are related to beneficiary care furnished by the provider, the intermediary pays for those services, if otherwise covered. The intermediary follows the rules in §§ 415.55 and 415.60 for payment on the basis of reasonable cost or PPS, as appropriate.

(c) *Effect of billing charges for physician services to a provider.*

(1) If a physician furnishes services that may be paid under the reasonable cost rules in § 415.55 or § 415.60, and paid by the intermediary, or would be paid under those rules except for the PPS rules in part 412 of this chapter, and under the payment rules for GME established by § 413.86 of this chapter, neither the provider nor the physician may seek payment from the carrier, beneficiary, or another insurer.

(2) If a physician furnishes services to an individual beneficiary that do not meet the applicable conditions in §§ 415.120 (concerning conditions for payment for radiology services) and 415.130 (concerning conditions for payment for physician pathology services), the carrier does not pay on a fee schedule basis.

(3) If the physician, the provider, or another entity bills the carrier or the beneficiary or another insurer for physician services furnished to the provider, as described in § 415.55(a), HCFA considers the provider to which the services are furnished to have violated its provider participation agreement, and may terminate that agreement. See part 489 of this chapter for rules governing provider agreements.

(d) *Effect of physician assumption of operating costs.* If a physician or other entity enters into an agreement (such as a lease or concession) with a provider, and the physician (or entity) assumes some or all of the operating costs of the provider department in which the physician furnishes physician services, the following rules apply:

(1) If the conditions set forth in paragraph (a) of this section are met, the carrier pays for the physician services under the physician fee schedule in part 414 of this chapter.

(2) To the extent the provider incurs a cost payable on a reasonable cost basis under part 413 of this chapter, the intermediary pays the provider on a reasonable cost basis for the costs associated with producing these services, including overhead, supplies, equipment costs, and services furnished by nonphysician personnel.

(3) The physician (or other entity) is treated as being related to the provider within the meaning of § 413.17 of this

chapter (concerning cost to related organizations).

(4) The physician (or other entity) must make its books and records available to the provider and the intermediary as necessary to verify the nature and extent of the costs of the services furnished by the physician (or other entity).

§ 415.105 Amounts of payment for physician services to beneficiaries in providers.

(a) *General rule.* The carrier determines amounts of payment for physician services to beneficiaries in providers in accordance with the general rules governing the physician fee schedule payment in part 414 of this chapter, except as provided in paragraph (b) of this section.

(b) *Application in certain settings—(1) Teaching hospitals.* The carrier applies the rules in subpart D of this part (concerning physician services in teaching settings), in addition to those in this section, in determining whether fee schedule payment should be made for physician services to individual beneficiaries in a teaching hospital.

(2) *Hospital-based ESRD facilities.* The carrier applies §§ 414.310 through 414.314 of this chapter, which set forth determination of reasonable charges under the ESRD program, to determine the amount of payment for physician services furnished to individual beneficiaries in a hospital-based ESRD facility approved under part 405 subpart U.

§ 415.110 Conditions for payment: Anesthesiology services.

(a) *Services furnished directly or concurrently.* The carrier pays a physician for anesthesia services furnished to patients in a provider on a fee schedule basis only if the services meet the conditions in § 415.102(a) and the following additional conditions:

- (1) For each patient, the physician—
 - (i) Performs a pre-anesthetic examination and evaluation;
 - (ii) Prescribes the anesthesia plan;
 - (iii) Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
 - (iv) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions;
 - (v) Monitors the course of anesthesia administration at frequent intervals;

(vi) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) Provides indicated post-anesthesia care.

(2) The physician performs the procedure personally or directs no more than four anesthesia procedures concurrently and does not perform any other services while he or she is directing the concurrent procedures.

(b) *Supervision of more than four procedures concurrently.* If a physician is involved in furnishing more than four procedures concurrently, or is performing other services while directing the concurrent procedures, the concurrent anesthesia services are physician services to the provider in which the procedures are performed. In these cases, the physician is not required to meet the criteria of paragraphs (a)(1)(iii) and (vii) of this section personally, but must ensure that a qualified individual performs any procedure in which the physician does not personally participate. In these cases, the intermediary pays for the services under the rules in §§ 415.55 and 415.60 on reasonable cost payment for physician services to providers or under the rules in part 412 of this chapter for payment under the prospective payment system.

§ 415.120 Conditions for payment: Radiology services.

(a) *Services to beneficiaries.* The carrier pays for radiology services furnished by a physician to a beneficiary on a fee schedule basis only if the services meet the conditions for fee schedule payment in § 415.102(a) and are identifiable, direct, and discrete diagnostic or therapeutic services furnished to an individual beneficiary, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures. The carrier pays for interpretations only if there is a written report prepared for inclusion in the patient's medical record maintained by the hospital.

(b) *Services to providers.* The carrier does not pay on a fee schedule basis for physician services to the provider (for example, administrative or supervisory services) or for provider services needed to produce the x-ray films or other items that are interpreted by the radiologist. However, the intermediary pays the provider for these services in accordance with § 415.55 for provider costs; § 415.102(d)(2) for costs incurred by a physician, such as under a lease or

concession agreement; or part 412 of this chapter for payment under PPS.

§ 415.130 Conditions for payment: Physician pathology services.

(a) *Physician pathology services.* The carrier pays for pathology services furnished by a physician to an individual beneficiary on a fee schedule basis only if the services meet the conditions for payment in § 415.102(a) and are one of the following services:

- (1) Surgical pathology services.
- (2) Specific cytopathology, hematology, and blood banking services that have been identified to require performance by a physician and are listed in program operating instructions.
- (3) Clinical consultation services that meet the requirements in paragraph (b) of this section.
- (4) Clinical laboratory interpretative services that meet the requirements of paragraphs (b)(1), (b)(3), and (b)(4) of this section and that are specifically listed in program operating instructions.

(b) *Clinical consultation services.* For purposes of this section, clinical consultation services must meet the following requirements:

- (1) Be requested by the beneficiary's attending physician.
 - (2) Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the beneficiary.
 - (3) Result in a written narrative report included in the beneficiary's medical record.
 - (4) Require the exercise of medical judgment by the consultant physician.
- (c) *Physician pathology services furnished by an independent laboratory.* Laboratory services, including the technical component of a service, furnished to a hospital inpatient or outpatient by an independent laboratory are paid on a fee schedule basis under this subpart only if they are physician pathology services as described in paragraph (a) of this section.

Subpart D—Physician Services in Teaching Settings

§ 415.150 Scope.

This subpart sets forth the rules governing payment for the services of physicians in teaching settings and the criteria for determining whether the payments are made as one of the following:

- (a) Services to the hospital under the reasonable cost election in §§ 415.160 through 415.164.

(b) Provider services through the direct GME payment mechanism in § 413.86 of this chapter.

(c) Physician services to beneficiaries under the physician fee schedule as set forth in part 414 of this chapter.

§ 415.152 Definitions.

As used in this subpart—

Approved graduate medical education (GME) program means a residency program approved by the Accreditation Council for Graduate Medical Education of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Council on Dental Education of the American Dental Association, or by the Council on Podiatric Medicine Education of the American Podiatric Medical Association.

Direct medical and surgical services means services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital making the cost election described in §§ 415.160 through 415.162.

Nonprovider setting means a setting other than a hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility in which residents furnish services. These include, but are not limited to, family practice or multispecialty clinics and physician offices.

Resident means one of the following:

(1) An individual who participates in an approved GME program, including programs in osteopathy, dentistry, and podiatry.

(2) A physician who is not in an approved GME program, but who is authorized to practice only in a hospital, for example, individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools. For purposes of this subpart, the term *resident* is synonymous with the terms *intern* and *fellow*.

Teaching hospital means a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

Teaching physician means a physician (other than another resident) who involves residents in the care of his or her patients.

Teaching setting means any provider, hospital-based provider, or nonprovider settings in which Medicare payment for the services of residents is made under

the direct GME payment provisions of § 413.86, or on a reasonable-cost basis under the provisions of § 409.26 or § 409.40(f) for resident services furnished in skilled nursing facilities or home health agencies, respectively.

§ 415.160 Election of reasonable cost payment for direct medical and surgical services of physicians in teaching hospitals: General provisions.

(a) *Scope.* A teaching hospital may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments that might otherwise be made for these services.

(b) *Conditions.* A teaching hospital may elect to receive these payments only if—

(1) The hospital notifies its intermediary in writing of the election and meets the conditions of either paragraph (b)(2) or paragraph (b)(3) of this section;

(2) All physicians who furnish services to Medicare beneficiaries in the hospital agree not to bill charges for these services; or

(3) All physicians who furnish services to Medicare beneficiaries in the hospital are employees of the hospital and, as a condition of employment, are precluded from billing for these services.

(c) *Effect of election.* If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to beneficiaries—

(1) Those services and the supervision of interns and residents furnishing care to individual beneficiaries are covered as hospital services, and

(2) The intermediary pays the hospital for those services on a reasonable cost basis under the rules in § 415.162.

(Payment for other physician compensation costs related to approved GME programs is made as described in § 413.86 of this chapter.)

(d) *Election declined.* If the teaching hospital does not make this election, payment is made—

(1) For physician services furnished to beneficiaries on a fee schedule basis as described in part 414 subject to the rules in this subpart, and

(2) For the supervision of interns and residents as described in § 413.86.

§ 415.162 Determining payment for physician services furnished to beneficiaries in teaching hospitals.

(a) *General rule.* Payments for direct medical and surgical services of

physicians furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries is made by Medicare on the basis of reasonable cost if the hospital exercises the election as provided for in § 415.160. If this election is made, the following occurs:

(1) Physician services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries are paid on a reasonable-cost basis, as provided for in paragraph (b) of this section.

(2) Payment for certain medical school costs may be made as provided for in paragraph (c) of this section.

(3) Payments for services donated by volunteer physicians to beneficiaries are made to a fund designated by the organized medical staff of the teaching hospital or medical school as provided for in paragraph (d) of this section.

(b) *Reasonable cost of physician services and supervision of interns and residents.*

(1) Physician services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries in a teaching hospital are payable as provider services on a reasonable-cost basis.

(2) For purposes of this paragraph, *reasonable cost* is defined as the direct salary paid to these physicians, plus applicable fringe benefits.

(3) The costs must be allocated to the services as provided by paragraph (j) of this section and apportioned to program beneficiaries as provided by paragraph (g) of this section.

(4) Other allowable costs incurred by the provider related to the services described in this paragraph are payable subject to the requirements applicable to all other provider services.

(c) *Reasonable costs for the services furnished by a medical school or related organization in a hospital.* An amount is payable to the hospital by HCFA under the Medicare program provided that the costs would be payable if incurred directly by the hospital rather than under the arrangement. The amount must not be in excess of the reasonable costs (as defined in paragraphs (c)(1) and (c)(2) of this section) incurred by a teaching hospital for services furnished by a medical school or organization as described in § 413.17 of this chapter for certain costs to the medical school (or a related organization) in furnishing services in the hospital.

(1) *Reasonable costs of physician services.*

(i) *When the medical school and the hospital are related organizations.* If the

medical school (or organization related to the medical school) and the hospital are related by common ownership or control as described in § 413.17 of this chapter—

(A) The costs of these services are allowable costs to the hospital under the provisions of § 413.17 of this chapter; and

(B) The reimbursable costs to the hospital are determined under the provisions of this section in the same manner as the costs incurred for physicians on the hospital staff and without regard to payments made to the medical school by the hospital.

(ii) *When the medical school and the hospital are not related organizations.*

(A) If the medical school and the hospital are not related organizations under the provisions of § 413.17 of this chapter and the hospital makes payment to the medical school for the costs of those services furnished to all patients, payment is made by Medicare to the hospital for the reasonable cost incurred by the hospital for its payments to the medical school for services furnished to beneficiaries.

(B) Costs incurred under an arrangement must be allocated to the full range of services furnished to the hospital by the medical school physicians on the same basis as provided for under paragraph (j) of this section, and costs allocated to direct medical and surgical services furnished to hospital patients must be apportioned to beneficiaries as provided for under paragraph (g) of this section.

(C) If the medical school and the hospital are not related organizations under the provisions of § 413.17 of this chapter and the hospital makes payment to the medical school only for the costs of those services furnished to beneficiaries, costs of the medical school not to exceed 105 percent of the sum of physician direct salaries, applicable fringe benefits, employer's portion of FICA taxes, Federal and State unemployment taxes, and workmen's compensation paid by the medical school or an organization related to the medical school may be recognized as allowable costs of the medical school.

(D) These allowable medical school costs must be allocated to the full range of services furnished by the physicians of the medical school or organization related as provided by paragraph (j) of this section.

(E) Costs allocated to direct medical and surgical services furnished to hospital patients must be apportioned to

beneficiaries as provided by paragraph (g) of this section.

(2) *Reasonable costs of other than direct medical and surgical services.*

These costs are determined in accordance with paragraph (c)(1) of this section except that—

(i) If the hospital makes payment to the medical school for other than direct medical and surgical services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries, these payments are subject to the required cost-finding and apportionment methods applicable to the cost of other hospital services (except for direct medical and surgical services furnished to beneficiaries); or

(ii) If the hospital makes payment to the medical school only for these services furnished to beneficiaries, the cost of these services is not subject to cost-finding and apportionment as otherwise provided by this subpart, and the reasonable cost paid by Medicare must be determined on the basis of the health insurance ratio(s) used in the apportionment of all other provider costs (excluding physician direct medical and surgical services furnished to beneficiaries) applied to the allowable medical school costs incurred by the medical school for the services furnished to all patients of the hospital.

(d) *“Salary equivalent” payments for direct medical and surgical services furnished by physicians on the voluntary staff of the hospital.*

(1) HCFA makes payments under the Medicare program to a fund as defined in § 415.164 for direct medical and surgical services furnished to beneficiaries on a regularly scheduled basis by physicians on the unpaid voluntary medical staff of the hospital (or medical school under arrangement with the hospital).

(i) These payments represent compensation for contributed medical staff time which, if not contributed, would have to be obtained through employed staff on a payable basis.

(ii) Payments for volunteer services are determined by applying to the regularly scheduled contributed time an hourly rate not to exceed the equivalent of the average direct salary (exclusive of fringe benefits) paid to all full-time, salaried physicians (other than interns and residents) on the hospital staff or, if the number of full-time salaried physicians is minimal in absolute terms or in relation to the number of physicians on the voluntary staff, to physicians at like institutions in the area.

(iii) This “salary equivalent” is a single hourly rate covering all physicians regardless of specialty and is applied to the actual regularly scheduled time contributed by the physicians in furnishing direct medical and surgical services to beneficiaries including supervision of interns and residents in that care.

(iv) A physician who receives any compensation from the hospital or a medical school related to the hospital by common ownership or control (within the meaning of § 413.17 of this chapter) for direct medical and surgical services furnished to any patient in the hospital is not considered an unpaid voluntary physician for purposes of this paragraph.

(v) If, however, a physician receives compensation from the hospital or related medical school or organization only for services that are other than direct medical and surgical services, a salary equivalent payment for the physician's regularly scheduled direct medical and surgical services to beneficiaries in the hospital may be imputed. However, the sum of the imputed value for volunteer services and the physician's actual compensation from the hospital and the related medical school (or organization) may not exceed the amount that would have been imputed if all of the physician's hospital and medical school services (compensated and volunteer) had been volunteer services, or paid at the rate of \$30,000 per year, whichever is less.

(2) The following examples illustrate how the allowable imputed value for volunteer services is determined. In each example, it has been assumed that the average salary equivalent hourly rate is equal to the hourly rate for the individual physician's compensated services.

Example No. 1. Dr. Jones received \$3,000 a year from Hospital X for services other than direct medical services to all patients, for example, utilization review and administrative services. Dr. Jones also voluntarily furnished direct medical services to beneficiaries. The imputed value of the volunteer services amounted to \$10,000 for the cost reporting period. The full imputed value of Dr. Jones' volunteer direct medical services would be allowed since the total amount of the imputed value (\$10,000) and the compensated services (\$3,000) does not exceed \$30,000.

Example No. 2. Dr. Smith received \$25,000 from Hospital X for services as a department head in a teaching hospital. Dr. Smith also voluntarily furnished direct medical services to beneficiaries. The imputed value of the

volunteer services amounted to \$10,000. Only \$5,000 of the imputed value of volunteer services would be allowed since the total amount of the imputed value (\$10,000) and the compensated services (\$25,000) exceeds the \$30,000 maximum amount allowable for all of Dr. Smith's services.

Computation:

Maximum amount allowable for all services performed by Dr. Smith for purposes of this computation	\$30,000
Less compensation received from Hospital X for other than direct medical services to individual patients	\$25,000
Allowable amount of imputed value for the volunteer services furnished by Dr. Smith	\$5,000

Example No. 3. Dr. Brown is not compensated by Hospital X for any services furnished in the hospital. Dr. Brown voluntarily furnished direct surgical services to beneficiaries for a period of 6 months, and the imputed value of these services amounted to \$20,000. The allowable amount of the imputed value for volunteer services furnished by Dr. Brown would be limited to \$15,000 (\$30,000 x 6/12).

(3) The amount of the imputed value for volunteer services applicable to beneficiaries and payable to a fund is determined in accordance with the aggregate per diem method described in paragraph (g) of this section.

(4) Medicare payments to a fund must be used by the fund solely for improvement of care of hospital patients or for educational or charitable purposes (which may include but are not limited to medical and other scientific research).

(i) No personal financial gain, either direct or indirect, from benefits of the fund may inure to any of the hospital staff physicians, medical school faculty, or physicians for whom Medicare imputes costs for purposes of payment into the fund.

(ii) Expenses met from contributions made to the hospital from a fund are not included as a reimbursable cost when expended by the hospital, and depreciation expense is not allowed with respect to equipment or facilities donated to the hospital by a fund or purchased by the hospital from monies in a fund.

(e) *Requirements for payment—(1) Physicians on the hospital staff.* The requirements under which the costs of physician direct medical and surgical services (including supervision of interns and residents) to beneficiaries are the same as those applicable to the

cost of all other covered provider services except that the costs of these services are separately determined as provided by this section and are not subject to cost-finding as described in § 413.24 of this chapter.

(2) *Physicians on the medical school faculty.* Payment is made to a hospital for the costs of services of physicians on the medical school faculty, provided that if the medical school is not related to the hospital (within the meaning of § 413.17 of this chapter, concerning cost to related organizations), the hospital does not make payment to the medical school for services furnished to all patients and the following requirements are met: If the hospital makes payment to the medical school for services furnished to all patients, these requirements do not apply. (See paragraph (c)(1)(ii) of this section.)

(i) There is a written agreement between the hospital and the medical school or organization, specifying the types and extent of services to be furnished by the medical school and specifying that the hospital must pay to the medical school an amount at least equal to the reasonable cost (as defined in paragraph (c) of this section) of furnishing the services to beneficiaries.

(ii) The costs are paid to the medical school by the hospital no later than the date on which the cost report covering the period in which the services were furnished is due to HCFA.

(iii) Payment for the services furnished under an arrangement would have been made to the hospital had the services been furnished directly by the hospital.

(3) *Physicians on the voluntary staff of the hospital (or medical school under arrangement with the hospital).* If the conditions for payment to a fund outlined in § 415.164 are met, payments are made on a "salary equivalent" basis (as defined in paragraph (d) of this section) to a fund.

(f) *Requirements for payment for medical school faculty services other than physician direct medical and surgical services.* If the requirements for payment for physician direct medical and surgical services furnished to beneficiaries in a teaching hospital described in paragraph (e) of this section are met, payment is made to a hospital for the costs of medical school faculty services other than physician direct medical and surgical services furnished in a teaching hospital.

(g) *Aggregate per diem methods of apportionment—(1) For the costs of physician direct medical and surgical*

services. The cost of physician direct medical and surgical services furnished in a teaching hospital to beneficiaries is determined on the basis of an average cost per diem as defined in paragraph (h)(1) of this section for physician direct medical and surgical services to all patients (see §§ 415.172 through 415.184) for each of the following categories of physicians:

(i) Physicians on the hospital staff.

(ii) Physicians on the medical school faculty.

(2) *For the imputed value of physician volunteer direct medical and surgical services.* The imputed value of physician direct medical and surgical services furnished to beneficiaries in a teaching hospital is determined on the basis of an average per diem, as defined in paragraph (h)(1) of this section, for physician direct medical and surgical services to all patients except that the average per diem is derived from the imputed value of the physician volunteer direct medical and surgical services furnished to all patients.

(h) *Definitions.* (1) *Average cost per diem for physician direct medical and surgical services (including supervision of interns and residents) furnished in a teaching hospital to patients in each category of physician services described in paragraph (g)(1) of this section* means the amount computed by dividing total reasonable costs of these services in each category by the sum of—

(i) Inpatient days (as defined in paragraph (h)(2) of this section); and

(ii) Outpatient visit days (as defined in paragraph (h)(3) of this section).

(2) *Inpatient days* are determined by counting the day of admission as 3.5 days and each day after a patient's day of admission, except the day of discharge, as 1 day.

(3) *Outpatient visit days* are determined by counting only one visit day for each calendar day that a patient visits an outpatient department or multiple outpatient departments.

(i) *Application.* (1) The following illustrates how apportionment based on the aggregate per diem method for costs of physician direct medical and surgical services furnished in a teaching hospital to patients is determined.

Teaching Hospital Y

Statistical and financial data:

Total inpatient days as defined in paragraph (h)(2) of this section and outpatient visit days as defined in paragraph (h)(3) of this section	75,000

Total inpatient Part A days	20,000	<i>Example:</i> The physicians on the medical staff of Teaching Hospital Y donated a total of 5,000 hours in furnishing direct medical and surgical services to patients of the hospital during a cost reporting period and did not receive any compensation from either the hospital or the medical school. Also, the imputed value for any physician volunteer services did not exceed the rate of \$30,000 per year per physician.
Total inpatient Part B days where Part A coverage is not available	1,000	Statistical and financial data:
Total outpatient Part B visit days	5,000	Total salaries paid to the full-time salaried physicians by the hospital (excluding interns and residents)
Total cost of direct medical and surgical services furnished to all patients by physicians on the hospital staff as determined in accordance with paragraph (i) of this section	\$1,500,000	\$800,000
Total cost of direct medical and surgical services furnished to all patients by physicians on the medical school faculty as determined in accordance with paragraph (i) of this section	\$1,650,000	Total physicians who were paid for an average of 40 hours per week or 2,080 (52 weeks x 40 hours per week) hours per year
Computation of cost applicable to program for physicians on the hospital staff:		20
Average cost per diem for direct medical and surgical services to patients by physicians on the hospital staff: \$1,500,000 ÷ 75,000 = \$20 per diem.		Average hourly rate equivalent: \$800,000 ÷ 41,600 (2,080 × 20)
Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part A: \$20 per diem × 20,000	\$400,000	\$19.23
Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part B: \$20 per diem × 1,000	\$20,000	Computation of total imputed value of physician volunteer services applicable to all patients:
Cost of physician direct medical and surgical services furnished to outpatient beneficiaries covered under Part B: \$20 per diem × 5,000	\$100,000	(Total donated hours × average hourly rate equivalent):
Computation of cost applicable to program for physicians on the medical school faculty:		5,000 × \$19.23
Average cost per diem for direct medical and surgical services to patients by physicians on the medical school faculty: \$1,650,000 ÷ 75,000 = \$22 per diem.		\$96,150
Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part A: \$22 per diem × 20,000	\$440,000	Total inpatient days (as defined in paragraph (h)(2) of this section) and outpatient visit days (as defined in paragraph (h)(3) of this section)
Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part B: \$22 per diem × 1,000	\$22,000	75,000
Cost of physician direct medical and surgical services furnished to outpatient beneficiaries covered under Part B: \$22 per diem × 5,000	\$110,000	20,000
(2) The following illustrates how the imputed value of physician volunteer direct medical and surgical services furnished in a teaching hospital to beneficiaries is determined.		Total inpatient Part A days
		Total inpatient Part B days if Part A coverage is not available
		1,000
		Total outpatient Part B visit days
		5,000
		Computation of imputed value of physician volunteer direct medical and surgical services furnished to Medicare beneficiaries:
		Average per diem for physician direct medical and surgical services to all patients: \$96,150 ÷ 75,000 = \$1.28 per diem
		Imputed value of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part A: \$1.28 per diem × 20,000
		\$25,600
		Imputed value of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part B: \$1.28 per diem × 1,000
		\$1,280
		Imputed value of physician direct medical and surgical services furnished to outpatient beneficiaries covered under Part B: \$1.28 per diem × 5,000
		\$6,400
		Total
		\$33,280

(j) *Allocation of compensation paid to physicians in a teaching hospital.*

(1) In determining reasonable cost under this section, the compensation paid by a teaching hospital, or a medical school or related organization under arrangement with the hospital, to physicians in a teaching hospital must be allocated to the full range of services implicit in the physician compensation arrangements. (However, see paragraph (d) of this section for the computation of the "salary equivalent" payments for volunteer services furnished to patients.)

(2) This allocation must be made and must be capable of substantiation on the basis of the proportion of each physician's time spent in furnishing each type of service to the hospital or medical school.

§ 415.164 Payment to a fund.

(a) *General rules.* Payment for certain voluntary services by physicians in teaching hospitals (as these services are described in § 415.160) is made on a salary equivalent basis (as described in § 415.162(d)) subject to the conditions and limitations contained in parts 405 and 413 of this chapter and this part 415, to a single fund (as defined in paragraph (b) of this section) designated by the organized medical staff of the hospital (or, if the services are furnished in the hospital by the faculty of a medical school, to a fund as may be designated by the faculty), if the following conditions are met:

(1) The hospital (or medical school furnishing the services under arrangement with the hospital) incurs no actual cost in furnishing the services.

(2) The hospital has an agreement with HCFA under part 489 of this chapter.

(3) The intermediary, or HCFA as appropriate, has received written assurances that—

(i) The payment is used solely for the improvement of care of hospital patients or for educational or charitable purposes; and

(ii) Neither the individuals who are furnished the services nor any other persons are charged for the services (and if charged, provision is made for the return of any monies incorrectly collected).

(b) *Definition of a fund.* For purposes of paragraph (a) of this section, a *fund* is an organization that meets either of the following requirements:

(1) The organization has and retains exemption, as a governmental entity or under section 501(c)(3) of the Internal Revenue Code (nonprofit educational, charitable, and similar organizations), from Federal taxation.

(2) The organization is an organization of physicians who, under the terms of their employment by an entity that meets the requirements of paragraph (b)(1) of this section, are required to turn over to that entity all income that the physician organization derives from the physician services.

(c) *Status of a fund.* A fund approved for payment under paragraph (a) of this section has all the rights and responsibilities of a provider under Medicare except that it does not enter into an agreement with HCFA under part 489 of this chapter.

§ 415.170 Conditions for payment on a fee schedule basis for physician services in a teaching setting.

Services meeting the conditions for payment in § 415.102(a) furnished in teaching settings are payable under the physician fee schedule if—

(a) The services are personally furnished by a physician who is not a resident; or

(b) The services are furnished by a resident in the presence of a teaching physician except as provided in § 415.172 (concerning physician fee schedule payment for services of teaching physicians), § 415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), § 415.176 (concerning renal dialysis services), and § 415.184 (concerning psychiatric services), as applicable.

§ 415.172 Physician fee schedule payment for services of teaching physicians.

(a) *General rule.* If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought.

(1) In the case of surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.

(i) In the case of surgery, the teaching physician's presence is not required

during opening and closing of the surgical field.

(ii) In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing.

(2) In the case of evaluation and management services, the teaching physician must be present during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of § 415.174 apply.)

(b) *Documentation.* Except for services furnished as set forth in §§ 415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), 415.176 (concerning renal dialysis services), and 415.184 (concerning psychiatric services), the medical records must document the teaching physician was present at the time the service is furnished. The presence of the teaching physician during procedures may be demonstrated by the notes in the medical records made by a physician, resident, or nurse. In the case of evaluation and management procedures, the teaching physician must personally document his or her participation in the service in the medical records.

(c) *Payment level.* In the case of services such as evaluation and management for which there are several levels of service codes available for reporting purposes, the appropriate payment level must reflect the extent and complexity of the service when fully furnished by the teaching physician.

§ 415.174 Exception: Evaluation and management services furnished in certain centers.

(a) In the case of certain evaluation and management codes of lower and mid-level complexity (as specified by HCFA in program instructions), carriers may make physician fee schedule payment for a service furnished by a resident without the presence of a teaching physician. For the exception to apply, all of the following conditions must be met:

(1) The services must be furnished in a center that is located in an outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining intermediary payments to a hospital under § 413.86.

(2) Any resident furnishing the service without the presence of a teaching physician must have completed more than 6 months of an approved residency program.

(3) The teaching physician must not direct the care of more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must—

(i) Have no other responsibilities at the time;

(ii) Assume management responsibility for those beneficiaries seen by the residents;

(iii) Ensure that the services furnished are appropriate;

(iv) Review with each resident during or immediately after each visit, the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies; and

(v) Document the extent of the teaching physician's participation in the review and direction of the services furnished to each beneficiary.

(4) The range of services furnished by residents in the center includes all of the following:

(i) Acute care for undifferentiated problems or chronic care for ongoing conditions.

(ii) Coordination of care furnished by other physicians and providers.

(iii) Comprehensive care not limited by organ system, diagnosis, or gender.

(5) The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians.

(b) Nothing in paragraph (a) of this section may be construed as providing a basis for the coverage of services not determined to be covered under Medicare, such as routine physical checkups.

§ 415.176 Renal dialysis services.

In the case of renal dialysis services, physicians who are not paid under the physician monthly capitation payment method (as described in § 414.314 of this chapter) must meet the requirements of §§ 415.170 and 415.172 (concerning physician fee schedule payment for services of teaching physicians).

§ 415.178 Anesthesia services.

(a) *General rule.* An unreduced physician fee schedule payment may be made if a physician is involved in a

single anesthesia procedure involving an anesthesia resident. In the case of anesthesia services, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. The teaching physician cannot receive an unreduced fee if he or she performs services involving other patients during the period the anesthesia resident is furnishing services in a single case. For additional rules for payment of anesthesia services involving residents, see § 414.46(c)(1)(iii)).

(b) *Documentation.* Documentation must indicate the physician's presence or participation in the administration of the anesthesia and a preoperative and postoperative visit by the physician.

§ 415.180 Teaching setting requirements for the interpretation of diagnostic radiology and other diagnostic tests.

(a) *General rule.* Physician fee schedule payment is made for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed or reviewed by a physician other than a resident.

(b) *Documentation.* Documentation must indicate that the physician personally performed the interpretation or reviewed the resident's interpretation with the resident.

§ 415.184 Psychiatric services.

To qualify for physician fee schedule payment for psychiatric services furnished under an approved GME program, the physician must meet the requirements of §§ 415.170 and 415.172, including documentation, except that the requirement for the presence of the teaching physician during the service in which a resident is involved may be met by observation of the service by use of a one-way mirror, video equipment, or similar device.

§ 415.190 Conditions of payment: Assistants at surgery in teaching hospitals.

(a) *Basis, purpose, and scope.* This section describes the conditions under which Medicare pays on a fee schedule basis for the services of an assistant at surgery in a teaching hospital. This section is based on section 1842(b)(7)(D)(I) of the Act and applies only to hospitals with an approved GME residency program. Except as specified in paragraph (c) of this section, fee schedule payment is not available for assistants at surgery in hospitals with—

(1) A training program relating to the medical specialty required for the surgical procedure; and

(2) A resident in a training program relating to the specialty required for the surgery available to serve as an assistant at surgery.

(b) *Definition.* *Assistant at surgery* means a physician who actively assists the physician in charge of a case in performing a surgical procedure.

(c) *Conditions for payment for assistants at surgery.* Payment on a fee schedule basis is made for the services of an assistant at surgery in a teaching hospital only if the services meet one of the following conditions:

(1) Are required as a result of exceptional medical circumstances.

(2) Are complex medical procedures performed by a team of physicians, each performing a discrete, unique function integral to the performance of a complex medical procedure that requires the special skills of more than one physician.

(3) Constitute concurrent medical care relating to a medical condition that requires the presence of, and active care by, a physician of another specialty during surgery.

(4) Are medically required and are furnished by a physician who is primarily engaged in the field of surgery, and the primary surgeon does not use interns and residents in the surgical procedures that the surgeon performs (including preoperative and postoperative care).

(5) Are not related to a surgical procedure for which HCFA determines that assistants are used less than 5 percent of the time.

Subpart E—Services of Residents

§ 415.200 Services of residents in approved GME programs.

(a) *General rules.* Services furnished in hospitals by residents in approved GME programs are specifically excluded from being paid as “physician services” defined in § 414.2 of this chapter and are payable as hospital services. This exclusion applies whether or not the resident is licensed to practice under the laws of the State in which he or she performs the service. The payment methodology for services of residents in hospitals and hospital-based providers is set forth in § 413.86 of this chapter.

(b) *Exception.* For low and mid-level evaluation and management services furnished under certain conditions in centers located in hospital outpatient

departments and other ambulatory settings, see § 415.174.

(c) *Definitions.* See § 415.152 for definitions of terms used in this subpart E.

§ 415.202 Services of residents not in approved GME programs.

(a) *General rules.* For services of a physician employed by a hospital who is authorized to practice only in a hospital setting and for the services of a resident who is not in any approved GME program, payment is made to the hospital on a Part B reasonable cost basis regardless of whether the services are furnished to hospital inpatients or outpatients.

(b) *Payment.* For services described in paragraph (a) of this section, payment is made under Part B by reducing the reasonable costs of furnishing the services by the beneficiary deductible and paying 80 percent of the remaining amount. No payment is made for other costs of unapproved programs, such as administrative costs related to teaching activities of physicians.

§ 415.204 Services of residents in skilled nursing facilities and home health agencies.

(a) *Medicare Part A payment.* Payment is made under Medicare Part A for interns' and residents' services furnished in the following settings that meet the specified requirements:

(1) *Skilled nursing facility.* Payment to a participating skilled nursing facility may include the cost of services of an intern or resident who is in an approved GME program in a hospital with which the skilled nursing facility has a transfer agreement that provides, in part, for the transfer of patients and the interchange of medical records.

(2) *Home health agency.* A participating home health agency may receive payment for the cost of the services of an intern or resident who is under an approved GME program of a hospital with which the home health agency is affiliated or under common control if these services are furnished as part of the home health visits for a Medicare beneficiary. (Nevertheless, see § 413.86 of this chapter for the costs of approved GME programs in hospital-based providers.)

(b) *Medicare Part B payment.* Medical services of a resident of a hospital that are furnished by a skilled nursing facility or home health agency are paid under Medicare Part B if payment is not provided under Medicare Part A. Payment is made under Part B for a resident's services by reducing the

reasonable costs of furnishing the services by the beneficiary deductible and paying 80 percent of the remaining amount.

§ 415.206 Services of residents in nonprovider settings.

Patient care activities of residents in approved GME programs that are furnished in nonprovider settings are payable in one of the following two ways:

(a) *Direct GME payments.* If the conditions in § 413.86(f)(1)(iii) regarding patient care activities and training of residents are met, the time residents spend in nonprovider settings such as clinics, nursing facilities, and physician offices in connection with approved GME programs is included in determining the number of full-time equivalency residents in the calculation of a teaching hospital's resident count. The teaching physician rules on carrier payments in §§ 415.170 through 415.184 apply in these teaching settings.

(b) *Physician fee schedule.* (1) Services furnished by a resident in a nonprovider setting are covered as physician services and payable under the physician fee schedule if the following requirements are met:

(i) The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry in the State in which the service is performed.

(ii) The time spent in patient care activities in the nonprovider setting is not included in a teaching hospital's full-time equivalency resident count for the purpose of direct GME payments.

(2) Payment may be made regardless of whether a resident is functioning within the scope of his or her GME program in the nonprovider setting.

(3) If fee schedule payment is made for the resident's services in a nonprovider setting, payment must not be made for the services of a teaching physician.

(4) The carrier must apply the physician fee schedule payment rules set forth in subpart A of part 414 of this chapter to payments for services furnished by a resident in a nonprovider setting.

§ 415.208 Services of moonlighting residents.

(a) *Definition.* For purposes of this section, the term *services of moonlighting residents* refers to services that licensed residents perform that are outside the scope of an approved GME program.

(b) *Services in GME program hospitals.* (1) The services of residents

to inpatients of hospitals in which the residents have their approved GME program are not covered as physician services and are payable under § 413.86 regarding direct GME payments.

(2) Services of residents that are not related to their approved GME programs and are performed in an outpatient department or emergency department of a hospital in which they have their training program are covered as physician services and payable under the physician fee schedule if all of the following criteria are met:

(i) The services are identifiable physician services and meet the conditions for payment of physician services to beneficiaries in providers in § 415.102(a).

(ii) The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed.

(iii) The services performed can be separately identified from those services that are required as part of the approved GME program.

(3) If the criteria specified in paragraph (b)(2) of this section are met, the services of the moonlighting resident are considered to have been furnished by the individual in his or her capacity as a physician, rather than in the capacity of a resident. The carrier must review the contracts and agreements for these services to ensure compliance with the criteria specified in paragraph (b)(2) of this section.

(4) No payment is made for services of a "teaching physician" associated with moonlighting services, and the time spent furnishing these services is not included in the teaching hospital's full-time equivalency count for the indirect GME payment (§ 412.105 of this chapter) and for the direct GME payment (§ 413.86 of this chapter).

(c) *Other settings.* Moonlighting services of a licensed resident in an approved GME program furnished outside the scope of that program in a hospital or other setting that does not participate in the approved GME program are payable under the physician fee schedule as set forth in § 415.206(b)(1).

F. Technical Amendments

PART 400—[AMENDED]

1. In § 400.310, the following changes are made:

a. The entries for §§ 405.481 and 405.552 are removed.

b. The table is amended by adding the following entries:

§ 400.310 Display of currently valid OMB control numbers.

Sections in 42 CFR that contain collections of information	Current OMB control numbers
* * *	* * *
415.60	0938-0301
415.162	0938-0301
* * *	* * *

PART 405—[AMENDED]

§ 405.502 [Amended]

2. In § 405.502(a)(10), the phrase "§ 405.580(c)(2) or (3)" is removed, and the phrase "§ 415.190(c)(2) or (c)(3) of this chapter" is added in its place.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

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

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

§ 411.15 [Amended]

4. In § 411.15(m)(2)(i), "§ 405.550(b)" is removed, and "§ 415.102(a)" is added in its place.

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

Authority: Secs. 1102, 1815(e), 1820, 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395g(e), 1395i-4, 1395hh, and 1395ww).

§ 412.50 [Amended]

6. In § 412.50, the following changes are made:

a. In paragraph (a), "§ 405.550(b)" is removed, and "§ 415.102(a)" is added in its place.

b. In paragraph (b), "§ 405.550(b)" is removed, and "§ 415.102(a)" is added in its place.

§ 412.71 [Amended]

7. In § 412.71(c)(1)(i), "§ 405.550(b)" is removed, and "§ 415.102(a)" is added in its place.

§ 412.105 [Amended]

8. In § 412.105(g)(1)(i)(A), "§ 405.522(a)" is removed, and "§ 415.200(a)" is added in its place.

PART 413—[AMENDED]

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

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

§ 413.5 [Amended]

10. In § 413.5(c)(9), the phrase “(as described in § 405.465 of this chapter) where elected as provided for in § 405.521 of this chapter.” is removed, and the phrase “(as described in § 415.162 of this chapter) if elected as provided for in § 415.160 of this chapter.” is added in its place.

§ 413.13 [Amended]

11. In § 413.13(g)(1)(i), the phrase “§§ 405.480 through 405.482” is removed, and the phrase “§§ 415.55 through 415.70” is added in its place.

§ 413.80 [Amended]

12. In § 413.80(h), the phrase “, as described in § 414.450 of this chapter,” is removed.

§ 413.86 [Amended]

13. In § 413.86, the following changes are made:

a. In paragraph (b), in the definition of “Approved medical residency program” in paragraph (1), “§ 405.522(a)” is removed, and “§ 415.200(a)” is added in its place.

b. In paragraph (g)(1)(ii), “§ 405.522(a)” is removed, and “§ 415.200(a)” is added in its place.

§ 413.174 [Amended]

14. In § 413.174(b)(4)(iv), the phrase “§§ 405.465 through 405.482” is removed, and the phrase “§§ 415.55 through 415.70, § 415.162, and § 415.164” is added in its place.

PART 414—[AMENDED]**§ 414.58 [Amended]**

15. In § 414.58, the following changes are made:

a. In paragraph (a), the phrase “§§ 405.550 through 405.580” is removed, and the phrase “§§ 415.100 through 415.130, and § 415.190” is added in its place.

b. In paragraph (b), the phrase “§ 405.465 of this chapter if the hospital exercises the election described in § 405.521(c)(2) of this chapter” is removed, and the phrase “§ 415.162 of this chapter if the hospital exercises the election described in § 415.160 of this chapter” is added in its place.

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

16. The authority citation for part 417 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), secs. 1301, 1306, and 1310 of the Public Health Service Act (42 U.S.C. 300e, 300e–5, and 300e–9); and 31 U.S.C. 9701.

§ 417.554 [Amended]

17. In § 417.554, the phrase “§ 405.480, part 412 of this chapter, and §§ 413.55 and 413.24” is removed, and the phrase “part 412, §§ 413.24, 413.55, and 415.55” is added in its place.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

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

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

§ 489.20 [Amended]

19. In § 489.20(d)(1), “§ 405.550(b)” is removed, and “§ 415.102(a)” is added in its place.

§ 489.21 [Amended]

20. In § 489.21(f), “§ 405.550(b)” is removed, and “§ 415.102(a)” is added in its place.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 28, 1995.

Bruce C. Vladeck,
Administrator, Health Care Financing Administration.

Dated: December 1, 1995.

Donna E. Shalala,
Secretary.

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

Addendum A—Explanation and Use of Addenda B Through E

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physician services furnished in 1995. Addendum B contains the RVUs for work, practice expense, and malpractice expense, and other information for all services included in the physician fee schedule. Addendum C provides interim RVUs and related information for codes that are subject to comment. Each code listed in Addendum C is also included in Addendum B. Further explanations of the information in these addenda are provided at the beginning of each addendum.

To compute a fee schedule amount according to the formula provided in the final rule, use the RVUs listed in Addendum B and the GPCIs for 1996 listed in Addendum D of this final rule. In applying the formula, use the appropriate CF: For services designated as surgical, use a CF of \$40.7986. For primary care services, use a CF of \$35.4173. For other nonsurgical services, use a CF of \$34.6293.

Addendum D lists the GPCIs for 1996.

Addendum E lists the procedure codes subject to the site-of-service differential.

Addendum B—1996 Relative Value Units and Related Information Used in Determining Medicare Payments for 1996

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

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

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

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

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

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

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

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

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

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

H = Deleted modifier. This code had TC and PC components in 1995. For 1996, these components are deleted.

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

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

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

—If the item or service is covered as other than incident to a physician service, it is excluded from the physician fee schedule (for example, colostomy supplies) and is

paid under the other payment provisions of the Act.

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

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

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

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

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 1996. Codes that are not used for Medicare payment are identified with a “#.”

6. *Practice expense RVUs.* These are the RVUs for the practice expense for the service for 1996. Codes that are subject to the OBRA 1993 practice expense reduction are identified by an asterisk in this column.

7. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 1996.

8. *Total RVUs.* This is the sum of the work, practice expense, and malpractice expense RVUs for 1996.

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

MMM = The code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1996 Physicians’ Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

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

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

10. *Update indicator.* This column indicates whether the update for surgical procedures, primary care services, or other nonsurgical services applies to the CPT/HCPCS code in column 1. A “0” appears in this field for codes that are deleted in 1996 or are not paid under the physician fee schedule. A “P” in this column indicates that the update and CF for primary care services applies to this code. An “N” in this column indicates that the update and CF for other nonsurgical services applies to this code. An “S” in this column indicates that the separate update and CF for surgical procedures applies.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physician work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
10040		A	Acne surgery of skin abscess	1.34	0.32	0.03	1.69	010	S
10060		A	Drainage of skin abscess	1.12	0.44	0.04	1.60	010	S
10061		A	Drainage of skin abscess	2.48	0.64	0.06	3.18	010	S
10080		A	Drainage of pilonidal cyst	1.62	0.50	0.05	2.17	010	N
10081		A	Drainage of pilonidal cyst	2.40	1.11	0.16	3.67	010	S
10120		A	Remove foreign body	1.19	0.46	0.05	1.70	010	S
10121		A	Remove foreign body	2.64	1.00	0.12	3.76	010	S
10140		A	Drainage of hematoma/fluid	1.48	0.48	0.05	2.01	010	S
10160		A	Puncture drainage of lesion	1.15	0.38	0.05	1.58	010	S
10180		A	Complex drainage, wound	2.20	1.05	0.18	3.43	010	S
11000		A	Surgical cleansing of skin	0.91	0.40	0.04	1.35	000	S
11001		A	Additional cleansing of skin	0.45	0.26	0.02	0.73	ZZZ	S
11040		A	Surgical cleansing, abrasion	0.50	0.40	0.04	0.94	000	S
11041		A	Surgical cleansing of skin	0.82	0.56	0.06	1.44	000	S
11042		A	Cleansing of skin/tissue	1.12	0.65	0.08	1.85	000	S
11043		A	Cleansing of tissue/muscle	1.83	1.81	0.34	3.98	010	S
11044		A	Cleansing tissue/muscle/bone	2.28	2.82	0.49	5.59	010	S
11050		A	Trim skin lesion	0.43	0.37	0.03	0.83	000	S
11051		A	Trim 2 to 4 skin lesions	0.66	0.50	0.05	1.21	000	S
11052		A	Trim over 4 skin lesions	0.86	0.41	0.04	1.31	000	S
11100		A	Biopsy of skin lesion	0.81	0.51	0.04	1.36	000	S
11101		A	Biopsy, each added lesion	0.41	0.29	0.02	0.72	ZZZ	S
11200		A	Removal of skin tags	0.69	0.43	0.04	1.16	010	S
11201		A	Removal of added skin tags	0.26	0.17	0.02	0.45	ZZZ	S
11300		A	Shave skin lesion	0.51	0.53	0.05	1.09	000	S
11301		A	Shave skin lesion	0.85	0.67	0.06	1.58	000	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.

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

³ # Indicates RVUs are not used for Medicare payment.

⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
11302		A	Shave skin lesion	1.05	0.89	0.09	2.03	000	S
11303		A	Shave skin lesion	1.24	1.36	0.17	2.77	000	S
11305		A	Shave skin lesion	0.67	0.52	0.05	1.24	000	S
11306		A	Shave skin lesion	0.99	0.71	0.07	1.77	000	S
11307		A	Shave skin lesion	1.14	0.94	0.10	2.18	000	S
11308		A	Shave skin lesion	1.41	1.40	0.17	2.98	000	S
11310		A	Shave skin lesion	0.73	0.69	0.06	1.48	000	S
11311		A	Shave skin lesion	1.05	0.85	0.08	1.98	000	S
11312		A	Shave skin lesion	1.20	1.12	0.11	2.43	000	S
11313		A	Shave skin lesion	1.62	1.49	0.15	3.26	000	S
11400		A	Removal of skin lesion	0.86	0.53	0.05	1.44	010	S
11401		A	Removal of skin lesion	1.27	0.67	0.06	2.00	010	S
11402		A	Removal of skin lesion	1.56	0.89	0.09	2.54	010	S
11403		A	Removal of skin lesion	1.87	1.17	0.13	3.17	010	S
11404		A	Removal of skin lesion	2.15	1.38	0.17	3.70	010	S
11406		A	Removal of skin lesion	2.71	1.88	0.33	4.92	010	S
11420		A	Removal of skin lesion	1.01	0.52	0.05	1.58	010	S
11421		A	Removal of skin lesion	1.48	0.71	0.07	2.26	010	S
11422		A	Removal of skin lesion	1.71	0.94	0.10	2.75	010	S
11423		A	Removal of skin lesion	2.12	1.31	0.15	3.58	010	S
11424		A	Removal of skin lesion	2.57	1.39	0.16	4.12	010	S
11426		A	Removal of skin lesion	3.73	1.83	0.29	5.85	010	S
11440		A	Removal of skin lesion	1.10	0.69	0.06	1.85	010	S
11441		A	Removal of skin lesion	1.56	0.85	0.08	2.49	010	S
11442		A	Removal of skin lesion	1.82	1.12	0.11	3.05	010	S
11443		A	Removal of skin lesion	2.44	1.45	0.15	4.04	010	S
11444		A	Removal of skin lesion	3.37	1.47	0.14	4.98	010	S
11446		A	Removal of skin lesion	4.44	1.78	0.18	6.40	010	S
11450		A	Removal, sweat gland lesion	2.58	2.68	0.44	5.70	090	S
11451		A	Removal, sweat gland lesion	3.80	2.90	0.46	7.16	090	S
11462		A	Removal, sweat gland lesion	2.36	2.41	0.36	5.13	090	S
11463		A	Removal, sweat gland lesion	3.80	2.00	0.34	6.14	090	S
11470		A	Removal, sweat gland lesion	3.10	2.78	0.45	6.33	090	S
11471		A	Removal, sweat gland lesion	4.26	2.46	0.48	7.20	090	S
11600		A	Removal of skin lesion	1.36	1.13	0.10	2.59	010	S
11601		A	Removal of skin lesion	1.88	1.39	0.12	3.39	010	S
11602		A	Removal of skin lesion	2.04	1.82	0.16	4.02	010	S
11603		A	Removal of skin lesion	2.30	2.25	0.21	4.76	010	S
11604		A	Removal of skin lesion	2.53	2.59	0.26	5.38	010	S
11606		A	Removal of skin lesion	3.38	3.11	0.49	6.98	010	S
11620		A	Removal of skin lesion	1.29	1.34	0.12	2.75	010	S
11621		A	Removal of skin lesion	1.92	1.75	0.16	3.83	010	S
11622		A	Removal of skin lesion	2.29	2.20	0.19	4.68	010	S
11623		A	Removal of skin lesion	2.88	2.58	0.25	5.71	010	S
11624		A	Removal of skin lesion	3.38	3.21	0.32	6.91	010	S
11626		A	Removal of skin lesion	4.20	3.41	0.51	8.12	010	S
11640		A	Removal of skin lesion	1.48	1.65	0.15	3.28	010	S
11641		A	Removal of skin lesion	2.39	2.09	0.18	4.66	010	S
11642		A	Removal of skin lesion	2.88	2.57	0.23	5.68	010	S
11643		A	Removal of skin lesion	3.45	3.01	0.28	6.74	010	S
11644		A	Removal of skin lesion	4.50	3.51	0.33	8.34	010	S
11646		A	Removal of skin lesion	5.85	4.32	0.60	10.77	010	S
11700		A	Scraping of 1–5 nails	0.32	0.32	0.03	0.67	000	S
11701		A	Scraping of additional nails	0.23	0.23	0.02	0.48	ZZZ	S
11710		A	Scraping of 1–5 nails	0.32	0.32	0.03	0.67	000	S
11711		A	Scraping of additional nails	0.20	0.19	0.02	0.41	ZZZ	S
11730		A	Removal of nail plate	1.13	0.45	0.04	1.62	000	S
11731		A	Removal of second nail plate	0.55	0.51	0.05	1.11	ZZZ	S
11732		A	Remove additional nail plate	0.38	0.25	0.02	0.65	ZZZ	S
11740		A	Drain blood from under nail	0.37	0.39	0.04	0.80	000	S
11750		A	Removal of nail bed	1.66	2.10	0.19	3.95	010	S
11752		A	Remove nail bed/finger tip	2.37	2.82	0.36	5.55	010	S
11755		A	Biopsy, nail unit	1.31	0.99	0.12	2.42	000	S
11760		A	Reconstruction of nail bed	1.53	0.93	0.09	2.55	010	S
11762		A	Reconstruction of nail bed	2.84	2.57	0.24	5.65	010	S
11765		A	Excision of nail fold, toe	0.64	0.51	0.05	1.20	010	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
11770		A	Removal of pilonidal lesion	2.56	2.67	0.44	5.67	010	S
11771		A	Removal of pilonidal lesion	5.15	4.52	0.92	10.59	090	S
11772		A	Removal of pilonidal lesion	6.36	4.82	1.01	12.19	090	S
11900		A	Injection into skin lesions	0.52	0.25	0.02	0.79	000	S
11901		A	Added skin lesions injection	0.80	0.41	0.03	1.24	000	S
11920		R	Correct skin color defects	1.61	1.18	0.23	3.02	000	S
11921		R	Correct skin color defects	1.93	1.40	0.28	3.61	000	S
11922		R	Correct skin color defects	0.49	0.36	0.07	0.92	ZZZ	S
11950		R	Therapy for contour defects	0.84	1.19	0.11	2.14	000	S
11951		R	Therapy for contour defects	1.19	1.19	0.11	2.49	000	S
11952		R	Therapy for contour defects	1.69	1.19	0.11	2.99	000	S
11954		R	Therapy for contour defects	1.85	1.19	0.11	3.15	000	S
11960		A	Insert tissue expander(s)	6.04	*7.73	1.48	15.25	090	S
11970		A	Replace tissue expander	6.65	*8.51	1.61	16.77	090	S
11971		A	Remove tissue expander(s)	1.51	*2.30	0.82	4.63	090	S
11975		N	Insert contraceptive cap	#1.48	1.06	0.25	2.79	XXX	0
11976		R	Removal of contraceptive cap	1.78	1.28	0.30	3.36	XXX	N
11977		N	Removal/reinsert contra cap	#3.30	2.36	0.55	6.21	XXX	0
12001		A	Repair superficial wound(s)	1.65	0.57	0.05	2.27	010	N
12002		A	Repair superficial wound(s)	1.81	0.79	0.07	2.67	010	N
12004		A	Repair superficial wound(s)	2.19	1.14	0.10	3.43	010	N
12005		A	Repair superficial wound(s)	2.81	1.47	0.14	4.42	010	N
12006		A	Repair superficial wound(s)	3.62	1.78	0.19	5.59	010	N
12007		A	Repair superficial wound(s)	4.07	1.80	0.19	6.06	010	S
12011		A	Repair superficial wound(s)	1.71	0.74	0.06	2.51	010	N
12013		A	Repair superficial wound(s)	1.94	1.03	0.08	3.05	010	N
12014		A	Repair superficial wound(s)	2.41	1.19	0.10	3.70	010	N
12015		A	Repair superficial wound(s)	3.14	1.62	0.14	4.90	010	N
12016		A	Repair superficial wound(s)	3.88	2.26	0.19	6.33	010	N
12017		A	Repair superficial wound(s)	4.66	3.36	0.31	8.33	010	N
12018		A	Repair superficial wound(s)	5.48	5.15	0.48	11.11	010	S
12020		A	Closure of split wound	2.57	1.19	0.18	3.94	010	S
12021		A	Closure of split wound	1.79	0.62	0.11	2.52	010	S
12031		A	Layer closure of wound(s)	2.10	0.72	0.07	2.89	010	S
12032		A	Layer closure of wound(s)	2.42	1.05	0.10	3.57	010	S
12034		A	Layer closure of wound(s)	2.87	1.47	0.15	4.49	010	S
12035		A	Layer closure of wound(s)	3.38	1.92	0.23	5.53	010	S
12036		A	Layer closure of wound(s)	4.00	2.32	0.37	6.69	010	S
12037		A	Layer closure of wound(s)	4.62	3.09	0.48	8.19	010	S
12041		A	Layer closure of wound(s)	2.32	0.84	0.08	3.24	010	N
12042		A	Layer closure of wound(s)	2.69	1.17	0.12	3.98	010	N
12044		A	Layer closure of wound(s)	3.09	1.62	0.17	4.88	010	N
12045		A	Layer closure of wound(s)	3.59	2.13	0.23	5.95	010	N
12046		A	Layer closure of wound(s)	4.20	2.82	0.37	7.39	010	S
12047		A	Layer closure of wound(s)	4.60	4.02	0.56	9.18	010	N
12051		A	Layer closure of wound(s)	2.42	1.01	0.10	3.53	010	S
12052		A	Layer closure of wound(s)	2.72	1.47	0.14	4.33	010	S
12053		A	Layer closure of wound(s)	3.07	1.76	0.17	5.00	010	S
12054		A	Layer closure of wound(s)	3.41	2.60	0.25	6.26	010	S
12055		A	Layer closure of wound(s)	4.38	3.24	0.37	7.99	010	S
12056		A	Layer closure of wound(s)	5.19	4.74	0.52	10.45	010	S
12057		A	Layer closure of wound(s)	5.91	5.57	0.48	11.96	010	S
13100		A	Repair of wound or lesion	3.07	1.14	0.13	4.34	010	S
13101		A	Repair of wound or lesion	3.87	2.08	0.21	6.16	010	S
13120		A	Repair of wound or lesion	3.25	1.35	0.17	4.77	010	S
13121		A	Repair of wound or lesion	4.28	2.65	0.33	7.26	010	S
13131		A	Repair of wound or lesion	3.74	1.98	0.23	5.95	010	S
13132		A	Repair of wound or lesion	4.21	4.57	0.44	9.22	010	S
13150		A	Repair of wound or lesion	3.76	1.76	0.23	5.75	010	S
13151		A	Repair of wound or lesion	4.40	2.45	0.35	7.20	010	S
13152		A	Repair of wound or lesion	6.28	5.13	0.68	12.09	010	S
13160		A	Late closure of wound	9.53	3.33	0.58	13.44	090	S
13300		A	Repair of wound or lesion	5.11	5.71	0.86	11.68	010	S
14000		A	Skin tissue rearrangement	5.43	3.41	0.38	9.22	090	S
14001		A	Skin tissue rearrangement	7.78	4.75	0.76	13.29	090	S
14020		A	Skin tissue rearrangement	6.08	4.90	0.49	11.47	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
14021		A	Skin tissue rearrangement	9.37	6.21	0.94	16.52	090	S
14040		A	Skin tissue rearrangement	7.18	6.77	0.65	14.60	090	S
14041		A	Skin tissue rearrangement	10.74	7.88	1.02	19.64	090	S
14060		A	Skin tissue rearrangement	8.05	7.75	1.04	16.84	090	S
14061		A	Skin tissue rearrangement	11.42	10.49	1.27	23.18	090	S
14300		A	Skin tissue rearrangement	10.76	11.31	1.84	23.91	090	S
14350		A	Skin tissue rearrangement	9.05	6.07	1.05	16.17	090	S
15000		A	Skin graft procedure	1.95	*2.49	0.53	4.97	ZZZ	S
15050		A	Skin pinch graft procedure	3.90	1.79	0.30	5.99	090	S
15100		A	Skin split graft procedure	8.05	4.54	0.89	13.48	090	S
15101		A	Skin split graft procedure	1.72	1.59	0.33	3.64	ZZZ	S
15120		A	Skin split graft procedure	9.14	6.05	0.94	16.13	090	S
15121		A	Skin split graft procedure	2.67	2.91	0.53	6.11	ZZZ	S
15200		A	Skin full graft procedure	7.46	4.13	0.69	12.28	090	S
15201		A	Skin full graft procedure	1.32	*1.68	0.50	3.50	ZZZ	S
15220		A	Skin full graft procedure	7.42	4.84	0.85	13.11	090	S
15221		A	Skin full graft procedure	1.19	*1.59	0.50	3.28	ZZZ	S
15240		A	Skin full graft procedure	8.30	6.10	1.03	15.43	090	S
15241		A	Skin full graft procedure	1.86	*2.38	0.58	4.82	ZZZ	S
15260		A	Skin full graft procedure	9.56	7.46	0.99	18.01	090	S
15261		A	Skin full graft procedure	2.23	*2.85	0.60	5.68	ZZZ	S
15350		A	Skin homograft procedure	3.89	2.15	0.42	6.46	090	S
15400		A	Skin heterograft procedure	4.91	1.06	0.17	6.14	090	S
15570		A	Form skin pedicle flap	3.75	*5.50	2.08	11.33	090	S
15572		A	Form skin pedicle flap	3.80	*5.38	1.86	11.04	090	S
15574		A	Form skin pedicle flap	3.85	*5.40	1.66	10.91	090	S
15576		A	Form skin pedicle flap	4.27	3.12	0.60	7.99	090	S
15580		A	Attach skin pedicle graft	3.30	*4.31	1.30	8.91	090	S
15600		A	Skin graft procedure	1.70	*2.51	0.88	5.09	090	S
15610		A	Skin graft procedure	2.21	*2.82	0.80	5.83	090	S
15620		A	Skin graft procedure	2.69	*3.44	0.86	6.99	090	S
15625		A	Skin graft procedure	1.81	*2.41	0.78	5.00	090	S
15630		A	Skin graft procedure	3.02	*3.86	0.90	7.78	090	S
15650		A	Transfer skin pedicle flap	3.61	*4.62	0.93	9.16	090	S
15732		A	Muscle-skin graft, head/neck	12.10	*15.48	3.46	31.04	090	S
15734		A	Muscle-skin graft, trunk	16.52	19.01	3.24	38.77	090	S
15736		A	Muscle-skin graft, arm	15.26	16.21	3.02	34.49	090	S
15738		A	Muscle-skin graft, leg	10.07	*12.89	3.29	26.25	090	S
15740		A	Island pedicle flap graft	9.45	10.39	1.62	21.46	090	S
15750		A	Neurovascular pedicle graft	10.61	11.96	2.03	24.60	090	S
15755		A	Microvascular flap graft	28.33	30.09	5.33	63.75	090	S
15760		A	Composite skin graft	8.28	7.29	1.11	16.68	090	S
15770		A	Derma-fat-fascia graft	6.85	7.46	0.95	15.26	090	S
15775		R	Hair transplant punch grafts	3.96	2.88	0.56	7.40	000	S
15776		R	Hair transplant punch grafts	5.54	4.03	0.79	10.36	000	S
15780		A	Abrasion treatment of skin	6.73	1.53	0.13	8.39	090	S
15781		A	Abrasion treatment of skin	4.67	3.77	0.39	8.83	090	S
15782		A	Abrasion treatment of skin	4.19	1.19	0.13	5.51	090	S
15783		A	Abrasion treatment of skin	4.16	1.85	0.19	6.20	090	S
15786		A	Abrasion treatment of lesion	1.98	0.62	0.06	2.66	010	S
15787		A	Abrasion, added skin lesions	0.33	0.23	0.03	0.59	ZZZ	S
15788		R	Chemical peel, face, epiderm	1.96	1.48	0.12	3.56	090	S
15789		R	Chemical peel, face, dermal	4.69	1.48	0.12	6.29	090	S
15792		R	Chemical peel, nonfacial	1.73	0.50	0.05	2.28	090	S
15793		A	Chemical peel, nonfacial	3.51	0.50	0.05	4.06	090	S
15810		A	Salabrasion	4.49	3.80	0.29	8.58	090	S
15811		A	Salabrasion	5.14	3.74	0.73	9.61	090	S
15819		A	Plastic surgery, neck	8.87	8.01	0.87	17.75	090	S
15820		A	Revision of lower eyelid	4.80	*6.14	0.64	11.58	090	S
15821		A	Revision of lower eyelid	5.37	*6.87	0.68	12.92	090	S
15822		A	Revision of upper eyelid	4.27	*5.47	0.56	10.30	090	S
15823		A	Revision of upper eyelid	6.65	7.71	0.61	14.97	090	S
15824		R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	XXX	S
15825		R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	XXX	S
15826		R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	XXX	S
15828		R	Removal of face wrinkles	0.00	0.00	0.00	0.00	XXX	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	XXX	S
15831		A	Excise excessive skin tissue	11.66	9.84	2.01	23.51	090	S
15832		A	Excise excessive skin tissue	10.97	8.29	1.33	20.59	090	S
15833		A	Excise excessive skin tissue	10.02	6.22	1.12	17.36	090	S
15834		A	Excise excessive skin tissue	10.16	7.18	1.22	18.56	090	S
15835		A	Excise excessive skin tissue	10.98	7.00	1.22	19.20	090	S
15836		A	Excise excessive skin tissue	8.83	5.80	1.10	15.73	090	S
15837		A	Excise excessive skin tissue	8.08	5.97	0.85	14.90	090	S
15838		A	Excise excessive skin tissue	6.78	5.88	0.73	13.39	090	S
15839		A	Excise excessive skin tissue	8.92	2.44	0.46	11.82	090	S
15840		A	Graft for face nerve palsy	12.26	15.54	2.28	30.08	090	S
15841		A	Graft for face nerve palsy	21.53	16.87	2.76	41.16	090	S
15842		A	Graft for face nerve palsy	35.98	29.00	2.68	67.66	090	S
15845		A	Skin and muscle repair, face	11.80	*15.10	2.54	29.44	090	S
15850		B	Removal of sutures	#0.78	0.36	0.04	1.18	XXX	0
15851		A	Removal of sutures	0.86	0.30	0.03	1.19	000	N
15852		A	Dressing change, not for burn	0.86	0.44	0.07	1.37	000	N
15860		A	Test for blood flow in graft	1.95	1.35	0.25	3.55	000	S
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	XXX	S
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	XXX	S
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	XXX	S
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	XXX	S
15920		A	Removal of tail bone ulcer	7.37	2.95	0.63	10.95	090	S
15922		A	Removal of tail bone ulcer	9.17	5.98	1.19	16.34	090	S
15931		A	Remove sacrum pressure sore	8.13	2.93	0.55	11.61	090	S
15933		A	Remove sacrum pressure sore	9.64	6.92	1.43	17.99	090	S
15934		A	Remove sacrum pressure sore	11.40	7.46	1.50	20.36	090	S
15935		A	Remove sacrum pressure sore	13.05	11.24	2.27	26.56	090	S
15936		A	Remove sacrum pressure sore	11.31	10.27	2.05	23.63	090	S
15937		A	Remove sacrum pressure sore	12.98	13.47	2.67	29.12	090	S
15940		A	Removal of pressure sore	8.19	3.55	0.73	12.47	090	S
15941		A	Removal of pressure sore	10.15	7.05	1.39	18.59	090	S
15944		A	Removal of pressure sore	10.18	9.26	1.82	21.26	090	S
15945		A	Removal of pressure sore	11.32	11.14	2.09	24.55	090	S
15946		A	Removal of pressure sore	19.81	16.61	3.24	39.66	090	S
15950		A	Remove thigh pressure sore	6.79	3.01	0.58	10.38	090	S
15951		A	Remove thigh pressure sore	9.57	7.65	1.58	18.80	090	S
15952		A	Remove thigh pressure sore	10.18	7.13	1.37	18.68	090	S
15953		A	Remove thigh pressure sore	11.39	9.08	1.87	22.34	090	S
15956		A	Remove thigh pressure sore	13.93	17.17	3.39	34.49	090	S
15958		A	Remove thigh pressure sore	13.89	*17.77	3.76	35.42	090	S
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	YYY	S
16000		A	Initial treatment of burn(s)	0.89	0.35	0.03	1.27	000	N
16010		A	Treatment of burn(s)	0.87	0.32	0.03	1.22	000	N
16015		A	Treatment of burn(s)	2.35	2.04	0.38	4.77	000	S
16020		A	Treatment of burn(s)	0.80	0.34	0.03	1.17	000	N
16025		A	Treatment of burn(s)	1.85	0.45	0.05	2.35	000	S
16030		A	Treatment of burn(s)	2.08	0.52	0.08	2.68	000	S
16035		A	Incision of burn scab	4.53	1.88	0.34	6.75	090	S
16040		A	Burn wound excision	1.02	*1.56	0.53	3.11	000	S
16041		A	Burn wound excision	2.70	3.16	0.53	6.39	000	S
16042		A	Burn wound excision	2.35	*3.02	0.53	5.90	000	S
17000		A	Destroy benign/premalignant lesion	0.64	0.42	0.03	1.09	010	S
17001		A	Destruction of add'l lesions	0.19	0.19	0.02	0.40	ZZZ	S
17002		A	Destruction of add'l lesions	0.19	0.10	0.01	0.30	ZZZ	S
17010		A	Destruction skin lesion(s)	1.01	0.48	0.04	1.53	010	S
17100		A	Destruction of skin lesion	0.53	0.37	0.03	0.93	010	S
17101		A	Destruction of 2nd lesion	0.11	0.18	0.02	0.31	ZZZ	S
17102		A	Destruction of add'l lesions	0.11	0.08	0.01	0.20	ZZZ	S
17104		A	Destruction of skin lesions	2.01	0.07	0.01	2.09	010	S
17105		A	Destruction of skin lesions	0.76	0.31	0.03	1.10	010	S
17106		A	Destruction of skin lesions	4.54	1.93	0.18	6.65	090	S
17107		A	Destruction of skin lesions	9.06	3.70	0.39	13.15	090	S
17108		A	Destruction of skin lesions	13.10	9.32	0.69	23.11	090	S
17110		A	Destruction of skin lesions	0.55	0.40	0.03	0.98	010	S
17200		A	Electrocautery of skin tags	0.59	0.41	0.04	1.04	010	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
17201		A	Electrocautery added lesions	0.38	0.15	0.01	0.54	ZZZ	S
17250		A	Chemical cautery, tissue	0.50	0.34	0.04	0.88	000	S
17260		A	Destruction of skin lesions	0.86	1.13	0.10	2.09	010	S
17261		A	Destruction of skin lesions	1.12	1.39	0.12	2.63	010	S
17262		A	Destruction of skin lesions	1.53	1.82	0.16	3.51	010	S
17263		A	Destruction of skin lesions	1.74	2.25	0.21	4.20	010	S
17264		A	Destruction of skin lesions	1.89	2.59	0.26	4.74	010	S
17266		A	Destruction of skin lesions	2.29	3.11	0.49	5.89	010	S
17270		A	Destruction of skin lesions	1.27	1.34	0.12	2.73	010	S
17271		A	Destruction of skin lesions	1.44	1.75	0.16	3.35	010	S
17272		A	Destruction of skin lesions	1.72	2.20	0.19	4.11	010	S
17273		A	Destruction of skin lesions	2.00	2.58	0.25	4.83	010	S
17274		A	Destruction of skin lesions	2.54	3.21	0.32	6.07	010	S
17276		A	Destruction of skin lesions	3.15	3.41	0.51	7.07	010	S
17280		A	Destruction of skin lesions	1.12	1.65	0.15	2.92	010	S
17281		A	Destruction of skin lesions	1.67	2.09	0.18	3.94	010	S
17282		A	Destruction of skin lesions	1.99	2.57	0.23	4.79	010	S
17283		A	Destruction of skin lesions	2.59	3.01	0.28	5.88	010	S
17284		A	Destruction of skin lesions	3.16	3.51	0.33	7.00	010	S
17286		A	Destruction of skin lesions	4.39	4.32	0.60	9.31	010	S
17304		A	Chemosurgery of skin lesion	7.60	4.02	0.31	11.93	000	S
17305		A	2nd stage chemosurgery	2.85	2.26	0.17	5.28	000	S
17306		A	3rd stage chemosurgery	2.85	1.40	0.11	4.36	000	S
17307		A	Followup skin lesion therapy	2.85	1.47	0.12	4.44	000	S
17310		A	Extensive skin chemosurgery	0.95	0.13	0.01	1.09	000	S
17340		A	Cryotherapy of skin	0.73	0.28	0.02	1.03	010	S
17360		A	Skin peel therapy	1.40	0.27	0.02	1.69	010	S
17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	XXX	S
17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	YYY	S
19000		A	Drainage of breast lesion	0.84	0.38	0.07	1.29	000	S
19001		A	Drain added breast lesion	0.42	0.24	0.05	0.71	ZZZ	S
19020		A	Incision of breast lesion	3.37	1.40	0.28	5.05	090	S
19030		A	Injection for breast x-ray	1.53	0.49	0.04	2.06	000	N
19100		A	Biopsy of breast	1.27	0.64	0.13	2.04	000	S
19101		A	Biopsy of breast	3.13	2.34	0.45	5.92	010	S
19110		A	Nipple exploration	4.15	2.46	0.51	7.12	090	S
19112		A	Excise breast duct fistula	3.52	2.34	0.35	6.21	090	S
19120		A	Removal of breast lesion	4.84	2.90	0.60	8.34	090	S
19125		A	Excision, breast lesion	5.85	2.90	0.60	9.35	090	S
19126		A	Excision, add'l breast lesion	2.93	1.45	0.31	4.69	ZZZ	S
19140		A	Removal of breast tissue	4.90	4.29	0.91	10.10	090	S
19160		A	Removal of breast tissue	6.65	4.13	0.88	11.66	090	S
19162		A	Remove breast tissue, nodes	12.81	9.38	1.96	24.15	090	S
19180		A	Removal of breast	8.15	5.61	1.17	14.93	090	S
19182		A	Removal of breast	7.28	6.07	1.27	14.62	090	S
19200		A	Removal of breast	14.23	10.22	2.15	26.60	090	S
19220		A	Removal of breast	14.23	10.73	2.38	27.34	090	S
19240		A	Removal of breast	14.71	9.44	1.99	26.14	090	S
19260		A	Removal of chest wall lesion	13.91	5.05	1.04	20.00	090	S
19271		A	Revision of chest wall	17.07	13.95	2.77	33.79	090	S
19272		A	Extensive chest wall surgery	19.47	12.60	2.56	34.63	090	S
19290		A	Place needle wire, breast	1.27	0.44	0.07	1.78	000	S
19291		A	Place needle wire, breast	0.63	0.25	0.04	0.92	ZZZ	S
19316		A	Suspension of breast	10.07	12.84	2.43	25.34	090	S
19318		A	Reduction of large breast	11.08	*14.18	3.23	28.49	090	S
19324		A	Enlarge breast	5.55	3.29	0.67	9.51	090	S
19325		A	Enlarge breast with implant	8.05	5.87	1.13	15.05	090	S
19328		A	Removal of breast implant	5.32	3.76	0.73	9.81	090	S
19330		A	Removal of implant material	7.18	3.88	0.75	11.81	090	S
19340		A	Immediate breast prosthesis	6.33	*8.10	2.06	16.49	ZZZ	S
19342		A	Delayed breast prosthesis	10.64	10.81	2.03	23.48	090	S
19350		A	Breast reconstruction	8.21	7.08	1.38	16.67	090	S
19355		A	Correct inverted nipple(s)	7.27	4.93	1.00	13.20	090	S
19357		A	Breast reconstruction	16.72	12.15	2.37	31.24	090	S
19361		A	Breast reconstruction	17.82	20.13	3.88	41.83	090	S
19364		A	Breast reconstruction	27.60	16.68	3.58	47.86	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
19366		A	Breast reconstruction	19.84	16.40	3.18	39.42	090	S
19367		A	Breast reconstruction	24.73	20.13	3.88	48.74	090	S
19368		A	Breast reconstruction	31.15	20.13	3.88	55.16	090	S
19369		A	Breast reconstruction	28.68	20.13	3.88	52.69	090	S
19370		A	Surgery of breast capsule	7.59	6.17	1.19	14.95	090	S
19371		A	Removal of breast capsule	8.84	7.91	1.54	18.29	090	S
19380		A	Revise breast reconstruction	8.63	8.11	1.57	18.31	090	S
19396		A	Design custom breast implant	2.17	1.57	0.31	4.05	000	S
19499		C	Breast surgery procedure	0.00	0.00	0.00	0.00	YYY	S
20000		A	Incision of abscess	1.85	0.85	0.08	2.78	010	S
20005		A	Incision of deep abscess	3.02	1.83	0.28	5.13	010	S
20100		A	Explore wound, neck	9.50	4.97	1.16	15.63	010	S
20101		A	Explore wound, chest	3.00	1.57	0.37	4.94	010	S
20102		A	Explore wound, abdomen	3.68	1.92	0.45	6.05	010	S
20103		A	Explore wound, extremity	4.95	2.59	0.60	8.14	010	S
20200		A	Muscle biopsy	1.46	1.12	0.18	2.76	000	S
20205		A	Deep muscle biopsy	2.35	1.88	0.33	4.56	000	S
20206		A	Needle biopsy, muscle	0.99	0.96	0.14	2.09	000	S
20220		A	Bone biopsy, trocar/needle	1.27	1.31	0.09	2.67	000	N
20225		A	Bone biopsy, trocar/needle	1.87	*2.39	0.28	4.54	000	N
20240		A	Bone biopsy, excisional	3.07	1.88	0.18	5.13	010	S
20245		A	Bone biopsy, excisional	3.68	3.58	0.44	7.70	010	S
20250		A	Open bone biopsy	4.63	5.07	0.76	10.46	010	S
20251		A	Open bone biopsy	5.16	5.84	0.92	11.92	010	S
20500		A	Injection of sinus tract	1.18	0.36	0.04	1.58	010	N
20501		A	Inject sinus tract for x-ray	0.76	0.30	0.02	1.08	000	N
20520		A	Removal of foreign body	1.80	0.71	0.08	2.59	010	S
20525		A	Removal of foreign body	3.23	2.23	0.33	5.79	010	S
20550		A	Inj tendon/ligament/cyst	0.86	0.38	0.04	1.28	000	N
20600		A	Drain/inject joint/bursa	0.66	0.47	0.05	1.18	000	S
20605		A	Drain/inject joint/bursa	0.68	0.45	0.05	1.18	000	S
20610		A	Drain/inject joint/bursa	0.79	0.45	0.05	1.29	000	N
20615		A	Treatment of bone cyst	2.23	0.49	0.06	2.78	010	N
20650		A	Insert and remove bone pin	2.07	1.08	0.14	3.29	010	S
20660		A	Apply, remove fixation device	2.51	1.56	0.21	4.28	000	S
20661		A	Application of head brace	4.27	3.82	0.65	8.74	090	S
20662		A	Application of pelvis brace	5.52	6.54	1.03	13.09	090	S
20663		A	Application of thigh brace	4.88	4.64	0.76	10.28	090	S
20665		A	Removal of fixation device	1.26	0.50	0.07	1.83	010	S
20670		A	Removal of support implant	1.69	0.74	0.11	2.54	010	S
20680		A	Removal of support implant	3.25	3.33	0.51	7.09	090	S
20690		A	Apply bone fixation device	3.52	3.66	0.58	7.76	ZZZ	S
20692		A	Apply bone fixation device	6.41	5.51	0.89	12.81	ZZZ	S
20693		A	Adjust bone fixation device	5.42	2.49	0.42	8.33	090	S
20694		A	Remove bone fixation device	3.81	2.60	0.41	6.82	090	S
20802		A	Replantation, arm, complete	39.56	37.72	6.17	83.45	090	S
20804		D	Replantation, arm, partial	0.00	0.00	0.00	0.00	090	S
20805		A	Replant forearm, complete	48.41	46.17	7.56	102.14	090	S
20806		D	Replantation, forearm, partial	0.00	0.00	0.00	0.00	090	S
20808		A	Replantation, hand, complete	60.19	57.40	9.40	126.99	090	S
20812		D	Replantation, hand, partial	0.00	0.00	0.00	0.00	090	S
20816		A	Replantation digit, complete	29.67	28.30	4.63	62.60	090	S
20820		D	Replantation, digit, partial	0.00	0.00	0.00	0.00	090	S
20822		A	Replantation digit, complete	24.53	23.39	3.83	51.75	090	S
20823		D	Replantation, digit, partial	0.00	0.00	0.00	0.00	090	S
20824		A	Replantation thumb, complete	29.67	28.30	4.63	62.60	090	S
20826		D	Replantation, thumb, partial	0.00	0.00	0.00	0.00	090	S
20827		A	Replantation thumb, complete	25.22	24.05	3.94	53.21	090	S
20828		D	Replantation, thumb, partial	0.00	0.00	0.00	0.00	090	S
20832		D	Replantation, leg, complete	0.00	0.00	0.00	0.00	090	S
20834		D	Replantation, leg, partial	0.00	0.00	0.00	0.00	090	S
20838		A	Replantation, foot, complete	39.56	37.72	6.17	83.45	090	S
20840		D	Replantation, foot, partial	0.00	0.00	0.00	0.00	090	S
20900		A	Removal of bone for graft	5.03	2.80	0.45	8.28	090	S
20902		A	Removal of bone for graft	6.74	4.95	0.80	12.49	090	S
20910		A	Remove cartilage for graft	5.03	0.79	0.09	5.91	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
20912		A	Remove cartilage for graft	6.04	4.62	0.64	11.30	090	S
20920		A	Removal of fascia for graft	4.87	3.93	0.50	9.30	090	S
20922		A	Removal of fascia for graft	6.04	4.39	0.71	11.14	090	S
20924		A	Removal of tendon for graft	6.04	5.45	0.85	12.34	090	S
20926		A	Removal of tissue for graft	5.03	2.59	0.39	8.01	090	S
20930		B	Spinal bone allograft	0.00	0.00	0.00	0.00	XXX	0
20931		A	Spinal bone allograft	1.81	1.73	0.28	3.82	ZZZ	S
20936		B	Spinal bone autograft	0.00	0.00	0.00	0.00	XXX	0
20937		A	Spinal bone autograft	2.79	2.66	0.44	5.89	ZZZ	S
20938		A	Spinal bone autograft	3.02	2.88	0.47	6.37	ZZZ	S
20950		A	Record fluid pressure, muscle	1.26	1.09	0.17	2.52	000	S
20955		A	Microvascular fibula graft	37.58	35.84	5.87	79.29	090	S
20960		C	Microvascular rib graft	0.00	0.00	0.00	0.00	090	S
20962		C	Microvascular bone graft	0.00	0.00	0.00	0.00	090	S
20969		A	Bone-skin graft	42.08	40.13	6.57	88.78	090	S
20970		A	Bone-skin graft, pelvis	41.22	39.31	6.44	86.97	090	S
20971		C	Bone-skin graft, rib	0.00	0.00	0.00	0.00	090	S
20972		A	Bone-skin graft, metatarsal	41.54	39.61	6.49	87.64	090	S
20973		A	Bone-skin graft, great toe	44.31	42.25	6.91	93.47	090	S
20974		A	Electrical bone stimulation	0.62	3.42	0.53	4.57	ZZZ	S
20975		A	Electrical bone stimulation	2.60	*3.33	0.56	6.49	ZZZ	S
20999		C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	YYY	S
21010		A	Incision of jaw joint	9.06	10.24	0.93	20.23	090	S
21015		A	Resection of facial tumor	4.94	*6.32	1.13	12.39	090	S
21025		A	Excision of bone, lower jaw	5.03	4.14	0.38	9.55	090	S
21026		A	Excision of facial bone(s)	4.53	3.14	0.28	7.95	090	S
21029		A	Contour of face bone lesion	7.21	*9.23	0.78	17.22	090	S
21030		A	Removal of face bone lesion	7.05	3.35	0.29	10.69	090	S
21031		A	Remove exostosis, mandible	2.01	3.68	0.32	6.01	090	S
21032		A	Remove exostosis, maxilla	4.27	3.88	0.35	8.50	090	S
21034		A	Removal of face bone lesion	15.11	6.98	0.89	22.98	090	S
21040		A	Removal of jaw bone lesion	2.01	2.76	0.24	5.01	090	S
21041		A	Removal of jaw bone lesion	5.03	5.76	0.50	11.29	090	S
21044		A	Removal of jaw bone lesion	11.08	9.55	1.11	21.74	090	S
21045		A	Extensive jaw surgery	15.11	13.83	1.58	30.52	090	S
21050		A	Removal of jaw joint	10.07	12.33	1.08	23.48	090	S
21060		A	Remove jaw joint cartilage	9.56	11.59	1.04	22.19	090	S
21070		A	Remove coronoid process	7.66	6.81	0.82	15.29	090	S
21076		A	Prepare face/oral prosthesis	12.54	16.77	1.35	30.66	010	S
21077		A	Prepare face/oral prosthesis	31.54	42.18	3.39	77.11	090	S
21079		A	Prepare face/oral prosthesis	20.88	27.93	2.25	51.06	090	S
21080		A	Prepare face/oral prosthesis	23.46	31.38	2.52	57.36	090	S
21081		A	Prepare face/oral prosthesis	21.38	28.59	2.30	52.27	090	S
21082		A	Prepare face/oral prosthesis	19.50	26.08	2.10	47.68	090	S
21083		A	Prepare face/oral prosthesis	18.04	24.13	1.94	44.11	090	S
21084		A	Prepare face/oral prosthesis	21.04	28.14	2.28	51.46	090	S
21085		A	Prepare face/oral prosthesis	8.41	11.25	0.90	20.56	010	S
21086		A	Prepare face/oral prosthesis	23.29	31.15	2.51	56.95	090	S
21087		A	Prepare face/oral prosthesis	23.29	31.15	2.51	56.95	090	S
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	090	S
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	090	S
21100		A	Maxillofacial fixation	4.04	1.06	0.11	5.21	090	S
21110		A	Interdental fixation	5.03	5.53	0.46	11.02	090	S
21116		A	Injection, jaw joint x-ray	0.81	0.73	0.06	1.60	000	S
21120		A	Reconstruction of chin	4.75	3.59	0.42	8.76	090	S
21121		A	Reconstruction of chin	7.46	5.65	0.66	13.77	090	S
21122		A	Reconstruction of chin	8.21	6.23	0.73	15.17	090	S
21123		A	Reconstruction of chin	10.74	8.14	0.95	19.83	090	S
21125		A	Augmentation lower jaw bone	6.22	4.72	0.54	11.48	090	S
21127		A	Augmentation lower jaw bone	10.43	7.91	0.92	19.26	090	S
21137		A	Reduction of forehead	9.40	7.11	0.83	17.34	090	S
21138		A	Reduction of forehead	11.72	8.86	1.04	21.62	090	S
21139		A	Reduction of forehead	14.06	10.64	1.25	25.95	090	S
21141		A	Reconstruct midface, left	16.92	14.34	1.68	32.94	090	S
21142		A	Reconstruct midface, left	17.58	14.84	1.74	34.16	090	S
21143		A	Reconstruct midface, left	18.30	15.40	1.81	35.51	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
21144		D	Reconstruct midface, left	0.00	0.00	0.00	0.00	090	S
21145		A	Reconstruct midface, left	18.92	14.34	1.68	34.94	090	S
21146		A	Reconstruct midface, left	19.58	14.84	1.74	36.16	090	S
21147		A	Reconstruct midface, left	20.30	15.40	1.81	37.51	090	S
21150		A	Reconstruct midface, left	24.41	18.46	2.17	45.04	090	S
21151		A	Reconstruct midface, left	27.34	20.68	2.42	50.44	090	S
21154		A	Reconstruct midface, left	29.28	22.15	2.59	54.02	090	S
21155		A	Reconstruct midface, left	33.19	25.11	2.94	61.24	090	S
21159		A	Reconstruct midface, left	40.99	31.02	3.63	75.64	090	S
21160		A	Reconstruct midface, left	44.90	33.96	3.98	82.84	090	S
21172		A	Reconstruct orbit/forehead	26.84	20.30	2.37	49.51	090	S
21175		A	Reconstruct orbit/forehead	32.21	24.37	2.85	59.43	090	S
21179		A	Reconstruct entire forehead	21.47	16.24	1.90	39.61	090	S
21180		A	Reconstruct entire forehead	24.41	18.46	2.17	45.04	090	S
21181		A	Contour cranial bone lesion	9.40	7.11	0.83	17.34	090	S
21182		A	Reconstruct cranial bone	31.23	23.63	2.77	57.63	090	S
21183		A	Reconstruct cranial bone	34.17	25.85	3.03	63.05	090	S
21184		A	Reconstruct cranial bone	37.10	28.06	3.28	68.44	090	S
21188		A	Reconstruction of midface	21.47	16.24	1.90	39.61	090	S
21193		A	Reconstruct lower jaw bone	16.23	12.31	1.44	29.98	090	S
21194		A	Reconstruct lower jaw bone	18.81	14.26	1.67	34.74	090	S
21195		A	Reconstruct lower jaw bone	16.27	12.34	1.44	30.05	090	S
21196		A	Reconstruct lower jaw bone	17.94	13.61	1.58	33.13	090	S
21198		A	Reconstruct lower jaw bone	13.36	14.82	1.74	29.92	090	S
21206		A	Reconstruct upper jaw bone	13.36	10.14	1.19	24.69	090	S
21208		A	Augmentation of facial bones	9.56	11.26	1.07	21.89	090	S
21209		A	Reduction of facial bones	6.28	4.59	0.76	11.63	090	S
21210		A	Face bone graft	9.56	*12.24	1.29	23.09	090	S
21215		A	Lower jaw bone graft	10.07	*12.89	1.42	24.38	090	S
21230		A	Rib cartilage graft	10.07	10.37	1.69	22.13	090	S
21235		A	Ear cartilage graft	6.28	*8.04	1.09	15.41	090	S
21240		A	Reconstruction of jaw joint	13.10	*16.77	2.09	31.96	090	S
21242		A	Reconstruction of jaw joint	12.10	*15.55	2.25	29.90	090	S
21243		A	Reconstruction of jaw joint	18.98	14.40	1.68	35.06	090	S
21244		A	Reconstruction of lower jaw	11.08	*14.18	1.93	27.19	090	S
21245		A	Reconstruction of jaw	11.08	11.47	1.31	23.86	090	S
21246		A	Reconstruction of jaw	11.65	8.83	1.04	21.52	090	S
21247		A	Reconstruct lower jaw bone	21.15	*27.08	2.27	50.50	090	S
21248		A	Reconstruction of jaw	11.08	*14.18	1.75	27.01	090	S
21249		A	Reconstruction of jaw	17.12	*23.10	3.29	43.51	090	S
21255		A	Reconstruct lower jaw bone	15.63	*20.00	1.68	37.31	090	S
21256		A	Reconstruction of orbit	15.13	*19.36	1.63	36.12	090	S
21260		A	Revise eye sockets	15.44	*19.76	1.66	36.86	090	S
21261		A	Revise eye sockets	29.43	17.78	1.65	48.86	090	S
21263		A	Revise eye sockets	26.56	*34.00	2.86	63.42	090	S
21267		A	Revise eye sockets	17.66	14.61	2.13	34.40	090	S
21268		A	Revise eye sockets	22.88	15.35	3.13	41.36	090	S
21270		A	Augmentation cheek bone	12.10	9.60	1.41	23.11	090	S
21275		A	Revision orbitofacial bones	10.50	8.95	1.26	20.71	090	S
21280		A	Revision of eyelid	5.64	7.19	0.61	13.44	090	S
21282		A	Revision of eyelid	3.26	*4.52	0.79	8.57	090	S
21295		A	Revision of jaw muscle/bone	1.43	0.96	0.13	2.52	090	S
21296		A	Revision of jaw muscle/bone	3.97	3.62	0.22	7.81	090	S
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	YYY	S
21300		A	Treatment of skull fracture	0.72	*0.92	0.11	1.75	000	S
21310		A	Treatment of nose fracture	0.58	*0.75	0.09	1.42	000	N
21315		A	Treatment of nose fracture	1.41	1.81	0.21	3.43	010	S
21320		A	Treatment of nose fracture	1.82	*2.33	0.34	4.49	010	S
21325		A	Repair of nose fracture	3.52	4.09	0.52	8.13	090	S
21330		A	Repair of nose fracture	5.03	*6.45	0.86	12.34	090	S
21335		A	Repair of nose fracture	8.05	*10.31	1.56	19.92	090	S
21336		A	Repair nasal septal fracture	5.35	4.09	0.52	9.96	090	S
21337		A	Repair nasal septal fracture	2.52	2.82	0.38	5.72	090	S
21338		A	Repair nasoethmoid fracture	6.04	5.01	0.66	11.71	090	S
21339		A	Repair nasoethmoid fracture	7.56	7.09	0.70	15.35	090	S
21340		A	Repair of nose fracture	10.07	8.91	1.04	20.02	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
21343		A	Repair of sinus fracture	12.10	9.17	1.08	22.35	090	S
21344		A	Repair of sinus fracture	18.43	9.17	1.08	28.68	090	S
21345		A	Repair of nose/jaw fracture	7.63	7.90	0.81	16.34	090	S
21346		A	Repair of nose/jaw fracture	9.92	9.40	1.04	20.36	090	S
21347		A	Repair of nose/jaw fracture	11.86	10.36	1.36	23.58	090	S
21348		A	Repair of nose/jaw fracture	15.60	11.34	2.22	29.16	090	S
21355		A	Repair cheek bone fracture	3.52	1.56	0.17	5.25	010	S
21356		A	Repair cheek bone fracture	3.88	*4.96	0.89	9.73	010	S
21360		A	Repair cheek bone fracture	6.04	7.28	0.89	14.21	090	S
21365		A	Repair cheek bone fracture	13.97	12.35	1.63	27.95	090	S
21366		A	Repair cheek bone fracture	16.61	12.08	2.36	31.05	090	S
21385		A	Repair eye socket fracture	8.56	9.59	1.13	19.28	090	S
21386		A	Repair eye socket fracture	8.56	9.07	1.25	18.88	090	S
21387		A	Repair eye socket fracture	9.07	7.45	0.96	17.48	090	S
21390		A	Repair eye socket fracture	9.47	11.89	1.37	22.73	090	S
21395		A	Repair eye socket fracture	11.85	9.63	1.37	22.85	090	S
21400		A	Treat eye socket fracture	1.31	*1.67	0.17	3.15	090	N
21401		A	Repair eye socket fracture	3.05	2.58	0.32	5.95	090	S
21406		A	Repair eye socket fracture	6.55	5.21	0.74	12.50	090	S
21407		A	Repair eye socket fracture	8.05	7.09	0.78	15.92	090	S
21408		A	Repair eye socket fracture	11.57	8.49	0.99	21.05	090	S
21421		A	Treat mouth roof fracture	4.80	*6.14	0.62	11.56	090	S
21422		A	Repair mouth roof fracture	7.78	9.80	1.19	18.77	090	S
21423		A	Repair mouth roof fracture	9.72	9.80	1.19	20.71	090	S
21431		A	Treat craniofacial fracture	6.59	6.02	0.71	13.32	090	S
21432		A	Repair craniofacial fracture	8.05	6.76	0.84	15.65	090	S
21433		A	Repair craniofacial fracture	23.69	17.96	2.10	43.75	090	S
21435		A	Repair craniofacial fracture	16.12	13.25	1.88	31.25	090	S
21436		A	Repair craniofacial fracture	26.21	14.65	2.08	42.94	090	S
21440		A	Repair dental ridge fracture	2.52	3.07	0.28	5.87	090	S
21445		A	Repair dental ridge fracture	5.03	6.11	0.56	11.70	090	S
21450		A	Treat lower jaw fracture	2.78	2.84	0.26	5.88	090	S
21451		A	Treat lower jaw fracture	4.55	*5.83	0.74	11.12	090	S
21452		A	Treat lower jaw fracture	1.85	1.39	0.17	3.41	090	S
21453		A	Treat lower jaw fracture	5.18	*6.64	0.55	12.37	090	S
21454		A	Treat lower jaw fracture	6.04	*8.19	1.42	15.65	090	S
21461		A	Repair lower jaw fracture	7.56	*9.67	1.30	18.53	090	S
21462		A	Repair lower jaw fracture	9.15	*11.71	1.34	22.20	090	S
21465		A	Repair lower jaw fracture	11.13	8.44	0.99	20.56	090	S
21470		A	Repair lower jaw fracture	14.19	17.13	1.74	33.06	090	S
21480		A	Reset dislocated jaw	0.61	*0.78	0.09	1.48	000	S
21485		A	Reset dislocated jaw	3.73	2.19	0.20	6.12	090	S
21490		A	Repair dislocated jaw	11.08	6.31	0.52	17.91	090	S
21493		A	Treat hyoid bone fracture	1.19	*1.52	0.13	2.84	090	S
21494		A	Repair hyoid bone fracture	5.87	*7.52	0.63	14.02	090	S
21495		A	Repair hyoid bone fracture	5.32	4.82	0.51	10.65	090	S
21497		A	Interdental wiring	3.61	3.97	0.38	7.96	090	S
21499		C	Head surgery procedure	0.00	0.00	0.00	0.00	YYY	S
21501		A	Drain neck/chest lesion	3.52	1.82	0.26	5.60	090	S
21502		A	Drain chest lesion	6.44	4.22	0.75	11.41	090	S
21510		A	Drainage of bone lesion	5.03	3.82	0.50	9.35	090	S
21550		A	Biopsy of neck/chest	2.01	0.85	0.12	2.98	010	S
21555		A	Remove lesion neck/chest	4.09	1.60	0.25	5.94	090	S
21556		A	Remove lesion neck/chest	5.28	3.80	0.64	9.72	090	S
21557		A	Remove tumor, neck or chest	8.56	8.50	1.41	18.47	090	S
21600		A	Partial removal of rib	6.27	4.50	0.88	11.65	090	S
21610		A	Partial removal of rib	8.54	5.17	0.76	14.47	090	S
21615		A	Removal of rib	9.03	10.13	1.96	21.12	090	S
21616		A	Removal of rib and nerves	11.11	7.26	1.50	19.87	090	S
21620		A	Partial removal of sternum	6.04	6.85	1.23	14.12	090	S
21627		A	Sternal debridement	6.06	5.03	0.90	11.99	090	S
21630		A	Extensive sternum surgery	15.77	12.89	2.40	31.06	090	S
21632		A	Extensive sternum surgery	16.62	11.54	2.22	30.38	090	S
21700		A	Revision of neck muscle	5.84	4.16	0.50	10.50	090	S
21705		A	Revision of neck muscle/rib	9.03	4.85	0.96	14.84	090	S
21720		A	Revision of neck muscle	5.44	3.84	0.52	9.80	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
21725		A	Revision of neck muscle	6.55	4.84	0.74	12.13	090	S
21740		A	Reconstruction of sternum	15.42	8.99	1.64	26.05	090	S
21750		A	Repair of sternum separation	10.07	7.33	1.43	18.83	090	S
21800		A	Treatment of rib fracture	0.91	0.77	0.07	1.75	090	N
21805		A	Treatment of rib fracture	2.62	1.35	0.17	4.14	090	S
21810		A	Treatment of rib fracture(s)	6.68	7.33	0.61	14.62	090	N
21820		A	Treat sternum fracture	1.20	1.36	0.17	2.73	090	S
21825		A	Repair sternum fracture	6.82	6.90	1.12	14.84	090	S
21899		C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	YYY	S
21920		A	Biopsy soft tissue of back	2.01	0.79	0.11	2.91	010	S
21925		A	Biopsy soft tissue of back	4.23	1.95	0.32	6.50	090	S
21930		A	Remove lesion, back or flank	6.55	2.72	0.49	9.76	090	S
21935		A	Remove tumor of back	17.12	6.59	1.30	25.01	090	S
22100		A	Remove part of neck vertebra	9.05	7.64	1.09	17.78	090	S
22101		A	Remove part, thorax vertebra	9.00	8.01	1.38	18.39	090	S
22102		A	Remove part, lumbar vertebra	9.00	4.50	0.67	14.17	090	S
22103		A	Remove extra spine segment	2.34	2.23	0.37	4.94	ZZZ	S
22105		D	Remove part of neck vertebra	0.00	0.00	0.00	0.00	090	S
22106		D	Remove part, thorax vertebra	0.00	0.00	0.00	0.00	090	S
22107		D	Remove part, lumbar vertebra	0.00	0.00	0.00	0.00	090	S
22110		A	Remove part of neck vertebra	11.59	9.72	1.64	22.95	090	S
22112		A	Remove part, thorax vertebra	11.59	9.90	1.63	23.12	090	S
22114		A	Remove part, lumbar vertebra	11.59	7.25	1.17	20.01	090	S
22116		A	Remove extra spine segment	2.32	2.21	0.36	4.89	ZZZ	S
22140		D	Reconstruct neck spine	0.00	0.00	0.00	0.00	090	S
22141		D	Reconstruct thorax spine	0.00	0.00	0.00	0.00	090	S
22142		D	Reconstruct lumbar spine	0.00	0.00	0.00	0.00	090	S
22145		D	Reconstruct vertebra(e)	0.00	0.00	0.00	0.00	ZZZ	S
22148		D	Harvesting bone graft	0.00	0.00	0.00	0.00	ZZZ	S
22150		D	Reconstruct neck spine	0.00	0.00	0.00	0.00	090	S
22151		D	Reconstruct thorax spine	0.00	0.00	0.00	0.00	090	S
22152		D	Reconstruct lumbar spine	0.00	0.00	0.00	0.00	090	S
22210		A	Revision of neck spine	22.51	13.83	2.43	38.77	090	S
22212		A	Revision of thorax spine	18.14	17.29	2.83	38.26	090	S
22214		A	Revision of lumbar spine	18.14	15.11	2.68	35.93	090	S
22216		A	Revise, extra spine segment	6.04	5.07	0.89	12.00	ZZZ	S
22220		A	Revision of neck spine	20.15	16.64	2.63	39.42	090	S
22222		A	Revision of thorax spine	20.15	13.61	1.58	35.34	090	S
22224		A	Revision of lumbar spine	20.15	14.68	2.66	37.49	090	S
22226		A	Revise, extra spine segment	6.04	5.07	0.89	12.00	ZZZ	S
22230		D	Additional revision of spine	0.00	0.00	0.00	0.00	ZZZ	S
22305		A	Treat spine process fracture	1.86	*2.38	0.37	4.61	090	S
22310		A	Treat spine fracture	1.86	*2.52	0.69	5.07	090	S
22315		A	Treat spine fracture	8.36	5.51	0.86	14.73	090	S
22325		A	Repair of spine fracture	17.19	8.32	1.34	26.85	090	S
22326		A	Repair neck spine fracture	18.43	15.93	2.74	37.10	090	S
22327		A	Repair thorax spine fracture	17.56	15.95	2.35	35.86	090	S
22328		A	Repair each add spine fx	4.61	4.40	0.72	9.73	ZZZ	S
22505		A	Manipulation of spine	1.77	1.31	0.17	3.25	010	N
22548		A	Neck spine fusion	24.08	22.74	3.82	50.64	090	S
22554		A	Neck spine fusion	17.24	19.81	3.52	40.57	090	S
22556		A	Thorax spine fusion	22.27	21.68	3.58	47.53	090	S
22558		A	Lumbar spine fusion	21.22	20.17	3.38	44.77	090	S
22585		A	Additional spinal fusion	5.53	5.40	0.93	11.86	ZZZ	S
22590		A	Spine & skull spinal fusion	19.50	21.57	3.44	44.51	090	S
22595		A	Neck spinal fusion	18.19	22.46	3.87	44.52	090	S
22600		A	Neck spine fusion	14.74	19.36	3.32	37.42	090	S
22610		A	Thorax spine fusion	14.62	17.87	2.75	35.24	090	S
22612		A	Lumbar spine fusion	20.19	20.60	3.33	44.12	090	S
22614		A	Spine fusion, extra segment	6.44	5.65	0.92	13.01	ZZZ	S
22625		D	Lumbar spine fusion	0.00	0.00	0.00	0.00	090	S
22630		A	Lumbar spine fusion	20.03	18.44	3.15	41.62	090	S
22632		A	Spine fusion, extra segment	5.23	4.99	0.82	11.04	ZZZ	S
22650		D	Additional spinal fusion	0.00	0.00	0.00	0.00	ZZZ	S
22800		A	Fusion of spine	16.92	*21.66	3.58	42.16	090	S
22802		A	Fusion of spine	29.74	28.32	4.61	62.67	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
22804		A	Fusion of spine	35.00	28.32	4.61	67.93	090	S
22808		A	Fusion of spine	25.00	18.41	3.15	46.56	090	S
22810		A	Fusion of spine	29.00	18.41	3.15	50.56	090	S
22812		A	Fusion of spine	31.00	25.93	4.24	61.17	090	S
22820		D	Harvesting of bone	0.00	0.00	0.00	0.00	ZZZ	S
22830		A	Exploration of spinal fusion	10.22	*13.07	2.18	25.47	090	S
22840		A	Insert spine fixation device	6.27	5.98	0.98	13.23	ZZZ	S
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	XXX	0
22842		A	Insert spine fixation device	7.19	6.86	1.12	15.17	ZZZ	S
22843		A	Insert spine fixation device	8.97	8.55	1.40	18.92	ZZZ	S
22844		A	Insert spine fixation device	10.96	10.45	1.71	23.12	ZZZ	S
22845		A	Insert spine fixation device	5.98	5.70	0.93	12.61	ZZZ	S
22846		A	Insert spine fixation device	8.28	7.90	1.29	17.47	ZZZ	S
22847		A	Insert spine fixation device	9.20	8.77	1.44	19.41	ZZZ	S
22848		A	Insert pelvic fixation device	6.00	5.72	0.94	12.66	ZZZ	S
22849		A	Reinsert spinal fixation	12.86	11.76	1.97	26.59	090	S
22850		A	Remove spine fixation device	8.98	9.17	1.50	19.65	090	S
22851		A	Apply spine prosth device	6.71	6.40	1.05	14.16	ZZZ	S
22852		A	Remove spine fixation device	8.40	9.80	1.57	19.77	090	S
22855		A	Remove spine fixation device	9.10	7.46	1.25	17.81	090	S
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	YYY	S
22900		A	Remove abdominal wall lesion	6.56	3.03	0.60	10.19	090	S
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	YYY	S
23000		A	Removal of calcium deposits	4.12	3.24	0.47	7.83	090	S
23020		A	Release shoulder joint	8.25	7.27	1.09	16.61	090	S
23030		A	Drain shoulder lesion	3.16	2.16	0.35	5.67	010	S
23031		A	Drain shoulder bursa	2.69	0.50	0.05	3.24	010	S
23035		A	Drain shoulder bone lesion	7.80	6.22	1.04	15.06	090	S
23040		A	Exploratory shoulder surgery	8.39	9.27	1.47	19.13	090	S
23044		A	Exploratory shoulder surgery	6.40	6.91	1.18	14.49	090	S
23065		A	Biopsy shoulder tissues	2.24	0.66	0.09	2.99	010	S
23066		A	Biopsy shoulder tissues	4.01	1.18	0.10	5.29	090	S
23075		A	Removal of shoulder lesion	2.34	1.68	0.29	4.31	010	S
23076		A	Removal of shoulder lesion	7.12	3.54	0.65	11.31	090	S
23077		A	Remove tumor of shoulder	14.65	7.38	1.38	23.41	090	S
23100		A	Biopsy of shoulder joint	5.63	*7.20	1.24	14.07	090	S
23101		A	Shoulder joint surgery	5.21	*6.68	1.21	13.10	090	S
23105		A	Remove shoulder joint lining	7.74	*9.91	1.73	19.38	090	S
23106		A	Incision of collarbone joint	5.56	4.75	0.80	11.11	090	S
23107		A	Explore, treat shoulder joint	8.13	9.59	1.60	19.32	090	S
23120		A	Partial removal, collar bone	6.65	4.61	0.74	12.00	090	S
23125		A	Removal of collarbone	8.90	8.49	1.27	18.66	090	S
23130		A	Partial removal, shoulder bone	7.10	7.05	1.14	15.29	090	S
23140		A	Removal of bone lesion	6.43	4.16	0.73	11.32	090	S
23145		A	Removal of bone lesion	8.54	8.13	1.33	18.00	090	S
23146		A	Removal of bone lesion	7.34	5.23	1.01	13.58	090	S
23150		A	Removal of humerus lesion	7.80	6.64	1.01	15.45	090	S
23155		A	Removal of humerus lesion	9.58	8.80	1.37	19.75	090	S
23156		A	Removal of humerus lesion	8.00	7.64	1.25	16.89	090	S
23170		A	Remove collarbone lesion	6.27	4.81	0.78	11.86	090	S
23172		A	Remove shoulder blade lesion	6.24	5.16	0.73	12.13	090	S
23174		A	Remove humerus lesion	8.71	8.55	1.21	18.47	090	S
23180		A	Remove collar bone lesion	7.82	4.30	0.67	12.79	090	S
23182		A	Remove shoulder blade lesion	7.44	6.57	1.13	15.14	090	S
23184		A	Remove humerus lesion	8.61	8.83	1.48	18.92	090	S
23190		A	Partial removal of scapula	6.78	6.07	0.98	13.83	090	S
23195		A	Removal of head of humerus	9.00	8.91	1.45	19.36	090	S
23200		A	Removal of collar bone	11.05	9.17	1.26	21.48	090	S
23210		A	Removal of shoulderblade	11.39	9.01	1.41	21.81	090	S
23220		A	Partial removal of humerus	13.31	12.05	2.03	27.39	090	S
23221		A	Partial removal of humerus	16.62	18.13	1.19	35.94	090	S
23222		A	Partial removal of humerus	16.64	15.02	2.30	33.96	090	S
23330		A	Remove shoulder foreign body	1.80	0.55	0.07	2.42	010	S
23331		A	Remove shoulder foreign body	6.89	2.26	0.38	9.53	090	S
23332		A	Remove shoulder foreign body	10.59	9.72	1.57	21.88	090	S
23350		A	Injection for shoulder x-ray	1.00	0.52	0.05	1.57	000	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
23395		A	Muscle transfer, shoulder/arm	12.42	11.13	1.84	25.39	090	S
23397		A	Muscle transfers	15.23	13.97	2.34	31.54	090	S
23400		A	Fixation of shoulder blade	12.96	9.84	1.68	24.48	090	S
23405		A	Incision of tendon & muscle	7.97	7.49	0.99	16.45	090	S
23406		A	Incise tendon(s) & muscle(s)	10.33	9.41	1.58	21.32	090	S
23410		A	Repair of tendon(s)	11.90	10.94	1.75	24.59	090	S
23412		A	Repair of tendon(s)	12.69	13.37	2.16	28.22	090	S
23415		A	Release of shoulder ligament	9.51	5.18	0.83	15.52	090	S
23420		A	Repair of shoulder	12.60	14.68	2.34	29.62	090	S
23430		A	Repair biceps tendon	9.56	7.34	1.19	18.09	090	S
23440		A	Removal/transplant tendon	10.08	7.17	1.17	18.42	090	S
23450		A	Repair shoulder capsule	12.85	12.75	2.04	27.64	090	S
23455		A	Repair shoulder capsule	13.82	15.56	2.50	31.88	090	S
23460		A	Repair shoulder capsule	14.66	14.07	2.24	30.97	090	S
23462		A	Repair shoulder capsule	14.62	15.13	2.48	32.23	090	S
23465		A	Repair shoulder capsule	15.14	14.15	2.27	31.56	090	S
23466		A	Repair shoulder capsule	13.65	16.53	2.67	32.85	090	S
23470		A	Reconstruct shoulder joint	16.12	16.76	2.65	35.53	090	S
23472		A	Reconstruct shoulder joint	16.09	*20.60	4.89	41.58	090	S
23480		A	Revision of collarbone	10.56	6.59	1.02	18.17	090	S
23485		A	Revision of collarbone	12.68	11.35	1.87	25.90	090	S
23490		A	Reinforce clavicle	11.31	9.98	0.80	22.09	090	S
23491		A	Reinforce shoulder bones	13.63	12.70	2.11	28.44	090	S
23500		A	Treat clavicle fracture	1.95	1.65	0.21	3.81	090	S
23505		A	Treat clavicle fracture	3.54	2.57	0.38	6.49	090	S
23515		A	Repair clavicle fracture	7.01	6.93	1.12	15.06	090	S
23520		A	Treat clavicle dislocation	2.03	1.38	0.19	3.60	090	S
23525		A	Treat clavicle dislocation	3.40	1.98	0.27	5.65	090	S
23530		A	Repair clavicle dislocation	7.02	6.58	0.91	14.51	090	S
23532		A	Repair clavicle dislocation	7.59	7.23	1.19	16.01	090	S
23540		A	Treat clavicle dislocation	2.10	1.55	0.19	3.84	090	S
23545		A	Treat clavicle dislocation	3.07	1.98	0.29	5.34	090	S
23550		A	Repair clavicle dislocation	6.65	*8.51	1.46	16.62	090	S
23552		A	Repair clavicle dislocation	7.83	7.29	1.17	16.29	090	S
23570		A	Treat shoulderblade fracture	2.10	1.70	0.25	4.05	090	S
23575		A	Treat shoulderblade fracture	3.88	2.75	0.43	7.06	090	S
23585		A	Repair scapula fracture	8.41	7.70	1.29	17.40	090	S
23600		A	Treat humerus fracture	2.75	2.90	0.43	6.08	090	S
23605		A	Treat humerus fracture	4.56	4.76	0.76	10.08	090	S
23615		A	Repair humerus fracture	8.38	*10.72	1.78	20.88	090	S
23616		A	Repair humerus fracture	19.88	22.32	3.54	45.74	090	S
23620		A	Treat humerus fracture	2.25	*2.88	0.46	5.59	090	S
23625		A	Treat humerus fracture	3.64	3.82	0.60	8.06	090	S
23630		A	Repair humerus fracture	6.89	8.82	1.40	17.11	090	S
23650		A	Treat shoulder dislocation	3.24	2.10	0.24	5.58	090	S
23655		A	Treat shoulder dislocation	4.26	2.93	0.44	7.63	090	S
23660		A	Repair shoulder dislocation	7.09	9.07	1.40	17.56	090	S
23665		A	Treat dislocation/fracture	4.16	3.35	0.51	8.02	090	S
23670		A	Repair dislocation/fracture	7.44	*9.52	1.85	18.81	090	S
23675		A	Treat dislocation/fracture	5.60	3.93	0.61	10.14	090	S
23680		A	Repair dislocation/fracture	9.44	*12.09	2.13	23.66	090	S
23700		A	Fixation of shoulder	2.47	2.09	0.34	4.90	010	S
23800		A	Fusion of shoulder joint	13.32	16.35	2.63	32.30	090	S
23802		A	Fusion of shoulder joint	14.67	14.07	2.24	30.98	090	S
23900		A	Amputation of arm & girdle	18.40	12.57	2.40	33.37	090	S
23920		A	Amputation at shoulder joint	13.60	13.85	2.54	29.99	090	S
23921		A	Amputation follow-up surgery	5.03	4.27	0.74	10.04	090	S
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	YYY	S
23930		A	Drainage of arm lesion	2.78	1.61	0.24	4.63	010	S
23931		A	Drainage of arm bursa	1.63	0.75	0.11	2.49	010	S
23935		A	Drain arm/elbow bone lesion	5.56	4.69	0.78	11.03	090	S
24000		A	Exploratory elbow surgery	5.32	*6.81	1.44	13.57	090	S
24006		A	Release elbow joint	8.70	7.14	1.17	17.01	090	S
24065		A	Biopsy arm/elbow soft tissue	2.03	0.79	0.10	2.92	010	S
24066		A	Biopsy arm/elbow soft tissue	4.95	2.71	0.41	8.07	090	S
24075		A	Remove arm/elbow lesion	3.79	1.98	0.35	6.12	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
24076		A	Remove arm/elbow lesion	6.01	3.68	0.67	10.36	090	S
24077		A	Remove tumor of arm/elbow	11.18	9.79	1.87	22.84	090	S
24100		A	Biopsy elbow joint lining	4.67	4.23	0.69	9.59	090	S
24101		A	Explore/treat elbow joint	5.84	*7.47	1.41	14.72	090	S
24102		A	Remove elbow joint lining	7.57	*9.68	1.81	19.06	090	S
24105		A	Removal of elbow bursa	3.43	3.77	0.63	7.83	090	S
24110		A	Remove humerus lesion	7.08	7.69	1.22	15.99	090	S
24115		A	Remove/graft bone lesion	8.88	7.68	1.33	17.89	090	S
24116		A	Remove/graft bone lesion	11.13	9.72	1.47	22.32	090	S
24120		A	Remove elbow lesion	6.36	6.02	0.98	13.36	090	S
24125		A	Remove/graft bone lesion	7.40	5.79	0.61	13.80	090	S
24126		A	Remove/graft bone lesion	7.76	7.40	1.21	16.37	090	S
24130		A	Removal of head of radius	5.96	6.72	1.08	13.76	090	S
24134		A	Removal of arm bone lesion	8.98	8.69	1.24	18.91	090	S
24136		A	Remove radius bone lesion	7.33	8.78	0.92	17.03	090	S
24138		A	Remove elbow bone lesion	7.36	6.39	1.06	14.81	090	S
24140		A	Partial removal of arm bone	8.56	8.77	1.45	18.78	090	S
24145		A	Partial removal of radius	7.12	6.38	1.03	14.53	090	S
24147		A	Partial removal of elbow	7.00	6.61	1.08	14.69	090	S
24150		A	Extensive humerus surgery	12.43	14.08	2.24	28.75	090	S
24151		A	Extensive humerus surgery	14.65	13.83	2.11	30.59	090	S
24152		A	Extensive radius surgery	9.51	6.80	1.16	17.47	090	S
24153		A	Extensive radius surgery	10.96	10.44	1.71	23.11	090	S
24155		A	Removal of elbow joint	11.11	10.75	1.72	23.58	090	S
24160		A	Remove elbow joint implant	7.43	4.84	0.80	13.07	090	S
24164		A	Remove radius head implant	5.79	5.53	0.90	12.22	090	S
24200		A	Removal of arm foreign body	1.71	0.56	0.06	2.33	010	N
24201		A	Removal of arm foreign body	4.30	3.06	0.49	7.85	090	S
24220		A	Injection for elbow x-ray	1.31	0.51	0.05	1.87	000	N
24301		A	Muscle/tendon transfer	9.78	7.90	1.23	18.91	090	S
24305		A	Arm tendon lengthening	7.16	3.08	0.29	10.53	090	S
24310		A	Revision of arm tendon	5.72	2.95	0.48	9.15	090	S
24320		A	Repair of arm tendon	10.01	9.20	1.29	20.50	090	S
24330		A	Revision of arm muscles	9.18	8.74	1.43	19.35	090	S
24331		A	Revision of arm muscles	10.10	9.62	1.57	21.29	090	S
24340		A	Repair of biceps tendon	7.58	7.00	1.13	15.71	090	S
24342		A	Repair of ruptured tendon	10.13	10.38	1.76	22.27	090	S
24350		A	Repair of tennis elbow	5.05	4.23	0.69	9.97	090	S
24351		A	Repair of tennis elbow	5.73	4.57	0.73	11.03	090	S
24352		A	Repair of tennis elbow	6.14	5.69	0.93	12.76	090	S
24354		A	Repair of tennis elbow	6.19	5.61	0.94	12.74	090	S
24356		A	Revision of tennis elbow	6.39	7.28	1.18	14.85	090	S
24360		A	Reconstruct elbow joint	11.76	*15.05	2.47	29.28	090	S
24361		A	Reconstruct elbow joint	13.50	13.13	2.00	28.63	090	S
24362		A	Reconstruct elbow joint	14.41	13.14	0.80	28.35	090	S
24363		A	Replace elbow joint	17.66	*22.61	4.13	44.40	090	S
24365		A	Reconstruct head of radius	7.93	7.52	1.19	16.64	090	S
24366		A	Reconstruct head of radius	8.67	11.05	1.80	21.52	090	S
24400		A	Revision of humerus	10.55	8.43	1.37	20.35	090	S
24410		A	Revision of humerus	14.28	14.04	2.06	30.38	090	S
24420		A	Revision of humerus	12.90	12.30	2.01	27.21	090	S
24430		A	Repair of humerus	12.26	14.66	2.34	29.26	090	S
24435		A	Repair humerus with graft	12.19	*15.61	2.84	30.64	090	S
24470		A	Revision of elbow joint	8.32	7.92	1.30	17.54	090	S
24495		A	Decompression of forearm	7.59	5.75	1.10	14.44	090	S
24498		A	Reinforce humerus	11.30	10.37	1.62	23.29	090	S
24500		A	Treat humerus fracture	3.01	2.54	0.36	5.91	090	S
24505		A	Treat humerus fracture	4.83	4.50	0.71	10.04	090	S
24515		A	Repair humerus fracture	10.92	9.65	1.54	22.11	090	S
24516		A	Repair humerus fracture	10.92	9.65	1.54	22.11	090	S
24530		A	Treat humerus fracture	3.30	2.73	0.42	6.45	090	S
24535		A	Treat humerus fracture	6.51	4.85	0.78	12.14	090	S
24538		A	Treat humerus fracture	8.85	7.98	1.26	18.09	090	S
24545		A	Repair humerus fracture	9.65	9.97	1.59	21.21	090	S
24546		A	Repair humerus fracture	14.66	9.97	1.59	26.22	090	S
24560		A	Treat humerus fracture	2.62	2.16	0.30	5.08	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
24565		A	Treat humerus fracture	5.22	3.45	0.54	9.21	090	S
24566		A	Treat humerus fracture	7.17	6.06	0.96	14.19	090	S
24575		A	Repair humerus fracture	9.91	7.79	1.24	18.94	090	S
24576		A	Treat humerus fracture	2.66	2.16	0.33	5.15	090	S
24577		A	Treat humerus fracture	5.45	4.00	0.61	10.06	090	S
24579		A	Repair humerus fracture	10.85	8.37	1.35	20.57	090	S
24582		A	Treat humerus fracture	7.83	6.62	1.06	15.51	090	S
24586		A	Repair elbow fracture	14.37	14.72	2.36	31.45	090	S
24587		A	Repair elbow fracture	14.26	13.72	2.17	30.15	090	S
24600		A	Treat elbow dislocation	4.08	1.95	0.26	6.29	090	S
24605		A	Treat elbow dislocation	5.08	2.29	0.37	7.74	090	S
24615		A	Repair elbow dislocation	8.76	9.29	1.48	19.53	090	S
24620		A	Treat elbow fracture	6.62	3.78	0.57	10.97	090	S
24635		A	Repair elbow fracture	12.42	11.06	1.78	25.26	090	S
24640		A	Treat elbow dislocation	1.15	1.01	0.08	2.24	010	N
24650		A	Treat radius fracture	2.01	2.25	0.33	4.59	090	S
24655		A	Treat radius fracture	4.17	3.01	0.45	7.63	090	S
24665		A	Repair radius fracture	7.69	7.13	1.14	15.96	090	S
24666		A	Repair radius fracture	8.87	10.27	1.60	20.74	090	S
24670		A	Treatment of ulna fracture	2.39	1.95	0.27	4.61	090	S
24675		A	Treatment of ulna fracture	4.52	3.51	0.54	8.57	090	S
24685		A	Repair ulna fracture	8.34	8.40	1.34	18.08	090	S
24800		A	Fusion of elbow joint	10.75	10.59	1.55	22.89	090	S
24802		A	Fusion/graft of elbow joint	12.79	12.18	1.99	26.96	090	S
24900		A	Amputation of upper arm	8.76	7.68	1.39	17.83	090	S
24920		A	Amputation of upper arm	8.69	6.78	1.19	16.66	090	S
24925		A	Amputation follow-up surgery	6.61	6.27	0.75	13.63	090	S
24930		A	Amputation follow-up surgery	9.40	8.16	1.17	18.73	090	S
24931		A	Amputate upper arm & implant	11.71	11.17	1.84	24.72	090	S
24935		A	Revision of amputation	14.37	13.70	2.24	30.31	090	S
24940		C	Revision of upper arm	0.00	0.00	0.00	0.00	090	S
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	YYY	S
25000		A	Incision of tendon sheath	3.20	3.94	0.62	7.76	090	S
25020		A	Decompression of forearm	5.55	4.35	0.77	10.67	090	S
25023		A	Decompression of forearm	11.80	5.44	0.94	18.18	090	S
25028		A	Drainage of forearm lesion	4.88	2.06	0.36	7.30	090	S
25031		A	Drainage of forearm bursa	3.90	0.66	0.09	4.65	090	S
25035		A	Treat forearm bone lesion	6.83	6.30	1.01	14.14	090	S
25040		A	Explore/treat wrist joint	6.61	5.69	0.90	13.20	090	S
25065		A	Biopsy forearm soft tissues	2.39	0.75	0.09	3.23	010	S
25066		A	Biopsy forearm soft tissues	3.87	1.54	0.22	5.63	090	S
25075		A	Removal of forearm lesion	3.61	2.19	0.37	6.17	090	S
25076		A	Removal of forearm lesion	4.77	3.77	0.67	9.21	090	S
25077		A	Remove tumor, forearm/wrist	9.25	8.48	1.67	19.40	090	S
25085		A	Incision of wrist capsule	5.13	4.62	0.71	10.46	090	S
25100		A	Biopsy of wrist joint	3.66	*4.69	0.79	9.14	090	S
25101		A	Explore/treat wrist joint	4.43	5.61	0.98	11.02	090	S
25105		A	Remove wrist joint lining	5.56	*7.11	1.19	13.86	090	S
25107		A	Remove wrist joint cartilage	5.89	5.28	0.89	12.06	090	S
25110		A	Remove wrist tendon lesion	3.79	2.80	0.46	7.05	090	S
25111		A	Remove wrist tendon lesion	3.24	3.22	0.55	7.01	090	S
25112		A	Reremove wrist tendon lesion	4.38	3.72	0.66	8.76	090	S
25115		A	Remove wrist/forearm lesion	6.26	7.14	1.23	14.63	090	S
25116		A	Remove wrist/forearm lesion	6.44	8.17	1.38	15.99	090	S
25118		A	Excise wrist tendon sheath	4.11	*5.26	1.02	10.39	090	S
25119		A	Partial removal of ulna	5.64	*7.22	1.32	14.18	090	S
25120		A	Removal of forearm lesion	5.70	6.53	1.14	13.37	090	S
25125		A	Remove/graft forearm lesion	7.06	6.84	1.04	14.94	090	S
25126		A	Remove/graft forearm lesion	7.13	6.80	1.12	15.05	090	S
25130		A	Removal of wrist lesion	5.08	4.21	0.67	9.96	090	S
25135		A	Remove & graft wrist lesion	6.58	5.46	0.97	13.01	090	S
25136		A	Remove & graft wrist lesion	5.68	4.74	0.85	11.27	090	S
25145		A	Remove forearm bone lesion	5.97	5.95	0.75	12.67	090	S
25150		A	Partial removal of ulna	6.56	6.67	1.12	14.35	090	S
25151		A	Partial removal of radius	6.86	5.75	1.02	13.63	090	S
25170		A	Extensive forearm surgery	10.45	9.79	1.51	21.75	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
25210		A	Removal of wrist bone	5.55	4.88	0.80	11.23	090	S
25215		A	Removal of wrist bones	7.40	8.68	1.42	17.50	090	S
25230		A	Partial removal of radius	4.86	5.57	0.85	11.28	090	S
25240		A	Partial removal of ulna	4.91	5.30	0.86	11.07	090	S
25246		A	Injection for wrist x-ray	1.45	0.50	0.05	2.00	000	N
25248		A	Remove forearm foreign body	4.96	2.18	0.37	7.51	090	S
25250		A	Removal of wrist prosthesis	6.31	5.63	0.91	12.85	090	S
25251		A	Removal of wrist prosthesis	9.08	8.25	1.39	18.72	090	S
25260		A	Repair forearm tendon/muscle	7.33	4.61	0.78	12.72	090	S
25263		A	Repair forearm tendon/muscle	7.37	5.77	1.03	14.17	090	S
25265		A	Repair forearm tendon/muscle	9.54	7.93	1.41	18.88	090	S
25270		A	Repair forearm tendon/muscle	5.71	3.36	0.55	9.62	090	S
25272		A	Repair forearm tendon/muscle	6.75	3.44	0.54	10.73	090	S
25274		A	Repair forearm tendon/muscle	8.44	6.62	1.13	16.19	090	S
25280		A	Revise wrist/forearm tendon	6.82	4.22	0.69	11.73	090	S
25290		A	Incise wrist/forearm tendon	5.03	2.47	0.41	7.91	090	S
25295		A	Release wrist/forearm tendon	6.26	3.05	0.52	9.83	090	S
25300		A	Fusion of tendons at wrist	8.46	7.36	1.19	17.01	090	S
25301		A	Fusion of tendons at wrist	8.09	6.77	1.18	16.04	090	S
25310		A	Transplant forearm tendon	7.68	7.14	1.17	15.99	090	S
25312		A	Transplant forearm tendon	9.08	7.63	1.31	18.02	090	S
25315		A	Revise palsy hand tendon(s)	9.45	8.06	1.34	18.85	090	S
25316		A	Revise palsy hand tendon(s)	11.49	10.58	1.78	23.85	090	S
25320		A	Repair/revise wrist joint	9.89	8.60	1.45	19.94	090	S
25330		A	Revise wrist joint	10.85	9.23	1.50	21.58	090	S
25331		A	Revise wrist joint	12.60	14.66	2.40	29.66	090	S
25332		A	Revise wrist joint	10.83	9.98	1.61	22.42	090	S
25335		A	Realignment of hand	12.11	11.41	1.56	25.08	090	S
25337		A	Reconstruct ulna/radioulnar	9.50	8.60	1.45	19.55	090	S
25350		A	Revision of radius	8.23	7.61	1.26	17.10	090	S
25355		A	Revision of radius	9.55	9.12	1.49	20.16	090	S
25360		A	Revision of ulna	7.88	6.41	0.99	15.28	090	S
25365		A	Revise radius & ulna	11.63	10.31	1.57	23.51	090	S
25370		A	Revise radius or ulna	12.34	11.76	1.92	26.02	090	S
25375		A	Revise radius & ulna	12.27	13.38	0.87	26.52	090	S
25390		A	Shorten radius/ulna	9.85	8.82	1.50	20.17	090	S
25391		A	Lengthen radius/ulna	12.75	11.25	1.93	25.93	090	S
25392		A	Shorten radius & ulna	13.05	12.44	2.04	27.53	090	S
25393		A	Lengthen radius & ulna	14.90	14.21	2.32	31.43	090	S
25400		A	Repair radius or ulna	10.30	10.78	1.75	22.83	090	S
25405		A	Repair/graft radius or ulna	13.48	12.42	2.02	27.92	090	S
25415		A	Repair radius & ulna	12.64	11.42	1.92	25.98	090	S
25420		A	Repair/graft radius & ulna	15.34	14.70	2.28	32.32	090	S
25425		A	Repair/graft radius or ulna	12.44	12.02	1.87	26.33	090	S
25426		A	Repair/graft radius & ulna	14.92	11.72	2.13	28.77	090	S
25440		A	Repair/graft wrist bone	9.95	9.05	1.50	20.50	090	S
25441		A	Reconstruct wrist joint	12.26	11.36	1.89	25.51	090	S
25442		A	Reconstruct wrist joint	10.34	7.06	1.22	18.62	090	S
25443		A	Reconstruct wrist joint	9.88	9.38	1.52	20.78	090	S
25444		A	Reconstruct wrist joint	10.64	10.14	1.66	22.44	090	S
25445		A	Reconstruct wrist joint	9.27	10.36	1.72	21.35	090	S
25446		A	Wrist replacement	15.52	*19.86	3.49	38.87	090	S
25447		A	Repair wrist joint(s)	9.86	9.65	1.56	21.07	090	S
25449		A	Remove wrist joint implant	13.78	7.84	1.16	22.78	090	S
25450		A	Revision of wrist joint	7.67	7.31	1.19	16.17	090	S
25455		A	Revision of wrist joint	9.15	8.71	1.42	19.28	090	S
25490		A	Reinforce radius	9.12	8.69	1.42	19.23	090	S
25491		A	Reinforce ulna	9.54	9.10	1.49	20.13	090	S
25492		A	Reinforce radius and ulna	11.75	11.20	1.84	24.79	090	S
25500		A	Treat fracture of radius	2.30	2.33	0.29	4.92	090	S
25505		A	Treat fracture of radius	4.96	3.57	0.51	9.04	090	S
25515		A	Repair fracture of radius	8.63	7.63	1.22	17.48	090	S
25520		A	Repair fracture of radius	6.01	5.74	0.94	12.69	090	S
25525		A	Repair fracture of radius	11.69	11.15	1.83	24.67	090	S
25526		A	Repair fracture of radius	12.43	11.85	1.94	26.22	090	S
25530		A	Treat fracture of ulna	1.94	2.44	0.35	4.73	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
25535		A	Treat fracture of ulna	4.91	3.57	0.54	9.02	090	S
25545		A	Repair fracture of ulna	8.35	7.58	1.20	17.13	090	S
25560		A	Treat fracture radius & ulna	2.29	2.27	0.27	4.83	090	S
25565		A	Treat fracture radius & ulna	5.29	4.66	0.70	10.65	090	S
25574		A	Treat fracture radius & ulna	6.03	*7.72	1.73	15.48	090	S
25575		A	Repair fracture radius/ulna	9.47	10.70	1.73	21.90	090	S
25600		A	Treat fracture radius/ulna	2.48	2.84	0.42	5.74	090	S
25605		A	Treat fracture radius/ulna	5.36	3.95	0.61	9.92	090	S
25611		A	Repair fracture radius/ulna	7.11	6.01	0.97	14.09	090	S
25620		A	Repair fracture radius/ulna	8.15	7.13	1.14	16.42	090	S
25622		A	Treat wrist bone fracture	2.43	2.28	0.33	5.04	090	S
25624		A	Treat wrist bone fracture	4.28	3.67	0.57	8.52	090	S
25628		A	Repair wrist bone fracture	7.81	7.13	1.16	16.10	090	S
25630		A	Treat wrist bone fracture	2.73	2.19	0.30	5.22	090	S
25635		A	Treat wrist bone fracture	4.16	3.36	0.50	8.02	090	S
25645		A	Repair wrist bone fracture	6.85	6.68	0.95	14.48	090	S
25650		A	Repair wrist bone fracture	2.87	2.66	0.36	5.89	090	S
25660		A	Treat wrist dislocation	4.53	1.82	0.26	6.61	090	S
25670		A	Repair wrist dislocation	7.52	7.08	1.12	15.72	090	S
25675		A	Treat wrist dislocation	4.44	2.28	0.34	7.06	090	S
25676		A	Repair wrist dislocation	7.55	7.32	1.11	15.98	090	S
25680		A	Treat wrist fracture	5.63	2.44	0.36	8.43	090	S
25685		A	Repair wrist fracture	9.23	8.79	1.44	19.46	090	S
25690		A	Treat wrist dislocation	5.16	4.89	0.73	10.78	090	S
25695		A	Repair wrist dislocation	7.94	7.04	1.17	16.15	090	S
25800		A	Fusion of wrist joint	9.21	10.94	1.80	21.95	090	S
25805		A	Fusion/graft of wrist joint	10.57	12.85	2.09	25.51	090	S
25810		A	Fusion/graft of wrist joint	9.79	*12.53	2.06	24.38	090	S
25820		A	Fusion of hand bones	7.14	8.91	1.48	17.53	090	S
25825		A	Fusion hand bones with graft	8.60	*11.02	1.99	21.61	090	S
25830		A	Fusion radioulnar jnt/ulna	9.50	8.60	1.45	19.55	090	S
25900		A	Amputation of forearm	8.15	7.08	1.31	16.54	090	S
25905		A	Amputation of forearm	8.40	7.11	1.15	16.66	090	S
25907		A	Amputation follow-up surgery	7.27	5.74	1.00	14.01	090	S
25909		A	Amputation follow-up surgery	8.37	5.55	1.06	14.98	090	S
25915		A	Amputation of forearm	16.61	15.83	2.59	35.03	090	S
25920		A	Amputate hand at wrist	8.09	7.00	1.20	16.29	090	S
25922		A	Amputate hand at wrist	6.96	5.55	1.02	13.53	090	S
25924		A	Amputation follow-up surgery	7.87	7.50	1.22	16.59	090	S
25927		A	Amputation of hand	8.27	6.29	1.22	15.78	090	S
25929		A	Amputation follow-up surgery	7.13	4.74	0.96	12.83	090	S
25931		A	Amputation follow-up surgery	7.35	4.54	0.90	12.79	090	S
25999		C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	YYY	S
26010		A	Drainage of finger abscess	1.49	0.48	0.05	2.02	010	N
26011		A	Drainage of finger abscess	2.14	1.54	0.24	3.92	010	S
26020		A	Drain hand tendon sheath	4.01	3.72	0.63	8.36	090	S
26025		A	Drainage of palm bursa	4.32	4.51	0.76	9.59	090	S
26030		A	Drainage of palm bursa(s)	5.36	5.73	0.98	12.07	090	S
26034		A	Treat hand bone lesion	5.59	4.23	0.71	10.53	090	S
26035		A	Decompress fingers/hand	8.38	5.17	0.86	14.41	090	S
26037		A	Decompress fingers/hand	6.68	6.37	1.05	14.10	090	S
26040		A	Release palm contracture	3.09	2.86	0.49	6.44	090	S
26045		A	Release palm contracture	5.27	4.83	0.81	10.91	090	S
26055		A	Incise finger tendon sheath	2.56	*3.28	0.56	6.40	090	S
26060		A	Incision of finger tendon	2.71	1.13	0.17	4.01	090	S
26070		A	Explore/treat hand joint	3.34	2.76	0.42	6.52	090	S
26075		A	Explore/treat finger joint	3.44	3.78	0.62	7.84	090	S
26080		A	Explore/treat finger joint	3.78	3.14	0.51	7.43	090	S
26100		A	Biopsy hand joint lining	3.54	2.99	0.45	6.98	090	S
26105		A	Biopsy finger joint lining	3.58	4.17	0.67	8.42	090	S
26110		A	Biopsy finger joint lining	3.40	2.93	0.50	6.83	090	S
26115		A	Removal of hand lesion	3.68	2.01	0.34	6.03	090	S
26116		A	Removal of hand lesion	5.19	3.71	0.62	9.52	090	S
26117		A	Remove tumor, hand/finger	8.24	5.07	0.91	14.22	090	S
26121		A	Release palm contracture	7.34	*9.40	1.61	18.35	090	S
26123		A	Release palm contracture	8.64	9.10	1.53	19.27	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
26125		A	Release palm contracture	4.61	2.62	0.45	7.68	ZZZ	S
26130		A	Remove wrist joint lining	5.13	5.01	0.86	11.00	090	S
26135		A	Revise finger joint, each	6.67	4.86	0.82	12.35	090	S
26140		A	Revise finger joint, each	5.88	4.40	0.75	11.03	090	S
26145		A	Tendon excision, palm/finger	6.03	4.71	0.80	11.54	090	S
26160		A	Remove tendon sheath lesion	3.00	2.32	0.40	5.72	090	S
26170		A	Removal of palm tendon, each	4.62	2.83	0.45	7.90	090	S
26180		A	Removal of finger tendon	5.00	4.01	0.71	9.72	090	S
26200		A	Remove hand bone lesion	5.25	4.48	0.72	10.45	090	S
26205		A	Remove/graft bone lesion	7.24	6.40	1.03	14.67	090	S
26210		A	Removal of finger lesion	4.97	3.90	0.64	9.51	090	S
26215		A	Remove/graft finger lesion	6.81	5.55	0.94	13.30	090	S
26230		A	Partial removal of hand bone	5.96	4.26	0.69	10.91	090	S
26235		A	Partial removal, finger bone	5.82	4.17	0.71	10.70	090	S
26236		A	Partial removal, finger bone	4.95	3.86	0.66	9.47	090	S
26250		A	Extensive hand surgery	7.26	6.00	1.07	14.33	090	S
26255		A	Extensive hand surgery	11.66	8.94	1.54	22.14	090	S
26260		A	Extensive finger surgery	6.74	5.73	0.97	13.44	090	S
26261		A	Extensive finger surgery	8.54	7.70	1.31	17.55	090	S
26262		A	Partial removal of finger	5.41	4.75	0.76	10.92	090	S
26320		A	Removal of implant from hand	3.74	3.54	0.57	7.85	090	S
26350		A	Repair finger/hand tendon	5.76	5.74	0.99	12.49	090	S
26352		A	Repair/graft hand tendon	7.26	6.60	1.10	14.96	090	S
26356		A	Repair finger/hand tendon	7.05	7.21	1.24	15.50	090	S
26357		A	Repair finger/hand tendon	8.16	6.58	1.19	15.93	090	S
26358		A	Repair/graft hand tendon	8.69	7.40	1.27	17.36	090	S
26370		A	Repair finger/hand tendon	6.71	6.71	1.13	14.55	090	S
26372		A	Repair/graft hand tendon	8.27	6.39	1.15	15.81	090	S
26373		A	Repair finger/hand tendon	7.67	6.85	1.11	15.63	090	S
26390		A	Revise hand/finger tendon	8.73	7.95	1.23	17.91	090	S
26392		A	Repair/graft hand tendon	9.77	8.61	1.26	19.64	090	S
26410		A	Repair hand tendon	4.37	3.29	0.51	8.17	090	S
26412		A	Repair/graft hand tendon	5.91	6.01	0.97	12.89	090	S
26415		A	Excision, hand/finger tendon	8.05	6.75	0.90	15.70	090	S
26416		A	Graft hand or finger tendon	9.06	8.64	1.41	19.11	090	S
26418		A	Repair finger tendon	4.02	3.58	0.59	8.19	090	S
26420		A	Repair/graft finger tendon	6.37	5.68	0.96	13.01	090	S
26426		A	Repair finger/hand tendon	5.86	6.31	1.07	13.24	090	S
26428		A	Repair/graft finger tendon	6.90	5.50	1.00	13.40	090	S
26432		A	Repair finger tendon	3.87	3.15	0.51	7.53	090	S
26433		A	Repair finger tendon	4.41	3.94	0.66	9.01	090	S
26434		A	Repair/graft finger tendon	5.80	4.95	0.84	11.59	090	S
26437		A	Realignment of tendons	5.53	4.05	0.68	10.26	090	S
26440		A	Release palm/finger tendon	4.76	3.57	0.59	8.92	090	S
26442		A	Release palm & finger tendon	6.10	3.37	0.59	10.06	090	S
26445		A	Release hand/finger tendon	4.16	3.25	0.54	7.95	090	S
26449		A	Release forearm/hand tendon	6.39	5.57	0.96	12.92	090	S
26450		A	Incision of palm tendon	3.54	2.28	0.36	6.18	090	S
26455		A	Incision of finger tendon	3.51	1.89	0.33	5.73	090	S
26460		A	Incise hand/finger tendon	3.33	1.72	0.30	5.35	090	S
26471		A	Fusion of finger tendons	5.55	4.15	0.67	10.37	090	S
26474		A	Fusion of finger tendons	5.14	4.61	0.75	10.50	090	S
26476		A	Tendon lengthening	5.00	2.89	0.27	8.16	090	S
26477		A	Tendon shortening	4.97	3.99	0.73	9.69	090	S
26478		A	Lengthening of hand tendon	5.62	4.30	0.72	10.64	090	S
26479		A	Shortening of hand tendon	5.56	5.29	0.86	11.71	090	S
26480		A	Transplant hand tendon	6.49	6.53	1.11	14.13	090	S
26483		A	Transplant/graft hand tendon	7.87	8.50	1.40	17.77	090	S
26485		A	Transplant palm tendon	7.28	6.50	1.08	14.86	090	S
26489		A	Transplant/graft palm tendon	9.00	3.40	0.51	12.91	090	S
26490		A	Revise thumb tendon	7.99	7.80	1.28	17.07	090	S
26492		A	Tendon transfer with graft	9.17	8.75	1.21	19.13	090	S
26494		A	Hand tendon/muscle transfer	8.05	7.28	1.23	16.56	090	S
26496		A	Revise thumb tendon	9.17	8.73	1.53	19.43	090	S
26497		A	Finger tendon transfer	9.15	8.02	1.38	18.55	090	S
26498		A	Finger tendon transfer	13.55	11.78	2.04	27.37	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
26499		A	Revision of finger	8.56	7.75	1.25	17.56	090	S
26500		A	Hand tendon reconstruction	5.67	3.49	0.60	9.76	090	S
26502		A	Hand tendon reconstruction	6.74	5.27	0.95	12.96	090	S
26504		A	Hand tendon reconstruction	7.05	6.72	1.11	14.88	090	S
26508		A	Release thumb contracture	5.61	4.15	0.72	10.48	090	S
26510		A	Thumb tendon transfer	5.03	4.15	0.68	9.86	090	S
26516		A	Fusion of knuckle joint	6.75	4.16	0.67	11.58	090	S
26517		A	Fusion of knuckle joints	8.34	7.07	1.23	16.64	090	S
26518		A	Fusion of knuckle joints	8.53	6.51	1.22	16.26	090	S
26520		A	Release knuckle contracture	5.01	4.48	0.71	10.20	090	S
26525		A	Release finger contracture	5.04	3.64	0.62	9.30	090	S
26530		A	Revise knuckle joint	6.38	5.16	0.85	12.39	090	S
26531		A	Revise knuckle with implant	7.57	6.65	1.11	15.33	090	S
26535		A	Revise finger joint	4.95	4.84	0.58	10.37	090	S
26536		A	Revise/implant finger joint	6.06	7.21	1.19	14.46	090	S
26540		A	Repair hand joint	6.03	6.64	1.12	13.79	090	S
26541		A	Repair hand joint with graft	8.20	8.94	1.47	18.61	090	S
26542		A	Repair hand joint with graft	6.38	5.67	0.97	13.02	090	S
26545		A	Reconstruct finger joint	6.50	5.27	0.94	12.71	090	S
26548		A	Reconstruct finger joint	7.61	5.79	1.00	14.40	090	S
26550		A	Construct thumb replacement	20.77	19.81	3.24	43.82	090	S
26552		C	Construct thumb replacement	0.00	0.00	0.00	0.00	090	S
26555		A	Positional change of finger	16.16	15.41	2.52	34.09	090	S
26557		C	Construct finger replacement	0.00	0.00	0.00	0.00	090	S
26558		C	Added finger surgery	0.00	0.00	0.00	0.00	090	S
26559		C	Added finger surgery	0.00	0.00	0.00	0.00	090	S
26560		A	Repair of web finger	5.23	4.65	0.66	10.54	090	S
26561		A	Repair of web finger	10.50	8.89	1.56	20.95	090	S
26562		A	Repair of web finger	9.23	10.97	0.82	21.02	090	S
26565		A	Correct metacarpal flaw	6.45	5.82	0.85	13.12	090	S
26567		A	Correct finger deformity	6.53	4.28	0.67	11.48	090	S
26568		A	Lengthen metacarpal/finger	8.66	8.45	1.06	18.17	090	S
26580		A	Repair hand deformity	17.71	16.89	2.76	37.36	090	S
26585		A	Repair finger deformity	13.58	12.95	2.12	28.65	090	S
26587		C	Reconstruct extra finger	0.00	0.00	0.00	0.00	090	S
26590		A	Repair finger deformity	17.44	16.63	2.72	36.79	090	S
26591		A	Repair muscles of hand	2.90	2.29	0.39	5.58	090	S
26593		A	Release muscles of hand	4.89	4.12	0.70	9.71	090	S
26596		A	Excision constricting tissue	8.64	8.24	1.35	18.23	090	S
26597		A	Release of scar contracture	9.37	8.02	1.37	18.76	090	S
26600		A	Treat metacarpal fracture	1.81	1.54	0.22	3.57	090	S
26605		A	Treat metacarpal fracture	2.67	2.29	0.36	5.32	090	S
26607		A	Treat metacarpal fracture	5.12	3.55	0.57	9.24	090	S
26608		A	Treat metacarpal fracture	5.12	3.55	0.57	9.24	090	S
26615		A	Repair metacarpal fracture	5.18	4.87	0.80	10.85	090	S
26641		A	Treat thumb dislocation	3.74	1.11	0.14	4.99	090	S
26645		A	Treat thumb fracture	4.23	2.20	0.33	6.76	090	S
26650		A	Repair thumb fracture	5.49	4.01	0.64	10.14	090	S
26665		A	Repair thumb fracture	7.14	6.39	1.09	14.62	090	S
26670		A	Treat hand dislocation	3.54	0.96	0.10	4.60	090	S
26675		A	Treat hand dislocation	4.44	4.34	0.60	9.38	090	S
26676		A	Pin hand dislocation	5.29	4.86	0.67	10.82	090	S
26685		A	Repair hand dislocation	6.54	5.76	0.91	13.21	090	S
26686		A	Repair hand dislocation	7.48	6.31	1.04	14.83	090	S
26700		A	Treat knuckle dislocation	3.54	0.88	0.10	4.52	090	S
26705		A	Treat knuckle dislocation	3.99	1.78	0.27	6.04	090	S
26706		A	Pin knuckle dislocation	4.92	4.68	0.75	10.35	090	S
26715		A	Repair knuckle dislocation	5.48	4.13	0.66	10.27	090	S
26720		A	Treat finger fracture, each	1.56	1.10	0.15	2.81	090	S
26725		A	Treat finger fracture, each	3.18	1.54	0.23	4.95	090	S
26727		A	Treat finger fracture, each	4.92	2.45	0.38	7.75	090	S
26735		A	Repair finger fracture, each	5.72	3.73	0.61	10.06	090	S
26740		A	Treat finger fracture, each	1.81	1.16	0.16	3.13	090	S
26742		A	Treat finger fracture, each	3.70	1.98	0.32	6.00	090	S
26746		A	Repair finger fracture, each	5.55	4.75	0.80	11.10	090	S
26750		A	Treat finger fracture, each	1.60	0.83	0.10	2.53	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
26755		A	Treat finger fracture, each	2.97	1.08	0.15	4.20	090	S
26756		A	Pin finger fracture, each	4.19	1.90	0.33	6.42	090	S
26765		A	Repair finger fracture, each	4.04	2.66	0.45	7.15	090	S
26770		A	Treat finger dislocation	2.89	0.76	0.08	3.73	090	S
26775		A	Treat finger dislocation	3.51	1.13	0.17	4.81	090	S
26776		A	Pin finger dislocation	4.60	2.08	0.35	7.03	090	S
26785		A	Repair finger dislocation	4.08	2.97	0.48	7.53	090	S
26820		A	Thumb fusion with graft	7.84	6.65	1.05	15.54	090	S
26841		A	Fusion of thumb	6.79	6.17	1.00	13.96	090	S
26842		A	Thumb fusion with graft	7.75	8.58	1.37	17.70	090	S
26843		A	Fusion of hand joint	7.21	6.37	1.10	14.68	090	S
26844		A	Fusion/graft of hand joint	8.24	7.35	1.19	16.78	090	S
26850		A	Fusion of knuckle	6.57	4.63	0.76	11.96	090	S
26852		A	Fusion of knuckle with graft	7.97	5.72	1.00	14.69	090	S
26860		A	Fusion of finger joint	4.49	4.30	0.68	9.47	090	S
26861		A	Fusion of finger joint, added	1.74	*2.23	0.43	4.40	ZZZ	S
26862		A	Fusion/graft of finger joint	7.06	5.16	0.85	13.07	090	S
26863		A	Fuse/graft added joint	3.90	3.37	0.57	7.84	ZZZ	S
26910		A	Amputate metacarpal bone	7.18	5.16	0.93	13.27	090	S
26951		A	Amputation of finger/thumb	4.41	2.87	0.49	7.77	090	S
26952		A	Amputation of finger/thumb	6.02	4.00	0.69	10.71	090	S
26989		C	Hand/finger surgery	0.00	0.00	0.00	0.00	YYY	S
26990		A	Drainage of pelvis lesion	6.76	3.10	0.51	10.37	090	S
26991		A	Drainage of pelvis bursa	6.05	1.81	0.29	8.15	090	S
26992		A	Drainage of bone lesion	13.97	6.38	1.05	21.40	090	S
27000		A	Incision of hip tendon	5.27	1.85	0.24	7.36	090	S
27001		A	Incision of hip tendon	7.70	2.34	0.38	10.42	090	S
27003		A	Incision of hip tendon	6.53	6.77	1.08	14.38	090	S
27005		A	Incision of hip tendon	9.00	3.37	0.54	12.91	090	S
27006		A	Incision of hip tendons	9.50	4.64	0.77	14.91	090	S
27025		A	Incision of hip/thigh fascia	10.16	6.12	1.02	17.30	090	S
27030		A	Drainage of hip joint	12.09	11.42	1.86	25.37	090	S
27033		A	Exploration of hip joint	12.38	11.52	1.85	25.75	090	S
27035		A	Denervation of hip joint	15.72	11.86	2.21	29.79	090	S
27040		A	Biopsy of soft tissues	3.26	0.72	0.11	4.09	010	N
27041		A	Biopsy of soft tissues	9.36	2.67	0.44	12.47	090	S
27047		A	Remove hip/pelvis lesion	7.16	1.89	0.32	9.37	090	S
27048		A	Remove hip/pelvis lesion	5.70	4.33	0.82	10.85	090	S
27049		A	Remove tumor, hip/pelvis	12.52	10.14	1.87	24.53	090	S
27050		A	Biopsy of sacroiliac joint	3.73	*4.78	0.90	9.41	090	S
27052		A	Biopsy of hip joint	5.45	*6.97	1.59	14.01	090	S
27054		A	Removal of hip joint lining	7.60	*9.72	2.26	19.58	090	S
27060		A	Removal of ischial bursa	4.73	3.93	0.68	9.34	090	S
27062		A	Remove femur lesion/bursa	4.74	4.23	0.70	9.67	090	S
27065		A	Removal of hip bone lesion	4.98	5.59	0.90	11.47	090	S
27066		A	Removal of hip bone lesion	9.17	7.90	1.30	18.37	090	S
27067		A	Remove/graft hip bone lesion	12.64	11.63	1.93	26.20	090	S
27070		A	Partial removal of hip bone	9.58	7.41	1.21	18.20	090	S
27071		A	Partial removal of hip bone	10.23	8.50	1.45	20.18	090	S
27075		A	Extensive hip surgery	15.85	13.54	2.32	31.71	090	S
27076		A	Extensive hip surgery	17.93	16.37	2.61	36.91	090	S
27077		A	Extensive hip surgery	21.29	18.98	3.24	43.51	090	S
27078		A	Extensive hip surgery	11.86	9.20	1.67	22.73	090	S
27079		A	Extensive hip surgery	12.11	8.64	1.66	22.41	090	S
27080		A	Removal of tail bone	5.63	4.78	0.87	11.28	090	S
27086		A	Remove hip foreign body	1.82	0.58	0.07	2.47	010	S
27087		A	Remove hip foreign body	8.01	3.62	0.60	12.23	090	S
27090		A	Removal of hip prosthesis	12.00	9.09	1.46	22.55	090	S
27091		A	Removal of hip prosthesis	20.48	19.81	3.16	43.45	090	S
27093		A	Injection for hip x-ray	1.30	0.82	0.11	2.23	000	S
27095		A	Injection for hip x-ray	1.50	0.93	0.13	2.56	000	N
27097		A	Revision of hip tendon	8.08	7.71	1.26	17.05	090	S
27098		A	Transfer tendon to pelvis	8.08	7.71	1.26	17.05	090	S
27100		A	Transfer of abdominal muscle	10.57	7.68	1.42	19.67	090	S
27105		A	Transfer of spinal muscle	11.26	5.89	1.36	18.51	090	S
27110		A	Transfer of iliopsoas muscle	12.49	10.61	1.86	24.96	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
27111		A	Transfer of iliopsoas muscle	11.44	11.63	1.65	24.72	090	S
27120		A	Reconstruction of hip socket	16.43	18.10	2.95	37.48	090	S
27122		A	Reconstruction of hip socket	13.56	*17.36	2.94	33.86	090	S
27125		A	Partial hip replacement	13.21	*16.91	3.01	33.13	090	S
27130		A	Total hip replacement	18.68	*23.91	4.58	47.17	090	S
27132		A	Total hip replacement	21.44	*27.44	5.09	53.97	090	S
27134		A	Revise hip joint replacement	24.54	*31.41	5.96	61.91	090	S
27137		A	Revise hip joint replacement	18.67	*23.90	4.82	47.39	090	S
27138		A	Revise hip joint replacement	18.93	*24.23	4.58	47.74	090	S
27140		A	Transplant of femur ridge	11.43	11.05	1.71	24.19	090	S
27146		A	Incision of hip bone	13.72	10.88	1.35	25.95	090	S
27147		A	Revision of hip bone	17.58	16.97	2.76	37.31	090	S
27151		A	Incision of hip bones	18.58	17.71	2.90	39.19	090	S
27156		A	Revision of hip bones	20.16	18.32	3.08	41.56	090	S
27158		A	Revision of pelvis	18.10	14.42	2.64	35.16	090	S
27161		A	Incision of neck of femur	15.20	14.31	2.31	31.82	090	S
27165		A	Incision/fixation of femur	16.20	16.76	2.63	35.59	090	S
27170		A	Repair/graft femur head/neck	14.90	16.41	2.65	33.96	090	S
27175		A	Treat slipped epiphysis	7.24	1.18	0.18	8.60	090	S
27176		A	Treat slipped epiphysis	10.89	10.39	1.70	22.98	090	S
27177		A	Repair slipped epiphysis	13.76	12.39	2.05	28.20	090	S
27178		A	Repair slipped epiphysis	10.76	10.46	1.55	22.77	090	S
27179		A	Revise head/neck of femur	11.69	11.15	1.83	24.67	090	S
27181		A	Repair slipped epiphysis	13.80	13.14	2.16	29.10	090	S
27185		A	Revision of femur epiphysis	8.30	2.77	0.87	11.94	090	S
27187		A	Reinforce hip bones	12.57	*16.09	2.76	31.42	090	S
27193		A	Treat pelvic ring fracture	4.64	2.41	0.39	7.44	090	S
27194		A	Treat pelvic ring fracture	8.73	3.90	0.50	13.13	090	S
27200		A	Treat tail bone fracture	1.76	1.49	0.17	3.42	090	S
27202		A	Repair tail bone fracture	6.52	6.15	0.89	13.56	090	S
27215		A	Pelvic fracture(s) treatment	9.39	*12.02	2.33	23.74	090	S
27216		A	Treat pelvic ring fracture	14.20	4.30	0.66	19.16	090	S
27217		A	Treat pelvic ring fracture	13.19	14.55	2.33	30.07	090	S
27218		A	Treat pelvic ring fracture	18.83	14.55	2.33	35.71	090	S
27220		A	Treat hip socket fracture	5.26	4.26	0.64	10.16	090	S
27222		A	Treat hip socket fracture	10.95	6.37	1.03	18.35	090	S
27226		A	Treat hip wall fracture	13.93	15.78	2.52	32.23	090	S
27227		A	Treat hip fracture(s)	15.39	*19.70	3.20	38.29	090	S
27228		A	Treat hip fracture(s)	17.90	19.95	3.20	41.05	090	S
27230		A	Treat fracture of thigh	4.95	3.30	0.41	8.66	090	S
27232		A	Treat fracture of thigh	9.32	8.98	1.46	19.76	090	S
27235		A	Repair of thigh fracture	11.02	*14.10	2.60	27.72	090	S
27236		A	Repair of thigh fracture	14.14	16.91	2.71	33.76	090	S
27238		A	Treatment of thigh fracture	5.06	4.91	0.71	10.68	090	S
27240		A	Treatment of thigh fracture	10.86	9.70	1.53	22.09	090	S
27244		A	Repair of thigh fracture	14.35	16.30	2.62	33.27	090	S
27245		A	Repair of thigh fracture	18.72	16.30	2.62	37.64	090	S
27246		A	Treatment of thigh fracture	4.36	3.87	0.60	8.83	090	S
27248		A	Repair of thigh fracture	9.73	*12.46	2.11	24.30	090	S
27250		A	Treat hip dislocation	6.31	3.19	0.45	9.95	090	S
27252		A	Treat hip dislocation	9.47	4.34	0.68	14.49	090	S
27253		A	Repair of hip dislocation	11.98	13.14	2.11	27.23	090	S
27254		A	Repair of hip dislocation	17.29	13.47	2.27	33.03	090	S
27256		A	Treatment of hip dislocation	3.72	1.88	0.31	5.91	010	S
27257		A	Treatment of hip dislocation	4.82	4.62	0.73	10.17	010	S
27258		A	Repair of hip dislocation	14.40	13.73	2.25	30.38	090	S
27259		A	Repair of hip dislocation	18.03	17.20	2.82	38.05	090	S
27265		A	Treatment of hip dislocation	5.58	3.46	0.54	9.58	090	S
27266		A	Treatment of hip dislocation	7.73	4.45	0.71	12.89	090	S
27275		A	Manipulation of hip joint	2.00	1.88	0.30	4.18	010	S
27280		A	Fusion of sacroiliac joint	11.81	10.06	1.77	23.64	090	S
27282		A	Fusion of pubic bones	10.57	9.01	1.69	21.27	090	S
27284		A	Fusion of hip joint	15.62	14.50	2.40	32.52	090	S
27286		A	Fusion of hip joint	15.65	15.20	2.26	33.11	090	S
27290		A	Amputation of leg at hip	21.68	25.40	4.70	51.78	090	S
27295		A	Amputation of leg at hip	17.32	16.54	2.95	36.81	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
27299		C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	YYY	S
27301		A	Drain thigh/knee lesion	5.96	2.46	0.40	8.82	090	S
27303		A	Drainage of bone lesion	7.69	5.86	0.96	14.51	090	S
27305		A	Incise thigh tendon & fascia	5.42	3.80	0.68	9.90	090	S
27306		A	Incision of thigh tendon	4.27	1.99	0.32	6.58	090	S
27307		A	Incision of thigh tendons	5.30	3.01	0.48	8.79	090	S
27310		A	Exploration of knee joint	8.26	9.60	1.51	19.37	090	S
27315		A	Partial removal, thigh nerve	6.51	5.38	0.96	12.85	090	S
27320		A	Partial removal, thigh nerve	5.90	5.18	0.73	11.81	090	S
27323		A	Biopsy thigh soft tissues	2.67	0.91	0.13	3.71	010	S
27324		A	Biopsy thigh soft tissues	4.53	2.63	0.45	7.61	090	S
27327		A	Removal of thigh lesion	4.32	2.29	0.40	7.01	090	S
27328		A	Removal of thigh lesion	5.31	4.07	0.73	10.11	090	S
27329		A	Remove tumor, thigh/knee	11.74	11.69	2.14	25.57	090	S
27330		A	Biopsy knee joint lining	4.71	*6.02	1.19	11.92	090	S
27331		A	Explore/treat knee joint	5.51	*7.05	1.49	14.05	090	S
27332		A	Removal of knee cartilage	7.85	*10.05	1.73	19.63	090	S
27333		A	Removal of knee cartilage	6.81	*9.01	2.52	18.34	090	S
27334		A	Remove knee joint lining	7.95	*10.18	1.77	19.90	090	S
27335		A	Remove knee joint lining	9.19	*11.76	2.05	23.00	090	S
27340		A	Removal of kneecap bursa	3.92	3.85	0.62	8.39	090	S
27345		A	Removal of knee cyst	5.63	5.63	0.95	12.21	090	S
27350		A	Removal of kneecap	7.42	*9.49	1.54	18.45	090	S
27355		A	Remove femur lesion	7.06	7.58	1.23	15.87	090	S
27356		A	Remove femur lesion/graft	8.60	8.20	1.34	18.14	090	S
27357		A	Remove femur lesion/graft	9.63	8.80	1.43	19.86	090	S
27358		A	Remove femur lesion/fixation	4.74	4.55	0.72	10.01	ZZZ	S
27360		A	Partial removal leg bone(s)	9.23	8.56	1.40	19.19	090	S
27365		A	Extensive leg surgery	13.84	13.94	2.43	30.21	090	S
27370		A	Injection for knee x-ray	0.96	0.60	0.05	1.61	000	N
27372		A	Removal of foreign body	4.81	3.42	0.54	8.77	090	S
27380		A	Repair of kneecap tendon	6.63	7.94	1.29	15.86	090	S
27381		A	Repair/graft kneecap tendon	9.66	11.27	1.82	22.75	090	S
27385		A	Repair of thigh muscle	7.17	8.84	1.42	17.43	090	S
27386		A	Repair/graft of thigh muscle	9.72	*12.44	2.02	24.18	090	S
27390		A	Incision of thigh tendon	4.89	4.36	0.71	9.96	090	S
27391		A	Incision of thigh tendons	6.67	5.42	0.90	12.99	090	S
27392		A	Incision of thigh tendons	8.52	7.67	1.28	17.47	090	S
27393		A	Lengthening of thigh tendon	5.95	5.67	0.93	12.55	090	S
27394		A	Lengthening of thigh tendons	7.97	5.73	0.94	14.64	090	S
27395		A	Lengthening of thigh tendons	10.96	10.48	1.65	23.09	090	S
27396		A	Transplant of thigh tendon	7.33	7.06	1.11	15.50	090	S
27397		A	Transplants of thigh tendons	9.33	8.88	1.45	19.66	090	S
27400		A	Revise thigh muscles/tendons	8.47	7.89	1.24	17.60	090	S
27403		A	Repair of knee cartilage	7.80	8.79	1.44	18.03	090	S
27405		A	Repair of knee ligament	7.97	10.17	1.67	19.81	090	S
27407		A	Repair of knee ligament	9.44	8.87	1.42	19.73	090	S
27409		A	Repair of knee ligaments	11.80	*15.10	2.48	29.38	090	S
27418		A	Repair degenerated kneecap	9.82	12.23	1.85	23.90	090	S
27420		A	Revision of unstable kneecap	9.15	10.99	1.74	21.88	090	S
27422		A	Revision of unstable kneecap	9.10	11.45	1.83	22.38	090	S
27424		A	Revision/removal of kneecap	9.13	*11.68	1.89	22.70	090	S
27425		A	Lateral retinacular release	5.04	*6.46	1.08	12.58	090	S
27427		A	Reconstruction, knee	8.68	*11.12	2.25	22.05	090	S
27428		A	Reconstruction, knee	10.68	*13.67	2.71	27.06	090	S
27429		A	Reconstruction, knee	11.86	11.27	1.83	24.96	090	S
27430		A	Revision of thigh muscles	8.92	9.36	1.50	19.78	090	S
27435		A	Incision of knee joint	8.74	7.03	1.13	16.90	090	S
27437		A	Revise kneecap	7.74	*9.91	1.55	19.20	090	S
27438		A	Revise kneecap with implant	10.29	13.13	2.14	25.56	090	S
27440		A	Revision of knee joint	9.49	11.83	2.10	23.42	090	S
27441		A	Revision of knee joint	9.81	9.14	1.51	20.46	090	S
27442		A	Revision of knee joint	11.14	*14.25	3.05	28.44	090	S
27443		A	Revision of knee joint	10.18	*13.03	3.34	26.55	090	S
27445		A	Revision of knee joint	16.39	*20.98	4.21	41.58	090	S
27446		A	Revision of knee joint	15.03	*19.25	3.87	38.15	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
27447		A	Total knee replacement	19.69	*25.20	4.95	49.84	090	S
27448		A	Incision of thigh	10.25	12.87	2.09	25.21	090	S
27450		A	Incision of thigh	13.08	14.84	2.36	30.28	090	S
27454		A	Realignment of thigh bone	12.26	*15.70	2.82	30.78	090	S
27455		A	Realignment of knee	12.01	12.01	1.95	25.97	090	S
27457		A	Realignment of knee	12.60	13.30	2.14	28.04	090	S
27465		A	Shortening of thigh bone	12.84	12.24	2.00	27.08	090	S
27466		A	Lengthening of thigh bone	15.08	13.43	2.27	30.78	090	S
27468		A	Shorten/lengthen thighs	17.65	16.84	2.75	37.24	090	S
27470		A	Repair of thigh	14.82	16.67	2.60	34.09	090	S
27472		A	Repair/graft of thigh	16.40	19.87	3.16	39.43	090	S
27475		A	Surgery to stop leg growth	8.11	7.74	1.27	17.12	090	S
27477		A	Surgery to stop leg growth	9.32	*11.93	2.57	23.82	090	S
27479		A	Surgery to stop leg growth	12.18	11.63	1.89	25.70	090	S
27485		A	Surgery to stop leg growth	8.31	7.91	1.30	17.52	090	S
27486		A	Revise knee joint replace	16.63	*21.28	4.26	42.17	090	S
27487		A	Revise knee joint replace	21.69	*27.76	5.97	55.42	090	S
27488		A	Removal of knee prosthesis	14.48	16.16	2.58	33.22	090	S
27495		A	Reinforce thigh	14.26	17.63	2.82	34.71	090	S
27496		A	Decompression of thigh/knee	4.75	4.53	0.74	10.02	090	S
27497		A	Decompression of thigh/knee	5.81	5.55	0.91	12.27	090	S
27498		A	Decompression of thigh/knee	6.63	6.32	1.04	13.99	090	S
27499		A	Decompression of thigh/knee	7.64	7.28	1.19	16.11	090	S
27500		A	Treatment of thigh fracture	5.29	5.41	0.82	11.52	090	S
27501		A	Treatment of thigh fracture	5.29	5.41	0.82	11.52	090	S
27502		A	Treatment of thigh fracture	9.51	7.67	1.21	18.39	090	S
27503		A	Treatment of thigh fracture	9.51	7.67	1.21	18.39	090	S
27506		A	Repair of thigh fracture	15.93	16.02	2.56	34.51	090	S
27507		A	Treatment of thigh fracture	12.85	16.02	2.56	31.43	090	S
27508		A	Treatment of thigh fracture	5.21	4.22	0.65	10.08	090	S
27509		A	Treatment of thigh fracture	6.77	4.22	0.65	11.64	090	S
27510		A	Treatment of thigh fracture	8.19	6.82	1.09	16.10	090	S
27511		A	Treatment of thigh fracture	12.50	*16.00	2.56	31.06	090	S
27513		A	Treatment of thigh fracture	16.78	16.02	2.56	35.36	090	S
27514		A	Repair of thigh fracture	15.98	15.76	2.53	34.27	090	S
27516		A	Repair of thigh growth plate	4.92	4.82	0.71	10.45	090	S
27517		A	Repair of thigh growth plate	8.20	7.82	1.28	17.30	090	S
27519		A	Repair of thigh growth plate	13.82	12.68	2.05	28.55	090	S
27520		A	Treat kneecap fracture	2.68	3.04	0.45	6.17	090	S
27524		A	Repair of kneecap fracture	9.38	10.34	1.65	21.37	090	S
27530		A	Treatment of knee fracture	3.23	3.40	0.51	7.14	090	S
27532		A	Treatment of knee fracture	6.81	5.68	0.91	13.40	090	S
27535		A	Treatment of knee fracture	10.36	11.69	1.88	23.93	090	S
27536		A	Repair of knee fracture	14.51	11.69	1.88	28.08	090	S
27538		A	Treat knee fracture(s)	4.64	3.37	0.51	8.52	090	S
27540		A	Repair of knee fracture	12.38	10.95	1.74	25.07	090	S
27550		A	Treat knee dislocation	5.53	2.57	0.36	8.46	090	S
27552		A	Treat knee dislocation	7.39	3.43	0.53	11.35	090	S
27556		A	Repair of knee dislocation	13.47	12.48	1.95	27.90	090	S
27557		A	Repair of knee dislocation	15.80	14.60	2.43	32.83	090	S
27558		A	Repair of knee dislocation	16.75	14.60	2.43	33.78	090	S
27560		A	Treat kneecap dislocation	3.64	1.43	0.16	5.23	090	S
27562		A	Treat kneecap dislocation	5.48	5.18	0.76	11.42	090	S
27566		A	Repair kneecap dislocation	11.48	10.58	1.67	23.73	090	S
27570		A	Fixation of knee joint	1.69	1.72	0.28	3.69	010	S
27580		A	Fusion of knee	12.26	*15.70	2.56	30.52	090	S
27590		A	Amputate leg at thigh	10.24	9.11	1.80	21.15	090	S
27591		A	Amputate leg at thigh	11.09	11.77	2.11	24.97	090	S
27592		A	Amputate leg at thigh	8.75	8.11	1.61	18.47	090	S
27594		A	Amputation follow-up surgery	6.30	3.65	0.68	10.63	090	S
27596		A	Amputation follow-up surgery	9.63	7.37	1.42	18.42	090	S
27598		A	Amputate lower leg at knee	9.56	10.04	1.78	21.38	090	S
27599		C	Leg surgery procedure	0.00	0.00	0.00	0.00	YYY	S
27600		A	Decompression of lower leg	5.02	3.39	0.64	9.05	090	S
27601		A	Decompression of lower leg	4.98	3.38	0.67	9.03	090	S
27602		A	Decompression of lower leg	6.63	4.05	0.77	11.45	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
27603		A	Drain lower leg lesion	4.41	2.38	0.41	7.20	090	S
27604		A	Drain lower leg bursa	4.23	1.02	0.14	5.39	090	S
27605		A	Incision of achilles tendon	2.82	1.18	0.14	4.14	010	S
27606		A	Incision of achilles tendon	3.87	2.12	0.35	6.34	010	S
27607		A	Treat lower leg bone lesion	7.05	6.01	0.98	14.04	090	S
27610		A	Explore/treat ankle joint	7.27	7.43	1.13	15.83	090	S
27612		A	Exploration of ankle joint	6.23	*7.97	1.30	15.50	090	S
27613		A	Biopsy lower leg soft tissue	2.12	0.67	0.10	2.89	010	S
27614		A	Biopsy lower leg soft tissue	5.29	2.26	0.38	7.93	090	S
27615		A	Remove tumor, lower leg	11.79	8.23	1.42	21.44	090	S
27618		A	Remove lower leg lesion	4.94	2.10	0.32	7.36	090	S
27619		A	Remove lower leg lesion	7.98	4.13	0.67	12.78	090	S
27620		A	Explore, treat ankle joint	5.69	6.03	0.96	12.68	090	S
27625		A	Remove ankle joint lining	7.88	8.71	1.27	17.86	090	S
27626		A	Remove ankle joint lining	8.49	*10.86	1.25	20.60	090	S
27630		A	Removal of tendon lesion	4.65	3.10	0.46	8.21	090	S
27635		A	Remove lower leg bone lesion	7.29	8.04	1.27	16.60	090	S
27637		A	Remove/graft leg bone lesion	9.14	8.47	1.40	19.01	090	S
27638		A	Remove/graft leg bone lesion	9.89	9.15	1.52	20.56	090	S
27640		A	Partial removal of tibia	10.21	9.81	1.57	21.59	090	S
27641		A	Partial removal of fibula	8.36	7.13	1.18	16.67	090	S
27645		A	Extensive lower leg surgery	13.14	11.64	1.98	26.76	090	S
27646		A	Extensive lower leg surgery	11.69	10.75	1.71	24.15	090	S
27647		A	Extensive ankle/heel surgery	11.21	9.95	1.35	22.51	090	S
27648		A	Injection for ankle x-ray	0.96	0.52	0.05	1.53	000	N
27650		A	Repair achilles tendon	9.07	8.98	1.41	19.46	090	S
27652		A	Repair/graft achilles tendon	9.62	10.41	1.56	21.59	090	S
27654		A	Repair of achilles tendon	9.34	10.93	1.65	21.92	090	S
27656		A	Repair leg fascia defect	4.31	3.18	0.54	8.03	090	S
27658		A	Repair of leg tendon, each	4.61	4.02	0.60	9.23	090	S
27659		A	Repair of leg tendon, each	6.28	5.87	0.86	13.01	090	S
27664		A	Repair of leg tendon, each	4.33	3.41	0.52	8.26	090	S
27665		A	Repair of leg tendon, each	5.11	4.95	0.76	10.82	090	S
27675		A	Repair lower leg tendons	6.78	6.40	0.94	14.12	090	S
27676		A	Repair lower leg tendons	7.87	7.56	1.14	16.57	090	S
27680		A	Release of lower leg tendon	5.37	4.12	0.61	10.10	090	S
27681		A	Release of lower leg tendons	6.36	5.97	0.86	13.19	090	S
27685		A	Revision of lower leg tendon	6.08	3.83	0.41	10.32	090	S
27686		A	Revise lower leg tendons	6.93	6.56	0.90	14.39	090	S
27687		A	Revision of calf tendon	5.84	5.45	0.76	12.05	090	S
27690		A	Revise lower leg tendon	8.09	6.74	0.88	15.71	090	S
27691		A	Revise lower leg tendon	9.25	7.89	1.23	18.37	090	S
27692		A	Revise additional leg tendon	1.87	2.03	0.29	4.19	ZZZ	S
27695		A	Repair of ankle ligament	6.09	*7.79	1.32	15.20	090	S
27696		A	Repair of ankle ligaments	7.72	7.06	1.16	15.94	090	S
27698		A	Repair of ankle ligament	8.87	*11.35	1.86	22.08	090	S
27700		A	Revision of ankle joint	8.67	*11.11	1.51	21.29	090	S
27702		A	Reconstruct ankle joint	12.64	*16.18	3.99	32.81	090	S
27703		A	Reconstruction, ankle joint	14.49	13.82	2.25	30.56	090	S
27704		A	Removal of ankle implant	7.20	5.84	0.98	14.02	090	S
27705		A	Incision of tibia	9.63	10.74	1.76	22.13	090	S
27707		A	Incision of fibula	3.71	*4.75	0.79	9.25	090	S
27709		A	Incision of tibia & fibula	9.14	*11.70	2.14	22.98	090	S
27712		A	Realignment of lower leg	11.81	10.99	1.63	24.43	090	S
27715		A	Revision of lower leg	12.97	12.61	1.88	27.46	090	S
27720		A	Repair of tibia	10.95	13.97	2.25	27.17	090	S
27722		A	Repair/graft of tibia	10.92	10.50	1.64	23.06	090	S
27724		A	Repair/graft of tibia	12.11	*15.50	2.87	30.48	090	S
27725		A	Repair of lower leg	11.04	10.43	1.53	23.00	090	S
27727		A	Repair of lower leg	12.89	9.38	1.84	24.11	090	S
27730		A	Repair of tibia epiphysis	6.88	3.59	0.84	11.31	090	S
27732		A	Repair of fibula epiphysis	5.06	4.84	0.79	10.69	090	S
27734		A	Repair lower leg epiphyses	7.89	7.54	1.23	16.66	090	S
27740		A	Repair of leg epiphyses	8.75	8.36	1.36	18.47	090	S
27742		A	Repair of leg epiphyses	9.72	9.29	1.52	20.53	090	S
27745		A	Reinforce tibia	9.39	8.97	1.39	19.75	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
27750		A	Treatment of tibia fracture	2.90	3.45	0.50	6.85	090	S
27752		A	Treatment of tibia fracture	5.16	5.09	0.81	11.06	090	S
27756		A	Repair of tibia fracture	5.84	*7.48	1.70	15.02	090	S
27758		A	Repair of tibia fracture	10.51	*13.46	2.22	26.19	090	S
27759		A	Repair of tibia fracture	12.60	13.74	2.22	28.56	090	S
27760		A	Treatment of ankle fracture	2.81	2.58	0.37	5.76	090	S
27762		A	Treatment of ankle fracture	4.80	3.36	0.50	8.66	090	S
27766		A	Repair of ankle fracture	7.61	7.87	1.26	16.74	090	S
27780		A	Treatment of fibula fracture	2.47	1.97	0.26	4.70	090	S
27781		A	Treatment of fibula fracture	4.20	3.29	0.49	7.98	090	S
27784		A	Repair of fibula fracture	6.45	5.59	0.87	12.91	090	S
27786		A	Treatment of ankle fracture	2.66	2.52	0.38	5.56	090	S
27788		A	Treatment of ankle fracture	4.25	3.27	0.50	8.02	090	S
27792		A	Repair of ankle fracture	7.04	7.38	1.17	15.59	090	S
27808		A	Treatment of ankle fracture	2.63	2.79	0.39	5.81	090	S
27810		A	Treatment of ankle fracture	4.82	5.05	0.80	10.67	090	S
27814		A	Repair of ankle fracture	9.87	10.00	1.60	21.47	090	S
27816		A	Treatment of ankle fracture	2.71	*3.47	0.55	6.73	090	S
27818		A	Treatment of ankle fracture	5.08	*6.51	1.06	12.65	090	S
27822		A	Repair of ankle fracture	8.39	*10.73	1.88	21.00	090	S
27823		A	Repair of ankle fracture	10.90	12.79	2.05	25.74	090	S
27824		A	Treat lower leg fracture	2.71	*3.47	0.55	6.73	090	S
27825		A	Treat lower leg fracture	5.08	*6.51	1.06	12.65	090	S
27826		A	Treat lower leg fracture	7.43	*9.50	1.88	18.81	090	S
27827		A	Treat lower leg fracture	9.90	11.71	1.88	23.49	090	S
27828		A	Treat lower leg fracture	12.33	12.79	2.05	27.17	090	S
27829		A	Treat lower leg joint	4.87	*6.23	1.37	12.47	090	S
27830		A	Treat lower leg dislocation	3.50	3.25	0.46	7.21	090	S
27831		A	Treat lower leg dislocation	4.27	3.98	0.59	8.84	090	S
27832		A	Repair lower leg dislocation	5.96	5.70	0.89	12.55	090	S
27840		A	Treat ankle dislocation	4.27	1.87	0.21	6.35	090	S
27842		A	Treat ankle dislocation	5.72	2.22	0.34	8.28	090	S
27846		A	Repair ankle dislocation	9.04	8.59	1.37	19.00	090	S
27848		A	Repair ankle dislocation	10.45	8.36	1.32	20.13	090	S
27860		A	Fixation of ankle joint	2.29	1.39	0.23	3.91	010	S
27870		A	Fusion of ankle joint	10.42	*13.34	2.22	25.98	090	S
27871		A	Fusion of tibiofibular joint	8.55	7.79	1.21	17.55	090	S
27880		A	Amputation of lower leg	10.69	8.36	1.60	20.65	090	S
27881		A	Amputation of lower leg	10.89	10.82	1.87	23.58	090	S
27882		A	Amputation of lower leg	7.80	7.36	1.42	16.58	090	S
27884		A	Amputation follow-up surgery	7.40	3.37	0.61	11.38	090	S
27886		A	Amputation follow-up surgery	8.35	7.17	1.34	16.86	090	S
27888		A	Amputation of foot at ankle	8.70	9.49	1.65	19.84	090	S
27889		A	Amputation of foot at ankle	8.82	8.43	1.55	18.80	090	S
27892		A	Decompression of leg	6.03	3.39	0.64	10.06	090	S
27893		A	Decompression of leg	5.99	3.38	0.67	10.04	090	S
27894		A	Decompression of leg	7.64	4.05	0.77	12.46	090	S
27899		C	Leg/ankle surgery procedure	0.00	0.00	0.00	0.00	YYY	S
28001		A	Drainage of bursa of foot	2.68	0.52	0.05	3.25	010	S
28002		A	Treatment of foot infection	3.76	2.25	0.33	6.34	010	S
28003		A	Treatment of foot infection	7.49	3.50	0.59	11.58	090	S
28005		A	Treat foot bone lesion	7.65	4.08	0.61	12.34	090	S
28008		A	Incision of foot fascia	4.19	2.68	0.29	7.16	090	S
28010		A	Incision of toe tendon	2.97	3.62	0.33	6.92	090	S
28011		A	Incision of toe tendons	3.99	1.77	0.19	5.95	090	S
28020		A	Exploration of a foot joint	4.75	4.40	0.56	9.71	090	S
28022		A	Exploration of a foot joint	4.41	2.74	0.31	7.46	090	S
28024		A	Exploration of a toe joint	4.12	2.39	0.24	6.75	090	S
28030		A	Removal of foot nerve	5.78	3.93	0.42	10.13	090	S
28035		A	Decompression of tibia nerve	4.83	*6.18	0.90	11.91	090	S
28043		A	Excision of foot lesion	3.41	1.73	0.20	5.34	090	S
28045		A	Excision of foot lesion	4.46	3.99	0.46	8.91	090	S
28046		A	Resection of tumor, foot	9.41	5.35	0.79	15.55	090	S
28050		A	Biopsy of foot joint lining	3.99	3.84	0.53	8.36	090	S
28052		A	Biopsy of foot joint lining	3.70	3.82	0.43	7.95	090	S
28054		A	Biopsy of toe joint lining	3.21	2.24	0.28	5.73	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
28060		A	Partial removal foot fascia	5.05	4.22	0.53	9.80	090	S
28062		A	Removal of foot fascia	6.23	7.06	0.86	14.15	090	S
28070		A	Removal of foot joint lining	4.73	4.48	0.48	9.69	090	S
28072		A	Removal of foot joint lining	4.32	3.21	0.42	7.95	090	S
28080		A	Removal of foot lesion	3.18	*4.07	0.45	7.70	090	S
28086		A	Excise foot tendon sheath	4.52	3.12	0.46	8.10	090	S
28088		A	Excise foot tendon sheath	3.62	3.62	0.40	7.64	090	S
28090		A	Removal of foot lesion	4.26	3.02	0.29	7.57	090	S
28092		A	Removal of toe lesions	3.49	2.03	0.25	5.77	090	S
28100		A	Removal of ankle/heel lesion	5.37	4.58	0.56	10.51	090	S
28102		A	Remove/graft foot lesion	7.31	6.84	0.85	15.00	090	S
28103		A	Remove/graft foot lesion	6.10	5.61	0.69	12.40	090	S
28104		A	Removal of foot lesion	4.86	4.33	0.49	9.68	090	S
28106		A	Remove/graft foot lesion	6.74	6.42	0.79	13.95	090	S
28107		A	Remove/graft foot lesion	5.16	4.86	0.48	10.50	090	S
28108		A	Removal of toe lesions	4.01	4.20	0.38	8.59	090	S
28110		A	Part removal of metatarsal	3.82	3.48	0.39	7.69	090	S
28111		A	Part removal of metatarsal	4.64	5.04	0.65	10.33	090	S
28112		A	Part removal of metatarsal	4.23	3.96	0.45	8.64	090	S
28113		A	Part removal of metatarsal	4.09	4.44	0.48	9.01	090	S
28114		A	Removal of metatarsal heads	7.16	*9.17	1.42	17.75	090	S
28116		A	Revision of foot	6.17	5.48	0.57	12.22	090	S
28118		A	Removal of heel bone	5.56	5.71	0.66	11.93	090	S
28119		A	Removal of heel spur	5.10	5.44	0.57	11.11	090	S
28120		A	Part removal of ankle/heel	4.81	5.04	0.67	10.52	090	S
28122		A	Partial removal of foot bone	6.62	4.48	0.54	11.64	090	S
28124		A	Partial removal of toe	4.39	4.11	0.37	8.87	090	S
28126		A	Partial removal of toe	3.39	3.98	0.36	7.73	090	S
28130		A	Removal of ankle bone	7.33	7.03	0.88	15.24	090	S
28140		A	Removal of metatarsal	6.45	4.93	0.62	12.00	090	S
28150		A	Removal of toe	3.83	3.29	0.38	7.50	090	S
28153		A	Partial removal of toe	3.40	3.99	0.36	7.75	090	S
28160		A	Partial removal of toe	3.59	4.12	0.38	8.09	090	S
28171		A	Extensive foot surgery	8.98	7.99	0.88	17.85	090	S
28173		A	Extensive foot surgery	8.18	5.74	0.74	14.66	090	S
28175		A	Extensive foot surgery	5.59	5.38	0.58	11.55	090	S
28190		A	Removal of foot foreign body	1.91	0.52	0.05	2.48	010	S
28192		A	Removal of foot foreign body	4.49	1.95	0.24	6.68	090	S
28193		A	Removal of foot foreign body	5.44	2.38	0.30	8.12	090	S
28200		A	Repair of foot tendon	4.45	5.06	0.50	10.01	090	S
28202		A	Repair/graft of foot tendon	6.38	5.82	0.77	12.97	090	S
28208		A	Repair of foot tendon	4.11	2.81	0.28	7.20	090	S
28210		A	Repair/graft of foot tendon	5.95	5.60	0.60	12.15	090	S
28220		A	Release of foot tendon	4.27	3.87	0.43	8.57	090	S
28222		A	Release of foot tendons	5.36	6.40	0.63	12.39	090	S
28225		A	Release of foot tendon	3.42	2.37	0.25	6.04	090	S
28226		A	Release of foot tendons	4.27	3.38	0.40	8.05	090	S
28230		A	Incision of foot tendon(s)	4.00	2.43	0.22	6.65	090	S
28232		A	Incision of toe tendon	3.26	1.60	0.15	5.01	090	S
28234		A	Incision of foot tendon	3.19	1.53	0.14	4.86	090	S
28236		D	Transfer of foot tendon	0.00	0.00	0.00	0.00	090	S
28238		A	Revision of foot tendon	7.27	7.23	0.85	15.35	090	S
28240		A	Release of big toe	4.12	2.13	0.23	6.48	090	S
28250		A	Revision of foot fascia	5.66	4.46	0.50	10.62	090	S
28260		A	Release of midfoot joint	7.50	4.43	0.48	12.41	090	S
28261		A	Revision of foot tendon	8.92	5.91	0.58	15.41	090	S
28262		A	Revision of foot and ankle	12.19	11.91	1.44	25.54	090	S
28264		A	Release of midfoot joint	9.80	9.56	1.17	20.53	090	S
28270		A	Release of foot contracture	4.58	2.63	0.23	7.44	090	S
28272		A	Release of toe joint, each	3.67	2.04	0.18	5.89	090	S
28280		A	Fusion of toes	4.93	2.22	0.30	7.45	090	S
28285		A	Repair of hammertoe	4.41	4.37	0.39	9.17	090	S
28286		A	Repair of hammertoe	4.41	3.58	0.38	8.37	090	S
28288		A	Partial removal of foot bone	3.73	3.75	0.43	7.91	090	S
28290		A	Correction of bunion	5.37	5.36	0.63	11.36	090	S
28292		A	Correction of bunion	6.24	7.05	0.74	14.03	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
28293		A	Correction of bunion	8.25	9.55	0.98	18.78	090	S
28294		A	Correction of bunion	8.14	9.16	0.86	18.16	090	S
28296		A	Correction of bunion	8.69	8.81	0.98	18.48	090	S
28297		A	Correction of bunion	8.69	9.02	1.05	18.76	090	S
28298		A	Correction of bunion	7.52	8.89	0.79	17.20	090	S
28299		A	Correction of bunion	8.46	10.14	1.08	19.68	090	S
28300		A	Incision of heel bone	9.12	6.52	0.79	16.43	090	S
28302		A	Incision of ankle bone	9.13	8.89	1.12	19.14	090	S
28304		A	Incision of midfoot bones	8.67	6.44	0.70	15.81	090	S
28305		A	Incise/graft midfoot bones	9.99	9.85	1.03	20.87	090	S
28306		A	Incision of metatarsal	5.71	4.57	0.47	10.75	090	S
28307		A	Incision of metatarsal	6.04	5.87	0.76	12.67	090	S
28308		A	Incision of metatarsal	5.09	5.71	0.50	11.30	090	S
28309		A	Incision of metatarsals	8.83	6.87	1.00	16.70	090	S
28310		A	Revision of big toe	5.06	4.17	0.42	9.65	090	S
28312		A	Revision of toe	4.29	4.56	0.45	9.30	090	S
28313		A	Repair deformity of toe	4.75	2.57	0.31	7.63	090	S
28315		A	Removal of sesamoid bone	4.60	4.24	0.41	9.25	090	S
28320		A	Repair of foot bones	8.76	8.69	1.03	18.48	090	S
28322		A	Repair of metatarsals	8.03	4.67	0.52	13.22	090	S
28340		A	Resect enlarged toe tissue	6.58	6.34	0.91	13.83	090	S
28341		A	Resect enlarged toe	7.86	7.66	0.96	16.48	090	S
28344		A	Repair extra toe(s)	3.89	3.70	0.60	8.19	090	S
28345		A	Repair webbed toe(s)	5.52	5.34	0.73	11.59	090	S
28360		A	Reconstruct cleft foot	12.49	11.91	1.95	26.35	090	S
28400		A	Treatment of heel fracture	2.01	*2.57	0.40	4.98	090	S
28405		A	Treatment of heel fracture	4.28	3.90	0.58	8.76	090	S
28406		A	Treatment of heel fracture	5.82	6.09	0.93	12.84	090	S
28415		A	Repair of heel fracture	13.28	9.02	1.39	23.69	090	S
28420		A	Repair/graft heel fracture	15.80	10.89	1.63	28.32	090	S
28430		A	Treatment of ankle fracture	1.96	2.45	0.35	4.76	090	S
28435		A	Treatment of ankle fracture	3.25	3.36	0.50	7.11	090	S
28436		A	Treatment of ankle fracture	4.40	4.19	0.68	9.27	090	S
28445		A	Repair of ankle fracture	8.78	8.80	1.40	18.98	090	S
28450		A	Treat midfoot fracture, each	1.77	1.87	0.25	3.89	090	S
28455		A	Treat midfoot fracture, each	2.94	2.54	0.34	5.82	090	S
28456		A	Repair midfoot fracture	2.39	2.27	0.38	5.04	090	S
28465		A	Repair midfoot fracture, each	6.55	5.54	0.81	12.90	090	S
28470		A	Treat metatarsal fracture	1.76	1.80	0.23	3.79	090	S
28475		A	Treat metatarsal fracture	2.74	2.34	0.30	5.38	090	S
28476		A	Repair metatarsal fracture	3.15	3.37	0.45	6.97	090	S
28485		A	Repair metatarsal fracture	5.31	4.68	0.60	10.59	090	S
28490		A	Treat big toe fracture	1.01	0.90	0.10	2.01	090	S
28495		A	Treat big toe fracture	1.48	1.12	0.13	2.73	090	S
28496		A	Repair big toe fracture	2.18	2.07	0.31	4.56	090	S
28505		A	Repair big toe fracture	3.55	2.99	0.43	6.97	090	S
28510		A	Treatment of toe fracture	1.01	0.89	0.09	1.99	090	S
28515		A	Treatment of toe fracture	1.36	1.12	0.11	2.59	090	S
28525		A	Repair of toe fracture	3.08	2.06	0.29	5.43	090	S
28530		A	Treat sesamoid bone fracture	1.01	1.00	0.10	2.11	090	S
28531		A	Treat sesamoid bone fracture	2.01	1.91	0.32	4.24	090	S
28540		A	Treat foot dislocation	1.89	0.60	0.06	2.55	090	S
28545		A	Treat foot dislocation	2.19	1.31	0.14	3.64	090	S
28546		A	Treat foot dislocation	2.89	2.74	0.45	6.08	090	S
28555		A	Repair foot dislocation	5.84	5.58	0.73	12.15	090	S
28570		A	Treat foot dislocation	1.56	1.59	0.17	3.32	090	S
28575		A	Treat foot dislocation	2.91	2.77	0.42	6.10	090	S
28576		A	Treat foot dislocation	3.75	2.77	0.42	6.94	090	S
28585		A	Repair foot dislocation	7.46	4.96	0.55	12.97	090	S
28600		A	Treat foot dislocation	1.76	0.68	0.08	2.52	090	S
28605		A	Treat foot dislocation	2.42	2.26	0.34	5.02	090	S
28606		A	Treat foot dislocation	4.48	3.49	0.55	8.52	090	S
28615		A	Repair foot dislocation	5.12	4.96	0.78	10.86	090	S
28630		A	Treat toe dislocation	1.65	1.03	0.11	2.79	010	S
28635		A	Treat toe dislocation	1.86	1.45	0.18	3.49	010	S
28636		A	Treat toe dislocation	2.67	2.56	0.42	5.65	010	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
28645		A	Repair toe dislocation	3.96	3.24	0.38	7.58	090	S
28660		A	Treat toe dislocation	1.18	0.63	0.06	1.87	010	S
28665		A	Treat toe dislocation	1.87	0.98	0.11	2.96	010	S
28666		A	Treat toe dislocation	2.56	2.44	0.40	5.40	010	S
28675		A	Repair of toe dislocation	2.68	3.00	0.41	6.09	090	S
28705		A	Fusion of foot bones	14.23	15.11	2.35	31.69	090	S
28715		A	Fusion of foot bones	12.18	12.33	1.89	26.40	090	S
28725		A	Fusion of foot bones	10.86	9.44	1.44	21.74	090	S
28730		A	Fusion of foot bones	9.91	9.00	1.33	20.24	090	S
28735		A	Fusion of foot bones	10.07	9.76	1.37	21.20	090	S
28737		A	Revision of foot bones	8.89	8.87	1.13	18.89	090	S
28740		A	Fusion of foot bones	6.20	5.14	0.72	12.06	090	S
28750		A	Fusion of big toe joint	4.77	5.32	0.82	10.91	090	S
28755		A	Fusion of big toe joint	4.48	3.69	0.45	8.62	090	S
28760		A	Fusion of big toe joint	5.47	5.40	0.65	11.52	090	S
28800		A	Amputation of midfoot	7.37	6.65	1.19	15.21	090	S
28805		A	Amputation thru metatarsal	7.55	6.32	1.21	15.08	090	S
28810		A	Amputation toe & metatarsal	5.53	3.91	0.75	10.19	090	S
28820		A	Amputation of toe	3.56	2.58	0.46	6.60	090	S
28825		A	Partial amputation of toe	3.13	2.40	0.41	5.94	090	S
28899		C	Foot/toes surgery procedure	0.00	0.00	0.00	0.00	YYY	S
29000		A	Application of body cast	2.25	1.85	0.21	4.31	000	S
29010		A	Application of body cast	2.06	2.33	0.34	4.73	000	S
29015		A	Application of body cast	2.41	2.33	0.33	5.07	000	S
29020		A	Application of body cast	2.11	1.82	0.23	4.16	000	S
29025		A	Application of body cast	2.40	0.75	0.14	3.29	000	S
29035		A	Application of body cast	1.77	1.95	0.32	4.04	000	S
29040		A	Application of body cast	2.22	2.02	0.30	4.54	000	S
29044		A	Application of body cast	2.12	2.09	0.34	4.55	000	S
29046		A	Application of body cast	2.41	2.23	0.36	5.00	000	S
29049		A	Application of shoulder cast	0.89	0.42	0.06	1.37	000	S
29055		A	Application of shoulder cast	1.78	1.20	0.17	3.15	000	S
29058		A	Application of shoulder cast	1.31	0.65	0.09	2.05	000	S
29065		A	Application of long arm cast	0.87	0.80	0.13	1.80	000	S
29075		A	Application of forearm cast	0.77	0.61	0.10	1.48	000	S
29085		A	Apply hand/wrist cast	0.87	0.50	0.08	1.45	000	S
29105		A	Apply long arm splint	0.87	0.50	0.08	1.45	000	S
29125		A	Apply forearm splint	0.59	0.37	0.05	1.01	000	S
29126		A	Apply forearm splint	0.77	0.40	0.06	1.23	000	S
29130		A	Application of finger splint	0.50	0.17	0.02	0.69	000	S
29131		A	Application of finger splint	0.55	0.39	0.06	1.00	000	S
29200		A	Strapping of chest	0.65	0.27	0.03	0.95	000	N
29220		A	Strapping of low back	0.64	0.38	0.05	1.07	000	S
29240		A	Strapping of shoulder	0.71	0.27	0.03	1.01	000	S
29260		A	Strapping of elbow or wrist	0.55	0.23	0.03	0.81	000	S
29280		A	Strapping of hand or finger	0.51	0.21	0.02	0.74	000	S
29305		A	Application of hip cast	2.03	1.88	0.31	4.22	000	S
29325		A	Application of hip casts	2.32	1.94	0.28	4.54	000	S
29345		A	Application of long leg cast	1.40	1.02	0.16	2.58	000	S
29355		A	Application of long leg cast	1.53	1.10	0.17	2.80	000	S
29358		A	Apply long leg cast brace	1.43	*1.84	0.33	3.60	000	S
29365		A	Application of long leg cast	1.18	0.86	0.14	2.18	000	S
29405		A	Apply short leg cast	0.86	0.79	0.12	1.77	000	S
29425		A	Apply short leg cast	1.01	0.97	0.14	2.12	000	S
29435		A	Apply short leg cast	1.18	1.18	0.18	2.54	000	S
29440		A	Addition of walker to cast	0.57	0.23	0.03	0.83	000	S
29445		A	Apply rigid leg cast	1.78	1.70	0.28	3.76	000	S
29450		A	Application of leg cast	1.02	0.39	0.04	1.45	000	S
29505		A	Application long leg splint	0.69	0.57	0.07	1.33	000	S
29515		A	Application lower leg splint	0.73	0.47	0.06	1.26	000	S
29520		A	Strapping of hip	0.54	0.36	0.03	0.93	000	S
29530		A	Strapping of knee	0.57	0.35	0.05	0.97	000	S
29540		A	Strapping of ankle	0.51	0.30	0.03	0.84	000	S
29550		A	Strapping of toes	0.47	0.28	0.03	0.78	000	S
29580		A	Application of paste boot	0.57	0.79	0.04	1.40	000	S
29590		A	Application of foot splint	0.76	0.28	0.03	1.07	000	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
29700		A	Removal/revision of cast	0.88	0.32	0.05	1.25	000	S
29705		A	Removal/revision of cast	1.12	0.35	0.05	1.52	000	S
29710		A	Removal/revision of cast	1.34	0.45	0.07	1.86	000	S
29715		A	Removal/revision of cast	0.94	0.86	0.12	1.92	000	S
29720		A	Repair of body cast	0.68	0.23	0.04	0.95	000	S
29730		A	Windowing of cast	0.75	0.26	0.04	1.05	000	S
29740		A	Wedging of cast	1.12	0.38	0.06	1.56	000	S
29750		A	Wedging of clubfoot cast	1.26	0.50	0.07	1.83	000	S
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	YYY	S
29800		A	Jaw arthroscopy/surgery	5.28	4.01	0.46	9.75	090	S
29804		A	Jaw arthroscopy/surgery	7.99	*10.23	1.46	19.68	090	S
29815		A	Shoulder arthroscopy	5.74	4.84	0.76	11.34	090	S
29819		A	Shoulder arthroscopy/surgery	7.33	*9.38	1.73	18.44	090	S
29820		A	Shoulder arthroscopy/surgery	6.81	*8.72	1.73	17.26	090	S
29821		A	Shoulder arthroscopy/surgery	7.43	*9.50	2.13	19.06	090	S
29822		A	Shoulder arthroscopy/surgery	7.14	*9.14	1.74	18.02	090	S
29823		A	Shoulder arthroscopy/surgery	7.86	*10.07	2.32	20.25	090	S
29825		A	Shoulder arthroscopy/surgery	7.33	*9.38	2.05	18.76	090	S
29826		A	Shoulder arthroscopy/surgery	8.70	*11.14	2.31	22.15	090	S
29830		A	Elbow arthroscopy	5.63	5.32	0.83	11.78	090	S
29834		A	Elbow arthroscopy/surgery	6.13	5.84	0.96	12.93	090	S
29835		A	Elbow arthroscopy/surgery	6.33	6.03	0.99	13.35	090	S
29836		A	Elbow arthroscopy/surgery	7.37	7.03	1.15	15.55	090	S
29837		A	Elbow arthroscopy/surgery	6.72	6.40	1.06	14.18	090	S
29838		A	Elbow arthroscopy/surgery	7.42	7.05	1.14	15.61	090	S
29840		A	Wrist arthroscopy	5.39	3.29	0.54	9.22	090	S
29843		A	Wrist arthroscopy/surgery	5.86	5.60	0.91	12.37	090	S
29844		A	Wrist arthroscopy/surgery	6.22	5.59	0.95	12.76	090	S
29845		A	Wrist arthroscopy/surgery	7.34	7.00	1.15	15.49	090	S
29846		A	Wrist arthroscopy/surgery	6.60	*8.45	2.20	17.25	090	S
29847		A	Wrist arthroscopy/surgery	6.93	6.78	0.97	14.68	090	S
29848		A	Wrist arthroscopy/surgery	4.04	3.85	0.62	8.51	090	S
29850		A	Knee arthroscopy/surgery	7.96	*10.19	1.74	19.89	090	S
29851		A	Knee arthroscopy/surgery	12.38	10.95	1.74	25.07	090	S
29855		A	Tibial arthroscopy/surgery	9.48	11.69	1.88	23.05	090	S
29856		A	Tibial arthroscopy/surgery	13.28	11.69	1.88	26.85	090	S
29870		A	Knee arthroscopy, diagnostic	4.94	4.02	0.64	9.60	090	S
29871		A	Knee arthroscopy/drainage	6.29	6.77	0.96	14.02	090	S
29874		A	Knee arthroscopy/surgery	6.79	*8.69	1.52	17.00	090	S
29875		A	Knee arthroscopy/surgery	6.16	*7.88	1.61	15.65	090	S
29876		A	Knee arthroscopy/surgery	7.51	*9.61	1.95	19.07	090	S
29877		A	Knee arthroscopy/surgery	7.05	*9.03	1.81	17.89	090	S
29879		A	Knee arthroscopy/surgery	7.63	*9.76	2.19	19.58	090	S
29880		A	Knee arthroscopy/surgery	8.09	*10.35	2.22	20.66	090	S
29881		A	Knee arthroscopy/surgery	7.46	*9.54	1.82	18.82	090	S
29882		A	Knee arthroscopy/surgery	8.24	*10.54	1.90	20.68	090	S
29883		A	Knee arthroscopy/surgery	9.00	*11.52	2.80	23.32	090	S
29884		A	Knee arthroscopy/surgery	6.92	*8.86	1.56	17.34	090	S
29885		A	Knee arthroscopy/surgery	8.63	8.23	1.35	18.21	090	S
29886		A	Knee arthroscopy/surgery	7.13	6.80	1.12	15.05	090	S
29887		A	Knee arthroscopy/surgery	8.58	10.52	1.71	20.81	090	S
29888		A	Knee arthroscopy/surgery	13.28	*17.00	3.18	33.46	090	S
29889		A	Knee arthroscopy/surgery	10.76	10.26	1.68	22.70	090	S
29894		A	Ankle arthroscopy/surgery	6.95	*8.90	1.47	17.32	090	S
29895		A	Ankle arthroscopy/surgery	6.73	*8.60	1.51	16.84	090	S
29897		A	Ankle arthroscopy/surgery	6.92	*8.86	1.77	17.55	090	S
29898		A	Ankle arthroscopy/surgery	8.03	*10.28	1.91	20.22	090	S
29909		C	Arthroscopy of joint	0.00	0.00	0.00	0.00	YYY	S
30000		A	Drainage of nose lesion	1.38	0.58	0.05	2.01	010	S
30020		A	Drainage of nose lesion	1.38	0.60	0.06	2.04	010	S
30100		A	Intranasal biopsy	0.94	0.69	0.08	1.71	000	S
30110		A	Removal of nose polyp(s)	1.58	1.29	0.14	3.01	010	S
30115		A	Removal of nose polyp(s)	4.25	2.81	0.30	7.36	090	S
30117		A	Removal of intranasal lesion	3.06	2.84	0.31	6.21	090	S
30118		A	Removal of intranasal lesion	9.23	8.01	0.92	18.16	090	S
30120		A	Revision of nose	5.14	*6.59	1.00	12.73	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
30124		A	Removal of nose lesion	3.00	1.34	0.16	4.50	090	S
30125		A	Removal of nose lesion	6.79	5.55	0.73	13.07	090	S
30130		A	Removal of turbinate bones	3.17	1.67	0.17	5.01	090	S
30140		A	Removal of turbinate bones	3.28	3.04	0.34	6.66	090	S
30150		A	Partial removal of nose	8.48	7.92	1.07	17.47	090	S
30160		A	Removal of nose	8.92	*11.42	1.73	22.07	090	S
30200		A	Injection treatment of nose	0.78	0.37	0.04	1.19	000	S
30210		A	Nasal sinus therapy	1.03	0.26	0.03	1.32	010	S
30220		A	Insert nasal septal button	1.49	1.51	0.16	3.16	010	S
30300		A	Remove nasal foreign body	0.99	0.46	0.05	1.50	010	S
30310		A	Remove nasal foreign body	1.91	1.62	0.18	3.71	010	S
30320		A	Remove nasal foreign body	4.39	4.29	0.43	9.11	090	S
30400		R	Reconstruction of nose	9.24	9.97	1.36	20.57	090	S
30410		R	Reconstruction of nose	12.39	14.54	2.01	28.94	090	S
30420		R	Reconstruction of nose	15.40	17.78	2.22	35.40	090	S
30430		R	Revision of nose	6.73	6.09	0.66	13.48	090	S
30435		R	Revision of nose	11.23	10.17	1.10	22.50	090	S
30450		R	Revision of nose	18.06	11.24	0.91	30.21	090	S
30460		A	Revision of nose	9.48	8.58	0.93	18.99	090	S
30462		A	Revision of nose	18.98	17.16	1.87	38.01	090	S
30520		A	Repair of nasal septum	5.55	*7.10	0.96	13.61	090	S
30540		A	Repair nasal defect	7.46	6.63	0.70	14.79	090	S
30545		A	Repair nasal defect	10.89	10.83	0.93	22.65	090	S
30560		A	Release of nasal adhesions	1.21	0.55	0.06	1.82	010	S
30580		A	Repair upper jaw fistula	6.49	6.24	0.57	13.30	090	S
30600		A	Repair mouth/nose fistula	5.87	3.77	0.36	10.00	090	S
30620		A	Intranasal reconstruction	5.55	*7.10	1.10	13.75	090	S
30630		A	Repair nasal septum defect	6.83	6.24	0.71	13.78	090	S
30801		A	Cauterization inner nose	1.02	0.47	0.05	1.54	010	S
30802		A	Cauterization inner nose	1.98	0.94	0.11	3.03	010	S
30901		A	Control of nosebleed	1.21	0.56	0.06	1.83	000	S
30903		A	Control of nosebleed	1.54	0.85	0.08	2.47	000	S
30905		A	Control of nosebleed	1.97	1.79	0.17	3.93	000	S
30906		A	Repeat control of nosebleed	2.45	1.08	0.11	3.64	000	S
30915		A	Ligation nasal sinus artery	6.72	4.95	0.52	12.19	090	S
30920		A	Ligation upper jaw artery	7.46	*9.54	1.32	18.32	090	S
30930		A	Therapy fracture of nose	1.21	0.71	0.08	2.00	010	S
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	YYY	N
31000		A	Irrigation maxillary sinus	1.10	0.43	0.05	1.58	010	S
31002		A	Irrigation sphenoid sinus	1.86	0.46	0.05	2.37	010	S
31020		A	Exploration maxillary sinus	2.81	2.66	0.29	5.76	090	S
31030		A	Exploration maxillary sinus	5.60	*7.16	0.86	13.62	090	S
31032		A	Explore sinus, remove polyps	6.22	*7.96	0.99	15.17	090	S
31040		A	Exploration behind upper jaw	8.83	7.98	0.86	17.67	090	S
31050		A	Exploration sphenoid sinus	5.07	5.96	0.64	11.67	090	S
31051		A	Sphenoid sinus surgery	6.85	8.12	0.85	15.82	090	S
31070		A	Exploration of frontal sinus	4.04	4.69	0.50	9.23	090	S
31075		A	Exploration of frontal sinus	8.57	10.51	1.10	20.18	090	S
31080		A	Removal of frontal sinus	10.73	9.21	1.12	21.06	090	S
31081		A	Removal of frontal sinus	11.93	10.32	1.30	23.55	090	S
31084		A	Removal of frontal sinus	12.69	14.79	1.62	29.10	090	S
31085		A	Removal of frontal sinus	13.38	15.65	1.76	30.79	090	S
31086		A	Removal of frontal sinus	11.98	10.87	1.15	24.00	090	S
31087		A	Removal of frontal sinus	12.14	10.39	1.33	23.86	090	S
31090		A	Exploration of sinuses	8.65	*11.32	2.12	22.09	090	S
31200		A	Removal of ethmoid sinus	4.68	4.62	0.48	9.78	090	S
31201		A	Removal of ethmoid sinus	7.91	7.01	0.75	15.67	090	S
31205		A	Removal of ethmoid sinus	9.65	8.03	0.81	18.49	090	S
31225		A	Removal of upper jaw	15.19	*19.44	2.37	37.00	090	S
31230		A	Removal of upper jaw	21.06	21.74	2.48	45.28	090	S
31231		A	Nasal endoscopy, dx	1.10	1.37	0.15	2.62	000	S
31233		A	Nasal/sinus endoscopy, dx	2.18	*2.79	0.31	5.28	000	S
31235		A	Nasal/sinus endoscopy, dx	2.64	2.39	0.26	5.29	000	S
31237		A	Nasal/sinus endoscopy, surg	2.98	3.37	0.37	6.72	000	S
31238		A	Nasal/sinus endoscopy, surg	3.26	*4.17	0.45	7.88	000	S
31239		A	Nasal/sinus endoscopy, surg	8.50	*10.88	1.18	20.56	010	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
31240		A	Nasal/sinus endoscopy, surg	2.61	*3.34	0.37	6.32	000	S
31254		A	Revision of ethmoid sinus	4.65	*5.95	0.69	11.29	000	S
31255		A	Removal of ethmoid sinus	6.96	*8.91	1.14	17.01	000	S
31256		A	Exploration maxillary sinus	3.29	3.77	0.41	7.47	000	S
31267		A	Endoscopy, maxillary sinus	5.46	5.23	0.81	11.50	000	S
31276		A	Sinus surgical endoscopy	8.85	6.72	0.73	16.30	000	S
31287		A	Nasal/sinus endoscopy, surg	3.92	*5.01	0.65	9.58	000	S
31288		A	Nasal/sinus endoscopy, surg	4.58	*5.86	0.78	11.22	000	S
31290		A	Nasal/sinus endoscopy, surg	12.87	*16.47	1.80	31.14	010	S
31291		A	Nasal/sinus endoscopy, surg	13.52	*17.31	1.88	32.71	010	S
31292		A	Nasal/sinus endoscopy, surg	10.45	*13.38	1.45	25.28	010	S
31293		A	Nasal/sinus endoscopy, surg	11.43	*14.64	1.59	27.66	010	S
31294		A	Nasal/sinus endoscopy, surg	13.06	*16.72	1.83	31.61	010	S
31299		C	Sinus surgery procedure	0.00	0.00	0.00	0.00	YYY	S
31300		A	Removal of larynx lesion	13.28	11.58	1.28	26.14	090	S
31320		A	Diagnostic incision larynx	4.54	3.87	0.48	8.89	090	S
31360		A	Removal of larynx	15.19	19.36	2.19	36.74	090	S
31365		A	Removal of larynx	21.83	27.14	3.10	52.07	090	S
31367		A	Partial removal of larynx	18.98	17.22	1.88	38.08	090	S
31368		A	Partial removal of larynx	23.72	26.76	3.06	53.54	090	S
31370		A	Partial removal of larynx	18.50	17.18	1.88	37.56	090	S
31375		A	Partial removal of larynx	18.50	14.84	1.56	34.90	090	S
31380		A	Partial removal of larynx	18.50	17.27	1.88	37.65	090	S
31382		A	Partial removal of larynx	18.50	16.06	1.78	36.34	090	S
31390		A	Removal of larynx & pharynx	21.15	*27.08	4.05	52.28	090	S
31395		A	Reconstruct larynx & pharynx	26.19	*33.52	4.42	64.13	090	S
31400		A	Revision of larynx	9.06	7.81	0.91	17.78	090	S
31420		A	Removal of epiglottis	9.06	8.08	0.84	17.98	090	S
31500		A	Insert emergency airway	2.33	1.14	0.14	3.61	000	N
31502		A	Change of windpipe airway	0.65	0.58	0.07	1.30	000	S
31505		A	Diagnostic laryngoscopy	0.61	0.43	0.05	1.09	000	S
31510		A	Laryngoscopy with biopsy	1.92	0.55	0.07	2.54	000	S
31511		A	Remove foreign body, larynx	2.16	0.96	0.10	3.22	000	S
31512		A	Removal of larynx lesion	2.07	1.79	0.20	4.06	000	S
31513		A	Injection into vocal cord	2.10	*2.68	0.38	5.16	000	S
31515		A	Laryngoscopy for aspiration	1.80	1.13	0.14	3.07	000	S
31520		A	Diagnostic laryngoscopy	2.56	1.64	0.18	4.38	000	S
31525		A	Diagnostic laryngoscopy	2.63	2.20	0.23	5.06	000	S
31526		A	Diagnostic laryngoscopy	2.57	*3.29	0.38	6.24	000	S
31527		A	Laryngoscopy for treatment	3.27	2.99	0.30	6.56	000	S
31528		A	Laryngoscopy and dilatation	2.37	2.66	0.30	5.33	000	S
31529		A	Laryngoscopy and dilatation	2.68	2.46	0.25	5.39	000	S
31530		A	Operative laryngoscopy	3.39	3.63	0.39	7.41	000	S
31531		A	Operative laryngoscopy	3.73	*4.78	0.60	9.11	000	S
31535		A	Operative laryngoscopy	3.16	4.01	0.45	7.62	000	S
31536		A	Operative laryngoscopy	3.17	*4.06	0.59	7.82	000	S
31540		A	Operative laryngoscopy	4.13	*5.29	0.61	10.03	000	S
31541		A	Operative laryngoscopy	3.56	*4.56	0.75	8.87	000	S
31560		A	Operative laryngoscopy	5.46	4.99	0.51	10.96	000	S
31561		A	Operative laryngoscopy	4.90	*6.27	1.08	12.25	000	S
31570		A	Laryngoscopy with injection	3.87	*4.95	0.60	9.42	000	S
31571		A	Laryngoscopy with injection	3.52	*4.51	0.69	8.72	000	S
31575		A	Diagnostic laryngoscopy	1.10	1.56	0.17	2.83	000	S
31576		A	Laryngoscopy with biopsy	1.97	*2.52	0.33	4.82	000	S
31577		A	Remove foreign body, larynx	2.47	*3.16	0.37	6.00	000	S
31578		A	Removal of larynx lesion	2.84	*3.63	0.48	6.95	000	S
31579		A	Diagnostic laryngoscopy	2.26	2.33	0.26	4.85	000	S
31580		A	Revision of larynx	11.01	*14.09	1.63	26.73	090	S
31582		A	Revision of larynx	19.73	17.87	1.94	39.54	090	S
31584		A	Repair of larynx fracture	18.50	12.72	1.34	32.56	090	S
31585		A	Repair of larynx fracture	4.40	3.77	0.40	8.57	090	S
31586		A	Repair of larynx fracture	7.24	6.55	0.71	14.50	090	S
31587		A	Revision of larynx	7.98	7.21	0.79	15.98	090	S
31588		A	Revision of larynx	11.82	10.70	1.16	23.68	090	S
31590		A	Reinnervate larynx	6.36	5.76	0.62	12.74	090	S
31595		A	Larynx nerve surgery	7.58	6.84	0.74	15.16	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
31599		C	Larynx surgery procedure	0.00	0.00	0.00	0.00	YYY	S
31600		A	Incision of windpipe	3.62	4.04	0.65	8.31	000	S
31601		A	Incision of windpipe	4.45	5.03	0.66	10.14	000	S
31603		A	Incision of windpipe	4.15	4.23	0.66	9.04	000	S
31605		A	Incision of windpipe	3.58	4.19	0.50	8.27	000	S
31610		A	Incision of windpipe	7.87	6.67	0.92	15.46	090	S
31611		A	Surgery/speech prosthesis	5.03	*6.45	1.04	12.52	090	S
31612		A	Puncture/clear windpipe	0.91	1.17	0.12	2.20	000	S
31613		A	Repair windpipe opening	4.24	2.21	0.28	6.73	090	S
31614		A	Repair windpipe opening	6.11	6.74	0.73	13.58	090	S
31615		A	Visualization of windpipe	2.09	1.95	0.22	4.26	000	S
31622		A	Diagnostic bronchoscopy	2.80	3.57	0.34	6.71	000	N
31625		A	Bronchoscopy with biopsy	3.37	3.83	0.35	7.55	000	N
31628		A	Bronchoscopy with biopsy	3.81	*4.88	0.38	9.07	000	N
31629		A	Bronchoscopy with biopsy	3.37	*4.31	0.34	8.02	000	N
31630		A	Bronchoscopy with repair	3.82	3.72	0.50	8.04	000	S
31631		A	Bronchoscopy with dilation	4.37	3.94	0.48	8.79	000	N
31635		A	Remove foreign body, airway	3.68	4.53	0.53	8.74	000	S
31640		A	Bronchoscopy & remove lesion	4.94	5.02	0.67	10.63	000	S
31641		A	Bronchoscopy, treat blockage	5.03	*6.45	0.85	12.33	000	N
31645		A	Bronchoscopy, clear airways	3.16	3.62	0.30	7.08	000	N
31646		A	Bronchoscopy, reclear airways	2.72	3.06	0.27	6.05	000	N
31656		A	Bronchoscopy, inject for x-ray	2.17	*2.77	0.31	5.25	000	N
31700		A	Insertion of airway catheter	1.34	1.38	0.17	2.89	000	N
31708		A	Instill airway contrast dye	1.41	0.77	0.09	2.27	000	N
31710		A	Insertion of airway catheter	1.30	0.90	0.12	2.32	000	N
31715		A	Injection for bronchus x-ray	1.11	0.48	0.04	1.63	000	N
31717		A	Bronchial brush biopsy	2.12	0.73	0.06	2.91	000	N
31720		A	Clearance of airways	1.06	0.74	0.09	1.89	000	N
31725		A	Clearance of airways	1.96	1.41	0.15	3.52	000	N
31730		A	Intro windpipe wire/tube	2.85	2.47	0.23	5.55	000	N
31750		A	Repair of windpipe	9.05	8.88	1.09	19.02	090	S
31755		A	Repair of windpipe	14.69	13.30	1.44	29.43	090	S
31760		A	Repair of windpipe	20.89	10.92	2.55	34.36	090	S
31766		A	Reconstruction of windpipe	28.82	18.40	1.12	48.34	090	S
31770		A	Repair/graft of bronchus	21.15	15.07	2.08	38.30	090	S
31775		A	Reconstruct bronchus	22.15	16.37	1.92	40.44	090	S
31780		A	Reconstruct windpipe	16.14	17.33	2.08	35.55	090	S
31781		A	Reconstruct windpipe	22.22	16.86	1.96	41.04	090	S
31785		A	Remove windpipe lesion	16.14	8.92	1.17	26.23	090	S
31786		A	Remove windpipe lesion	22.54	13.30	2.24	38.08	090	S
31800		A	Repair of windpipe injury	6.77	4.90	0.76	12.43	090	S
31805		A	Repair of windpipe injury	12.59	9.82	1.41	23.82	090	S
31820		A	Closure of windpipe lesion	4.10	3.58	0.46	8.14	090	S
31825		A	Repair of windpipe defect	6.31	5.00	0.58	11.89	090	S
31830		A	Revise windpipe scar	4.26	3.66	0.42	8.34	090	S
31899		C	Airways surgical procedure	0.00	0.00	0.00	0.00	YYY	S
32000		A	Drainage of chest	1.54	0.90	0.08	2.52	000	N
32002		A	Treatment of collapsed lung	2.19	1.34	0.22	3.75	000	N
32005		A	Treat lung lining chemically	2.19	1.09	0.15	3.43	000	S
32020		A	Insertion of chest tube	3.98	2.63	0.43	7.04	000	S
32035		A	Exploration of chest	6.55	6.76	1.25	14.56	090	S
32036		A	Exploration of chest	7.56	7.13	1.32	16.01	090	S
32095		A	Biopsy through chest wall	7.13	8.25	1.45	16.83	090	S
32100		A	Exploration/biopsy of chest	10.07	11.24	2.10	23.41	090	S
32110		A	Explore/repair chest	11.76	11.51	2.01	25.28	090	S
32120		A	Re-exploration of chest	9.62	9.45	1.72	20.79	090	S
32124		A	Explore chest, free adhesions	10.93	10.94	2.21	24.08	090	S
32140		A	Removal of lung lesion(s)	12.14	12.37	2.42	26.93	090	S
32141		A	Remove/treat lung lesions	12.14	13.42	2.53	28.09	090	S
32150		A	Removal of lung lesion(s)	12.42	10.34	2.01	24.77	090	S
32151		A	Remove lung foreign body	12.42	9.15	1.37	22.94	090	S
32160		A	Open chest heart massage	7.13	*9.13	1.52	17.78	090	S
32200		A	Drainage of lung lesion	13.10	6.89	0.93	20.92	090	S
32215		A	Treat chest lining	10.07	7.62	1.28	18.97	090	S
32220		A	Release of lung	17.62	15.81	3.01	36.44	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
32225		A	Partial release of lung	12.10	11.84	2.28	26.22	090	S
32310		A	Removal of chest lining	12.05	11.64	2.10	25.79	090	S
32320		A	Free/remove chest lining	19.15	18.10	3.40	40.65	090	S
32400		A	Needle biopsy chest lining	1.76	1.48	0.12	3.36	000	N
32402		A	Open biopsy chest lining	6.55	7.58	1.34	15.47	090	S
32405		A	Biopsy, lung or mediastinum	1.93	2.12	0.18	4.23	000	N
32420		A	Puncture/clear lung	2.18	1.50	0.13	3.81	000	N
32440		A	Removal of lung	19.15	18.56	3.55	41.26	090	S
32442		A	Sleeve pneumonectomy	24.68	17.94	3.50	46.12	090	S
32445		A	Removal of lung	23.37	20.46	3.88	47.71	090	S
32480		A	Partial removal of lung	16.84	17.15	3.23	37.22	090	S
32482		A	Bilobectomy	18.54	17.15	3.23	38.92	090	S
32484		A	Segmentectomy	19.52	17.15	3.23	39.90	090	S
32485		D	Partial removal of lung	0.00	0.00	0.00	0.00	090	S
32486		A	Sleeve lobectomy	22.75	16.54	3.23	42.52	090	S
32488		A	Completion pneumonectomy	24.41	17.74	3.46	45.61	090	S
32500		A	Partial removal of lung	13.10	13.47	2.56	29.13	090	S
32501		A	Repair bronchus (add-on)	4.69	4.31	0.70	9.70	ZZZ	S
32520		A	Remove lung & revise chest	19.42	20.67	3.93	44.02	090	S
32522		A	Remove lung & revise chest	21.94	21.90	4.19	48.03	090	S
32525		A	Remove lung & revise chest	24.33	23.50	4.61	52.44	090	S
32540		A	Removal of lung lesion	13.31	11.67	2.05	27.03	090	S
32601		A	Thoracoscopy, diagnostic	5.46	3.47	0.57	9.50	000	S
32602		A	Thoracoscopy, diagnostic	5.96	3.87	0.64	10.47	000	S
32603		A	Thoracoscopy, diagnostic	7.81	3.47	0.57	11.85	000	S
32604		A	Thoracoscopy, diagnostic	8.78	3.87	0.64	13.29	000	S
32605		A	Thoracoscopy, diagnostic	6.93	3.47	0.57	10.97	000	S
32606		A	Thoracoscopy, diagnostic	8.40	3.87	0.64	12.91	000	S
32650		A	Thoracoscopy, surgical	10.07	7.62	1.28	18.97	090	S
32651		A	Thoracoscopy, surgical	12.10	11.84	2.28	26.22	090	S
32652		A	Thoracoscopy, surgical	17.62	15.81	3.01	36.44	090	S
32653		A	Thoracoscopy, surgical	12.42	10.34	2.01	24.77	090	S
32654		A	Thoracoscopy, surgical	11.76	11.51	2.01	25.28	090	S
32655		A	Thoracoscopy, surgical	12.42	13.42	2.53	28.37	090	S
32656		A	Thoracoscopy, surgical	12.10	13.36	2.36	27.82	090	S
32657		A	Thoracoscopy, surgical	13.10	13.47	2.56	29.13	090	S
32658		A	Thoracoscopy, surgical	11.08	13.26	2.52	26.86	090	S
32659		A	Thoracoscopy, surgical	10.91	*13.96	2.61	27.48	090	S
32660		A	Thoracoscopy, surgical	16.62	19.93	3.56	40.11	090	S
32661		A	Thoracoscopy, surgical	12.70	9.25	1.47	23.42	090	S
32662		A	Thoracoscopy, surgical	15.76	14.55	2.74	33.05	090	S
32663		A	Thoracoscopy, surgical	17.43	17.15	3.23	37.81	090	S
32664		A	Thoracoscopy, surgical	13.65	10.55	2.04	26.24	090	S
32665		A	Thoracoscopy, surgical	14.73	14.33	2.64	31.70	090	S
32800		A	Repair lung hernia	12.10	8.28	1.58	21.96	090	S
32810		A	Close chest after drainage	11.59	6.50	1.19	19.28	090	S
32815		A	Close bronchial fistula	21.36	15.22	2.62	39.20	090	S
32820		A	Reconstruct injured chest	19.78	19.01	3.24	42.03	090	S
32850		X	Donor pneumonectomy	0.00	0.00	0.00	0.00	XXX	0
32851		A	Lung transplant, single	35.14	25.55	4.99	65.68	090	S
32852		A	Lung transplant w/bypass	38.11	27.71	5.41	71.23	090	S
32853		A	Lung transplant, double	43.93	31.94	6.24	82.11	090	S
32854		A	Lung transplant w/bypass	46.90	34.10	6.67	87.67	090	S
32900		A	Removal of rib(s)	18.14	8.47	1.63	28.24	090	S
32905		A	Revise & repair chest wall	19.15	12.74	2.60	34.49	090	S
32906		A	Revise & repair chest wall	25.17	15.42	2.92	43.51	090	S
32940		A	Revision of lung	18.14	11.37	1.75	31.26	090	S
32960		A	Therapeutic pneumothorax	1.84	0.93	0.13	2.90	000	N
32999		C	Chest surgery procedure	0.00	0.00	0.00	0.00	YYY	S
33010		A	Drainage of heart sac	2.24	1.54	0.14	3.92	000	N
33011		A	Repeat drainage of heart sac	2.24	1.11	0.12	3.47	000	N
33015		A	Incision of heart sac	5.64	4.26	0.62	10.52	090	S
33020		A	Incision of heart sac	11.08	13.26	2.52	26.86	090	S
33025		A	Incision of heart sac	10.91	*13.96	2.61	27.48	090	S
33030		A	Partial removal of heart sac	16.62	21.02	3.92	41.56	090	S
33031		A	Partial removal of heart sac	19.64	13.25	2.50	35.39	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
33050		A	Removal of heart sac lesion	12.70	9.25	1.47	23.42	090	S
33120		A	Removal of heart lesion	22.57	*28.89	5.17	56.63	090	S
33130		A	Removal of heart lesion	19.53	13.50	2.22	35.25	090	S
33200		A	Insertion of heart pacemaker	11.08	12.27	1.90	25.25	090	S
33201		A	Insertion of heart pacemaker	8.93	11.19	1.67	21.79	090	S
33206		A	Insertion of heart pacemaker	6.04	*7.73	1.34	15.11	090	S
33207		A	Insertion of heart pacemaker	7.28	9.01	1.33	17.62	090	S
33208		A	Insertion of heart pacemaker	7.28	*9.50	1.54	18.32	090	N
33210		A	Insertion of heart electrode	3.30	3.30	0.27	6.87	000	N
33211		A	Insertion of heart electrode	3.40	3.30	0.27	6.97	000	N
33212		A	Insertion of pulse generator	5.21	5.38	0.88	11.47	090	S
33213		A	Insertion of pulse generator	6.15	5.38	0.88	12.41	090	N
33214		A	Upgrade of pacemaker system	7.43	5.40	1.06	13.89	090	N
33216		A	Revision implanted electrode	5.07	5.02	0.55	10.64	090	N
33217		A	Insert/revise electrode	5.43	5.02	0.55	11.00	090	N
33218		A	Repair pacemaker electrodes	5.02	4.59	0.62	10.23	090	S
33220		A	Repair pacemaker electrode	5.10	4.59	0.62	10.31	090	N
33222		A	Pacemaker aicd pocket	4.59	5.70	1.01	11.30	090	S
33223		A	Pacemaker aicd pocket	6.14	5.70	1.01	12.85	090	S
33233		A	Removal of pacemaker system	2.97	2.64	0.05	5.66	090	N
33234		A	Removal of pacemaker system	8.69	4.74	0.38	13.81	090	S
33235		A	Removal pacemaker electrode	9.93	5.21	0.55	15.69	090	N
33236		A	Remove electrode/thoracotomy	11.71	3.98	0.62	16.31	090	S
33237		A	Remove electrode/thoracotomy	12.69	9.60	1.13	23.42	090	S
33238		A	Remove electrode/thoracotomy	14.15	10.29	2.01	26.45	090	S
33240		A	Insert/replace pulse gener	7.20	5.38	0.88	13.46	090	S
33241		A	Remove pulse generator only	2.97	2.16	0.43	5.56	090	S
33242		A	Repair pulse generator/leads	5.85	*7.50	1.54	14.89	090	S
33243		A	Remove generator/thoracotomy	21.47	9.02	1.54	32.03	090	S
33244		A	Remove generator	8.34	9.02	1.54	18.90	090	S
33245		A	Implant heart defibrillator	12.57	*16.09	2.36	31.02	090	S
33246		A	Implant heart defibrillator	19.28	20.79	3.19	43.26	090	S
33247		A	Insert/replace leads	9.76	*12.49	2.36	24.61	090	N
33249		A	Insert/replace leads/gener	12.83	*16.42	3.19	32.44	090	S
33250		A	Ablate heart dysrhythm focus	19.54	11.56	0.86	31.96	090	S
33251		A	Ablate heart dysrhythm focus	22.57	16.41	3.21	42.19	090	S
33253		A	Reconstruct atria	30.00	21.81	4.26	56.07	090	S
33260		D	Ablate heart dysrhythm focus	0.00	0.00	0.00	0.00	090	S
33261		A	Ablate heart dysrhythm focus	22.57	13.96	2.73	39.26	090	S
33300		A	Repair of heart wound	16.19	14.36	2.60	33.15	090	S
33305		A	Repair of heart wound	19.22	17.40	3.07	39.69	090	S
33310		A	Exploratory heart surgery	17.12	11.28	1.93	30.33	090	S
33315		A	Exploratory heart surgery	20.15	14.48	2.57	37.20	090	S
33320		A	Repair major blood vessel(s)	15.39	14.14	2.51	32.04	090	S
33321		A	Repair major vessel	18.74	21.75	3.61	44.10	090	S
33322		A	Repair major blood vessel(s)	18.40	21.75	3.61	43.76	090	S
33330		A	Insert major vessel graft	19.15	12.67	1.93	33.75	090	S
33332		A	Insert major vessel graft	22.50	15.07	2.39	39.96	090	S
33335		A	Insert major vessel graft	27.66	15.07	2.39	45.12	090	S
33350		D	Repair major blood vessel(s)	0.00	0.00	0.00	0.00	090	S
33400		A	Repair of aortic valve	23.16	26.21	2.83	52.20	090	S
33401		A	Valvuloplasty, open	22.45	26.21	2.83	51.49	090	S
33403		A	Valvuloplasty, w/cp bypass	23.43	26.21	2.83	52.47	090	S
33404		A	Prepare heart-aorta conduit	26.62	31.25	5.59	63.46	090	S
33405		A	Replacement of aortic valve	28.47	30.48	5.33	64.28	090	S
33406		A	Replacement, aortic valve	31.23	38.65	7.45	77.33	090	S
33411		A	Replacement of aortic valve	30.37	38.65	7.45	76.47	090	S
33412		A	Replacement of aortic valve	32.26	38.65	7.45	78.36	090	S
33413		A	Replacement, aortic valve	34.17	41.09	7.23	82.49	090	S
33414		A	Repair, aortic valve	29.28	38.65	7.45	75.38	090	S
33415		A	Revision, subvalvular tissue	25.02	30.48	5.33	60.83	090	S
33416		A	Revise ventricle muscle	28.20	28.14	4.99	61.33	090	S
33417		A	Repair of aortic valve	27.34	34.71	6.18	68.23	090	S
33420		A	Revision of mitral valve	20.69	19.82	2.45	42.96	090	S
33422		A	Revision of mitral valve	23.72	*30.35	6.45	60.52	090	S
33425		A	Repair of mitral valve	25.57	31.27	5.42	62.26	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
33426		A	Repair of mitral valve	26.07	31.96	5.80	63.83	090	S
33427		A	Repair of mitral valve	32.07	34.71	6.30	73.08	090	S
33430		A	Replacement of mitral valve	29.42	34.85	6.11	70.38	090	S
33460		A	Revision of tricuspid valve	21.60	26.07	4.73	52.40	090	S
33463		A	Valvuloplasty, tricuspid	24.16	32.67	5.95	62.78	090	S
33464		A	Valvuloplasty, tricuspid	25.87	32.67	5.95	64.49	090	S
33465		A	Replace tricuspid valve	26.57	32.67	5.95	65.19	090	S
33468		A	Revision of tricuspid valve	28.20	34.71	6.30	69.21	090	S
33470		A	Revision of pulmonary valve	19.52	19.82	2.45	41.79	090	S
33471		A	Valvotomy, pulmonary valve	21.13	26.21	2.83	50.17	090	S
33472		A	Revision of pulmonary valve	20.91	*28.70	2.83	52.44	090	S
33474		A	Revision of pulmonary valve	20.91	*28.70	2.83	52.44	090	S
33475		A	Replacement, pulmonary valve	27.34	34.85	6.11	68.30	090	S
33476		A	Revision of heart chamber	24.41	28.14	4.99	57.54	090	S
33478		A	Revision of heart chamber	25.38	31.27	5.42	62.07	090	S
33500		A	Repair heart vessel fistula	23.91	29.55	5.20	58.66	090	S
33501		A	Repair heart vessel fistula	16.14	14.14	2.51	32.79	090	S
33502		A	Coronary artery correction	19.80	14.14	2.51	36.45	090	S
33503		A	Coronary artery graft	20.15	29.55	5.20	54.90	090	S
33504		A	Coronary artery graft	23.16	29.55	5.20	57.91	090	S
33505		A	Repair artery w/tunnel	25.38	34.24	6.03	65.65	090	S
33506		A	Repair artery, translocation	25.38	34.24	6.03	65.65	090	S
33510		A	CABG, vein, single	23.29	29.55	5.20	58.04	090	S
33511		A	CABG, vein, two	25.57	32.44	5.71	63.72	090	S
33512		A	CABG, vein, three	27.84	35.33	6.22	69.39	090	S
33513		A	CABG, vein, four	30.12	38.21	6.73	75.06	090	S
33514		A	CABG, vein, five	32.39	41.09	7.23	80.71	090	S
33516		A	CABG, vein, six+	34.66	43.97	7.74	86.37	090	S
33517		A	CABG, artery-vein, single	2.27	2.89	0.50	5.66	090	S
33518		A	CABG, artery-vein, two	4.55	5.77	1.02	11.34	090	S
33519		A	CABG, artery-vein, three	6.82	8.65	1.52	16.99	090	S
33521		A	CABG, artery-vein, four	9.10	11.54	2.03	22.67	090	S
33522		A	CABG, artery-vein, five	11.37	14.43	2.54	28.34	090	S
33523		A	CABG, artery-vein, six+	13.65	17.32	3.05	34.02	090	S
33530		A	Coronary artery, bypass/reop	5.86	*7.51	2.18	15.55	ZZZ	S
33533		A	CABG, arterial, single	24.00	30.45	5.36	59.81	090	S
33534		A	CABG, arterial, two	26.99	34.24	6.03	67.26	090	S
33535		A	CABG, arterial, three	29.98	38.03	6.70	74.71	090	S
33536		A	CABG, arterial, four+	32.96	41.82	7.37	82.15	090	S
33542		A	Removal of heart lesion	26.57	30.73	5.53	62.83	090	S
33545		A	Repair of heart damage	33.96	34.92	6.28	75.16	090	S
33572		A	Open coronary endarterectomy	4.45	3.23	0.63	8.31	ZZZ	S
33600		A	Closure of valve	28.31	34.85	6.11	69.27	090	S
33602		A	Closure of valve	27.34	30.48	5.33	63.15	090	S
33606		A	Anastomosis/artery-aorta	29.28	38.65	7.45	75.38	090	S
33608		A	Repair anomaly w/conduit	30.02	38.65	7.45	76.12	090	S
33610		A	Repair by enlargement	29.28	38.65	7.45	75.38	090	S
33611		A	Repair double ventricle	31.23	38.65	7.45	77.33	090	S
33612		A	Repair double ventricle	32.06	38.65	7.45	78.16	090	S
33615		A	Repair (simple fontan)	30.50	38.65	7.45	76.60	090	S
33617		A	Repair by modified fontan	32.21	38.65	7.45	78.31	090	S
33619		A	Repair single ventricle	35.39	44.30	8.04	87.73	090	S
33641		A	Repair heart septum defect	19.93	*25.51	4.87	50.31	090	S
33645		A	Revision of heart veins	22.78	27.61	4.87	55.26	090	S
33647		A	Repair heart septum defects	27.44	34.92	6.28	68.64	090	S
33660		A	Repair of heart defects	24.41	31.27	5.42	61.10	090	S
33665		A	Repair of heart defects	27.34	31.27	5.42	64.03	090	S
33670		A	Repair of heart chambers	31.23	38.65	7.45	77.33	090	S
33681		A	Repair heart septum defect	26.36	34.92	6.28	67.56	090	S
33684		A	Repair heart septum defect	28.31	34.92	6.28	69.51	090	S
33688		A	Repair heart septum defect	29.28	34.92	6.28	70.48	090	S
33690		A	Reinforce pulmonary artery	18.31	22.10	4.29	44.70	090	S
33692		A	Repair of heart defects	29.28	38.65	7.45	75.38	090	S
33694		A	Repair of heart defects	30.26	38.65	7.45	76.36	090	S
33696		D	Repair of heart defects	0.00	0.00	0.00	0.00	090	S
33697		A	Repair of heart defects	32.21	38.65	7.45	78.31	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
33698		D	Repair of heart defects	0.00	0.00	0.00	0.00	090	S
33702		A	Repair of heart defects	25.38	30.48	5.33	61.19	090	S
33710		A	Repair of heart defects	28.35	34.92	6.28	69.55	090	S
33720		A	Repair of heart defect	25.38	30.48	5.33	61.19	090	S
33722		A	Repair of heart defect	27.34	30.48	5.33	63.15	090	S
33730		A	Repair heart-vein defect(s)	29.89	38.65	7.45	75.99	090	S
33732		A	Repair heart-vein defect	27.09	31.27	5.42	63.78	090	S
33735		A	Revision of heart chamber	19.97	25.69	4.87	50.53	090	S
33736		A	Revision of heart chamber	22.45	25.69	4.87	53.01	090	S
33737		A	Revision of heart chamber	20.50	25.69	4.87	51.06	090	S
33750		A	Major vessel shunt	20.15	22.10	4.29	46.54	090	S
33755		A	Major vessel shunt	20.50	22.10	4.29	46.89	090	S
33762		A	Major vessel shunt	20.50	22.10	4.29	46.89	090	S
33764		A	Major vessel shunt & graft	20.50	22.10	4.29	46.89	090	S
33766		A	Major vessel shunt	21.47	22.10	4.29	47.86	090	S
33767		A	Atrial septectomy/septostomy	23.43	25.69	4.87	53.99	090	S
33770		A	Repair great vessels defect	31.96	38.65	7.45	78.06	090	S
33771		A	Repair great vessels defect	33.19	38.65	7.45	79.29	090	S
33774		A	Repair great vessels defect	29.28	31.27	5.42	65.97	090	S
33775		A	Repair great vessels defect	30.50	31.27	5.42	67.19	090	S
33776		A	Repair great vessels defect	32.21	34.92	6.28	73.41	090	S
33777		A	Repair great vessels defect	31.73	31.27	5.42	68.42	090	S
33778		A	Repair great vessels defect	34.17	41.82	7.37	83.36	090	S
33779		A	Repair great vessels defect	34.41	41.82	7.37	83.60	090	S
33780		A	Repair great vessels defect	35.14	41.82	7.37	84.33	090	S
33781		A	Repair great vessels defect	34.65	41.82	7.37	83.84	090	S
33786		A	Repair arterial trunk	33.19	38.65	7.45	79.29	090	S
33788		A	Revision of pulmonary artery	25.38	29.55	5.20	60.13	090	S
33800		A	Aortic suspension	15.18	14.14	2.51	31.83	090	S
33802		A	Repair vessel defect	16.60	22.10	4.29	42.99	090	S
33803		A	Repair vessel defect	18.54	22.10	4.29	44.93	090	S
33813		A	Repair septal defect	19.52	22.10	4.29	45.91	090	S
33814		A	Repair septal defect	24.41	30.48	5.33	60.22	090	S
33820		A	Revise major vessel	15.62	22.10	4.29	42.01	090	S
33822		A	Revise major vessel	16.60	22.10	4.29	42.99	090	S
33824		A	Revise major vessel	18.54	22.10	4.29	44.93	090	S
33840		A	Remove aorta constriction	19.52	31.25	5.59	56.36	090	S
33845		A	Remove aorta constriction	20.99	31.25	5.59	57.83	090	S
33851		A	Remove aorta constriction	20.01	31.25	5.59	56.85	090	S
33852		A	Repair septal defect	22.45	31.25	5.59	59.29	090	S
33853		A	Repair septal defect	30.26	38.65	7.45	76.36	090	S
33860		A	Ascending aorta graft	31.23	34.71	6.18	72.12	090	S
33861		A	Ascending aorta graft	33.19	34.71	6.18	74.08	090	S
33863		A	Ascending aorta graft	35.14	34.71	6.18	76.03	090	S
33870		A	Transverse aortic arch graft	37.74	44.30	8.04	90.08	090	S
33875		A	Thoracic aorta graft	26.94	31.25	5.59	63.78	090	S
33877		A	Thoracoabdominal graft	40.29	44.11	8.38	92.78	090	S
33910		A	Remove lung artery emboli	21.86	14.65	2.77	39.28	090	S
33915		A	Remove lung artery emboli	18.84	12.02	2.22	33.08	090	S
33916		A	Surgery of great vessel	24.17	17.57	3.43	45.17	090	S
33917		A	Repair pulmonary artery	23.43	34.71	6.30	64.44	090	S
33918		A	Repair pulmonary atresia	25.38	29.55	5.20	60.13	090	S
33919		A	Repair pulmonary atresia	31.11	38.65	7.45	77.21	090	S
33920		A	Repair pulmonary atresia	30.75	38.65	7.45	76.85	090	S
33922		A	Transect pulmonary artery	22.45	26.21	2.83	51.49	090	S
33924		A	Remove pulmonary shunt	5.50	4.00	0.78	10.28	ZZZ	S
33930		X	Removal of donor heart/lung	0.00	0.00	0.00	0.00	XXX	0
33935		R	Transplantation, heart/lung	56.87	77.57	13.54	147.98	090	S
33940		X	Removal of donor heart	0.00	0.00	0.00	0.00	XXX	0
33945		R	Transplantation of heart	39.56	64.80	11.05	115.41	090	S
33960		A	External circulation assist	19.36	7.01	0.94	27.31	XXX	S
33961		A	External circulation assist	10.93	7.01	0.94	18.88	XXX	S
33970		A	Aortic circulation assist	8.05	7.54	1.00	16.59	000	S
33971		A	Aortic circulation assist	4.04	*5.16	0.91	10.11	090	S
33973		A	Insert balloon device	9.76	7.54	1.00	18.30	000	S
33974		A	Remove intra-aortic balloon	12.69	5.56	0.91	19.16	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
33975		A	Implant ventricular device	19.52	14.19	2.77	36.48	090	S
33976		A	Implant ventricular device	26.60	19.33	3.78	49.71	090	S
33977		A	Remove ventricular device	17.08	12.41	2.43	31.92	090	S
33978		A	Remove ventricular device	19.52	14.19	2.77	36.48	090	S
33999		C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	YYY	S
34001		A	Removal of artery clot	11.69	9.58	1.87	23.14	090	S
34051		A	Removal of artery clot	13.62	8.81	1.59	24.02	090	S
34101		A	Removal of artery clot	8.73	8.34	1.71	18.78	090	S
34111		A	Removal of arm artery clot	7.18	7.59	1.59	16.36	090	S
34151		A	Removal of artery clot	15.23	11.96	2.39	29.58	090	S
34201		A	Removal of artery clot	8.04	8.90	1.78	18.72	090	S
34203		A	Removal of leg artery clot	11.06	8.63	1.72	21.41	090	S
34401		A	Removal of vein clot	11.64	8.07	1.39	21.10	090	S
34421		A	Removal of vein clot	8.89	7.45	1.51	17.85	090	S
34451		A	Removal of vein clot	13.13	10.69	2.14	25.96	090	S
34471		A	Removal of vein clot	9.12	3.51	0.55	13.18	090	S
34490		A	Removal of vein clot	6.51	7.27	1.54	15.32	090	S
34501		A	Repair valve, femoral vein	9.71	7.35	0.86	17.92	090	S
34502		A	Reconstruct, vena cava	25.65	18.65	3.64	47.94	090	S
34510		A	Transposition of vein valve	11.75	8.89	1.04	21.68	090	S
34520		A	Cross-over vein graft	12.33	9.33	1.09	22.75	090	S
34530		A	Leg vein fusion	16.33	12.35	1.44	30.12	090	S
35001		A	Repair defect of artery	18.14	15.90	3.18	37.22	090	S
35002		A	Repair artery rupture, neck	19.43	12.64	2.41	34.48	090	S
35005		A	Repair defect of artery	16.62	10.28	2.19	29.09	090	S
35011		A	Repair defect of artery	10.43	*13.35	2.76	26.54	090	S
35013		A	Repair artery rupture, arm	15.96	14.70	3.03	33.69	090	S
35021		A	Repair defect of artery	17.62	18.13	3.06	38.81	090	S
35022		A	Repair artery rupture, chest	21.15	14.78	2.80	38.73	090	S
35045		A	Repair defect of arm artery	9.98	12.35	2.50	24.83	090	S
35081		A	Repair defect of artery	22.15	21.45	4.18	47.78	090	S
35082		A	Repair artery rupture, aorta	28.82	22.91	4.59	56.32	090	S
35091		A	Repair defect of artery	28.10	22.67	4.25	55.02	090	S
35092		A	Repair artery rupture, aorta	36.06	26.27	5.21	67.54	090	S
35102		A	Repair defect of artery	23.44	22.15	4.32	49.91	090	S
35103		A	Repair artery rupture, groin	31.31	26.16	5.21	62.68	090	S
35111		A	Repair defect of artery	15.12	17.60	3.70	36.42	090	S
35112		A	Repair artery rupture, spleen	17.38	10.45	2.22	30.05	090	S
35121		A	Repair defect of artery	24.68	19.12	3.66	47.46	090	S
35122		A	Repair artery rupture, belly	32.08	17.92	3.96	53.96	090	S
35131		A	Repair defect of artery	17.00	15.88	3.15	36.03	090	S
35132		A	Repair artery rupture, groin	20.40	18.68	3.58	42.66	090	S
35141		A	Repair defect of artery	13.28	14.70	2.88	30.86	090	S
35142		A	Repair artery rupture, thigh	14.62	16.10	3.24	33.96	090	S
35151		A	Repair defect of artery	15.76	15.36	2.94	34.06	090	S
35152		A	Repair artery rupture, knee	15.46	9.27	1.95	26.68	090	S
35161		A	Repair defect of artery	17.45	15.88	3.15	36.48	090	S
35162		A	Repair artery rupture	18.45	18.68	3.58	40.71	090	S
35180		A	Repair blood vessel lesion	12.16	7.37	1.48	21.01	090	S
35182		A	Repair blood vessel lesion	16.12	10.65	1.61	28.38	090	S
35184		A	Repair blood vessel lesion	10.79	9.73	1.96	22.48	090	S
35188		A	Repair blood vessel lesion	13.10	8.11	1.59	22.80	090	S
35189		A	Repair blood vessel lesion	17.12	11.33	2.21	30.66	090	S
35190		A	Repair blood vessel lesion	11.79	10.34	2.14	24.27	090	S
35201		A	Repair blood vessel lesion	8.90	10.07	1.94	20.91	090	S
35206		A	Repair blood vessel lesion	8.49	10.15	2.03	20.67	090	S
35207		A	Repair blood vessel lesion	9.06	10.80	1.93	21.79	090	S
35211		A	Repair blood vessel lesion	20.15	13.38	2.59	36.12	090	S
35216		A	Repair blood vessel lesion	17.12	10.68	2.08	29.88	090	S
35221		A	Repair blood vessel lesion	15.11	11.09	2.20	28.40	090	S
35226		A	Repair blood vessel lesion	8.17	10.28	1.95	20.40	090	S
35231		A	Repair blood vessel lesion	10.76	*13.78	2.91	27.45	090	S
35236		A	Repair blood vessel lesion	9.39	*12.02	2.56	23.97	090	S
35241		A	Repair blood vessel lesion	21.15	13.49	2.60	37.24	090	S
35246		A	Repair blood vessel lesion	18.14	16.95	2.15	37.24	090	S
35251		A	Repair blood vessel lesion	16.12	9.59	1.88	27.59	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
35256		A	Repair blood vessel lesion	10.14	12.40	2.39	24.93	090	S
35261		A	Repair blood vessel lesion	10.39	13.16	2.66	26.21	090	S
35266		A	Repair blood vessel lesion	9.06	*11.59	2.41	23.06	090	S
35271		A	Repair blood vessel lesion	20.15	12.53	2.56	35.24	090	S
35276		A	Repair blood vessel lesion	17.12	10.85	2.26	30.23	090	S
35281		A	Repair blood vessel lesion	15.11	17.28	3.37	35.76	090	S
35286		A	Repair blood vessel lesion	10.78	11.71	2.33	24.82	090	S
35301		A	Rechanneling of artery	15.95	14.46	2.81	33.22	090	S
35311		A	Rechanneling of artery	22.61	22.06	4.61	49.28	090	S
35321		A	Rechanneling of artery	11.08	12.96	2.69	26.73	090	S
35331		A	Rechanneling of artery	22.15	13.34	2.66	38.15	090	S
35341		A	Rechanneling of artery	23.67	17.37	3.53	44.57	090	S
35351		A	Rechanneling of artery	19.15	14.95	2.97	37.07	090	S
35355		A	Rechanneling of artery	15.11	15.42	2.99	33.52	090	S
35361		A	Rechanneling of artery	22.15	19.37	3.88	45.40	090	S
35363		A	Rechanneling of artery	23.16	22.77	4.40	50.33	090	S
35371		A	Rechanneling of artery	10.49	12.51	2.50	25.50	090	S
35372		A	Rechanneling of artery	12.28	11.20	2.28	25.76	090	S
35381		A	Rechanneling of artery	14.50	13.67	2.71	30.88	090	S
35390		A	Reoperation, carotid	3.19	1.67	0.39	5.25	ZZZ	S
35450		A	Repair arterial blockage	10.07	*12.89	1.38	24.34	000	N
35452		A	Repair arterial blockage	6.91	4.35	0.61	11.87	000	S
35454		A	Repair arterial blockage	6.04	*7.73	1.53	15.30	000	S
35456		A	Repair arterial blockage	7.35	*9.41	1.69	18.45	000	S
35458		A	Repair arterial blockage	9.49	10.13	1.83	21.45	000	S
35459		A	Repair arterial blockage	8.63	10.39	1.69	20.71	000	S
35460		A	Repair venous blockage	6.04	3.16	0.74	9.94	000	S
35470		A	Repair arterial blockage	8.63	10.39	1.69	20.71	000	N
35471		A	Repair arterial blockage	10.07	*12.89	1.38	24.34	000	N
35472		A	Repair arterial blockage	6.91	3.61	0.85	11.37	000	N
35473		A	Repair arterial blockage	6.04	*7.73	1.53	15.30	000	N
35474		A	Repair arterial blockage	7.36	*9.42	1.69	18.47	000	N
35475		R	Repair arterial blockage	9.49	10.13	1.83	21.45	000	N
35476		A	Repair venous blockage	6.04	3.16	0.74	9.94	000	N
35480		A	Atherectomy, open	11.08	13.43	1.38	25.89	000	S
35481		A	Atherectomy, open	7.61	4.35	0.61	12.57	000	S
35482		A	Atherectomy, open	6.65	*8.51	1.53	16.69	000	S
35483		A	Atherectomy, open	8.10	*10.36	1.69	20.15	000	S
35484		A	Atherectomy, open	10.44	10.13	1.83	22.40	000	S
35485		A	Atherectomy, open	9.49	4.52	1.06	15.07	000	S
35490		A	Atherectomy, percutaneous	11.08	13.43	1.38	25.89	000	N
35491		A	Atherectomy, percutaneous	7.61	4.35	0.61	12.57	000	N
35492		A	Atherectomy, percutaneous	6.65	*8.51	1.53	16.69	000	N
35493		A	Atherectomy, percutaneous	8.10	*10.36	1.69	20.15	000	N
35494		A	Atherectomy, percutaneous	10.44	10.13	1.83	22.40	000	N
35495		A	Atherectomy, percutaneous	9.49	4.52	1.06	15.07	000	N
35501		A	Artery bypass graft	18.23	19.35	3.49	41.07	090	S
35506		A	Artery bypass graft	18.23	19.17	3.64	41.04	090	S
35507		A	Artery bypass graft	18.23	17.92	3.61	39.76	090	S
35508		A	Artery bypass graft	17.21	18.11	3.43	38.75	090	S
35509		A	Artery bypass graft	16.70	18.90	3.92	39.52	090	S
35511		A	Artery bypass graft	15.39	10.40	1.92	27.71	090	S
35515		A	Artery bypass graft	17.21	11.25	2.01	30.47	090	S
35516		A	Artery bypass graft	14.88	17.37	3.54	35.79	090	S
35518		A	Artery bypass graft	14.05	17.47	3.38	34.90	090	S
35521		A	Artery bypass graft	14.80	17.53	3.34	35.67	090	S
35526		A	Artery bypass graft	18.63	12.95	2.44	34.02	090	S
35531		A	Artery bypass graft	24.17	20.25	3.90	48.32	090	S
35533		A	Artery bypass graft	19.15	21.04	4.43	44.62	090	S
35536		A	Artery bypass graft	21.65	21.37	4.17	47.19	090	S
35541		A	Artery bypass graft	24.17	19.55	3.65	47.37	090	S
35546		A	Artery bypass graft	24.17	21.39	4.26	49.82	090	S
35548		A	Artery bypass graft	20.13	19.55	3.65	43.33	090	S
35549		A	Artery bypass graft	21.91	21.39	4.26	47.56	090	S
35551		A	Artery bypass graft	25.17	19.25	3.87	48.29	090	S
35556		A	Artery bypass graft	15.47	18.71	3.71	37.89	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
35558		A	Artery bypass graft	12.82	*16.41	3.23	32.46	090	S
35560		A	Artery bypass graft	22.12	20.22	3.93	46.27	090	S
35563		A	Artery bypass graft	13.83	8.32	1.70	23.85	090	S
35565		A	Artery bypass graft	13.83	*17.69	3.51	35.03	090	S
35566		A	Artery bypass graft	20.21	20.62	4.08	44.91	090	S
35571		A	Artery bypass graft	16.66	19.36	3.87	39.89	090	S
35582		A	Vein bypass graft	25.69	23.74	4.89	54.32	090	S
35583		A	Vein bypass graft	15.97	*20.44	4.13	40.54	090	S
35585		A	Vein bypass graft	19.05	22.95	4.63	46.63	090	S
35587		A	Vein bypass graft	17.07	21.51	4.13	42.71	090	S
35601		A	Artery bypass graft	16.19	18.83	3.33	38.35	090	S
35606		A	Artery bypass graft	17.40	17.55	3.51	38.46	090	S
35612		A	Artery bypass graft	14.39	16.75	3.30	34.44	090	S
35616		A	Artery bypass graft	14.39	16.79	3.42	34.60	090	S
35621		A	Artery bypass graft	13.23	*16.94	3.80	33.97	090	S
35623		A	Bypass graft, not vein	15.42	8.06	1.88	25.36	090	S
35626		A	Artery bypass graft	22.26	20.51	4.08	46.85	090	S
35631		A	Artery bypass graft	23.16	17.87	3.57	44.60	090	S
35636		A	Artery bypass graft	21.15	13.50	2.45	37.10	090	S
35641		A	Artery bypass graft	22.67	20.56	4.08	47.31	090	S
35642		A	Artery bypass graft	16.70	10.33	2.20	29.23	090	S
35645		A	Artery bypass graft	16.19	11.15	2.05	29.39	090	S
35646		A	Artery bypass graft	24.00	23.78	4.73	52.51	090	S
35650		A	Artery bypass graft	13.05	*16.71	3.56	33.32	090	S
35651		A	Artery bypass graft	23.67	24.09	4.69	52.45	090	S
35654		A	Artery bypass graft	17.62	22.10	4.42	44.14	090	S
35656		A	Artery bypass graft	13.86	*17.73	3.60	35.19	090	S
35661		A	Artery bypass graft	11.81	*15.11	3.30	30.22	090	S
35663		A	Artery bypass graft	12.82	*16.41	3.80	33.03	090	S
35665		A	Artery bypass graft	14.05	17.79	3.57	35.41	090	S
35666		A	Artery bypass graft	15.97	20.06	4.00	40.03	090	S
35671		A	Artery bypass graft	12.18	*15.60	4.08	31.86	090	S
35681		A	Artery bypass graft	8.05	*10.42	3.52	21.99	ZZZ	S
35691		A	Arterial transposition	16.70	19.62	3.81	40.13	090	S
35693		A	Arterial transposition	14.01	9.40	1.91	25.32	090	S
35694		A	Arterial transposition	17.81	9.33	2.17	29.31	090	S
35695		A	Arterial transposition	17.81	9.33	2.17	29.31	090	S
35700		A	Reoperation, bypass graft	3.08	1.61	0.38	5.07	ZZZ	S
35701		A	Exploration, carotid artery	4.54	*5.82	1.25	11.61	090	S
35721		A	Exploration, femoral artery	4.54	5.56	1.11	11.21	090	S
35741		A	Exploration popliteal artery	4.54	5.73	1.15	11.42	090	S
35761		A	Exploration of artery/vein	4.54	5.81	1.14	11.49	090	S
35800		A	Explore neck vessels	6.04	5.28	0.97	12.29	090	S
35820		A	Explore chest vessels	11.64	7.92	1.43	20.99	090	S
35840		A	Explore abdominal vessels	8.63	7.23	1.44	17.30	090	S
35860		A	Explore limb vessels	4.54	5.81	1.15	11.50	090	S
35870		A	Repair vessel graft defect	20.35	10.64	2.47	33.46	090	S
35875		A	Removal of clot in graft	9.07	8.21	1.65	18.93	090	S
35876		A	Removal of clot in graft	12.91	8.21	1.65	22.77	090	S
35901		A	Excision, graft, neck	7.25	7.18	1.46	15.89	090	S
35903		A	Excision, graft, extremity	8.63	7.18	1.46	17.27	090	S
35905		A	Excision, graft, thorax	16.89	7.18	1.46	25.53	090	S
35907		A	Excision, graft, abdomen	17.68	7.18	1.46	26.32	090	S
36000		A	Place needle in vein	0.18	*0.24	0.04	0.46	XXX	N
36005		A	Injection, venography	0.95	0.47	0.04	1.46	000	N
36010		A	Place catheter in vein	2.43	2.11	0.31	4.85	XXX	N
36011		A	Place catheter in vein	3.14	1.90	0.22	5.26	XXX	N
36012		A	Place catheter in vein	3.52	2.67	0.32	6.51	XXX	N
36013		A	Place catheter in artery	2.52	2.11	0.31	4.94	XXX	N
36014		A	Place catheter in artery	3.02	2.28	0.27	5.57	XXX	N
36015		A	Place catheter in artery	3.52	2.67	0.32	6.51	XXX	N
36100		A	Establish access to artery	3.02	2.59	0.32	5.93	XXX	N
36120		A	Establish access to artery	2.01	2.32	0.30	4.63	XXX	N
36140		A	Establish access to artery	2.01	1.41	0.24	3.66	XXX	N
36145		A	Artery to vein shunt	2.01	*2.57	0.49	5.07	XXX	N
36160		A	Establish access to aorta	2.52	2.32	0.35	5.19	XXX	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
36200		A	Place catheter in aorta	3.02	2.73	0.28	6.03	XXX	N
36215		A	Place catheter in artery	4.47	2.78	0.23	7.48	XXX	N
36216		A	Place catheter in artery	5.28	3.29	0.27	8.84	XXX	N
36217		A	Place catheter in artery	6.30	3.92	0.32	10.54	XXX	N
36218		A	Place catheter in artery	1.01	0.62	0.05	1.68	XXX	N
36245		A	Place catheter in artery	5.07	3.15	0.26	8.48	XXX	N
36246		A	Place catheter in artery	5.28	3.29	0.27	8.84	XXX	N
36247		A	Place catheter in artery	6.30	3.92	0.32	10.54	XXX	N
36248		A	Place catheter in artery	1.01	0.62	0.05	1.68	XXX	N
36260		A	Insertion of infusion pump	9.27	6.74	1.41	17.42	090	S
36261		A	Revision of infusion pump	5.04	2.23	0.42	7.69	090	S
36262		A	Removal of infusion pump	3.70	1.93	0.40	6.03	090	S
36299		C	Vessel injection procedure	0.00	0.00	0.00	0.00	YYY	N
36400		A	Drawing blood	0.18	0.09	0.01	0.28	XXX	N
36405		A	Drawing blood	0.18	0.45	0.03	0.66	XXX	N
36406		A	Drawing blood	0.18	0.16	0.01	0.35	XXX	S
36410		A	Drawing blood	0.18	0.22	0.02	0.42	XXX	N
36415		G	Drawing blood	0.00	0.00	0.00	0.00	XXX	O
36420		A	Establish access to vein	1.01	0.51	0.05	1.57	XXX	N
36425		A	Establish access to vein	0.76	0.08	0.01	0.85	XXX	N
36430		A	Blood transfusion service	0.00	0.96	0.07	1.03	XXX	N
36440		A	Blood transfusion service	1.03	0.94	0.07	2.04	XXX	S
36450		A	Exchange transfusion service	2.23	1.88	0.18	4.29	XXX	N
36455		A	Exchange transfusion service	2.43	2.27	0.22	4.92	XXX	N
36460		A	Transfusion service, fetal	6.59	4.71	1.09	12.39	XXX	N
36468		R	Injection(s); spider veins	0.00	0.00	0.00	0.00	XXX	S
36469		R	Injection(s); spider veins	0.00	0.00	0.00	0.00	XXX	S
36470		A	Injection therapy of vein	1.02	0.27	0.04	1.33	010	S
36471		A	Injection therapy of veins	1.49	0.39	0.05	1.93	010	S
36481		A	Insertion of catheter, vein	6.99	5.30	0.61	12.90	000	S
36488		A	Insertion of catheter, vein	1.35	0.97	0.14	2.46	000	N
36489		A	Insertion of catheter, vein	1.22	1.12	0.17	2.51	000	N
36490		A	Insertion of catheter, vein	1.67	1.38	0.20	3.25	000	N
36491		A	Insertion of catheter, vein	1.43	1.71	0.32	3.46	000	N
36493		A	Repositioning of cvc	1.21	0.63	0.16	2.00	000	N
36500		A	Insertion of catheter, vein	3.52	0.08	0.01	3.61	000	N
36510		A	Insertion of catheter, vein	1.09	0.34	0.02	1.45	000	N
36520		A	Plasma and/or cell exchange	1.74	1.92	0.12	3.78	000	N
36522		A	Photopheresis	1.67	*2.48	0.37	4.52	000	S
36530		R	Insertion of infusion pump	4.83	4.82	1.02	10.67	010	S
36531		R	Revision of infusion pump	4.80	4.37	0.27	9.44	010	S
36532		R	Removal of infusion pump	3.23	1.77	0.37	5.37	010	S
36533		A	Insertion of access port	3.82	4.29	0.85	8.96	010	S
36534		A	Revision of access port	3.79	3.46	0.21	7.46	010	S
36535		A	Removal of access port	2.22	1.81	0.38	4.41	010	S
36600		A	Withdrawal of arterial blood	0.32	0.28	0.02	0.62	XXX	N
36620		A	Insertion catheter, artery	1.15	0.66	0.14	1.95	000	N
36625		A	Insertion catheter, artery	2.11	0.86	0.18	3.15	000	N
36640		A	Insertion catheter, artery	2.10	2.32	0.40	4.82	000	N
36660		A	Insertion catheter, artery	1.40	0.49	0.04	1.93	000	N
36680		A	Insert needle, bone cavity	1.20	1.24	0.10	2.54	000	N
36800		A	Insertion of cannula	2.43	2.22	0.28	4.93	000	N
36810		A	Insertion of cannula	3.97	4.85	0.74	9.56	000	S
36815		A	Insertion of cannula	2.62	*3.35	0.70	6.67	000	S
36821		A	Artery-vein fusion	8.39	7.24	1.46	17.09	090	S
36822		A	Insertion of cannula(s)	5.03	5.60	0.77	11.40	090	S
36825		A	Artery-vein graft	9.36	11.20	2.21	22.77	090	S
36830		A	Artery-vein graft	7.78	*9.96	2.36	20.10	090	S
36832		A	Revise artery-vein fistula	5.84	*7.48	2.38	15.70	090	S
36834		A	Repair A-V aneurysm	9.32	7.80	1.66	18.78	090	S
36835		A	Artery to vein shunt	6.54	3.42	0.79	10.75	090	S
36860		A	Cannula declotting	2.01	2.57	0.43	5.01	000	N
36861		A	Cannula declotting	2.52	*3.22	1.01	6.75	000	S
37140		A	Revision of circulation	22.15	16.29	3.34	41.78	090	S
37145		A	Revision of circulation	23.16	17.13	1.72	42.01	090	S
37160		A	Revision of circulation	20.15	17.74	3.79	41.68	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
37180		A	Revision of circulation	23.16	14.19	2.76	40.11	090	S
37181		A	Splice spleen/kidney veins	25.17	16.41	3.52	45.10	090	S
37200		A	Transcatheter biopsy	4.56	1.59	0.13	6.28	000	N
37201		A	Transcatheter therapy infuse	7.25	5.50	0.64	13.39	000	N
37202		A	Transcatheter therapy infuse	5.68	4.30	0.50	10.48	000	N
37203		A	Transcatheter retrieval	5.03	3.82	0.45	9.30	000	N
37204		A	Transcatheter occlusion	18.14	13.76	1.60	33.50	000	N
37205		A	Transcatheter stent	8.28	5.16	0.42	13.86	000	S
37206		A	Transcatheter stent	4.13	2.58	0.21	6.92	ZZZ	S
37207		A	Transcatheter stent	8.28	5.16	0.42	13.86	000	S
37208		A	Transcatheter stent	4.13	2.58	0.21	6.92	ZZZ	S
37209		A	Exchange arterial catheter	2.27	1.41	0.11	3.79	000	N
37565		A	Ligation of neck vein	3.90	3.79	0.74	8.43	090	S
37600		A	Ligation of neck artery	3.90	*4.98	0.80	9.68	090	S
37605		A	Ligation of neck artery	4.63	5.56	1.04	11.23	090	S
37606		A	Ligation of neck artery	4.63	*5.92	0.72	11.27	090	S
37607		A	Ligation of fistula	5.84	3.06	0.71	9.61	090	S
37609		A	Temporal artery procedure	2.27	2.22	0.38	4.87	010	S
37615		A	Ligation of neck artery	4.39	*5.62	1.11	11.12	090	S
37616		A	Ligation of chest artery	14.69	4.21	0.83	19.73	090	S
37617		A	Ligation of abdomen artery	14.19	8.00	1.54	23.73	090	S
37618		A	Ligation of extremity artery	3.90	*4.98	1.06	9.94	090	S
37620		A	Revision of major vein	9.24	8.81	1.48	19.53	090	S
37650		A	Revision of major vein	4.39	4.02	0.52	8.93	090	S
37660		A	Revision of major vein	9.65	5.75	1.07	16.47	090	S
37700		A	Revise leg vein	3.52	3.64	0.73	7.89	090	S
37720		A	Removal of leg vein	5.22	5.11	1.04	11.37	090	S
37730		A	Removal of leg veins	6.63	6.95	1.40	14.98	090	S
37735		A	Removal of leg veins/lesion	9.90	8.34	1.68	19.92	090	S
37760		A	Revision of leg veins	9.90	7.48	1.52	18.90	090	S
37780		A	Revision of leg vein	3.52	1.89	0.35	5.76	090	S
37785		A	Revise secondary varicosity	3.56	0.98	0.18	4.72	090	S
37788		A	Revascularization, penis	21.33	15.14	1.48	37.95	090	S
37790		A	Penile venous occlusion	8.02	5.70	0.55	14.27	090	S
37799		C	Vascular surgery procedure	0.00	0.00	0.00	0.00	YYY	S
38100		A	Removal of spleen, total	11.99	8.55	1.81	22.35	090	S
38101		A	Removal of spleen, partial	12.59	6.99	1.51	21.09	090	S
38102		A	Removal of spleen, total	4.80	2.51	0.58	7.89	ZZZ	S
38115		A	Repair of ruptured spleen	12.59	7.64	1.49	21.72	090	S
38200		A	Injection for spleen x-ray	2.64	1.71	0.15	4.50	000	S
38230		A	Bone marrow collection	3.16	2.78	0.21	6.15	010	N
38231		A	Stem cell collection	1.50	1.37	0.08	2.95	000	N
38240		A	Bone marrow/stem transplant	2.24	2.08	0.14	4.46	XXX	N
38241		A	Bone marrow/stem transplant	2.24	2.04	0.13	4.41	XXX	N
38300		A	Drainage lymph node lesion	1.48	0.58	0.10	2.16	010	S
38305		A	Drainage lymph node lesion	4.24	1.96	0.36	6.56	090	S
38308		A	Incision of lymph channels	4.55	3.37	0.45	8.37	090	S
38380		A	Thoracic duct procedure	6.53	4.44	0.76	11.73	090	S
38381		A	Thoracic duct procedure	12.10	7.56	1.50	21.16	090	S
38382		A	Thoracic duct procedure	9.24	4.84	1.13	15.21	090	S
38500		A	Biopsy/removal, lymph node(s)	2.83	1.59	0.31	4.73	010	S
38505		A	Needle biopsy, lymph node(s)	1.14	1.12	0.17	2.43	000	S
38510		A	Biopsy/removal, lymph node(s)	3.90	2.54	0.45	6.89	090	S
38520		A	Biopsy/removal, lymph node(s)	4.86	2.99	0.56	8.41	090	S
38525		A	Biopsy/removal, lymph node(s)	4.37	2.59	0.53	7.49	090	S
38530		A	Biopsy/removal, lymph node(s)	5.82	3.17	0.65	9.64	090	S
38542		A	Explore deep node(s), neck	5.41	4.26	0.59	10.26	090	S
38550		A	Removal neck/armpit lesion	6.42	3.23	0.63	10.28	090	S
38555		A	Removal neck/armpit lesion	13.05	7.27	1.38	21.70	090	S
38562		A	Removal, pelvic lymph nodes	9.65	6.88	1.20	17.73	090	S
38564		A	Removal, abdomen lymph nodes	10.00	7.39	1.51	18.90	090	S
38700		A	Removal of lymph nodes, neck	7.56	9.64	1.31	18.51	090	S
38720		A	Removal of lymph nodes, neck	12.29	*15.73	2.04	30.06	090	S
38724		A	Removal of lymph nodes, neck	13.22	14.36	2.00	29.58	090	S
38740		A	Remove armpit lymph nodes	6.28	4.72	1.00	12.00	090	S
38745		A	Remove armpits lymph nodes	8.08	8.28	1.76	18.12	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
38746		A	Remove thoracic lymph nodes	4.39	2.29	0.53	7.21	ZZZ	S
38747		A	Remove abdominal lymph nodes	4.89	2.56	0.59	8.04	ZZZ	S
38760		A	Remove groin lymph nodes	8.19	6.63	1.35	16.17	090	S
38765		A	Remove groin lymph nodes	14.98	12.67	2.42	30.07	090	S
38770		A	Remove pelvis lymph nodes	12.10	15.40	1.73	29.23	090	S
38780		A	Remove abdomen lymph nodes	15.17	16.06	3.13	34.36	090	S
38790		A	Injection for lymphatic xray	1.29	*1.64	0.19	3.12	000	N
38794		A	Access thoracic lymph duct	4.05	2.84	0.38	7.27	090	S
38999		C	Blood/lymph system procedure	0.00	0.00	0.00	0.00	YYY	S
39000		A	Exploration of chest	5.03	6.05	1.08	12.16	090	S
39010		A	Exploration of chest	10.78	11.46	2.08	24.32	090	S
39200		A	Removal chest lesion	12.40	11.58	2.14	26.12	090	S
39220		A	Removal chest lesion	16.16	14.94	2.83	33.93	090	S
39400		A	Visualization of chest	5.11	5.12	0.95	11.18	010	S
39499		C	Chest procedure	0.00	0.00	0.00	0.00	YYY	S
39501		A	Repair diaphragm laceration	12.10	10.66	2.10	24.86	090	S
39502		A	Repair paraesophageal hernia	15.18	11.93	2.45	29.56	090	S
39503		A	Repair of diaphragm hernia	33.22	25.18	2.94	61.34	090	S
39520		A	Repair of diaphragm hernia	15.18	12.53	2.46	30.17	090	S
39530		A	Repair of diaphragm hernia	14.22	14.06	2.71	30.99	090	S
39531		A	Repair of diaphragm hernia	15.23	10.00	1.80	27.03	090	S
39540		A	Repair of diaphragm hernia	12.10	11.98	2.51	26.59	090	S
39541		A	Repair of diaphragm hernia	13.10	12.16	2.37	27.63	090	S
39545		A	Revision of diaphragm	12.10	7.90	1.31	21.31	090	S
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	YYY	S
40490		A	Biopsy of lip	1.22	0.74	0.07	2.03	000	S
40500		A	Partial excision of lip	4.08	*5.23	0.94	10.25	090	S
40510		A	Partial excision of lip	4.57	*5.84	0.83	11.24	090	S
40520		A	Partial excision of lip	4.54	4.50	0.68	9.72	090	S
40525		A	Reconstruct lip with flap	7.26	*9.30	1.43	17.99	090	S
40527		A	Reconstruct lip with flap	8.71	*11.16	1.65	21.52	090	S
40530		A	Partial removal of lip	5.14	5.10	0.74	10.98	090	S
40650		A	Repair lip	3.49	*4.47	0.65	8.61	090	S
40652		A	Repair lip	4.08	*5.23	0.79	10.10	090	S
40654		A	Repair lip	5.13	*6.57	1.00	12.70	090	S
40700		A	Repair cleft lip/nasal	12.04	8.46	1.28	21.78	090	S
40701		A	Repair cleft lip/nasal	15.10	*19.33	1.62	36.05	090	S
40702		A	Repair cleft lip/nasal	12.34	9.37	1.10	22.81	090	S
40720		A	Repair cleft lip/nasal	12.91	9.59	1.79	24.29	090	S
40761		A	Repair cleft lip/nasal	14.00	10.84	1.74	26.58	090	S
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	YYY	S
40800		A	Drainage of mouth lesion	1.12	0.74	0.07	1.93	010	S
40801		A	Drainage of mouth lesion	2.48	1.70	0.16	4.34	010	S
40804		A	Removal foreign body, mouth	1.19	0.58	0.06	1.83	010	S
40805		A	Removal foreign body, mouth	2.64	2.50	0.30	5.44	010	S
40806		A	Incision of lip fold	0.31	0.36	0.03	0.70	000	S
40808		A	Biopsy of mouth lesion	0.91	0.76	0.08	1.75	010	S
40810		A	Excision of mouth lesion	1.26	1.18	0.11	2.55	010	S
40812		A	Excise/repair mouth lesion	2.26	1.50	0.14	3.90	010	S
40814		A	Excise/repair mouth lesion	3.27	3.23	0.32	6.82	090	S
40816		A	Excision of mouth lesion	3.52	3.22	0.33	7.07	090	S
40818		A	Excise oral mucosa for graft	2.26	2.25	0.20	4.71	090	S
40819		A	Excise lip or cheek fold	2.26	1.23	0.14	3.63	090	S
40820		A	Treatment of mouth lesion	1.23	0.53	0.06	1.82	010	S
40830		A	Repair mouth laceration	1.71	0.67	0.07	2.45	010	S
40831		A	Repair mouth laceration	2.41	1.94	0.21	4.56	010	S
40840		R	Reconstruction of mouth	8.31	6.28	0.73	15.32	090	S
40842		R	Reconstruction of mouth	8.31	6.28	0.73	15.32	090	S
40843		R	Reconstruction of mouth	11.63	8.80	1.03	21.46	090	S
40844		R	Reconstruction of mouth	15.37	11.63	1.36	28.36	090	S
40845		R	Reconstruction of mouth	17.94	23.99	1.93	43.86	090	S
40899		C	Mouth surgery procedure	0.00	0.00	0.00	0.00	YYY	S
41000		A	Drainage of mouth lesion	1.25	0.76	0.08	2.09	010	S
41005		A	Drainage of mouth lesion	1.21	0.62	0.07	1.90	010	S
41006		A	Drainage of mouth lesion	3.03	1.01	0.11	4.15	090	S
41007		A	Drainage of mouth lesion	2.89	2.90	0.30	6.09	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
41008		A	Drainage of mouth lesion	3.16	1.06	0.11	4.33	090	S
41009		A	Drainage of mouth lesion	3.35	3.31	0.34	7.00	090	S
41010		A	Incision of tongue fold	1.19	0.37	0.04	1.60	010	S
41015		A	Drainage of mouth lesion	3.72	0.87	0.10	4.69	090	S
41016		A	Drainage of mouth lesion	3.72	3.69	0.38	7.79	090	S
41017		A	Drainage of mouth lesion	3.72	1.40	0.14	5.26	090	S
41018		A	Drainage of mouth lesion	4.75	3.93	0.38	9.06	090	S
41100		A	Biopsy of tongue	1.58	0.80	0.08	2.46	010	S
41105		A	Biopsy of tongue	1.37	1.03	0.12	2.52	010	S
41108		A	Biopsy of floor of mouth	1.00	0.85	0.09	1.94	010	S
41110		A	Excision of tongue lesion	1.46	1.30	0.15	2.91	010	S
41112		A	Excision of tongue lesion	2.63	2.39	0.23	5.25	090	S
41113		A	Excision of tongue lesion	3.09	3.41	0.37	6.87	090	S
41114		A	Excision of tongue lesion	7.88	6.39	0.73	15.00	090	S
41115		A	Excision of tongue fold	1.69	1.78	0.17	3.64	010	S
41116		A	Excision of mouth lesion	2.36	2.49	0.27	5.12	090	S
41120		A	Partial removal of tongue	8.83	7.28	0.88	16.99	090	S
41130		A	Partial removal of tongue	10.27	9.06	1.14	20.47	090	S
41135		A	Tongue and neck surgery	14.29	*18.30	2.64	35.23	090	S
41140		A	Removal of tongue	23.46	18.89	2.45	44.80	090	S
41145		A	Tongue removal; neck surgery	27.58	22.79	2.95	53.32	090	S
41150		A	Tongue, mouth, jaw surgery	19.36	18.96	2.46	40.78	090	S
41153		A	Tongue, mouth, neck surgery	21.18	25.00	3.03	49.21	090	S
41155		A	Tongue, jaw, & neck surgery	23.40	*29.95	3.75	57.10	090	S
41250		A	Repair tongue laceration	1.86	1.07	0.11	3.04	010	S
41251		A	Repair tongue laceration	2.22	2.07	0.21	4.50	010	S
41252		A	Repair tongue laceration	2.92	2.35	0.26	5.53	010	S
41500		A	Fixation of tongue	3.50	3.29	0.26	7.05	090	S
41510		A	Tongue to lip surgery	3.32	2.53	0.45	6.30	090	S
41520		A	Reconstruction, tongue fold	2.63	2.88	0.28	5.79	090	S
41599		C	Tongue and mouth surgery	0.00	0.00	0.00	0.00	YYY	S
41800		A	Drainage of gum lesion	1.12	0.69	0.07	1.88	010	S
41805		A	Removal foreign body, gum	1.19	0.84	0.08	2.11	010	S
41806		A	Removal foreign body, jawbone	2.64	1.64	0.15	4.43	010	S
41820		R	Excision, gum, each quadrant	0.00	0.00	0.00	0.00	XXX	S
41821		R	Excision of gum flap	0.00	0.00	0.00	0.00	XXX	S
41822		R	Excision of gum lesion	2.26	3.03	0.25	5.54	010	S
41823		R	Excision of gum lesion	3.15	4.20	0.34	7.69	090	S
41825		A	Excision of gum lesion	1.26	1.49	0.14	2.89	010	S
41826		A	Excision of gum lesion	2.26	2.07	0.18	4.51	010	S
41827		A	Excision of gum lesion	3.27	3.78	0.38	7.43	090	S
41828		R	Excision of gum lesion	3.04	4.07	0.33	7.44	010	S
41830		R	Removal of gum tissue	3.30	4.41	0.36	8.07	010	S
41850		R	Treatment of gum lesion	0.00	0.00	0.00	0.00	XXX	S
41870		R	Gum graft	0.00	0.00	0.00	0.00	XXX	S
41872		R	Repair gum	2.44	3.26	0.27	5.97	090	S
41874		R	Repair tooth socket	2.94	3.93	0.32	7.19	090	S
41899		C	Dental surgery procedure	0.00	0.00	0.00	0.00	YYY	S
42000		A	Drainage mouth roof lesion	1.18	0.62	0.06	1.86	010	S
42100		A	Biopsy roof of mouth	1.26	0.79	0.08	2.13	010	S
42104		A	Excision lesion, mouth roof	1.59	1.62	0.17	3.38	010	S
42106		A	Excision lesion, mouth roof	2.63	2.22	0.21	5.06	010	S
42107		A	Excision lesion, mouth roof	4.20	4.91	0.50	9.61	090	S
42120		A	Remove palate/lesion	5.39	*6.90	1.01	13.30	090	S
42140		A	Excision of uvula	1.54	1.35	0.15	3.04	090	S
42145		A	Repair, palate, pharynx/uvula	7.04	*9.01	1.45	17.50	090	S
42160		A	Treatment mouth roof lesion	1.75	1.53	0.16	3.44	010	S
42180		A	Repair palate	2.45	2.24	0.26	4.95	010	S
42182		A	Repair palate	3.78	3.47	0.38	7.63	010	S
42200		A	Reconstruct cleft palate	9.48	7.19	0.85	17.52	090	S
42205		A	Reconstruct cleft palate	8.96	10.82	0.79	20.57	090	S
42210		A	Reconstruct cleft palate	10.02	12.51	0.95	23.48	090	S
42215		A	Reconstruct cleft palate	8.42	7.68	0.86	16.96	090	S
42220		A	Reconstruct cleft palate	6.65	5.40	0.81	12.86	090	S
42225		A	Reconstruct cleft palate	9.08	6.90	1.08	17.06	090	S
42226		A	Lengthening of palate	9.42	7.89	0.86	18.17	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
42227		A	Lengthening of palate	8.89	7.41	0.38	16.68	090	S
42235		A	Repair palate	7.50	5.55	0.49	13.54	090	S
42260		A	Repair nose to lip fistula	4.17	3.98	0.44	8.59	090	S
42280		A	Preparation, palate mold	1.49	1.99	0.17	3.65	010	S
42281		A	Insertion, palate prosthesis	1.77	1.47	0.15	3.39	010	S
42299		C	Palate/uvula surgery	0.00	0.00	0.00	0.00	YYY	S
42300		A	Drainage of salivary gland	1.88	0.96	0.12	2.96	010	S
42305		A	Drainage of salivary gland	5.59	2.18	0.27	8.04	090	S
42310		A	Drainage of salivary gland	1.51	1.03	0.12	2.66	010	S
42320		A	Drainage of salivary gland	2.30	1.83	0.22	4.35	010	S
42325		A	Create salivary cyst drain	2.65	2.12	0.20	4.97	090	S
42326		A	Create salivary cyst drain	3.65	4.34	0.33	8.32	090	S
42330		A	Removal of salivary stone	2.16	1.10	0.12	3.38	010	S
42335		A	Removal of salivary stone	3.21	2.47	0.27	5.95	090	S
42340		A	Removal of salivary stone	4.47	4.25	0.45	9.17	090	S
42400		A	Biopsy of salivary gland	0.78	0.79	0.10	1.67	000	S
42405		A	Biopsy of salivary gland	3.24	1.54	0.19	4.97	010	S
42408		A	Excision of salivary cyst	4.41	3.24	0.38	8.03	090	S
42409		A	Drainage of salivary cyst	2.71	2.81	0.30	5.82	090	S
42410		A	Excise parotid gland/lesion	8.88	5.94	0.92	15.74	090	S
42415		A	Excise parotid gland/lesion	16.12	12.68	1.68	30.48	090	S
42420		A	Excise parotid gland/lesion	18.63	14.82	1.87	35.32	090	S
42425		A	Excise parotid gland/lesion	12.36	11.10	1.43	24.89	090	S
42426		A	Excise parotid gland/lesion	19.88	24.12	3.21	47.21	090	S
42440		A	Excision submaxillary gland	6.61	7.98	0.99	15.58	090	S
42450		A	Excision sublingual gland	4.38	3.42	0.35	8.15	090	S
42500		A	Repair salivary duct	4.06	4.61	0.50	9.17	090	S
42505		A	Repair salivary duct	5.92	7.34	0.86	14.12	090	S
42507		A	Parotid duct diversion	5.96	4.65	0.67	11.28	090	S
42508		A	Parotid duct diversion	8.64	7.61	0.94	17.19	090	S
42509		A	Parotid duct diversion	11.08	7.31	1.23	19.62	090	S
42510		A	Parotid duct diversion	7.71	7.65	0.84	16.20	090	S
42550		A	Injection for salivary x-ray	1.25	0.44	0.04	1.73	000	N
42600		A	Closure of salivary fistula	4.58	3.89	0.46	8.93	090	S
42650		A	Dilation of salivary duct	0.77	0.39	0.04	1.20	000	S
42660		A	Dilation of salivary duct	1.13	0.50	0.06	1.69	000	S
42665		A	Ligation of salivary duct	2.43	2.04	0.25	4.72	090	S
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	YYY	S
42700		A	Drainage of tonsil abscess	1.57	0.85	0.10	2.52	010	S
42720		A	Drainage of throat abscess	2.61	1.89	0.22	4.72	010	S
42725		A	Drainage of throat abscess	7.60	4.45	0.53	12.58	090	S
42800		A	Biopsy of throat	1.34	0.74	0.08	2.16	010	S
42802		A	Biopsy of throat	1.49	1.02	0.12	2.63	010	S
42804		A	Biopsy of upper nose/throat	1.19	1.09	0.13	2.41	010	S
42806		A	Biopsy of upper nose/throat	1.53	1.40	0.16	3.09	010	S
42808		A	Excise pharynx lesion	2.25	2.52	0.29	5.06	010	S
42809		A	Remove pharynx foreign body	1.76	0.82	0.08	2.66	010	S
42810		A	Excision of neck cyst	3.20	3.14	0.47	6.81	090	S
42815		A	Excision of neck cyst	6.75	8.47	1.12	16.34	090	S
42820		A	Remove tonsils and adenoids	3.59	3.15	0.32	7.06	090	S
42821		A	Remove tonsils and adenoids	4.10	3.93	0.46	8.49	090	S
42825		A	Removal of tonsils	3.21	2.64	0.33	6.18	090	S
42826		A	Removal of tonsils	3.19	3.86	0.43	7.48	090	S
42830		A	Removal of adenoids	2.49	1.86	0.27	4.62	090	S
42831		A	Removal of adenoids	2.61	2.36	0.25	5.22	090	S
42835		A	Removal of adenoids	2.22	1.86	0.10	4.18	090	S
42836		A	Removal of adenoids	3.10	2.79	0.31	6.20	090	S
42842		A	Extensive surgery of throat	8.13	6.69	0.73	15.55	090	S
42844		A	Extensive surgery of throat	12.73	10.85	1.27	24.85	090	S
42845		A	Extensive surgery of throat	21.88	18.62	2.22	42.72	090	S
42860		A	Excision of tonsil tags	2.14	1.89	0.21	4.24	090	S
42870		A	Excision of lingual tonsil	5.16	2.32	0.26	7.74	090	S
42880		A	Excise nose/throat lesion	6.01	4.62	0.52	11.15	090	S
42890		A	Partial removal of pharynx	11.67	8.99	1.03	21.69	090	S
42892		A	Revision of pharyngeal walls	13.94	10.92	1.27	26.13	090	S
42894		A	Revision of pharyngeal walls	20.68	16.06	1.83	38.57	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
42900		A	Repair throat wound	4.98	4.26	0.48	9.72	010	S
42950		A	Reconstruction of throat	7.70	9.86	1.10	18.66	090	S
42953		A	Repair throat, esophagus	8.21	6.34	0.93	15.48	090	S
42955		A	Surgical opening of throat	6.50	3.32	0.43	10.25	090	S
42960		A	Control throat bleeding	2.28	1.08	0.12	3.48	010	S
42961		A	Control throat bleeding	5.18	1.75	0.19	7.12	090	S
42962		A	Control throat bleeding	6.64	5.98	0.68	13.30	090	S
42970		A	Control nose/throat bleeding	4.78	1.03	0.10	5.91	090	N
42971		A	Control nose/throat bleeding	5.56	2.90	0.34	8.80	090	S
42972		A	Control nose/throat bleeding	6.55	4.55	0.73	11.83	090	S
42999		C	Throat surgery procedure	0.00	0.00	0.00	0.00	YYY	S
43020		A	Incision of esophagus	7.72	6.58	0.71	15.01	090	S
43030		A	Throat muscle surgery	7.15	*9.15	1.21	17.51	090	S
43045		A	Incision of esophagus	18.83	12.45	2.36	33.64	090	S
43100		A	Excision of esophagus lesion	8.47	6.19	0.95	15.61	090	S
43101		A	Excision of esophagus lesion	15.11	9.48	1.88	26.47	090	S
43107		A	Removal of esophagus	27.20	22.50	4.42	54.12	090	S
43108		A	Removal of esophagus	32.64	25.27	4.77	62.68	090	S
43112		A	Removal of esophagus	29.67	21.65	4.22	55.54	090	S
43113		A	Removal of esophagus	33.63	25.27	4.77	63.67	090	S
43116		A	Partial removal of esophagus	29.67	25.27	4.77	59.71	090	S
43117		A	Partial removal of esophagus	28.47	25.27	4.77	58.51	090	S
43118		A	Partial removal of esophagus	31.65	25.27	4.77	61.69	090	S
43121		A	Partial removal of esophagus	27.69	21.36	4.19	53.24	090	S
43122		A	Partial removal of esophagus	27.69	21.36	4.19	53.24	090	S
43123		A	Partial removal of esophagus	31.65	25.27	4.77	61.69	090	S
43124		A	Removal of esophagus	24.73	22.50	4.42	51.65	090	S
43130		A	Removal of esophagus pouch	10.68	10.51	1.60	22.79	090	S
43135		A	Removal of esophagus pouch	15.11	11.72	2.17	29.00	090	S
43200		A	Esophagus endoscopy	1.59	*2.04	0.26	3.89	000	S
43202		A	Esophagus endoscopy, biopsy	1.89	*2.41	0.31	4.61	000	N
43204		A	Esophagus endoscopy & inject	3.77	*4.83	0.36	8.96	000	N
43205		A	Esophagus endoscopy/ligation	3.79	2.70	0.18	6.67	000	N
43215		A	Esophagus endoscopy	2.60	*3.33	0.46	6.39	000	N
43216		A	Esophagus endoscopy/lesion	2.40	*3.58	0.37	6.35	000	N
43217		A	Esophagus endoscopy	2.90	*3.58	0.37	6.85	000	N
43219		A	Esophagus endoscopy	2.80	*3.58	0.34	6.72	000	N
43220		A	Esophagus endoscopy, dilation	2.10	*2.68	0.27	5.05	000	N
43226		A	Esophagus endoscopy, dilation	2.34	*3.00	0.26	5.60	000	N
43227		A	Esophagus endoscopy, repair	3.60	*4.61	0.34	8.55	000	N
43228		A	Esophagus endoscopy, ablation	3.77	4.79	0.38	8.94	000	N
43234		A	Upper GI endoscopy, exam	2.01	*2.57	0.30	4.88	000	N
43235		A	Upper GI endoscopy, diagnosis	2.39	*3.07	0.29	5.75	000	N
43239		A	Upper GI endoscopy, biopsy	2.69	*3.44	0.33	6.46	000	N
43241		A	Upper GI endoscopy with tube	2.59	*3.31	0.38	6.28	000	N
43243		A	Upper GI endoscopy & inject	4.57	5.63	0.39	10.59	000	N
43244		A	Upper GI endoscopy/ligation	4.59	3.47	0.41	8.47	000	N
43245		A	Operative upper GI endoscopy	3.39	*4.34	0.40	8.13	000	N
43246		A	Place gastrostomy tube	4.33	*5.55	0.51	10.39	000	N
43247		A	Operative upper GI endoscopy	3.39	*4.34	0.38	8.11	000	N
43248		A	Upper GI endoscopy/guidewire	3.15	*4.03	0.35	7.53	000	N
43249		A	Esophagus endoscopy, dilation	2.90	3.73	0.30	6.93	000	N
43250		A	Upper GI endoscopy/tumor	3.20	*4.60	0.43	8.23	000	N
43251		A	Operative upper GI endoscopy	3.70	*4.60	0.43	8.73	000	N
43255		A	Operative upper GI endoscopy	4.40	5.63	0.38	10.41	000	N
43258		A	Operative upper GI endoscopy	4.55	5.41	0.38	10.34	000	N
43259		A	Endoscopic ultrasound exam	4.89	4.02	0.35	9.26	000	N
43260		A	Endoscopy,bile duct/pancreas	5.96	5.98	0.39	12.33	000	N
43261		A	Endoscopy,bile duct/pancreas	6.27	5.98	0.39	12.64	000	N
43262		A	Endoscopy,bile duct/pancreas	7.39	9.00	0.58	16.97	000	N
43263		A	Endoscopy,bile duct/pancreas	6.19	5.83	0.38	12.40	000	N
43264		A	Endoscopy,bile duct/pancreas	8.90	8.92	0.61	18.43	000	N
43265		A	Endoscopy,bile duct/pancreas	8.90	6.82	0.49	16.21	000	N
43267		A	Endoscopy,bile duct/pancreas	7.39	7.41	0.48	15.28	000	N
43268		A	Endoscopy,bile duct/pancreas	7.39	8.72	0.56	16.67	000	N
43269		A	Endoscopy,bile duct/pancreas	6.04	7.35	0.51	13.90	000	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
43271		A	Endoscopy,bile duct/pancreas	7.39	7.63	0.50	15.52	000	N
43272		A	Endoscopy,bile duct/pancreas	7.39	5.60	0.42	13.41	000	N
43300		A	Repair of esophagus	8.72	*11.17	1.70	21.59	090	S
43305		A	Repair esophagus and fistula	16.14	13.71	1.78	31.63	090	S
43310		A	Repair of esophagus	24.20	16.99	3.23	44.42	090	S
43312		A	Repair esophagus and fistula	27.26	13.72	2.30	43.28	090	S
43320		A	Fuse esophagus & stomach	14.49	11.68	2.05	28.22	090	S
43324		A	Revise esophagus & stomach	15.18	11.88	2.53	29.59	090	S
43325		A	Revise esophagus & stomach	14.63	11.61	2.29	28.53	090	S
43326		A	Revise esophagus & stomach	14.37	7.52	1.75	23.64	090	S
43330		A	Repair of esophagus	14.27	11.36	2.39	28.02	090	S
43331		A	Repair of esophagus	14.73	14.33	2.64	31.70	090	S
43340		A	Fuse esophagus & intestine	14.16	12.44	2.52	29.12	090	S
43341		A	Fuse esophagus & intestine	15.26	9.90	1.56	26.72	090	S
43350		A	Surgical opening, esophagus	11.25	7.88	1.15	20.28	090	S
43351		A	Surgical opening, esophagus	13.42	8.77	1.53	23.72	090	S
43352		A	Surgical opening, esophagus	10.92	8.86	1.47	21.25	090	S
43360		A	Gastrointestinal repair	26.06	21.36	4.19	51.61	090	S
43361		A	Gastrointestinal repair	29.67	25.27	4.77	59.71	090	S
43400		A	Ligate esophagus veins	15.55	10.82	1.63	28.00	090	S
43401		A	Esophagus surgery for veins	16.26	9.59	1.93	27.78	090	S
43405		A	Ligate/staple esophagus	14.84	14.33	2.64	31.81	090	S
43410		A	Repair esophagus wound	9.61	8.90	1.54	20.05	090	S
43415		A	Repair esophagus wound	15.86	12.74	2.52	31.12	090	S
43420		A	Repair esophagus opening	10.19	5.88	0.78	16.85	090	S
43425		A	Repair esophagus opening	15.58	9.94	1.71	27.23	090	S
43450		A	Dilate esophagus	1.38	0.68	0.05	2.11	000	N
43453		A	Dilate esophagus	1.51	1.51	0.11	3.13	000	N
43456		A	Dilate esophagus	3.52	2.47	0.24	6.23	000	N
43458		A	Dilation of esophagus	3.06	*1.52	0.27	4.85	000	N
43460		A	Pressure treatment esophagus	3.80	1.67	0.15	5.62	000	N
43499		C	Esophagus surgery procedure	0.00	0.00	0.00	0.00	YYY	N
43500		A	Surgical opening of stomach	7.60	6.13	1.20	14.93	090	S
43501		A	Surgical repair of stomach	13.85	8.58	1.83	24.26	090	S
43502		A	Surgical repair of stomach	15.82	8.58	1.83	26.23	090	S
43510		A	Surgical opening of stomach	9.27	8.29	0.94	18.50	090	N
43520		A	Incision of pyloric muscle	7.00	4.48	0.87	12.35	090	S
43600		A	Biopsy of stomach	1.91	0.50	0.05	2.46	000	N
43605		A	Biopsy of stomach	8.23	5.91	1.29	15.43	090	S
43610		A	Excision of stomach lesion	10.11	8.17	1.71	19.99	090	S
43611		A	Excision of stomach lesion	12.43	8.17	1.71	22.31	090	S
43620		A	Removal of stomach	21.03	15.38	3.19	39.60	090	S
43621		A	Removal of stomach	21.47	15.38	3.19	40.04	090	S
43622		A	Removal of stomach	22.82	15.38	3.19	41.39	090	S
43631		A	Removal of stomach, partial	18.10	12.42	2.66	33.18	090	S
43632		A	Removal stomach, partial	18.10	12.42	2.66	33.18	090	S
43633		A	Removal stomach, partial	18.54	12.42	2.66	33.62	090	S
43634		A	Removal stomach, partial	19.89	20.83	4.57	45.29	090	S
43635		A	Partial removal of stomach	2.06	1.08	0.26	3.40	ZZZ	S
43638		A	Partial removal of stomach	20.15	12.75	2.73	35.63	090	S
43639		A	Removal stomach, partial	20.64	12.75	2.73	36.12	090	S
43640		A	Vagotomy & pylorus repair	13.28	10.34	2.19	25.81	090	S
43641		A	Vagotomy & pylorus repair	13.28	10.34	2.18	25.80	090	S
43750		A	Place gastrostomy tube	5.71	4.35	0.56	10.62	010	N
43760		A	Change gastrostomy tube	1.10	0.69	0.09	1.88	000	N
43761		A	Reposition gastrostomy tube	2.01	1.06	0.25	3.32	000	N
43800		A	Reconstruction of pylorus	9.41	6.85	1.47	17.73	090	S
43810		A	Fusion of stomach and bowel	10.08	7.64	1.53	19.25	090	S
43820		A	Fusion of stomach and bowel	10.43	8.29	1.75	20.47	090	S
43825		A	Fusion of stomach and bowel	13.28	11.08	2.30	26.66	090	S
43830		A	Place gastrostomy tube	4.84	*6.19	1.19	12.22	090	S
43831		A	Place gastrostomy tube	6.41	5.20	0.93	12.54	090	S
43832		A	Place gastrostomy tube	10.68	7.95	1.36	19.99	090	S
43840		A	Repair of stomach lesion	10.45	7.84	1.66	19.95	090	S
43842		A	Gastroplasty for obesity	13.76	13.72	2.93	30.41	090	S
43843		A	Gastroplasty for obesity	13.76	13.72	2.93	30.41	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
43846		A	Gastric bypass for obesity	17.84	14.80	3.30	35.94	090	S
43847		A	Gastric bypass for obesity	19.87	14.80	3.30	37.97	090	S
43848		A	Revision gastroplasty	22.10	14.80	3.30	40.20	090	S
43850		A	Revise stomach-bowel fusion	18.14	11.64	2.25	32.03	090	S
43855		A	Revise stomach-bowel fusion	19.15	10.44	2.28	31.87	090	S
43860		A	Revise stomach-bowel fusion	18.14	11.46	2.51	32.11	090	S
43865		A	Revise stomach-bowel fusion	19.15	13.39	2.98	35.52	090	S
43870		A	Repair stomach opening	6.56	5.77	1.14	13.47	090	S
43880		A	Repair stomach-bowel fistula	18.14	8.25	1.76	28.15	090	S
43999		C	Stomach surgery procedure	0.00	0.00	0.00	0.00	YYY	N
44005		A	Freeing of bowel adhesion	12.52	8.28	1.75	22.55	090	S
44010		A	Incision of small bowel	9.24	6.91	1.42	17.57	090	S
44015		A	Insert needle catheter, bowel	2.62	3.22	0.45	6.29	ZZZ	S
44020		A	Exploration of small bowel	10.69	7.81	1.65	20.15	090	S
44021		A	Decompress small bowel	10.83	7.00	1.48	19.31	090	S
44025		A	Incision of large bowel	11.07	7.74	1.61	20.42	090	S
44050		A	Reduce bowel obstruction	10.05	7.77	1.64	19.46	090	S
44055		A	Correct malrotation of bowel	11.92	7.66	1.60	21.18	090	S
44100		A	Biopsy of bowel	2.01	1.38	0.13	3.52	000	N
44110		A	Excision of bowel lesion(s)	9.01	7.67	1.58	18.26	090	S
44111		A	Excision of bowel lesion(s)	11.05	9.67	2.14	22.86	090	S
44120		A	Removal of small intestine	13.15	9.46	2.02	24.63	090	S
44121		A	Removal of small intestine	4.45	2.32	0.54	7.31	ZZZ	S
44125		A	Removal of small intestine	13.15	10.75	2.28	26.18	090	S
44130		A	Bowel to bowel fusion	11.09	8.67	1.86	21.62	090	S
44139		A	Mobilization of colon	2.23	1.17	0.27	3.67	ZZZ	S
44140		A	Partial removal of colon	16.97	11.37	2.40	30.74	090	S
44141		A	Partial removal of colon	17.36	11.86	2.55	31.77	090	S
44143		A	Partial removal of colon	15.00	12.26	2.62	29.88	090	S
44144		A	Partial removal of colon	15.00	12.06	2.53	29.59	090	S
44145		A	Partial removal of colon	21.29	13.25	2.78	37.32	090	S
44146		A	Partial removal of colon	22.22	14.98	3.14	40.34	090	S
44147		A	Partial removal of colon	16.23	15.34	3.30	34.87	090	S
44150		A	Removal of colon	19.04	14.84	3.17	37.05	090	S
44151		A	Removal of colon/ileostomy	17.95	10.21	2.22	30.38	090	S
44152		A	Removal of colon/ileostomy	22.98	15.44	3.36	41.78	090	S
44153		A	Removal of colon/ileostomy	24.69	19.35	3.63	47.67	090	S
44155		A	Removal of colon	22.09	16.65	3.50	42.24	090	S
44156		A	Removal of colon/ileostomy	20.48	11.40	2.52	34.40	090	S
44160		A	Removal of colon	14.09	12.44	2.68	29.21	090	S
44300		A	Open bowel to skin	7.77	6.03	1.29	15.09	090	S
44310		A	Ileostomy/jejunostomy	10.07	7.88	1.66	19.61	090	S
44312		A	Revision of ileostomy	5.34	3.08	0.45	8.87	090	S
44314		A	Revision of ileostomy	9.77	6.68	1.21	17.66	090	S
44316		A	Devise bowel pouch	13.59	9.64	1.43	24.66	090	S
44320		A	Colostomy	11.39	7.46	1.57	20.42	090	S
44322		A	Colostomy with biopsies	10.31	9.07	1.88	21.26	090	S
44340		A	Revision of colostomy	4.92	1.68	0.35	6.95	090	S
44345		A	Revision of colostomy	10.05	4.84	1.03	15.92	090	S
44346		A	Revision of colostomy	11.13	6.65	1.38	19.16	090	S
44360		A	Small bowel endoscopy	2.92	*3.74	0.32	6.98	000	N
44361		A	Small bowel endoscopy, biopsy	3.23	*4.14	0.34	7.71	000	N
44363		A	Small bowel endoscopy	3.94	2.99	0.36	7.29	000	N
44364		A	Small bowel endoscopy	4.22	4.73	0.72	9.67	000	N
44365		A	Small bowel endoscopy	3.73	4.73	0.72	9.18	000	N
44366		A	Small bowel endoscopy	4.97	5.86	0.45	11.28	000	N
44369		A	Small bowel endoscopy	5.09	*6.52	0.50	12.11	000	N
44372		A	Small bowel endoscopy	4.97	5.83	0.67	11.47	000	N
44373		A	Small bowel endoscopy	3.94	*5.03	0.50	9.47	000	N
44376		A	Small bowel endoscopy	5.69	4.05	0.26	10.00	000	N
44377		A	Small bowel endoscopy	5.98	4.26	0.28	10.52	000	N
44378		A	Small bowel endoscopy	7.71	5.27	0.35	13.33	000	N
44380		A	Small bowel endoscopy	1.51	*1.94	0.22	3.67	000	N
44382		A	Small bowel endoscopy	1.82	*2.33	0.29	4.44	000	N
44385		A	Endoscopy of bowel pouch	1.82	*2.33	0.34	4.49	000	S
44386		A	Endoscopy, bowel pouch, biopsy	2.12	1.54	0.15	3.81	000	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
44388		A	Colon endoscopy	2.82	*3.61	0.50	6.93	000	S
44389		A	Colonoscopy with biopsy	3.13	*4.00	0.45	7.58	000	N
44390		A	Colonoscopy for foreign body	3.83	2.63	0.28	6.74	000	N
44391		A	Colonoscopy for bleeding	4.32	5.26	0.53	10.11	000	N
44392		A	Colonoscopy & polypectomy	3.82	*5.16	0.70	9.68	000	N
44393		A	Colonoscopy, lesion removal	4.84	5.41	0.70	10.95	000	N
44394		A	Colonoscopy w/snare	4.43	*5.16	0.70	10.29	000	N
44500		A	Intro, gastrointestinal tube	0.49	0.36	0.02	0.87	000	N
44602		A	Suture, small intestine	9.72	7.65	1.62	18.99	090	S
44603		A	Suture, small intestine	12.94	9.09	1.96	23.99	090	S
44604		A	Suture, large intestine	12.94	7.87	1.67	22.48	090	S
44605		A	Repair of bowel lesion	13.91	9.37	2.02	25.30	090	S
44615		A	Intestinal stricturoplasty	12.89	6.74	1.57	21.20	090	S
44620		A	Repair bowel opening	9.65	5.97	1.26	16.88	090	S
44625		A	Repair bowel opening	12.10	9.58	2.03	23.71	090	S
44640		A	Repair bowel-skin fistula	13.34	6.54	1.35	21.23	090	S
44650		A	Repair bowel fistula	13.76	7.33	1.46	22.55	090	S
44660		A	Repair bowel-bladder fistula	13.14	8.34	1.21	22.69	090	S
44661		A	Repair bowel-bladder fistula	15.44	13.94	2.52	31.90	090	S
44680		A	Surgical revision, intestine	12.41	9.71	2.14	24.26	090	S
44799		C	Intestine surgery procedure	0.00	0.00	0.00	0.00	YYY	S
44800		A	Excision of bowel pouch	10.12	5.24	1.08	16.44	090	S
44820		A	Excision of mesentery lesion	9.31	5.80	1.21	16.32	090	S
44850		A	Repair of mesentery	8.64	5.60	1.18	15.42	090	S
44899		C	Bowel surgery procedure	0.00	0.00	0.00	0.00	YYY	S
44900		A	Drainage of appendix abscess	7.86	4.28	0.88	13.02	090	S
44950		A	Appendectomy	6.06	4.89	1.01	11.96	090	S
44955		A	Appendectomy	1.53	*1.96	0.60	4.09	ZZZ	S
44960		A	Appendectomy	9.78	5.89	1.24	16.91	090	S
45000		A	Drainage of pelvic abscess	4.28	1.59	0.24	6.11	090	S
45005		A	Drainage of rectal abscess	1.96	1.29	0.21	3.46	010	S
45020		A	Drainage of rectal abscess	4.40	2.61	0.51	7.52	090	S
45100		A	Biopsy of rectum	3.38	1.88	0.35	5.61	090	S
45108		A	Removal of anorectal lesion	4.28	2.66	0.53	7.47	090	S
45110		A	Removal of rectum	21.68	16.32	3.43	41.43	090	S
45111		A	Partial removal of rectum	14.97	11.77	2.49	29.23	090	S
45112		A	Removal of rectum	24.02	16.06	3.36	43.44	090	S
45113		A	Partial proctectomy	24.69	16.06	3.36	44.11	090	S
45114		A	Partial removal of rectum	21.20	15.39	3.24	39.83	090	S
45116		A	Partial removal of rectum	19.09	10.77	2.34	32.20	090	S
45120		A	Removal of rectum	22.78	16.39	3.54	42.71	090	S
45121		A	Removal of rectum and colon	24.96	10.79	2.01	37.76	090	S
45123		A	Partial proctectomy	13.27	11.77	2.49	27.53	090	S
45130		A	Excision of rectal prolapse	13.03	8.92	1.79	23.74	090	S
45135		A	Excision of rectal prolapse	15.36	15.95	3.50	34.81	090	S
45150		A	Excision of rectal stricture	5.26	3.38	0.63	9.27	090	S
45160		A	Excision of rectal lesion	12.34	7.46	1.56	21.36	090	S
45170		A	Excision of rectal lesion	9.40	4.62	0.96	14.98	090	S
45190		A	Destruction, rectal tumor	7.91	5.09	1.06	14.06	090	S
45300		A	Proctosigmoidoscopy	0.70	0.55	0.07	1.32	000	S
45303		A	Proctosigmoidoscopy	0.50	*0.64	0.12	1.26	000	S
45305		A	Proctosigmoidoscopy; biopsy	1.01	0.84	0.14	1.99	000	S
45307		A	Proctosigmoidoscopy	1.71	1.27	0.18	3.16	000	S
45308		A	Proctosigmoidoscopy	1.51	1.13	0.20	2.84	000	S
45309		A	Proctosigmoidoscopy	2.01	1.13	0.20	3.34	000	S
45315		A	Proctosigmoidoscopy	2.54	1.19	0.18	3.91	000	S
45317		A	Proctosigmoidoscopy	2.73	1.26	0.19	4.18	000	S
45320		A	Proctosigmoidoscopy	2.88	1.87	0.34	5.09	000	S
45321		A	Proctosigmoidoscopy	2.12	1.47	0.27	3.86	000	S
45330		A	Sigmoidoscopy, diagnostic	0.96	*1.23	0.12	2.31	000	N
45331		A	Sigmoidoscopy and biopsy	1.26	*1.61	0.15	3.02	000	N
45332		A	Sigmoidoscopy	1.96	1.76	0.16	3.88	000	N
45333		A	Sigmoidoscopy & polypectomy	1.96	2.24	0.26	4.46	000	N
45334		A	Sigmoidoscopy for bleeding	2.99	2.71	0.23	5.93	000	N
45337		A	Sigmoidoscopy, decompression	2.36	*3.03	0.38	5.77	000	N
45338		A	Sigmoidoscopy	2.57	2.24	0.26	5.07	000	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
45339		A	Sigmoidoscopy	3.14	3.24	0.31	6.69	000	N
45355		A	Surgical colonoscopy	3.52	1.17	0.10	4.79	000	N
45378		A	Diagnostic colonoscopy	3.70	4.13	0.39	8.22	000	N
45379		A	Colonoscopy	4.72	5.33	0.45	10.50	000	N
45380		A	Colonoscopy and biopsy	4.01	4.79	0.40	9.20	000	N
45382		A	Colonoscopy, control bleeding	5.73	5.87	0.41	12.01	000	N
45383		A	Colonoscopy, lesion removal	5.87	5.92	0.50	12.29	000	N
45384		A	Colonoscopy	4.70	*6.65	0.58	11.93	000	N
45385		A	Colonoscopy, lesion removal	5.31	*6.65	0.58	12.54	000	N
45500		A	Repair of rectum	6.59	5.95	1.21	13.75	090	S
45505		A	Repair of rectum	5.54	6.29	1.23	13.06	090	S
45520		A	Treatment of rectal prolapse	0.55	0.61	0.10	1.26	000	N
45540		A	Correct rectal prolapse	11.98	9.89	2.10	23.97	090	S
45541		A	Correct rectal prolapse	9.79	10.17	2.04	22.00	090	S
45550		A	Repair rectum; remove sigmoid	13.38	11.49	2.38	27.25	090	S
45560		A	Repair of rectocele	7.48	4.79	0.98	13.25	090	S
45562		A	Exploration/repair of rectum	11.13	8.09	1.58	20.80	090	S
45563		A	Exploration/repair of rectum	17.55	12.77	2.49	32.81	090	S
45800		A	Repair rectumbladder fistula	12.75	9.82	1.45	24.02	090	S
45805		A	Repair fistula; colostomy	15.08	12.32	2.39	29.79	090	S
45820		A	Repair rectourethral fistula	13.31	8.98	1.23	23.52	090	S
45825		A	Repair fistula; colostomy	15.45	9.87	1.66	26.98	090	S
45900		A	Reduction of rectal prolapse	1.68	0.58	0.11	2.37	010	S
45905		A	Dilation of anal sphincter	1.51	0.71	0.12	2.34	010	S
45910		A	Dilation of rectal narrowing	1.86	0.87	0.13	2.86	010	S
45915		A	Remove rectal obstruction	2.09	0.78	0.09	2.96	010	N
45999		C	Rectum surgery procedure	0.00	0.00	0.00	0.00	YYY	N
46030		A	Removal of rectal marker	1.20	0.40	0.07	1.67	010	S
46040		A	Incision of rectal abscess	4.90	1.69	0.34	6.93	090	S
46045		A	Incision of rectal abscess	3.91	1.85	0.38	6.14	090	S
46050		A	Incision of anal abscess	1.14	0.60	0.11	1.85	010	S
46060		A	Incision of rectal abscess	5.03	5.35	1.12	11.50	090	S
46070		A	Incision of anal septum	2.63	1.37	0.33	4.33	090	S
46080		A	Incision of anal sphincter	2.35	2.13	0.43	4.91	010	S
46083		A	Incise external hemorrhoid	1.35	0.63	0.08	2.06	010	N
46200		A	Removal of anal fissure	3.02	3.29	0.66	6.97	090	S
46210		A	Removal of anal crypt	2.52	0.77	0.14	3.43	090	S
46211		A	Removal of anal crypts	4.07	1.90	0.38	6.35	090	S
46220		A	Removal of anal tab	1.51	0.63	0.12	2.26	010	S
46221		A	Ligation of hemorrhoid(s)	1.38	0.66	0.14	2.18	010	S
46230		A	Removal of anal tabs	2.52	0.83	0.12	3.47	010	S
46250		A	Hemorrhoidectomy	4.29	2.84	0.52	7.65	090	S
46255		A	Hemorrhoidectomy	4.95	4.72	0.85	10.52	090	S
46257		A	Remove hemorrhoids & fissure	5.87	5.23	1.08	12.18	090	S
46258		A	Remove hemorrhoids & fistula	6.26	5.87	1.22	13.35	090	S
46260		A	Hemorrhoidectomy	6.70	6.07	1.25	14.02	090	S
46261		A	Remove hemorrhoids & fissure	6.54	6.62	1.34	14.50	090	S
46262		A	Remove hemorrhoids & fistula	6.77	6.72	1.39	14.88	090	S
46270		A	Removal of anal fistula	3.51	1.87	0.37	5.75	090	S
46275		A	Removal of anal fistula	4.35	5.50	1.13	10.98	090	S
46280		A	Removal of anal fistula	5.63	6.08	1.24	12.95	090	S
46285		A	Removal of anal fistula	3.88	2.28	0.43	6.59	090	S
46288		A	Repair anal fistula	6.83	3.57	0.83	11.23	090	S
46320		A	Removal of hemorrhoid clot	1.58	0.70	0.11	2.39	010	S
46500		A	Injection into hemorrhoids	1.53	0.32	0.06	1.91	010	S
46600		A	Diagnostic anoscopy	0.50	0.28	0.03	0.81	000	N
46604		A	Anoscopy and dilation	1.31	0.38	0.06	1.75	000	S
46606		A	Anoscopy and biopsy	0.81	0.36	0.06	1.23	000	S
46608		A	Anoscopy; remove foreign body	1.51	1.07	0.12	2.70	000	N
46610		A	Anoscopy; remove lesion	1.32	0.85	0.15	2.32	000	S
46611		A	Anoscopy	1.81	0.85	0.15	2.81	000	S
46612		A	Anoscopy; remove lesions	2.34	1.39	0.20	3.93	000	S
46614		A	Anoscopy; control bleeding	2.01	1.55	0.25	3.81	000	S
46615		A	Anoscopy	2.68	1.55	0.25	4.48	000	S
46700		A	Repair of anal stricture	6.40	6.14	1.24	13.78	090	S
46705		A	Repair of anal stricture	6.38	3.60	0.77	10.75	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
46715		A	Repair of anovaginal fistula	6.73	3.51	0.82	11.06	090	S
46716		A	Repair of anovaginal fistula	11.58	6.05	1.40	19.03	090	S
46730		A	Construction of absent anus	20.54	10.74	2.50	33.78	090	S
46735		A	Construction of absent anus	24.91	13.04	3.04	40.99	090	S
46740		A	Construction of absent anus	22.08	11.55	2.68	36.31	090	S
46742		A	Repair, imperforated anus	27.82	19.75	1.93	49.50	090	S
46744		A	Repair, cloacal anomaly	31.23	22.17	2.17	55.57	090	S
46746		A	Repair, cloacal anomaly	34.17	24.26	2.37	60.80	090	S
46748		A	Repair, cloacal anomaly	38.07	27.03	2.64	67.74	090	S
46750		A	Repair of anal sphincter	7.35	6.00	1.22	14.57	090	S
46751		A	Repair of anal sphincter	7.78	4.07	0.95	12.80	090	S
46753		A	Reconstruction of anus	6.04	4.89	1.02	11.95	090	S
46754		A	Removal of suture from anus	1.51	1.48	0.30	3.29	010	S
46760		A	Repair of anal sphincter	10.61	6.80	1.41	18.82	090	S
46761		A	Repair of anal sphincter	10.16	6.83	1.35	18.34	090	S
46762		A	Implant artificial sphincter	9.26	5.72	1.21	16.19	090	S
46900		A	Destruction, anal lesion(s)	1.81	0.39	0.06	2.26	010	S
46910		A	Destruction, anal lesion(s)	1.81	0.64	0.08	2.53	010	S
46916		A	Cryosurgery, anal lesion(s)	1.81	0.67	0.06	2.54	010	S
46917		A	Laser surgery, anal lesion(s)	1.81	1.94	0.31	4.06	010	S
46922		A	Excision of anal lesion(s)	1.81	1.28	0.23	3.32	010	S
46924		A	Destruction, anal lesion(s)	2.71	2.56	0.46	5.73	010	S
46934		A	Destruction of hemorrhoids	3.84	1.19	0.17	5.20	090	N
46935		A	Destruction of hemorrhoids	2.40	1.62	0.22	4.24	010	N
46936		A	Destruction of hemorrhoids	4.17	2.29	0.24	6.70	090	N
46937		A	Cryotherapy of rectal lesion	2.66	2.35	0.45	5.46	010	S
46938		A	Cryotherapy of rectal lesion	4.42	2.50	0.52	7.44	090	S
46940		A	Treatment of anal fissure	2.29	0.51	0.09	2.89	010	S
46942		A	Treatment of anal fissure	2.01	0.46	0.08	2.55	010	S
46945		A	Ligation of hemorrhoids	3.06	0.63	0.12	3.81	090	S
46946		A	Ligation of hemorrhoids	4.04	0.94	0.17	5.15	090	S
46999		C	Anus surgery procedure	0.00	0.00	0.00	0.00	YYY	S
47000		A	Needle biopsy of liver	1.90	1.40	0.13	3.43	000	N
47001		A	Needle biopsy, liver	1.90	1.40	0.13	3.43	ZZZ	S
47010		A	Drainage of liver lesion	8.75	6.75	1.13	16.63	090	S
47015		A	Inject/aspirate liver cyst	8.78	6.75	1.13	16.66	090	S
47100		A	Wedge biopsy of liver	6.75	3.29	0.67	10.71	090	S
47120		A	Partial removal of liver	19.99	12.00	2.48	34.47	090	S
47122		A	Extensive removal of liver	32.54	17.58	3.59	53.71	090	S
47125		A	Partial removal of liver	28.68	17.43	3.61	49.72	090	S
47130		A	Partial removal of liver	31.56	19.19	3.89	54.64	090	S
47133		X	Removal of donor liver	0.00	0.00	0.00	0.00	XXX	0
47134		R	Partial removal, donor liver	39.15	20.48	4.77	64.40	XXX	S
47135		R	Transplantation of liver	77.61	54.48	8.49	140.58	090	S
47136		R	Transplantation of liver	64.04	33.50	7.79	105.33	090	S
47300		A	Surgery for liver lesion	8.75	7.67	1.59	18.01	090	S
47350		A	Repair liver wound	11.29	7.46	1.49	20.24	090	S
47355		D	Repair liver wound	0.00	0.00	0.00	0.00	090	S
47360		A	Repair liver wound	15.34	10.93	2.18	28.45	090	S
47361		A	Repair liver wound	28.00	14.64	3.41	46.05	090	S
47362		A	Repair liver wound	10.00	5.23	1.22	16.45	090	S
47399		C	Liver surgery procedure	0.00	0.00	0.00	0.00	YYY	S
47400		A	Incision of liver duct	18.90	8.53	1.36	28.79	090	S
47420		A	Incision of bile duct	15.31	9.48	1.99	26.78	090	S
47425		A	Incision of bile duct	14.79	11.71	2.45	28.95	090	S
47460		A	Incise bile duct sphincter	14.41	15.54	1.82	31.77	090	N
47480		A	Incision of gallbladder	8.05	7.60	1.59	17.24	090	S
47490		A	Incision of gallbladder	6.04	3.57	0.38	9.99	090	N
47500		A	Injection for liver x-rays	1.96	1.51	0.14	3.61	000	N
47505		A	Injection for liver x-rays	0.76	*0.98	0.14	1.88	000	N
47510		A	Insert catheter, bile duct	7.39	2.87	0.25	10.51	090	N
47511		A	Insert bile duct drain	9.91	2.87	0.25	13.03	090	N
47525		A	Change bile duct catheter	5.41	1.59	0.16	7.16	010	N
47530		A	Revise, reinsert bile tube	5.41	1.51	0.19	7.11	090	N
47550		A	Bile duct endoscopy	3.02	1.56	0.35	4.93	000	S
47552		A	Biliary endoscopy, thru skin	6.04	1.36	0.21	7.61	000	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
47553		A	Biliary endoscopy, thru skin	6.35	3.80	0.62	10.77	000	N
47554		A	Biliary endoscopy, thru skin	9.06	3.93	0.67	13.66	000	S
47555		A	Biliary endoscopy, thru skin	7.56	2.63	0.30	10.49	000	N
47556		A	Biliary endoscopy, thru skin	8.56	2.63	0.30	11.49	000	N
47600		A	Removal of gallbladder	10.68	7.53	1.58	19.79	090	S
47605		A	Removal of gallbladder	11.53	8.14	1.75	21.42	090	S
47610		A	Removal of gallbladder	13.86	9.37	2.00	25.23	090	S
47612		A	Removal of gallbladder	14.75	14.23	3.05	32.03	090	S
47620		A	Removal of gallbladder	15.79	11.23	2.36	29.38	090	S
47630		A	Remove bile duct stone	8.31	3.75	0.40	12.46	090	N
47700		A	Exploration of bile ducts	13.75	7.63	1.58	22.96	090	S
47701		A	Bile duct revision	26.57	8.21	1.90	36.68	090	S
47711		A	Excision of bile duct tumor	18.16	12.06	2.46	32.68	090	S
47712		A	Excision of bile duct tumor	23.74	12.06	2.46	38.26	090	S
47715		A	Excision of bile duct cyst	14.50	8.22	1.71	24.43	090	S
47716		A	Fusion of bile duct cyst	12.53	6.56	1.53	20.62	090	S
47720		A	Fuse gallbladder & bowel	11.90	9.16	1.93	22.99	090	S
47721		A	Fuse upper gi structures	14.41	11.42	2.47	28.30	090	S
47740		A	Fuse gallbladder & bowel	13.93	10.21	2.14	26.28	090	S
47741		A	Fuse gallbladder & bowel	16.23	14.35	3.02	33.60	090	S
47760		A	Fuse bile ducts and bowel	19.93	11.61	2.53	34.07	090	S
47765		A	Fuse liver ducts & bowel	19.04	14.61	2.97	36.62	090	S
47780		A	Fuse bile ducts and bowel	20.40	13.07	2.73	36.20	090	S
47785		A	Fuse bile ducts and bowel	24.41	13.07	2.73	40.21	090	S
47800		A	Reconstruction of bile ducts	17.71	13.22	2.43	33.36	090	S
47801		A	Placement, bile duct support	11.28	5.48	0.81	17.57	090	S
47802		A	Fuse liver duct & intestine	16.01	10.27	1.75	28.03	090	S
47900		A	Suture bile duct injury	15.63	13.22	2.43	31.28	090	S
47999		C	Bile tract surgery procedure	0.00	0.00	0.00	0.00	YYY	S
48000		A	Drainage of abdomen	13.10	7.05	1.40	21.55	090	S
48001		A	Placement of drain, pancreas	15.54	8.13	1.89	25.56	090	S
48005		A	Resect/debride pancreas	17.57	9.19	2.14	28.90	090	S
48020		A	Removal of pancreatic stone	12.98	6.78	1.57	21.33	090	S
48100		A	Biopsy of pancreas	10.19	4.21	0.79	15.19	090	S
48102		A	Needle biopsy, pancreas	4.43	2.41	0.25	7.09	010	N
48120		A	Removal of pancreas lesion	12.79	9.72	2.07	24.58	090	S
48140		A	Partial removal of pancreas	18.27	13.29	2.83	34.39	090	S
48145		A	Partial removal of pancreas	19.09	15.71	3.16	37.96	090	S
48146		A	Pancreatectomy	21.73	16.49	1.92	40.14	090	S
48148		A	Removal of pancreatic duct	14.41	8.23	1.68	24.32	090	S
48150		A	Partial removal of pancreas	40.25	22.54	4.75	67.54	090	S
48152		A	Pancreatectomy	36.50	22.54	4.75	63.79	090	S
48153		A	Pancreatectomy	40.25	22.54	4.75	67.54	090	S
48154		A	Pancreatectomy	36.50	22.54	4.75	63.79	090	S
48155		A	Removal of pancreas	19.43	20.40	4.26	44.09	090	S
48160		N	Pancreas removal, transplant	0.00	0.00	0.00	0.00	XXX	0
48180		A	Fuse pancreas and bowel	20.88	12.60	2.63	36.11	090	S
48400		A	Injection, intraoperative	1.95	1.03	0.24	3.22	ZZZ	N
48500		A	Surgery of pancreas cyst	12.04	8.53	1.66	22.23	090	S
48510		A	Drain pancreatic pseudocyst	11.22	7.54	1.44	20.20	090	S
48520		A	Fuse pancreas cyst and bowel	12.97	11.30	2.43	26.70	090	S
48540		A	Fuse pancreas cyst and bowel	15.77	12.66	2.65	31.08	090	S
48545		A	Pancreatorrhaphy	14.65	7.66	1.79	24.10	090	S
48547		A	Duodenal exclusion	21.18	11.08	2.58	34.84	090	S
48550		N	Donor pancreatectomy	0.00	0.00	0.00	0.00	XXX	0
48554		N	Transplantallograft pancreas	#34.17	17.87	4.16	56.20	XXX	0
48556		A	Removal, allograft pancreas	13.89	7.26	1.69	22.84	090	S
48999		C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	YYY	S
49000		A	Exploration of abdomen	8.99	6.79	1.40	17.18	090	S
49002		A	Reopening of abdomen	9.40	6.05	1.21	16.66	090	S
49010		A	Exploration behind abdomen	11.19	6.95	1.31	19.45	090	S
49020		A	Drain abdominal abscess	9.06	4.82	0.91	14.79	090	S
49040		A	Drain abdominal abscess	8.74	6.54	1.27	16.55	090	S
49060		A	Drain abdominal abscess	10.55	5.54	1.01	17.10	090	S
49080		A	Puncture, peritoneal cavity	1.35	0.87	0.08	2.30	000	N
49081		A	Removal of abdominal fluid	1.26	0.75	0.07	2.08	000	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
49085		A	Remove abdomen foreign body	7.91	3.46	0.67	12.04	090	S
49180		A	Biopsy, abdominal mass	1.49	1.82	0.20	3.51	000	N
49200		A	Removal of abdominal lesion	9.19	8.38	1.70	19.27	090	S
49201		A	Removal of abdominal lesion	13.60	12.10	2.50	28.20	090	S
49215		A	Excise sacral spine tumor	21.05	8.50	1.59	31.14	090	S
49220		A	Multiple surgery, abdomen	13.66	12.30	2.53	28.49	090	S
49250		A	Excision of umbilicus	7.42	4.52	0.96	12.90	090	S
49255		A	Removal of omentum	4.04	*5.16	1.15	10.35	090	S
49400		A	Air injection into abdomen	1.88	1.12	0.17	3.17	000	S
49420		A	Insert abdominal drain	2.22	1.58	0.20	4.00	000	S
49421		A	Insert abdominal drain	4.89	4.14	0.81	9.84	090	S
49422		A	Remove perm cannula/catheter	5.85	4.14	0.81	10.80	010	S
49425		A	Insert abdomen-venous drain	10.22	8.48	1.78	20.48	090	S
49426		A	Revise abdomen-venous shunt	8.57	5.39	1.07	15.03	090	S
49427		A	Injection, abdominal shunt	0.89	0.49	0.03	1.41	000	N
49428		A	Ligation of shunt	1.98	1.04	0.24	3.26	010	S
49429		A	Removal of shunt	6.35	3.32	0.77	10.44	010	S
49495		A	Repair inguinal hernia, init	5.79	4.98	0.95	11.72	090	S
49496		A	Repair inguinal hernia, init	8.37	5.04	1.08	14.49	090	S
49500		A	Repair inguinal hernia	4.41	4.98	0.95	10.34	090	S
49501		A	Repair inguinal hernia, init	7.26	5.04	1.08	13.38	090	S
49505		A	Repair inguinal hernia	6.17	4.51	0.94	11.62	090	S
49507		A	Repair, inguinal hernia	7.40	5.04	1.08	13.52	090	S
49520		A	Rerepair inguinal hernia	7.87	5.22	1.11	14.20	090	S
49521		A	Repair inguinal hernia, rec	9.43	5.04	1.08	15.55	090	S
49525		A	Repair inguinal hernia	6.97	5.55	1.16	13.68	090	S
49540		A	Repair lumbar hernia	7.91	5.20	1.12	14.23	090	S
49550		A	Repair femoral hernia	6.97	4.61	0.97	12.55	090	S
49553		A	Repair femoral hernia, init	7.40	4.61	0.97	12.98	090	S
49555		A	Repair femoral hernia	7.29	6.07	1.26	14.62	090	S
49557		A	Repair femoral hernia, recur	8.73	6.07	1.26	16.06	090	S
49560		A	Repair abdominal hernia	9.48	5.65	1.19	16.32	090	S
49561		A	Repair incisional hernia	11.38	5.65	1.19	18.22	090	S
49565		A	Rerepair abdominal hernia	9.48	6.41	1.35	17.24	090	S
49566		A	Repair incisional hernia	11.38	6.41	1.35	19.14	090	S
49568		A	Hernia repair w/mesh	4.89	2.56	0.59	8.04	ZZZ	S
49570		A	Repair epigastric hernia	4.46	4.38	0.91	9.75	090	S
49572		A	Repair, epigastric hernia	5.35	5.60	1.18	12.13	090	S
49580		A	Repair umbilical hernia	3.24	*4.15	0.94	8.33	090	S
49582		A	Repair umbilical hernia	5.13	4.61	0.94	10.68	090	S
49585		A	Repair umbilical hernia	4.95	4.41	0.91	10.27	090	S
49587		A	Repair umbilical hernia	5.93	4.41	0.91	11.25	090	S
49590		A	Repair abdominal hernia	6.55	5.63	1.22	13.40	090	S
49600		A	Repair umbilical lesion	9.48	5.26	0.77	15.51	090	S
49605		A	Repair umbilical lesion	21.92	8.57	1.77	32.26	090	S
49606		A	Repair umbilical lesion	17.93	8.31	0.96	27.20	090	S
49610		A	Repair umbilical lesion	9.83	5.48	1.27	16.58	090	S
49611		A	Repair umbilical lesion	8.25	9.00	0.58	17.83	090	S
49900		A	Repair of abdominal wall	4.54	3.66	0.75	8.95	090	S
49905		A	Omental flap	6.55	3.42	0.80	10.77	ZZZ	S
49999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	YYY	S
50010		A	Exploration of kidney	10.07	9.55	1.13	20.75	090	S
50020		A	Drainage of kidney abscess	12.41	6.80	0.85	20.06	090	S
50040		A	Drainage of kidney	13.80	7.18	0.62	21.60	090	N
50045		A	Exploration of kidney	14.48	9.81	0.89	25.18	090	S
50060		A	Removal of kidney stone	18.00	12.25	1.21	31.46	090	S
50065		A	Incision of kidney	19.62	13.93	1.35	34.90	090	S
50070		A	Incision of kidney	19.15	12.87	1.35	33.37	090	S
50075		A	Removal of kidney stone	24.05	16.87	1.62	42.54	090	S
50080		A	Removal of kidney stone	13.98	12.20	1.15	27.33	090	S
50081		A	Removal of kidney stone	20.58	14.96	1.44	36.98	090	S
50100		A	Revise kidney blood vessels	15.11	10.34	1.35	26.80	090	S
50120		A	Exploration of kidney	15.00	10.91	1.24	27.15	090	S
50125		A	Explore and drain kidney	15.61	10.95	1.06	27.62	090	S
50130		A	Removal of kidney stone	16.12	12.80	1.26	30.18	090	S
50135		A	Exploration of kidney	18.14	17.05	1.63	36.82	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
50200		A	Biopsy of kidney	2.63	2.61	0.22	5.46	000	N
50205		A	Biopsy of kidney	12.69	5.64	0.69	19.02	090	S
50220		A	Removal of kidney	15.98	13.31	1.43	30.72	090	S
50225		A	Removal of kidney	18.93	16.52	1.70	37.15	090	S
50230		A	Removal of kidney	20.56	18.40	1.84	40.80	090	S
50234		A	Removal of kidney & ureter	21.11	16.65	1.65	39.41	090	S
50236		A	Removal of kidney & ureter	23.33	17.74	1.74	42.81	090	S
50240		A	Partial removal of kidney	20.24	16.00	1.70	37.94	090	S
50280		A	Removal of kidney lesion	14.63	10.86	1.16	26.65	090	S
50290		A	Removal of kidney lesion	13.69	8.87	1.19	23.75	090	S
50300		X	Removal of donor kidney	0.00	0.00	0.00	0.00	XXX	0
50320		A	Removal of donor kidney	21.22	16.49	2.40	40.11	090	S
50340		A	Removal of kidney	10.73	12.49	2.24	25.46	090	S
50360		A	Transplantation of kidney	27.05	24.45	4.24	55.74	090	S
50365		A	Transplantation of kidney	32.54	30.71	3.89	67.14	090	S
50370		A	Remove transplanted kidney	11.11	11.08	1.92	24.11	090	S
50380		A	Reimplantation of kidney	16.49	10.12	1.71	28.32	090	S
50390		A	Drainage of kidney lesion	3.24	1.69	0.15	5.08	000	N
50392		A	Insert kidney drain	5.59	2.36	0.20	8.15	000	N
50393		A	Insert ureteral tube	6.88	3.01	0.26	10.15	000	N
50394		A	Injection for kidney x-ray	0.76	0.55	0.05	1.36	000	N
50395		A	Create passage to kidney	5.15	3.33	0.29	8.77	000	N
50396		A	Measure kidney pressure	2.09	0.50	0.05	2.64	000	N
50398		A	Change kidney tube	1.46	0.53	0.05	2.04	000	S
50400		A	Revision of kidney/ureter	18.07	13.66	1.36	33.09	090	S
50405		A	Revision of kidney/ureter	22.45	17.29	1.74	41.48	090	S
50500		A	Repair of kidney wound	18.27	12.46	1.64	32.37	090	S
50520		A	Close kidney-skin fistula	15.93	10.34	1.50	27.77	090	S
50525		A	Repair renal-abdomen fistula	20.59	12.61	1.99	35.19	090	S
50526		A	Repair renal-abdomen fistula	22.15	7.39	2.32	31.86	090	S
50540		A	Revision of horseshoe kidney	19.15	13.41	1.54	34.10	090	S
50551		A	Kidney endoscopy	5.60	2.19	0.21	8.00	000	S
50553		A	Kidney endoscopy	5.99	1.66	0.17	7.82	000	S
50555		A	Kidney endoscopy & biopsy	6.53	4.70	0.45	11.68	000	S
50557		A	Kidney endoscopy & treatment	6.62	4.71	0.49	11.82	000	S
50559		A	Renal endoscopy; radiotracer	6.78	1.34	0.14	8.26	000	S
50561		A	Kidney endoscopy & treatment	7.59	5.12	0.49	13.20	000	S
50570		A	Kidney endoscopy	9.54	1.45	0.14	11.13	000	S
50572		A	Kidney endoscopy	10.35	7.25	0.75	18.35	000	S
50574		A	Kidney endoscopy & biopsy	11.02	7.08	0.64	18.74	000	S
50575		A	Kidney endoscopy	13.98	9.93	0.97	24.88	000	S
50576		A	Kidney endoscopy & treatment	10.99	8.69	0.77	20.45	000	S
50578		A	Renal endoscopy; radiotracer	11.35	3.79	1.19	16.33	000	S
50580		A	Kidney endoscopy & treatment	11.86	3.58	0.35	15.79	000	S
50590		A	Fragmenting of kidney stone	9.62	10.11	0.97	20.70	090	S
50600		A	Exploration of ureter	14.78	9.69	1.01	25.48	090	S
50605		A	Insert ureteral support	14.40	6.11	0.60	21.11	090	S
50610		A	Removal of ureter stone	14.86	11.77	1.17	27.80	090	S
50620		A	Removal of ureter stone	14.17	11.49	1.16	26.82	090	S
50630		A	Removal of ureter stone	13.95	12.71	1.25	27.91	090	S
50650		A	Removal of ureter	16.37	12.07	1.21	29.65	090	S
50660		A	Removal of ureter	18.44	12.49	1.53	32.46	090	S
50684		A	Injection for ureter x-ray	0.76	0.49	0.05	1.30	000	S
50686		A	Measure ureter pressure	1.51	0.37	0.04	1.92	000	S
50688		A	Change of ureter tube	1.14	0.39	0.04	1.57	010	S
50690		A	Injection for ureter x-ray	1.16	0.32	0.03	1.51	000	S
50700		A	Revision of ureter	14.10	12.57	1.29	27.96	090	S
50715		A	Release of ureter	17.60	11.24	1.49	30.33	090	S
50722		A	Release of ureter	15.11	10.32	1.97	27.40	090	S
50725		A	Release/revise ureter	17.12	12.05	1.75	30.92	090	S
50727		A	Revise ureter	7.57	5.37	0.51	13.45	090	S
50728		A	Revise ureter	11.13	7.90	0.77	19.80	090	S
50740		A	Fusion of ureter & kidney	17.12	13.03	1.88	32.03	090	S
50750		A	Fusion of ureter & kidney	18.14	14.04	1.26	33.44	090	S
50760		A	Fusion of ureters	17.12	13.47	1.48	32.07	090	S
50770		A	Splicing of ureters	18.14	15.23	1.53	34.90	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
50780		A	Reimplant ureter in bladder	17.12	13.78	1.46	32.36	090	S
50782		A	Reimplant ureter in bladder	18.23	13.78	1.46	33.47	090	S
50783		A	Reimplant ureter in bladder	19.17	13.78	1.46	34.41	090	S
50785		A	Reimplant ureter in bladder	19.15	15.42	1.80	36.37	090	S
50800		A	Implant ureter in bowel	13.10	14.67	1.51	29.28	090	S
50810		A	Fusion of ureter & bowel	18.14	12.57	1.75	32.46	090	S
50815		A	Urine shunt to bowel	18.14	19.76	2.75	40.65	090	S
50820		A	Construct bowel bladder	20.15	18.97	2.50	41.62	090	S
50825		A	Construct bowel bladder	26.19	30.54	3.33	60.06	090	S
50830		A	Revise urine flow	29.29	20.93	2.27	52.49	090	S
50840		A	Replace ureter by bowel	18.14	13.32	1.35	32.81	090	S
50845		A	Appendico-vesicostomy	19.52	13.87	1.35	34.74	090	S
50860		A	Transplant ureter to skin	13.99	10.92	1.16	26.07	090	S
50900		A	Repair of ureter	12.58	9.98	1.15	23.71	090	S
50920		A	Closure ureter/skin fistula	13.22	9.52	0.99	23.73	090	S
50930		A	Closure ureter/bowel fistula	17.61	12.50	1.22	31.33	090	S
50940		A	Release of ureter	13.47	9.90	0.95	24.32	090	S
50951		A	Endoscopy of ureter	5.84	1.67	0.17	7.68	000	S
50953		A	Endoscopy of ureter	6.24	1.66	0.16	8.06	000	S
50955		A	Ureter endoscopy & biopsy	6.75	2.55	0.25	9.55	000	S
50957		A	Ureter endoscopy & treatment	6.79	2.50	0.25	9.54	000	S
50959		A	Ureter endoscopy & tracer	4.40	3.38	0.29	8.07	000	S
50961		A	Ureter endoscopy & treatment	6.05	2.62	0.26	8.93	000	S
50970		A	Ureter endoscopy	7.14	5.17	0.52	12.83	000	S
50972		A	Ureter endoscopy & catheter	6.89	1.54	0.16	8.59	000	S
50974		A	Ureter endoscopy & biopsy	9.17	7.01	0.65	16.83	000	S
50976		A	Ureter endoscopy & treatment	9.04	6.41	0.62	16.07	000	S
50978		A	Ureter endoscopy & tracer	5.10	4.05	0.48	9.63	000	S
50980		A	Ureter endoscopy & treatment	6.85	3.13	0.30	10.28	000	S
51000		A	Drainage of bladder	0.78	0.48	0.05	1.31	000	S
51005		A	Drainage of bladder	1.02	0.46	0.04	1.52	000	S
51010		A	Drainage of bladder	2.54	0.97	0.11	3.62	010	S
51020		A	Incise & treat bladder	6.04	6.85	0.71	13.60	090	S
51030		A	Incise & treat bladder	6.04	4.53	0.43	11.00	090	S
51040		A	Incise & drain bladder	4.08	*5.23	0.75	10.06	090	S
51045		A	Incise bladder, drain ureter	6.04	4.96	0.50	11.50	090	S
51050		A	Removal of bladder stone	6.04	7.12	0.70	13.86	090	S
51060		A	Removal of ureter stone	8.05	*10.31	1.19	19.55	090	S
51065		A	Removal of ureter stone	8.05	7.08	0.71	15.84	090	S
51080		A	Drainage of bladder abscess	5.41	5.18	0.57	11.16	090	S
51500		A	Removal of bladder cyst	9.54	6.86	1.21	17.61	090	S
51520		A	Removal of bladder lesion	8.69	8.53	0.87	18.09	090	S
51525		A	Removal of bladder lesion	12.78	10.67	1.06	24.51	090	S
51530		A	Removal of bladder lesion	11.32	9.25	1.02	21.59	090	S
51535		A	Repair of ureter lesion	11.51	7.68	1.14	20.33	090	S
51550		A	Partial removal of bladder	14.34	10.71	1.17	26.22	090	S
51555		A	Partial removal of bladder	19.60	12.26	1.31	33.17	090	S
51565		A	Revise bladder & ureter(s)	20.01	15.84	1.67	37.52	090	S
51570		A	Removal of bladder	22.16	15.66	1.62	39.44	090	S
51575		A	Removal of bladder & nodes	27.93	22.87	2.25	53.05	090	S
51580		A	Remove bladder; revise tract	28.20	19.95	2.04	50.19	090	S
51585		A	Removal of bladder & nodes	32.22	25.12	2.42	59.76	090	S
51590		A	Remove bladder; revise tract	30.21	24.52	2.56	57.29	090	S
51595		A	Remove bladder; revise tract	34.25	33.80	3.34	71.39	090	S
51596		A	Remove bladder, create pouch	36.27	34.89	3.45	74.61	090	S
51597		A	Removal of pelvic structures	35.27	30.63	4.31	70.21	090	S
51600		A	Injection for bladder x-ray	0.88	0.28	0.03	1.19	000	S
51605		A	Preparation for bladder xray	1.13	0.30	0.03	1.46	000	S
51610		A	Injection for bladder x-ray	1.59	0.27	0.02	1.88	000	S
51700		A	Irrigation of bladder	0.88	0.22	0.02	1.12	000	S
51705		A	Change of bladder tube	0.99	0.38	0.04	1.41	010	S
51710		A	Change of bladder tube	1.46	0.57	0.06	2.09	010	S
51715		A	Endoscopic injection/implant	3.74	2.65	0.27	6.66	000	S
51720		A	Treatment of bladder lesion	1.96	0.45	0.05	2.46	000	S
51725		A	Simple cystometrogram	1.51	1.01	0.11	2.63	000	S
51725	26	A	Simple cystometrogram	1.51	0.63	0.07	2.21	000	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
51725	TC	A	Simple cystometrogram	0.00	0.38	0.04	0.42	000	S
51726	.....	A	Complex cystometrogram	1.71	1.29	0.13	3.13	000	S
51726	26	A	Complex cystometrogram	1.71	0.81	0.08	2.60	000	S
51726	TC	A	Complex cystometrogram	0.00	0.48	0.05	0.53	000	S
51736	.....	A	Urine flow measurement	0.84	0.41	0.04	1.29	000	S
51736	26	A	Urine flow measurement	0.84	0.26	0.03	1.13	000	S
51736	TC	A	Urine flow measurement	0.00	0.15	0.01	0.16	000	S
51741	.....	A	Electro-uroflowmetry, first	1.57	0.56	0.06	2.19	000	S
51741	26	A	Electro-uroflowmetry, first	1.57	0.35	0.04	1.96	000	S
51741	TC	A	Electro-uroflowmetry, first	0.00	0.21	0.02	0.23	000	S
51772	.....	A	Urethra pressure profile	1.61	0.94	0.11	2.66	000	S
51772	26	A	Urethra pressure profile	1.61	0.52	0.06	2.19	000	S
51772	TC	A	Urethra pressure profile	0.00	0.42	0.05	0.47	000	S
51784	.....	A	Anal/urinary muscle study	1.53	1.04	0.11	2.68	000	S
51784	26	A	Anal/urinary muscle study	1.53	0.65	0.07	2.25	000	S
51784	TC	A	Anal/urinary muscle study	0.00	0.39	0.04	0.43	000	S
51785	.....	A	Anal/urinary muscle study	1.53	1.04	0.11	2.68	000	S
51785	26	A	Anal/urinary muscle study	1.53	0.65	0.07	2.25	000	S
51785	TC	A	Anal/urinary muscle study	0.00	0.39	0.04	0.43	000	S
51792	.....	A	Urinary reflex study	1.10	1.93	0.20	3.23	000	S
51792	26	A	Urinary reflex study	1.10	0.59	0.06	1.75	000	S
51792	TC	A	Urinary reflex study	0.00	1.34	0.14	1.48	000	S
51795	.....	A	Urine voiding pressure study	1.53	1.44	0.16	3.13	000	S
51795	26	A	Urine voiding pressure study	1.53	0.57	0.06	2.16	000	S
51795	TC	A	Urine voiding pressure study	0.00	0.87	0.10	0.97	000	S
51797	.....	A	Intraabdominal pressure test	1.60	0.96	0.10	2.66	000	S
51797	26	A	Intraabdominal pressure test	1.60	0.51	0.05	2.16	000	S
51797	TC	A	Intraabdominal pressure test	0.00	0.45	0.05	0.50	000	S
51800	.....	A	Revision of bladder/urethra	16.31	12.02	1.47	29.80	090	S
51820	.....	A	Revision of urinary tract	16.67	7.39	1.32	25.38	090	S
51840	.....	A	Attach bladder/urethra	9.78	9.22	1.26	20.26	090	S
51841	.....	A	Attach bladder/urethra	12.10	11.01	1.48	24.59	090	S
51845	.....	A	Repair bladder neck	9.06	10.71	1.09	20.86	090	S
51860	.....	A	Repair of bladder wound	11.17	7.62	0.91	19.70	090	S
51865	.....	A	Repair of bladder wound	13.99	10.96	1.27	26.22	090	S
51880	.....	A	Repair of bladder opening	7.21	4.96	0.52	12.69	090	S
51900	.....	A	Repair bladder/vagina lesion	11.67	11.65	1.41	24.73	090	S
51920	.....	A	Close bladder-uterus fistula	10.57	7.51	0.73	18.81	090	S
51925	.....	A	Hysterectomy/bladder repair	14.10	10.07	2.33	26.50	090	S
51940	.....	A	Correction of bladder defect	25.00	18.95	2.22	46.17	090	S
51960	.....	A	Revision of bladder & bowel	21.15	21.40	2.27	44.82	090	S
51980	.....	A	Construct bladder opening	10.43	7.46	0.75	18.64	090	S
52000	.....	A	Cystoscopy	2.01	1.33	0.14	3.48	000	S
52005	.....	A	Cystoscopy & ureter catheter	2.37	2.20	0.22	4.79	000	S
52007	.....	A	Cystoscopy and biopsy	3.02	2.82	0.28	6.12	000	S
52010	.....	A	Cystoscopy & duct catheter	3.02	1.90	0.20	5.12	000	S
52204	.....	A	Cystoscopy	2.37	2.38	0.24	4.99	000	S
52214	.....	A	Cystoscopy and treatment	3.71	2.80	0.28	6.79	000	S
52224	.....	A	Cystoscopy and treatment	3.14	2.90	0.29	6.33	000	S
52234	.....	A	Cystoscopy and treatment	4.63	4.71	0.45	9.79	000	S
52235	.....	A	Cystoscopy and treatment	5.45	*6.97	0.81	13.23	000	S
52240	.....	A	Cystoscopy and treatment	9.72	10.65	1.04	21.41	000	S
52250	.....	A	Cystoscopy & radiotracer	4.50	2.86	0.29	7.65	000	S
52260	.....	A	Cystoscopy & treatment	3.92	2.11	0.22	6.25	000	S
52265	.....	A	Cystoscopy & treatment	2.94	1.35	0.14	4.43	000	S
52270	.....	A	Cystoscopy & revise urethra	3.84	3.47	0.35	7.66	000	S
52275	.....	A	Cystoscopy & revise urethra	4.70	3.42	0.34	8.46	000	S
52276	.....	A	Cystoscopy and treatment	3.93	4.58	0.45	8.96	000	S
52277	.....	A	Cystoscopy and treatment	6.17	4.82	0.47	11.46	000	S
52281	.....	A	Cystoscopy and treatment	2.80	2.31	0.23	5.34	000	S
52283	.....	A	Cystoscopy and treatment	3.74	1.51	0.15	5.40	000	S
52285	.....	A	Cystoscopy and treatment	3.61	2.94	0.30	6.85	000	S
52290	.....	A	Cystoscopy and treatment	4.59	2.34	0.24	7.17	000	S
52300	.....	A	Cystoscopy and treatment	5.35	3.47	0.36	9.18	000	S
52305	.....	A	Cystoscopy and treatment	5.31	3.50	0.35	9.16	000	S
52310	.....	A	Cystoscopy and treatment	2.81	2.99	0.30	6.10	000	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
52315		A	Cystoscopy and treatment	5.21	4.07	0.40	9.68	000	S
52317		A	Remove bladder stone	6.72	6.19	0.59	13.50	000	S
52318		A	Remove bladder stone	9.19	7.88	0.77	17.84	000	S
52320		A	Cystoscopy and treatment	4.70	4.86	0.47	10.03	000	S
52325		A	Cystoscopy, stone removal	6.16	7.01	0.68	13.85	000	S
52327		A	Cystoscopy, inject material	5.19	3.69	0.36	9.24	000	S
52330		A	Cystoscopy and treatment	5.04	3.47	0.35	8.86	000	S
52332		A	Cystoscopy and treatment	2.83	3.21	0.32	6.36	000	S
52334		A	Create passage to kidney	4.83	3.33	0.34	8.50	000	S
52335		A	Endoscopy of urinary tract	5.86	4.69	0.45	11.00	000	S
52336		A	Cystoscopy, stone removal	6.88	*8.81	0.99	16.68	000	S
52337		A	Cystoscopy, stone removal	7.97	*10.21	1.08	19.26	000	S
52338		A	Cystoscopy and treatment	7.34	5.92	0.57	13.83	000	S
52339		A	Cystoscopy and treatment	8.82	5.92	0.57	15.31	000	S
52340		A	Cystoscopy and treatment	7.76	5.15	0.50	13.41	090	S
52450		A	Incision of prostate	7.05	4.99	0.49	12.53	090	S
52500		A	Revision of bladder neck	7.82	7.44	0.72	15.98	090	S
52510		A	Dilation prostatic urethra	6.04	7.64	0.74	14.42	090	S
52601		A	Prostatectomy (TURP)	11.51	11.87	1.16	24.54	090	S
52606		A	Control postop bleeding	7.51	3.32	0.33	11.16	090	S
52612		A	Prostatectomy, first stage	7.05	*9.03	0.99	17.07	090	S
52614		A	Prostatectomy, second stage	6.04	7.09	0.68	13.81	090	S
52620		A	Remove residual prostate	6.04	5.33	0.51	11.88	090	S
52630		A	Remove prostate regrowth	6.55	*8.38	1.13	16.06	090	S
52640		A	Relieve bladder contracture	6.04	6.43	0.62	13.09	090	S
52647		A	Laser surgery of prostate	9.84	11.87	1.16	22.87	090	S
52648		A	Laser surgery of prostate	10.69	11.87	1.16	23.72	090	S
52700		A	Drainage of prostate abscess	6.31	3.30	0.34	9.95	090	S
53000		A	Incision of urethra	2.01	1.76	0.17	3.94	010	S
53010		A	Incision of urethra	3.02	3.52	0.37	6.91	090	S
53020		A	Incision of urethra	1.77	0.82	0.09	2.68	000	S
53025		A	Incision of urethra	1.13	0.80	0.08	2.01	000	S
53040		A	Drainage of urethra abscess	6.01	1.85	0.19	8.05	090	S
53060		A	Drainage of urethra abscess	2.58	0.51	0.07	3.16	010	S
53080		A	Drainage of urinary leakage	5.87	3.98	0.45	10.30	090	S
53085		A	Drainage of urinary leakage	9.67	6.75	0.70	17.12	090	S
53200		A	Biopsy of urethra	2.59	1.10	0.12	3.81	000	S
53210		A	Removal of urethra	11.71	6.64	0.67	19.02	090	S
53215		A	Removal of urethra	14.59	10.00	0.96	25.55	090	S
53220		A	Treatment of urethra lesion	6.58	4.77	0.49	11.84	090	S
53230		A	Removal of urethra lesion	9.04	7.93	0.79	17.76	090	S
53235		A	Removal of urethra lesion	9.60	5.02	0.49	15.11	090	N
53240		A	Surgery for urethra pouch	6.03	4.33	0.45	10.81	090	S
53250		A	Removal of urethra gland	5.69	4.05	0.40	10.14	090	S
53260		A	Treatment of urethra lesion	2.93	1.12	0.16	4.21	010	S
53265		A	Treatment of urethra lesion	3.07	1.88	0.22	5.17	010	S
53270		A	Removal of urethra gland	2.93	0.84	0.18	3.95	010	S
53275		A	Repair of urethra defect	4.37	2.37	0.25	6.99	010	S
53400		A	Revise urethra, 1st stage	11.79	7.47	0.76	20.02	090	S
53405		A	Revise urethra, 2nd stage	13.70	10.38	1.21	25.29	090	S
53410		A	Reconstruction of urethra	15.59	8.56	0.84	24.99	090	S
53415		A	Reconstruction of urethra	18.50	11.87	1.15	31.52	090	S
53420		A	Reconstruct urethra, stage 1	13.28	10.88	1.05	25.21	090	S
53425		A	Reconstruct urethra, stage 2	15.18	9.25	0.88	25.31	090	S
53430		A	Reconstruction of urethra	15.54	7.16	0.76	23.46	090	S
53440		A	Correct bladder function	11.49	13.14	1.39	26.02	090	S
53442		A	Remove perineal prosthesis	7.67	5.84	0.67	14.18	090	S
53443		A	Reconstruction of urethra	18.98	10.03	1.07	30.08	090	S
53445		A	Correct urine flow control	13.15	*16.83	2.03	32.01	090	S
53447		A	Remove artificial sphincter	12.37	9.16	0.89	22.42	090	S
53449		A	Correct artificial sphincter	9.16	8.41	0.82	18.39	090	S
53450		A	Revision of urethra	5.72	2.74	0.27	8.73	090	S
53460		A	Revision of urethra	6.70	2.44	0.25	9.39	090	S
53502		A	Repair of urethra injury	7.21	4.97	0.56	12.74	090	S
53505		A	Repair of urethra injury	7.21	5.18	0.51	12.90	090	S
53510		A	Repair of urethra injury	9.57	6.98	0.66	17.21	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
53515		A	Repair of urethra injury	12.71	9.03	0.88	22.62	090	S
53520		A	Repair of urethra defect	8.21	5.89	0.56	14.66	090	S
53600		A	Dilate urethra stricture	1.21	0.33	0.03	1.57	000	S
53601		A	Dilate urethra stricture	0.98	0.29	0.03	1.30	000	S
53605		A	Dilate urethra stricture	1.28	0.46	0.05	1.79	000	S
53620		A	Dilate urethra stricture	1.62	0.47	0.05	2.14	000	S
53621		A	Dilate urethra stricture	1.35	0.38	0.04	1.77	000	S
53640		A	Relieve bladder retention	1.59	0.57	0.06	2.22	000	S
53660		A	Dilation of urethra	0.71	0.28	0.03	1.02	000	S
53661		A	Dilation of urethra	0.72	0.25	0.03	1.00	000	S
53665		A	Dilation of urethra	0.76	0.36	0.04	1.16	000	S
53670		A	Insert urinary catheter	0.50	0.22	0.02	0.74	000	S
53675		A	Insert urinary catheter	1.47	0.47	0.05	1.99	000	S
53899		C	Urology surgery procedure	0.00	0.00	0.00	0.00	YYY	S
54000		A	Slitting of prepuce	1.49	0.63	0.07	2.19	010	S
54001		A	Slitting of prepuce	2.14	0.84	0.09	3.07	010	S
54015		A	Drain penis lesion	5.16	0.83	0.09	6.08	010	S
54050		A	Destruction, penis lesion(s)	1.19	0.38	0.03	1.60	010	S
54055		A	Destruction, penis lesion(s)	1.19	0.61	0.06	1.86	010	S
54056		A	Cryosurgery, penis lesion(s)	1.19	0.53	0.04	1.76	010	S
54057		A	Laser surg, penis lesion(s)	1.19	*1.52	0.21	2.92	010	S
54060		A	Excision of penis lesion(s)	1.88	1.17	0.12	3.17	010	S
54065		A	Destruction, penis lesion(s)	2.37	2.47	0.25	5.09	010	S
54100		A	Biopsy of penis	1.90	0.65	0.07	2.62	000	S
54105		A	Biopsy of penis	3.45	1.01	0.11	4.57	010	S
54110		A	Treatment of penis lesion	9.66	6.03	0.61	16.30	090	S
54111		A	Treat penis lesion, graft	13.03	9.18	0.97	23.18	090	S
54112		A	Treat penis lesion, graft	15.14	10.84	1.14	27.12	090	S
54115		A	Treatment of penis lesion	5.68	4.18	0.44	10.30	090	S
54120		A	Partial removal of penis	9.24	6.47	0.62	16.33	090	S
54125		A	Removal of penis	12.80	11.56	1.17	25.53	090	S
54130		A	Remove penis & nodes	18.92	14.66	1.32	34.90	090	S
54135		A	Remove penis & nodes	25.01	17.75	1.74	44.50	090	S
54150		A	Circumcision	1.78	0.54	0.05	2.37	010	S
54152		A	Circumcision	2.26	1.82	0.20	4.28	010	S
54160		A	Circumcision	2.43	1.66	0.21	4.30	010	S
54161		A	Circumcision	3.22	2.17	0.23	5.62	010	S
54200		A	Treatment of penis lesion	1.01	0.32	0.03	1.36	010	S
54205		A	Treatment of penis lesion	7.20	5.11	0.50	12.81	090	S
54220		A	Treatment of penis lesion	2.42	1.58	0.17	4.17	000	S
54230		A	Prepare penis study	1.34	1.34	0.13	2.81	000	S
54231		A	Dynamic cavernosometry	2.04	1.44	0.14	3.62	000	S
54235		A	Penile injection	1.19	0.43	0.04	1.66	000	S
54240		A	Penis study	1.31	0.99	0.12	2.42	000	S
54240	26	A	Penis study	1.31	0.51	0.06	1.88	000	S
54240	TC	A	Penis study	0.00	0.48	0.06	0.54	000	S
54250		A	Penis study	2.22	0.80	0.08	3.10	000	S
54250	26	A	Penis study	2.22	0.50	0.05	2.77	000	S
54250	TC	A	Penis study	0.00	0.30	0.03	0.33	000	S
54300		A	Revision of penis	10.05	6.88	0.87	17.80	090	S
54304		A	Revision of penis	12.13	8.66	0.90	21.69	090	S
54308		A	Reconstruction of urethra	11.58	5.84	0.74	18.16	090	S
54312		A	Reconstruction of urethra	13.16	9.37	0.91	23.44	090	S
54316		A	Reconstruction of urethra	15.97	11.34	1.12	28.43	090	S
54318		A	Reconstruction of urethra	10.47	7.53	1.11	19.11	090	S
54322		A	Reconstruction of urethra	12.34	7.61	0.74	20.69	090	S
54324		A	Reconstruction of urethra	15.46	10.98	1.08	27.52	090	S
54326		A	Reconstruction of urethra	14.81	10.51	1.03	26.35	090	S
54328		A	Revise penis, urethra	14.80	10.72	1.24	26.76	090	S
54332		A	Revise penis, urethra	16.17	12.52	1.13	29.82	090	S
54336		A	Revise penis, urethra	18.95	18.79	1.40	39.14	090	S
54340		A	Secondary urethral surgery	8.55	6.07	0.59	15.21	090	S
54344		A	Secondary urethral surgery	15.22	16.61	1.10	32.93	090	S
54348		A	Secondary urethral surgery	16.37	11.62	1.14	29.13	090	S
54352		A	Reconstruct urethra, penis	23.84	16.18	1.49	41.51	090	S
54360		A	Penis plastic surgery	11.39	7.02	0.73	19.14	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
54380		A	Repair penis	12.59	9.42	0.75	22.76	090	S
54385		A	Repair penis	14.75	10.46	0.89	26.10	090	S
54390		A	Repair penis and bladder	20.97	13.57	1.58	36.12	090	S
54400		A	Insert semi-rigid prosthesis	8.58	*10.99	1.27	20.84	090	S
54401		A	Insert self-contd prosthesis	9.67	*12.38	1.73	23.78	090	S
54402		A	Remove penis prosthesis	8.67	6.00	0.58	15.25	090	S
54405		A	Insert multi-comp prosthesis	12.63	*16.17	2.10	30.90	090	S
54407		A	Remove multi-comp prosthesis	12.61	11.22	1.10	24.93	090	S
54409		A	Revise penis prosthesis	11.53	8.97	0.87	21.37	090	S
54420		A	Revision of penis	10.75	7.74	0.87	19.36	090	S
54430		A	Revision of penis	9.55	6.99	0.69	17.23	090	S
54435		A	Revision of penis	5.63	4.15	0.39	10.17	090	S
54440		C	Repair of penis	0.00	0.00	0.00	0.00	090	S
54450		A	Preputial stretching	1.12	0.68	0.07	1.87	000	S
54500		A	Biopsy of testis	1.31	0.44	0.05	1.80	000	S
54505		A	Biopsy of testis	3.41	1.86	0.22	5.49	010	S
54510		A	Removal of testis lesion	5.24	3.03	0.38	8.65	090	S
54520		A	Removal of testis	4.93	5.31	0.52	10.76	090	S
54530		A	Removal of testis	8.04	7.32	0.77	16.13	090	S
54535		A	Extensive testis surgery	11.43	8.54	1.02	20.99	090	S
54550		A	Exploration for testis	7.36	5.25	0.61	13.22	090	S
54560		A	Exploration for testis	10.46	7.23	0.81	18.50	090	S
54600		A	Reduce testis torsion	6.59	4.62	0.48	11.69	090	S
54620		A	Suspension of testis	4.69	3.32	0.33	8.34	010	S
54640		A	Suspension of testis	6.55	7.82	0.91	15.28	090	S
54650		A	Orchiopexy (Fowler-Stephens)	10.93	7.82	0.91	19.66	090	S
54660		A	Revision of testis	4.80	3.40	0.34	8.54	090	S
54670		A	Repair testis injury	6.06	4.30	0.43	10.79	090	S
54680		A	Relocation of testis(es)	11.53	8.19	0.80	20.52	090	S
54700		A	Drainage of scrotum	3.38	0.90	0.11	4.39	010	S
54800		A	Biopsy of epididymis	2.33	1.97	0.19	4.49	000	S
54820		A	Exploration of epididymis	4.72	2.62	0.29	7.63	090	S
54830		A	Remove epididymis lesion	5.07	3.51	0.39	8.97	090	S
54840		A	Remove epididymis lesion	5.01	4.84	0.48	10.33	090	S
54860		A	Removal of epididymis	6.01	5.17	0.50	11.68	090	S
54861		A	Removal of epididymis	8.54	7.30	0.72	16.56	090	S
54900		A	Fusion of spermatic ducts	12.61	8.95	0.87	22.43	090	S
54901		A	Fusion of spermatic ducts	17.30	12.29	1.20	30.79	090	S
55000		A	Drainage of hydrocele	1.43	0.40	0.04	1.87	000	S
55040		A	Removal of hydrocele	5.15	4.88	0.55	10.58	090	S
55041		A	Removal of hydroceles	7.38	7.47	0.81	15.66	090	S
55060		A	Repair of hydrocele	5.21	4.13	0.50	9.84	090	S
55100		A	Drainage of scrotum abscess	2.03	0.63	0.07	2.73	010	S
55110		A	Explore scrotum	5.28	3.48	0.37	9.13	090	S
55120		A	Removal of scrotum lesion	4.78	1.79	0.21	6.78	090	S
55150		A	Removal of scrotum	6.62	5.45	0.57	12.64	090	S
55175		A	Revision of scrotum	4.93	4.49	0.48	9.90	090	S
55180		A	Revision of scrotum	10.07	6.83	0.82	17.72	090	S
55200		A	Incision of sperm duct	4.14	1.97	0.20	6.31	090	S
55250		A	Removal of sperm duct(s)	3.21	2.63	0.28	6.12	090	S
55300		A	Preparation, sperm duct x-ray	3.51	2.71	0.27	6.49	000	S
55400		A	Repair of sperm duct	8.25	6.56	0.62	15.43	090	S
55450		A	Ligation of sperm duct	3.91	2.61	0.32	6.84	010	S
55500		A	Removal of hydrocele	5.28	4.32	0.50	10.10	090	S
55520		A	Removal of sperm cord lesion	5.72	3.12	0.51	9.35	090	S
55530		A	Revise spermatic cord veins	5.45	5.20	0.60	11.25	090	S
55535		A	Revise spermatic cord veins	6.25	4.40	0.45	11.10	090	S
55540		A	Revise hernia & sperm veins	7.25	4.54	0.91	12.70	090	S
55600		A	Incise sperm duct pouch	6.07	4.31	0.55	10.93	090	S
55605		A	Incise sperm duct pouch	7.60	5.60	0.59	13.79	090	S
55650		A	Remove sperm duct pouch	11.26	7.22	0.76	19.24	090	S
55680		A	Remove sperm pouch lesion	4.82	4.43	0.38	9.63	090	S
55700		A	Biopsy of prostate	1.57	1.50	0.15	3.22	000	S
55705		A	Biopsy of prostate	4.41	3.37	0.34	8.12	010	S
55720		A	Drainage of prostate abscess	7.54	3.51	0.37	11.42	090	S
55725		A	Drainage of prostate abscess	7.70	5.62	0.54	13.86	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
55801		A	Removal of prostate	16.25	12.76	1.44	30.45	090	S
55810		A	Extensive prostate surgery	21.21	17.88	1.77	40.86	090	S
55812		A	Extensive prostate surgery	25.65	17.68	1.94	45.27	090	S
55815		A	Extensive prostate surgery	28.47	25.20	2.42	56.09	090	S
55821		A	Removal of prostate	13.00	13.59	1.35	27.94	090	S
55831		A	Removal of prostate	14.30	14.56	1.44	30.30	090	S
55840		A	Extensive prostate surgery	21.21	16.60	1.61	39.42	090	S
55842		A	Extensive prostate surgery	22.70	19.16	1.88	43.74	090	S
55845		A	Extensive prostate surgery	26.73	25.10	2.44	54.27	090	S
55859		A	Percut/needle insert, pros	8.29	5.89	0.58	14.76	090	S
55860		A	Surgical exposure, prostate	13.33	7.13	0.70	21.16	090	S
55862		A	Extensive prostate surgery	17.09	11.69	1.20	29.98	090	S
55865		A	Extensive prostate surgery	21.65	24.52	2.39	48.56	090	S
55870		A	Electroejaculation	2.58	1.83	0.18	4.59	000	N
55899		C	Genital surgery procedure	0.00	0.00	0.00	0.00	YYY	S
55970		N	Sex transformation, M to F	0.00	0.00	0.00	0.00	XXX	0
55980		N	Sex transformation, F to M	0.00	0.00	0.00	0.00	XXX	0
56300		A	Pelvis laparoscopy, dx	3.58	*4.58	1.03	9.19	010	S
56301		A	Laparoscopy; tubal cautery	3.68	*4.71	1.28	9.67	010	S
56302		A	Laparoscopy; tubal block	4.11	*5.26	1.32	10.69	010	S
56303		A	Laparoscopy; excise lesions	5.69	5.53	1.16	12.38	010	S
56304		A	Laparoscopy; lysis	4.37	*5.60	1.20	11.17	010	S
56305		A	Pelvic laparoscopy; biopsy	3.80	*4.87	0.95	9.62	010	S
56306		A	Laparoscopy; aspiration	3.80	*4.87	1.18	9.85	010	S
56307		A	Laparoscopy; remove adnexa	5.60	*7.16	1.60	14.36	010	S
56308		A	Laparoscopy; hysterectomy	13.87	9.39	2.07	25.33	010	S
56309		A	Laparoscopy; remove myoma	5.60	4.76	1.03	11.39	010	S
56311		A	Laparoscopic lymph node biop	8.93	6.38	1.47	16.78	010	S
56312		A	Laparoscopic lymphadenectomy	12.06	8.56	0.84	21.46	010	S
56313		A	Laparoscopic lymphadenectomy	14.00	10.01	2.31	26.32	010	S
56315		A	Laparoscopic appendectomy	6.06	4.89	1.01	11.96	090	S
56316		A	Laparoscopic hernia repair	6.17	4.51	0.94	11.62	090	S
56317		A	Laparoscopic hernia repair	7.87	5.22	1.11	14.20	090	S
56320		A	Laparoscopy, spermatic veins	6.25	4.40	0.45	11.10	090	S
56322		A	Laparoscopy, vagus nerves	9.70	5.07	1.18	15.95	090	S
56323		A	Laparoscopy, vagus nerves	11.65	6.09	1.41	19.15	090	S
56324		A	Laparoscopy, cholecystoenter	11.90	9.16	1.93	22.99	090	S
56340		A	Laparoscopic cholecystectomy	10.68	7.99	1.74	20.41	090	S
56341		A	Laparoscopic cholecystectomy	11.53	8.43	1.84	21.80	090	S
56342		A	Laparoscopic cholecystectomy	13.86	9.37	2.00	25.23	090	S
56343		A	Laparoscopic salpingostomy	6.96	5.28	1.11	13.35	090	S
56344		A	Laparoscopic fimbrioplasty	7.16	5.11	1.19	13.46	090	S
56350		A	Hysteroscopy; diagnostic	2.39	1.99	0.44	4.82	000	S
56351		A	Hysteroscopy; biopsy	2.85	1.99	0.44	5.28	000	S
56352		A	Hysteroscopy; lysis	3.14	3.77	0.85	7.76	000	S
56353		A	Hysteroscopy; resect septum	3.51	3.77	0.85	8.13	000	S
56354		A	Hysteroscopy; remove myoma	3.85	*4.93	1.30	10.08	000	S
56355		A	Hysteroscopy; remove impact	3.09	1.99	0.44	5.52	000	S
56356		A	Hysteroscopy; ablation	3.43	*4.39	1.49	9.31	000	S
56360		A	Peritoneoscopy	4.04	3.80	0.43	8.27	000	S
56361		A	Peritoneoscopy w/biopsy	4.32	4.93	0.49	9.74	000	S
56362		A	Peritoneoscopy w/cholangio	4.89	2.77	0.19	7.85	000	S
56363		A	Peritoneoscopy w/biopsy	5.18	3.93	0.45	9.56	000	S
56399		C	Laparoscopy procedure	0.00	0.00	0.00	0.00	YYY	S
56405		A	I & D of vulva/perineum	1.39	0.76	0.15	2.30	010	S
56420		A	Drainage of gland abscess	1.34	0.80	0.13	2.27	010	S
56440		A	Surgery for vulva lesion	2.79	2.63	0.52	5.94	010	S
56441		A	Lysis of labial lesion(s)	1.92	1.65	0.30	3.87	010	S
56501		A	Destruction, vulva lesion(s)	1.48	0.54	0.11	2.13	010	S
56515		A	Destruction, vulva lesion(s)	1.85	*2.36	0.66	4.87	010	S
56605		A	Biopsy of vulva/perineum	0.86	0.68	0.15	1.69	000	S
56606		A	Biopsy of vulva/perineum	0.43	0.35	0.08	0.86	000	S
56620		A	Partial removal of vulva	6.67	6.47	1.40	14.54	090	S
56625		A	Complete removal of vulva	7.41	*9.52	2.13	19.06	090	S
56630		A	Extensive vulva surgery	10.47	*13.46	3.28	27.21	090	S
56631		A	Extensive vulva surgery	14.57	*18.70	4.51	37.78	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
56632		A	Extensive vulva surgery	18.66	*21.32	4.51	44.49	090	S
56633		A	Extensive vulva surgery	12.15	*15.97	3.28	31.40	090	S
56634		A	Extensive vulva surgery	16.25	*21.21	4.51	41.97	090	S
56637		A	Extensive vulva surgery	20.34	21.42	4.51	46.27	090	S
56640		A	Extensive vulva surgery	20.09	19.95	4.36	44.40	090	S
56700		A	Partial removal of hymen	2.42	1.82	0.35	4.59	010	S
56720		A	Incision of hymen	0.68	0.48	0.11	1.27	000	S
56740		A	Remove vagina gland lesion	3.60	2.87	0.55	7.02	010	S
56800		A	Repair of vagina	3.73	2.92	0.57	7.22	010	S
56805		A	Repair clitoris	15.49	11.75	1.37	28.61	090	S
56810		A	Repair of perineum	3.97	2.62	0.51	7.10	010	S
57000		A	Exploration of vagina	2.92	2.03	0.35	5.30	010	S
57010		A	Drainage of pelvic abscess	5.41	2.65	0.51	8.57	090	S
57020		A	Drainage of pelvic fluid	1.50	0.65	0.14	2.29	000	S
57061		A	Destruction vagina lesion(s)	1.20	0.82	0.17	2.19	010	S
57065		A	Destruction vagina lesion(s)	2.56	*3.28	0.74	6.58	010	S
57100		A	Biopsy of vagina	0.97	0.62	0.13	1.72	000	S
57105		A	Biopsy of vagina	1.64	1.57	0.33	3.54	010	S
57108		A	Partial removal of vagina	5.69	5.28	1.10	12.07	090	S
57110		A	Removal of vagina	13.48	7.88	1.76	23.12	090	S
57120		A	Closure of vagina	6.73	6.99	1.51	15.23	090	S
57130		A	Remove vagina lesion	2.40	2.62	0.55	5.57	010	S
57135		A	Remove vagina lesion	2.64	1.93	0.38	4.95	010	S
57150		A	Treat vagina infection	0.94	0.19	0.04	1.17	000	S
57160		A	Insertion of pessary	0.89	0.25	0.05	1.19	000	S
57170		A	Fitting of diaphragm/cap	0.91	0.32	0.06	1.29	000	S
57180		A	Treat vaginal bleeding	1.53	0.55	0.11	2.19	010	S
57200		A	Repair of vagina	3.68	2.71	0.60	6.99	090	S
57210		A	Repair vagina/perineum	4.73	3.27	0.65	8.65	090	S
57220		A	Revision of urethra	3.87	4.44	0.80	9.11	090	S
57230		A	Repair of urethral lesion	5.07	3.84	0.64	9.55	090	S
57240		A	Repair bladder & vagina	5.39	*6.90	1.60	13.89	090	S
57250		A	Repair rectum & vagina	4.96	*6.36	1.69	13.01	090	S
57260		A	Repair of vagina	7.59	8.65	1.88	18.12	090	S
57265		A	Extensive repair of vagina	7.36	*9.42	2.11	18.89	090	S
57268		A	Repair of bowel bulge	6.14	7.02	1.50	14.66	090	S
57270		A	Repair of bowel pouch	7.36	6.83	1.44	15.63	090	S
57280		A	Suspension of vagina	8.35	8.53	1.85	18.73	090	S
57282		A	Repair of vaginal prolapse	8.06	8.72	1.89	18.67	090	S
57284		A	Repair paravaginal defect	12.10	8.59	0.84	21.53	090	S
57288		A	Repair bladder defect	12.34	10.72	1.36	24.42	090	S
57289		A	Repair bladder & vagina	6.40	*8.19	1.13	15.72	090	S
57291		A	Construction of vagina	7.46	5.35	1.19	14.00	090	S
57292		A	Construct vagina with graft	12.34	6.55	1.38	20.27	090	S
57300		A	Repair rectum-vagina fistula	6.81	7.91	1.66	16.38	090	S
57305		A	Repair rectum-vagina fistula	8.69	7.55	1.56	17.80	090	S
57307		A	Fistula repair & colostomy	10.05	6.11	1.28	17.44	090	S
57310		A	Repair urethrovaginal lesion	6.10	4.32	0.48	10.90	090	S
57311		A	Repair urethrovaginal lesion	7.23	5.58	0.41	13.22	090	S
57320		A	Repair bladder-vagina lesion	7.33	*9.38	1.35	18.06	090	S
57330		A	Repair bladder-vagina lesion	11.67	8.29	0.81	20.77	090	S
57335		A	Repair vagina	9.11	6.91	0.81	16.83	090	S
57400		A	Dilation of vagina	0.83	0.33	0.06	1.22	000	S
57410		A	Pelvic examination	0.59	0.36	0.05	1.00	000	S
57415		A	Removal vaginal foreign body	0.91	0.36	0.05	1.32	010	S
57452		A	Examination of vagina	0.99	0.65	0.14	1.78	000	S
57454		A	Vagina examination & biopsy	1.27	1.21	0.26	2.74	000	S
57460		A	Cervix excision	2.83	2.02	0.46	5.31	000	S
57500		A	Biopsy of cervix	0.97	0.57	0.12	1.66	000	S
57505		A	Endocervical curettage	1.09	0.63	0.13	1.85	010	S
57510		A	Cauterization of cervix	1.85	0.52	0.09	2.46	010	S
57511		A	Cryocautery of cervix	1.85	0.85	0.17	2.87	010	S
57513		A	Laser surgery of cervix	1.85	*2.36	0.67	4.88	010	S
57520		A	Conization of cervix	3.96	3.45	0.73	8.14	090	S
57522		A	Conization of cervix	3.26	3.45	0.73	7.44	090	S
57530		A	Removal of cervix	4.42	3.61	0.78	8.81	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
57540		A	Removal of residual cervix	6.01	6.74	1.51	14.26	090	S
57545		A	Remove cervix, repair pelvis	6.63	4.58	1.03	12.24	090	S
57550		A	Removal of residual cervix	4.91	*6.28	1.54	12.73	090	S
57555		A	Remove cervix, repair vagina	8.14	10.10	2.17	20.41	090	S
57556		A	Remove cervix, repair bowel	7.56	9.44	1.92	18.92	090	S
57700		A	Revision of cervix	3.30	2.39	0.34	6.03	090	S
57720		A	Revision of cervix	3.87	2.76	0.50	7.13	090	S
57800		A	Dilation of cervical canal	0.77	0.48	0.10	1.35	000	S
57820		A	D&C of residual cervix	1.62	*2.08	0.46	4.16	010	S
58100		A	Biopsy of uterus lining	0.71	0.66	0.14	1.51	000	S
58120		A	Dilation and curettage (D&C)	2.45	2.70	0.56	5.71	010	S
58140		A	Removal of uterus lesion	7.61	8.33	1.71	17.65	090	S
58145		A	Removal of uterus lesion	7.36	8.24	1.54	17.14	090	S
58150		A	Total hysterectomy	13.00	9.57	2.08	24.65	090	S
58152		A	Total hysterectomy	14.10	11.99	2.59	28.68	090	S
58180		A	Partial hysterectomy	9.06	9.76	2.11	20.93	090	S
58200		A	Extensive hysterectomy	20.34	12.98	2.80	36.12	090	S
58210		A	Extensive hysterectomy	23.97	17.77	3.87	45.61	090	S
58240		A	Removal of pelvis contents	28.79	28.73	6.15	63.67	090	S
58260		A	Vaginal hysterectomy	11.39	9.39	2.07	22.85	090	S
58262		A	Vaginal hysterectomy	13.06	9.39	2.07	24.52	090	S
58263		A	Vaginal hysterectomy	14.27	10.32	2.22	26.81	090	S
58267		A	Hysterectomy & vagina repair	13.94	11.53	2.46	27.93	090	S
58270		A	Hysterectomy & vagina repair	12.60	10.32	2.22	25.14	090	S
58275		A	Hysterectomy, revise vagina	13.99	11.02	2.32	27.33	090	S
58280		A	Hysterectomy, revise vagina	14.35	10.50	2.30	27.15	090	S
58285		A	Extensive hysterectomy	17.45	11.60	2.70	31.75	090	S
58300		N	Insert intrauterine device	#1.01	0.77	0.13	1.91	XXX	0
58301		A	Remove intrauterine device	0.73	0.45	0.08	1.26	000	S
58321		A	Artificial insemination	0.92	0.71	0.15	1.78	000	S
58322		A	Artificial insemination	1.10	0.71	0.15	1.96	000	S
58323		A	Sperm washing	0.23	0.16	0.04	0.43	000	S
58340		A	Inject for uterus/tube x-ray	0.88	0.57	0.08	1.53	000	S
58345		A	Reopen fallopian tube	4.61	3.49	0.41	8.51	010	S
58350		A	Reopen fallopian tube	0.96	0.69	0.16	1.81	010	S
58400		A	Suspension of uterus	5.66	5.64	1.16	12.46	090	S
58410		A	Suspension of uterus	6.78	5.53	0.84	13.15	090	S
58520		A	Repair of ruptured uterus	6.35	4.24	0.99	11.58	090	S
58540		A	Revision of uterus	8.58	6.13	1.42	16.13	090	S
58600		A	Division of fallopian tube	3.74	*4.79	1.38	9.91	090	S
58605		A	Division of fallopian tube	3.29	*4.21	1.01	8.51	090	S
58611		A	Ligate oviduct(s)	0.63	0.47	0.10	1.20	ZZZ	S
58615		A	Occlude fallopian tube(s)	3.85	2.91	0.35	7.11	010	S
58700		A	Removal of fallopian tube	5.92	6.33	1.31	13.56	090	S
58720		A	Removal of ovary/tube(s)	6.20	7.50	1.63	15.33	090	S
58740		A	Revise fallopian tube(s)	5.28	*6.76	1.88	13.92	090	S
58750		A	Repair oviduct	8.82	6.31	1.46	16.59	090	S
58752		A	Revise ovarian tube(s)	7.94	6.74	0.93	15.61	090	S
58760		A	Remove tubal obstruction	7.16	5.11	1.19	13.46	090	S
58770		A	Create new tubal opening	6.96	5.28	1.11	13.35	090	S
58800		A	Drainage of ovarian cyst(s)	3.77	2.68	0.53	6.98	090	S
58805		A	Drainage of ovarian cyst(s)	5.44	6.38	1.36	13.18	090	S
58820		A	Drainage of ovarian abscess	3.96	2.76	0.49	7.21	090	S
58822		A	Drainage of ovarian abscess	6.18	3.55	0.81	10.54	090	S
58825		A	Transposition, ovary(s)	5.63	4.03	0.93	10.59	090	S
58900		A	Biopsy of ovary(s)	5.49	5.19	1.07	11.75	090	S
58920		A	Partial removal of ovary(s)	6.28	6.78	1.41	14.47	090	S
58925		A	Removal of ovarian cyst(s)	6.40	6.56	1.38	14.34	090	S
58940		A	Removal of ovary(s)	6.54	6.49	1.33	14.36	090	S
58943		A	Removal of ovary(s)	17.49	12.11	2.63	32.23	090	S
58950		A	Resect ovarian malignancy	14.10	11.24	2.38	27.72	090	S
58951		A	Resect ovarian malignancy	20.34	18.34	3.93	42.61	090	S
58952		A	Resect ovarian malignancy	21.35	18.11	3.92	43.38	090	S
58960		A	Exploration of abdomen	10.14	*12.98	2.95	26.07	090	S
58970		A	Retrieval of oocyte	3.53	2.52	0.58	6.63	000	N
58972		D	Fertilization of oocyte	0.00	0.00	0.00	0.00	000	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
58974		C	Transfer of embryo	0.00	0.00	0.00	0.00	000	N
58976		A	Transfer of embryo	3.83	2.73	0.63	7.19	000	N
58999		C	Genital surgery procedure	0.00	0.00	0.00	0.00	YYY	S
59000		A	Amniocentesis	1.30	0.97	0.18	2.45	000	S
59012		A	Fetal cord puncture, prenatal	3.45	2.62	0.31	6.38	000	S
59015		A	Chorion biopsy	2.20	1.20	0.10	3.50	000	S
59020		A	Fetal contract stress test	0.66	*1.35	0.29	2.30	000	S
59020	26	A	Fetal contract stress test	0.66	*0.85	0.19	1.70	000	S
59020	TC	A	Fetal contract stress test	0.00	0.50	0.10	0.60	000	S
59025		A	Fetal non-stress test	0.53	0.61	0.12	1.26	000	S
59025	26	A	Fetal non-stress test	0.53	0.39	0.08	1.00	000	S
59025	TC	A	Fetal non-stress test	0.00	0.22	0.04	0.26	000	S
59030		A	Fetal scalp blood sample	1.99	1.58	0.21	3.78	000	S
59050		A	Fetal monitor w/report	0.89	0.81	0.15	1.85	XXX	S
59051		A	Fetal monitor/interpret only	0.74	0.81	0.15	1.70	XXX	N
59100		A	Remove uterus lesion	5.96	4.14	0.96	11.06	090	S
59120		A	Treat ectopic pregnancy	7.11	7.86	1.50	16.47	090	S
59121		A	Treat ectopic pregnancy	6.99	5.38	1.07	13.44	090	S
59130		A	Treat ectopic pregnancy	7.88	5.96	0.70	14.54	090	S
59135		A	Treat ectopic pregnancy	13.00	9.85	1.15	24.00	090	S
59136		A	Treat ectopic pregnancy	8.69	6.22	1.44	16.35	090	S
59140		A	Treat ectopic pregnancy	5.09	4.66	0.29	10.04	090	S
59150		A	Treat ectopic pregnancy	6.34	4.53	1.05	11.92	090	S
59151		A	Treat ectopic pregnancy	7.24	8.61	0.64	16.49	090	S
59160		A	D&C after delivery	2.66	2.93	0.52	6.11	010	S
59200		A	Insert cervical dilator	0.79	0.54	0.11	1.44	000	S
59300		A	Episiotomy or vaginal repair	2.41	0.99	0.10	3.50	000	S
59320		A	Revision of cervix	2.48	1.78	0.41	4.67	000	S
59325		A	Revision of cervix	4.07	2.89	0.29	7.25	000	S
59350		A	Repair of uterus	4.95	3.54	0.82	9.31	000	S
59400		A	Obstetrical care	20.99	14.99	3.47	39.45	MMM	S
59409		A	Obstetrical care	13.28	9.48	2.20	24.96	MMM	S
59410		A	Obstetrical care	14.44	10.31	2.39	27.14	MMM	S
59412		A	Antepartum manipulation	1.71	1.22	0.29	3.22	MMM	S
59414		A	Deliver placenta	1.61	1.15	0.27	3.03	MMM	S
59425		A	Antepartum care only	4.04	2.88	0.66	7.58	MMM	S
59426		A	Antepartum care only	6.91	4.94	1.14	12.99	MMM	S
59430		A	Care after delivery	2.01	0.38	0.07	2.46	MMM	S
59510		A	Cesarean delivery	23.67	16.90	3.92	44.49	MMM	S
59514		A	Cesarean delivery only	15.39	10.99	2.55	28.93	MMM	S
59515		A	Cesarean delivery	16.55	11.82	2.73	31.10	MMM	S
59525		A	Remove uterus after cesarean	8.54	3.81	0.88	13.23	MMM	S
59610		A	Vbac delivery	22.55	14.99	3.47	41.01	MMM	S
59612		A	Vbac delivery only	14.84	9.48	2.20	26.52	MMM	S
59614		A	Vbac care after delivery	15.96	10.31	2.39	28.66	MMM	S
59618		A	Attempted vbac delivery	25.23	16.90	3.92	46.05	MMM	S
59620		A	Attempted vbac delivery only	16.95	10.99	2.55	30.49	MMM	S
59622		A	Attempted vbac after care	18.11	11.82	2.73	32.66	MMM	S
59812		A	Treatment of miscarriage	3.10	3.61	0.77	7.48	090	S
59820		A	Care of miscarriage	3.73	3.75	0.77	8.25	090	S
59821		A	Treatment of miscarriage	4.26	2.72	0.62	7.60	090	S
59830		A	Treat uterus infection	5.96	4.53	0.52	11.01	090	S
59840		A	Abortion	2.91	3.22	0.69	6.82	010	S
59841		A	Abortion	3.24	3.75	0.76	7.75	010	S
59850		A	Abortion	5.46	4.00	0.85	10.31	090	S
59851		A	Abortion	5.62	4.28	0.88	10.78	090	S
59852		A	Abortion	7.70	5.51	1.27	14.48	090	S
59855		A	Abortion	5.80	4.14	0.96	10.90	090	S
59856		A	Abortion	7.16	5.11	1.19	13.46	090	S
59857		A	Abortion	8.71	6.22	1.44	16.37	090	S
59870		A	Evacuate mole of uterus	4.08	2.91	0.67	7.66	090	S
59899		C	Maternity care procedure	0.00	0.00	0.00	0.00	YYY	S
60000		A	Drain thyroid/tongue cyst	1.71	0.60	0.09	2.40	010	N
60001		A	Aspirate/inject thyroid cyst	0.97	1.05	0.12	2.14	000	N
60100		A	Biopsy of thyroid	0.97	1.05	0.12	2.14	000	N
60200		A	Remove thyroid lesion	8.83	6.02	1.04	15.89	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
60210		A	Partial excision thyroid	10.51	8.68	1.65	20.84	090	S
60212		A	Parital thyroid excision	15.48	9.04	1.74	26.26	090	S
60220		A	Partial removal of thyroid	9.86	8.54	1.61	20.01	090	S
60225		A	Partial removal of thyroid	11.65	10.49	1.92	24.06	090	S
60240		A	Removal of thyroid	15.66	10.58	1.96	28.20	090	S
60252		A	Removal of thyroid	15.40	13.65	2.55	31.60	090	S
60254		A	Extensive thyroid surgery	16.68	19.21	3.08	38.97	090	S
60260		A	Repeat thyroid surgery	14.49	3.14	0.34	17.97	090	S
60270		A	Removal of thyroid	16.44	13.97	2.54	32.95	090	S
60271		A	Removal of thyroid	14.16	12.14	2.25	28.55	090	S
60280		A	Remove thyroid duct lesion	5.55	*7.10	1.11	13.76	090	S
60281		A	Remove thyroid duct lesion	8.00	5.04	0.95	13.99	090	S
60500		A	Explore parathyroid glands	15.40	11.36	2.31	29.07	090	S
60502		A	Re-explore parathyroids	19.25	11.39	2.33	32.97	090	S
60505		A	Explore parathyroid glands	19.93	13.14	2.56	35.63	090	S
60512		A	Autotransplant, parathyroid	4.45	2.32	0.54	7.31	ZZZ	S
60520		A	Removal of thymus gland	15.82	13.54	2.46	31.82	090	S
60521		A	Removal thymus gland	17.80	13.54	2.46	33.80	090	S
60522		A	Removal of thymus gland	21.76	13.54	2.46	37.76	090	S
60540		A	Explore adrenal gland	15.72	12.05	2.08	29.85	090	S
60545		A	Explore adrenal gland	18.51	14.27	2.34	35.12	090	S
60600		A	Remove carotid body lesion	16.13	11.46	1.88	29.47	090	S
60605		A	Remove carotid body lesion	18.20	10.71	2.21	31.12	090	S
60699		C	Endocrine surgery procedure	0.00	0.00	0.00	0.00	YYY	S
61000		A	Remove cranial cavity fluid	1.58	1.07	0.17	2.82	000	S
61001		A	Remove cranial cavity fluid	1.49	0.88	0.17	2.54	000	S
61020		A	Remove brain cavity fluid	1.51	1.26	0.20	2.97	000	S
61026		A	Injection into brain canal	1.69	2.03	0.22	3.94	000	N
61050		A	Remove brain canal fluid	1.51	1.23	0.15	2.89	000	N
61055		A	Injection into brain canal	2.10	1.88	0.19	4.17	000	N
61070		A	Brain canal shunt procedure	0.89	0.49	0.03	1.41	000	N
61105		A	Drill skull for examination	8.19	6.89	1.24	16.32	090	S
61106		A	Drill skull for exam/surgery	7.35	6.15	1.15	14.65	ZZZ	S
61107		A	Drill skull for implantation	4.35	*5.57	1.26	11.18	000	S
61108		A	Drill skull for drainage	10.80	12.05	2.22	25.07	090	S
61120		A	Pierce skull for examination	9.31	5.95	1.08	16.34	090	S
61130		A	Pierce skull, exam/surgery	6.37	4.95	0.96	12.28	ZZZ	S
61140		A	Pierce skull for biopsy	14.84	14.13	2.56	31.53	090	S
61150		A	Pierce skull for drainage	16.37	14.65	2.63	33.65	090	S
61151		A	Pierce skull for drainage	11.40	2.13	0.37	13.90	090	S
61154		A	Pierce skull, remove clot	13.67	*17.50	3.27	34.44	090	S
61156		A	Pierce skull for drainage	15.23	16.19	3.05	34.47	090	S
61210		A	Pierce skull; implant device	4.72	*6.04	1.53	12.29	000	S
61215		A	Insert brain-fluid device	10.05	9.00	1.63	20.68	090	S
61250		A	Pierce skull & explore	11.03	8.03	1.44	20.50	090	S
61253		A	Pierce skull & explore	13.00	9.62	1.69	24.31	090	S
61304		A	Open skull for exploration	20.63	26.03	4.78	51.44	090	S
61305		A	Open skull for exploration	24.77	29.11	5.05	58.93	090	S
61312		A	Open skull for drainage	20.54	24.13	4.46	49.13	090	S
61313		A	Open skull for drainage	20.54	24.04	4.38	48.96	090	S
61314		A	Open skull for drainage	22.78	25.62	4.68	53.08	090	S
61315		A	Open skull for drainage	25.91	24.41	4.47	54.79	090	S
61320		A	Open skull for drainage	23.90	18.70	3.41	46.01	090	S
61321		A	Open skull for drainage	26.66	19.83	3.54	50.03	090	S
61330		A	Decompress eye socket	15.65	12.97	1.22	29.84	090	S
61332		A	Explore/biopsy eye socket	26.08	20.72	2.76	49.56	090	S
61333		A	Explore orbit; remove lesion	26.75	20.46	3.26	50.47	090	S
61334		A	Explore orbit; remove object	17.07	14.65	1.82	33.54	090	S
61340		A	Relieve cranial pressure	11.56	*14.80	2.54	28.90	090	S
61343		A	Incise skull, pressure relief	27.87	30.05	5.28	63.20	090	S
61345		A	Relieve cranial pressure	25.36	19.18	3.45	47.99	090	S
61440		A	Incise skull for surgery	24.79	20.75	3.00	48.54	090	S
61450		A	Incise skull for surgery	24.29	20.43	3.43	48.15	090	S
61458		A	Incise skull for brain wound	25.97	27.28	4.87	58.12	090	S
61460		A	Incise skull for surgery	26.75	25.05	3.98	55.78	090	S
61470		A	Incise skull for surgery	20.79	13.86	2.53	37.18	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
61480		A	Incise skull for surgery	16.77	15.07	1.78	33.62	090	S
61490		A	Incise skull for surgery	15.63	11.72	2.16	29.51	090	S
61500		A	Removal of skull lesion	16.93	20.07	3.58	40.58	090	S
61501		A	Remove infected skull bone	13.59	*17.40	3.33	34.32	090	S
61510		A	Removal of brain lesion	23.39	27.04	4.90	55.33	090	S
61512		A	Remove brain lining lesion	24.26	29.02	5.28	58.56	090	S
61514		A	Removal of brain abscess	23.49	25.52	4.74	53.75	090	S
61516		A	Removal of brain lesion	22.84	26.48	4.57	53.89	090	S
61518		A	Removal of brain lesion	32.27	30.02	5.46	67.75	090	S
61519		A	Remove brain lining lesion	33.84	31.22	5.77	70.83	090	S
61520		A	Removal of brain lesion	38.35	33.85	5.89	78.09	090	S
61521		A	Removal of brain lesion	39.48	32.97	5.85	78.30	090	S
61522		A	Removal of brain abscess	27.55	19.96	3.79	51.30	090	S
61524		A	Removal of brain lesion	26.02	27.45	5.15	58.62	090	S
61526		A	Removal of brain lesion	29.71	34.01	4.79	68.51	090	S
61530		A	Removal of brain lesion	42.35	34.01	4.79	81.15	090	S
61531		A	Implant brain electrodes	20.50	14.98	1.75	37.23	090	S
61533		A	Implant brain electrodes	23.41	17.02	3.33	43.76	090	S
61534		A	Removal of brain lesion	19.13	6.38	2.01	27.52	090	S
61535		A	Remove brain electrodes	10.23	7.66	1.25	19.14	090	S
61536		A	Removal of brain lesion	29.43	21.96	3.99	55.38	090	S
61538		A	Removal of brain tissue	28.05	29.08	4.97	62.10	090	S
61539		A	Removal of brain tissue	30.05	22.96	4.07	57.08	090	S
61541		A	Incision of brain tissue	26.95	19.80	3.78	50.53	090	S
61542		A	Removal of brain tissue	27.39	19.91	3.90	51.20	090	S
61543		A	Removal of brain tissue	20.62	17.24	2.49	40.35	090	S
61544		A	Remove & treat brain lesion	23.71	28.19	2.11	54.01	090	S
61545		A	Excision of brain tumor	34.50	25.66	4.80	64.96	090	S
61546		A	Removal of pituitary gland	29.33	27.01	4.78	61.12	090	S
61548		A	Removal of pituitary gland	20.15	24.78	4.03	48.96	090	S
61550		A	Release of skull seams	14.24	11.81	1.11	27.16	090	S
61552		A	Release of skull seams	19.02	13.83	2.70	35.55	090	S
61556		A	Incise skull/sutures	21.35	15.53	3.04	39.92	090	S
61557		A	Incise skull/sutures	21.47	15.62	3.05	40.14	090	S
61558		A	Excision of skull/sutures	24.41	17.74	3.47	45.62	090	S
61559		A	Excision of skull/sutures	31.65	23.01	4.50	59.16	090	S
61563		A	Excision of skull tumor	25.87	18.81	3.68	48.36	090	S
61564		A	Excision of skull tumor	32.64	23.73	4.64	61.01	090	S
61570		A	Remove brain foreign body	22.89	16.49	3.06	42.44	090	S
61571		A	Incise skull for brain wound	24.55	18.32	3.21	46.08	090	S
61575		A	Skull base/brainstem surgery	32.33	32.99	5.05	70.37	090	S
61576		A	Skull base/brainstem surgery	33.82	28.23	3.91	65.96	090	S
61580		A	Craniofacial approach, skull	28.90	21.01	4.10	54.01	090	S
61581		A	Craniofacial approach, skull	32.80	23.84	4.66	61.30	090	S
61582		A	Craniofacial approach, skull	29.77	21.65	4.22	55.64	090	S
61583		A	Craniofacial approach, skull	33.97	24.70	4.83	63.50	090	S
61584		A	Orbitocranial approach/skull	32.89	23.91	4.68	61.48	090	S
61585		A	Orbitocranial approach/skull	36.80	26.75	5.23	68.78	090	S
61590		A	Infratemporal approach/skull	40.02	29.10	5.68	74.80	090	S
61591		A	Infratemporal approach/skull	41.97	30.52	5.96	78.45	090	S
61592		A	Orbitocranial approach/skull	38.07	27.68	5.41	71.16	090	S
61595		A	Transtemporal approach/skull	28.12	20.44	4.00	52.56	090	S
61596		A	Transcochlear approach/skull	34.17	24.84	4.86	63.87	090	S
61597		A	Transcondylar approach/skull	36.12	26.26	5.13	67.51	090	S
61598		A	Transpetrosal approach/skull	31.83	23.13	4.52	59.48	090	S
61600		A	Resect/excise cranial lesion	24.41	17.74	3.46	45.61	090	S
61601		A	Resect/excise cranial lesion	26.16	19.03	3.72	48.91	090	S
61605		A	Resect/excise cranial lesion	27.62	20.09	3.93	51.64	090	S
61606		A	Resect/excise cranial lesion	37.00	26.90	5.25	69.15	090	S
61607		A	Resect/excise cranial lesion	34.56	25.13	4.91	64.60	090	S
61608		A	Resect/excise cranial lesion	40.21	29.24	5.71	75.16	090	S
61609		A	Transect, artery, sinus	9.89	7.19	1.40	18.48	ZZZ	S
61610		A	Transect, artery, sinus	29.67	21.57	4.21	55.45	ZZZ	S
61611		A	Transect, artery, sinus	7.42	5.39	1.06	13.87	ZZZ	S
61612		A	Transect, artery, sinus	27.88	20.27	3.96	52.11	ZZZ	S
61613		A	Remove aneurysm, sinus	39.43	28.67	5.61	73.71	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
61615		A	Resect/excise lesion, skull	30.36	22.07	4.31	56.74	090	S
61616		A	Resect/excise lesion, skull	41.29	30.03	5.86	77.18	090	S
61618		A	Repair dura	15.62	11.35	2.22	29.19	090	S
61619		A	Repair dura	19.52	14.19	2.77	36.48	090	S
61624		A	Occlusion/embolization cath	20.15	15.28	1.79	37.22	000	N
61626		A	Occlusion/embolization cath	16.62	12.60	1.47	30.69	000	N
61680		A	Intracranial vessel surgery	36.45	31.06	5.79	73.30	090	S
61682		A	Intracranial vessel surgery	42.21	35.31	6.36	83.88	090	S
61684		A	Intracranial vessel surgery	39.25	29.76	3.47	72.48	090	S
61686		A	Intracranial vessel surgery	47.45	35.98	4.20	87.63	090	S
61690		A	Intracranial vessel surgery	33.82	27.46	4.09	65.37	090	S
61692		A	Intracranial vessel surgery	37.96	28.79	3.36	70.11	090	S
61700		A	Inner skull vessel surgery	34.83	31.69	5.67	72.19	090	S
61702		A	Inner skull vessel surgery	39.20	36.31	6.61	82.12	090	S
61703		A	Clamp neck artery	16.27	12.21	2.24	30.72	090	S
61705		A	Revise circulation to head	34.49	30.41	5.25	70.15	090	S
61708		A	Revise circulation to head	33.59	25.20	2.32	61.11	090	S
61710		A	Revise circulation to head	28.14	16.63	1.75	46.52	090	S
61711		A	Fusion of skull arteries	34.62	33.04	6.20	73.86	090	S
61712		A	Skull or spine microsurgery	3.49	*4.47	0.93	8.89	ZZZ	S
61720		A	Incise skull/brain surgery	15.85	*20.29	4.05	40.19	090	S
61735		A	Incise skull/brain surgery	17.08	12.96	1.51	31.55	090	S
61750		A	Incise skull; brain biopsy	10.03	*13.54	4.31	27.88	090	S
61751		A	Brain biopsy with cat scan	15.18	*19.43	4.44	39.05	090	S
61760		A	Implant brain electrodes	24.83	14.98	1.75	41.56	090	S
61770		A	Incise skull for treatment	15.14	*19.38	3.43	37.95	090	S
61790		A	Treat trigeminal nerve	10.31	*13.19	3.03	26.53	090	S
61791		A	Treat trigeminal tract	7.29	*9.77	3.16	20.22	090	S
61793		A	Focus radiation beam	16.70	21.35	1.96	40.01	090	S
61795		A	Brain surgery using computer	4.04	*5.24	1.55	10.83	000	S
61850		A	Implant neuroelectrodes	15.98	11.63	2.26	29.87	090	S
61855		A	Implant neuroelectrodes	12.94	10.39	1.47	24.80	090	S
61860		A	Implant neuroelectrodes	11.20	8.14	1.59	20.93	090	S
61865		A	Implant neuroelectrodes	21.70	15.78	3.09	40.57	090	S
61870		A	Implant neuroelectrodes	5.77	4.19	0.82	10.78	090	S
61875		A	Implant neuroelectrodes	9.20	6.69	1.31	17.20	090	S
61880		A	Revise/remove neuroelectrode	5.72	4.79	0.66	11.17	090	S
61885		A	Implant neuroreceiver	2.35	1.96	0.29	4.60	090	S
61888		A	Revise/remove neuroreceiver	3.10	2.25	0.44	5.79	010	S
62000		A	Repair of skull fracture	11.26	5.73	0.95	17.94	090	S
62005		A	Repair of skull fracture	14.84	11.08	1.97	27.89	090	S
62010		A	Treatment of head injury	18.43	19.20	3.39	41.02	090	S
62100		A	Repair brain fluid leakage	20.78	21.62	3.72	46.12	090	S
62115		A	Reduction of skull defect	20.50	15.51	1.82	37.83	090	S
62116		A	Reduction of skull defect	22.45	16.98	1.99	41.42	090	S
62117		A	Reduction of skull defect	25.38	19.20	2.25	46.83	090	S
62120		A	Repair skull cavity lesion	22.34	16.90	1.98	41.22	090	S
62121		A	Incise skull repair	20.25	17.51	3.41	41.17	090	S
62140		A	Repair of skull defect	12.63	13.43	2.39	28.45	090	S
62141		A	Repair of skull defect	13.90	17.73	3.28	34.91	090	S
62142		A	Remove skull plate/flap	9.91	*12.69	2.64	25.24	090	S
62143		A	Replace skull plate/flap	12.11	9.17	1.65	22.93	090	S
62145		A	Repair of skull & brain	17.68	13.16	2.29	33.13	090	S
62146		A	Repair of skull with graft	15.11	10.99	2.15	28.25	090	S
62147		A	Repair of skull with graft	18.14	13.17	2.57	33.88	090	S
62180		A	Establish brain cavity shunt	12.72	14.21	2.70	29.63	090	S
62190		A	Establish brain cavity shunt	10.13	*12.97	3.21	26.31	090	S
62192		A	Establish brain cavity shunt	11.31	*14.48	2.74	28.53	090	S
62194		A	Replace/irrigate catheter	2.81	1.88	0.29	4.98	010	N
62200		A	Establish brain cavity shunt	13.24	*16.95	3.09	33.28	090	S
62201		A	Establish brain cavity shunt	12.10	8.78	1.72	22.60	090	S
62220		A	Establish brain cavity shunt	12.06	*15.43	3.12	30.61	090	S
62223		A	Establish brain cavity shunt	12.81	*16.40	3.02	32.23	090	S
62225		A	Replace/irrigate catheter	4.71	4.80	0.58	10.09	090	S
62230		A	Replace/revise brain shunt	9.71	9.83	1.82	21.36	090	S
62256		A	Remove brain cavity shunt	5.90	6.38	1.17	13.45	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
62258		A	Replace brain cavity shunt	13.60	14.78	2.55	30.93	090	S
62268		A	Drain spinal cord cyst	3.87	2.98	0.36	7.21	000	N
62269		A	Needle biopsy spinal cord	4.07	1.75	0.28	6.10	000	N
62270		A	Spinal fluid tap, diagnostic	1.13	0.71	0.06	1.90	000	N
62272		A	Drain spinal fluid	1.35	1.01	0.12	2.48	000	N
62273		A	Treat lumbar spine lesion	2.15	1.12	0.26	3.53	000	N
62274		A	Inject spinal anesthetic	1.78	0.74	0.17	2.69	000	N
62275		A	Inject spinal anesthetic	1.79	0.59	0.19	2.57	000	N
62276		A	Inject spinal anesthetic	2.04	1.23	0.23	3.50	000	N
62277		A	Inject spinal anesthetic	2.15	0.84	0.23	3.22	000	N
62278		A	Inject spinal anesthetic	1.51	0.98	0.26	2.75	000	N
62279		A	Inject spinal anesthetic	1.58	0.82	0.24	2.64	000	N
62280		A	Treat spinal cord lesion	2.58	0.71	0.14	3.43	010	N
62281		A	Treat spinal cord lesion	2.61	0.87	0.28	3.76	010	N
62282		A	Treat spinal canal lesion	2.28	1.70	0.40	4.38	010	N
62284		A	Injection for myelogram	1.54	*1.98	0.34	3.86	000	S
62287		A	Percutaneous discectomy	4.13	*6.96	2.65	13.74	090	S
62288		A	Injection into spinal canal	1.74	1.12	0.24	3.10	000	N
62289		A	Injection into spinal canal	1.64	1.07	0.29	3.00	000	N
62290		A	Inject for spine disk x-ray	3.58	1.86	0.24	5.68	000	N
62291		A	Inject for spine disk x-ray	2.91	1.78	0.39	5.08	000	N
62292		A	Injection into disk lesion	7.00	*8.96	2.13	18.09	090	S
62294		A	Injection into spinal artery	8.05	5.84	0.68	14.57	090	S
62298		A	Injection into spinal canal	2.20	1.04	0.13	3.37	000	N
62350		A	Implant spinal catheter	6.25	3.49	1.02	10.76	090	S
62351		A	Implant spinal catheter	9.25	5.16	1.50	15.91	090	S
62355		A	Remove spinal canal catheter	4.80	3.49	0.68	8.97	090	S
62360		A	Insert spine infusion device	2.00	1.12	0.33	3.45	090	S
62361		A	Implant spine infusion pump	4.80	2.68	0.78	8.26	090	S
62362		A	Implant spine infusion pump	6.29	3.51	1.02	10.82	090	S
62365		A	Remove spine infusion device	4.77	3.47	0.68	8.92	090	S
62367		C	Analyze spine infusion pump	0.00	0.00	0.00	0.00	XXX	N
62367	26	A	Analyze spine infusion pump	0.48	0.35	0.07	0.90	XXX	N
62367	TC	C	Analyze spine infusion pump	0.00	0.00	0.00	0.00	XXX	N
62368		C	Analyze spine infusion pump	0.00	0.00	0.00	0.00	XXX	N
62368	26	A	Analyze spine infusion pump	0.75	0.55	0.11	1.41	XXX	N
62368	TC	C	Analyze spine infusion pump	0.00	0.00	0.00	0.00	XXX	N
63001		A	Removal of spinal lamina	14.50	*18.55	3.42	36.47	090	S
63003		A	Removal of spinal lamina	14.63	17.93	3.23	35.79	090	S
63005		A	Removal of spinal lamina	13.53	*17.32	3.10	33.95	090	S
63011		A	Removal of spinal lamina	11.11	9.99	1.87	22.97	090	S
63012		A	Removal of spinal lamina	14.21	18.07	3.15	35.43	090	S
63015		A	Removal of spinal lamina	16.59	*21.23	4.18	42.00	090	S
63016		A	Removal of spinal lamina	17.43	*22.30	4.11	43.84	090	S
63017		A	Removal of spinal lamina	15.85	*20.29	4.00	40.14	090	S
63020		A	Neck spine disk surgery	12.53	*16.04	3.38	31.95	090	S
63030		A	Low back disk surgery	12.11	*15.50	2.81	30.42	090	S
63035		A	Added spinal disk surgery	3.15	*4.04	0.76	7.95	ZZZ	S
63040		A	Neck spine disk surgery	17.56	*22.48	4.30	44.34	090	S
63042		A	Low back disk surgery	17.27	*22.10	4.38	43.75	090	S
63045		A	Removal of spinal lamina	15.31	*19.59	4.38	39.28	090	S
63046		A	Removal of spinal lamina	14.61	*18.70	4.58	37.89	090	S
63047		A	Removal of spinal lamina	12.76	*16.33	4.48	33.57	090	S
63048		A	Removal of spinal lamina	3.26	*4.17	1.03	8.46	ZZZ	S
63055		A	Decompress spinal cord	20.67	23.73	4.18	48.58	090	S
63056		A	Decompress spinal cord	19.11	21.84	3.76	44.71	090	S
63057		A	Decompress spinal cord	3.00	*3.84	0.85	7.69	ZZZ	S
63064		A	Decompress spinal cord	23.23	23.83	4.09	51.15	090	S
63066		A	Decompress spinal cord	3.26	2.48	0.45	6.19	ZZZ	S
63075		A	Neck spine disk surgery	19.77	17.57	3.21	40.55	090	S
63076		A	Neck spine disk surgery	4.05	*5.19	0.97	10.21	ZZZ	S
63077		A	Spine disk surgery, thorax	20.25	18.42	3.17	41.84	090	S
63078		A	Spine disk surgery, thorax	3.28	2.61	0.45	6.34	ZZZ	S
63081		A	Removal of vertebral body	22.08	26.26	4.50	52.84	090	S
63082		A	Removal of vertebral body	4.37	*5.60	1.22	11.19	ZZZ	S
63085		A	Removal of vertebral body	25.07	27.39	4.69	57.15	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
63086		A	Removal of vertebral body	3.19	*4.08	1.07	8.34	ZZZ	S
63087		A	Removal of vertebral body	27.56	28.25	4.85	60.66	090	S
63088		A	Removal of vertebral body	4.33	*5.55	1.18	11.06	ZZZ	S
63090		A	Removal of vertebral body	26.20	29.22	4.92	60.34	090	S
63091		A	Removal of vertebral body	3.03	2.73	0.46	6.22	ZZZ	S
63170		A	Incise spinal cord tract(s)	18.18	18.88	3.28	40.34	090	S
63172		A	Drainage of spinal cyst	16.19	*20.72	4.26	41.17	090	S
63173		A	Drainage of spinal cyst	20.40	15.47	1.81	37.68	090	S
63180		A	Revise spinal cord ligaments	16.75	11.61	2.05	30.41	090	S
63182		A	Revise spinal cord ligaments	18.91	16.44	2.21	37.56	090	S
63185		A	Incise spinal column/nerves	13.85	15.55	2.93	32.33	090	S
63190		A	Incise spinal column/nerves	16.26	*20.81	3.91	40.98	090	S
63191		A	Incise spinal column/nerves	16.42	13.04	2.21	31.67	090	S
63194		A	Incise spinal column & cord	17.53	13.02	2.33	32.88	090	S
63195		A	Incise spinal column & cord	17.16	13.86	2.11	33.13	090	S
63196		A	Incise spinal column & cord	20.57	15.59	1.83	37.99	090	S
63197		A	Incise spinal column & cord	19.38	14.36	2.62	36.36	090	S
63198		A	Incise spinal column & cord	22.45	16.32	3.19	41.96	090	S
63199		A	Incise spinal column & cord	23.89	21.40	2.61	47.90	090	S
63200		A	Release of spinal cord	17.66	12.49	1.83	31.98	090	S
63250		A	Revise spinal cord vessels	38.67	27.99	5.22	71.88	090	S
63251		A	Revise spinal cord vessels	38.86	22.74	4.32	65.92	090	S
63252		A	Revise spinal cord vessels	38.85	28.25	5.52	72.62	090	S
63265		A	Excise intraspinal lesion	20.04	22.01	3.90	45.95	090	S
63266		A	Excise intraspinal lesion	20.65	24.76	4.43	49.84	090	S
63267		A	Excise intraspinal lesion	16.70	*21.38	4.20	42.28	090	S
63268		A	Excise intraspinal lesion	17.27	12.56	2.46	32.29	090	S
63270		A	Excise intraspinal lesion	24.84	18.14	3.42	46.40	090	S
63271		A	Excise intraspinal lesion	24.96	26.60	4.79	56.35	090	S
63272		A	Excise intraspinal lesion	23.69	23.15	4.26	51.10	090	S
63273		A	Excise intraspinal lesion	22.66	17.56	3.12	43.34	090	S
63275		A	Biopsy/excise spinal tumor	22.05	27.82	5.09	54.96	090	S
63276		A	Biopsy/excise spinal tumor	21.76	25.31	4.62	51.69	090	S
63277		A	Biopsy/excise spinal tumor	19.51	23.75	4.25	47.51	090	S
63278		A	Biopsy/excise spinal tumor	19.24	23.34	4.32	46.90	090	S
63280		A	Biopsy/excise spinal tumor	26.72	28.08	4.99	59.79	090	S
63281		A	Biopsy/excise spinal tumor	26.42	27.67	4.96	59.05	090	S
63282		A	Biopsy/excise spinal tumor	24.96	24.11	4.44	53.51	090	S
63283		A	Biopsy/excise spinal tumor	23.57	18.77	3.44	45.78	090	S
63285		A	Biopsy/excise spinal tumor	34.24	24.49	4.49	63.22	090	S
63286		A	Biopsy/excise spinal tumor	33.94	28.76	4.92	67.62	090	S
63287		A	Biopsy/excise spinal tumor	34.43	25.72	4.53	64.68	090	S
63290		A	Biopsy/excise spinal tumor	35.04	27.16	4.65	66.85	090	S
63300		A	Removal of vertebral body	22.78	17.27	2.02	42.07	090	S
63301		A	Removal of vertebral body	25.08	18.45	3.58	47.11	090	S
63302		A	Removal of vertebral body	25.60	21.36	3.02	49.98	090	S
63303		A	Removal of vertebral body	28.47	18.50	3.39	50.36	090	S
63304		A	Removal of vertebral body	28.10	21.31	2.49	51.90	090	S
63305		A	Removal of vertebral body	29.42	22.49	3.75	55.66	090	S
63306		A	Removal of vertebral body	30.01	22.76	2.65	55.42	090	S
63307		A	Removal of vertebral body	29.42	24.42	2.98	56.82	090	S
63308		A	Removal of vertebral body	5.25	4.05	0.73	10.03	ZZZ	S
63600		A	Remove spinal cord lesion	13.08	10.70	2.63	26.41	090	N
63610		A	Stimulation of spinal cord	8.73	6.73	2.06	17.52	000	N
63615		A	Remove lesion of spinal cord	15.40	11.55	2.03	28.98	090	S
63650		A	Implant neuroelectrodes	5.99	*7.67	2.13	15.79	090	S
63655		A	Implant neuroelectrodes	8.95	*11.93	3.64	24.52	090	S
63660		A	Revise/remove neuroelectrode	5.54	*7.09	1.56	14.19	090	S
63685		A	Implant neuroreceiver	6.29	7.40	1.46	15.15	090	S
63688		A	Revise/remove neuroreceiver	4.77	*6.10	1.26	12.13	090	S
63690		A	Analysis of neuroreceiver	0.45	*0.58	0.12	1.15	XXX	N
63691		A	Analysis of neuroreceiver	0.65	0.41	0.11	1.17	XXX	N
63700		A	Repair of spinal herniation	15.62	11.35	2.22	29.19	090	S
63702		A	Repair of spinal herniation	17.57	12.78	2.49	32.84	090	S
63704		A	Repair of spinal herniation	19.52	14.19	2.77	36.48	090	S
63706		A	Repair of spinal herniation	22.45	16.33	3.18	41.96	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
63707		A	Repair spinal fluid leakage	10.14	*12.98	2.56	25.68	090	S
63709		A	Repair spinal fluid leakage	13.26	*16.97	3.30	33.53	090	S
63710		A	Graft repair of spine defect	13.01	9.75	1.58	24.34	090	S
63740		A	Install spinal shunt	10.43	*13.35	2.99	26.77	090	S
63741		A	Install spinal shunt	7.13	*9.13	2.39	18.65	090	S
63744		A	Revision of spinal shunt	6.83	8.15	1.68	16.66	090	S
63746		A	Removal of spinal shunt	5.60	5.52	1.08	12.20	090	S
63750		D	Insert spinal canal catheter	0.00	0.00	0.00	0.00	090	S
63780		D	Insert spinal canal catheter	0.00	0.00	0.00	0.00	090	N
64400		A	Injection for nerve block	1.11	0.48	0.05	1.64	000	N
64402		A	Injection for nerve block	1.25	0.62	0.09	1.96	000	S
64405		A	Injection for nerve block	1.32	0.64	0.07	2.03	000	N
64408		A	Injection for nerve block	1.41	1.04	0.11	2.56	000	N
64410		A	Injection for nerve block	1.43	0.71	0.15	2.29	000	N
64412		A	Injection for nerve block	1.18	0.62	0.08	1.88	000	N
64413		A	Injection for nerve block	1.40	0.74	0.08	2.22	000	N
64415		A	Injection for nerve block	1.48	0.26	0.07	1.81	000	N
64417		A	Injection for nerve block	1.44	0.63	0.15	2.22	000	N
64418		A	Injection for nerve block	1.32	0.85	0.10	2.27	000	N
64420		A	Injection for nerve block	1.18	0.64	0.07	1.89	000	N
64421		A	Injection for nerve block	1.68	0.83	0.17	2.68	000	N
64425		A	Injection for nerve block	1.75	0.57	0.10	2.42	000	N
64430		A	Injection for nerve block	1.46	0.70	0.12	2.28	000	S
64435		A	Injection for nerve block	1.45	0.47	0.09	2.01	000	S
64440		A	Injection for nerve block	1.34	0.79	0.09	2.22	000	N
64441		A	Injection for nerve block	1.79	1.01	0.12	2.92	000	N
64442		A	Injection for nerve block	1.41	1.19	0.16	2.76	000	N
64443		A	Injection for nerve block	1.35	0.63	0.12	2.10	ZZZ	N
64445		A	Injection for nerve block	1.48	0.49	0.06	2.03	000	N
64450		A	Injection for nerve block	1.27	0.53	0.05	1.85	000	S
64505		A	Injection for nerve block	1.36	0.62	0.06	2.04	000	N
64508		A	Injection for nerve block	1.12	1.04	0.08	2.24	000	N
64510		A	Injection for nerve block	1.22	0.71	0.18	2.11	000	N
64520		A	Injection for nerve block	1.35	0.72	0.17	2.24	000	N
64530		A	Injection for nerve block	1.58	1.17	0.28	3.03	000	N
64550		A	Apply neurostimulator	0.18	0.44	0.04	0.66	000	N
64553		A	Implant neuroelectrodes	2.26	1.02	0.10	3.38	010	N
64555		A	Implant neuroelectrodes	2.22	0.42	0.10	2.74	010	N
64560		A	Implant neuroelectrodes	2.31	1.45	0.24	4.00	010	S
64565		A	Implant neuroelectrodes	1.71	0.76	0.08	2.55	010	N
64573		A	Implant neuroelectrodes	4.35	3.16	0.61	8.12	090	S
64575		A	Implant neuroelectrodes	4.27	3.07	0.40	7.74	090	S
64577		A	Implant neuroelectrodes	4.54	2.76	0.45	7.75	090	S
64580		A	Implant neuroelectrodes	4.04	2.91	0.20	7.15	090	S
64585		A	Revise/remove neuroelectrode	2.01	0.97	0.09	3.07	010	S
64590		A	Implant neuroreceiver	2.35	1.84	0.35	4.54	010	S
64595		A	Revise/remove neuroreceiver	1.68	1.12	0.21	3.01	010	S
64600		A	Injection treatment of nerve	3.40	1.69	0.17	5.26	010	N
64605		A	Injection treatment of nerve	5.56	1.56	0.33	7.45	010	N
64610		A	Injection treatment of nerve	7.11	7.26	1.35	15.72	010	N
64612		A	Destroy nerve, face muscle	1.91	1.45	0.17	3.53	010	S
64613		A	Destroy nerve, spine muscle	1.91	1.45	0.17	3.53	010	S
64620		A	Injection treatment of nerve	2.79	1.00	0.19	3.98	010	N
64622		A	Injection treatment of nerve	2.95	1.82	0.35	5.12	010	N
64623		A	Injection treatment of nerve	0.99	0.85	0.17	2.01	ZZZ	N
64630		A	Injection treatment of nerve	2.95	1.74	0.38	5.07	010	N
64640		A	Injection treatment of nerve	2.49	0.92	0.09	3.50	010	N
64680		A	Injection treatment of nerve	2.57	1.55	0.41	4.53	010	N
64702		A	Revise finger/toe nerve	4.02	4.22	0.70	8.94	090	S
64704		A	Revise hand/foot nerve	4.44	5.38	0.74	10.56	090	S
64708		A	Revise arm/leg nerve	5.71	*7.31	1.26	14.28	090	S
64712		A	Revision of sciatic nerve	7.18	*9.19	1.68	18.05	090	S
64713		A	Revision of arm nerve(s)	10.34	9.40	1.72	21.46	090	S
64714		A	Revise low back nerve(s)	9.87	6.13	1.41	17.41	090	S
64716		A	Revision of cranial nerve	5.80	4.83	0.67	11.30	090	S
64718		A	Revise ulnar nerve at elbow	5.48	6.72	1.13	13.33	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
64719		A	Revise ulnar nerve at wrist	4.72	4.95	0.85	10.52	090	S
64721		A	Carpal tunnel surgery	3.99	4.90	0.83	9.72	090	S
64722		A	Relieve pressure on nerve(s)	4.46	*5.71	1.11	11.28	090	S
64726		A	Release foot/toe nerve	3.97	0.72	0.07	4.76	090	S
64727		A	Internal nerve revision	3.10	3.24	0.55	6.89	ZZZ	S
64732		A	Incision of brow nerve	4.15	4.31	0.72	9.18	090	S
64734		A	Incision of cheek nerve	4.62	4.61	0.67	9.90	090	S
64736		A	Incision of chin nerve	4.40	4.46	0.42	9.28	090	S
64738		A	Incision of jaw nerve	5.42	5.07	0.61	11.10	090	S
64740		A	Incision of tongue nerve	5.28	5.18	0.62	11.08	090	S
64742		A	Incision of facial nerve	5.91	5.00	0.44	11.35	090	S
64744		A	Incise nerve, back of head	4.87	6.10	1.10	12.07	090	S
64746		A	Incise diaphragm nerve	5.62	3.77	0.77	10.16	090	S
64752		A	Incision of vagus nerve	6.64	3.93	0.85	11.42	090	S
64755		A	Incision of stomach nerves	13.10	10.47	2.27	25.84	090	S
64760		A	Incision of vagus nerve	6.54	6.65	1.50	14.69	090	S
64761		A	Incision of pelvis nerve	6.10	4.66	0.50	11.26	090	S
64763		A	Incise hip/thigh nerve	6.72	4.80	0.92	12.44	090	S
64766		A	Incise hip/thigh nerve	8.31	6.67	1.20	16.18	090	S
64771		A	Sever cranial nerve	6.99	6.42	0.73	14.14	090	S
64772		A	Incision of spinal nerve	6.79	6.77	1.30	14.86	090	S
64774		A	Remove skin nerve lesion	4.86	2.74	0.45	8.05	090	S
64776		A	Remove digit nerve lesion	4.86	2.78	0.41	8.05	090	S
64778		A	Added digit nerve surgery	3.11	2.73	0.43	6.27	ZZZ	S
64782		A	Remove limb nerve lesion	5.81	4.70	0.46	10.97	090	S
64783		A	Added limb nerve surgery	3.72	3.26	0.47	7.45	ZZZ	S
64784		A	Remove nerve lesion	9.46	5.64	0.96	16.06	090	S
64786		A	Remove sciatic nerve lesion	15.10	12.66	2.14	29.90	090	S
64787		A	Implant nerve end	4.30	3.47	0.60	8.37	ZZZ	S
64788		A	Remove skin nerve lesion	4.30	3.63	0.50	8.43	090	S
64790		A	Removal of nerve lesion	10.95	7.11	1.22	19.28	090	S
64792		A	Removal of nerve lesion	14.40	8.99	1.66	25.05	090	S
64795		A	Biopsy of nerve	3.01	2.38	0.39	5.78	000	S
64802		A	Remove sympathetic nerves	8.22	5.40	1.10	14.72	090	S
64804		A	Remove sympathetic nerves	13.65	12.77	2.44	28.86	090	S
64809		A	Remove sympathetic nerves	12.79	10.55	2.04	25.38	090	S
64818		A	Remove sympathetic nerves	9.42	8.57	1.72	19.71	090	S
64820		A	Remove sympathetic nerves	10.00	7.27	1.42	18.69	090	S
64830		A	Microrepair of nerve	3.10	2.01	0.38	5.49	ZZZ	S
64831		A	Repair of digit nerve	8.84	3.38	0.56	12.78	090	S
64832		A	Repair additional nerve	5.66	1.40	0.24	7.30	ZZZ	S
64834		A	Repair of hand or foot nerve	9.77	3.50	0.56	13.83	090	S
64835		A	Repair of hand or foot nerve	10.47	5.96	1.03	17.46	090	S
64836		A	Repair of hand or foot nerve	10.47	6.70	1.22	18.39	090	S
64837		A	Repair additional nerve	6.26	4.45	0.85	11.56	ZZZ	S
64840		A	Repair of leg nerve	12.43	10.35	0.53	23.31	090	S
64856		A	Repair/transpose nerve	12.81	8.21	1.46	22.48	090	S
64857		A	Repair arm/leg nerve	13.43	9.53	1.54	24.50	090	S
64858		A	Repair sciatic nerve	15.43	10.98	2.11	28.52	090	S
64859		A	Additional nerve surgery	4.26	3.50	0.58	8.34	ZZZ	S
64861		A	Repair of arm nerves	17.94	13.42	1.38	32.74	090	S
64862		A	Repair of low back nerves	18.14	21.56	1.61	41.31	090	S
64864		A	Repair of facial nerve	11.87	7.86	1.16	20.89	090	S
64865		A	Repair of facial nerve	14.70	12.34	1.50	28.54	090	S
64866		A	Fusion of facial/other nerve	14.94	11.19	1.84	27.97	090	S
64868		A	Fusion of facial/other nerve	13.36	11.19	1.47	26.02	090	S
64870		A	Fusion of facial/other nerve	15.19	13.91	1.70	30.80	090	S
64872		A	Subsequent repair of nerve	1.99	1.44	0.29	3.72	ZZZ	S
64874		A	Repair & revise nerve	2.98	2.17	0.43	5.58	ZZZ	S
64876		A	Repair nerve; shorten bone	3.38	2.46	0.48	6.32	ZZZ	N
64885		A	Nerve graft, head or neck	16.73	12.69	1.48	30.90	090	S
64886		A	Nerve graft, head or neck	19.95	15.13	1.77	36.85	090	S
64890		A	Nerve graft, hand or foot	14.35	12.26	2.12	28.73	090	S
64891		A	Nerve graft, hand or foot	15.21	10.42	1.73	27.36	090	S
64892		A	Nerve graft, arm or leg	13.85	11.04	1.69	26.58	090	S
64893		A	Nerve graft, arm or leg	14.61	13.93	2.27	30.81	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
64895		A	Nerve graft, hand or foot	18.39	13.16	2.55	34.10	090	S
64896		A	Nerve graft, hand or foot	19.38	17.53	1.90	38.81	090	S
64897		A	Nerve graft, arm or leg	17.38	12.63	2.47	32.48	090	S
64898		A	Nerve graft, arm or leg	18.39	14.40	2.35	35.14	090	S
64901		A	Additional nerve graft	10.22	10.16	0.87	21.25	ZZZ	S
64902		A	Additional nerve graft	11.83	11.92	0.99	24.74	ZZZ	S
64905		A	Nerve pedicle transfer	13.22	9.40	0.70	23.32	090	S
64907		A	Nerve pedicle transfer	17.90	13.02	2.55	33.47	090	S
64999		C	Nervous system surgery	0.00	0.00	0.00	0.00	YYY	N
65091		A	Revise eye	6.10	*7.81	0.45	14.36	090	S
65093		A	Revise eye with implant	6.47	*8.28	0.52	15.27	090	S
65101		A	Removal of eye	6.52	*8.35	0.47	15.34	090	S
65103		A	Remove eye/insert implant	7.06	*9.04	0.50	16.60	090	S
65105		A	Remove eye/attach implant	7.82	*10.01	0.55	18.38	090	S
65110		A	Removal of eye	13.18	15.99	1.14	30.31	090	S
65112		A	Remove eye, revise socket	15.44	12.16	1.09	28.69	090	S
65114		A	Remove eye, revise socket	16.59	13.07	1.65	31.31	090	S
65125		A	Revise ocular implant	2.97	2.47	0.13	5.57	090	S
65130		A	Insert ocular implant	6.75	*8.64	0.50	15.89	090	S
65135		A	Insert ocular implant	6.93	5.42	0.35	12.70	090	S
65140		A	Attach ocular implant	7.46	6.22	0.33	14.01	090	S
65150		A	Revise ocular implant	5.97	*7.64	0.56	14.17	090	S
65155		A	Reinsert ocular implant	8.21	*10.50	0.90	19.61	090	S
65175		A	Removal of ocular implant	5.93	7.49	0.40	13.82	090	S
65205		A	Remove foreign body from eye	0.78	0.37	0.02	1.17	000	S
65210		A	Remove foreign body from eye	0.84	0.46	0.03	1.33	000	S
65220		A	Remove foreign body from eye	0.71	0.52	0.04	1.27	000	N
65222		A	Remove foreign body from eye	0.93	0.57	0.03	1.53	000	S
65235		A	Remove foreign body from eye	7.12	5.61	0.30	13.03	090	S
65260		A	Remove foreign body from eye	10.35	8.63	0.45	19.43	090	S
65265		A	Remove foreign body from eye	12.04	10.04	0.51	22.59	090	S
65270		A	Repair of eye wound	1.85	1.17	0.07	3.09	010	S
65272		A	Repair of eye wound	3.57	1.64	0.10	5.31	090	S
65273		A	Repair of eye wound	3.89	3.22	0.21	7.32	090	S
65275		A	Repair of eye wound	5.04	0.66	0.04	5.74	090	S
65280		A	Repair of eye wound	7.10	*9.09	0.49	16.68	090	S
65285		A	Repair of eye wound	12.06	12.26	0.64	24.96	090	S
65286		A	Repair of eye wound	5.16	4.79	0.25	10.20	090	S
65290		A	Repair of eye socket wound	5.06	6.20	0.37	11.63	090	S
65400		A	Removal of eye lesion	5.61	6.46	0.35	12.42	090	S
65410		A	Biopsy of cornea	1.47	1.59	0.11	3.17	000	S
65420		A	Removal of eye lesion	3.97	4.28	0.23	8.48	090	S
65426		A	Removal of eye lesion	5.05	*6.47	0.38	11.90	090	S
65430		A	Corneal smear	0.87	0.54	0.03	1.44	000	S
65435		A	Curette/treat cornea	0.92	0.77	0.04	1.73	000	S
65436		A	Curette/treat cornea	3.99	1.53	0.08	5.60	090	S
65450		A	Treatment of corneal lesion	3.07	3.28	0.17	6.52	090	S
65600		A	Revision of cornea	3.15	2.62	0.14	5.91	090	S
65710		A	Corneal transplant	9.52	*12.44	1.13	23.09	090	S
65730		A	Corneal transplant	11.83	*15.14	1.29	28.26	090	S
65750		A	Corneal transplant	12.58	*16.10	1.33	30.01	090	S
65755		A	Corneal transplant	12.58	*16.10	1.39	30.07	090	S
65760		N	Revision of cornea	0.00	0.00	0.00	0.00	XXX	0
65765		N	Revision of cornea	0.00	0.00	0.00	0.00	XXX	0
65767		N	Corneal tissue transplant	0.00	0.00	0.00	0.00	XXX	0
65770		A	Revise cornea with implant	16.56	13.81	0.71	31.08	090	S
65771		N	Radial keratotomy	0.00	0.00	0.00	0.00	XXX	0
65772		A	Correction of astigmatism	4.04	*5.16	0.31	9.51	090	S
65775		A	Correction of astigmatism	5.44	*6.96	0.50	12.90	090	S
65800		A	Drainage of eye	1.91	1.72	0.10	3.73	000	S
65805		A	Drainage of eye	1.91	1.81	0.10	3.82	000	S
65810		A	Drainage of eye	4.57	5.45	0.30	10.32	090	S
65815		A	Drainage of eye	4.75	4.49	0.24	9.48	090	S
65820		A	Relieve inner eye pressure	7.60	9.54	0.51	17.65	090	S
65850		A	Incision of eye	10.18	*13.03	0.69	23.90	090	S
65855		A	Laser surgery of eye	4.65	*6.01	0.52	11.18	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
65860		A	Incise inner eye adhesions	3.37	*4.31	0.37	8.05	090	S
65865		A	Incise inner eye adhesions	5.42	*6.93	0.41	12.76	090	S
65870		A	Incise inner eye adhesions	5.92	5.86	0.31	12.09	090	S
65875		A	Incise inner eye adhesions	6.14	6.28	0.34	12.76	090	S
65880		A	Incise inner eye adhesions	6.69	6.85	0.37	13.91	090	S
65900		A	Remove eye lesion	10.43	7.91	0.92	19.26	090	S
65920		A	Remove implant from eye	7.90	8.36	0.44	16.70	090	S
65930		A	Remove blood clot from eye	7.03	7.68	0.41	15.12	090	S
66020		A	Injection treatment of eye	1.54	*1.98	0.14	3.66	010	S
66030		A	Injection treatment of eye	1.20	0.54	0.03	1.77	010	S
66130		A	Remove eye lesion	7.54	5.28	0.28	13.10	090	S
66150		A	Glaucoma surgery	7.60	*9.72	0.59	17.91	090	S
66155		A	Glaucoma surgery	7.48	*9.57	0.50	17.55	090	S
66160		A	Glaucoma surgery	9.47	10.77	0.55	20.79	090	S
66165		A	Glaucoma surgery	7.31	*9.36	0.57	17.24	090	S
66170		A	Glaucoma surgery	11.31	12.15	0.63	24.09	090	S
66172		A	Incision of eye	13.67	12.15	0.63	26.45	090	S
66180		A	Implant eye shunt	12.63	*16.17	1.03	29.83	090	S
66185		A	Revise eye shunt	7.69	*9.85	0.58	18.12	090	S
66220		A	Repair eye lesion	7.32	5.95	0.34	13.61	090	S
66225		A	Repair/graft eye lesion	10.55	*13.51	0.86	24.92	090	S
66250		A	Follow-up surgery of eye	5.63	*7.20	0.38	13.21	090	S
66500		A	Incision of iris	3.58	*4.58	0.27	8.43	090	S
66505		A	Incision of iris	3.93	3.27	0.17	7.37	090	S
66600		A	Remove iris and lesion	8.23	9.36	0.51	18.10	090	S
66605		A	Removal of iris	12.34	11.87	0.67	24.88	090	S
66625		A	Removal of iris	4.95	*6.33	0.48	11.76	090	S
66630		A	Removal of iris	5.81	*7.43	0.45	13.69	090	S
66635		A	Removal of iris	5.90	*7.56	0.49	13.95	090	S
66680		A	Repair iris and ciliary body	5.14	6.42	0.35	11.91	090	S
66682		A	Repair iris and ciliary body	5.86	7.33	0.38	13.57	090	S
66700		A	Destruction, ciliary body	4.55	*5.83	0.35	10.73	090	S
66710		A	Destruction, ciliary body	4.55	*5.83	0.41	10.79	090	S
66720		A	Destruction, ciliary body	4.55	*5.83	0.38	10.76	090	S
66740		A	Destruction, ciliary body	4.55	*5.83	0.39	10.77	090	S
66761		A	Revision of iris	3.77	*5.10	0.47	9.34	090	S
66762		A	Revision of iris	4.33	*5.92	0.55	10.80	090	S
66770		A	Removal of inner eye lesion	4.88	*6.24	0.45	11.57	090	S
66820		A	Incision, secondary cataract	3.76	*4.81	0.29	8.86	090	S
66821		A	After cataract laser surgery	2.78	*3.81	0.37	6.96	090	S
66825		A	Reposition intraocular lens	7.73	7.33	0.38	15.44	090	S
66830		A	Removal of lens lesion	7.80	7.67	0.40	15.87	090	S
66840		A	Removal of lens material	7.51	*9.61	0.54	17.66	090	S
66850		A	Removal of lens material	8.66	*11.09	0.70	20.45	090	S
66852		A	Removal of lens material	9.52	*12.19	0.90	22.61	090	S
66920		A	Extraction of lens	8.46	*10.82	0.60	19.88	090	S
66930		A	Extraction of lens	9.73	10.49	0.57	20.79	090	S
66940		A	Extraction of lens	8.48	*10.85	0.62	19.95	090	S
66983		A	Remove cataract, insert lens	8.54	*10.94	0.95	20.43	090	S
66984		A	Remove cataract, insert lens	9.89	*12.66	0.94	23.49	090	S
66985		A	Insert lens prosthesis	7.89	*10.10	0.63	18.62	090	S
66986		A	Exchange lens prosthesis	11.78	12.20	0.63	24.61	090	S
66999		C	Eye surgery procedure	0.00	0.00	0.00	0.00	YYY	S
67005		A	Partial removal of eye fluid	6.63	*10.28	1.13	18.04	090	S
67010		A	Partial removal of eye fluid	6.67	*9.98	1.04	17.69	090	S
67015		A	Release of eye fluid	6.69	6.45	0.35	13.49	090	S
67025		A	Replace eye fluid	6.44	6.75	0.36	13.55	090	S
67028		A	Injection eye drug	2.52	*3.22	0.18	5.92	000	S
67030		A	Incise inner eye strands	4.44	*5.75	0.50	10.69	090	S
67031		A	Laser surgery, eye strands	3.42	*6.15	0.75	10.32	090	S
67036		A	Removal of inner eye fluid	11.33	*15.67	1.49	28.49	090	S
67038		A	Strip retinal membrane	20.20	*25.85	1.80	47.85	090	S
67039		A	Laser treatment of retina	13.60	*18.22	1.68	33.50	090	S
67040		A	Laser treatment of retina	16.26	*20.81	1.75	38.82	090	S
67101		A	Repair, detached retina	7.02	*8.99	0.66	16.67	090	S
67105		A	Repair, detached retina	7.06	*9.14	0.80	17.00	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
67107		A	Repair, detached retina	13.99	*17.91	1.10	33.00	090	S
67108		A	Repair, detached retina	19.90	*25.47	1.76	47.13	090	S
67109		D	Repair, detached retina	0.00	0.00	0.00	0.00	090	S
67110		A	Repair, detached retina	8.14	*10.60	0.97	19.71	090	S
67112		A	Re-repair, detached retina	16.15	16.51	0.86	33.52	090	S
67115		A	Release, encircling material	4.64	*5.93	0.44	11.01	090	S
67120		A	Remove eye implant material	5.63	7.15	0.38	13.16	090	S
67121		A	Remove eye implant material	10.17	9.42	0.49	20.08	090	S
67141		A	Treatment of retina	4.90	*6.27	0.48	11.65	090	S
67145		A	Treatment of retina	5.07	*6.50	0.49	12.06	090	S
67208		A	Treatment of retinal lesion	6.40	*8.19	0.52	15.11	090	S
67210		A	Treatment of retinal lesion	9.48	9.02	0.47	18.97	090	S
67218		A	Treatment of retinal lesion	12.73	13.31	0.70	26.74	090	S
67227		A	Treatment of retinal lesion	6.28	*8.04	0.51	14.83	090	S
67228		A	Treatment of retinal lesion	12.39	9.39	0.48	22.26	090	S
67250		A	Reinforce eye wall	8.36	6.99	0.40	15.75	090	S
67255		A	Reinforce/graft eye wall	8.39	*10.73	0.87	19.99	090	S
67299		C	Eye surgery procedure	0.00	0.00	0.00	0.00	YYY	S
67311		A	Revise eye muscle	6.30	*8.06	0.47	14.83	090	S
67312		A	Revise two eye muscles	7.55	*9.66	0.53	17.74	090	S
67314		A	Revise eye muscle	7.12	*9.12	0.58	16.82	090	S
67316		A	Revise two eye muscles	8.02	*10.27	0.67	18.96	090	S
67318		A	Revise eye muscle(s)	7.45	6.21	0.33	13.99	090	S
67320		A	Revise eye muscle(s)	8.26	*10.57	0.69	19.52	090	S
67331		A	Eye surgery follow-up	7.72	*9.89	0.54	18.15	090	S
67332		A	Rerevise eye muscles	8.59	*11.00	0.58	20.17	090	S
67334		A	Revise eye muscle w/suture	7.56	6.30	0.33	14.19	090	S
67335		A	Eye suture during surgery	2.49	*3.89	0.43	6.81	ZZZ	S
67340		A	Revise eye muscle	9.45	7.88	0.41	17.74	090	S
67343		A	Release eye tissue	7.00	5.83	0.31	13.14	090	S
67345		A	Destroy nerve of eye muscle	2.91	2.22	0.26	5.39	010	S
67350		A	Biopsy eye muscle	2.87	2.39	0.13	5.39	000	S
67399		C	Eye muscle surgery procedure	0.00	0.00	0.00	0.00	YYY	S
67400		A	Explore/biopsy eye socket	9.20	10.91	0.62	20.73	090	S
67405		A	Explore/drain eye socket	7.42	*9.49	0.67	17.58	090	S
67412		A	Explore/treat eye socket	9.14	*11.70	0.67	21.51	090	S
67413		A	Explore/treat eye socket	9.75	8.09	0.57	18.41	090	S
67414		A	Explore/decompress eye socket	10.07	8.39	0.44	18.90	090	S
67415		A	Aspiration orbital contents	1.76	2.02	0.12	3.90	000	S
67420		A	Explore/treat eye socket	13.36	16.78	1.11	31.25	090	S
67430		A	Explore/treat eye socket	12.79	10.65	0.54	23.98	090	S
67440		A	Explore/drain eye socket	12.43	*15.91	0.97	29.31	090	S
67445		A	Explore/decompress eye socket	13.36	11.13	0.57	25.06	090	S
67450		A	Explore/biopsy eye socket	12.80	15.29	0.87	28.96	090	S
67500		A	Inject/treat eye socket	0.79	0.73	0.06	1.58	000	S
67505		A	Inject/treat eye socket	0.82	1.04	0.06	1.92	000	S
67515		A	Inject/treat eye socket	0.61	0.56	0.03	1.20	000	S
67550		A	Insert eye socket implant	9.69	9.62	0.70	20.01	090	S
67560		A	Revise eye socket implant	10.10	8.30	0.48	18.88	090	S
67570		A	Decompress optic nerve	12.52	7.56	0.39	20.47	090	S
67599		C	Orbit surgery procedure	0.00	0.00	0.00	0.00	YYY	S
67700		A	Drainage of eyelid abscess	1.30	0.49	0.03	1.82	010	S
67710		A	Incision of eyelid	0.97	1.01	0.06	2.04	010	S
67715		A	Incision of eyelid fold	1.17	*1.49	0.09	2.75	010	S
67800		A	Remove eyelid lesion	1.35	0.94	0.05	2.34	010	S
67801		A	Remove eyelid lesions	1.85	1.39	0.08	3.32	010	S
67805		A	Remove eyelid lesions	2.17	1.38	0.08	3.63	010	S
67808		A	Remove eyelid lesion(s)	3.55	2.13	0.13	5.81	090	S
67810		A	Biopsy of eyelid	1.48	0.81	0.05	2.34	000	S
67820		A	Revise eyelashes	0.89	0.38	0.02	1.29	000	S
67825		A	Revise eyelashes	1.33	0.90	0.05	2.28	010	S
67830		A	Revise eyelashes	1.65	*2.12	0.17	3.94	010	S
67835		A	Revise eyelashes	5.41	*6.92	0.45	12.78	090	S
67840		A	Remove eyelid lesion	1.99	1.22	0.07	3.28	010	S
67850		A	Treat eyelid lesion	1.64	0.82	0.05	2.51	010	S
67875		A	Closure of eyelid by suture	1.35	*1.72	0.13	3.20	000	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
67880		A	Revision of eyelid	3.55	3.94	0.23	7.72	090	S
67882		A	Revision of eyelid	4.77	*6.10	0.37	11.24	090	S
67900		A	Repair brow defect	4.54	3.78	0.20	8.52	090	S
67901		A	Repair eyelid defect	6.82	*8.73	0.64	16.19	090	S
67902		A	Repair eyelid defect	6.88	*8.81	0.72	16.41	090	S
67903		A	Repair eyelid defect	6.22	*7.96	0.73	14.91	090	S
67904		A	Repair eyelid defect	5.96	*7.64	0.71	14.31	090	S
67906		A	Repair eyelid defect	6.64	5.46	0.36	12.46	090	S
67908		A	Repair eyelid defect	4.95	*6.34	0.54	11.83	090	S
67909		A	Revise eyelid defect	5.22	*6.69	0.48	12.39	090	S
67911		A	Revise eyelid defect	5.09	*6.58	0.79	12.46	090	S
67914		A	Repair eyelid defect	3.60	*4.61	0.39	8.60	090	S
67915		A	Repair eyelid defect	3.10	1.25	0.07	4.42	090	S
67916		A	Repair eyelid defect	5.13	6.50	0.38	12.01	090	S
67917		A	Repair eyelid defect	5.84	*7.48	0.47	13.79	090	S
67921		A	Repair eyelid defect	3.32	3.82	0.20	7.34	090	S
67922		A	Repair eyelid defect	2.98	1.19	0.07	4.24	090	S
67923		A	Repair eyelid defect	5.70	6.88	0.38	12.96	090	S
67924		A	Repair eyelid defect	5.64	*7.22	0.43	13.29	090	S
67930		A	Repair eyelid wound	3.56	1.27	0.08	4.91	010	S
67935		A	Repair eyelid wound	6.07	3.79	0.24	10.10	090	S
67938		A	Remove eyelid foreign body	1.28	0.52	0.03	1.83	010	S
67950		A	Revision of eyelid	5.64	*7.22	0.45	13.31	090	S
67961		A	Revision of eyelid	5.51	*7.05	0.50	13.06	090	S
67966		A	Revision of eyelid	6.39	*8.18	0.66	15.23	090	S
67971		A	Reconstruction of eyelid	9.56	10.68	0.64	20.88	090	S
67973		A	Reconstruction of eyelid	12.59	13.54	0.91	27.04	090	S
67974		A	Reconstruction of eyelid	12.56	14.07	0.87	27.50	090	S
67975		A	Reconstruction of eyelid	8.90	4.15	0.24	13.29	090	S
67999		C	Revision of eyelid	0.00	0.00	0.00	0.00	YYY	S
68020		A	Incise/drain eyelid lining	1.32	0.51	0.03	1.86	010	S
68040		A	Treatment of eyelid lesions	0.85	0.45	0.02	1.32	000	S
68100		A	Biopsy of eyelid lining	1.35	0.99	0.06	2.40	000	S
68110		A	Remove eyelid lining lesion	1.72	1.24	0.07	3.03	010	S
68115		A	Remove eyelid lining lesion	2.31	1.93	0.11	4.35	010	S
68130		A	Remove eyelid lining lesion	4.75	4.09	0.22	9.06	090	S
68135		A	Remove eyelid lining lesion	1.79	0.74	0.04	2.57	010	S
68200		A	Treat eyelid by injection	0.49	0.52	0.03	1.04	000	S
68320		A	Revise/graft eyelid lining	4.97	*6.37	0.42	11.76	090	S
68325		A	Revise/graft eyelid lining	6.96	*8.91	0.62	16.49	090	S
68326		A	Revise/graft eyelid lining	6.75	8.62	0.49	15.86	090	S
68328		A	Revise/graft eyelid lining	7.78	*9.96	0.82	18.56	090	S
68330		A	Revise eyelid lining	4.53	*5.80	0.35	10.68	090	S
68335		A	Revise/graft eyelid lining	6.79	*8.69	0.68	16.16	090	S
68340		A	Separate eyelid adhesions	3.92	3.14	0.17	7.23	090	S
68360		A	Revise eyelid lining	4.12	*5.28	0.33	9.73	090	S
68362		A	Revise eyelid lining	6.94	8.01	0.42	15.37	090	S
68399		C	Eyelid lining surgery	0.00	0.00	0.00	0.00	YYY	S
68400		A	Incise/drain tear gland	1.64	1.00	0.06	2.70	010	S
68420		A	Incise/drain tear sac	2.25	1.02	0.06	3.33	010	S
68440		A	Incise tear duct opening	0.89	0.76	0.04	1.69	010	S
68500		A	Removal of tear gland	10.47	7.61	0.75	18.83	090	S
68505		A	Partial removal tear gland	10.39	8.69	0.49	19.57	090	S
68510		A	Biopsy of tear gland	4.61	3.69	0.28	8.58	000	S
68520		A	Removal of tear sac	7.11	*9.10	0.51	16.72	090	S
68525		A	Biopsy of tear sac	4.43	3.68	0.23	8.34	000	S
68530		A	Clearance of tear duct	3.61	2.85	0.17	6.63	010	S
68540		A	Remove tear gland lesion	10.10	8.31	0.50	18.91	090	S
68550		A	Remove tear gland lesion	12.66	11.34	0.74	24.74	090	S
68700		A	Repair tear ducts	6.20	2.69	0.15	9.04	090	S
68705		A	Revise tear duct opening	2.01	1.02	0.05	3.08	010	S
68720		A	Create tear sac drain	7.68	*9.84	0.74	18.26	090	S
68745		A	Create tear duct drain	8.23	6.56	0.45	15.24	090	S
68750		A	Create tear duct drain	8.21	*10.50	0.83	19.54	090	S
68760		A	Close tear duct opening	1.68	0.92	0.04	2.64	010	S
68761		A	Close tear duct opening	1.31	0.92	0.04	2.27	010	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
68770		A	Close tear system fistula	6.62	4.24	0.23	11.09	090	S
68800		A	Dilate tear duct opening(s)	1.11	0.42	0.02	1.55	010	S
68820		A	Explore tear duct system	1.47	0.55	0.03	2.05	010	S
68825		A	Explore tear duct system	1.53	1.49	0.09	3.11	010	S
68830		A	Reopen tear duct channel	2.12	1.93	0.10	4.15	010	S
68840		A	Explore/irrigate tear ducts	1.22	0.49	0.03	1.74	010	S
68850		A	Injection for tear sac x-ray	0.80	0.51	0.04	1.35	000	S
68899		C	Tear duct system surgery	0.00	0.00	0.00	0.00	YYY	S
69000		A	Drain external ear lesion	1.40	0.35	0.03	1.78	010	S
69005		A	Drain external ear lesion	2.06	1.16	0.13	3.35	010	S
69020		A	Drain outer ear canal lesion	1.43	0.45	0.04	1.92	010	S
69090		N	Pierce earlobes	0.00	0.00	0.00	0.00	XXX	0
69100		A	Biopsy of external ear	0.76	0.66	0.07	1.49	000	S
69105		A	Biopsy of external ear canal	0.85	0.80	0.09	1.74	000	S
69110		A	Partial removal external ear	3.34	2.63	0.37	6.34	090	S
69120		A	Removal of external ear	3.95	0.78	0.07	4.80	090	S
69140		A	Remove ear canal lesion(s)	7.68	8.00	0.88	16.56	090	S
69145		A	Remove ear canal lesion(s)	2.54	2.51	0.28	5.33	090	S
69150		A	Extensive ear canal surgery	13.01	10.46	1.25	24.72	090	S
69155		A	Extensive ear/neck surgery	17.03	15.92	1.61	34.56	090	S
69200		A	Clear outer ear canal	0.77	0.42	0.04	1.23	000	N
69205		A	Clear outer ear canal	1.15	1.07	0.11	2.33	010	S
69210		A	Remove impacted ear wax	0.61	0.23	0.02	0.86	000	N
69220		A	Clean out mastoid cavity	0.83	0.50	0.05	1.38	000	S
69222		A	Clean out mastoid cavity	1.35	0.74	0.08	2.17	010	S
69300		R	Revise external ear	6.36	5.30	0.28	11.94	YYY	S
69310		A	Rebuild outer ear canal	10.59	9.84	1.08	21.51	090	S
69320		A	Rebuild outer ear canal	16.60	14.65	1.66	32.91	090	S
69399		C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	YYY	S
69400		A	Inflate middle ear canal	0.83	0.45	0.05	1.33	000	S
69401		A	Inflate middle ear canal	0.63	0.25	0.03	0.91	000	S
69405		A	Catheterize middle ear canal	2.58	0.48	0.04	3.10	010	S
69410		A	Inset middle ear baffle	0.33	0.60	0.07	1.00	000	S
69420		A	Incision of eardrum	1.28	0.69	0.08	2.05	010	S
69421		A	Incision of eardrum	1.68	1.14	0.13	2.95	010	S
69424		A	Remove ventilating tube	0.85	0.60	0.06	1.51	000	S
69433		A	Create eardrum opening	1.47	1.33	0.15	2.95	010	S
69436		A	Create eardrum opening	1.91	2.13	0.23	4.27	010	S
69440		A	Exploration of middle ear	7.31	8.69	0.93	16.93	090	S
69450		A	Eardrum revision	5.44	*6.96	1.15	13.55	090	S
69501		A	Mastoidectomy	8.81	10.90	1.17	20.88	090	S
69502		A	Mastoidectomy	11.96	13.36	1.45	26.77	090	S
69505		A	Remove mastoid structures	12.57	*16.09	1.79	30.45	090	S
69511		A	Extensive mastoid surgery	13.10	*16.77	1.84	31.71	090	S
69530		A	Extensive mastoid surgery	18.04	16.71	1.72	36.47	090	S
69535		A	Remove part of temporal bone	34.50	25.27	2.85	62.62	090	S
69540		A	Remove ear lesion	1.15	1.27	0.14	2.56	010	S
69550		A	Remove ear lesion	10.70	*13.70	2.00	26.40	090	S
69552		A	Remove ear lesion	18.84	16.73	1.86	37.43	090	S
69554		A	Remove ear lesion	25.78	22.87	2.63	51.28	090	S
69601		A	Mastoid surgery revision	12.79	14.02	1.55	28.36	090	S
69602		A	Mastoid surgery revision	13.16	16.27	1.75	31.18	090	S
69603		A	Mastoid surgery revision	13.60	17.34	1.88	32.82	090	S
69604		A	Mastoid surgery revision	13.60	*17.41	2.70	33.71	090	S
69605		A	Mastoid surgery revision	18.04	14.95	1.86	34.85	090	S
69610		A	Repair of eardrum	4.38	0.93	0.10	5.41	010	S
69620		A	Repair of eardrum	5.74	*7.34	1.16	14.24	090	S
69631		A	Repair eardrum structures	9.55	*12.22	1.61	23.38	090	S
69632		A	Rebuild eardrum structures	12.41	*15.88	1.73	30.02	090	S
69633		A	Rebuild eardrum structures	11.76	*15.05	1.78	28.59	090	S
69635		A	Repair eardrum structures	13.02	*16.65	1.91	31.58	090	S
69636		A	Rebuild eardrum structures	14.88	*19.05	2.11	36.04	090	S
69637		A	Rebuild eardrum structures	14.77	*18.90	2.22	35.89	090	S
69641		A	Revise middle ear & mastoid	12.29	*15.73	1.87	29.89	090	S
69642		A	Revise middle ear & mastoid	16.37	20.62	2.21	39.20	090	S
69643		A	Revise middle ear & mastoid	14.81	*18.95	2.51	36.27	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
69644	.....	A	Revise middle ear & mastoid	16.46	*21.07	2.70	40.23	090	S
69645	.....	A	Revise middle ear & mastoid	15.80	*20.23	2.51	38.54	090	S
69646	.....	A	Revise middle ear & mastoid	17.35	21.97	2.40	41.72	090	S
69650	.....	A	Release middle ear bone	9.40	*12.03	1.33	22.76	090	S
69660	.....	A	Revise middle ear bone	11.64	*14.90	1.82	28.36	090	S
69661	.....	A	Revise middle ear bone	15.32	18.44	1.93	35.69	090	S
69662	.....	A	Revise middle ear bone	15.04	18.02	1.94	35.00	090	S
69666	.....	A	Repair middle ear structures	9.38	*12.00	1.77	23.15	090	S
69667	.....	A	Repair middle ear structures	9.39	*12.02	1.66	23.07	090	S
69670	.....	A	Remove mastoid air cells	11.05	10.18	1.08	22.31	090	S
69676	.....	A	Remove middle ear nerve	9.23	8.53	0.86	18.62	090	S
69700	.....	A	Close mastoid fistula	7.97	7.86	0.84	16.67	090	S
69710	.....	N	Implant/replace hearing aid	0.00	0.00	0.00	0.00	XXX	0
69711	.....	A	Remove/repair hearing aid	10.13	8.44	0.44	19.01	090	S
69720	.....	A	Release facial nerve	13.80	*17.66	2.27	33.73	090	S
69725	.....	A	Release facial nerve	18.98	14.65	1.51	35.14	090	S
69740	.....	A	Repair facial nerve	15.39	11.83	1.69	28.91	090	S
69745	.....	A	Repair facial nerve	16.10	15.95	1.53	33.58	090	S
69799	.....	C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	YYY	S
69801	.....	A	Incise inner ear	8.19	*10.48	1.84	20.51	090	S
69802	.....	A	Incise inner ear	12.44	11.24	1.22	24.90	090	S
69805	.....	A	Explore inner ear	10.27	*13.14	2.00	25.41	090	S
69806	.....	A	Explore inner ear	11.82	*15.13	2.54	29.49	090	S
69820	.....	A	Establish inner ear window	10.14	8.85	1.00	19.99	090	S
69840	.....	A	Revise inner ear window	10.06	8.49	0.51	19.06	090	S
69905	.....	A	Remove inner ear	10.70	*13.70	2.07	26.47	090	S
69910	.....	A	Remove inner ear & mastoid	13.10	*16.77	2.34	32.21	090	S
69915	.....	A	Incise inner ear nerve	19.89	17.71	2.02	39.62	090	S
69930	.....	A	Implant cochlear device	14.00	*18.56	3.34	35.90	090	S
69949	.....	C	Inner ear surgery procedure	0.00	0.00	0.00	0.00	YYY	S
69950	.....	A	Incise inner ear nerve	21.15	17.99	2.31	41.45	090	S
69955	.....	A	Release facial nerve	22.12	20.28	2.25	44.65	090	S
69960	.....	A	Release inner ear canal	19.75	17.85	1.93	39.53	090	S
69970	.....	A	Remove inner ear lesion	22.30	19.69	2.26	44.25	090	S
69979	.....	C	Temporal bone surgery	0.00	0.00	0.00	0.00	YYY	S
70010	.....	A	Contrast x-ray of brain	1.19	4.65	0.34	6.18	XXX	N
70010	26	A	Contrast x-ray of brain	1.19	0.52	0.08	1.79	XXX	N
70010	TC	A	Contrast x-ray of brain	0.00	4.13	0.26	4.39	XXX	N
70015	.....	A	Contrast x-ray of brain	1.19	1.81	0.17	3.17	XXX	N
70015	26	A	Contrast x-ray of brain	1.19	0.52	0.08	1.79	XXX	N
70015	TC	A	Contrast x-ray of brain	0.00	1.29	0.09	1.38	XXX	N
70030	.....	A	X-ray eye for foreign body	0.17	0.48	0.04	0.69	XXX	N
70030	26	A	X-ray eye for foreign body	0.17	0.08	0.01	0.26	XXX	N
70030	TC	A	X-ray eye for foreign body	0.00	0.40	0.03	0.43	XXX	N
70100	.....	A	X-ray exam of jaw	0.18	0.59	0.04	0.81	XXX	N
70100	26	A	X-ray exam of jaw	0.18	0.09	0.01	0.28	XXX	N
70100	TC	A	X-ray exam of jaw	0.00	0.50	0.03	0.53	XXX	N
70110	.....	A	X-ray exam of jaw	0.25	0.71	0.06	1.02	XXX	N
70110	26	A	X-ray exam of jaw	0.25	0.12	0.02	0.39	XXX	N
70110	TC	A	X-ray exam of jaw	0.00	0.59	0.04	0.63	XXX	N
70120	.....	A	X-ray exam of mastoids	0.18	0.68	0.05	0.91	XXX	N
70120	26	A	X-ray exam of mastoids	0.18	0.09	0.01	0.28	XXX	N
70120	TC	A	X-ray exam of mastoids	0.00	0.59	0.04	0.63	XXX	N
70130	.....	A	X-ray exam of mastoids	0.34	0.91	0.07	1.32	XXX	N
70130	26	A	X-ray exam of mastoids	0.34	0.16	0.02	0.52	XXX	N
70130	TC	A	X-ray exam of mastoids	0.00	0.75	0.05	0.80	XXX	N
70134	.....	A	X-ray exam of middle ear	0.34	0.86	0.07	1.27	XXX	N
70134	26	A	X-ray exam of middle ear	0.34	0.16	0.02	0.52	XXX	N
70134	TC	A	X-ray exam of middle ear	0.00	0.70	0.05	0.75	XXX	N
70140	.....	A	X-ray exam of facial bones	0.19	0.68	0.05	0.92	XXX	N
70140	26	A	X-ray exam of facial bones	0.19	0.09	0.01	0.29	XXX	N
70140	TC	A	X-ray exam of facial bones	0.00	0.59	0.04	0.63	XXX	N
70150	.....	A	X-ray exam of facial bones	0.26	0.87	0.07	1.20	XXX	N
70150	26	A	X-ray exam of facial bones	0.26	0.12	0.02	0.40	XXX	N
70150	TC	A	X-ray exam of facial bones	0.00	0.75	0.05	0.80	XXX	N
70160	.....	A	X-ray exam of nasal bones	0.17	0.58	0.04	0.79	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
70160	26	A	X-ray exam of nasal bones	0.17	0.08	0.01	0.26	XXX	N
70160	TC	A	X-ray exam of nasal bones	0.00	0.50	0.03	0.53	XXX	N
70170	.....	A	X-ray exam of tear duct	0.30	1.04	0.08	1.42	XXX	N
70170	26	A	X-ray exam of tear duct	0.30	0.14	0.02	0.46	XXX	N
70170	TC	A	X-ray exam of tear duct	0.00	0.90	0.06	0.96	XXX	N
70190	.....	A	X-ray exam of eye sockets	0.21	0.69	0.05	0.95	XXX	N
70190	26	A	X-ray exam of eye sockets	0.21	0.10	0.01	0.32	XXX	N
70190	TC	A	X-ray exam of eye sockets	0.00	0.59	0.04	0.63	XXX	N
70200	.....	A	X-ray exam of eye sockets	0.28	0.88	0.07	1.23	XXX	N
70200	26	A	X-ray exam of eye sockets	0.28	0.13	0.02	0.43	XXX	N
70200	TC	A	X-ray exam of eye sockets	0.00	0.75	0.05	0.80	XXX	N
70210	.....	A	X-ray exam of sinuses	0.17	0.67	0.05	0.89	XXX	N
70210	26	A	X-ray exam of sinuses	0.17	0.08	0.01	0.26	XXX	N
70210	TC	A	X-ray exam of sinuses	0.00	0.59	0.04	0.63	XXX	N
70220	.....	A	X-ray exam of sinuses	0.25	0.87	0.07	1.19	XXX	N
70220	26	A	X-ray exam of sinuses	0.25	0.12	0.02	0.39	XXX	N
70220	TC	A	X-ray exam of sinuses	0.00	0.75	0.05	0.80	XXX	N
70240	.....	A	X-ray exam pituitary saddle	0.19	0.49	0.04	0.72	XXX	N
70240	26	A	X-ray exam pituitary saddle	0.19	0.09	0.01	0.29	XXX	N
70240	TC	A	X-ray exam pituitary saddle	0.00	0.40	0.03	0.43	XXX	N
70250	.....	A	X-ray exam of skull	0.24	0.70	0.06	1.00	XXX	N
70250	26	A	X-ray exam of skull	0.24	0.11	0.02	0.37	XXX	N
70250	TC	A	X-ray exam of skull	0.00	0.59	0.04	0.63	XXX	N
70260	.....	A	X-ray exam of skull	0.34	1.01	0.08	1.43	XXX	N
70260	26	A	X-ray exam of skull	0.34	0.16	0.02	0.52	XXX	N
70260	TC	A	X-ray exam of skull	0.00	0.85	0.06	0.91	XXX	N
70300	.....	A	X-ray exam of teeth	0.10	0.30	0.03	0.43	XXX	N
70300	26	A	X-ray exam of teeth	0.10	0.05	0.01	0.16	XXX	N
70300	TC	A	X-ray exam of teeth	0.00	0.25	0.02	0.27	XXX	N
70310	.....	A	X-ray exam of teeth	0.16	0.47	0.04	0.67	XXX	N
70310	26	A	X-ray exam of teeth	0.16	0.07	0.01	0.24	XXX	N
70310	TC	A	X-ray exam of teeth	0.00	0.40	0.03	0.43	XXX	N
70320	.....	A	Full mouth x-ray of teeth	0.22	0.85	0.07	1.14	XXX	N
70320	26	A	Full mouth x-ray of teeth	0.22	0.10	0.02	0.34	XXX	N
70320	TC	A	Full mouth x-ray of teeth	0.00	0.75	0.05	0.80	XXX	N
70328	.....	A	X-ray exam of jaw joint	0.18	0.56	0.04	0.78	XXX	N
70328	26	A	X-ray exam of jaw joint	0.18	0.09	0.01	0.28	XXX	N
70328	TC	A	X-ray exam of jaw joint	0.00	0.47	0.03	0.50	XXX	N
70330	.....	A	X-ray exam of jaw joints	0.24	0.91	0.07	1.22	XXX	N
70330	26	A	X-ray exam of jaw joints	0.24	0.11	0.02	0.37	XXX	N
70330	TC	A	X-ray exam of jaw joints	0.00	0.80	0.05	0.85	XXX	N
70332	.....	A	X-ray exam of jaw joint	0.54	2.25	0.17	2.96	XXX	N
70332	26	A	X-ray exam of jaw joint	0.54	0.25	0.04	0.83	XXX	N
70332	TC	A	X-ray exam of jaw joint	0.00	2.00	0.13	2.13	XXX	N
70336	.....	A	Magnetic image jaw joint	0.95	11.11	0.73	12.79	XXX	N
70336	26	A	Magnetic image jaw joint	0.95	0.43	0.06	1.44	XXX	N
70336	TC	A	Magnetic image jaw joint	0.00	10.68	0.67	11.35	XXX	N
70350	.....	A	X-ray head for orthodontia	0.17	0.44	0.03	0.64	XXX	N
70350	26	A	X-ray head for orthodontia	0.17	0.08	0.01	0.26	XXX	N
70350	TC	A	X-ray head for orthodontia	0.00	0.36	0.02	0.38	XXX	N
70355	.....	A	Panoramic x-ray of jaws	0.20	0.63	0.05	0.88	XXX	N
70355	26	A	Panoramic x-ray of jaws	0.20	0.09	0.01	0.30	XXX	N
70355	TC	A	Panoramic x-ray of jaws	0.00	0.54	0.04	0.58	XXX	N
70360	.....	A	X-ray exam of neck	0.17	0.48	0.04	0.69	XXX	N
70360	26	A	X-ray exam of neck	0.17	0.08	0.01	0.26	XXX	N
70360	TC	A	X-ray exam of neck	0.00	0.40	0.03	0.43	XXX	N
70370	.....	A	Throat x-ray & fluoroscopy	0.32	1.39	0.10	1.81	XXX	N
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.15	0.02	0.49	XXX	N
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.24	0.08	1.32	XXX	N
70371	.....	A	Speech evaluation, complex	0.84	2.38	0.19	3.41	XXX	N
70371	26	A	Speech evaluation, complex	0.84	0.38	0.06	1.28	XXX	N
70371	TC	A	Speech evaluation, complex	0.00	2.00	0.13	2.13	XXX	N
70373	.....	A	Contrast x-ray of larynx	0.44	1.90	0.14	2.48	XXX	N
70373	26	A	Contrast x-ray of larynx	0.44	0.20	0.03	0.67	XXX	N
70373	TC	A	Contrast x-ray of larynx	0.00	1.70	0.11	1.81	XXX	N
70380	.....	A	X-ray exam of salivary gland	0.17	0.72	0.05	0.94	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
70380	26	A	X-ray exam of salivary gland	0.17	0.08	0.01	0.26	XXX	N
70380	TC	A	X-ray exam of salivary gland	0.00	0.64	0.04	0.68	XXX	N
70390	.....	A	X-ray exam of salivary duct	0.38	1.87	0.14	2.39	XXX	N
70390	26	A	X-ray exam of salivary duct	0.38	0.17	0.03	0.58	XXX	N
70390	TC	A	X-ray exam of salivary duct	0.00	1.70	0.11	1.81	XXX	N
70450	.....	A	CAT scan of head or brain	0.85	4.88	0.35	6.08	XXX	N
70450	26	A	CAT scan of head or brain	0.85	0.38	0.06	1.29	XXX	N
70450	TC	A	CAT scan of head or brain	0.00	4.50	0.29	4.79	XXX	N
70460	.....	A	Contrast CAT scan of head	1.13	5.89	0.43	7.45	XXX	N
70460	26	A	Contrast CAT scan of head	1.13	0.50	0.08	1.71	XXX	N
70460	TC	A	Contrast CAT scan of head	0.00	5.39	0.35	5.74	XXX	N
70470	.....	A	Contrast CAT scans of head	1.27	7.30	0.52	9.09	XXX	N
70470	26	A	Contrast CAT scans of head	1.27	0.56	0.09	1.92	XXX	N
70470	TC	A	Contrast CAT scans of head	0.00	6.74	0.43	7.17	XXX	N
70480	.....	A	CAT scan of skull	1.28	5.07	0.38	6.73	XXX	N
70480	26	A	CAT scan of skull	1.28	0.57	0.09	1.94	XXX	N
70480	TC	A	CAT scan of skull	0.00	4.50	0.29	4.79	XXX	N
70481	.....	A	Contrast CAT scan of skull	1.38	6.00	0.44	7.82	XXX	N
70481	26	A	Contrast CAT scan of skull	1.38	0.61	0.09	2.08	XXX	N
70481	TC	A	Contrast CAT scan of skull	0.00	5.39	0.35	5.74	XXX	N
70482	.....	A	Contrast CAT scans of skull	1.45	7.38	0.53	9.36	XXX	N
70482	26	A	Contrast CAT scans of skull	1.45	0.64	0.10	2.19	XXX	N
70482	TC	A	Contrast CAT scans of skull	0.00	6.74	0.43	7.17	XXX	N
70486	.....	A	CAT scan of face, jaw	1.14	5.00	0.37	6.51	XXX	N
70486	26	A	CAT scan of face, jaw	1.14	0.50	0.08	1.72	XXX	N
70486	TC	A	CAT scan of face, jaw	0.00	4.50	0.29	4.79	XXX	N
70487	.....	A	Contrast CAT scan, face/jaw	1.30	5.96	0.44	7.70	XXX	N
70487	26	A	Contrast CAT scan, face/jaw	1.30	0.57	0.09	1.96	XXX	N
70487	TC	A	Contrast CAT scan, face/jaw	0.00	5.39	0.35	5.74	XXX	N
70488	.....	A	Contrast CAT scans face/jaw	1.42	7.37	0.53	9.32	XXX	N
70488	26	A	Contrast CAT scans face/jaw	1.42	0.63	0.10	2.15	XXX	N
70488	TC	A	Contrast CAT scans face/jaw	0.00	6.74	0.43	7.17	XXX	N
70490	.....	A	CAT scan of neck tissue	1.28	5.07	0.38	6.73	XXX	N
70490	26	A	CAT scan of neck tissue	1.28	0.57	0.09	1.94	XXX	N
70490	TC	A	CAT scan of neck tissue	0.00	4.50	0.29	4.79	XXX	N
70491	.....	A	Contrast CAT of neck tissue	1.38	6.00	0.44	7.82	XXX	N
70491	26	A	Contrast CAT of neck tissue	1.38	0.61	0.09	2.08	XXX	N
70491	TC	A	Contrast CAT of neck tissue	0.00	5.39	0.35	5.74	XXX	N
70492	.....	A	Contrast CAT of neck tissue	1.45	7.38	0.53	9.36	XXX	N
70492	26	A	Contrast CAT of neck tissue	1.45	0.64	0.10	2.19	XXX	N
70492	TC	A	Contrast CAT of neck tissue	0.00	6.74	0.43	7.17	XXX	N
70540	.....	A	Magnetic image, face, neck	1.48	11.34	0.77	13.59	XXX	N
70540	26	A	Magnetic image, face, neck	1.48	0.66	0.10	2.24	XXX	N
70540	TC	A	Magnetic image, face, neck	0.00	10.68	0.67	11.35	XXX	N
70541	.....	R	Magnetic image, head (MRA)	1.81	11.34	0.77	13.92	XXX	N
70541	26	R	Magnetic image, head (MRA)	1.81	0.66	0.10	2.57	XXX	N
70541	TC	R	Magnetic image, head (MRA)	0.00	10.68	0.67	11.35	XXX	N
70551	.....	A	Magnetic image, brain (MRI)	1.48	11.34	0.77	13.59	XXX	N
70551	26	A	Magnetic image, brain (MRI)	1.48	0.66	0.10	2.24	XXX	N
70551	TC	A	Magnetic image, brain (MRI)	0.00	10.68	0.67	11.35	XXX	N
70552	.....	A	Magnetic image, brain (MRI)	1.78	13.61	0.93	16.32	XXX	N
70552	26	A	Magnetic image, brain (MRI)	1.78	0.80	0.12	2.70	XXX	N
70552	TC	A	Magnetic image, brain (MRI)	0.00	12.81	0.81	13.62	XXX	N
70553	.....	A	Magnetic image, brain	2.36	24.79	1.65	28.80	XXX	N
70553	26	A	Magnetic image, brain	2.36	1.07	0.16	3.59	XXX	N
70553	TC	A	Magnetic image, brain	0.00	23.72	1.49	25.21	XXX	N
71010	.....	A	Chest x-ray	0.18	0.53	0.04	0.75	XXX	N
71010	26	A	Chest x-ray	0.18	0.08	0.01	0.27	XXX	N
71010	TC	A	Chest x-ray	0.00	0.45	0.03	0.48	XXX	N
71015	.....	A	X-ray exam of chest	0.21	0.60	0.04	0.85	XXX	N
71015	26	A	X-ray exam of chest	0.21	0.10	0.01	0.32	XXX	N
71015	TC	A	X-ray exam of chest	0.00	0.50	0.03	0.53	XXX	N
71020	.....	A	Chest x-ray	0.22	0.69	0.05	0.96	XXX	N
71020	26	A	Chest x-ray	0.22	0.10	0.01	0.33	XXX	N
71020	TC	A	Chest x-ray	0.00	0.59	0.04	0.63	XXX	N
71021	.....	A	Chest x-ray	0.27	0.82	0.07	1.16	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110—D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
71021	26	A	Chest x-ray	0.27	0.12	0.02	0.41	XXX	N
71021	TC	A	Chest x-ray	0.00	0.70	0.05	0.75	XXX	N
71022	.....	A	Chest x-ray	0.31	0.84	0.07	1.22	XXX	N
71022	26	A	Chest x-ray	0.31	0.14	0.02	0.47	XXX	N
71022	TC	A	Chest x-ray	0.00	0.70	0.05	0.75	XXX	N
71023	.....	A	Chest x-ray and fluoroscopy	0.38	0.92	0.08	1.38	XXX	N
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.17	0.03	0.58	XXX	N
71023	TC	A	Chest x-ray and fluoroscopy	0.00	0.75	0.05	0.80	XXX	N
71030	.....	A	Chest x-ray	0.31	0.89	0.07	1.27	XXX	N
71030	26	A	Chest x-ray	0.31	0.14	0.02	0.47	XXX	N
71030	TC	A	Chest x-ray	0.00	0.75	0.05	0.80	XXX	N
71034	.....	A	Chest x-ray & fluoroscopy	0.46	1.58	0.12	2.16	XXX	N
71034	26	A	Chest x-ray & fluoroscopy	0.46	0.21	0.03	0.70	XXX	N
71034	TC	A	Chest x-ray & fluoroscopy	0.00	1.37	0.09	1.46	XXX	N
71035	.....	A	Chest x-ray	0.18	0.58	0.04	0.80	XXX	N
71035	26	A	Chest x-ray	0.18	0.08	0.01	0.27	XXX	N
71035	TC	A	Chest x-ray	0.00	0.50	0.03	0.53	XXX	N
71036	.....	A	X-ray guidance for biopsy	0.54	1.75	0.14	2.43	XXX	N
71036	26	A	X-ray guidance for biopsy	0.54	0.25	0.04	0.83	XXX	N
71036	TC	A	X-ray guidance for biopsy	0.00	1.50	0.10	1.60	XXX	N
71038	.....	A	X-ray guidance for biopsy	0.54	1.85	0.15	2.54	XXX	N
71038	26	A	X-ray guidance for biopsy	0.54	0.25	0.04	0.83	XXX	N
71038	TC	A	X-ray guidance for biopsy	0.00	1.60	0.11	1.71	XXX	N
71040	.....	A	Contrast x-ray of bronchi	0.58	1.66	0.13	2.37	XXX	N
71040	26	A	Contrast x-ray of bronchi	0.58	0.27	0.04	0.89	XXX	N
71040	TC	A	Contrast x-ray of bronchi	0.00	1.39	0.09	1.48	XXX	N
71060	.....	A	Contrast x-ray of bronchi	0.74	2.44	0.19	3.37	XXX	N
71060	26	A	Contrast x-ray of bronchi	0.74	0.34	0.05	1.13	XXX	N
71060	TC	A	Contrast x-ray of bronchi	0.00	2.10	0.14	2.24	XXX	N
71090	.....	A	X-ray & pacemaker insertion	0.54	1.85	0.15	2.54	XXX	N
71090	26	A	X-ray & pacemaker insertion	0.54	0.25	0.04	0.83	XXX	N
71090	TC	A	X-ray & pacemaker insertion	0.00	1.60	0.11	1.71	XXX	N
71100	.....	A	X-ray exam of ribs	0.22	0.64	0.06	0.92	XXX	N
71100	26	A	X-ray exam of ribs	0.22	0.10	0.02	0.34	XXX	N
71100	TC	A	X-ray exam of ribs	0.00	0.54	0.04	0.58	XXX	N
71101	.....	A	X-ray exam of ribs, chest	0.27	0.77	0.06	1.10	XXX	N
71101	26	A	X-ray exam of ribs, chest	0.27	0.13	0.02	0.42	XXX	N
71101	TC	A	X-ray exam of ribs, chest	0.00	0.64	0.04	0.68	XXX	N
71110	.....	A	X-ray exam of ribs	0.27	0.88	0.07	1.22	XXX	N
71110	26	A	X-ray exam of ribs	0.27	0.13	0.02	0.42	XXX	N
71110	TC	A	X-ray exam of ribs	0.00	0.75	0.05	0.80	XXX	N
71111	.....	A	X-ray exam of ribs, chest	0.32	1.00	0.08	1.40	XXX	N
71111	26	A	X-ray exam of ribs, chest	0.32	0.15	0.02	0.49	XXX	N
71111	TC	A	X-ray exam of ribs, chest	0.00	0.85	0.06	0.91	XXX	N
71120	.....	A	X-ray exam of breastbone	0.20	0.71	0.05	0.96	XXX	N
71120	26	A	X-ray exam of breastbone	0.20	0.09	0.01	0.30	XXX	N
71120	TC	A	X-ray exam of breastbone	0.00	0.62	0.04	0.66	XXX	N
71130	.....	A	X-ray exam of breastbone	0.22	0.77	0.05	1.04	XXX	N
71130	26	A	X-ray exam of breastbone	0.22	0.10	0.01	0.33	XXX	N
71130	TC	A	X-ray exam of breastbone	0.00	0.67	0.04	0.71	XXX	N
71250	.....	A	Cat scan of chest	1.16	6.14	0.44	7.74	XXX	N
71250	26	A	Cat scan of chest	1.16	0.51	0.08	1.75	XXX	N
71250	TC	A	Cat scan of chest	0.00	5.63	0.36	5.99	XXX	N
71260	.....	A	Contrast CAT scan of chest	1.24	7.29	0.51	9.04	XXX	N
71260	26	A	Contrast CAT scan of chest	1.24	0.55	0.08	1.87	XXX	N
71260	TC	A	Contrast CAT scan of chest	0.00	6.74	0.43	7.17	XXX	N
71270	.....	A	Contrast CAT scans of chest	1.38	9.04	0.61	11.03	XXX	N
71270	26	A	Contrast CAT scans of chest	1.38	0.61	0.09	2.08	XXX	N
71270	TC	A	Contrast CAT scans of chest	0.00	8.43	0.52	8.95	XXX	N
71550	.....	A	Magnetic image, chest	1.60	11.40	0.78	13.78	XXX	N
71550	26	A	Magnetic image, chest	1.60	0.72	0.11	2.43	XXX	N
71550	TC	A	Magnetic image, chest	0.00	10.68	0.67	11.35	XXX	N
71555	.....	N	Magnetic imaging/chest (MRA)	#1.81	11.40	0.78	13.99	XXX	0
71555	26	N	Magnetic imaging/chest (MRA)	#1.81	0.72	0.11	2.64	XXX	0
71555	TC	N	Magnetic imaging/chest (MRA)	#0.00	10.68	0.67	11.35	XXX	0
72010	.....	A	X-ray exam of spine	0.45	1.18	0.09	1.72	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
72010	26	A	X-ray exam of spine	0.45	0.20	0.03	0.68	XXX	N
72010	TC	A	X-ray exam of spine	0.00	0.98	0.06	1.04	XXX	N
72020	.....	A	X-ray exam of spine	0.15	0.47	0.04	0.66	XXX	N
72020	26	A	X-ray exam of spine	0.15	0.07	0.01	0.23	XXX	N
72020	TC	A	X-ray exam of spine	0.00	0.40	0.03	0.43	XXX	N
72040	.....	A	X-ray exam of neck spine	0.22	0.67	0.05	0.94	XXX	N
72040	26	A	X-ray exam of neck spine	0.22	0.10	0.01	0.33	XXX	N
72040	TC	A	X-ray exam of neck spine	0.00	0.57	0.04	0.61	XXX	N
72050	.....	A	X-ray exam of neck spine	0.31	0.99	0.08	1.38	XXX	N
72050	26	A	X-ray exam of neck spine	0.31	0.14	0.02	0.47	XXX	N
72050	TC	A	X-ray exam of neck spine	0.00	0.85	0.06	0.91	XXX	N
72052	.....	A	X-ray exam of neck spine	0.36	1.25	0.09	1.70	XXX	N
72052	26	A	X-ray exam of neck spine	0.36	0.17	0.02	0.55	XXX	N
72052	TC	A	X-ray exam of neck spine	0.00	1.08	0.07	1.15	XXX	N
72069	.....	A	X-ray exam of trunk spine	0.22	0.57	0.04	0.83	XXX	N
72069	26	A	X-ray exam of trunk spine	0.22	0.10	0.01	0.33	XXX	N
72069	TC	A	X-ray exam of trunk spine	0.00	0.47	0.03	0.50	XXX	N
72070	.....	A	X-ray exam of thorax spine	0.22	0.72	0.05	0.99	XXX	N
72070	26	A	X-ray exam of thorax spine	0.22	0.10	0.01	0.33	XXX	N
72070	TC	A	X-ray exam of thorax spine	0.00	0.62	0.04	0.66	XXX	N
72072	.....	A	X-ray exam of thoracic spine	0.22	0.80	0.06	1.08	XXX	N
72072	26	A	X-ray exam of thoracic spine	0.22	0.10	0.01	0.33	XXX	N
72072	TC	A	X-ray exam of thoracic spine	0.00	0.70	0.05	0.75	XXX	N
72074	.....	A	X-ray exam of thoracic spine	0.22	0.97	0.07	1.26	XXX	N
72074	26	A	X-ray exam of thoracic spine	0.22	0.10	0.01	0.33	XXX	N
72074	TC	A	X-ray exam of thoracic spine	0.00	0.87	0.06	0.93	XXX	N
72080	.....	A	X-ray exam of trunk spine	0.22	0.74	0.05	1.01	XXX	N
72080	26	A	X-ray exam of trunk spine	0.22	0.10	0.01	0.33	XXX	N
72080	TC	A	X-ray exam of trunk spine	0.00	0.64	0.04	0.68	XXX	N
72090	.....	A	X-ray exam of trunk spine	0.28	0.77	0.06	1.11	XXX	N
72090	26	A	X-ray exam of trunk spine	0.28	0.13	0.02	0.43	XXX	N
72090	TC	A	X-ray exam of trunk spine	0.00	0.64	0.04	0.68	XXX	N
72100	.....	A	X-ray exam of lower spine	0.22	0.74	0.05	1.01	XXX	N
72100	26	A	X-ray exam of lower spine	0.22	0.10	0.01	0.33	XXX	N
72100	TC	A	X-ray exam of lower spine	0.00	0.64	0.04	0.68	XXX	N
72110	.....	A	X-ray exam of lower spine	0.31	1.01	0.08	1.40	XXX	N
72110	26	A	X-ray exam of lower spine	0.31	0.14	0.02	0.47	XXX	N
72110	TC	A	X-ray exam of lower spine	0.00	0.87	0.06	0.93	XXX	N
72114	.....	A	X-ray exam of lower spine	0.36	1.30	0.09	1.75	XXX	N
72114	26	A	X-ray exam of lower spine	0.36	0.17	0.02	0.55	XXX	N
72114	TC	A	X-ray exam of lower spine	0.00	1.13	0.07	1.20	XXX	N
72120	.....	A	X-ray exam of lower spine	0.22	0.95	0.07	1.24	XXX	N
72120	26	A	X-ray exam of lower spine	0.22	0.10	0.01	0.33	XXX	N
72120	TC	A	X-ray exam of lower spine	0.00	0.85	0.06	0.91	XXX	N
72125	.....	A	CAT scan of neck spine	1.16	6.14	0.44	7.74	XXX	N
72125	26	A	CAT scan of neck spine	1.16	0.51	0.08	1.75	XXX	N
72125	TC	A	CAT scan of neck spine	0.00	5.63	0.36	5.99	XXX	N
72126	.....	A	Contrast CAT scan of neck	1.22	7.27	0.51	9.00	XXX	N
72126	26	A	Contrast CAT scan of neck	1.22	0.53	0.08	1.83	XXX	N
72126	TC	A	Contrast CAT scan of neck	0.00	6.74	0.43	7.17	XXX	N
72127	.....	A	Contrast CAT scans of neck	1.27	8.99	0.61	10.87	XXX	N
72127	26	A	Contrast CAT scans of neck	1.27	0.56	0.09	1.92	XXX	N
72127	TC	A	Contrast CAT scans of neck	0.00	8.43	0.52	8.95	XXX	N
72128	.....	A	CAT scan of thorax spine	1.16	6.14	0.44	7.74	XXX	N
72128	26	A	CAT scan of thorax spine	1.16	0.51	0.08	1.75	XXX	N
72128	TC	A	CAT scan of thorax spine	0.00	5.63	0.36	5.99	XXX	N
72129	.....	A	Contrast CAT scan of thorax	1.22	7.27	0.51	9.00	XXX	N
72129	26	A	Contrast CAT scan of thorax	1.22	0.53	0.08	1.83	XXX	N
72129	TC	A	Contrast CAT scan of thorax	0.00	6.74	0.43	7.17	XXX	N
72130	.....	A	Contrast CAT scans of thorax	1.27	8.99	0.61	10.87	XXX	N
72130	26	A	Contrast CAT scans of thorax	1.27	0.56	0.09	1.92	XXX	N
72130	TC	A	Contrast CAT scans of thorax	0.00	8.43	0.52	8.95	XXX	N
72131	.....	A	CAT scan of lower spine	1.16	6.14	0.44	7.74	XXX	N
72131	26	A	CAT scan of lower spine	1.16	0.51	0.08	1.75	XXX	N
72131	TC	A	CAT scan of lower spine	0.00	5.63	0.36	5.99	XXX	N
72132	.....	A	Contrast CAT of lower spine	1.22	7.27	0.51	9.00	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
72132	26	A	Contrast CAT of lower spine	1.22	0.53	0.08	1.83	XXX	N
72132	TC	A	Contrast CAT of lower spine	0.00	6.74	0.43	7.17	XXX	N
72133	.....	A	Contrast CAT scans,low spine	1.27	8.99	0.61	10.87	XXX	N
72133	26	A	Contrast CAT scans,low spine	1.27	0.56	0.09	1.92	XXX	N
72133	TC	A	Contrast CAT scans,low spine	0.00	8.43	0.52	8.95	XXX	N
72141	.....	A	Magnetic image, neck spine	1.60	11.40	0.78	13.78	XXX	N
72141	26	A	Magnetic image, neck spine	1.60	0.72	0.11	2.43	XXX	N
72141	TC	A	Magnetic image, neck spine	0.00	10.68	0.67	11.35	XXX	N
72142	.....	A	Magnetic image, neck spine	1.92	13.67	0.94	16.53	XXX	N
72142	26	A	Magnetic image, neck spine	1.92	0.86	0.13	2.91	XXX	N
72142	TC	A	Magnetic image, neck spine	0.00	12.81	0.81	13.62	XXX	N
72146	.....	A	Magnetic image, chest spine	1.60	12.58	0.85	15.03	XXX	N
72146	26	A	Magnetic image, chest spine	1.60	0.72	0.11	2.43	XXX	N
72146	TC	A	Magnetic image, chest spine	0.00	11.86	0.74	12.60	XXX	N
72147	.....	A	Magnetic image, chest spine	1.92	13.67	0.94	16.53	XXX	N
72147	26	A	Magnetic image, chest spine	1.92	0.86	0.13	2.91	XXX	N
72147	TC	A	Magnetic image, chest spine	0.00	12.81	0.81	13.62	XXX	N
72148	.....	A	Magnetic image, lumbar spine	1.48	12.52	0.84	14.84	XXX	N
72148	26	A	Magnetic image, lumbar spine	1.48	0.66	0.10	2.24	XXX	N
72148	TC	A	Magnetic image, lumbar spine	0.00	11.86	0.74	12.60	XXX	N
72149	.....	A	Magnetic image, lumbar spine	1.78	13.61	0.93	16.32	XXX	N
72149	26	A	Magnetic image, lumbar spine	1.78	0.80	0.12	2.70	XXX	N
72149	TC	A	Magnetic image, lumbar spine	0.00	12.81	0.81	13.62	XXX	N
72156	.....	A	Magnetic image, neck spine	2.57	24.87	1.66	29.10	XXX	N
72156	26	A	Magnetic image, neck spine	2.57	1.15	0.17	3.89	XXX	N
72156	TC	A	Magnetic image, neck spine	0.00	23.72	1.49	25.21	XXX	N
72157	.....	A	Magnetic image, chest spine	2.57	24.87	1.66	29.10	XXX	N
72157	26	A	Magnetic image, chest spine	2.57	1.15	0.17	3.89	XXX	N
72157	TC	A	Magnetic image, chest spine	0.00	23.72	1.49	25.21	XXX	N
72158	.....	A	Magnetic image, lumbar spine	2.36	24.79	1.65	28.80	XXX	N
72158	26	A	Magnetic image, lumbar spine	2.36	1.07	0.16	3.59	XXX	N
72158	TC	A	Magnetic image, lumbar spine	0.00	23.72	1.49	25.21	XXX	N
72159	.....	N	Magnetic imaging/spine (MRA)	#1.80	12.52	0.84	15.16	XXX	0
72159	26	N	Magnetic imaging/spine (MRA)	#1.80	0.66	0.10	2.56	XXX	0
72159	TC	N	Magnetic imaging/spine (MRA)	#0.00	11.86	0.74	12.60	XXX	0
72170	.....	A	X-ray exam of pelvis	0.17	0.57	0.04	0.78	XXX	N
72170	26	A	X-ray exam of pelvis	0.17	0.07	0.01	0.25	XXX	N
72170	TC	A	X-ray exam of pelvis	0.00	0.50	0.03	0.53	XXX	N
72190	.....	A	X-ray exam of pelvis	0.21	0.74	0.05	1.00	XXX	N
72190	26	A	X-ray exam of pelvis	0.21	0.10	0.01	0.32	XXX	N
72190	TC	A	X-ray exam of pelvis	0.00	0.64	0.04	0.68	XXX	N
72192	.....	A	CAT scan of pelvis	1.09	6.11	0.43	7.63	XXX	N
72192	26	A	CAT scan of pelvis	1.09	0.48	0.07	1.64	XXX	N
72192	TC	A	CAT scan of pelvis	0.00	5.63	0.36	5.99	XXX	N
72193	.....	A	Contrast CAT scan of pelvis	1.16	7.03	0.49	8.68	XXX	N
72193	26	A	Contrast CAT scan of pelvis	1.16	0.51	0.08	1.75	XXX	N
72193	TC	A	Contrast CAT scan of pelvis	0.00	6.52	0.41	6.93	XXX	N
72194	.....	A	Contrast CAT scans of pelvis	1.22	8.62	0.58	10.42	XXX	N
72194	26	A	Contrast CAT scans of pelvis	1.22	0.53	0.08	1.83	XXX	N
72194	TC	A	Contrast CAT scans of pelvis	0.00	8.09	0.50	8.59	XXX	N
72196	.....	A	Magnetic image, pelvis	1.60	11.40	0.78	13.78	XXX	N
72196	26	A	Magnetic image, pelvis	1.60	0.72	0.11	2.43	XXX	N
72196	TC	A	Magnetic image, pelvis	0.00	10.68	0.67	11.35	XXX	N
72198	.....	N	Magnetic imaging/pelvis(MRA)	#1.80	11.40	0.78	13.98	XXX	0
72198	26	N	Magnetic imaging/pelvis(MRA)	#1.80	0.72	0.11	2.63	XXX	0
72198	TC	N	Magnetic imaging/pelvis(MRA)	#0.00	10.68	0.67	11.35	XXX	0
72200	.....	A	X-ray exam sacroiliac joints	0.17	0.58	0.04	0.79	XXX	N
72200	26	A	X-ray exam sacroiliac joints	0.17	0.08	0.01	0.26	XXX	N
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.50	0.03	0.53	XXX	N
72202	.....	A	X-ray exam sacroiliac joints	0.19	0.68	0.05	0.92	XXX	N
72202	26	A	X-ray exam sacroiliac joints	0.19	0.09	0.01	0.29	XXX	N
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.59	0.04	0.63	XXX	N
72220	.....	A	X-ray exam of tailbone	0.17	0.62	0.05	0.84	XXX	N
72220	26	A	X-ray exam of tailbone	0.17	0.08	0.01	0.26	XXX	N
72220	TC	A	X-ray exam of tailbone	0.00	0.54	0.04	0.58	XXX	N
72240	.....	A	Contrast x-ray of neck spine	0.91	4.93	0.35	6.19	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
72240	26	A	Contrast x-ray of neck spine	0.91	0.41	0.06	1.38	XXX	N
72240	TC	A	Contrast x-ray of neck spine	0.00	4.52	0.29	4.81	XXX	N
72255	.....	A	Contrast x-ray thorax spine	0.91	4.54	0.32	5.77	XXX	N
72255	26	A	Contrast x-ray thorax spine	0.91	0.41	0.06	1.38	XXX	N
72255	TC	A	Contrast x-ray thorax spine	0.00	4.13	0.26	4.39	XXX	N
72265	.....	A	Contrast x-ray lower spine	0.83	4.26	0.31	5.40	XXX	N
72265	26	A	Contrast x-ray lower spine	0.83	0.38	0.06	1.27	XXX	N
72265	TC	A	Contrast x-ray lower spine	0.00	3.88	0.25	4.13	XXX	N
72270	.....	A	Contrast x-ray of spine	1.33	6.40	0.46	8.19	XXX	N
72270	26	A	Contrast x-ray of spine	1.33	0.59	0.09	2.01	XXX	N
72270	TC	A	Contrast x-ray of spine	0.00	5.81	0.37	6.18	XXX	N
72285	.....	A	X-ray of neck spine disk	0.83	8.37	0.56	9.76	XXX	N
72285	26	A	X-ray of neck spine disk	0.83	0.38	0.06	1.27	XXX	N
72285	TC	A	X-ray of neck spine disk	0.00	7.99	0.50	8.49	XXX	N
72295	.....	A	X-ray of lower spine disk	0.83	7.87	0.52	9.22	XXX	N
72295	26	A	X-ray of lower spine disk	0.83	0.38	0.06	1.27	XXX	N
72295	TC	A	X-ray of lower spine disk	0.00	7.49	0.46	7.95	XXX	N
73000	.....	A	X-ray exam of collarbone	0.16	0.57	0.04	0.77	XXX	N
73000	26	A	X-ray exam of collarbone	0.16	0.07	0.01	0.24	XXX	N
73000	TC	A	X-ray exam of collarbone	0.00	0.50	0.03	0.53	XXX	N
73010	.....	A	X-ray exam of shoulder blade	0.17	0.58	0.04	0.79	XXX	N
73010	26	A	X-ray exam of shoulder blade	0.17	0.08	0.01	0.26	XXX	N
73010	TC	A	X-ray exam of shoulder blade	0.00	0.50	0.03	0.53	XXX	N
73020	.....	A	X-ray exam of shoulder	0.15	0.52	0.04	0.71	XXX	N
73020	26	A	X-ray exam of shoulder	0.15	0.07	0.01	0.23	XXX	N
73020	.....	A	Contrast CAT scans of leg	1.22	7.61	0.53	9.36	XXX	N
73020	26	A	Contrast CAT scans of leg	1.22	0.53	0.08	1.83	XXX	N
73020	TC	A	X-ray exam of shoulder	0.00	0.45	0.03	0.48	XXX	N
73030	.....	A	X-ray exam of shoulder	0.18	0.62	0.05	0.85	XXX	N
73030	26	A	X-ray exam of shoulder	0.18	0.08	0.01	0.27	XXX	N
73030	TC	A	X-ray exam of shoulder	0.00	0.54	0.04	0.58	XXX	N
73040	.....	A	Contrast x-ray of shoulder	0.54	2.25	0.17	2.96	XXX	N
73040	26	A	Contrast x-ray of shoulder	0.54	0.25	0.04	0.83	XXX	N
73040	TC	A	Contrast x-ray of shoulder	0.00	2.00	0.13	2.13	XXX	N
73050	.....	A	X-ray exam of shoulders	0.20	0.73	0.05	0.98	XXX	N
73050	26	A	X-ray exam of shoulders	0.20	0.09	0.01	0.30	XXX	N
73050	TC	A	X-ray exam of shoulders	0.00	0.64	0.04	0.68	XXX	N
73060	.....	A	X-ray exam of humerus	0.17	0.62	0.05	0.84	XXX	N
73060	26	A	X-ray exam of humerus	0.17	0.08	0.01	0.26	XXX	N
73060	TC	A	X-ray exam of humerus	0.00	0.54	0.04	0.58	XXX	N
73070	.....	A	X-ray exam of elbow	0.15	0.57	0.04	0.76	XXX	N
73070	26	A	X-ray exam of elbow	0.15	0.07	0.01	0.23	XXX	N
73070	TC	A	X-ray exam of elbow	0.00	0.50	0.03	0.53	XXX	N
73080	.....	A	X-ray exam of elbow	0.17	0.62	0.05	0.84	XXX	N
73080	26	A	X-ray exam of elbow	0.17	0.08	0.01	0.26	XXX	N
73080	TC	A	X-ray exam of elbow	0.00	0.54	0.04	0.58	XXX	N
73085	.....	A	Contrast x-ray of elbow	0.54	2.25	0.17	2.96	XXX	N
73085	26	A	Contrast x-ray of elbow	0.54	0.25	0.04	0.83	XXX	N
73085	TC	A	Contrast x-ray of elbow	0.00	2.00	0.13	2.13	XXX	N
73090	.....	A	X-ray exam of forearm	0.16	0.57	0.04	0.77	XXX	N
73090	26	A	X-ray exam of forearm	0.16	0.07	0.01	0.24	XXX	N
73090	TC	A	X-ray exam of forearm	0.00	0.50	0.03	0.53	XXX	N
73092	.....	A	X-ray exam of arm, infant	0.16	0.54	0.04	0.74	XXX	N
73092	26	A	X-ray exam of arm, infant	0.16	0.07	0.01	0.24	XXX	N
73092	TC	A	X-ray exam of arm, infant	0.00	0.47	0.03	0.50	XXX	N
73100	.....	A	X-ray exam of wrist	0.16	0.54	0.04	0.74	XXX	N
73100	26	A	X-ray exam of wrist	0.16	0.07	0.01	0.24	XXX	N
73100	TC	A	X-ray exam of wrist	0.00	0.47	0.03	0.50	XXX	N
73110	.....	A	X-ray exam of wrist	0.17	0.59	0.04	0.80	XXX	N
73110	26	A	X-ray exam of wrist	0.17	0.08	0.01	0.26	XXX	N
73110	TC	A	X-ray exam of wrist	0.00	0.51	0.03	0.54	XXX	N
73115	.....	A	Contrast x-ray of wrist	0.54	1.75	0.14	2.43	XXX	N
73115	26	A	Contrast x-ray of wrist	0.54	0.25	0.04	0.83	XXX	N
73115	TC	A	Contrast x-ray of wrist	0.00	1.50	0.10	1.60	XXX	N
73120	.....	A	X-ray exam of hand	0.16	0.54	0.04	0.74	XXX	N
73120	26	A	X-ray exam of hand	0.16	0.07	0.01	0.24	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
73120	TC	A	X-ray exam of hand	0.00	0.47	0.03	0.50	XXX	N
73130	.....	A	X-ray exam of hand	0.17	0.59	0.04	0.80	XXX	N
73130	26	A	X-ray exam of hand	0.17	0.08	0.01	0.26	XXX	N
73130	TC	A	X-ray exam of hand	0.00	0.51	0.03	0.54	XXX	N
73140	.....	A	X-ray exam of finger(s)	0.13	0.46	0.04	0.63	XXX	N
73140	26	A	X-ray exam of finger(s)	0.13	0.06	0.01	0.20	XXX	N
73140	TC	A	X-ray exam of finger(s)	0.00	0.40	0.03	0.43	XXX	N
73200	.....	A	CAT scan of arm	1.09	5.21	0.37	6.67	XXX	N
73200	26	A	CAT scan of arm	1.09	0.48	0.07	1.64	XXX	N
73200	TC	A	CAT scan of arm	0.00	4.73	0.30	5.03	XXX	N
73201	.....	A	Contrast CAT scan of arm	1.16	6.14	0.44	7.74	XXX	N
73201	26	A	Contrast CAT scan of arm	1.16	0.51	0.08	1.75	XXX	N
73201	TC	A	Contrast CAT scan of arm	0.00	5.63	0.36	5.99	XXX	N
73202	.....	A	Contrast CAT scans of arm	1.22	7.61	0.53	9.36	XXX	N
73202	26	A	Contrast CAT scans of arm	1.22	0.53	0.08	1.83	XXX	N
73202	TC	A	Contrast CAT scans of arm	0.00	7.08	0.45	7.53	XXX	N
73220	.....	A	Magnetic image, arm, hand	1.48	11.34	0.77	13.59	XXX	N
73220	26	A	Magnetic image, arm, hand	1.48	0.66	0.10	2.24	XXX	N
73220	TC	A	Magnetic image, arm, hand	0.00	10.68	0.67	11.35	XXX	N
73221	.....	A	Magnetic image, joint of arm	0.95	11.11	0.73	12.79	XXX	N
73221	26	A	Magnetic image, joint of arm	0.95	0.43	0.06	1.44	XXX	N
73221	TC	A	Magnetic image, joint of arm	0.00	10.68	0.67	11.35	XXX	N
73225	.....	N	Magnetic imaging/upper (MRA)	#1.73	11.34	0.77	13.84	XXX	0
73225	26	N	Magnetic imaging/upper (MRA)	#1.73	0.66	0.10	2.49	XXX	0
73225	TC	N	Magnetic imaging/upper (MRA)	#0.00	10.68	0.67	11.35	XXX	0
73500	.....	A	X-ray exam of hip	0.17	0.53	0.04	0.74	XXX	N
73500	26	A	X-ray exam of hip	0.17	0.08	0.01	0.26	XXX	N
73500	TC	A	X-ray exam of hip	0.00	0.45	0.03	0.48	XXX	N
73510	.....	A	X-ray exam of hip	0.21	0.64	0.05	0.90	XXX	N
73510	26	A	X-ray exam of hip	0.21	0.10	0.01	0.32	XXX	N
73510	TC	A	X-ray exam of hip	0.00	0.54	0.04	0.58	XXX	N
73520	.....	A	X-ray exam of hips	0.26	0.76	0.06	1.08	XXX	N
73520	26	A	X-ray exam of hips	0.26	0.12	0.02	0.40	XXX	N
73520	TC	A	X-ray exam of hips	0.00	0.64	0.04	0.68	XXX	N
73525	.....	A	Contrast x-ray of hip	0.54	2.25	0.17	2.96	XXX	N
73525	26	A	Contrast x-ray of hip	0.54	0.25	0.04	0.83	XXX	N
73525	TC	A	Contrast x-ray of hip	0.00	2.00	0.13	2.13	XXX	N
73530	.....	A	X-ray exam of hip	0.29	0.63	0.05	0.97	XXX	N
73530	26	A	X-ray exam of hip	0.29	0.13	0.02	0.44	XXX	N
73530	TC	A	X-ray exam of hip	0.00	0.50	0.03	0.53	XXX	N
73540	.....	A	X-ray exam of pelvis & hips	0.20	0.64	0.05	0.89	XXX	N
73540	26	A	X-ray exam of pelvis & hips	0.20	0.10	0.01	0.31	XXX	N
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.54	0.04	0.58	XXX	N
73550	.....	A	X-ray exam of thigh	0.17	0.62	0.05	0.84	XXX	N
73550	26	A	X-ray exam of thigh	0.17	0.08	0.01	0.26	XXX	N
73550	TC	A	X-ray exam of thigh	0.00	0.54	0.04	0.58	XXX	N
73560	.....	A	X-ray exam of knee	0.17	0.57	0.04	0.78	XXX	N
73560	26	A	X-ray exam of knee	0.17	0.07	0.01	0.25	XXX	N
73560	TC	A	X-ray exam of knee	0.00	0.50	0.03	0.53	XXX	N
73562	.....	A	X-ray exam of knee	0.18	0.63	0.05	0.86	XXX	N
73562	26	A	X-ray exam of knee	0.18	0.09	0.01	0.28	XXX	N
73562	TC	A	X-ray exam of knee	0.00	0.54	0.04	0.58	XXX	N
73564	.....	A	X-ray exam of knee	0.22	0.69	0.06	0.97	XXX	N
73564	26	A	X-ray exam of knee	0.22	0.10	0.02	0.34	XXX	N
73564	TC	A	X-ray exam of knee	0.00	0.59	0.04	0.63	XXX	N
73565	.....	A	X-ray exam of knee	0.17	0.54	0.04	0.75	XXX	N
73565	26	A	X-ray exam of knee	0.17	0.07	0.01	0.25	XXX	N
73565	TC	A	X-ray exam of knee	0.00	0.47	0.03	0.50	XXX	N
73580	.....	A	Contrast x-ray of knee joint	0.54	2.75	0.21	3.50	XXX	N
73580	26	A	Contrast x-ray of knee joint	0.54	0.25	0.04	0.83	XXX	N
73580	TC	A	Contrast x-ray of knee joint	0.00	2.50	0.17	2.67	XXX	N
73590	.....	A	X-ray exam of lower leg	0.17	0.57	0.04	0.78	XXX	N
73590	26	A	X-ray exam of lower leg	0.17	0.07	0.01	0.25	XXX	N
73590	TC	A	X-ray exam of lower leg	0.00	0.50	0.03	0.53	XXX	N
73592	.....	A	X-ray exam of leg, infant	0.16	0.54	0.04	0.74	XXX	N
73592	26	A	X-ray exam of leg, infant	0.16	0.07	0.01	0.24	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
73592	TC	A	X-ray exam of leg, infant	0.00	0.47	0.03	0.50	XXX	N
73600	.....	A	X-ray exam of ankle	0.16	0.54	0.04	0.74	XXX	N
73600	26	A	X-ray exam of ankle	0.16	0.07	0.01	0.24	XXX	N
73600	TC	A	X-ray exam of ankle	0.00	0.47	0.03	0.50	XXX	N
73610	.....	A	X-ray exam of ankle	0.17	0.59	0.04	0.80	XXX	N
73610	26	A	X-ray exam of ankle	0.17	0.08	0.01	0.26	XXX	N
73610	TC	A	X-ray exam of ankle	0.00	0.51	0.03	0.54	XXX	N
73615	.....	A	Contrast x-ray of ankle	0.54	2.25	0.17	2.96	XXX	N
73615	26	A	Contrast x-ray of ankle	0.54	0.25	0.04	0.83	XXX	N
73615	TC	A	Contrast x-ray of ankle	0.00	2.00	0.13	2.13	XXX	N
73620	.....	A	X-ray exam of foot	0.16	0.54	0.04	0.74	XXX	N
73620	26	A	X-ray exam of foot	0.16	0.07	0.01	0.24	XXX	N
73620	TC	A	X-ray exam of foot	0.00	0.47	0.03	0.50	XXX	N
73630	.....	A	X-ray exam of foot	0.17	0.59	0.04	0.80	XXX	N
73630	26	A	X-ray exam of foot	0.17	0.08	0.01	0.26	XXX	N
73630	TC	A	X-ray exam of foot	0.00	0.51	0.03	0.54	XXX	N
73650	.....	A	X-ray exam of heel	0.16	0.52	0.04	0.72	XXX	N
73650	26	A	X-ray exam of heel	0.16	0.07	0.01	0.24	XXX	N
73650	TC	A	X-ray exam of heel	0.00	0.45	0.03	0.48	XXX	N
73660	.....	A	X-ray exam of toe(s)	0.13	0.46	0.04	0.63	XXX	N
73660	26	A	X-ray exam of toe(s)	0.13	0.06	0.01	0.20	XXX	N
73660	TC	A	X-ray exam of toe(s)	0.00	0.40	0.03	0.43	XXX	N
73700	.....	A	CAT scan of leg	1.09	5.21	0.37	6.67	XXX	N
73700	26	A	CAT scan of leg	1.09	0.48	0.07	1.64	XXX	N
73700	TC	A	CAT scan of leg	0.00	4.73	0.30	5.03	XXX	N
73701	.....	A	Contrast CAT scan of leg	1.16	6.14	0.44	7.74	XXX	N
73701	26	A	Contrast CAT scan of leg	1.16	0.51	0.08	1.75	XXX	N
73701	TC	A	Contrast CAT scan of leg	0.00	5.63	0.36	5.99	XXX	N
73702	.....	A	Contrast CAT scans of leg	1.22	7.61	0.53	9.36	XXX	N
73702	26	A	Contrast CAT scans of leg	1.22	0.53	0.08	1.83	XXX	N
73702	TC	A	Contrast CAT scans of leg	0.00	7.08	0.45	7.53	XXX	N
73720	.....	A	Magnetic image, leg, foot	1.48	11.34	0.77	13.59	XXX	N
73720	26	A	Magnetic image, leg, foot	1.48	0.66	0.10	2.24	XXX	N
73720	TC	A	Magnetic image, leg, foot	0.00	10.68	0.67	11.35	XXX	N
73721	.....	A	Magnetic image, joint of leg	0.95	11.11	0.73	12.79	XXX	N
73721	26	A	Magnetic image, joint of leg	0.95	0.43	0.06	1.44	XXX	N
73721	TC	A	Magnetic image, joint of leg	0.00	10.68	0.67	11.35	XXX	N
73725	.....	N	Magnetic imaging/lower (MRA)	#1.82	11.34	0.77	13.93	XXX	0
73725	26	N	Magnetic imaging/lower (MRA)	#1.82	0.66	0.10	2.58	XXX	0
73725	TC	N	Magnetic imaging/lower (MRA)	#0.00	10.68	0.67	11.35	XXX	0
74000	.....	A	X-ray exam of abdomen	0.18	0.58	0.04	0.80	XXX	N
74000	26	A	X-ray exam of abdomen	0.18	0.08	0.01	0.27	XXX	N
74000	TC	A	X-ray exam of abdomen	0.00	0.50	0.03	0.53	XXX	N
74010	.....	A	X-ray exam of abdomen	0.23	0.65	0.06	0.94	XXX	N
74010	26	A	X-ray exam of abdomen	0.23	0.11	0.02	0.36	XXX	N
74010	TC	A	X-ray exam of abdomen	0.00	0.54	0.04	0.58	XXX	N
74020	.....	A	X-ray exam of abdomen	0.27	0.72	0.06	1.05	XXX	N
74020	26	A	X-ray exam of abdomen	0.27	0.13	0.02	0.42	XXX	N
74020	TC	A	X-ray exam of abdomen	0.00	0.59	0.04	0.63	XXX	N
74022	.....	A	X-ray exam series, abdomen	0.32	0.85	0.07	1.24	XXX	N
74022	26	A	X-ray exam series, abdomen	0.32	0.15	0.02	0.49	XXX	N
74022	TC	A	X-ray exam series, abdomen	0.00	0.70	0.05	0.75	XXX	N
74150	.....	A	CAT scan of abdomen	1.19	5.91	0.43	7.53	XXX	N
74150	26	A	CAT scan of abdomen	1.19	0.52	0.08	1.79	XXX	N
74150	TC	A	CAT scan of abdomen	0.00	5.39	0.35	5.74	XXX	N
74160	.....	A	Contrast CAT scan of abdomen	1.27	7.08	0.50	8.85	XXX	N
74160	26	A	Contrast CAT scan of abdomen	1.27	0.56	0.09	1.92	XXX	N
74160	TC	A	Contrast CAT scan of abdomen	0.00	6.52	0.41	6.93	XXX	N
74170	.....	A	Contrast CAT scans, abdomen	1.40	8.71	0.60	10.71	XXX	N
74170	26	A	Contrast CAT scans, abdomen	1.40	0.62	0.10	2.12	XXX	N
74170	TC	A	Contrast CAT scans, abdomen	0.00	8.09	0.50	8.59	XXX	N
74181	.....	A	Magnetic image, abdomen (MRI)	1.60	11.40	0.78	13.78	XXX	N
74181	26	A	Magnetic image, abdomen (MRI)	1.60	0.72	0.11	2.43	XXX	N
74181	TC	A	Magnetic image, abdomen (MRI)	0.00	10.68	0.67	11.35	XXX	N
74185	.....	N	Magnetic image/abdomen (MRA)	#1.80	11.40	0.78	13.98	XXX	0
74185	26	N	Magnetic image/abdomen (MRA)	#1.80	0.72	0.11	2.63	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
74185	TC	N	Magnetic image/abdomen (MRA)	#0.00	10.68	0.67	11.35	XXX	0
74190	.....	A	X-ray exam of peritoneum	0.48	1.37	0.10	1.95	XXX	N
74190	26	A	X-ray exam of peritoneum	0.48	0.13	0.02	0.63	XXX	N
74190	TC	A	X-ray exam of peritoneum	0.00	1.24	0.08	1.32	XXX	N
74210	.....	A	Contrast xray exam of throat	0.36	1.29	0.09	1.74	XXX	N
74210	26	A	Contrast xray exam of throat	0.36	0.16	0.02	0.54	XXX	N
74210	TC	A	Contrast xray exam of throat	0.00	1.13	0.07	1.20	XXX	N
74220	.....	A	Contrast xray exam, esophagus	0.46	1.34	0.10	1.90	XXX	N
74220	26	A	Contrast xray exam, esophagus	0.46	0.21	0.03	0.70	XXX	N
74220	TC	A	Contrast xray exam, esophagus	0.00	1.13	0.07	1.20	XXX	N
74230	.....	A	Cinema xray throat/esophagus	0.53	1.49	0.12	2.14	XXX	N
74230	26	A	Cinema xray throat/esophagus	0.53	0.25	0.04	0.82	XXX	N
74230	TC	A	Cinema xray throat/esophagus	0.00	1.24	0.08	1.32	XXX	N
74235	.....	A	Remove esophagus obstruction	1.19	3.02	0.25	4.46	XXX	N
74235	26	A	Remove esophagus obstruction	1.19	0.52	0.08	1.79	XXX	N
74235	TC	A	Remove esophagus obstruction	0.00	2.50	0.17	2.67	XXX	N
74240	.....	A	X-ray exam upper GI tract	0.69	1.71	0.14	2.54	XXX	N
74240	26	A	X-ray exam upper GI tract	0.69	0.32	0.05	1.06	XXX	N
74240	TC	A	X-ray exam upper GI tract	0.00	1.39	0.09	1.48	XXX	N
74241	.....	A	X-ray exam upper GI tract	0.69	1.74	0.14	2.57	XXX	N
74241	26	A	X-ray exam upper GI tract	0.69	0.32	0.05	1.06	XXX	N
74241	TC	A	X-ray exam upper GI tract	0.00	1.42	0.09	1.51	XXX	N
74245	.....	A	X-ray exam upper GI tract	0.91	2.68	0.21	3.80	XXX	N
74245	26	A	X-ray exam upper GI tract	0.91	0.41	0.06	1.38	XXX	N
74245	TC	A	X-ray exam upper GI tract	0.00	2.27	0.15	2.42	XXX	N
74246	.....	A	Contrast xray upper GI tract	0.69	1.89	0.15	2.73	XXX	N
74246	26	A	Contrast xray upper GI tract	0.69	0.32	0.05	1.06	XXX	N
74246	TC	A	Contrast xray upper GI tract	0.00	1.57	0.10	1.67	XXX	N
74247	.....	A	Contrast xray upper GI tract	0.69	1.92	0.16	2.77	XXX	N
74247	26	A	Contrast xray upper GI tract	0.69	0.32	0.05	1.06	XXX	N
74247	TC	A	Contrast xray upper GI tract	0.00	1.60	0.11	1.71	XXX	N
74249	.....	A	Contrast xray upper GI tract	0.91	2.86	0.22	3.99	XXX	N
74249	26	A	Contrast xray upper GI tract	0.91	0.41	0.06	1.38	XXX	N
74249	TC	A	Contrast xray upper GI tract	0.00	2.45	0.16	2.61	XXX	N
74250	.....	A	X-ray exam of small bowel	0.47	1.45	0.11	2.03	XXX	N
74250	26	A	X-ray exam of small bowel	0.47	0.21	0.03	0.71	XXX	N
74250	TC	A	X-ray exam of small bowel	0.00	1.24	0.08	1.32	XXX	N
74251	.....	A	X-ray exam of small bowel	0.69	1.45	0.11	2.25	XXX	N
74251	26	A	X-ray exam of small bowel	0.69	0.21	0.03	0.93	XXX	N
74251	TC	A	X-ray exam of small bowel	0.00	1.24	0.08	1.32	XXX	N
74260	.....	A	X-ray exam of small bowel	0.50	1.65	0.12	2.27	XXX	N
74260	26	A	X-ray exam of small bowel	0.50	0.23	0.03	0.76	XXX	N
74260	TC	A	X-ray exam of small bowel	0.00	1.42	0.09	1.51	XXX	N
74270	.....	A	Contrast x-ray exam of colon	0.69	1.94	0.16	2.79	XXX	N
74270	26	A	Contrast x-ray exam of colon	0.69	0.32	0.05	1.06	XXX	N
74270	TC	A	Contrast x-ray exam of colon	0.00	1.62	0.11	1.73	XXX	N
74280	.....	A	Contrast x-ray exam of colon	0.99	2.58	0.21	3.78	XXX	N
74280	26	A	Contrast x-ray exam of colon	0.99	0.45	0.07	1.51	XXX	N
74280	TC	A	Contrast x-ray exam of colon	0.00	2.13	0.14	2.27	XXX	N
74283	.....	A	Contrast x-ray exam of colon	2.02	3.34	0.30	5.66	XXX	N
74283	26	A	Contrast x-ray exam of colon	2.02	0.90	0.14	3.06	XXX	N
74283	TC	A	Contrast x-ray exam of colon	0.00	2.44	0.16	2.60	XXX	N
74290	.....	A	Contrast x-ray, gallbladder	0.32	0.85	0.07	1.24	XXX	N
74290	26	A	Contrast x-ray, gallbladder	0.32	0.15	0.02	0.49	XXX	N
74290	TC	A	Contrast x-ray, gallbladder	0.00	0.70	0.05	0.75	XXX	N
74291	.....	A	Contrast x-rays, gallbladder	0.20	0.49	0.04	0.73	XXX	N
74291	26	A	Contrast x-rays, gallbladder	0.20	0.09	0.01	0.30	XXX	N
74291	TC	A	Contrast x-rays, gallbladder	0.00	0.40	0.03	0.43	XXX	N
74300	.....	C	X-ray bile ducts, pancreas	0.00	0.00	0.00	0.00	XXX	N
74300	26	A	X-ray bile ducts, pancreas	0.36	0.17	0.02	0.55	XXX	N
74300	TC	C	X-ray bile ducts, pancreas	0.00	0.00	0.00	0.00	XXX	N
74301	.....	C	Additional x-rays at surgery	0.00	0.00	0.00	0.00	XXX	N
74301	26	A	Additional x-rays at surgery	0.21	0.10	0.01	0.32	XXX	N
74301	TC	C	Additional x-rays at surgery	0.00	0.00	0.00	0.00	XXX	N
74305	.....	A	X-ray bile ducts, pancreas	0.42	0.94	0.08	1.44	XXX	N
74305	26	A	X-ray bile ducts, pancreas	0.42	0.19	0.03	0.64	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
74305	TC	A	X-ray bile ducts, pancreas	0.00	0.75	0.05	0.80	XXX	N
74320	.....	A	Contrast x-ray of bile ducts	0.54	3.25	0.23	4.02	XXX	N
74320	26	A	Contrast x-ray of bile ducts	0.54	0.25	0.04	0.83	XXX	N
74320	TC	A	Contrast x-ray of bile ducts	0.00	3.00	0.19	3.19	XXX	N
74327	.....	A	X-ray for bile stone removal	0.70	2.00	0.16	2.86	XXX	N
74327	26	A	X-ray for bile stone removal	0.70	0.32	0.05	1.07	XXX	N
74327	TC	A	X-ray for bile stone removal	0.00	1.68	0.11	1.79	XXX	N
74328	.....	A	Xray for bile duct endoscopy	0.70	3.32	0.24	4.26	XXX	N
74328	26	A	Xray for bile duct endoscopy	0.70	0.32	0.05	1.07	XXX	N
74328	TC	A	Xray for bile duct endoscopy	0.00	3.00	0.19	3.19	XXX	N
74329	.....	A	X-ray for pancreas endoscopy	0.70	3.32	0.24	4.26	XXX	N
74329	26	A	X-ray for pancreas endoscopy	0.70	0.32	0.05	1.07	XXX	N
74329	TC	A	X-ray for pancreas endoscopy	0.00	3.00	0.19	3.19	XXX	N
74330	.....	A	Xray, bile/pancreas endoscopy	0.70	3.32	0.24	4.26	XXX	N
74330	26	A	Xray, bile/pancreas endoscopy	0.70	0.32	0.05	1.07	XXX	N
74330	TC	A	Xray, bile/pancreas endoscopy	0.00	3.00	0.19	3.19	XXX	N
74340	.....	A	X-ray guide for GI tube	0.54	2.75	0.21	3.50	XXX	N
74340	26	A	X-ray guide for GI tube	0.54	0.25	0.04	0.83	XXX	N
74340	TC	A	X-ray guide for GI tube	0.00	2.50	0.17	2.67	XXX	N
74350	.....	A	X-ray guide, stomach tube	0.76	3.35	0.24	4.35	XXX	N
74350	26	A	X-ray guide, stomach tube	0.76	0.35	0.05	1.16	XXX	N
74350	TC	A	X-ray guide, stomach tube	0.00	3.00	0.19	3.19	XXX	N
74355	.....	A	X-ray guide, intestinal tube	0.76	2.85	0.22	3.83	XXX	N
74355	26	A	X-ray guide, intestinal tube	0.76	0.35	0.05	1.16	XXX	N
74355	TC	A	X-ray guide, intestinal tube	0.00	2.50	0.17	2.67	XXX	N
74360	.....	A	X-ray guide, GI dilation	0.54	3.25	0.23	4.02	XXX	N
74360	26	A	X-ray guide, GI dilation	0.54	0.25	0.04	0.83	XXX	N
74360	TC	A	X-ray guide, GI dilation	0.00	3.00	0.19	3.19	XXX	N
74363	.....	A	X-ray, bile duct dilation	0.88	6.21	0.43	7.52	XXX	N
74363	26	A	X-ray, bile duct dilation	0.88	0.40	0.06	1.34	XXX	N
74363	TC	A	X-ray, bile duct dilation	0.00	5.81	0.37	6.18	XXX	N
74400	.....	A	Contrast x-ray urinary tract	0.49	1.82	0.14	2.45	XXX	N
74400	26	A	Contrast x-ray urinary tract	0.49	0.22	0.03	0.74	XXX	N
74400	TC	A	Contrast x-ray urinary tract	0.00	1.60	0.11	1.71	XXX	N
74405	.....	A	Contrast x-ray urinary tract	0.49	2.11	0.16	2.76	XXX	N
74405	26	A	Contrast x-ray urinary tract	0.49	0.22	0.03	0.74	XXX	N
74405	TC	A	Contrast x-ray urinary tract	0.00	1.89	0.13	2.02	XXX	N
74410	.....	A	Contrast x-ray urinary tract	0.49	2.08	0.15	2.72	XXX	N
74410	26	A	Contrast x-ray urinary tract	0.49	0.22	0.03	0.74	XXX	N
74410	TC	A	Contrast x-ray urinary tract	0.00	1.86	0.12	1.98	XXX	N
74415	.....	A	Contrast x-ray urinary tract	0.49	2.24	0.16	2.89	XXX	N
74415	26	A	Contrast x-ray urinary tract	0.49	0.22	0.03	0.74	XXX	N
74415	TC	A	Contrast x-ray urinary tract	0.00	2.02	0.13	2.15	XXX	N
74420	.....	A	Contrast x-ray urinary tract	0.36	2.66	0.19	3.21	XXX	N
74420	26	A	Contrast x-ray urinary tract	0.36	0.16	0.02	0.54	XXX	N
74420	TC	A	Contrast x-ray urinary tract	0.00	2.50	0.17	2.67	XXX	N
74425	.....	A	Contrast x-ray urinary tract	0.36	1.40	0.10	1.86	XXX	N
74425	26	A	Contrast x-ray urinary tract	0.36	0.16	0.02	0.54	XXX	N
74425	TC	A	Contrast x-ray urinary tract	0.00	1.24	0.08	1.32	XXX	N
74430	.....	A	Contrast x-ray of bladder	0.32	1.15	0.09	1.56	XXX	N
74430	26	A	Contrast x-ray of bladder	0.32	0.15	0.02	0.49	XXX	N
74430	TC	A	Contrast x-ray of bladder	0.00	1.00	0.07	1.07	XXX	N
74440	.....	A	Xray exam male genital tract	0.38	1.25	0.10	1.73	XXX	N
74440	26	A	Xray exam male genital tract	0.38	0.17	0.03	0.58	XXX	N
74440	TC	A	Xray exam male genital tract	0.00	1.08	0.07	1.15	XXX	N
74445	.....	A	X-ray exam of penis	1.14	1.58	0.15	2.87	XXX	N
74445	26	A	X-ray exam of penis	1.14	0.50	0.08	1.72	XXX	N
74445	TC	A	X-ray exam of penis	0.00	1.08	0.07	1.15	XXX	N
74450	.....	A	X-ray exam urethra/bladder	0.33	1.54	0.11	1.98	XXX	N
74450	26	A	X-ray exam urethra/bladder	0.33	0.15	0.02	0.50	XXX	N
74450	TC	A	X-ray exam urethra/bladder	0.00	1.39	0.09	1.48	XXX	N
74455	.....	A	X-ray exam urethra/bladder	0.33	1.65	0.12	2.10	XXX	N
74455	26	A	X-ray exam urethra/bladder	0.33	0.15	0.02	0.50	XXX	N
74455	TC	A	X-ray exam urethra/bladder	0.00	1.50	0.10	1.60	XXX	N
74470	.....	A	X-ray exam of kidney lesion	0.54	1.44	0.12	2.10	XXX	N
74470	26	A	X-ray exam of kidney lesion	0.54	0.25	0.04	0.83	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
74470	TC	A	X-ray exam of kidney lesion	0.00	1.19	0.08	1.27	XXX	N
74475	.....	A	Xray control catheter insert	0.54	4.13	0.29	4.96	XXX	N
74475	26	A	Xray control catheter insert	0.54	0.25	0.04	0.83	XXX	N
74475	TC	A	Xray control catheter insert	0.00	3.88	0.25	4.13	XXX	N
74480	.....	A	Xray control catheter insert	0.54	4.13	0.29	4.96	XXX	N
74480	26	A	Xray control catheter insert	0.54	0.25	0.04	0.83	XXX	N
74480	TC	A	Xray control catheter insert	0.00	3.88	0.25	4.13	XXX	N
74485	.....	A	X-ray guide, GU dilation	0.54	3.25	0.23	4.02	XXX	N
74485	26	A	X-ray guide, GU dilation	0.54	0.25	0.04	0.83	XXX	N
74485	TC	A	X-ray guide, GU dilation	0.00	3.00	0.19	3.19	XXX	N
74710	.....	A	X-ray measurement of pelvis	0.34	1.16	0.09	1.59	XXX	N
74710	26	A	X-ray measurement of pelvis	0.34	0.16	0.02	0.52	XXX	N
74710	TC	A	X-ray measurement of pelvis	0.00	1.00	0.07	1.07	XXX	N
74740	.....	A	X-ray female genital tract	0.38	1.41	0.11	1.90	XXX	N
74740	26	A	X-ray female genital tract	0.38	0.17	0.03	0.58	XXX	N
74740	TC	A	X-ray female genital tract	0.00	1.24	0.08	1.32	XXX	N
74742	.....	A	X-ray fallopian tube	0.61	3.25	0.23	4.09	XXX	N
74742	26	A	X-ray fallopian tube	0.61	0.25	0.04	0.90	XXX	N
74742	TC	A	X-ray fallopian tube	0.00	3.00	0.19	3.19	XXX	N
74775	.....	A	X-ray exam of perineum	0.62	1.68	0.13	2.43	XXX	N
74775	26	A	X-ray exam of perineum	0.62	0.29	0.04	0.95	XXX	N
74775	TC	A	X-ray exam of perineum	0.00	1.39	0.09	1.48	XXX	N
75552	.....	A	Magnetic image, myocardium	1.60	11.40	0.78	13.78	XXX	N
75552	26	A	Magnetic image, myocardium	1.60	0.72	0.11	2.43	XXX	N
75552	TC	A	Magnetic image, myocardium	0.00	10.68	0.67	11.35	XXX	N
75553	.....	A	Magnetic image, myocardium	2.00	11.40	0.78	14.18	XXX	N
75553	26	A	Magnetic image, myocardium	2.00	0.72	0.11	2.83	XXX	N
75553	TC	A	Magnetic image, myocardium	0.00	10.68	0.67	11.35	XXX	N
75554	.....	A	Cardiac MRI/function	1.83	11.40	0.78	14.01	XXX	N
75554	26	A	Cardiac MRI/function	1.83	0.72	0.11	2.66	XXX	N
75554	TC	A	Cardiac MRI/function	0.00	10.68	0.67	11.35	XXX	N
75555	.....	A	Cardiac MRI/limited study	1.74	11.40	0.78	13.92	XXX	N
75555	26	A	Cardiac MRI/limited study	1.74	0.72	0.11	2.57	XXX	N
75555	TC	A	Cardiac MRI/limited study	0.00	10.68	0.67	11.35	XXX	N
75556	.....	N	Cardiac MRI/flow mapping	0.00	0.00	0.00	0.00	XXX	O
75600	.....	A	Contrast x-ray exam of aorta	0.49	12.23	0.78	13.50	XXX	N
75600	26	A	Contrast x-ray exam of aorta	0.49	0.22	0.03	0.74	XXX	N
75600	TC	A	Contrast x-ray exam of aorta	0.00	12.01	0.75	12.76	XXX	N
75605	.....	A	Contrast x-ray exam of aorta	1.14	12.51	0.83	14.48	XXX	N
75605	26	A	Contrast x-ray exam of aorta	1.14	0.50	0.08	1.72	XXX	N
75605	TC	A	Contrast x-ray exam of aorta	0.00	12.01	0.75	12.76	XXX	N
75625	.....	A	Contrast x-ray exam of aorta	1.14	12.51	0.83	14.48	XXX	N
75625	26	A	Contrast x-ray exam of aorta	1.14	0.50	0.08	1.72	XXX	N
75625	TC	A	Contrast x-ray exam of aorta	0.00	12.01	0.75	12.76	XXX	N
75630	.....	A	X-ray aorta, leg arteries	1.31	13.09	0.88	15.28	XXX	N
75630	26	A	X-ray aorta, leg arteries	1.31	0.58	0.09	1.98	XXX	N
75630	TC	A	X-ray aorta, leg arteries	0.00	12.51	0.79	13.30	XXX	N
75650	.....	A	Artery x-rays, head & neck	1.49	12.67	0.85	15.01	XXX	N
75650	26	A	Artery x-rays, head & neck	1.49	0.66	0.10	2.25	XXX	N
75650	TC	A	Artery x-rays, head & neck	0.00	12.01	0.75	12.76	XXX	N
75658	.....	A	X-ray exam of arm arteries	1.31	12.59	0.84	14.74	XXX	N
75658	26	A	X-ray exam of arm arteries	1.31	0.58	0.09	1.98	XXX	N
75658	TC	A	X-ray exam of arm arteries	0.00	12.01	0.75	12.76	XXX	N
75660	.....	A	Artery x-rays, head & neck	1.31	12.59	0.84	14.74	XXX	N
75660	26	A	Artery x-rays, head & neck	1.31	0.58	0.09	1.98	XXX	N
75660	TC	A	Artery x-rays, head & neck	0.00	12.01	0.75	12.76	XXX	N
75662	.....	A	Artery x-rays, head & neck	1.66	12.75	0.86	15.27	XXX	N
75662	26	A	Artery x-rays, head & neck	1.66	0.74	0.11	2.51	XXX	N
75662	TC	A	Artery x-rays, head & neck	0.00	12.01	0.75	12.76	XXX	N
75665	.....	A	Artery x-rays, head & neck	1.31	12.59	0.84	14.74	XXX	N
75665	26	A	Artery x-rays, head & neck	1.31	0.58	0.09	1.98	XXX	N
75665	TC	A	Artery x-rays, head & neck	0.00	12.01	0.75	12.76	XXX	N
75671	.....	A	Artery x-rays, head & neck	1.66	12.75	0.86	15.27	XXX	N
75671	26	A	Artery x-rays, head & neck	1.66	0.74	0.11	2.51	XXX	N
75671	TC	A	Artery x-rays, head & neck	0.00	12.01	0.75	12.76	XXX	N
75676	.....	A	Artery x-rays, neck	1.31	12.59	0.84	14.74	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
75676	26	A	Artery x-rays, neck	1.31	0.58	0.09	1.98	XXX	N
75676	TC	A	Artery x-rays, neck	0.00	12.01	0.75	12.76	XXX	N
75680	.....	A	Artery x-rays, neck	1.66	12.75	0.86	15.27	XXX	N
75680	26	A	Artery x-rays, neck	1.66	0.74	0.11	2.51	XXX	N
75680	TC	A	Artery x-rays, neck	0.00	12.01	0.75	12.76	XXX	N
75685	.....	A	Artery x-rays, spine	1.31	12.59	0.84	14.74	XXX	N
75685	26	A	Artery x-rays, spine	1.31	0.58	0.09	1.98	XXX	N
75685	TC	A	Artery x-rays, spine	0.00	12.01	0.75	12.76	XXX	N
75705	.....	A	Artery x-rays, spine	2.18	12.99	0.90	16.07	XXX	N
75705	26	A	Artery x-rays, spine	2.18	0.98	0.15	3.31	XXX	N
75705	TC	A	Artery x-rays, spine	0.00	12.01	0.75	12.76	XXX	N
75710	.....	A	Artery x-rays, arm/leg	1.14	12.51	0.83	14.48	XXX	N
75710	26	A	Artery x-rays, arm/leg	1.14	0.50	0.08	1.72	XXX	N
75710	TC	A	Artery x-rays, arm/leg	0.00	12.01	0.75	12.76	XXX	N
75716	.....	A	Artery x-rays, arms/legs	1.31	12.59	0.84	14.74	XXX	N
75716	26	A	Artery x-rays, arms/legs	1.31	0.58	0.09	1.98	XXX	N
75716	TC	A	Artery x-rays, arms/legs	0.00	12.01	0.75	12.76	XXX	N
75722	.....	A	Artery x-rays, kidney	1.14	12.51	0.83	14.48	XXX	N
75722	26	A	Artery x-rays, kidney	1.14	0.50	0.08	1.72	XXX	N
75722	TC	A	Artery x-rays, kidney	0.00	12.01	0.75	12.76	XXX	N
75724	.....	A	Artery x-rays, kidneys	1.49	12.67	0.85	15.01	XXX	N
75724	26	A	Artery x-rays, kidneys	1.49	0.66	0.10	2.25	XXX	N
75724	TC	A	Artery x-rays, kidneys	0.00	12.01	0.75	12.76	XXX	N
75726	.....	A	Artery x-rays, abdomen	1.14	12.51	0.83	14.48	XXX	N
75726	26	A	Artery x-rays, abdomen	1.14	0.50	0.08	1.72	XXX	N
75726	TC	A	Artery x-rays, abdomen	0.00	12.01	0.75	12.76	XXX	N
75731	.....	A	Artery x-rays, adrenal gland	1.14	12.51	0.83	14.48	XXX	N
75731	26	A	Artery x-rays, adrenal gland	1.14	0.50	0.08	1.72	XXX	N
75731	TC	A	Artery x-rays, adrenal gland	0.00	12.01	0.75	12.76	XXX	N
75733	.....	A	Artery x-rays, adrenal glands	1.31	12.59	0.84	14.74	XXX	N
75733	26	A	Artery x-rays, adrenal glands	1.31	0.58	0.09	1.98	XXX	N
75733	TC	A	Artery x-rays, adrenal glands	0.00	12.01	0.75	12.76	XXX	N
75736	.....	A	Artery x-rays, pelvis	1.14	12.51	0.83	14.48	XXX	N
75736	26	A	Artery x-rays, pelvis	1.14	0.50	0.08	1.72	XXX	N
75736	TC	A	Artery x-rays, pelvis	0.00	12.01	0.75	12.76	XXX	N
75741	.....	A	Artery x-rays, lung	1.31	12.59	0.84	14.74	XXX	N
75741	26	A	Artery x-rays, lung	1.31	0.58	0.09	1.98	XXX	N
75741	TC	A	Artery x-rays, lung	0.00	12.01	0.75	12.76	XXX	N
75743	.....	A	Artery x-rays, lungs	1.66	12.75	0.86	15.27	XXX	N
75743	26	A	Artery x-rays, lungs	1.66	0.74	0.11	2.51	XXX	N
75743	TC	A	Artery x-rays, lungs	0.00	12.01	0.75	12.76	XXX	N
75746	.....	A	Artery x-rays, lung	1.14	12.51	0.83	14.48	XXX	N
75746	26	A	Artery x-rays, lung	1.14	0.50	0.08	1.72	XXX	N
75746	TC	A	Artery x-rays, lung	0.00	12.01	0.75	12.76	XXX	N
75756	.....	A	Artery x-rays, chest	1.14	12.51	0.83	14.48	XXX	N
75756	26	A	Artery x-rays, chest	1.14	0.50	0.08	1.72	XXX	N
75756	TC	A	Artery x-rays, chest	0.00	12.01	0.75	12.76	XXX	N
75774	.....	A	Artery x-ray, each vessel	0.36	12.17	0.77	13.30	XXX	N
75774	26	A	Artery x-ray, each vessel	0.36	0.16	0.02	0.54	XXX	N
75774	TC	A	Artery x-ray, each vessel	0.00	12.01	0.75	12.76	XXX	N
75790	.....	A	Visualize A-V shunt	1.84	2.12	0.21	4.17	XXX	N
75790	26	A	Visualize A-V shunt	1.84	0.83	0.12	2.79	XXX	N
75790	TC	A	Visualize A-V shunt	0.00	1.29	0.09	1.38	XXX	N
75801	.....	A	Lymph vessel x-ray, arm/leg	0.81	5.53	0.38	6.72	XXX	N
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.37	0.05	1.23	XXX	N
75801	TC	A	Lymph vessel x-ray, arm/leg	0.00	5.16	0.33	5.49	XXX	N
75803	.....	A	Lymph vessel x-ray, arms/legs	1.17	5.67	0.41	7.25	XXX	N
75803	26	A	Lymph vessel x-ray, arms/legs	1.17	0.51	0.08	1.76	XXX	N
75803	TC	A	Lymph vessel x-ray, arms/legs	0.00	5.16	0.33	5.49	XXX	N
75805	.....	A	Lymph vessel x-ray, trunk	0.81	6.18	0.42	7.41	XXX	N
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.37	0.05	1.23	XXX	N
75805	TC	A	Lymph vessel x-ray, trunk	0.00	5.81	0.37	6.18	XXX	N
75807	.....	A	Lymph vessel x-ray, trunk	1.17	6.32	0.45	7.94	XXX	N
75807	26	A	Lymph vessel x-ray, trunk	1.17	0.51	0.08	1.76	XXX	N
75807	TC	A	Lymph vessel x-ray, trunk	0.00	5.81	0.37	6.18	XXX	N
75809	.....	A	Nonvascular shunt, x-ray	0.47	0.94	0.08	1.49	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
75809	26	A	Nonvascular shunt, x-ray	0.47	0.19	0.03	0.69	XXX	N
75809	TC	A	Nonvascular shunt, x-ray	0.00	0.75	0.05	0.80	XXX	N
75810	.....	A	Vein x-ray, spleen/liver	1.14	12.51	0.83	14.48	XXX	N
75810	26	A	Vein x-ray, spleen/liver	1.14	0.50	0.08	1.72	XXX	N
75810	TC	A	Vein x-ray, spleen/liver	0.00	12.01	0.75	12.76	XXX	N
75820	.....	A	Vein x-ray, arm/leg	0.70	1.22	0.11	2.03	XXX	N
75820	26	A	Vein x-ray, arm/leg	0.70	0.32	0.05	1.07	XXX	N
75820	TC	A	Vein x-ray, arm/leg	0.00	0.90	0.06	0.96	XXX	N
75822	.....	A	Vein x-ray, arms/legs	1.06	1.88	0.16	3.10	XXX	N
75822	26	A	Vein x-ray, arms/legs	1.06	0.47	0.07	1.60	XXX	N
75822	TC	A	Vein x-ray, arms/legs	0.00	1.41	0.09	1.50	XXX	N
75825	.....	A	Vein x-ray, trunk	1.14	12.51	0.83	14.48	XXX	N
75825	26	A	Vein x-ray, trunk	1.14	0.50	0.08	1.72	XXX	N
75825	TC	A	Vein x-ray, trunk	0.00	12.01	0.75	12.76	XXX	N
75827	.....	A	Vein x-ray, chest	1.14	12.51	0.83	14.48	XXX	N
75827	26	A	Vein x-ray, chest	1.14	0.50	0.08	1.72	XXX	N
75827	TC	A	Vein x-ray, chest	0.00	12.01	0.75	12.76	XXX	N
75831	.....	A	Vein x-ray, kidney	1.14	12.51	0.83	14.48	XXX	N
75831	26	A	Vein x-ray, kidney	1.14	0.50	0.08	1.72	XXX	N
75831	TC	A	Vein x-ray, kidney	0.00	12.01	0.75	12.76	XXX	N
75833	.....	A	Vein x-ray, kidneys	1.49	12.67	0.85	15.01	XXX	N
75833	26	A	Vein x-ray, kidneys	1.49	0.66	0.10	2.25	XXX	N
75833	TC	A	Vein x-ray, kidneys	0.00	12.01	0.75	12.76	XXX	N
75840	.....	A	Vein x-ray, adrenal gland	1.14	12.51	0.83	14.48	XXX	N
75840	26	A	Vein x-ray, adrenal gland	1.14	0.50	0.08	1.72	XXX	N
75840	TC	A	Vein x-ray, adrenal gland	0.00	12.01	0.75	12.76	XXX	N
75842	.....	A	Vein x-ray, adrenal glands	1.49	12.67	0.85	15.01	XXX	N
75842	26	A	Vein x-ray, adrenal glands	1.49	0.66	0.10	2.25	XXX	N
75842	TC	A	Vein x-ray, adrenal glands	0.00	12.01	0.75	12.76	XXX	N
75860	.....	A	Vein x-ray, neck	1.14	12.51	0.83	14.48	XXX	N
75860	26	A	Vein x-ray, neck	1.14	0.50	0.08	1.72	XXX	N
75860	TC	A	Vein x-ray, neck	0.00	12.01	0.75	12.76	XXX	N
75870	.....	A	Vein x-ray, skull	1.14	12.51	0.83	14.48	XXX	N
75870	26	A	Vein x-ray, skull	1.14	0.50	0.08	1.72	XXX	N
75870	TC	A	Vein x-ray, skull	0.00	12.01	0.75	12.76	XXX	N
75872	.....	A	Vein x-ray, skull	1.14	12.51	0.83	14.48	XXX	N
75872	26	A	Vein x-ray, skull	1.14	0.50	0.08	1.72	XXX	N
75872	TC	A	Vein x-ray, skull	0.00	12.01	0.75	12.76	XXX	N
75880	.....	A	Vein x-ray, eye socket	0.70	1.22	0.11	2.03	XXX	N
75880	26	A	Vein x-ray, eye socket	0.70	0.32	0.05	1.07	XXX	N
75880	TC	A	Vein x-ray, eye socket	0.00	0.90	0.06	0.96	XXX	N
75885	.....	A	Vein x-ray, liver	1.44	12.65	0.85	14.94	XXX	N
75885	26	A	Vein x-ray, liver	1.44	0.64	0.10	2.18	XXX	N
75885	TC	A	Vein x-ray, liver	0.00	12.01	0.75	12.76	XXX	N
75887	.....	A	Vein x-ray, liver	1.44	12.65	0.85	14.94	XXX	N
75887	26	A	Vein x-ray, liver	1.44	0.64	0.10	2.18	XXX	N
75887	TC	A	Vein x-ray, liver	0.00	12.01	0.75	12.76	XXX	N
75889	.....	A	Vein x-ray, liver	1.14	12.51	0.83	14.48	XXX	N
75889	26	A	Vein x-ray, liver	1.14	0.50	0.08	1.72	XXX	N
75889	TC	A	Vein x-ray, liver	0.00	12.01	0.75	12.76	XXX	N
75891	.....	A	Vein x-ray, liver	1.14	12.51	0.83	14.48	XXX	N
75891	26	A	Vein x-ray, liver	1.14	0.50	0.08	1.72	XXX	N
75891	TC	A	Vein x-ray, liver	0.00	12.01	0.75	12.76	XXX	N
75893	.....	A	Venous sampling by catheter	0.54	12.26	0.79	13.59	XXX	N
75893	26	A	Venous sampling by catheter	0.54	0.25	0.04	0.83	XXX	N
75893	TC	A	Venous sampling by catheter	0.00	12.01	0.75	12.76	XXX	N
75894	.....	A	X-rays, transcatheter therapy	1.31	23.58	1.53	26.42	XXX	N
75894	26	A	X-rays, transcatheter therapy	1.31	0.58	0.09	1.98	XXX	N
75894	TC	A	X-rays, transcatheter therapy	0.00	23.00	1.44	24.44	XXX	N
75896	.....	A	X-rays, transcatheter therapy	1.31	20.58	1.34	23.23	XXX	N
75896	26	A	X-rays, transcatheter therapy	1.31	0.58	0.09	1.98	XXX	N
75896	TC	A	X-rays, transcatheter therapy	0.00	20.00	1.25	21.25	XXX	N
75898	.....	A	Follow-up angiogram	1.65	1.74	0.18	3.57	XXX	N
75898	26	A	Follow-up angiogram	1.65	0.74	0.11	2.50	XXX	N
75898	TC	A	Follow-up angiogram	0.00	1.00	0.07	1.07	XXX	N
75900	.....	A	Arterial catheter exchange	0.49	20.22	1.29	22.00	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
75900	26	A	Arterial catheter exchange	0.49	0.23	0.03	0.75	XXX	N
75900	TC	A	Arterial catheter exchange	0.00	19.99	1.26	21.25	XXX	N
75940	.....	A	X-ray placement, vein filter	0.54	12.26	0.79	13.59	XXX	N
75940	26	A	X-ray placement, vein filter	0.54	0.25	0.04	0.83	XXX	N
75940	TC	A	X-ray placement, vein filter	0.00	12.01	0.75	12.76	XXX	N
75960	.....	A	Transcatheter intro, stent	0.82	14.57	0.94	16.33	XXX	N
75960	26	A	Transcatheter intro, stent	0.82	0.37	0.06	1.25	XXX	N
75960	TC	A	Transcatheter intro, stent	0.00	14.20	0.88	15.08	XXX	N
75961	.....	A	Retrieval, broken catheter	4.25	11.91	0.90	17.06	XXX	N
75961	26	A	Retrieval, broken catheter	4.25	1.90	0.28	6.43	XXX	N
75961	TC	A	Retrieval, broken catheter	0.00	10.01	0.62	10.63	XXX	N
75962	.....	A	Repair arterial blockage	0.54	15.25	0.98	16.77	XXX	N
75962	26	A	Repair arterial blockage	0.54	0.25	0.04	0.83	XXX	N
75962	TC	A	Repair arterial blockage	0.00	15.00	0.94	15.94	XXX	N
75964	.....	A	Repair artery blockage, each	0.36	8.16	0.52	9.04	XXX	N
75964	26	A	Repair artery blockage, each	0.36	0.16	0.02	0.54	XXX	N
75964	TC	A	Repair artery blockage, each	0.00	8.00	0.50	8.50	XXX	N
75966	.....	A	Repair arterial blockage	1.31	15.58	1.03	17.92	XXX	N
75966	26	A	Repair arterial blockage	1.31	0.58	0.09	1.98	XXX	N
75966	TC	A	Repair arterial blockage	0.00	15.00	0.94	15.94	XXX	N
75968	.....	A	Repair artery blockage, each	0.36	8.16	0.52	9.04	XXX	N
75968	26	A	Repair artery blockage, each	0.36	0.16	0.02	0.54	XXX	N
75968	TC	A	Repair artery blockage, each	0.00	8.00	0.50	8.50	XXX	N
75970	.....	A	Vascular biopsy	0.83	11.38	0.75	12.96	XXX	N
75970	26	A	Vascular biopsy	0.83	0.38	0.06	1.27	XXX	N
75970	TC	A	Vascular biopsy	0.00	11.00	0.69	11.69	XXX	N
75978	.....	A	Repair venous blockage	0.54	15.48	0.98	17.00	XXX	N
75978	26	A	Repair venous blockage	0.54	0.48	0.04	1.06	XXX	N
75978	TC	A	Repair venous blockage	0.00	15.00	0.94	15.94	XXX	N
75980	.....	A	Contrast x-ray exam bile duct	1.44	5.80	0.43	7.67	XXX	N
75980	26	A	Contrast x-ray exam bile duct	1.44	0.64	0.10	2.18	XXX	N
75980	TC	A	Contrast x-ray exam bile duct	0.00	5.16	0.33	5.49	XXX	N
75982	.....	A	Contrast x-ray exam bile duct	1.44	6.45	0.47	8.36	XXX	N
75982	26	A	Contrast x-ray exam bile duct	1.44	0.64	0.10	2.18	XXX	N
75982	TC	A	Contrast x-ray exam bile duct	0.00	5.81	0.37	6.18	XXX	N
75984	.....	A	X-ray control catheter change	0.72	2.19	0.17	3.08	XXX	N
75984	26	A	X-ray control catheter change	0.72	0.33	0.05	1.10	XXX	N
75984	TC	A	X-ray control catheter change	0.00	1.86	0.12	1.98	XXX	N
75989	.....	A	Abscess drainage under x-ray	1.19	3.52	0.27	4.98	XXX	N
75989	26	A	Abscess drainage under x-ray	1.19	0.52	0.08	1.79	XXX	N
75989	TC	A	Abscess drainage under x-ray	0.00	3.00	0.19	3.19	XXX	N
75992	.....	A	Atherectomy, x-ray exam	0.54	15.25	0.98	16.77	XXX	N
75992	26	A	Atherectomy, x-ray exam	0.54	0.25	0.04	0.83	XXX	N
75992	TC	A	Atherectomy, x-ray exam	0.00	15.00	0.94	15.94	XXX	N
75993	.....	A	Atherectomy, x-ray exam	0.36	8.16	0.52	9.04	XXX	N
75993	26	A	Atherectomy, x-ray exam	0.36	0.16	0.02	0.54	XXX	N
75993	TC	A	Atherectomy, x-ray exam	0.00	8.00	0.50	8.50	XXX	N
75994	.....	A	Atherectomy, x-ray exam	1.31	15.58	1.03	17.92	XXX	N
75994	26	A	Atherectomy, x-ray exam	1.31	0.58	0.09	1.98	XXX	N
75994	TC	A	Atherectomy, x-ray exam	0.00	15.00	0.94	15.94	XXX	N
75995	.....	A	Atherectomy, x-ray exam	1.31	15.58	1.03	17.92	XXX	N
75995	26	A	Atherectomy, x-ray exam	1.31	0.58	0.09	1.98	XXX	N
75995	TC	A	Atherectomy, x-ray exam	0.00	15.00	0.94	15.94	XXX	N
75996	.....	A	Atherectomy, x-ray exam	0.36	8.16	0.52	9.04	XXX	N
75996	26	A	Atherectomy, x-ray exam	0.36	0.16	0.02	0.54	XXX	N
75996	TC	A	Atherectomy, x-ray exam	0.00	8.00	0.50	8.50	XXX	N
76000	.....	A	Fluoroscope examination	0.17	1.31	0.09	1.57	XXX	N
76000	26	A	Fluoroscope examination	0.17	0.07	0.01	0.25	XXX	N
76000	TC	A	Fluoroscope examination	0.00	1.24	0.08	1.32	XXX	N
76001	.....	A	Fluoroscope exam, extensive	0.67	2.81	0.22	3.70	XXX	N
76001	26	A	Fluoroscope exam, extensive	0.67	0.31	0.05	1.03	XXX	N
76001	TC	A	Fluoroscope exam, extensive	0.00	2.50	0.17	2.67	XXX	N
76003	.....	A	Needle localization by x-ray	0.54	1.49	0.12	2.15	XXX	N
76003	26	A	Needle localization by x-ray	0.54	0.25	0.04	0.83	XXX	N
76003	TC	A	Needle localization by x-ray	0.00	1.24	0.08	1.32	XXX	N
76010	.....	A	X-ray, nose to rectum	0.18	0.58	0.04	0.80	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
76010	26	A	X-ray, nose to rectum	0.18	0.08	0.01	0.27	XXX	N
76010	TC	A	X-ray, nose to rectum	0.00	0.50	0.03	0.53	XXX	N
76020	.....	A	X-rays for bone age	0.19	0.59	0.04	0.82	XXX	N
76020	26	A	X-rays for bone age	0.19	0.09	0.01	0.29	XXX	N
76020	TC	A	X-rays for bone age	0.00	0.50	0.03	0.53	XXX	N
76040	.....	A	X-rays, bone evaluation	0.27	0.88	0.07	1.22	XXX	N
76040	26	A	X-rays, bone evaluation	0.27	0.13	0.02	0.42	XXX	N
76040	TC	A	X-rays, bone evaluation	0.00	0.75	0.05	0.80	XXX	N
76061	.....	A	X-rays, bone survey	0.45	1.15	0.09	1.69	XXX	N
76061	26	A	X-rays, bone survey	0.45	0.20	0.03	0.68	XXX	N
76061	TC	A	X-rays, bone survey	0.00	0.95	0.06	1.01	XXX	N
76062	.....	A	X-rays, bone survey	0.54	1.62	0.13	2.29	XXX	N
76062	26	A	X-rays, bone survey	0.54	0.25	0.04	0.83	XXX	N
76062	TC	A	X-rays, bone survey	0.00	1.37	0.09	1.46	XXX	N
76065	.....	A	X-rays, bone evaluation	0.28	0.83	0.07	1.18	XXX	N
76065	26	A	X-rays, bone evaluation	0.28	0.13	0.02	0.43	XXX	N
76065	TC	A	X-rays, bone evaluation	0.00	0.70	0.05	0.75	XXX	N
76066	.....	A	Joint(s) survey, single film	0.31	1.20	0.09	1.60	XXX	N
76066	26	A	Joint(s) survey, single film	0.31	0.14	0.02	0.47	XXX	N
76066	TC	A	Joint(s) survey, single film	0.00	1.06	0.07	1.13	XXX	N
76070	.....	A	CT scan, bone density study	0.25	2.93	0.20	3.38	XXX	N
76070	26	A	CT scan, bone density study	0.25	0.12	0.02	0.39	XXX	N
76070	TC	A	CT scan, bone density study	0.00	2.81	0.18	2.99	XXX	N
76075	.....	A	Dual energy x-ray study	0.30	3.07	0.21	3.58	XXX	N
76075	26	A	Dual energy x-ray study	0.30	0.12	0.02	0.44	XXX	N
76075	TC	A	Dual energy x-ray study	0.00	2.95	0.19	3.14	XXX	N
76080	.....	A	X-ray exam of fistula	0.54	1.25	0.11	1.90	XXX	N
76080	26	A	X-ray exam of fistula	0.54	0.25	0.04	0.83	XXX	N
76080	TC	A	X-ray exam of fistula	0.00	1.00	0.07	1.07	XXX	N
76086	.....	A	X-ray of mammary duct	0.36	2.67	0.19	3.22	XXX	N
76086	26	A	X-ray of mammary duct	0.36	0.17	0.02	0.55	XXX	N
76086	TC	A	X-ray of mammary duct	0.00	2.50	0.17	2.67	XXX	N
76088	.....	A	X-ray of mammary ducts	0.45	3.69	0.25	4.39	XXX	N
76088	26	A	X-ray of mammary ducts	0.45	0.20	0.03	0.68	XXX	N
76088	TC	A	X-ray of mammary ducts	0.00	3.49	0.22	3.71	XXX	N
76090	.....	A	Mammogram, one breast	0.25	1.12	0.09	1.46	XXX	N
76090	26	A	Mammogram, one breast	0.25	0.12	0.02	0.39	XXX	N
76090	TC	A	Mammogram, one breast	0.00	1.00	0.07	1.07	XXX	N
76091	.....	A	Mammogram, both breasts	0.41	1.42	0.11	1.94	XXX	N
76091	26	A	Mammogram, both breasts	0.41	0.18	0.03	0.62	XXX	N
76091	TC	A	Mammogram, both breasts	0.00	1.24	0.08	1.32	XXX	N
76092	.....	X	Mammogram, screening	0.00	0.00	0.00	0.00	XXX	0
76093	.....	A	Magnetic image, breast	1.63	17.52	1.16	20.31	XXX	N
76093	26	A	Magnetic image, breast	1.63	0.72	0.11	2.46	XXX	N
76093	TC	A	Magnetic image, breast	0.00	16.80	1.05	17.85	XXX	N
76094	.....	A	Magnetic image, both breasts	1.63	23.51	1.53	26.67	XXX	N
76094	26	A	Magnetic image, both breasts	1.63	0.72	0.11	2.46	XXX	N
76094	TC	A	Magnetic image, both breasts	0.00	22.79	1.42	24.21	XXX	N
76095	.....	A	Stereotactic breast biopsy	1.59	7.54	0.54	9.67	XXX	N
76095	26	A	Stereotactic breast biopsy	1.59	0.71	0.11	2.41	XXX	N
76095	TC	A	Stereotactic breast biopsy	0.00	6.83	0.43	7.26	XXX	N
76096	.....	A	X-ray of needle wire, breast	0.56	1.50	0.12	2.18	XXX	N
76096	26	A	X-ray of needle wire, breast	0.56	0.26	0.04	0.86	XXX	N
76096	TC	A	X-ray of needle wire, breast	0.00	1.24	0.08	1.32	XXX	N
76098	.....	A	X-ray exam, breast specimen	0.16	0.47	0.04	0.67	XXX	N
76098	26	A	X-ray exam, breast specimen	0.16	0.07	0.01	0.24	XXX	N
76098	TC	A	X-ray exam, breast specimen	0.00	0.40	0.03	0.43	XXX	N
76100	.....	A	X-ray exam of body section	0.58	1.46	0.12	2.16	XXX	N
76100	26	A	X-ray exam of body section	0.58	0.27	0.04	0.89	XXX	N
76100	TC	A	X-ray exam of body section	0.00	1.19	0.08	1.27	XXX	N
76101	.....	A	Complex body section x-ray	0.58	1.62	0.13	2.33	XXX	N
76101	26	A	Complex body section x-ray	0.58	0.27	0.04	0.89	XXX	N
76101	TC	A	Complex body section x-ray	0.00	1.35	0.09	1.44	XXX	N
76102	.....	A	Complex body section x-rays	0.58	1.92	0.15	2.65	XXX	N
76102	26	A	Complex body section x-rays	0.58	0.27	0.04	0.89	XXX	N
76102	TC	A	Complex body section x-rays	0.00	1.65	0.11	1.76	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
76120		A	Cinematic x-rays	0.38	1.17	0.10	1.65	XXX	N
76120	26	A	Cinematic x-rays	0.38	0.17	0.03	0.58	XXX	N
76120	TC	A	Cinematic x-rays	0.00	1.00	0.07	1.07	XXX	N
76125		A	Cinematic x-rays	0.27	0.87	0.07	1.21	XXX	N
76125	26	A	Cinematic x-rays	0.27	0.12	0.02	0.41	XXX	N
76125	TC	A	Cinematic x-rays	0.00	0.75	0.05	0.80	XXX	N
76140		G	X-ray consultation	0.00	0.00	0.00	0.00	XXX	0
76150		A	X-ray exam, dry process	0.00	0.40	0.03	0.43	XXX	N
76350		C	Special x-ray contrast study	0.00	0.00	0.00	0.00	XXX	N
76355		A	CAT scan for localization	1.21	8.40	0.57	10.18	XXX	N
76355	26	A	CAT scan for localization	1.21	0.53	0.08	1.82	XXX	N
76355	TC	A	CAT scan for localization	0.00	7.87	0.49	8.36	XXX	N
76360		A	CAT scan for needle biopsy	1.16	8.37	0.57	10.10	XXX	N
76360	26	A	CAT scan for needle biopsy	1.16	0.50	0.08	1.74	XXX	N
76360	TC	A	CAT scan for needle biopsy	0.00	7.87	0.49	8.36	XXX	N
76365		A	CAT scan for cyst aspiration	1.16	8.37	0.57	10.10	XXX	N
76365	26	A	CAT scan for cyst aspiration	1.16	0.50	0.08	1.74	XXX	N
76365	TC	A	CAT scan for cyst aspiration	0.00	7.87	0.49	8.36	XXX	N
76370		A	CAT scan for therapy guide	0.85	3.19	0.24	4.28	XXX	N
76370	26	A	CAT scan for therapy guide	0.85	0.38	0.06	1.29	XXX	N
76370	TC	A	CAT scan for therapy guide	0.00	2.81	0.18	2.99	XXX	N
76375		A	CAT scans, other planes	0.16	3.44	0.22	3.82	XXX	N
76375	26	A	CAT scans, other planes	0.16	0.07	0.01	0.24	XXX	N
76375	TC	A	CAT scans, other planes	0.00	3.37	0.21	3.58	XXX	N
76380		A	CAT scan follow-up study	0.98	3.78	0.28	5.04	XXX	N
76380	26	A	CAT scan follow-up study	0.98	0.44	0.07	1.49	XXX	N
76380	TC	A	CAT scan follow-up study	0.00	3.34	0.21	3.55	XXX	N
76400		A	Magnetic image, bone marrow	1.60	11.40	0.78	13.78	XXX	N
76400	26	A	Magnetic image, bone marrow	1.60	0.72	0.11	2.43	XXX	N
76400	TC	A	Magnetic image, bone marrow	0.00	10.68	0.67	11.35	XXX	N
76499		C	Radiographic procedure	0.00	0.00	0.00	0.00	XXX	N
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	XXX	N
76499	TC	C	Radiographic procedure	0.00	0.00	0.00	0.00	XXX	N
76506		A	Echo exam of head	0.63	1.64	0.13	2.40	XXX	N
76506	26	A	Echo exam of head	0.63	0.29	0.04	0.96	XXX	N
76506	TC	A	Echo exam of head	0.00	1.35	0.09	1.44	XXX	N
76511		A	Echo exam of eye	0.94	1.44	0.12	2.50	XXX	N
76511	26	A	Echo exam of eye	0.94	0.25	0.04	1.23	XXX	N
76511	TC	A	Echo exam of eye	0.00	1.19	0.08	1.27	XXX	N
76512		A	Echo exam of eye	0.66	1.75	0.15	2.56	XXX	N
76512	26	A	Echo exam of eye	0.66	0.30	0.05	1.01	XXX	N
76512	TC	A	Echo exam of eye	0.00	1.45	0.10	1.55	XXX	N
76513		A	Echo exam of eye, water bath	0.66	1.75	0.15	2.56	XXX	N
76513	26	A	Echo exam of eye, water bath	0.66	0.30	0.05	1.01	XXX	N
76513	TC	A	Echo exam of eye, water bath	0.00	1.45	0.10	1.55	XXX	N
76516		A	Echo exam of eye	0.54	1.44	0.12	2.10	XXX	N
76516	26	A	Echo exam of eye	0.54	0.25	0.04	0.83	XXX	N
76516	TC	A	Echo exam of eye	0.00	1.19	0.08	1.27	XXX	N
76519		A	Echo exam of eye	0.54	1.44	0.12	2.10	XXX	N
76519	26	A	Echo exam of eye	0.54	0.25	0.04	0.83	XXX	N
76519	TC	A	Echo exam of eye	0.00	1.19	0.08	1.27	XXX	N
76529		A	Echo exam of eye	0.57	1.56	0.13	2.26	XXX	N
76529	26	A	Echo exam of eye	0.57	0.26	0.04	0.87	XXX	N
76529	TC	A	Echo exam of eye	0.00	1.30	0.09	1.39	XXX	N
76536		A	Echo exam of head and neck	0.56	1.61	0.13	2.30	XXX	N
76536	26	A	Echo exam of head and neck	0.56	0.26	0.04	0.86	XXX	N
76536	TC	A	Echo exam of head and neck	0.00	1.35	0.09	1.44	XXX	N
76604		A	Echo exam of chest	0.55	1.50	0.12	2.17	XXX	N
76604	26	A	Echo exam of chest	0.55	0.26	0.04	0.85	XXX	N
76604	TC	A	Echo exam of chest	0.00	1.24	0.08	1.32	XXX	N
76645		A	Echo exam of breast	0.54	1.25	0.11	1.90	XXX	N
76645	26	A	Echo exam of breast	0.54	0.25	0.04	0.83	XXX	N
76645	TC	A	Echo exam of breast	0.00	1.00	0.07	1.07	XXX	N
76700		A	Echo exam of abdomen	0.81	2.25	0.17	3.23	XXX	N
76700	26	A	Echo exam of abdomen	0.81	0.37	0.05	1.23	XXX	N
76700	TC	A	Echo exam of abdomen	0.00	1.88	0.12	2.00	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
76705		A	Echo exam of abdomen	0.59	1.62	0.13	2.34	XXX	N
76705	26	A	Echo exam of abdomen	0.59	0.27	0.04	0.90	XXX	N
76705	TC	A	Echo exam of abdomen	0.00	1.35	0.09	1.44	XXX	N
76770		A	Echo exam abdomen back wall	0.74	2.22	0.17	3.13	XXX	N
76770	26	A	Echo exam abdomen back wall	0.74	0.34	0.05	1.13	XXX	N
76770	TC	A	Echo exam abdomen back wall	0.00	1.88	0.12	2.00	XXX	N
76775		A	Echo exam abdomen back wall	0.58	1.62	0.13	2.33	XXX	N
76775	26	A	Echo exam abdomen back wall	0.58	0.27	0.04	0.89	XXX	N
76775	TC	A	Echo exam abdomen back wall	0.00	1.35	0.09	1.44	XXX	N
76778		A	Echo exam kidney transplant	0.74	2.22	0.17	3.13	XXX	N
76778	26	A	Echo exam kidney transplant	0.74	0.34	0.05	1.13	XXX	N
76778	TC	A	Echo exam kidney transplant	0.00	1.88	0.12	2.00	XXX	N
76800		A	Echo exam spinal canal	1.13	1.85	0.17	3.15	XXX	N
76800	26	A	Echo exam spinal canal	1.13	0.50	0.08	1.71	XXX	N
76800	TC	A	Echo exam spinal canal	0.00	1.35	0.09	1.44	XXX	N
76805		A	Echo exam of pregnant uterus	0.99	2.45	0.20	3.64	XXX	N
76805	26	A	Echo exam of pregnant uterus	0.99	0.45	0.07	1.51	XXX	N
76805	TC	A	Echo exam of pregnant uterus	0.00	2.00	0.13	2.13	XXX	N
76810		A	Echo exam of pregnant uterus	1.97	4.88	0.38	7.23	XXX	N
76810	26	A	Echo exam of pregnant uterus	1.97	0.88	0.13	2.98	XXX	N
76810	TC	A	Echo exam of pregnant uterus	0.00	4.00	0.25	4.25	XXX	N
76815		A	Echo exam of pregnant uterus	0.65	1.65	0.13	2.43	XXX	N
76815	26	A	Echo exam of pregnant uterus	0.65	0.30	0.04	0.99	XXX	N
76815	TC	A	Echo exam of pregnant uterus	0.00	1.35	0.09	1.44	XXX	N
76816		A	Echo exam followup or repeat	0.57	1.32	0.11	2.00	XXX	N
76816	26	A	Echo exam followup or repeat	0.57	0.26	0.04	0.87	XXX	N
76816	TC	A	Echo exam followup or repeat	0.00	1.06	0.07	1.13	XXX	N
76818		A	Fetal biophysical profile	0.77	1.89	0.15	2.81	XXX	N
76818	26	A	Fetal biophysical profile	0.77	0.35	0.05	1.17	XXX	N
76818	TC	A	Fetal biophysical profile	0.00	1.54	0.10	1.64	XXX	N
76825		A	Echo exam of fetal heart	0.98	2.23	0.17	3.38	XXX	N
76825	26	A	Echo exam of fetal heart	0.98	0.35	0.05	1.38	XXX	N
76825	TC	A	Echo exam of fetal heart	0.00	1.88	0.12	2.00	XXX	N
76826		A	Echo exam of fetal heart	0.83	1.35	0.10	2.28	XXX	N
76826	26	A	Echo exam of fetal heart	0.83	0.68	0.05	1.56	XXX	N
76826	TC	A	Echo exam of fetal heart	0.00	0.67	0.05	0.72	XXX	N
76827		A	Echo exam of fetal heart	0.58	2.33	0.18	3.09	XXX	N
76827	26	A	Echo exam of fetal heart	0.58	0.69	0.05	1.32	XXX	N
76827	TC	A	Echo exam of fetal heart	0.00	1.64	0.13	1.77	XXX	N
76828		A	Echo exam of fetal heart	0.56	1.34	0.11	2.01	XXX	N
76828	26	A	Echo exam of fetal heart	0.56	0.28	0.02	0.86	XXX	N
76828	TC	A	Echo exam of fetal heart	0.00	1.06	0.09	1.15	XXX	N
76830		A	Echo exam, transvaginal	0.69	1.77	0.15	2.61	XXX	N
76830	26	A	Echo exam, transvaginal	0.69	0.32	0.05	1.06	XXX	N
76830	TC	A	Echo exam, transvaginal	0.00	1.45	0.10	1.55	XXX	N
76856		A	Echo exam of pelvis	0.69	1.77	0.15	2.61	XXX	N
76856	26	A	Echo exam of pelvis	0.69	0.32	0.05	1.06	XXX	N
76856	TC	A	Echo exam of pelvis	0.00	1.45	0.10	1.55	XXX	N
76857		A	Echo exam of pelvis	0.38	1.17	0.10	1.65	XXX	N
76857	26	A	Echo exam of pelvis	0.38	0.17	0.03	0.58	XXX	N
76857	TC	A	Echo exam of pelvis	0.00	1.00	0.07	1.07	XXX	N
76870		A	Echo exam of scrotum	0.64	1.74	0.14	2.52	XXX	N
76870	26	A	Echo exam of scrotum	0.64	0.29	0.04	0.97	XXX	N
76870	TC	A	Echo exam of scrotum	0.00	1.45	0.10	1.55	XXX	N
76872		A	Echo exam, transrectal	0.69	1.77	0.15	2.61	XXX	N
76872	26	A	Echo exam, transrectal	0.69	0.32	0.05	1.06	XXX	N
76872	TC	A	Echo exam, transrectal	0.00	1.45	0.10	1.55	XXX	N
76880		A	Echo exam of extremity	0.59	1.62	0.13	2.34	XXX	N
76880	26	A	Echo exam of extremity	0.59	0.27	0.04	0.90	XXX	N
76880	TC	A	Echo exam of extremity	0.00	1.35	0.09	1.44	XXX	N
76930		A	Echo guide for heart sac tap	0.67	1.76	0.15	2.58	XXX	N
76930	26	A	Echo guide for heart sac tap	0.67	0.31	0.05	1.03	XXX	N
76930	TC	A	Echo guide for heart sac tap	0.00	1.45	0.10	1.55	XXX	N
76932		A	Echo guide for heart biopsy	0.67	1.76	0.15	2.58	XXX	N
76932	26	A	Echo guide for heart biopsy	0.67	0.31	0.05	1.03	XXX	N
76932	TC	A	Echo guide for heart biopsy	0.00	1.45	0.10	1.55	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
76934	.....	A	Echo guide for chest tap	0.67	1.76	0.15	2.58	XXX	N
76934	26	A	Echo guide for chest tap	0.67	0.31	0.05	1.03	XXX	N
76934	TC	A	Echo guide for chest tap	0.00	1.45	0.10	1.55	XXX	N
76936	.....	A	Echo guide for artery repair	1.99	7.24	0.48	9.71	XXX	N
76936	26	A	Echo guide for artery repair	1.99	1.24	0.10	3.33	XXX	N
76936	TC	A	Echo guide for artery repair	0.00	6.00	0.38	6.38	XXX	N
76938	.....	A	Echo exam for drainage	0.67	1.76	0.15	2.58	XXX	N
76938	26	A	Echo exam for drainage	0.67	0.31	0.05	1.03	XXX	N
76938	TC	A	Echo exam for drainage	0.00	1.45	0.10	1.55	XXX	N
76941	.....	A	Echo guide for transfusion	1.34	2.07	0.19	3.60	XXX	N
76941	26	A	Echo guide for transfusion	1.34	0.61	0.10	2.05	XXX	N
76941	TC	A	Echo guide for transfusion	0.00	1.46	0.09	1.55	XXX	N
76942	.....	A	Echo guide for biopsy	0.67	1.76	0.15	2.58	XXX	N
76942	26	A	Echo guide for biopsy	0.67	0.31	0.05	1.03	XXX	N
76942	TC	A	Echo guide for biopsy	0.00	1.45	0.10	1.55	XXX	N
76945	.....	A	Echo guide, villus sampling	0.67	2.07	0.19	2.93	XXX	N
76945	26	A	Echo guide, villus sampling	0.67	0.61	0.10	1.38	XXX	N
76945	TC	A	Echo guide, villus sampling	0.00	1.46	0.09	1.55	XXX	N
76946	.....	A	Echo guide for amniocentesis	0.38	1.62	0.13	2.13	XXX	N
76946	26	A	Echo guide for amniocentesis	0.38	0.17	0.03	0.58	XXX	N
76946	TC	A	Echo guide for amniocentesis	0.00	1.45	0.10	1.55	XXX	N
76948	.....	A	Echo guide, ova aspiration	0.38	1.62	0.13	2.13	XXX	N
76948	26	A	Echo guide, ova aspiration	0.38	0.17	0.03	0.58	XXX	N
76948	TC	A	Echo guide, ova aspiration	0.00	1.45	0.10	1.55	XXX	N
76950	.....	A	Echo guidance radiotherapy	0.58	1.51	0.12	2.21	XXX	N
76950	26	A	Echo guidance radiotherapy	0.58	0.27	0.04	0.89	XXX	N
76950	TC	A	Echo guidance radiotherapy	0.00	1.24	0.08	1.32	XXX	N
76960	.....	A	Echo guidance radiotherapy	0.58	1.51	0.12	2.21	XXX	N
76960	26	A	Echo guidance radiotherapy	0.58	0.27	0.04	0.89	XXX	N
76960	TC	A	Echo guidance radiotherapy	0.00	1.24	0.08	1.32	XXX	N
76965	.....	A	Echo guidance radiotherapy	1.34	7.38	0.52	9.24	XXX	N
76965	26	A	Echo guidance radiotherapy	1.34	2.07	0.19	3.60	XXX	N
76965	TC	A	Echo guidance radiotherapy	0.00	5.31	0.33	5.64	XXX	N
76970	.....	A	Ultrasound exam follow-up	0.40	1.18	0.10	1.68	XXX	N
76970	26	A	Ultrasound exam follow-up	0.40	0.18	0.03	0.61	XXX	N
76970	TC	A	Ultrasound exam follow-up	0.00	1.00	0.07	1.07	XXX	N
76975	.....	A	GI endoscopic ultrasound	0.81	1.79	0.15	2.75	XXX	N
76975	26	A	GI endoscopic ultrasound	0.81	0.34	0.05	1.20	XXX	N
76975	TC	A	GI endoscopic ultrasound	0.00	1.45	0.10	1.55	XXX	N
76986	.....	A	Echo exam at surgery	1.20	3.03	0.25	4.48	XXX	N
76986	26	A	Echo exam at surgery	1.20	0.53	0.08	1.81	XXX	N
76986	TC	A	Echo exam at surgery	0.00	2.50	0.17	2.67	XXX	N
76999	.....	C	Echo examination procedure	0.00	0.00	0.00	0.00	XXX	N
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	XXX	N
76999	TC	C	Echo examination procedure	0.00	0.00	0.00	0.00	XXX	N
77261	.....	A	Radiation therapy planning	1.39	0.62	0.09	2.10	XXX	N
77262	.....	A	Radiation therapy planning	2.11	0.94	0.14	3.19	XXX	N
77263	.....	A	Radiation therapy planning	3.14	1.40	0.20	4.74	XXX	N
77280	.....	A	Set radiation therapy field	0.70	3.63	0.26	4.59	XXX	N
77280	26	A	Set radiation therapy field	0.70	0.32	0.05	1.07	XXX	N
77280	TC	A	Set radiation therapy field	0.00	3.31	0.21	3.52	XXX	N
77285	.....	A	Set radiation therapy field	1.05	5.77	0.41	7.23	XXX	N
77285	26	A	Set radiation therapy field	1.05	0.46	0.07	1.58	XXX	N
77285	TC	A	Set radiation therapy field	0.00	5.31	0.34	5.65	XXX	N
77290	.....	A	Set radiation therapy field	1.56	6.90	0.50	8.96	XXX	N
77290	26	A	Set radiation therapy field	1.56	0.70	0.11	2.37	XXX	N
77290	TC	A	Set radiation therapy field	0.00	6.20	0.39	6.59	XXX	N
77295	.....	A	Set radiation therapy field	4.57	28.68	1.93	35.18	XXX	N
77295	26	A	Set radiation therapy field	4.57	2.06	0.23	6.86	XXX	N
77295	TC	A	Set radiation therapy field	0.00	26.62	1.70	28.32	XXX	N
77299	.....	C	Radiation therapy planning	0.00	0.00	0.00	0.00	XXX	N
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	XXX	N
77299	TC	C	Radiation therapy planning	0.00	0.00	0.00	0.00	XXX	N
77300	.....	A	Radiation therapy dose plan	0.62	1.56	0.12	2.30	XXX	N
77300	26	A	Radiation therapy dose plan	0.62	0.28	0.04	0.94	XXX	N
77300	TC	A	Radiation therapy dose plan	0.00	1.28	0.08	1.36	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
77305		A	Radiation therapy dose plan	0.70	2.09	0.17	2.96	XXX	N
77305	26	A	Radiation therapy dose plan	0.70	0.32	0.05	1.07	XXX	N
77305	TC	A	Radiation therapy dose plan	0.00	1.77	0.12	1.89	XXX	N
77310		A	Radiation therapy dose plan	1.05	2.68	0.22	3.95	XXX	N
77310	26	A	Radiation therapy dose plan	1.05	0.46	0.07	1.58	XXX	N
77310	TC	A	Radiation therapy dose plan	0.00	2.22	0.15	2.37	XXX	N
77315		A	Radiation therapy dose plan	1.56	3.23	0.28	5.07	XXX	N
77315	26	A	Radiation therapy dose plan	1.56	0.70	0.11	2.37	XXX	N
77315	TC	A	Radiation therapy dose plan	0.00	2.53	0.17	2.70	XXX	N
77321		A	Radiation therapy port plan	0.95	4.28	0.30	5.53	XXX	N
77321	26	A	Radiation therapy port plan	0.95	0.43	0.06	1.44	XXX	N
77321	TC	A	Radiation therapy port plan	0.00	3.85	0.24	4.09	XXX	N
77326		A	Radiation therapy dose plan	0.93	2.67	0.21	3.81	XXX	N
77326	26	A	Radiation therapy dose plan	0.93	0.42	0.06	1.41	XXX	N
77326	TC	A	Radiation therapy dose plan	0.00	2.25	0.15	2.40	XXX	N
77327		A	Radiation therapy dose plan	1.39	3.93	0.30	5.62	XXX	N
77327	26	A	Radiation therapy dose plan	1.39	0.62	0.09	2.10	XXX	N
77327	TC	A	Radiation therapy dose plan	0.00	3.31	0.21	3.52	XXX	N
77328		A	Radiation therapy dose plan	2.09	5.66	0.44	8.19	XXX	N
77328	26	A	Radiation therapy dose plan	2.09	0.93	0.14	3.16	XXX	N
77328	TC	A	Radiation therapy dose plan	0.00	4.73	0.30	5.03	XXX	N
77331		A	Special radiation dosimetry	0.87	0.87	0.09	1.83	XXX	N
77331	26	A	Special radiation dosimetry	0.87	0.39	0.06	1.32	XXX	N
77331	TC	A	Special radiation dosimetry	0.00	0.48	0.03	0.51	XXX	N
77332		A	Radiation treatment aid(s)	0.54	1.53	0.12	2.19	XXX	N
77332	26	A	Radiation treatment aid(s)	0.54	0.25	0.04	0.83	XXX	N
77332	TC	A	Radiation treatment aid(s)	0.00	1.28	0.08	1.36	XXX	N
77333		A	Radiation treatment aid(s)	0.84	2.19	0.18	3.21	XXX	N
77333	26	A	Radiation treatment aid(s)	0.84	0.38	0.06	1.28	XXX	N
77333	TC	A	Radiation treatment aid(s)	0.00	1.81	0.12	1.93	XXX	N
77334		A	Radiation treatment aid(s)	1.24	3.64	0.27	5.15	XXX	N
77334	26	A	Radiation treatment aid(s)	1.24	0.54	0.08	1.86	XXX	N
77334	TC	A	Radiation treatment aid(s)	0.00	3.10	0.19	3.29	XXX	N
77336		A	Radiation physics consult	0.00	2.84	0.18	3.02	XXX	N
77370		A	Radiation physics consult	0.00	3.33	0.21	3.54	XXX	N
77399		C	External radiation dosimetry	0.00	0.00	0.00	0.00	XXX	N
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	XXX	N
77399	TC	C	External radiation dosimetry	0.00	0.00	0.00	0.00	XXX	N
77401		A	Radiation treatment delivery	0.00	1.69	0.11	1.80	XXX	N
77402		A	Radiation treatment delivery	0.00	1.69	0.11	1.80	XXX	N
77403		A	Radiation treatment delivery	0.00	1.69	0.11	1.80	XXX	N
77404		A	Radiation treatment delivery	0.00	1.69	0.11	1.80	XXX	N
77406		A	Radiation treatment delivery	0.00	1.69	0.11	1.80	XXX	N
77407		A	Radiation treatment delivery	0.00	1.99	0.13	2.12	XXX	N
77408		A	Radiation treatment delivery	0.00	1.99	0.13	2.12	XXX	N
77409		A	Radiation treatment delivery	0.00	1.99	0.13	2.12	XXX	N
77411		A	Radiation treatment delivery	0.00	1.99	0.13	2.12	XXX	N
77412		A	Radiation treatment delivery	0.00	2.22	0.15	2.37	XXX	N
77413		A	Radiation treatment delivery	0.00	2.22	0.15	2.37	XXX	N
77414		A	Radiation treatment delivery	0.00	2.22	0.15	2.37	XXX	N
77416		A	Radiation treatment delivery	0.00	2.22	0.15	2.37	XXX	N
77417		A	Radiology port film(s)	0.00	0.56	0.04	0.60	XXX	N
77419		A	Weekly radiation therapy	3.60	1.61	0.23	5.44	XXX	N
77420		A	Weekly radiation therapy	1.61	0.72	0.11	2.44	XXX	N
77425		A	Weekly radiation therapy	2.44	1.10	0.17	3.71	XXX	N
77430		A	Weekly radiation therapy	3.60	1.61	0.23	5.44	XXX	N
77431		A	Radiation therapy management	1.81	0.81	0.12	2.74	XXX	N
77432		A	Stereotactic radiation trmt	7.93	4.94	0.40	13.27	XXX	N
77470		A	Special radiation treatment	2.09	11.55	0.80	14.44	XXX	N
77470	26	A	Special radiation treatment	2.09	0.93	0.14	3.16	XXX	N
77470	TC	A	Special radiation treatment	0.00	10.62	0.66	11.28	XXX	N
77499		C	Radiation therapy management	0.00	0.00	0.00	0.00	XXX	N
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	XXX	N
77499	TC	C	Radiation therapy management	0.00	0.00	0.00	0.00	XXX	N
77600		A	Hyperthermia treatment	1.56	3.60	0.29	5.45	ZZZ	N
77600	26	A	Hyperthermia treatment	1.56	0.70	0.11	2.37	ZZZ	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
77600	TC	A	Hyperthermia treatment	0.00	2.90	0.18	3.08	ZZZ	N
77605	.....	A	Hyperthermia treatment	2.09	4.80	0.39	7.28	ZZZ	N
77605	26	A	Hyperthermia treatment	2.09	0.93	0.14	3.16	ZZZ	N
77605	TC	A	Hyperthermia treatment	0.00	3.87	0.25	4.12	ZZZ	N
77610	.....	A	Hyperthermia treatment	1.56	3.60	0.29	5.45	ZZZ	N
77610	26	A	Hyperthermia treatment	1.56	0.70	0.11	2.37	ZZZ	N
77610	TC	A	Hyperthermia treatment	0.00	2.90	0.18	3.08	ZZZ	N
77615	.....	A	Hyperthermia treatment	2.09	4.80	0.39	7.28	ZZZ	N
77615	26	A	Hyperthermia treatment	2.09	0.93	0.14	3.16	ZZZ	N
77615	TC	A	Hyperthermia treatment	0.00	3.87	0.25	4.12	ZZZ	N
77620	.....	A	Hyperthermia treatment	1.56	3.60	0.29	5.45	ZZZ	N
77620	26	A	Hyperthermia treatment	1.56	0.70	0.11	2.37	ZZZ	N
77620	TC	A	Hyperthermia treatment	0.00	2.90	0.18	3.08	ZZZ	N
77750	.....	A	Infuse radioactive materials	4.59	3.32	0.38	8.29	090	N
77750	26	A	Infuse radioactive materials	4.59	2.05	0.30	6.94	090	N
77750	TC	A	Infuse radioactive materials	0.00	1.27	0.08	1.35	090	N
77761	.....	A	Radioelement application	3.56	3.98	0.39	7.93	090	N
77761	26	A	Radioelement application	3.56	1.59	0.23	5.38	090	N
77761	TC	A	Radioelement application	0.00	2.39	0.16	2.55	090	N
77762	.....	A	Radioelement application	5.35	5.83	0.57	11.75	090	N
77762	26	A	Radioelement application	5.35	2.39	0.35	8.09	090	N
77762	TC	A	Radioelement application	0.00	3.44	0.22	3.66	090	N
77763	.....	A	Radioelement application	8.01	7.86	0.77	16.64	090	N
77763	26	A	Radioelement application	8.01	3.58	0.50	12.09	090	N
77763	TC	A	Radioelement application	0.00	4.28	0.27	4.55	090	N
77776	.....	A	Radioelement application	4.66	4.16	0.45	9.27	XXX	N
77776	26	A	Radioelement application	4.66	2.09	0.31	7.06	XXX	N
77776	TC	A	Radioelement application	0.00	2.07	0.14	2.21	XXX	N
77777	.....	A	Radioelement application	6.99	7.17	0.71	14.87	090	N
77777	26	A	Radioelement application	6.99	3.13	0.45	10.57	090	N
77777	TC	A	Radioelement application	0.00	4.04	0.26	4.30	090	N
77778	.....	A	Radioelement application	10.46	9.58	0.98	21.02	090	N
77778	26	A	Radioelement application	10.46	4.69	0.67	15.82	090	N
77778	TC	A	Radioelement application	0.00	4.89	0.31	5.20	090	N
77781	.....	A	High intensity brachytherapy	1.55	20.04	1.32	22.91	090	N
77781	26	A	High intensity brachytherapy	1.55	0.69	0.11	2.35	090	N
77781	TC	A	High intensity brachytherapy	0.00	19.35	1.21	20.56	090	N
77782	.....	A	High intensity brachytherapy	2.33	20.40	1.37	24.10	090	N
77782	26	A	High intensity brachytherapy	2.33	1.05	0.16	3.54	090	N
77782	TC	A	High intensity brachytherapy	0.00	19.35	1.21	20.56	090	N
77783	.....	A	High intensity brachytherapy	3.49	20.90	1.44	25.83	090	N
77783	26	A	High intensity brachytherapy	3.49	1.55	0.23	5.27	090	N
77783	TC	A	High intensity brachytherapy	0.00	19.35	1.21	20.56	090	N
77784	.....	A	High intensity brachytherapy	5.24	21.69	1.56	28.49	090	N
77784	26	A	High intensity brachytherapy	5.24	2.34	0.35	7.93	090	N
77784	TC	A	High intensity brachytherapy	0.00	19.35	1.21	20.56	090	N
77789	.....	A	Radioelement application	1.05	0.89	0.10	2.04	090	N
77789	26	A	Radioelement application	1.05	0.46	0.07	1.58	090	N
77789	TC	A	Radioelement application	0.00	0.43	0.03	0.46	090	N
77790	.....	A	Radioelement handling	1.05	0.94	0.10	2.09	XXX	N
77790	26	A	Radioelement handling	1.05	0.46	0.07	1.58	XXX	N
77790	TC	A	Radioelement handling	0.00	0.48	0.03	0.51	XXX	N
77799	.....	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	XXX	N
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	XXX	N
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	XXX	N
78000	.....	A	Thyroid, single uptake	0.19	1.01	0.07	1.27	XXX	N
78000	26	A	Thyroid, single uptake	0.19	0.09	0.01	0.29	XXX	N
78000	TC	A	Thyroid, single uptake	0.00	0.92	0.06	0.98	XXX	N
78001	.....	A	Thyroid, multiple uptakes	0.26	1.36	0.10	1.72	XXX	N
78001	26	A	Thyroid, multiple uptakes	0.26	0.12	0.02	0.40	XXX	N
78001	TC	A	Thyroid, multiple uptakes	0.00	1.24	0.08	1.32	XXX	N
78003	.....	A	Thyroid suppress/stimul	0.33	1.07	0.08	1.48	XXX	N
78003	26	A	Thyroid suppress/stimul	0.33	0.15	0.02	0.50	XXX	N
78003	TC	A	Thyroid suppress/stimul	0.00	0.92	0.06	0.98	XXX	N
78006	.....	A	Thyroid, imaging with uptake	0.49	2.49	0.18	3.16	XXX	N
78006	26	A	Thyroid, imaging with uptake	0.49	0.22	0.03	0.74	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
78006	TC	A	Thyroid, imaging with uptake	0.00	2.27	0.15	2.42	XXX	N
78007	.....	A	Thyroid, image, mult uptakes	0.50	2.68	0.19	3.37	XXX	N
78007	26	A	Thyroid, image, mult uptakes	0.50	0.23	0.03	0.76	XXX	N
78007	TC	A	Thyroid, image, mult uptakes	0.00	2.45	0.16	2.61	XXX	N
78010	.....	A	Thyroid imaging	0.39	1.90	0.14	2.43	XXX	N
78010	26	A	Thyroid imaging	0.39	0.17	0.03	0.59	XXX	N
78010	TC	A	Thyroid imaging	0.00	1.73	0.11	1.84	XXX	N
78011	.....	A	Thyroid imaging with flow	0.45	2.50	0.18	3.13	XXX	N
78011	26	A	Thyroid imaging with flow	0.45	0.21	0.03	0.69	XXX	N
78011	TC	A	Thyroid imaging with flow	0.00	2.29	0.15	2.44	XXX	N
78015	.....	A	Thyroid met imaging	0.67	2.76	0.21	3.64	XXX	N
78015	26	A	Thyroid met imaging	0.67	0.31	0.05	1.03	XXX	N
78015	TC	A	Thyroid met imaging	0.00	2.45	0.16	2.61	XXX	N
78016	.....	A	Thyroid met imaging/studies	0.82	3.70	0.27	4.79	XXX	N
78016	26	A	Thyroid met imaging/studies	0.82	0.38	0.06	1.26	XXX	N
78016	TC	A	Thyroid met imaging/studies	0.00	3.32	0.21	3.53	XXX	N
78017	.....	A	Thyroid met imaging, mult	0.87	3.94	0.28	5.09	XXX	N
78017	26	A	Thyroid met imaging, mult	0.87	0.39	0.06	1.32	XXX	N
78017	TC	A	Thyroid met imaging, mult	0.00	3.55	0.22	3.77	XXX	N
78018	.....	A	Thyroid, met imaging, body	0.95	5.60	0.39	6.94	XXX	N
78018	26	A	Thyroid, met imaging, body	0.95	0.43	0.06	1.44	XXX	N
78018	TC	A	Thyroid, met imaging, body	0.00	5.17	0.33	5.50	XXX	N
78070	.....	A	Parathyroid nuclear imaging	0.51	1.96	0.15	2.62	XXX	N
78070	26	A	Parathyroid nuclear imaging	0.51	0.23	0.04	0.78	XXX	N
78070	TC	A	Parathyroid nuclear imaging	0.00	1.73	0.11	1.84	XXX	N
78075	.....	A	Adrenal nuclear imaging	0.74	5.51	0.38	6.63	XXX	N
78075	26	A	Adrenal nuclear imaging	0.74	0.34	0.05	1.13	XXX	N
78075	TC	A	Adrenal nuclear imaging	0.00	5.17	0.33	5.50	XXX	N
78099	.....	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	XXX	N
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	XXX	N
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	XXX	N
78102	.....	A	Bone marrow imaging, ltd	0.55	2.19	0.17	2.91	XXX	N
78102	26	A	Bone marrow imaging, ltd	0.55	0.25	0.04	0.84	XXX	N
78102	TC	A	Bone marrow imaging, ltd	0.00	1.94	0.13	2.07	XXX	N
78103	.....	A	Bone marrow imaging, mult	0.75	3.36	0.24	4.35	XXX	N
78103	26	A	Bone marrow imaging, mult	0.75	0.34	0.05	1.14	XXX	N
78103	TC	A	Bone marrow imaging, mult	0.00	3.02	0.19	3.21	XXX	N
78104	.....	A	Bone marrow imaging, body	0.80	4.25	0.30	5.35	XXX	N
78104	26	A	Bone marrow imaging, body	0.80	0.37	0.05	1.22	XXX	N
78104	TC	A	Bone marrow imaging, body	0.00	3.88	0.25	4.13	XXX	N
78110	.....	A	Plasma volume, single	0.19	0.99	0.07	1.25	XXX	N
78110	26	A	Plasma volume, single	0.19	0.09	0.01	0.29	XXX	N
78110	TC	A	Plasma volume, single	0.00	0.90	0.06	0.96	XXX	N
78111	.....	A	Plasma volume, multiple	0.22	2.55	0.18	2.95	XXX	N
78111	26	A	Plasma volume, multiple	0.22	0.10	0.02	0.34	XXX	N
78111	TC	A	Plasma volume, multiple	0.00	2.45	0.16	2.61	XXX	N
78120	.....	A	Red cell mass, single	0.23	1.76	0.13	2.12	XXX	N
78120	26	A	Red cell mass, single	0.23	0.11	0.02	0.36	XXX	N
78120	TC	A	Red cell mass, single	0.00	1.65	0.11	1.76	XXX	N
78121	.....	A	Red cell mass, multiple	0.32	2.92	0.19	3.43	XXX	N
78121	26	A	Red cell mass, multiple	0.32	0.15	0.02	0.49	XXX	N
78121	TC	A	Red cell mass, multiple	0.00	2.77	0.17	2.94	XXX	N
78122	.....	A	Blood volume	0.45	4.59	0.31	5.35	XXX	N
78122	26	A	Blood volume	0.45	0.20	0.03	0.68	XXX	N
78122	TC	A	Blood volume	0.00	4.39	0.28	4.67	XXX	N
78130	.....	A	Red cell survival study	0.61	3.00	0.21	3.82	XXX	N
78130	26	A	Red cell survival study	0.61	0.28	0.04	0.93	XXX	N
78130	TC	A	Red cell survival study	0.00	2.72	0.17	2.89	XXX	N
78135	.....	A	Red cell survival kinetics	0.64	4.93	0.34	5.91	XXX	N
78135	26	A	Red cell survival kinetics	0.64	0.29	0.04	0.97	XXX	N
78135	TC	A	Red cell survival kinetics	0.00	4.64	0.30	4.94	XXX	N
78140	.....	A	Red cell sequestration	0.61	4.03	0.28	4.92	XXX	N
78140	26	A	Red cell sequestration	0.61	0.28	0.04	0.93	XXX	N
78140	TC	A	Red cell sequestration	0.00	3.75	0.24	3.99	XXX	N
78160	.....	A	Plasma iron turnover	0.33	3.64	0.24	4.21	XXX	N
78160	26	A	Plasma iron turnover	0.33	0.15	0.02	0.50	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
78160	TC	A	Plasma iron turnover	0.00	3.49	0.22	3.71	XXX	N
78162	.....	A	Iron absorption exam	0.45	3.25	0.22	3.92	XXX	N
78162	26	A	Iron absorption exam	0.45	0.20	0.03	0.68	XXX	N
78162	TC	A	Iron absorption exam	0.00	3.05	0.19	3.24	XXX	N
78170	.....	A	Red cell iron utilization	0.41	5.24	0.35	6.00	XXX	N
78170	26	A	Red cell iron utilization	0.41	0.18	0.03	0.62	XXX	N
78170	TC	A	Red cell iron utilization	0.00	5.06	0.32	5.38	XXX	N
78172	.....	C	Total body iron estimation	0.00	0.00	0.00	0.00	XXX	N
78172	26	A	Total body iron estimation	0.53	0.25	0.04	0.82	XXX	N
78172	TC	C	Total body iron estimation	0.00	0.00	0.00	0.00	XXX	N
78185	.....	A	Spleen imaging	0.40	2.43	0.18	3.01	XXX	N
78185	26	A	Spleen imaging	0.40	0.18	0.03	0.61	XXX	N
78185	TC	A	Spleen imaging	0.00	2.25	0.15	2.40	XXX	N
78190	.....	A	Platelet survival, kinetics	1.09	5.93	0.42	7.44	XXX	N
78190	26	A	Platelet survival, kinetics	1.09	0.48	0.07	1.64	XXX	N
78190	TC	A	Platelet survival, kinetics	0.00	5.45	0.35	5.80	XXX	N
78191	.....	A	Platelet survival	0.61	7.27	0.48	8.36	XXX	N
78191	26	A	Platelet survival	0.61	0.28	0.04	0.93	XXX	N
78191	TC	A	Platelet survival	0.00	6.99	0.44	7.43	XXX	N
78195	.....	A	Lymph system imaging	0.70	4.20	0.30	5.20	XXX	N
78195	26	A	Lymph system imaging	0.70	0.32	0.05	1.07	XXX	N
78195	TC	A	Lymph system imaging	0.00	3.88	0.25	4.13	XXX	N
78199	.....	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78201	.....	A	Liver imaging	0.44	2.44	0.18	3.06	XXX	N
78201	26	A	Liver imaging	0.44	0.19	0.03	0.66	XXX	N
78201	TC	A	Liver imaging	0.00	2.25	0.15	2.40	XXX	N
78202	.....	A	Liver imaging with flow	0.51	2.98	0.21	3.70	XXX	N
78202	26	A	Liver imaging with flow	0.51	0.23	0.04	0.78	XXX	N
78202	TC	A	Liver imaging with flow	0.00	2.75	0.17	2.92	XXX	N
78205	.....	A	Liver imaging (3D)	0.71	5.96	0.41	7.08	XXX	N
78205	26	A	Liver imaging (3D)	0.71	0.33	0.05	1.09	XXX	N
78205	TC	A	Liver imaging (3D)	0.00	5.63	0.36	5.99	XXX	N
78215	.....	A	Liver and spleen imaging	0.49	3.02	0.20	3.71	XXX	N
78215	26	A	Liver and spleen imaging	0.49	0.22	0.03	0.74	XXX	N
78215	TC	A	Liver and spleen imaging	0.00	2.80	0.17	2.97	XXX	N
78216	.....	A	Liver & spleen image, flow	0.57	3.58	0.25	4.40	XXX	N
78216	26	A	Liver & spleen image, flow	0.57	0.26	0.04	0.87	XXX	N
78216	TC	A	Liver & spleen image, flow	0.00	3.32	0.21	3.53	XXX	N
78220	.....	A	Liver function study	0.49	3.77	0.25	4.51	XXX	N
78220	26	A	Liver function study	0.49	0.22	0.03	0.74	XXX	N
78220	TC	A	Liver function study	0.00	3.55	0.22	3.77	XXX	N
78223	.....	A	Hepatobiliary imaging	0.84	3.87	0.28	4.99	XXX	N
78223	26	A	Hepatobiliary imaging	0.84	0.38	0.06	1.28	XXX	N
78223	TC	A	Hepatobiliary imaging	0.00	3.49	0.22	3.71	XXX	N
78230	.....	A	Salivary gland imaging	0.45	2.28	0.17	2.90	XXX	N
78230	26	A	Salivary gland imaging	0.45	0.21	0.03	0.69	XXX	N
78230	TC	A	Salivary gland imaging	0.00	2.07	0.14	2.21	XXX	N
78231	.....	A	Serial salivary imaging	0.52	3.26	0.23	4.01	XXX	N
78231	26	A	Serial salivary imaging	0.52	0.24	0.04	0.80	XXX	N
78231	TC	A	Serial salivary imaging	0.00	3.02	0.19	3.21	XXX	N
78232	.....	A	Salivary gland function exam	0.47	3.59	0.24	4.30	XXX	N
78232	26	A	Salivary gland function exam	0.47	0.22	0.03	0.72	XXX	N
78232	TC	A	Salivary gland function exam	0.00	3.37	0.21	3.58	XXX	N
78258	.....	A	Esophageal motility study	0.74	3.09	0.22	4.05	XXX	N
78258	26	A	Esophageal motility study	0.74	0.34	0.05	1.13	XXX	N
78258	TC	A	Esophageal motility study	0.00	2.75	0.17	2.92	XXX	N
78261	.....	A	Gastric mucosa imaging	0.69	4.23	0.30	5.22	XXX	N
78261	26	A	Gastric mucosa imaging	0.69	0.32	0.05	1.06	XXX	N
78261	TC	A	Gastric mucosa imaging	0.00	3.91	0.25	4.16	XXX	N
78262	.....	A	Gastroesophageal reflux exam	0.68	4.36	0.31	5.35	XXX	N
78262	26	A	Gastroesophageal reflux exam	0.68	0.31	0.05	1.04	XXX	N
78262	TC	A	Gastroesophageal reflux exam	0.00	4.05	0.26	4.31	XXX	N
78264	.....	A	Gastric emptying study	0.78	4.29	0.30	5.37	XXX	N
78264	26	A	Gastric emptying study	0.78	0.36	0.05	1.19	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
78264	TC	A	Gastric emptying study	0.00	3.93	0.25	4.18	XXX	N
78270	.....	A	Vit B-12 absorption exam	0.20	1.57	0.11	1.88	XXX	N
78270	26	A	Vit B-12 absorption exam	0.20	0.10	0.01	0.31	XXX	N
78270	TC	A	Vit B-12 absorption exam	0.00	1.47	0.10	1.57	XXX	N
78271	.....	A	Vit B-12 absorp exam, IF	0.20	1.67	0.11	1.98	XXX	N
78271	26	A	Vit B-12 absorp exam, IF	0.20	0.10	0.01	0.31	XXX	N
78271	TC	A	Vit B-12 absorp exam, IF	0.00	1.57	0.10	1.67	XXX	N
78272	.....	A	Vit B-12 absorp, combined	0.27	2.34	0.17	2.78	XXX	N
78272	26	A	Vit B-12 absorp, combined	0.27	0.13	0.02	0.42	XXX	N
78272	TC	A	Vit B-12 absorp, combined	0.00	2.21	0.15	2.36	XXX	N
78278	.....	A	Acute GI blood loss imaging	0.99	5.09	0.37	6.45	XXX	N
78278	26	A	Acute GI blood loss imaging	0.99	0.45	0.07	1.51	XXX	N
78278	TC	A	Acute GI blood loss imaging	0.00	4.64	0.30	4.94	XXX	N
78282	.....	C	GI protein loss exam	0.00	0.00	0.00	0.00	XXX	N
78282	26	A	GI protein loss exam	0.38	0.17	0.03	0.58	XXX	N
78282	TC	C	GI protein loss exam	0.00	0.00	0.00	0.00	XXX	N
78290	.....	A	Meckel's divert exam	0.68	3.21	0.23	4.12	XXX	N
78290	26	A	Meckel's divert exam	0.68	0.31	0.05	1.04	XXX	N
78290	TC	A	Meckel's divert exam	0.00	2.90	0.18	3.08	XXX	N
78291	.....	A	Leveen/shunt patency exam	0.88	3.31	0.24	4.43	XXX	N
78291	26	A	Leveen/shunt patency exam	0.88	0.39	0.06	1.33	XXX	N
78291	TC	A	Leveen/shunt patency exam	0.00	2.92	0.18	3.10	XXX	N
78299	.....	C	GI nuclear procedure	0.00	0.00	0.00	0.00	XXX	N
78299	26	C	GI nuclear procedure	0.00	0.00	0.00	0.00	XXX	N
78299	TC	C	GI nuclear procedure	0.00	0.00	0.00	0.00	XXX	N
78300	.....	A	Bone imaging, limited area	0.62	2.66	0.20	3.48	XXX	N
78300	26	A	Bone imaging, limited area	0.62	0.29	0.04	0.95	XXX	N
78300	TC	A	Bone imaging, limited area	0.00	2.37	0.16	2.53	XXX	N
78305	.....	A	Bone imaging, multiple areas	0.83	3.87	0.28	4.98	XXX	N
78305	26	A	Bone imaging, multiple areas	0.83	0.38	0.06	1.27	XXX	N
78305	TC	A	Bone imaging, multiple areas	0.00	3.49	0.22	3.71	XXX	N
78306	.....	A	Bone imaging, whole body	0.86	4.46	0.32	5.64	XXX	N
78306	26	A	Bone imaging, whole body	0.86	0.39	0.06	1.31	XXX	N
78306	TC	A	Bone imaging, whole body	0.00	4.07	0.26	4.33	XXX	N
78315	.....	A	Bone imaging, 3 phase	1.02	5.00	0.36	6.38	XXX	N
78315	26	A	Bone imaging, 3 phase	1.02	0.45	0.07	1.54	XXX	N
78315	TC	A	Bone imaging, 3 phase	0.00	4.55	0.29	4.84	XXX	N
78320	.....	A	Bone imaging (3D)	1.04	6.09	0.43	7.56	XXX	N
78320	26	A	Bone imaging (3D)	1.04	0.46	0.07	1.57	XXX	N
78320	TC	A	Bone imaging (3D)	0.00	5.63	0.36	5.99	XXX	N
78350	.....	A	Bone mineral, single photon	0.22	0.82	0.07	1.11	XXX	N
78350	26	A	Bone mineral, single photon	0.22	0.10	0.02	0.34	XXX	N
78350	TC	A	Bone mineral, single photon	0.00	0.72	0.05	0.77	XXX	N
78351	.....	N	Bone mineral, dual photon	#0.30	0.19	0.02	0.51	XXX	0
78399	.....	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78414	.....	C	Non-imaging heart function	0.00	0.00	0.00	0.00	XXX	N
78414	26	A	Non-imaging heart function	0.45	0.20	0.03	0.68	XXX	N
78414	TC	C	Non-imaging heart function	0.00	0.00	0.00	0.00	XXX	N
78428	.....	A	Cardiac shunt imaging	0.78	2.51	0.19	3.48	XXX	N
78428	26	A	Cardiac shunt imaging	0.78	0.36	0.05	1.19	XXX	N
78428	TC	A	Cardiac shunt imaging	0.00	2.15	0.14	2.29	XXX	N
78445	.....	A	Vascular flow imaging	0.49	2.01	0.15	2.65	XXX	N
78445	26	A	Vascular flow imaging	0.49	0.24	0.04	0.77	XXX	N
78445	TC	A	Vascular flow imaging	0.00	1.77	0.11	1.88	XXX	N
78455	.....	A	Venous thrombosis study	0.73	4.13	0.29	5.15	XXX	N
78455	26	A	Venous thrombosis study	0.73	0.33	0.05	1.11	XXX	N
78455	TC	A	Venous thrombosis study	0.00	3.80	0.24	4.04	XXX	N
78457	.....	A	Venous thrombosis imaging	0.77	2.88	0.22	3.87	XXX	N
78457	26	A	Venous thrombosis imaging	0.77	0.35	0.05	1.17	XXX	N
78457	TC	A	Venous thrombosis imaging	0.00	2.53	0.17	2.70	XXX	N
78458	.....	A	Ven thrombosis images, bilat	0.90	4.23	0.30	5.43	XXX	N
78458	26	A	Ven thrombosis images, bilat	0.90	0.40	0.06	1.36	XXX	N
78458	TC	A	Ven thrombosis images, bilat	0.00	3.83	0.24	4.07	XXX	N
78459	.....	G	Heart muscle imaging (PET)	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110-D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
78459	26	G	Heart muscle imaging (PET)	#1.88	1.34	0.10	3.32	XXX	0
78459	TC	G	Heart muscle imaging (PET)	0.00	0.00	0.00	0.00	XXX	0
78460	.....	A	Heart muscle blood single	0.86	2.64	0.21	3.71	XXX	N
78460	26	A	Heart muscle blood single	0.86	0.39	0.06	1.31	XXX	N
78460	TC	A	Heart muscle blood single	0.00	2.25	0.15	2.40	XXX	N
78461	.....	A	Heart muscle blood multiple	1.23	5.04	0.37	6.64	XXX	N
78461	26	A	Heart muscle blood multiple	1.23	0.54	0.08	1.85	XXX	N
78461	TC	A	Heart muscle blood multiple	0.00	4.50	0.29	4.79	XXX	N
78464	.....	A	Heart image (3D) single	1.09	7.22	0.50	8.81	XXX	N
78464	26	A	Heart image (3D) single	1.09	0.48	0.07	1.64	XXX	N
78464	TC	A	Heart image (3D) single	0.00	6.74	0.43	7.17	XXX	N
78465	.....	A	Heart image (3D) multiple	1.46	11.89	0.80	14.15	XXX	N
78465	26	A	Heart image (3D) multiple	1.46	0.65	0.10	2.21	XXX	N
78465	TC	A	Heart image (3D) multiple	0.00	11.24	0.70	11.94	XXX	N
78466	.....	A	Heart infarct image	0.69	2.82	0.22	3.73	XXX	N
78466	26	A	Heart infarct image	0.69	0.32	0.05	1.06	XXX	N
78466	TC	A	Heart infarct image	0.00	2.50	0.17	2.67	XXX	N
78468	.....	A	Heart infarct image, EF	0.80	3.85	0.27	4.92	XXX	N
78468	26	A	Heart infarct image, EF	0.80	0.36	0.05	1.21	XXX	N
78468	TC	A	Heart infarct image, EF	0.00	3.49	0.22	3.71	XXX	N
78469	.....	A	Heart infarct image (3D)	0.92	5.39	0.38	6.69	XXX	N
78469	26	A	Heart infarct image (3D)	0.92	0.41	0.06	1.39	XXX	N
78469	TC	A	Heart infarct image (3D)	0.00	4.98	0.32	5.30	XXX	N
78472	.....	A	Gated heart, resting	0.98	5.69	0.41	7.08	XXX	N
78472	26	A	Gated heart, resting	0.98	0.44	0.07	1.49	XXX	N
78472	TC	A	Gated heart, resting	0.00	5.25	0.34	5.59	XXX	N
78473	.....	A	Gated heart, multiple	1.47	8.52	0.59	10.58	XXX	N
78473	26	A	Gated heart, multiple	1.47	0.65	0.10	2.22	XXX	N
78473	TC	A	Gated heart, multiple	0.00	7.87	0.49	8.36	XXX	N
78478	.....	A	Heart wall motion (add-on)	0.62	1.76	0.14	2.52	XXX	N
78478	26	A	Heart wall motion (add-on)	0.62	0.28	0.04	0.94	XXX	N
78478	TC	A	Heart wall motion (add-on)	0.00	1.48	0.10	1.58	XXX	N
78480	.....	A	Heart function, (add-on)	0.62	1.76	0.14	2.52	XXX	N
78480	26	A	Heart function, (add-on)	0.62	0.28	0.04	0.94	XXX	N
78480	TC	A	Heart function, (add-on)	0.00	1.48	0.10	1.58	XXX	N
78481	.....	A	Heart first pass single	0.98	5.42	0.39	6.79	XXX	N
78481	26	A	Heart first pass single	0.98	0.44	0.07	1.49	XXX	N
78481	TC	A	Heart first pass single	0.00	4.98	0.32	5.30	XXX	N
78483	.....	A	Heart first pass multiple	1.47	8.15	0.57	10.19	XXX	N
78483	26	A	Heart first pass multiple	1.47	0.65	0.10	2.22	XXX	N
78483	TC	A	Heart first pass multiple	0.00	7.50	0.47	7.97	XXX	N
78499	.....	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78580	.....	A	Lung perfusion imaging	0.74	3.61	0.26	4.61	XXX	N
78580	26	A	Lung perfusion imaging	0.74	0.34	0.05	1.13	XXX	N
78580	TC	A	Lung perfusion imaging	0.00	3.27	0.21	3.48	XXX	N
78584	.....	A	Lung V/Q image single breath	0.99	3.50	0.26	4.75	XXX	N
78584	26	A	Lung V/Q image single breath	0.99	0.45	0.07	1.51	XXX	N
78584	TC	A	Lung V/Q image single breath	0.00	3.05	0.19	3.24	XXX	N
78585	.....	A	Lung V/Q imaging	1.09	5.85	0.41	7.35	XXX	N
78585	26	A	Lung V/Q imaging	1.09	0.48	0.07	1.64	XXX	N
78585	TC	A	Lung V/Q imaging	0.00	5.37	0.34	5.71	XXX	N
78586	.....	A	Aerosol lung image, single	0.40	2.65	0.19	3.24	XXX	N
78586	26	A	Aerosol lung image, single	0.40	0.18	0.03	0.61	XXX	N
78586	TC	A	Aerosol lung image, single	0.00	2.47	0.16	2.63	XXX	N
78587	.....	A	Aerosol lung image, multiple	0.49	2.89	0.20	3.58	XXX	N
78587	26	A	Aerosol lung image, multiple	0.49	0.22	0.03	0.74	XXX	N
78587	TC	A	Aerosol lung image, multiple	0.00	2.67	0.17	2.84	XXX	N
78591	.....	A	Vent image, 1 breath, 1 proj	0.40	2.90	0.20	3.50	XXX	N
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.18	0.03	0.61	XXX	N
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	2.72	0.17	2.89	XXX	N
78593	.....	A	Vent image, 1 proj, gas	0.49	3.51	0.24	4.24	XXX	N
78593	26	A	Vent image, 1 proj, gas	0.49	0.22	0.03	0.74	XXX	N
78593	TC	A	Vent image, 1 proj, gas	0.00	3.29	0.21	3.50	XXX	N
78594	.....	A	Vent image, mult proj, gas	0.53	5.00	0.34	5.87	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
78594	26	A	Vent image, mult proj, gas	0.53	0.25	0.04	0.82	XXX	N
78594	TC	A	Vent image, mult proj, gas	0.00	4.75	0.30	5.05	XXX	N
78596	.....	A	Lung differential function	1.27	7.30	0.52	9.09	XXX	N
78596	26	A	Lung differential function	1.27	0.56	0.09	1.92	XXX	N
78596	TC	A	Lung differential function	0.00	6.74	0.43	7.17	XXX	N
78599	.....	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78599	TC	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78600	.....	A	Brain imaging, ltd static	0.44	2.95	0.20	3.59	XXX	N
78600	26	A	Brain imaging, ltd static	0.44	0.20	0.03	0.67	XXX	N
78600	TC	A	Brain imaging, ltd static	0.00	2.75	0.17	2.92	XXX	N
78601	.....	A	Brain ltd imaging & flow	0.51	3.48	0.24	4.23	XXX	N
78601	26	A	Brain ltd imaging & flow	0.51	0.24	0.04	0.79	XXX	N
78601	TC	A	Brain ltd imaging & flow	0.00	3.24	0.20	3.44	XXX	N
78605	.....	A	Brain imaging, complete	0.53	3.49	0.24	4.26	XXX	N
78605	26	A	Brain imaging, complete	0.53	0.25	0.04	0.82	XXX	N
78605	TC	A	Brain imaging, complete	0.00	3.24	0.20	3.44	XXX	N
78606	.....	A	Brain imaging comp & flow	0.64	3.98	0.27	4.89	XXX	N
78606	26	A	Brain imaging comp & flow	0.64	0.29	0.04	0.97	XXX	N
78606	TC	A	Brain imaging comp & flow	0.00	3.69	0.23	3.92	XXX	N
78607	.....	A	Brain imaging (3D)	1.23	6.79	0.47	8.49	XXX	N
78607	26	A	Brain imaging (3D)	1.23	0.54	0.08	1.85	XXX	N
78607	TC	A	Brain imaging (3D)	0.00	6.25	0.39	6.64	XXX	N
78608	.....	N	Brain imaging (PET)	0.00	0.00	0.00	0.00	XXX	O
78609	.....	N	Brain imaging (PET)	0.00	0.00	0.00	0.00	XXX	O
78610	.....	A	Brain flow imaging only	0.30	1.64	0.12	2.06	XXX	N
78610	26	A	Brain flow imaging only	0.30	0.14	0.02	0.46	XXX	N
78610	TC	A	Brain flow imaging only	0.00	1.50	0.10	1.60	XXX	N
78615	.....	A	Cerebral blood flow imaging	0.42	3.86	0.26	4.54	XXX	N
78615	26	A	Cerebral blood flow imaging	0.42	0.19	0.03	0.64	XXX	N
78615	TC	A	Cerebral blood flow imaging	0.00	3.67	0.23	3.90	XXX	N
78630	.....	A	Cerebrospinal fluid scan	0.68	5.11	0.36	6.15	XXX	N
78630	26	A	Cerebrospinal fluid scan	0.68	0.31	0.05	1.04	XXX	N
78630	TC	A	Cerebrospinal fluid scan	0.00	4.80	0.31	5.11	XXX	N
78635	.....	A	CSF ventriculography	0.61	2.70	0.20	3.51	XXX	N
78635	26	A	CSF ventriculography	0.61	0.28	0.04	0.93	XXX	N
78635	TC	A	CSF ventriculography	0.00	2.42	0.16	2.58	XXX	N
78645	.....	A	CSF shunt evaluation	0.57	3.53	0.25	4.35	XXX	N
78645	26	A	CSF shunt evaluation	0.57	0.26	0.04	0.87	XXX	N
78645	TC	A	CSF shunt evaluation	0.00	3.27	0.21	3.48	XXX	N
78647	.....	A	Cerebrospinal fluid scan	0.90	6.04	0.42	7.36	XXX	N
78647	26	A	Cerebrospinal fluid scan	0.90	0.41	0.06	1.37	XXX	N
78647	TC	A	Cerebrospinal fluid scan	0.00	5.63	0.36	5.99	XXX	N
78650	.....	A	CSF leakage imaging	0.61	4.70	0.32	5.63	XXX	N
78650	26	A	CSF leakage imaging	0.61	0.28	0.04	0.93	XXX	N
78650	TC	A	CSF leakage imaging	0.00	4.42	0.28	4.70	XXX	N
78655	.....	D	Nuclear exam of eye lesion	0.00	0.00	0.00	0.00	XXX	N
78655	26	D	Nuclear exam of eye lesion	0.00	0.00	0.00	0.00	XXX	N
78655	TC	D	Nuclear exam of eye lesion	0.00	0.00	0.00	0.00	XXX	N
78660	.....	A	Nuclear exam of tear flow	0.53	2.27	0.17	2.97	XXX	N
78660	26	A	Nuclear exam of tear flow	0.53	0.25	0.04	0.82	XXX	N
78660	TC	A	Nuclear exam of tear flow	0.00	2.02	0.13	2.15	XXX	N
78699	.....	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78699	TC	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78700	.....	A	Kidney imaging, static	0.45	3.10	0.21	3.76	XXX	N
78700	26	A	Kidney imaging, static	0.45	0.20	0.03	0.68	XXX	N
78700	TC	A	Kidney imaging, static	0.00	2.90	0.18	3.08	XXX	N
78701	.....	A	Kidney imaging with flow	0.49	3.61	0.24	4.34	XXX	N
78701	26	A	Kidney imaging with flow	0.49	0.22	0.03	0.74	XXX	N
78701	TC	A	Kidney imaging with flow	0.00	3.39	0.21	3.60	XXX	N
78704	.....	A	Imaging renogram	0.74	4.11	0.29	5.14	XXX	N
78704	26	A	Imaging renogram	0.74	0.34	0.05	1.13	XXX	N
78704	TC	A	Imaging renogram	0.00	3.77	0.24	4.01	XXX	N
78707	.....	A	Kidney flow & function image	0.94	4.68	0.33	5.95	XXX	N
78707	26	A	Kidney flow & function image	0.94	0.42	0.06	1.42	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
78707	TC	A	Kidney flow & function image	0.00	4.26	0.27	4.53	XXX	N
78710	.....	A	Kidney imaging (3D)	0.66	5.93	0.41	7.00	XXX	N
78710	26	A	Kidney imaging (3D)	0.66	0.30	0.05	1.01	XXX	N
78710	TC	A	Kidney imaging (3D)	0.00	5.63	0.36	5.99	XXX	N
78715	.....	A	Renal vascular flow exam	0.30	1.64	0.12	2.06	XXX	N
78715	26	A	Renal vascular flow exam	0.30	0.14	0.02	0.46	XXX	N
78715	TC	A	Renal vascular flow exam	0.00	1.50	0.10	1.60	XXX	N
78725	.....	A	Kidney function study	0.38	1.87	0.14	2.39	XXX	N
78725	26	A	Kidney function study	0.38	0.17	0.03	0.58	XXX	N
78725	TC	A	Kidney function study	0.00	1.70	0.11	1.81	XXX	N
78726	.....	A	Kidney function w/intervent	0.87	3.21	0.24	4.32	XXX	N
78726	26	A	Kidney function w/intervent	0.87	0.39	0.06	1.32	XXX	N
78726	TC	A	Kidney function w/intervent	0.00	2.82	0.18	3.00	XXX	N
78727	.....	A	Kidney transplant evaluation	0.99	4.25	0.31	5.55	XXX	N
78727	26	A	Kidney transplant evaluation	0.99	0.45	0.07	1.51	XXX	N
78727	TC	A	Kidney transplant evaluation	0.00	3.80	0.24	4.04	XXX	N
78730	.....	A	Urinary bladder retention	0.36	1.55	0.11	2.02	XXX	N
78730	26	A	Urinary bladder retention	0.36	0.16	0.02	0.54	XXX	N
78730	TC	A	Urinary bladder retention	0.00	1.39	0.09	1.48	XXX	N
78740	.....	A	Ureteral reflux study	0.57	2.28	0.17	3.02	XXX	N
78740	26	A	Ureteral reflux study	0.57	0.26	0.04	0.87	XXX	N
78740	TC	A	Ureteral reflux study	0.00	2.02	0.13	2.15	XXX	N
78760	.....	A	Testicular imaging	0.66	2.85	0.21	3.72	XXX	N
78760	26	A	Testicular imaging	0.66	0.30	0.04	1.00	XXX	N
78760	TC	A	Testicular imaging	0.00	2.55	0.17	2.72	XXX	N
78761	.....	A	Testicular imaging & flow	0.71	3.38	0.24	4.33	XXX	N
78761	26	A	Testicular imaging & flow	0.71	0.33	0.05	1.09	XXX	N
78761	TC	A	Testicular imaging & flow	0.00	3.05	0.19	3.24	XXX	N
78799	.....	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	XXX	N
78800	.....	A	Tumor imaging, limited area	0.66	3.54	0.24	4.44	XXX	N
78800	26	A	Tumor imaging, limited area	0.66	0.30	0.04	1.00	XXX	N
78800	TC	A	Tumor imaging, limited area	0.00	3.24	0.20	3.44	XXX	N
78801	.....	A	Tumor imaging, mult areas	0.79	4.39	0.31	5.49	XXX	N
78801	26	A	Tumor imaging, mult areas	0.79	0.36	0.05	1.20	XXX	N
78801	TC	A	Tumor imaging, mult areas	0.00	4.03	0.26	4.29	XXX	N
78802	.....	A	Tumor imaging, whole body	0.86	5.66	0.40	6.92	XXX	N
78802	26	A	Tumor imaging, whole body	0.86	0.39	0.06	1.31	XXX	N
78802	TC	A	Tumor imaging, whole body	0.00	5.27	0.34	5.61	XXX	N
78803	.....	A	Tumor imaging (3D)	1.09	6.73	0.46	8.28	XXX	N
78803	26	A	Tumor imaging (3D)	1.09	0.48	0.07	1.64	XXX	N
78803	TC	A	Tumor imaging (3D)	0.00	6.25	0.39	6.64	XXX	N
78805	.....	A	Abscess imaging, ltd area	0.73	3.57	0.25	4.55	XXX	N
78805	26	A	Abscess imaging, ltd area	0.73	0.33	0.05	1.11	XXX	N
78805	TC	A	Abscess imaging, ltd area	0.00	3.24	0.20	3.44	XXX	N
78806	.....	A	Abscess imaging, whole body	0.86	6.51	0.45	7.82	XXX	N
78806	26	A	Abscess imaging, whole body	0.86	0.38	0.06	1.30	XXX	N
78806	TC	A	Abscess imaging, whole body	0.00	6.13	0.39	6.52	XXX	N
78807	.....	A	Nuclear localization/abscess	1.09	6.73	0.46	8.28	XXX	N
78807	26	A	Nuclear localization/abscess	1.09	0.48	0.07	1.64	XXX	N
78807	TC	A	Nuclear localization/abscess	0.00	6.25	0.39	6.64	XXX	N
78810	.....	N	Tumor imaging (PET)	0.00	0.00	0.00	0.00	XXX	0
78810	26	N	Tumor imaging (PET)	#1.93	1.37	0.10	3.40	XXX	0
78810	TC	N	Tumor imaging (PET)	0.00	0.00	0.00	0.00	XXX	0
78890	.....	B	Nuclear medicine data proc	#0.05	1.26	0.08	1.39	XXX	0
78890	26	B	Nuclear medicine data proc	#0.05	0.02	0.00	0.07	XXX	0
78890	TC	B	Nuclear medicine data proc	#0.00	1.24	0.08	1.32	XXX	0
78891	.....	B	Nuclear med data proc	#0.10	2.55	0.18	2.83	XXX	0
78891	26	B	Nuclear med data proc	#0.10	0.05	0.01	0.16	XXX	0
78891	TC	B	Nuclear med data proc	#0.00	2.50	0.17	2.67	XXX	0
78990	.....	G	Provide diag radionuclide(s)	0.00	0.00	0.00	0.00	XXX	0
78999	.....	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	XXX	N
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	XXX	N
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	XXX	N
79000	.....	A	Intial hyperthyroid therapy	1.80	3.31	0.29	5.40	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
79000	26	A	Initial hyperthyroid therapy	1.80	0.81	0.12	2.73	XXX	N
79000	TC	A	Initial hyperthyroid therapy	0.00	2.50	0.17	2.67	XXX	N
79001	.....	A	Repeat hyperthyroid therapy	1.05	1.70	0.15	2.90	XXX	N
79001	26	A	Repeat hyperthyroid therapy	1.05	0.46	0.07	1.58	XXX	N
79001	TC	A	Repeat hyperthyroid therapy	0.00	1.24	0.08	1.32	XXX	N
79020	.....	A	Thyroid ablation	1.81	3.31	0.29	5.41	XXX	N
79020	26	A	Thyroid ablation	1.81	0.81	0.12	2.74	XXX	N
79020	TC	A	Thyroid ablation	0.00	2.50	0.17	2.67	XXX	N
79030	.....	A	Thyroid ablation, carcinoma	2.10	3.44	0.31	5.85	XXX	N
79030	26	A	Thyroid ablation, carcinoma	2.10	0.94	0.14	3.18	XXX	N
79030	TC	A	Thyroid ablation, carcinoma	0.00	2.50	0.17	2.67	XXX	N
79035	.....	A	Thyroid metastatic therapy	2.52	3.63	0.34	6.49	XXX	N
79035	26	A	Thyroid metastatic therapy	2.52	1.13	0.17	3.82	XXX	N
79035	TC	A	Thyroid metastatic therapy	0.00	2.50	0.17	2.67	XXX	N
79100	.....	A	Hematopoietic nuclear therapy	1.32	3.08	0.26	4.66	XXX	N
79100	26	A	Hematopoietic nuclear therapy	1.32	0.58	0.09	1.99	XXX	N
79100	TC	A	Hematopoietic nuclear therapy	0.00	2.50	0.17	2.67	XXX	N
79200	.....	A	Intracavitary nuc treatment	1.99	3.39	0.31	5.69	XXX	N
79200	26	A	Intracavitary nuc treatment	1.99	0.89	0.14	3.02	XXX	N
79200	TC	A	Intracavitary nuc treatment	0.00	2.50	0.17	2.67	XXX	N
79300	.....	C	Interstitial nuclear therapy	0.00	0.00	0.00	0.00	XXX	N
79300	26	A	Interstitial nuclear therapy	1.60	0.71	0.11	2.42	XXX	N
79300	TC	C	Interstitial nuclear therapy	0.00	0.00	0.00	0.00	XXX	N
79400	.....	A	Nonhemato nuclear therapy	1.96	3.37	0.30	5.63	XXX	N
79400	26	A	Nonhemato nuclear therapy	1.96	0.87	0.13	2.96	XXX	N
79400	TC	A	Nonhemato nuclear therapy	0.00	2.50	0.17	2.67	XXX	N
79420	.....	C	Intravascular nuc therapy	0.00	0.00	0.00	0.00	XXX	N
79420	26	A	Intravascular nuc therapy	1.51	0.67	0.10	2.28	XXX	N
79420	TC	C	Intravascular nuc therapy	0.00	0.00	0.00	0.00	XXX	N
79440	.....	A	Nuclear joint therapy	1.99	3.39	0.31	5.69	XXX	N
79440	26	A	Nuclear joint therapy	1.99	0.89	0.14	3.02	XXX	N
79440	TC	A	Nuclear joint therapy	0.00	2.50	0.17	2.67	XXX	N
79900	.....	C	Provide ther radiopharm(s)	0.00	0.00	0.00	0.00	XXX	N
79999	.....	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	XXX	N
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	XXX	N
79999	TC	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	XXX	N
80002	.....	X	1–2 clinical chem tests	0.00	0.00	0.00	0.00	XXX	0
80003	.....	X	3 clinical chemistry tests	0.00	0.00	0.00	0.00	XXX	0
80004	.....	X	4 clinical chemistry tests	0.00	0.00	0.00	0.00	XXX	0
80005	.....	X	5 clinical chemistry tests	0.00	0.00	0.00	0.00	XXX	0
80006	.....	X	6 clinical chemistry tests	0.00	0.00	0.00	0.00	XXX	0
80007	.....	X	7 clinical chemistry tests	0.00	0.00	0.00	0.00	XXX	0
80008	.....	X	8 clinical chemistry tests	0.00	0.00	0.00	0.00	XXX	0
80009	.....	X	9 clinical chemistry tests	0.00	0.00	0.00	0.00	XXX	0
80010	.....	X	10 clinical chemistry tests	0.00	0.00	0.00	0.00	XXX	0
80011	.....	X	11 clinical chemistry tests	0.00	0.00	0.00	0.00	XXX	0
80012	.....	X	12 clinical chemistry tests	0.00	0.00	0.00	0.00	XXX	0
80016	.....	X	13–16 blood/urine tests	0.00	0.00	0.00	0.00	XXX	0
80018	.....	X	17–18 blood/urine tests	0.00	0.00	0.00	0.00	XXX	0
80019	.....	X	19 blood/urine tests	0.00	0.00	0.00	0.00	XXX	0
80050	.....	X	General health panel	0.00	0.00	0.00	0.00	XXX	0
80055	.....	X	Obstetric panel	0.00	0.00	0.00	0.00	XXX	0
80058	.....	X	Hepatic function panel	0.00	0.00	0.00	0.00	XXX	0
80059	.....	X	Hepatitis panel	0.00	0.00	0.00	0.00	XXX	0
80061	.....	X	Lipid panel	0.00	0.00	0.00	0.00	XXX	0
80072	.....	X	Arthritis panel	0.00	0.00	0.00	0.00	XXX	0
80090	.....	X	Torch antibody panel	0.00	0.00	0.00	0.00	XXX	0
80091	.....	X	Thyroid panel	0.00	0.00	0.00	0.00	XXX	0
80092	.....	X	Thyroid panel w/TSH	0.00	0.00	0.00	0.00	XXX	0
80100	.....	X	Drug screen	0.00	0.00	0.00	0.00	XXX	0
80101	.....	X	Drug screen	0.00	0.00	0.00	0.00	XXX	0
80102	.....	X	Drug confirmation	0.00	0.00	0.00	0.00	XXX	0
80103	.....	X	Drug analysis, tissue prep	0.00	0.00	0.00	0.00	XXX	0
80150	.....	X	Assay of amikacin	0.00	0.00	0.00	0.00	XXX	0
80152	.....	X	Assay of amitriptyline	0.00	0.00	0.00	0.00	XXX	0
80154	.....	X	Assay of benzodiazepines	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
80156		X	Assay carbamazepine	0.00	0.00	0.00	0.00	XXX	0
80158		X	Assay of cyclosporine	0.00	0.00	0.00	0.00	XXX	0
80160		X	Assay of desipramine	0.00	0.00	0.00	0.00	XXX	0
80162		X	Assay for digoxin	0.00	0.00	0.00	0.00	XXX	0
80164		X	Assay, dipropylacetic acid	0.00	0.00	0.00	0.00	XXX	0
80166		X	Assay of doxepin	0.00	0.00	0.00	0.00	XXX	0
80168		X	Assay of ethosuximide	0.00	0.00	0.00	0.00	XXX	0
80170		X	Gentamicin	0.00	0.00	0.00	0.00	XXX	0
80172		X	Assay for gold	0.00	0.00	0.00	0.00	XXX	0
80174		X	Assay of imipramine	0.00	0.00	0.00	0.00	XXX	0
80176		X	Assay for lidocaine	0.00	0.00	0.00	0.00	XXX	0
80178		X	Assay for lithium	0.00	0.00	0.00	0.00	XXX	0
80182		X	Assay for nortriptyline	0.00	0.00	0.00	0.00	XXX	0
80184		X	Assay for phenobarbital	0.00	0.00	0.00	0.00	XXX	0
80185		X	Assay for phenytoin	0.00	0.00	0.00	0.00	XXX	0
80186		X	Assay for phenytoin, free	0.00	0.00	0.00	0.00	XXX	0
80188		X	Assay for primidone	0.00	0.00	0.00	0.00	XXX	0
80190		X	Assay for procainamide	0.00	0.00	0.00	0.00	XXX	0
80192		X	Assay for procainamide	0.00	0.00	0.00	0.00	XXX	0
80194		X	Assay for quinidine	0.00	0.00	0.00	0.00	XXX	0
80196		X	Assay for salicylate	0.00	0.00	0.00	0.00	XXX	0
80198		X	Assay for theophylline	0.00	0.00	0.00	0.00	XXX	0
80200		X	Assay for tobramycin	0.00	0.00	0.00	0.00	XXX	0
80202		X	Assay for vancomycin	0.00	0.00	0.00	0.00	XXX	0
80299		X	Quantitative assay, drug	0.00	0.00	0.00	0.00	XXX	0
80400		X	Acth stimulation panel	0.00	0.00	0.00	0.00	XXX	0
80402		X	Acth stimulation panel	0.00	0.00	0.00	0.00	XXX	0
80406		X	Acth stimulation panel	0.00	0.00	0.00	0.00	XXX	0
80408		X	Aldosterone suppression eval	0.00	0.00	0.00	0.00	XXX	0
80410		X	Calcitonin stim panel	0.00	0.00	0.00	0.00	XXX	0
80412		X	CRH stimulation panel	0.00	0.00	0.00	0.00	XXX	0
80414		X	Testosterone response	0.00	0.00	0.00	0.00	XXX	0
80415		X	Estradiol response panel	0.00	0.00	0.00	0.00	XXX	0
80416		X	Renin stimulation panel	0.00	0.00	0.00	0.00	XXX	0
80417		X	Renin stimulation panel	0.00	0.00	0.00	0.00	XXX	0
80418		X	Pituitary evaluation panel	0.00	0.00	0.00	0.00	XXX	0
80420		X	Dexamethasone panel	0.00	0.00	0.00	0.00	XXX	0
80422		X	Glucagon tolerance panel	0.00	0.00	0.00	0.00	XXX	0
80424		X	Glucagon tolerance panel	0.00	0.00	0.00	0.00	XXX	0
80426		X	Gonadotropin hormone panel	0.00	0.00	0.00	0.00	XXX	0
80428		X	Growth hormone panel	0.00	0.00	0.00	0.00	XXX	0
80430		X	Growth hormone panel	0.00	0.00	0.00	0.00	XXX	0
80432		X	Insulin suppression panel	0.00	0.00	0.00	0.00	XXX	0
80434		X	Insulin tolerance panel	0.00	0.00	0.00	0.00	XXX	0
80435		X	Insulin tolerance panel	0.00	0.00	0.00	0.00	XXX	0
80436		X	Metyrapone panel	0.00	0.00	0.00	0.00	XXX	0
80438		X	TRH stimulation panel	0.00	0.00	0.00	0.00	XXX	0
80439		X	TRH stimulation panel	0.00	0.00	0.00	0.00	XXX	0
80440		X	TRH stimulation panel	0.00	0.00	0.00	0.00	XXX	0
80500		A	Lab pathology consultation	0.37	0.20	0.01	0.58	XXX	N
80502		A	Lab pathology consultation	1.33	0.33	0.02	1.68	XXX	N
81000		X	Urinalysis, nonauto, w/scope	0.00	0.00	0.00	0.00	XXX	0
81001		X	Urinalysis, auto, w/scope	0.00	0.00	0.00	0.00	XXX	0
81002		X	Urinalysis nonauto w/o scope	0.00	0.00	0.00	0.00	XXX	0
81003		X	Urinalysis, auto, w/o scope	0.00	0.00	0.00	0.00	XXX	0
81005		X	Urinalysis	0.00	0.00	0.00	0.00	XXX	0
81007		X	Urine screen for bacteria	0.00	0.00	0.00	0.00	XXX	0
81015		X	Microscopic exam of urine	0.00	0.00	0.00	0.00	XXX	0
81020		X	Urinalysis, glass test	0.00	0.00	0.00	0.00	XXX	0
81025		X	Urine pregnancy test	0.00	0.00	0.00	0.00	XXX	0
81050		X	Urinalysis, volume measure	0.00	0.00	0.00	0.00	XXX	0
81099		X	Urinalysis test procedure	0.00	0.00	0.00	0.00	XXX	0
82000		X	Assay blood acetaldehyde	0.00	0.00	0.00	0.00	XXX	0
82003		X	Assay acetaminophen	0.00	0.00	0.00	0.00	XXX	0
82009		X	Test for acetone/ketones	0.00	0.00	0.00	0.00	XXX	0
82010		X	Acetone assay	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
82013		X	Acetylcholinesterase assay	0.00	0.00	0.00	0.00	XXX	0
82024		X	ACTH	0.00	0.00	0.00	0.00	XXX	0
82030		X	ADP & AMP	0.00	0.00	0.00	0.00	XXX	0
82040		X	Assay serum albumin	0.00	0.00	0.00	0.00	XXX	0
82042		X	Assay urine albumin	0.00	0.00	0.00	0.00	XXX	0
82043		X	Microalbumin, quantitative	0.00	0.00	0.00	0.00	XXX	0
82044		X	Microalbumin, semiquant	0.00	0.00	0.00	0.00	XXX	0
82055		X	Assay ethanol	0.00	0.00	0.00	0.00	XXX	0
82075		X	Assay breath ethanol	0.00	0.00	0.00	0.00	XXX	0
82085		X	Assay of aldolase	0.00	0.00	0.00	0.00	XXX	0
82088		X	Aldosterone	0.00	0.00	0.00	0.00	XXX	0
82101		X	Assay of urine alkaloids	0.00	0.00	0.00	0.00	XXX	0
82103		X	Alpha-1-antitrypsin, total	0.00	0.00	0.00	0.00	XXX	0
82104		X	Alpha-1-antitrypsin, pheno	0.00	0.00	0.00	0.00	XXX	0
82105		X	Alpha-fetoprotein, serum	0.00	0.00	0.00	0.00	XXX	0
82106		X	Alpha-fetoprotein, amniotic	0.00	0.00	0.00	0.00	XXX	0
82108		X	Assay, aluminum	0.00	0.00	0.00	0.00	XXX	0
82128		X	Test for amino acids	0.00	0.00	0.00	0.00	XXX	0
82130		X	Amino acids analysis	0.00	0.00	0.00	0.00	XXX	0
82131		X	Amino acids	0.00	0.00	0.00	0.00	XXX	0
82135		X	Assay, aminolevulinic acid	0.00	0.00	0.00	0.00	XXX	0
82140		X	Assay of ammonia	0.00	0.00	0.00	0.00	XXX	0
82143		X	Amniotic fluid scan	0.00	0.00	0.00	0.00	XXX	0
82145		X	Assay of amphetamines	0.00	0.00	0.00	0.00	XXX	0
82150		X	Assay of amylase	0.00	0.00	0.00	0.00	XXX	0
82154		X	Androstenediol glucuronide	0.00	0.00	0.00	0.00	XXX	0
82157		X	Assay of androstenedione	0.00	0.00	0.00	0.00	XXX	0
82160		X	Androsterone assay	0.00	0.00	0.00	0.00	XXX	0
82163		X	Assay of angiotensin II	0.00	0.00	0.00	0.00	XXX	0
82164		X	Angiotensin I enzyme test	0.00	0.00	0.00	0.00	XXX	0
82172		X	Apolipoprotein	0.00	0.00	0.00	0.00	XXX	0
82175		X	Assay of arsenic	0.00	0.00	0.00	0.00	XXX	0
82180		X	Assay of ascorbic acid	0.00	0.00	0.00	0.00	XXX	0
82190		X	Atomic absorption	0.00	0.00	0.00	0.00	XXX	0
82205		X	Assay of barbiturates	0.00	0.00	0.00	0.00	XXX	0
82232		X	Beta-2 protein	0.00	0.00	0.00	0.00	XXX	0
82239		X	Bile acids, total	0.00	0.00	0.00	0.00	XXX	0
82240		X	Bile acids, cholyglycine	0.00	0.00	0.00	0.00	XXX	0
82250		X	Assay bilirubin	0.00	0.00	0.00	0.00	XXX	0
82251		X	Assay bilirubin	0.00	0.00	0.00	0.00	XXX	0
82252		X	Fecal bilirubin test	0.00	0.00	0.00	0.00	XXX	0
82270		X	Test feces for blood	0.00	0.00	0.00	0.00	XXX	0
82273		X	Test for blood, other source	0.00	0.00	0.00	0.00	XXX	0
82286		X	Assay of bradykinin	0.00	0.00	0.00	0.00	XXX	0
82300		X	Assay cadmium	0.00	0.00	0.00	0.00	XXX	0
82306		X	Assay of vitamin D	0.00	0.00	0.00	0.00	XXX	0
82307		X	Assay of vitamin D	0.00	0.00	0.00	0.00	XXX	0
82308		X	Assay of calcitonin	0.00	0.00	0.00	0.00	XXX	0
82310		X	Assay calcium	0.00	0.00	0.00	0.00	XXX	0
82330		X	Assay calcium	0.00	0.00	0.00	0.00	XXX	0
82331		X	Calcium infusion test	0.00	0.00	0.00	0.00	XXX	0
82340		X	Assay calcium in urine	0.00	0.00	0.00	0.00	XXX	0
82355		X	Calculus (stone) analysis	0.00	0.00	0.00	0.00	XXX	0
82360		X	Calculus (stone) assay	0.00	0.00	0.00	0.00	XXX	0
82365		X	Calculus (stone) assay	0.00	0.00	0.00	0.00	XXX	0
82370		X	X-ray assay, calculus (stone)	0.00	0.00	0.00	0.00	XXX	0
82374		X	Assay blood carbon dioxide	0.00	0.00	0.00	0.00	XXX	0
82375		X	Assay blood carbon monoxide	0.00	0.00	0.00	0.00	XXX	0
82376		X	Test for carbon monoxide	0.00	0.00	0.00	0.00	XXX	0
82378		X	Carcinoembryonic antigen	0.00	0.00	0.00	0.00	XXX	0
82380		X	Assay carotene	0.00	0.00	0.00	0.00	XXX	0
82382		X	Assay urine catecholamines	0.00	0.00	0.00	0.00	XXX	0
82383		X	Assay blood catecholamines	0.00	0.00	0.00	0.00	XXX	0
82384		X	Assay three catecholamines	0.00	0.00	0.00	0.00	XXX	0
82387		X	Cathepsin-D	0.00	0.00	0.00	0.00	XXX	0
82390		X	Assay ceruloplasmin	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
82397		X	Chemiluminescent assay	0.00	0.00	0.00	0.00	XXX	0
82415		X	Assay chloramphenicol	0.00	0.00	0.00	0.00	XXX	0
82435		X	Assay blood chloride	0.00	0.00	0.00	0.00	XXX	0
82436		X	Assay urine chloride	0.00	0.00	0.00	0.00	XXX	0
82438		X	Assay other fluid chlorides	0.00	0.00	0.00	0.00	XXX	0
82441		X	Test for chlorohydrocarbons	0.00	0.00	0.00	0.00	XXX	0
82465		X	Assay serum cholesterol	0.00	0.00	0.00	0.00	XXX	0
82480		X	Assay serum cholinesterase	0.00	0.00	0.00	0.00	XXX	0
82482		X	Assay rbc cholinesterase	0.00	0.00	0.00	0.00	XXX	0
82485		X	Assay chondroitin sulfate	0.00	0.00	0.00	0.00	XXX	0
82486		X	Gas/liquid chromatography	0.00	0.00	0.00	0.00	XXX	0
82487		X	Paper chromatography	0.00	0.00	0.00	0.00	XXX	0
82488		X	Paper chromatography	0.00	0.00	0.00	0.00	XXX	0
82489		X	Thin layer chromatography	0.00	0.00	0.00	0.00	XXX	0
82491		X	Chromatography, quantitative	0.00	0.00	0.00	0.00	XXX	0
82495		X	Assay chromium	0.00	0.00	0.00	0.00	XXX	0
82507		X	Assay citrate	0.00	0.00	0.00	0.00	XXX	0
82520		X	Assay for cocaine	0.00	0.00	0.00	0.00	XXX	0
82525		X	Assay copper	0.00	0.00	0.00	0.00	XXX	0
82528		X	Assay corticosterone	0.00	0.00	0.00	0.00	XXX	0
82530		X	Cortisol, free	0.00	0.00	0.00	0.00	XXX	0
82533		X	Total cortisol	0.00	0.00	0.00	0.00	XXX	0
82540		X	Assay creatine	0.00	0.00	0.00	0.00	XXX	0
82550		X	Assay CK (CPK)	0.00	0.00	0.00	0.00	XXX	0
82552		X	Assay CPK in blood	0.00	0.00	0.00	0.00	XXX	0
82553		X	Creatine, MB fraction	0.00	0.00	0.00	0.00	XXX	0
82554		X	Creatine, isoforms	0.00	0.00	0.00	0.00	XXX	0
82565		X	Assay creatinine	0.00	0.00	0.00	0.00	XXX	0
82570		X	Assay urine creatinine	0.00	0.00	0.00	0.00	XXX	0
82575		X	Creatinine clearance test	0.00	0.00	0.00	0.00	XXX	0
82585		X	Assay cryofibrinogen	0.00	0.00	0.00	0.00	XXX	0
82595		X	Assay cryoglobulin	0.00	0.00	0.00	0.00	XXX	0
82600		X	Assay cyanide	0.00	0.00	0.00	0.00	XXX	0
82607		X	Vitamin B-12	0.00	0.00	0.00	0.00	XXX	0
82608		X	B-12 binding capacity	0.00	0.00	0.00	0.00	XXX	0
82615		X	Test for urine cystines	0.00	0.00	0.00	0.00	XXX	0
82626		X	Dehydroepiandrosterone	0.00	0.00	0.00	0.00	XXX	0
82627		X	Dehydroepiandrosterone	0.00	0.00	0.00	0.00	XXX	0
82633		X	Desoxycorticosterone	0.00	0.00	0.00	0.00	XXX	0
82634		X	Deoxycortisol	0.00	0.00	0.00	0.00	XXX	0
82638		X	Assay dibucaine number	0.00	0.00	0.00	0.00	XXX	0
82646		X	Assay of dihydrocodeinone	0.00	0.00	0.00	0.00	XXX	0
82649		X	Assay of dihydromorphine	0.00	0.00	0.00	0.00	XXX	0
82651		X	Dihydrotestosterone assay	0.00	0.00	0.00	0.00	XXX	0
82652		X	Assay, dihydroxyvitamin D	0.00	0.00	0.00	0.00	XXX	0
82654		X	Assay of dimethadione	0.00	0.00	0.00	0.00	XXX	0
82664		X	Electrophoretic test	0.00	0.00	0.00	0.00	XXX	0
82666		X	Epiandrosterone assay	0.00	0.00	0.00	0.00	XXX	0
82668		X	Erythropoietin	0.00	0.00	0.00	0.00	XXX	0
82670		X	Estradiol	0.00	0.00	0.00	0.00	XXX	0
82671		X	Estrogen assay	0.00	0.00	0.00	0.00	XXX	0
82672		X	Estrogen assay	0.00	0.00	0.00	0.00	XXX	0
82677		X	Estrinol	0.00	0.00	0.00	0.00	XXX	0
82679		X	Estrone	0.00	0.00	0.00	0.00	XXX	0
82690		X	Ethchlorvynol	0.00	0.00	0.00	0.00	XXX	0
82693		X	Ethylene glycol	0.00	0.00	0.00	0.00	XXX	0
82696		X	Etiocolanolone	0.00	0.00	0.00	0.00	XXX	0
82705		X	Fats/lipids, feces, qualitative	0.00	0.00	0.00	0.00	XXX	0
82710		X	Fats/lipids, feces, quantitative	0.00	0.00	0.00	0.00	XXX	0
82715		X	Fecal fat assay	0.00	0.00	0.00	0.00	XXX	0
82725		X	Assay blood fatty acids	0.00	0.00	0.00	0.00	XXX	0
82728		X	Assay ferritin	0.00	0.00	0.00	0.00	XXX	0
82735		X	Assay fluoride	0.00	0.00	0.00	0.00	XXX	0
82742		X	Assay of flurazepam	0.00	0.00	0.00	0.00	XXX	0
82746		X	Blood folic acid serum	0.00	0.00	0.00	0.00	XXX	0
82747		X	Folic acid, RBC	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110-D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
82757		X	Assay semen fructose	0.00	0.00	0.00	0.00	XXX	0
82759		X	RBC galactokinase assay	0.00	0.00	0.00	0.00	XXX	0
82760		X	Assay galactose	0.00	0.00	0.00	0.00	XXX	0
82775		X	Assay galactose transferase	0.00	0.00	0.00	0.00	XXX	0
82776		X	Galactose transferase test	0.00	0.00	0.00	0.00	XXX	0
82784		X	Assay gammaglobulin IgM	0.00	0.00	0.00	0.00	XXX	0
82785		X	Assay, gammaglobulin IgE	0.00	0.00	0.00	0.00	XXX	0
82787		X	IgG1, 2, 3 and 4	0.00	0.00	0.00	0.00	XXX	0
82800		X	Blood pH	0.00	0.00	0.00	0.00	XXX	0
82803		X	Blood gases: pH, pO2 & pCO2	0.00	0.00	0.00	0.00	XXX	0
82805		X	Blood gases W/O2 saturation	0.00	0.00	0.00	0.00	XXX	0
82810		X	Blood gases, O2 sat only	0.00	0.00	0.00	0.00	XXX	0
82820		X	Hemoglobin-oxygen affinity	0.00	0.00	0.00	0.00	XXX	0
82926		X	Assay gastric acid	0.00	0.00	0.00	0.00	XXX	0
82928		X	Assay gastric acid	0.00	0.00	0.00	0.00	XXX	0
82938		X	Gastrin test	0.00	0.00	0.00	0.00	XXX	0
82941		X	Assay of gastrin	0.00	0.00	0.00	0.00	XXX	0
82943		X	Assay of glucagon	0.00	0.00	0.00	0.00	XXX	0
82946		X	Glucagon tolerance test	0.00	0.00	0.00	0.00	XXX	0
82947		X	Assay quantitative, glucose	0.00	0.00	0.00	0.00	XXX	0
82948		X	Reagent strip/blood glucose	0.00	0.00	0.00	0.00	XXX	0
82950		X	Glucose test	0.00	0.00	0.00	0.00	XXX	0
82951		X	Glucose tolerance test (GTT)	0.00	0.00	0.00	0.00	XXX	0
82952		X	GTT-added samples	0.00	0.00	0.00	0.00	XXX	0
82953		X	Glucose-tolbutamide test	0.00	0.00	0.00	0.00	XXX	0
82955		X	Assay G6PD enzyme	0.00	0.00	0.00	0.00	XXX	0
82960		X	Test for G6PD enzyme	0.00	0.00	0.00	0.00	XXX	0
82962		X	Glucose blood test	0.00	0.00	0.00	0.00	XXX	0
82963		X	Glucosidase assay	0.00	0.00	0.00	0.00	XXX	0
82965		X	Assay GDH enzyme	0.00	0.00	0.00	0.00	XXX	0
82975		X	Assay glutamine	0.00	0.00	0.00	0.00	XXX	0
82977		X	Assay of GGT	0.00	0.00	0.00	0.00	XXX	0
82978		X	Glutathione assay	0.00	0.00	0.00	0.00	XXX	0
82979		X	Assay RBC glutathione enzyme	0.00	0.00	0.00	0.00	XXX	0
82980		X	Assay of glutethimide	0.00	0.00	0.00	0.00	XXX	0
82985		X	Glycated protein	0.00	0.00	0.00	0.00	XXX	0
83001		X	Gonadotropin (FSH)	0.00	0.00	0.00	0.00	XXX	0
83002		X	Gonadotropin (LH)	0.00	0.00	0.00	0.00	XXX	0
83003		X	Assay growth hormone (HGH)	0.00	0.00	0.00	0.00	XXX	0
83008		X	Assay guanosine	0.00	0.00	0.00	0.00	XXX	0
83010		X	Quant assay haptoglobin	0.00	0.00	0.00	0.00	XXX	0
83012		X	Assay haptoglobins	0.00	0.00	0.00	0.00	XXX	0
83015		X	Heavy metal screen	0.00	0.00	0.00	0.00	XXX	0
83018		X	Quantitative screen, metals	0.00	0.00	0.00	0.00	XXX	0
83020		X	Assay hemoglobin	0.00	0.00	0.00	0.00	XXX	0
83020	26	A	Assay hemoglobin	0.37	0.20	0.01	0.58	XXX	N
83026		X	Hemoglobin, copper sulfate	0.00	0.00	0.00	0.00	XXX	0
83030		X	Fetal hemoglobin assay	0.00	0.00	0.00	0.00	XXX	0
83033		X	Fetal fecal hemoglobin assay	0.00	0.00	0.00	0.00	XXX	0
83036		X	Glycated hemoglobin test	0.00	0.00	0.00	0.00	XXX	0
83045		X	Blood methemoglobin test	0.00	0.00	0.00	0.00	XXX	0
83050		X	Blood methemoglobin assay	0.00	0.00	0.00	0.00	XXX	0
83051		X	Assay plasma hemoglobin	0.00	0.00	0.00	0.00	XXX	0
83055		X	Blood sulfhemoglobin test	0.00	0.00	0.00	0.00	XXX	0
83060		X	Blood sulfhemoglobin assay	0.00	0.00	0.00	0.00	XXX	0
83065		X	Hemoglobin heat assay	0.00	0.00	0.00	0.00	XXX	0
83068		X	Hemoglobin stability screen	0.00	0.00	0.00	0.00	XXX	0
83069		X	Assay urine hemoglobin	0.00	0.00	0.00	0.00	XXX	0
83070		X	Qualt assay hemosiderin	0.00	0.00	0.00	0.00	XXX	0
83071		X	Quant assay of hemosiderin	0.00	0.00	0.00	0.00	XXX	0
83088		X	Assay histamine	0.00	0.00	0.00	0.00	XXX	0
83150		X	Assay for HVA	0.00	0.00	0.00	0.00	XXX	0
83491		X	Assay of corticosteroids	0.00	0.00	0.00	0.00	XXX	0
83497		X	Assay 5-HIAA	0.00	0.00	0.00	0.00	XXX	0
83498		X	Assay of progesterone	0.00	0.00	0.00	0.00	XXX	0
83499		X	Assay of progesterone	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
83500		X	Assay free hydroxyproline	0.00	0.00	0.00	0.00	XXX	0
83505		X	Assay total hydroxyproline	0.00	0.00	0.00	0.00	XXX	0
83516		X	Immunoassay, non antibody	0.00	0.00	0.00	0.00	XXX	0
83518		X	Immunoassay, dipstick	0.00	0.00	0.00	0.00	XXX	0
83519		X	Immunoassay nonantibody	0.00	0.00	0.00	0.00	XXX	0
83520		X	Immunoassay, RIA	0.00	0.00	0.00	0.00	XXX	0
83525		X	Assay of insulin	0.00	0.00	0.00	0.00	XXX	0
83527		X	Assay of insulin	0.00	0.00	0.00	0.00	XXX	0
83528		X	Assay intrinsic factor	0.00	0.00	0.00	0.00	XXX	0
83540		X	Assay iron	0.00	0.00	0.00	0.00	XXX	0
83550		X	Iron binding test	0.00	0.00	0.00	0.00	XXX	0
83570		X	Assay IDH enzyme	0.00	0.00	0.00	0.00	XXX	0
83582		X	Assay ketogenic steroids	0.00	0.00	0.00	0.00	XXX	0
83586		X	Assay 17-(17-KS)ketosteroids	0.00	0.00	0.00	0.00	XXX	0
83593		X	Fractionation ketosteroids	0.00	0.00	0.00	0.00	XXX	0
83605		X	Lactic acid assay	0.00	0.00	0.00	0.00	XXX	0
83615		X	Lactate (LD) (LDH) enzyme	0.00	0.00	0.00	0.00	XXX	0
83625		X	Assay LDH enzymes	0.00	0.00	0.00	0.00	XXX	0
83632		X	Placental lactogen	0.00	0.00	0.00	0.00	XXX	0
83633		X	Test urine for lactose	0.00	0.00	0.00	0.00	XXX	0
83634		X	Assay urine for lactose	0.00	0.00	0.00	0.00	XXX	0
83655		X	Assay for lead	0.00	0.00	0.00	0.00	XXX	0
83661		X	Assay L/S ratio	0.00	0.00	0.00	0.00	XXX	0
83662		X	L/S ratio, foam stability	0.00	0.00	0.00	0.00	XXX	0
83670		X	Assay LAP enzyme	0.00	0.00	0.00	0.00	XXX	0
83690		X	Assay lipase	0.00	0.00	0.00	0.00	XXX	0
83715		X	Assay blood lipoproteins	0.00	0.00	0.00	0.00	XXX	0
83717		X	Assay blood lipoproteins	0.00	0.00	0.00	0.00	XXX	0
83718		X	Blood lipoprotein assay	0.00	0.00	0.00	0.00	XXX	0
83719		X	Blood lipoprotein assay	0.00	0.00	0.00	0.00	XXX	0
83721		X	Blood lipoprotein assay	0.00	0.00	0.00	0.00	XXX	0
83727		X	LRH hormone assay	0.00	0.00	0.00	0.00	XXX	0
83735		X	Assay magnesium	0.00	0.00	0.00	0.00	XXX	0
83775		X	Assay of md enzyme	0.00	0.00	0.00	0.00	XXX	0
83785		X	Assay of manganese	0.00	0.00	0.00	0.00	XXX	0
83805		X	Assay of meprobamate	0.00	0.00	0.00	0.00	XXX	0
83825		X	Assay mercury	0.00	0.00	0.00	0.00	XXX	0
83835		X	Assay metanephries	0.00	0.00	0.00	0.00	XXX	0
83840		X	Assay methadone	0.00	0.00	0.00	0.00	XXX	0
83857		X	Assay methemalbumin	0.00	0.00	0.00	0.00	XXX	0
83858		X	Assay methsuximide	0.00	0.00	0.00	0.00	XXX	0
83864		X	Mucopolysaccharides	0.00	0.00	0.00	0.00	XXX	0
83866		X	Mucopolysaccharides screen	0.00	0.00	0.00	0.00	XXX	0
83872		X	Assay synovial fluid mucin	0.00	0.00	0.00	0.00	XXX	0
83873		X	Assay, CSF protein	0.00	0.00	0.00	0.00	XXX	0
83874		X	Myoglobin	0.00	0.00	0.00	0.00	XXX	0
83883		X	Nephelometry, not specified	0.00	0.00	0.00	0.00	XXX	0
83885		X	Assay for nickel	0.00	0.00	0.00	0.00	XXX	0
83887		X	Assay nicotine	0.00	0.00	0.00	0.00	XXX	0
83890		X	Molecular diagnostics	0.00	0.00	0.00	0.00	XXX	0
83892		X	Molecular diagnostics	0.00	0.00	0.00	0.00	XXX	0
83894		X	Molecular diagnostics	0.00	0.00	0.00	0.00	XXX	0
83896		X	Molecular diagnostics	0.00	0.00	0.00	0.00	XXX	0
83898		X	Molecular diagnostics	0.00	0.00	0.00	0.00	XXX	0
83912		X	Genetic examination	0.00	0.00	0.00	0.00	XXX	0
83912	26	A	Genetic examination	0.37	0.20	0.01	0.58	XXX	N
83915		X	Assay nucleotidase	0.00	0.00	0.00	0.00	XXX	0
83916		X	Oligoclonal bands	0.00	0.00	0.00	0.00	XXX	0
83918		X	Assay organic acids	0.00	0.00	0.00	0.00	XXX	0
83925		X	Opiates	0.00	0.00	0.00	0.00	XXX	0
83930		X	Assay blood osmolality	0.00	0.00	0.00	0.00	XXX	0
83935		X	Assay urine osmolality	0.00	0.00	0.00	0.00	XXX	0
83937		X	Assay for osteocalcin	0.00	0.00	0.00	0.00	XXX	0
83945		X	Assay oxalate	0.00	0.00	0.00	0.00	XXX	0
83970		X	Assay of parathormone	0.00	0.00	0.00	0.00	XXX	0
83986		X	Assay body fluid acidity	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
83992		X	Assay for phencyclidine	0.00	0.00	0.00	0.00	XXX	0
84022		X	Assay of phenothiazine	0.00	0.00	0.00	0.00	XXX	0
84030		X	Assay blood PKU	0.00	0.00	0.00	0.00	XXX	0
84035		X	Assay phenylketones	0.00	0.00	0.00	0.00	XXX	0
84060		X	Assay acid phosphatase	0.00	0.00	0.00	0.00	XXX	0
84061		X	Phosphatase, forensic exam	0.00	0.00	0.00	0.00	XXX	0
84066		X	Assay prostate phosphatase	0.00	0.00	0.00	0.00	XXX	0
84075		X	Assay alkaline phosphatase	0.00	0.00	0.00	0.00	XXX	0
84078		X	Assay alkaline phosphatase	0.00	0.00	0.00	0.00	XXX	0
84080		X	Assay alkaline phosphatases	0.00	0.00	0.00	0.00	XXX	0
84081		X	Amniotic fluid enzyme test	0.00	0.00	0.00	0.00	XXX	0
84085		X	Assay RBC PG6D enzyme	0.00	0.00	0.00	0.00	XXX	0
84087		X	Assay phosphohexose enzymes	0.00	0.00	0.00	0.00	XXX	0
84100		X	Assay phosphorus	0.00	0.00	0.00	0.00	XXX	0
84105		X	Assay urine phosphorus	0.00	0.00	0.00	0.00	XXX	0
84106		X	Test for porphobilinogen	0.00	0.00	0.00	0.00	XXX	0
84110		X	Assay porphobilinogen	0.00	0.00	0.00	0.00	XXX	0
84119		X	Test urine for porphyrins	0.00	0.00	0.00	0.00	XXX	0
84120		X	Assay urine porphyrins	0.00	0.00	0.00	0.00	XXX	0
84126		X	Assay feces porphyrins	0.00	0.00	0.00	0.00	XXX	0
84127		X	Porphyrins, feces	0.00	0.00	0.00	0.00	XXX	0
84132		X	Assay serum potassium	0.00	0.00	0.00	0.00	XXX	0
84133		X	Assay urine potassium	0.00	0.00	0.00	0.00	XXX	0
84134		X	Prealbumin	0.00	0.00	0.00	0.00	XXX	0
84135		X	Assay pregnanediol	0.00	0.00	0.00	0.00	XXX	0
84138		X	Assay pregnanetriol	0.00	0.00	0.00	0.00	XXX	0
84140		X	Assay for pregnenolone	0.00	0.00	0.00	0.00	XXX	0
84143		X	Assay/17-hydroxypregnenolone	0.00	0.00	0.00	0.00	XXX	0
84144		X	Assay progesterone	0.00	0.00	0.00	0.00	XXX	0
84146		X	Assay for prolactin	0.00	0.00	0.00	0.00	XXX	0
84150		X	Assay of prostaglandin	0.00	0.00	0.00	0.00	XXX	0
84153		X	Prostate specific antigen	0.00	0.00	0.00	0.00	XXX	0
84155		X	Assay protein	0.00	0.00	0.00	0.00	XXX	0
84160		X	Assay serum protein	0.00	0.00	0.00	0.00	XXX	0
84165		X	Assay serum proteins	0.00	0.00	0.00	0.00	XXX	0
84165	26	A	Assay serum proteins	0.37	0.20	0.01	0.58	XXX	N
84181		X	Western blot test	0.00	0.00	0.00	0.00	XXX	0
84181	26	A	Western blot test	0.37	0.20	0.01	0.58	XXX	N
84182		X	Protein, western blot test	0.00	0.00	0.00	0.00	XXX	0
84182	26	A	Protein, western blot test	0.37	0.20	0.01	0.58	XXX	N
84202		X	Assay RBC protoporphyrin	0.00	0.00	0.00	0.00	XXX	0
84203		X	Test RBC protoporphyrin	0.00	0.00	0.00	0.00	XXX	0
84206		X	Assay of proinsulin	0.00	0.00	0.00	0.00	XXX	0
84207		X	Assay vitamin B-6	0.00	0.00	0.00	0.00	XXX	0
84210		X	Assay pyruvate	0.00	0.00	0.00	0.00	XXX	0
84220		X	Assay pyruvate kinase	0.00	0.00	0.00	0.00	XXX	0
84228		X	Assay quinine	0.00	0.00	0.00	0.00	XXX	0
84233		X	Assay estrogen	0.00	0.00	0.00	0.00	XXX	0
84234		X	Assay progesterone	0.00	0.00	0.00	0.00	XXX	0
84235		X	Assay endocrine hormone	0.00	0.00	0.00	0.00	XXX	0
84238		X	Assay non-endocrine receptor	0.00	0.00	0.00	0.00	XXX	0
84244		X	Assay of renin	0.00	0.00	0.00	0.00	XXX	0
84252		X	Assay vitamin B-2	0.00	0.00	0.00	0.00	XXX	0
84255		X	Assay selenium	0.00	0.00	0.00	0.00	XXX	0
84260		X	Assay serotonin	0.00	0.00	0.00	0.00	XXX	0
84270		X	Sex hormone globulin (SHBG)	0.00	0.00	0.00	0.00	XXX	0
84275		X	Assay sialic acid	0.00	0.00	0.00	0.00	XXX	0
84285		X	Assay silica	0.00	0.00	0.00	0.00	XXX	0
84295		X	Assay serum sodium	0.00	0.00	0.00	0.00	XXX	0
84300		X	Assay urine sodium	0.00	0.00	0.00	0.00	XXX	0
84305		X	Somatomedin	0.00	0.00	0.00	0.00	XXX	0
84307		X	Somatostatin	0.00	0.00	0.00	0.00	XXX	0
84311		X	Spectrophotometry	0.00	0.00	0.00	0.00	XXX	0
84315		X	Body fluid specific gravity	0.00	0.00	0.00	0.00	XXX	0
84375		X	Chromatogram assay, sugars	0.00	0.00	0.00	0.00	XXX	0
84392		X	Assay urine sulfate	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
84402		X	Testosterone	0.00	0.00	0.00	0.00	XXX	0
84403		X	Assay total testosterone	0.00	0.00	0.00	0.00	XXX	0
84425		X	Assay vitamin B-1	0.00	0.00	0.00	0.00	XXX	0
84430		X	Assay thiocyanate	0.00	0.00	0.00	0.00	XXX	0
84432		X	Thyroglobulin	0.00	0.00	0.00	0.00	XXX	0
84436		X	Assay, total thyroxine	0.00	0.00	0.00	0.00	XXX	0
84437		X	Assay neonatal thyroxine	0.00	0.00	0.00	0.00	XXX	0
84439		X	Assay, free thyroxine	0.00	0.00	0.00	0.00	XXX	0
84442		X	Thyroid activity (TBG) assay	0.00	0.00	0.00	0.00	XXX	0
84443		X	Assay thyroid stim hormone	0.00	0.00	0.00	0.00	XXX	0
84445		X	Thyroid immunoglobulins TSI	0.00	0.00	0.00	0.00	XXX	0
84446		X	Assay vitamin E	0.00	0.00	0.00	0.00	XXX	0
84449		X	Assay for transcortin	0.00	0.00	0.00	0.00	XXX	0
84450		X	Transferase (AST) (SGOT)	0.00	0.00	0.00	0.00	XXX	0
84460		X	Alanine amino (ALT) (SGPT)	0.00	0.00	0.00	0.00	XXX	0
84466		X	Transferrin	0.00	0.00	0.00	0.00	XXX	0
84478		X	Assay triglycerides	0.00	0.00	0.00	0.00	XXX	0
84479		X	Assay triiodothyronine (T-3)	0.00	0.00	0.00	0.00	XXX	0
84480		X	Total assay, TT-3	0.00	0.00	0.00	0.00	XXX	0
84481		X	Free assay (FT-3)	0.00	0.00	0.00	0.00	XXX	0
84482		X	T3 reverse	0.00	0.00	0.00	0.00	XXX	0
84485		X	Assay duodenal fluid trypsin	0.00	0.00	0.00	0.00	XXX	0
84488		X	Test feces for trypsin	0.00	0.00	0.00	0.00	XXX	0
84490		X	Assay feces for trypsin	0.00	0.00	0.00	0.00	XXX	0
84510		X	Assay tyrosine	0.00	0.00	0.00	0.00	XXX	0
84520		X	Assay urea nitrogen	0.00	0.00	0.00	0.00	XXX	0
84525		X	Urea nitrogen semi-quant	0.00	0.00	0.00	0.00	XXX	0
84540		X	Assay urine urea-N	0.00	0.00	0.00	0.00	XXX	0
84545		X	Urea-N clearance test	0.00	0.00	0.00	0.00	XXX	0
84550		X	Assay blood uric acid	0.00	0.00	0.00	0.00	XXX	0
84560		X	Assay urine uric acid	0.00	0.00	0.00	0.00	XXX	0
84577		X	Assay feces urobilinogen	0.00	0.00	0.00	0.00	XXX	0
84578		X	Test urine urobilinogen	0.00	0.00	0.00	0.00	XXX	0
84580		X	Assay urine urobilinogen	0.00	0.00	0.00	0.00	XXX	0
84583		X	Assay urine urobilinogen	0.00	0.00	0.00	0.00	XXX	0
84585		X	Assay urine VMA	0.00	0.00	0.00	0.00	XXX	0
84586		X	VIP assay	0.00	0.00	0.00	0.00	XXX	0
84588		X	Assay vasopressin	0.00	0.00	0.00	0.00	XXX	0
84590		X	Assay vitamin-A	0.00	0.00	0.00	0.00	XXX	0
84597		X	Assay vitamin-K	0.00	0.00	0.00	0.00	XXX	0
84600		X	Assay for volatiles	0.00	0.00	0.00	0.00	XXX	0
84620		X	Xylose tolerance test	0.00	0.00	0.00	0.00	XXX	0
84630		X	Assay zinc	0.00	0.00	0.00	0.00	XXX	0
84681		X	Assay C-peptide	0.00	0.00	0.00	0.00	XXX	0
84702		X	Chorionic gonadotropin test	0.00	0.00	0.00	0.00	XXX	0
84703		X	Chorionic gonadotropin assay	0.00	0.00	0.00	0.00	XXX	0
84830		X	Ovulation tests	0.00	0.00	0.00	0.00	XXX	0
84999		X	Clinical chemistry test	0.00	0.00	0.00	0.00	XXX	0
85002		X	Bleeding time test	0.00	0.00	0.00	0.00	XXX	0
85007		X	Differential WBC count	0.00	0.00	0.00	0.00	XXX	0
85008		X	Nondifferential WBC count	0.00	0.00	0.00	0.00	XXX	0
85009		X	Differential WBC count	0.00	0.00	0.00	0.00	XXX	0
85013		X	Hematocrit	0.00	0.00	0.00	0.00	XXX	0
85014		X	Hematocrit	0.00	0.00	0.00	0.00	XXX	0
85018		X	Hemoglobin	0.00	0.00	0.00	0.00	XXX	0
85021		X	Automated hemogram	0.00	0.00	0.00	0.00	XXX	0
85022		X	Automated hemogram	0.00	0.00	0.00	0.00	XXX	0
85023		X	Automated hemogram	0.00	0.00	0.00	0.00	XXX	0
85024		X	Automated hemogram	0.00	0.00	0.00	0.00	XXX	0
85025		X	Automated hemogram	0.00	0.00	0.00	0.00	XXX	0
85027		X	Automated hemogram	0.00	0.00	0.00	0.00	XXX	0
85029		X	Automated hemogram	0.00	0.00	0.00	0.00	XXX	0
85030		X	Automated hemogram	0.00	0.00	0.00	0.00	XXX	0
85031		X	Manual hemogram, complete cbc	0.00	0.00	0.00	0.00	XXX	0
85041		X	Red blood cell (RBC) count	0.00	0.00	0.00	0.00	XXX	0
85044		X	Reticulocyte count	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110-D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
85045		X	Reticulocyte count	0.00	0.00	0.00	0.00	XXX	0
85048		X	White blood cell (WBC) count	0.00	0.00	0.00	0.00	XXX	0
85060		A	Blood smear interpretation	0.45	0.22	0.02	0.69	XXX	N
85095		A	Bone marrow aspiration	1.08	0.67	0.05	1.80	XXX	N
85097		A	Bone marrow interpretation	0.94	0.48	0.04	1.46	XXX	N
85102		A	Bone marrow biopsy	1.37	0.80	0.05	2.22	XXX	N
85130		X	Chromogenic substrate assay	0.00	0.00	0.00	0.00	XXX	0
85170		X	Blood clot retraction	0.00	0.00	0.00	0.00	XXX	0
85175		X	Blood clot lysis time	0.00	0.00	0.00	0.00	XXX	0
85210		X	Blood clot factor II test	0.00	0.00	0.00	0.00	XXX	0
85220		X	Blood clot factor V test	0.00	0.00	0.00	0.00	XXX	0
85230		X	Blood clot factor VII test	0.00	0.00	0.00	0.00	XXX	0
85240		X	Blood clot factor VIII test	0.00	0.00	0.00	0.00	XXX	0
85244		X	Blood clot factor VIII test	0.00	0.00	0.00	0.00	XXX	0
85245		X	Blood clot factor VIII test	0.00	0.00	0.00	0.00	XXX	0
85246		X	Blood clot factor VIII test	0.00	0.00	0.00	0.00	XXX	0
85247		X	Blood clot factor VIII test	0.00	0.00	0.00	0.00	XXX	0
85250		X	Blood clot factor IX test	0.00	0.00	0.00	0.00	XXX	0
85260		X	Blood clot factor X test	0.00	0.00	0.00	0.00	XXX	0
85270		X	Blood clot factor XI test	0.00	0.00	0.00	0.00	XXX	0
85280		X	Blood clot factor XII test	0.00	0.00	0.00	0.00	XXX	0
85290		X	Blood clot factor XIII test	0.00	0.00	0.00	0.00	XXX	0
85291		X	Blood clot factor XIII test	0.00	0.00	0.00	0.00	XXX	0
85292		X	Blood clot factor assay	0.00	0.00	0.00	0.00	XXX	0
85293		X	Blood clot factor assay	0.00	0.00	0.00	0.00	XXX	0
85300		X	Antithrombin III test	0.00	0.00	0.00	0.00	XXX	0
85301		X	Antithrombin III test	0.00	0.00	0.00	0.00	XXX	0
85302		X	Blood clot inhibitor antigen	0.00	0.00	0.00	0.00	XXX	0
85303		X	Blood clot inhibitor test	0.00	0.00	0.00	0.00	XXX	0
85305		X	Blood clot inhibitor assay	0.00	0.00	0.00	0.00	XXX	0
85306		X	Blood clot inhibitor test	0.00	0.00	0.00	0.00	XXX	0
85335		X	Factor inhibitor test	0.00	0.00	0.00	0.00	XXX	0
85337		X	Thrombomodulin	0.00	0.00	0.00	0.00	XXX	0
85345		X	Coagulation time	0.00	0.00	0.00	0.00	XXX	0
85347		X	Coagulation time	0.00	0.00	0.00	0.00	XXX	0
85348		X	Coagulation time	0.00	0.00	0.00	0.00	XXX	0
85360		X	Euglobulin lysis	0.00	0.00	0.00	0.00	XXX	0
85362		X	Fibrin degradation products	0.00	0.00	0.00	0.00	XXX	0
85366		X	Fibrinogen test	0.00	0.00	0.00	0.00	XXX	0
85370		X	Fibrinogen test	0.00	0.00	0.00	0.00	XXX	0
85378		X	Fibrin degradation	0.00	0.00	0.00	0.00	XXX	0
85379		X	Fibrin degradation	0.00	0.00	0.00	0.00	XXX	0
85384		X	Fibrinogen	0.00	0.00	0.00	0.00	XXX	0
85385		X	Fibrinogen	0.00	0.00	0.00	0.00	XXX	0
85390		X	Fibrinolysins screen	0.00	0.00	0.00	0.00	XXX	0
85390	26	A	Fibrinolysins screen	0.37	0.20	0.01	0.58	XXX	N
85400		X	Fibrinolytic plasmin	0.00	0.00	0.00	0.00	XXX	0
85410		X	Fibrinolytic antiplasmin	0.00	0.00	0.00	0.00	XXX	0
85415		X	Fibrinolytic plasminogen	0.00	0.00	0.00	0.00	XXX	0
85420		X	Fibrinolytic plasminogen	0.00	0.00	0.00	0.00	XXX	0
85421		X	Fibrinolytic plasminogen	0.00	0.00	0.00	0.00	XXX	0
85441		X	Heinz bodies; direct	0.00	0.00	0.00	0.00	XXX	0
85445		X	Heinz bodies; induced	0.00	0.00	0.00	0.00	XXX	0
85460		X	Hemoglobin, fetal	0.00	0.00	0.00	0.00	XXX	0
85461		X	Hemoglobin, fetal	0.00	0.00	0.00	0.00	XXX	0
85475		X	Hemolysin	0.00	0.00	0.00	0.00	XXX	0
85520		X	Heparin assay	0.00	0.00	0.00	0.00	XXX	0
85525		X	Heparin	0.00	0.00	0.00	0.00	XXX	0
85530		X	Heparin-protamine tolerance	0.00	0.00	0.00	0.00	XXX	0
85535		X	Iron stain, blood cells	0.00	0.00	0.00	0.00	XXX	0
85540		X	Wbc alkaline phosphatase	0.00	0.00	0.00	0.00	XXX	0
85547		X	RBC mechanical fragility	0.00	0.00	0.00	0.00	XXX	0
85549		X	Muramidase	0.00	0.00	0.00	0.00	XXX	0
85555		X	RBC osmotic fragility	0.00	0.00	0.00	0.00	XXX	0
85557		X	RBC osmotic fragility	0.00	0.00	0.00	0.00	XXX	0
85576		X	Blood platelet aggregation	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
85576	26	A	Blood platelet aggregation	0.37	0.20	0.01	0.58	XXX	N
85585		X	Blood platelet estimation	0.00	0.00	0.00	0.00	XXX	0
85590		X	Platelet manual count	0.00	0.00	0.00	0.00	XXX	0
85595		X	Platelet count, automated	0.00	0.00	0.00	0.00	XXX	0
85597		X	Platelet neutralization	0.00	0.00	0.00	0.00	XXX	0
85610		X	Prothrombin time	0.00	0.00	0.00	0.00	XXX	0
85611		X	Prothrombin test	0.00	0.00	0.00	0.00	XXX	0
85612		X	Viper venom prothrombin time	0.00	0.00	0.00	0.00	XXX	0
85613		X	Russell viper venom, diluted	0.00	0.00	0.00	0.00	XXX	0
85635		X	Reptilase test	0.00	0.00	0.00	0.00	XXX	0
85651		X	RBC sed rate, nonauto	0.00	0.00	0.00	0.00	XXX	0
85652		X	RBC sed rate, auto	0.00	0.00	0.00	0.00	XXX	0
85660		X	RBC sickle cell test	0.00	0.00	0.00	0.00	XXX	0
85670		X	Thrombin time, plasma	0.00	0.00	0.00	0.00	XXX	0
85675		X	Thrombin time, titer	0.00	0.00	0.00	0.00	XXX	0
85705		X	Thromboplastin inhibition	0.00	0.00	0.00	0.00	XXX	0
85730		X	Thromboplastin time, partial	0.00	0.00	0.00	0.00	XXX	0
85732		X	Thromboplastin time, partial	0.00	0.00	0.00	0.00	XXX	0
85810		X	Blood viscosity examination	0.00	0.00	0.00	0.00	XXX	0
85999		X	Hematology procedure	0.00	0.00	0.00	0.00	XXX	0
86000		X	Agglutinins; febrile	0.00	0.00	0.00	0.00	XXX	0
86003		X	Allergen specific IgE	0.00	0.00	0.00	0.00	XXX	0
86005		X	Allergen specific IgE	0.00	0.00	0.00	0.00	XXX	0
86021		X	WBC antibody identification	0.00	0.00	0.00	0.00	XXX	0
86022		X	Platelet antibodies	0.00	0.00	0.00	0.00	XXX	0
86023		X	Immunoglobulin assay	0.00	0.00	0.00	0.00	XXX	0
86038		X	Antinuclear antibodies	0.00	0.00	0.00	0.00	XXX	0
86039		X	Antinuclear antibodies (ANA)	0.00	0.00	0.00	0.00	XXX	0
86060		X	Antistreptolysin O titer	0.00	0.00	0.00	0.00	XXX	0
86063		X	Antistreptolysin O screen	0.00	0.00	0.00	0.00	XXX	0
86077		A	Physician blood bank service	0.37	0.30	0.02	0.69	XXX	N
86078		A	Physician blood bank service	0.94	0.34	0.02	1.30	XXX	N
86079		A	Physician blood bank service	0.37	0.33	0.02	0.72	XXX	N
86140		X	C-reactive protein	0.00	0.00	0.00	0.00	XXX	0
86147		X	Cardiolipin antibody	0.00	0.00	0.00	0.00	XXX	0
86155		X	Chemotaxis assay	0.00	0.00	0.00	0.00	XXX	0
86156		X	Cold agglutinin screen	0.00	0.00	0.00	0.00	XXX	0
86157		X	Cold agglutinin, titer	0.00	0.00	0.00	0.00	XXX	0
86160		X	Complement, antigen	0.00	0.00	0.00	0.00	XXX	0
86161		X	Complement/function activity	0.00	0.00	0.00	0.00	XXX	0
86162		X	Complement, total (CH50)	0.00	0.00	0.00	0.00	XXX	0
86171		X	Complement fixation, each	0.00	0.00	0.00	0.00	XXX	0
86185		X	Counterimmunoelectrophoresis	0.00	0.00	0.00	0.00	XXX	0
86215		X	Deoxyribonuclease, antibody	0.00	0.00	0.00	0.00	XXX	0
86225		X	DNA antibody	0.00	0.00	0.00	0.00	XXX	0
86226		X	DNA antibody, single strand	0.00	0.00	0.00	0.00	XXX	0
86235		X	Nuclear antigen antibody	0.00	0.00	0.00	0.00	XXX	0
86243		X	Fc receptor	0.00	0.00	0.00	0.00	XXX	0
86255		X	Fluorescent antibody; screen	0.00	0.00	0.00	0.00	XXX	0
86255	26	A	Fluorescent antibody; screen	0.37	0.20	0.01	0.58	XXX	N
86256		X	Fluorescent antibody; titer	0.00	0.00	0.00	0.00	XXX	0
86256	26	A	Fluorescent antibody; titer	0.37	0.20	0.01	0.58	XXX	N
86277		X	Growth hormone antibody	0.00	0.00	0.00	0.00	XXX	0
86280		X	Hemagglutination inhibition	0.00	0.00	0.00	0.00	XXX	0
86287		X	Hepatitis B (HBsAg)	0.00	0.00	0.00	0.00	XXX	0
86289		X	Hepatitis BC antibody test	0.00	0.00	0.00	0.00	XXX	0
86290		X	Hepatitis BC antibody test	0.00	0.00	0.00	0.00	XXX	0
86291		X	Hepatitis BS antibody test	0.00	0.00	0.00	0.00	XXX	0
86293		X	Hepatitis Be antibody test	0.00	0.00	0.00	0.00	XXX	0
86295		X	Hepatitis Be antibody test	0.00	0.00	0.00	0.00	XXX	0
86296		X	Hepatitis A antibody test	0.00	0.00	0.00	0.00	XXX	0
86299		X	Hepatitis A antibody test	0.00	0.00	0.00	0.00	XXX	0
86302		X	Hepatitis C antibody	0.00	0.00	0.00	0.00	XXX	0
86303		X	Hepatitis C antibody	0.00	0.00	0.00	0.00	XXX	0
86306		X	Hepatitis, delta agent	0.00	0.00	0.00	0.00	XXX	0
86308		X	Heterophile antibodies	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
86309		X	Heterophile antibodies	0.00	0.00	0.00	0.00	XXX	0
86310		X	Heterophile antibodies	0.00	0.00	0.00	0.00	XXX	0
86311		X	HIV antigen test	0.00	0.00	0.00	0.00	XXX	0
86313		X	Immunoassay, infectious agent	0.00	0.00	0.00	0.00	XXX	0
86315		X	Immunoassay, infectious agent	0.00	0.00	0.00	0.00	XXX	0
86316		X	Immunoassay, tumor antigen	0.00	0.00	0.00	0.00	XXX	0
86317		X	Immunoassay, infectious agent	0.00	0.00	0.00	0.00	XXX	0
86318		X	Immunoassay, infectious agent	0.00	0.00	0.00	0.00	XXX	0
86320		X	Serum immunoelectrophoresis	0.00	0.00	0.00	0.00	XXX	0
86320	26	A	Serum immunoelectrophoresis	0.37	0.20	0.01	0.58	XXX	N
86325		X	Other immunoelectrophoresis	0.00	0.00	0.00	0.00	XXX	0
86325	26	A	Other immunoelectrophoresis	0.37	0.20	0.01	0.58	XXX	N
86327		X	Immunoelectrophoresis assay	0.00	0.00	0.00	0.00	XXX	0
86327	26	A	Immunoelectrophoresis assay	0.37	0.20	0.01	0.58	XXX	N
86329		X	Immunodiffusion	0.00	0.00	0.00	0.00	XXX	0
86331		X	Immunodiffusion ouchterlony	0.00	0.00	0.00	0.00	XXX	0
86332		X	Immune complex assay	0.00	0.00	0.00	0.00	XXX	0
86334		X	Immunofixation procedure	0.00	0.00	0.00	0.00	XXX	0
86334	26	A	Immunofixation procedure	0.37	0.20	0.01	0.58	XXX	N
86337		X	Insulin antibodies	0.00	0.00	0.00	0.00	XXX	0
86340		X	Intrinsic factor antibody	0.00	0.00	0.00	0.00	XXX	0
86341		X	Islet cell antibody	0.00	0.00	0.00	0.00	XXX	0
86343		X	Leukocyte histamine release	0.00	0.00	0.00	0.00	XXX	0
86344		X	Leukocyte phagocytosis	0.00	0.00	0.00	0.00	XXX	0
86353		X	Lymphocyte transformation	0.00	0.00	0.00	0.00	XXX	0
86359		X	T cells, total count	0.00	0.00	0.00	0.00	XXX	0
86360		X	T cell ratio	0.00	0.00	0.00	0.00	XXX	0
86376		X	Microsomal antibody	0.00	0.00	0.00	0.00	XXX	0
86378		X	Migration inhibitory factor	0.00	0.00	0.00	0.00	XXX	0
86382		X	Neutralization test, viral	0.00	0.00	0.00	0.00	XXX	0
86384		X	Nitroblue tetrazolium dye	0.00	0.00	0.00	0.00	XXX	0
86403		X	Particle agglutination test	0.00	0.00	0.00	0.00	XXX	0
86406		X	Particle agglutination test	0.00	0.00	0.00	0.00	XXX	0
86430		X	Rheumatoid factor test	0.00	0.00	0.00	0.00	XXX	0
86431		X	Rheumatoid factor, quant	0.00	0.00	0.00	0.00	XXX	0
86485		C	Skin test, candida	0.00	0.00	0.00	0.00	XXX	N
86490		A	Coccidioidomycosis skin test	0.00	0.28	0.02	0.30	XXX	N
86510		A	Histoplasmosis skin test	0.00	0.30	0.02	0.32	XXX	N
86580		A	TB intradermal test	0.00	0.24	0.02	0.26	XXX	N
86585		A	TB tine test	0.00	0.19	0.01	0.20	XXX	N
86586		C	Skin test, unlisted	0.00	0.00	0.00	0.00	XXX	N
86588		X	Streptococcus, direct screen	0.00	0.00	0.00	0.00	XXX	0
86590		X	Streptokinase, antibody	0.00	0.00	0.00	0.00	XXX	0
86592		X	Blood serology, qualitative	0.00	0.00	0.00	0.00	XXX	0
86593		X	Blood serology, quantitative	0.00	0.00	0.00	0.00	XXX	0
86602		X	Antinomyces antibody	0.00	0.00	0.00	0.00	XXX	0
86603		X	Adenovirus, antibody	0.00	0.00	0.00	0.00	XXX	0
86606		X	Aspergillus antibody	0.00	0.00	0.00	0.00	XXX	0
86609		X	Bacterium, antibody	0.00	0.00	0.00	0.00	XXX	0
86612		X	Blastomyces, antibody	0.00	0.00	0.00	0.00	XXX	0
86615		X	Bordetella antibody	0.00	0.00	0.00	0.00	XXX	0
86617		X	Lyme disease antibody	0.00	0.00	0.00	0.00	XXX	0
86618		X	Lyme disease antibody	0.00	0.00	0.00	0.00	XXX	0
86619		X	Borrelia antibody	0.00	0.00	0.00	0.00	XXX	0
86622		X	Brucella, antibody	0.00	0.00	0.00	0.00	XXX	0
86625		X	Campylobacter, antibody	0.00	0.00	0.00	0.00	XXX	0
86628		X	Candida, antibody	0.00	0.00	0.00	0.00	XXX	0
86631		X	Chlamydia, antibody	0.00	0.00	0.00	0.00	XXX	0
86632		X	Chlamydia, IgM, antibody	0.00	0.00	0.00	0.00	XXX	0
86635		X	Coccidioides, antibody	0.00	0.00	0.00	0.00	XXX	0
86638		X	Q fever antibody	0.00	0.00	0.00	0.00	XXX	0
86641		X	Cryptococcus antibody	0.00	0.00	0.00	0.00	XXX	0
86644		X	CMV antibody	0.00	0.00	0.00	0.00	XXX	0
86645		X	CMV antibody, IgM	0.00	0.00	0.00	0.00	XXX	0
86648		X	Diphtheria antibody	0.00	0.00	0.00	0.00	XXX	0
86651		X	Encephalitis, antibody	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
86652		X	Encephalitis, antibody	0.00	0.00	0.00	0.00	XXX	0
86653		X	Encephalitis, antibody	0.00	0.00	0.00	0.00	XXX	0
86654		X	Encephalitis, antibody	0.00	0.00	0.00	0.00	XXX	0
86658		X	Enterovirus, antibody	0.00	0.00	0.00	0.00	XXX	0
86663		X	Epstein-barr, antibody	0.00	0.00	0.00	0.00	XXX	0
86664		X	Epstein-barr, antibody	0.00	0.00	0.00	0.00	XXX	0
86665		X	Epstein-barr, antibody	0.00	0.00	0.00	0.00	XXX	0
86668		X	Francisella tularensis	0.00	0.00	0.00	0.00	XXX	0
86671		X	Fungus, antibody	0.00	0.00	0.00	0.00	XXX	0
86674		X	Giardia lamblia	0.00	0.00	0.00	0.00	XXX	0
86677		X	Helicobacter pylori	0.00	0.00	0.00	0.00	XXX	0
86682		X	Helminth, antibody	0.00	0.00	0.00	0.00	XXX	0
86684		X	Hemophilus influenza	0.00	0.00	0.00	0.00	XXX	0
86687		X	HTLV I	0.00	0.00	0.00	0.00	XXX	0
86688		X	HTLV-II	0.00	0.00	0.00	0.00	XXX	0
86689		X	HTLV/HIV confirmatory test	0.00	0.00	0.00	0.00	XXX	0
86692		X	Hepatitis, delta agent	0.00	0.00	0.00	0.00	XXX	0
86694		X	Herpes simplex test	0.00	0.00	0.00	0.00	XXX	0
86695		X	Herpes simplex test	0.00	0.00	0.00	0.00	XXX	0
86698		X	Histoplasma	0.00	0.00	0.00	0.00	XXX	0
86701		X	HIV-1	0.00	0.00	0.00	0.00	XXX	0
86702		X	HIV-2	0.00	0.00	0.00	0.00	XXX	0
86703		X	HIV-1/HIV-2, single assay	0.00	0.00	0.00	0.00	XXX	0
86710		X	Influenza virus	0.00	0.00	0.00	0.00	XXX	0
86713		X	Legionella	0.00	0.00	0.00	0.00	XXX	0
86717		X	Leishmania	0.00	0.00	0.00	0.00	XXX	0
86720		X	Leptospira	0.00	0.00	0.00	0.00	XXX	0
86723		X	Listeria monocytogenes	0.00	0.00	0.00	0.00	XXX	0
86727		X	Lymph choriomeningitis	0.00	0.00	0.00	0.00	XXX	0
86729		X	Lympho venereum	0.00	0.00	0.00	0.00	XXX	0
86732		X	Mucormycosis	0.00	0.00	0.00	0.00	XXX	0
86735		X	Mumps	0.00	0.00	0.00	0.00	XXX	0
86738		X	Mycoplasma	0.00	0.00	0.00	0.00	XXX	0
86741		X	Neisseria meningitidis	0.00	0.00	0.00	0.00	XXX	0
86744		X	Nocardia	0.00	0.00	0.00	0.00	XXX	0
86747		X	Parvovirus	0.00	0.00	0.00	0.00	XXX	0
86750		X	Malaria	0.00	0.00	0.00	0.00	XXX	0
86753		X	Protozoa, not elsewhere	0.00	0.00	0.00	0.00	XXX	0
86756		X	Respiratory virus	0.00	0.00	0.00	0.00	XXX	0
86759		X	Rotavirus	0.00	0.00	0.00	0.00	XXX	0
86762		X	Rubella	0.00	0.00	0.00	0.00	XXX	0
86765		X	Rubeola	0.00	0.00	0.00	0.00	XXX	0
86768		X	Salmonella	0.00	0.00	0.00	0.00	XXX	0
86771		X	Shigella	0.00	0.00	0.00	0.00	XXX	0
86774		X	Tetanus	0.00	0.00	0.00	0.00	XXX	0
86777		X	Toxoplasma	0.00	0.00	0.00	0.00	XXX	0
86778		X	Toxoplasma, IgM	0.00	0.00	0.00	0.00	XXX	0
86781		X	Treponema pallidum confirm	0.00	0.00	0.00	0.00	XXX	0
86784		X	Trichinella	0.00	0.00	0.00	0.00	XXX	0
86787		X	Varicella-zoster	0.00	0.00	0.00	0.00	XXX	0
86790		X	Virus, not specified	0.00	0.00	0.00	0.00	XXX	0
86793		X	Yersinia	0.00	0.00	0.00	0.00	XXX	0
86800		X	Thyroglobulin antibody	0.00	0.00	0.00	0.00	XXX	0
86805		X	Lymphocytotoxicity assay	0.00	0.00	0.00	0.00	XXX	0
86806		X	Lymphocytotoxicity assay	0.00	0.00	0.00	0.00	XXX	0
86807		X	Cytotoxic antibody screening	0.00	0.00	0.00	0.00	XXX	0
86808		X	Cytotoxic antibody screening	0.00	0.00	0.00	0.00	XXX	0
86812		X	HLA typing, A, B, or C	0.00	0.00	0.00	0.00	XXX	0
86813		X	HLA typing, A, B, or C	0.00	0.00	0.00	0.00	XXX	0
86816		X	HLA typing, DR/DQ	0.00	0.00	0.00	0.00	XXX	0
86817		X	HLA typing, DR/DQ	0.00	0.00	0.00	0.00	XXX	0
86821		X	Lymphocyte culture, mixed	0.00	0.00	0.00	0.00	XXX	0
86822		X	Lymphocyte culture, primed	0.00	0.00	0.00	0.00	XXX	0
86849		X	Immunology procedure	0.00	0.00	0.00	0.00	XXX	0
86850		X	RBC antibody screen	0.00	0.00	0.00	0.00	XXX	0
86860		X	RBC antibody elution	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
86870		X	RBC antibody identification	0.00	0.00	0.00	0.00	XXX	0
86880		X	Coombs test	0.00	0.00	0.00	0.00	XXX	0
86885		X	Coombs test	0.00	0.00	0.00	0.00	XXX	0
86886		X	Coombs test	0.00	0.00	0.00	0.00	XXX	0
86890		X	Autologous blood process	0.00	0.00	0.00	0.00	XXX	0
86891		X	Autologous blood, op salvage	0.00	0.00	0.00	0.00	XXX	0
86900		X	Blood typing, ABO	0.00	0.00	0.00	0.00	XXX	0
86901		X	Blood typing, Rh (D)	0.00	0.00	0.00	0.00	XXX	0
86903		X	Blood typing, antigen screen	0.00	0.00	0.00	0.00	XXX	0
86904		X	Blood typing, patient serum	0.00	0.00	0.00	0.00	XXX	0
86905		X	Blood typing, RBC antigens	0.00	0.00	0.00	0.00	XXX	0
86906		X	Blood typing, Rh phenotype	0.00	0.00	0.00	0.00	XXX	0
86910		N	Blood typing, paternity test	0.00	0.00	0.00	0.00	XXX	0
86911		N	Blood typing, antigen system	0.00	0.00	0.00	0.00	XXX	0
86915		X	Bone marrow	0.00	0.00	0.00	0.00	XXX	0
86920		X	Compatibility test	0.00	0.00	0.00	0.00	XXX	0
86921		X	Compatibility test	0.00	0.00	0.00	0.00	XXX	0
86922		X	Compatibility test	0.00	0.00	0.00	0.00	XXX	0
86927		X	Plasma, fresh frozen	0.00	0.00	0.00	0.00	XXX	0
86930		X	Frozen blood prep	0.00	0.00	0.00	0.00	XXX	0
86931		X	Frozen blood thaw	0.00	0.00	0.00	0.00	XXX	0
86932		X	Frozen blood, freeze/thaw	0.00	0.00	0.00	0.00	XXX	0
86940		X	Hemolysins/agglutinins auto	0.00	0.00	0.00	0.00	XXX	0
86941		X	Hemolysins/agglutinins	0.00	0.00	0.00	0.00	XXX	0
86945		X	Blood product/irradiation	0.00	0.00	0.00	0.00	XXX	0
86950		X	Leukocyte transfusion	0.00	0.00	0.00	0.00	XXX	0
86965		X	Pooling blood platelets	0.00	0.00	0.00	0.00	XXX	0
86970		X	RBC pretreatment	0.00	0.00	0.00	0.00	XXX	0
86971		X	RBC pretreatment	0.00	0.00	0.00	0.00	XXX	0
86972		X	RBC pretreatment	0.00	0.00	0.00	0.00	XXX	0
86975		X	RBC pretreatment, serum	0.00	0.00	0.00	0.00	XXX	0
86976		X	RBC pretreatment, serum	0.00	0.00	0.00	0.00	XXX	0
86977		X	RBC pretreatment, serum	0.00	0.00	0.00	0.00	XXX	0
86978		X	RBC pretreatment, serum	0.00	0.00	0.00	0.00	XXX	0
86985		X	Split blood or products	0.00	0.00	0.00	0.00	XXX	0
86999		X	Transfusion procedure	0.00	0.00	0.00	0.00	XXX	0
87001		X	Small animal inoculation	0.00	0.00	0.00	0.00	XXX	0
87003		X	Small animal inoculation	0.00	0.00	0.00	0.00	XXX	0
87015		X	Specimen concentration	0.00	0.00	0.00	0.00	XXX	0
87040		X	Blood culture for bacteria	0.00	0.00	0.00	0.00	XXX	0
87045		X	Stool culture for bacteria	0.00	0.00	0.00	0.00	XXX	0
87060		X	Nose/throat culture, bacteria	0.00	0.00	0.00	0.00	XXX	0
87070		X	Culture specimen, bacteria	0.00	0.00	0.00	0.00	XXX	0
87072		X	Culture of specimen by kit	0.00	0.00	0.00	0.00	XXX	0
87075		X	Culture specimen, bacteria	0.00	0.00	0.00	0.00	XXX	0
87076		X	Bacteria identification	0.00	0.00	0.00	0.00	XXX	0
87081		X	Bacteria culture screen	0.00	0.00	0.00	0.00	XXX	0
87082		X	Culture of specimen by kit	0.00	0.00	0.00	0.00	XXX	0
87083		X	Culture of specimen by kit	0.00	0.00	0.00	0.00	XXX	0
87084		X	Culture of specimen by kit	0.00	0.00	0.00	0.00	XXX	0
87085		X	Culture of specimen by kit	0.00	0.00	0.00	0.00	XXX	0
87086		X	Urine culture, colony count	0.00	0.00	0.00	0.00	XXX	0
87087		X	Urine bacteria culture	0.00	0.00	0.00	0.00	XXX	0
87088		X	Urine bacteria culture	0.00	0.00	0.00	0.00	XXX	0
87101		X	Skin fungus culture	0.00	0.00	0.00	0.00	XXX	0
87102		X	Fungus isolation culture	0.00	0.00	0.00	0.00	XXX	0
87103		X	Blood fungus culture	0.00	0.00	0.00	0.00	XXX	0
87106		X	Fungus identification	0.00	0.00	0.00	0.00	XXX	0
87109		X	Mycoplasma culture	0.00	0.00	0.00	0.00	XXX	0
87110		X	Culture, chlamydia	0.00	0.00	0.00	0.00	XXX	0
87116		X	Mycobacteria culture	0.00	0.00	0.00	0.00	XXX	0
87117		X	Mycobacteria culture	0.00	0.00	0.00	0.00	XXX	0
87118		X	Mycobacteria identification	0.00	0.00	0.00	0.00	XXX	0
87140		X	Culture typing, fluorescent	0.00	0.00	0.00	0.00	XXX	0
87143		X	Culture typing, GLC method	0.00	0.00	0.00	0.00	XXX	0
87145		X	Culture typing, phage method	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
87147		X	Culture typing, serologic	0.00	0.00	0.00	0.00	XXX	0
87151		X	Culture typing, serologic	0.00	0.00	0.00	0.00	XXX	0
87155		X	Culture typing, precipitin	0.00	0.00	0.00	0.00	XXX	0
87158		X	Culture typing, added method	0.00	0.00	0.00	0.00	XXX	0
87163		X	Special microbiology culture	0.00	0.00	0.00	0.00	XXX	0
87164		X	Dark field examination	0.00	0.00	0.00	0.00	XXX	0
87164	26	A	Dark field examination	0.37	0.20	0.01	0.58	XXX	N
87166		X	Dark field examination	0.00	0.00	0.00	0.00	XXX	0
87174		X	Endotoxin, bacterial	0.00	0.00	0.00	0.00	XXX	0
87175		X	Assay, endotoxin, bacterial	0.00	0.00	0.00	0.00	XXX	0
87176		X	Endotoxin, bacterial	0.00	0.00	0.00	0.00	XXX	0
87177		X	Ova and parasites smears	0.00	0.00	0.00	0.00	XXX	0
87178		X	Microbe identification	0.00	0.00	0.00	0.00	XXX	0
87179		X	Microbe identification	0.00	0.00	0.00	0.00	XXX	0
87181		X	Antibiotic sensitivity, each	0.00	0.00	0.00	0.00	XXX	0
87184		X	Antibiotic sensitivity, each	0.00	0.00	0.00	0.00	XXX	0
87186		X	Antibiotic sensitivity, MIC	0.00	0.00	0.00	0.00	XXX	0
87187		X	Antibiotic sensitivity, MBC	0.00	0.00	0.00	0.00	XXX	0
87188		X	Antibiotic sensitivity, each	0.00	0.00	0.00	0.00	XXX	0
87190		X	TB antibiotic sensitivity	0.00	0.00	0.00	0.00	XXX	0
87192		X	Antibiotic sensitivity, each	0.00	0.00	0.00	0.00	XXX	0
87197		X	Bactericidal level, serum	0.00	0.00	0.00	0.00	XXX	0
87205		X	Smear, stain & interpret	0.00	0.00	0.00	0.00	XXX	0
87206		X	Smear, stain & interpret	0.00	0.00	0.00	0.00	XXX	0
87207		X	Smear, stain & interpret	0.00	0.00	0.00	0.00	XXX	0
87207	26	A	Smear, stain & interpret	0.37	0.20	0.01	0.58	XXX	N
87208		X	Smear, stain & interpret	0.00	0.00	0.00	0.00	XXX	0
87210		X	Smear, stain & interpret	0.00	0.00	0.00	0.00	XXX	0
87211		X	Smear, stain & interpret	0.00	0.00	0.00	0.00	XXX	0
87220		X	Tissue exam for fungi	0.00	0.00	0.00	0.00	XXX	0
87230		X	Assay, toxin or antitoxin	0.00	0.00	0.00	0.00	XXX	0
87250		X	Virus inoculation for test	0.00	0.00	0.00	0.00	XXX	0
87252		X	Virus inoculation for test	0.00	0.00	0.00	0.00	XXX	0
87253		X	Virus inoculation for test	0.00	0.00	0.00	0.00	XXX	0
87999		X	Microbiology procedure	0.00	0.00	0.00	0.00	XXX	0
88000		N	Autopsy (necropsy), gross	0.00	0.00	0.00	0.00	XXX	0
88005		N	Autopsy (necropsy), gross	0.00	0.00	0.00	0.00	XXX	0
88007		N	Autopsy (necropsy), gross	0.00	0.00	0.00	0.00	XXX	0
88012		N	Autopsy (necropsy), gross	0.00	0.00	0.00	0.00	XXX	0
88014		N	Autopsy (necropsy), gross	0.00	0.00	0.00	0.00	XXX	0
88016		N	Autopsy (necropsy), gross	0.00	0.00	0.00	0.00	XXX	0
88020		N	Autopsy (necropsy), complete	0.00	0.00	0.00	0.00	XXX	0
88025		N	Autopsy (necropsy), complete	0.00	0.00	0.00	0.00	XXX	0
88027		N	Autopsy (necropsy), complete	0.00	0.00	0.00	0.00	XXX	0
88028		N	Autopsy (necropsy), complete	0.00	0.00	0.00	0.00	XXX	0
88029		N	Autopsy (necropsy), complete	0.00	0.00	0.00	0.00	XXX	0
88036		N	Limited autopsy	0.00	0.00	0.00	0.00	XXX	0
88037		N	Limited autopsy	0.00	0.00	0.00	0.00	XXX	0
88040		N	Forensic autopsy (necropsy)	0.00	0.00	0.00	0.00	XXX	0
88045		N	Coroner's autopsy (necropsy)	0.00	0.00	0.00	0.00	XXX	0
88099		N	Necropsy (autopsy) procedure	0.00	0.00	0.00	0.00	XXX	0
88104		A	Microscopic exam of cells	0.56	0.44	0.04	1.04	XXX	N
88104	26	A	Microscopic exam of cells	0.56	0.23	0.02	0.81	XXX	N
88104	TC	A	Microscopic exam of cells	0.00	0.21	0.02	0.23	XXX	N
88106		A	Microscopic exam of cells	0.56	0.37	0.03	0.96	XXX	N
88106	26	A	Microscopic exam of cells	0.56	0.20	0.01	0.77	XXX	N
88106	TC	A	Microscopic exam of cells	0.00	0.17	0.02	0.19	XXX	N
88107		A	Microscopic exam of cells	0.76	0.47	0.04	1.27	XXX	N
88107	26	A	Microscopic exam of cells	0.76	0.24	0.02	1.02	XXX	N
88107	TC	A	Microscopic exam of cells	0.00	0.23	0.02	0.25	XXX	N
88108		A	Cytopathology	0.56	0.47	0.04	1.07	XXX	N
88108	26	A	Cytopathology	0.56	0.24	0.02	0.82	XXX	N
88108	TC	A	Cytopathology	0.00	0.23	0.02	0.25	XXX	N
88125		A	Forensic cytopathology	0.26	0.11	0.00	0.37	XXX	N
88125	26	A	Forensic cytopathology	0.26	0.07	0.00	0.33	XXX	N
88125	TC	A	Forensic cytopathology	0.00	0.04	0.00	0.04	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
88130	.....	X	Sex chromatin identification	0.00	0.00	0.00	0.00	XXX	0
88140	.....	X	Sex chromatin identification	0.00	0.00	0.00	0.00	XXX	0
88150	.....	X	Cytopathology, pap smear	0.00	0.00	0.00	0.00	XXX	0
88151	.....	X	Cytopathology interpretation	0.00	0.00	0.00	0.00	XXX	0
88151	26	A	Cytopathology interpretation	0.42	0.32	0.04	0.78	XXX	N
88155	.....	X	Cytopathology, pap smear	0.00	0.00	0.00	0.00	XXX	0
88156	.....	X	TBS smear (bethesda system)	0.00	0.00	0.00	0.00	XXX	0
88157	.....	X	TBS smear (bethesda system)	0.00	0.00	0.00	0.00	XXX	0
88157	26	A	TBS smear (bethesda system)	0.42	0.32	0.04	0.78	XXX	N
88160	.....	A	Cytopathology	0.50	0.33	0.03	0.86	XXX	N
88160	26	A	Cytopathology	0.50	0.17	0.01	0.68	XXX	N
88160	TC	A	Cytopathology	0.00	0.16	0.02	0.18	XXX	N
88161	.....	A	Cytopathology	0.50	0.39	0.03	0.92	XXX	N
88161	26	A	Cytopathology	0.50	0.20	0.01	0.71	XXX	N
88161	TC	A	Cytopathology	0.00	0.19	0.02	0.21	XXX	N
88162	.....	A	Cytopathology, extensive	0.76	0.79	0.05	1.60	XXX	N
88162	26	A	Cytopathology, extensive	0.76	0.41	0.03	1.20	XXX	N
88162	TC	A	Cytopathology, extensive	0.00	0.38	0.02	0.40	XXX	N
88170	.....	A	Fine needle aspiration	0.50	0.99	0.09	1.58	XXX	N
88170	26	A	Fine needle aspiration	0.50	0.52	0.05	1.07	XXX	N
88170	TC	A	Fine needle aspiration	0.00	0.47	0.04	0.51	XXX	N
88171	.....	A	Fine needle aspiration	1.05	1.35	0.09	2.49	XXX	N
88171	26	A	Fine needle aspiration	1.05	0.71	0.05	1.81	XXX	N
88171	TC	A	Fine needle aspiration	0.00	0.64	0.04	0.68	XXX	N
88172	.....	A	Evaluation of smear	0.60	0.71	0.05	1.36	XXX	N
88172	26	A	Evaluation of smear	0.60	0.36	0.03	0.99	XXX	N
88172	TC	A	Evaluation of smear	0.00	0.35	0.02	0.37	XXX	N
88173	.....	A	Interpretation of smear	1.08	0.87	0.05	2.00	XXX	N
88173	26	A	Interpretation of smear	1.08	0.45	0.03	1.56	XXX	N
88173	TC	A	Interpretation of smear	0.00	0.42	0.02	0.44	XXX	N
88180	.....	A	Cell marker study	0.36	0.33	0.03	0.72	XXX	N
88180	26	A	Cell marker study	0.36	0.17	0.01	0.54	XXX	N
88180	TC	A	Cell marker study	0.00	0.16	0.02	0.18	XXX	N
88182	.....	A	Cell marker study	0.77	0.89	0.07	1.73	XXX	N
88182	26	A	Cell marker study	0.77	0.45	0.03	1.25	XXX	N
88182	TC	A	Cell marker study	0.00	0.44	0.04	0.48	XXX	N
88199	.....	C	Cytopathology procedure	0.00	0.00	0.00	0.00	XXX	N
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	XXX	N
88199	TC	C	Cytopathology procedure	0.00	0.00	0.00	0.00	XXX	N
88230	.....	X	Tissue culture, lymphocyte	0.00	0.00	0.00	0.00	XXX	0
88233	.....	X	Tissue culture, skin/biopsy	0.00	0.00	0.00	0.00	XXX	0
88235	.....	X	Tissue culture, placenta	0.00	0.00	0.00	0.00	XXX	0
88237	.....	X	Tissue culture, bone marrow	0.00	0.00	0.00	0.00	XXX	0
88239	.....	X	Tissue culture, other	0.00	0.00	0.00	0.00	XXX	0
88245	.....	X	Chromosome analysis	0.00	0.00	0.00	0.00	XXX	0
88248	.....	X	Chromosome analysis	0.00	0.00	0.00	0.00	XXX	0
88250	.....	X	Chromosome analysis	0.00	0.00	0.00	0.00	XXX	0
88260	.....	X	Chromosome analysis: 5 cells	0.00	0.00	0.00	0.00	XXX	0
88261	.....	X	Chromosome analysis: 5 cells	0.00	0.00	0.00	0.00	XXX	0
88262	.....	X	Chromosome count: 15–20 cells	0.00	0.00	0.00	0.00	XXX	0
88263	.....	X	Chromosome analysis: 45 cells	0.00	0.00	0.00	0.00	XXX	0
88267	.....	X	Chromosome analysis: placenta	0.00	0.00	0.00	0.00	XXX	0
88269	.....	X	Chromosome analysis: amniotic	0.00	0.00	0.00	0.00	XXX	0
88280	.....	X	Chromosome karyotype study	0.00	0.00	0.00	0.00	XXX	0
88283	.....	X	Chromosome banding study	0.00	0.00	0.00	0.00	XXX	0
88285	.....	X	Chromosome count: additional	0.00	0.00	0.00	0.00	XXX	0
88289	.....	X	Chromosome study: additional	0.00	0.00	0.00	0.00	XXX	0
88299	.....	C	Cytogenetic study	0.00	0.00	0.00	0.00	XXX	N
88300	.....	A	Surg path, gross	0.08	*0.20	0.01	0.29	XXX	N
88300	26	A	Surg path, gross	0.08	*0.10	0.01	0.19	XXX	N
88300	TC	A	Surg path, gross	0.00	0.10	0.00	0.10	XXX	N
88302	.....	A	Tissue exam by pathologist	0.13	*0.40	0.04	0.57	XXX	N
88302	26	A	Tissue exam by pathologist	0.13	*0.17	0.02	0.32	XXX	N
88302	TC	A	Tissue exam by pathologist	0.00	0.23	0.02	0.25	XXX	N
88304	.....	A	Tissue exam by pathologist	0.22	*0.61	0.04	0.87	XXX	N
88304	26	A	Tissue exam by pathologist	0.22	*0.28	0.02	0.52	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
88304	TC	A	Tissue exam by pathologist	0.00	0.33	0.02	0.35	XXX	N
88305	.....	A	Tissue exam by pathologist	0.75	1.03	0.08	1.86	XXX	N
88305	26	A	Tissue exam by pathologist	0.75	0.53	0.04	1.32	XXX	N
88305	TC	A	Tissue exam by pathologist	0.00	0.50	0.04	0.54	XXX	N
88307	.....	A	Tissue exam by pathologist	1.59	1.52	0.12	3.23	XXX	N
88307	26	A	Tissue exam by pathologist	1.59	0.78	0.06	2.43	XXX	N
88307	TC	A	Tissue exam by pathologist	0.00	0.74	0.06	0.80	XXX	N
88309	.....	A	Tissue exam by pathologist	2.28	1.92	0.13	4.33	XXX	N
88309	26	A	Tissue exam by pathologist	2.28	0.99	0.07	3.34	XXX	N
88309	TC	A	Tissue exam by pathologist	0.00	0.93	0.06	0.99	XXX	N
88311	.....	A	Decalcify tissue	0.24	0.21	0.01	0.46	XXX	N
88311	26	A	Decalcify tissue	0.24	0.11	0.01	0.36	XXX	N
88311	TC	A	Decalcify tissue	0.00	0.10	0.00	0.10	XXX	N
88312	.....	A	Special stains	0.54	0.26	0.01	0.81	XXX	N
88312	26	A	Special stains	0.54	0.14	0.01	0.69	XXX	N
88312	TC	A	Special stains	0.00	0.12	0.00	0.12	XXX	N
88313	.....	A	Special stains	0.24	0.21	0.01	0.46	XXX	N
88313	26	A	Special stains	0.24	0.11	0.01	0.36	XXX	N
88313	TC	A	Special stains	0.00	0.10	0.00	0.10	XXX	N
88314	.....	A	Histochemical stain	0.45	0.62	0.04	1.11	XXX	N
88314	26	A	Histochemical stain	0.45	0.35	0.02	0.82	XXX	N
88314	TC	A	Histochemical stain	0.00	0.27	0.02	0.29	XXX	N
88318	.....	A	Chemical histochemistry	0.42	0.24	0.01	0.67	XXX	N
88318	26	A	Chemical histochemistry	0.42	0.12	0.01	0.55	XXX	N
88318	TC	A	Chemical histochemistry	0.00	0.12	0.00	0.12	XXX	N
88319	.....	A	Enzyme histochemistry	0.53	0.49	0.04	1.06	XXX	N
88319	26	A	Enzyme histochemistry	0.53	0.26	0.02	0.81	XXX	N
88319	TC	A	Enzyme histochemistry	0.00	0.23	0.02	0.25	XXX	N
88321	.....	A	Microslide consultation	1.30	0.41	0.03	1.74	XXX	N
88323	.....	A	Microslide consultation	1.35	0.72	0.05	2.12	XXX	N
88323	26	A	Microslide consultation	1.35	0.39	0.03	1.77	XXX	N
88323	TC	A	Microslide consultation	0.00	0.33	0.02	0.35	XXX	N
88325	.....	A	Comprehensive review of data	2.22	0.47	0.04	2.73	XXX	N
88329	.....	A	Pathology consult in surgery	0.67	0.37	0.03	1.07	XXX	N
88331	.....	A	Pathology consult in surgery	1.19	1.10	0.08	2.37	XXX	N
88331	26	A	Pathology consult in surgery	1.19	0.56	0.04	1.79	XXX	N
88331	TC	A	Pathology consult in surgery	0.00	0.54	0.04	0.58	XXX	N
88332	.....	A	Pathology consult in surgery	0.59	0.56	0.04	1.19	XXX	N
88332	26	A	Pathology consult in surgery	0.59	0.29	0.02	0.90	XXX	N
88332	TC	A	Pathology consult in surgery	0.00	0.27	0.02	0.29	XXX	N
88342	.....	A	Immunocytochemistry	0.85	0.64	0.04	1.53	XXX	N
88342	26	A	Immunocytochemistry	0.85	0.33	0.02	1.20	XXX	N
88342	TC	A	Immunocytochemistry	0.00	0.31	0.02	0.33	XXX	N
88346	.....	A	Immunofluorescent study	0.86	0.58	0.04	1.48	XXX	N
88346	26	A	Immunofluorescent study	0.86	0.31	0.02	1.19	XXX	N
88346	TC	A	Immunofluorescent study	0.00	0.27	0.02	0.29	XXX	N
88347	.....	A	Immunofluorescent study	0.86	0.42	0.04	1.32	XXX	N
88347	26	A	Immunofluorescent study	0.86	0.15	0.02	1.03	XXX	N
88347	TC	A	Immunofluorescent study	0.00	0.27	0.02	0.29	XXX	N
88348	.....	A	Electron microscopy	1.51	2.28	0.16	3.95	XXX	N
88348	26	A	Electron microscopy	1.51	1.19	0.08	2.78	XXX	N
88348	TC	A	Electron microscopy	0.00	1.09	0.08	1.17	XXX	N
88349	.....	A	Scanning electron microscopy	0.76	1.55	0.12	2.43	XXX	N
88349	26	A	Scanning electron microscopy	0.76	0.79	0.06	1.61	XXX	N
88349	TC	A	Scanning electron microscopy	0.00	0.76	0.06	0.82	XXX	N
88355	.....	A	Analysis, skeletal muscle	1.85	1.74	0.13	3.72	XXX	N
88355	26	A	Analysis, skeletal muscle	1.85	0.92	0.07	2.84	XXX	N
88355	TC	A	Analysis, skeletal muscle	0.00	0.82	0.06	0.88	XXX	N
88356	.....	A	Analysis, nerve	3.02	2.66	0.18	5.86	XXX	N
88356	26	A	Analysis, nerve	3.02	1.39	0.10	4.51	XXX	N
88356	TC	A	Analysis, nerve	0.00	1.27	0.08	1.35	XXX	N
88358	.....	A	Analysis, tumor	2.82	2.32	0.16	5.30	XXX	N
88358	26	A	Analysis, tumor	2.82	1.16	0.08	4.06	XXX	N
88358	TC	A	Analysis, tumor	0.00	1.16	0.08	1.24	XXX	N
88362	.....	A	Nerve teasing preparations	2.17	1.97	0.13	4.27	XXX	N
88362	26	A	Nerve teasing preparations	2.17	1.00	0.07	3.24	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110—D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
88362	TC	A	Nerve teasing preparations	0.00	0.97	0.06	1.03	XXX	N
88365		A	Tissue hybridization	0.93	0.75	0.05	1.73	XXX	N
88365	26	A	Tissue hybridization	0.93	0.38	0.03	1.34	XXX	N
88365	TC	A	Tissue hybridization	0.00	0.37	0.02	0.39	XXX	N
88371		X	Protein, western blot tissue	0.00	0.00	0.00	0.00	XXX	0
88371	26	A	Protein, western blot tissue	0.37	0.20	0.01	0.58	XXX	N
88372		X	Protein analysis w/probe	0.00	0.00	0.00	0.00	XXX	0
88372	26	A	Protein analysis w/probe	0.37	0.20	0.01	0.58	XXX	N
88399		C	Surgical pathology procedure	0.00	0.00	0.00	0.00	XXX	N
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	XXX	N
88399	TC	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	XXX	N
89050		X	Body fluid cell count	0.00	0.00	0.00	0.00	XXX	0
89051		X	Body fluid cell count	0.00	0.00	0.00	0.00	XXX	0
89060		X	Exam, synovial fluid crystals	0.00	0.00	0.00	0.00	XXX	0
89060	26	A	Exam, synovial fluid crystals	0.37	0.20	0.01	0.58	XXX	N
89100		A	Sample intestinal contents	0.60	0.42	0.03	1.05	XXX	N
89105		A	Sample intestinal contents	0.50	0.39	0.03	0.92	XXX	N
89125		X	Specimen fat stain	0.00	0.00	0.00	0.00	XXX	0
89130		A	Sample stomach contents	0.45	0.41	0.03	0.89	XXX	N
89132		A	Sample stomach contents	0.19	0.19	0.02	0.40	XXX	N
89135		A	Sample stomach contents	0.79	0.58	0.04	1.41	XXX	N
89136		A	Sample stomach contents	0.21	0.22	0.02	0.45	XXX	N
89140		A	Sample stomach contents	0.94	0.81	0.07	1.82	XXX	N
89141		A	Sample stomach contents	0.85	0.73	0.06	1.64	XXX	N
89160		X	Exam feces for meat fibers	0.00	0.00	0.00	0.00	XXX	0
89190		X	Nasal smear for eosinophils	0.00	0.00	0.00	0.00	XXX	0
89250		X	Fertilization of oocyte	0.00	0.00	0.00	0.00	XXX	0
89300		X	Semen analysis	0.00	0.00	0.00	0.00	XXX	0
89310		X	Semen analysis	0.00	0.00	0.00	0.00	XXX	0
89320		X	Semen analysis	0.00	0.00	0.00	0.00	XXX	0
89325		X	Sperm antibody test	0.00	0.00	0.00	0.00	XXX	0
89329		X	Sperm evaluation test	0.00	0.00	0.00	0.00	XXX	0
89330		X	Evaluation, cervical mucus	0.00	0.00	0.00	0.00	XXX	0
89350		A	Sputum specimen collection	0.00	0.39	0.03	0.42	XXX	N
89355		X	Exam feces for starch	0.00	0.00	0.00	0.00	XXX	0
89360		A	Collect sweat for test	0.00	0.43	0.03	0.46	XXX	N
89365		X	Water load test	0.00	0.00	0.00	0.00	XXX	0
89399		C	Pathology lab procedure	0.00	0.00	0.00	0.00	XXX	N
89399	26	C	Pathology lab procedure	0.00	0.00	0.00	0.00	XXX	N
89399	TC	C	Pathology lab procedure	0.00	0.00	0.00	0.00	XXX	N
90700		E	DTaP immunization	0.00	0.00	0.00	0.00	XXX	0
90701		E	DTP immunization	0.00	0.00	0.00	0.00	XXX	0
90702		E	DT immunization	0.00	0.00	0.00	0.00	XXX	0
90703		E	Tetanus immunization	0.00	0.00	0.00	0.00	XXX	0
90704		E	Mumps immunization	0.00	0.00	0.00	0.00	XXX	0
90705		E	Measles immunization	0.00	0.00	0.00	0.00	XXX	0
90706		E	Rubella immunization	0.00	0.00	0.00	0.00	XXX	0
90707		E	MMR virus immunization	0.00	0.00	0.00	0.00	XXX	0
90708		E	Measles-rubella immunization	0.00	0.00	0.00	0.00	XXX	0
90709		E	Rubella & mumps immunization	0.00	0.00	0.00	0.00	XXX	0
90710		E	Combined vaccine	0.00	0.00	0.00	0.00	XXX	0
90711		E	Combined vaccine	0.00	0.00	0.00	0.00	XXX	0
90712		E	Oral poliovirus immunization	0.00	0.00	0.00	0.00	XXX	0
90713		E	Poliomyelitis immunization	0.00	0.00	0.00	0.00	XXX	0
90714		E	Typhoid immunization	0.00	0.00	0.00	0.00	XXX	0
90716		E	Chicken pox vaccine	0.00	0.00	0.00	0.00	XXX	0
90717		E	Yellow fever immunization	0.00	0.00	0.00	0.00	XXX	0
90718		E	Td immunization	0.00	0.00	0.00	0.00	XXX	0
90719		E	Diphtheria immunization	0.00	0.00	0.00	0.00	XXX	0
90720		E	DTP/HIB vaccine	0.00	0.00	0.00	0.00	XXX	0
90721		E	Dtap/hib vaccine	0.00	0.00	0.00	0.00	XXX	0
90724		X	Influenza immunization	0.00	0.00	0.00	0.00	XXX	0
90725		E	Cholera immunization	0.00	0.00	0.00	0.00	XXX	0
90726		E	Rabies immunization	0.00	0.00	0.00	0.00	XXX	0
90727		E	Plague immunization	0.00	0.00	0.00	0.00	XXX	0
90728		E	BCG immunization	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
90730		E	Hepatitis A vaccine	0.00	0.00	0.00	0.00	XXX	0
90731		D	Hepatitis B immunization	0.00	0.00	0.00	0.00	XXX	0
90732		X	Pneumococcal immunization	0.00	0.00	0.00	0.00	XXX	0
90733		E	Meningococcal immunization	0.00	0.00	0.00	0.00	XXX	0
90735		E	Encephalitis virus vaccine	0.00	0.00	0.00	0.00	XXX	0
90737		E	Influenza B immunization	0.00	0.00	0.00	0.00	XXX	0
90741		E	Passive immunization, ISG	0.00	0.00	0.00	0.00	XXX	0
90742		E	Special passive immunization	0.00	0.00	0.00	0.00	XXX	0
90744		X	Hepatitis B vaccine, under 11	0.00	0.00	0.00	0.00	XXX	0
90745		X	Hepatitis B vaccine, 11–19	0.00	0.00	0.00	0.00	XXX	0
90746		X	Hepatitis B vaccine, over 20	0.00	0.00	0.00	0.00	XXX	0
90747		X	Hepatitis B vaccine, ill pat	0.00	0.00	0.00	0.00	XXX	0
90749		C	Immunization procedure	0.00	0.00	0.00	0.00	XXX	N
90780		A	IV infusion therapy, 1 hour	0.00	1.06	0.08	1.14	XXX	N
90781		A	IV infusion, additional hour	0.00	0.53	0.04	0.57	XXX	N
90782		T	Injection (SC)/(IM)	0.00	0.10	0.01	0.11	XXX	N
90783		T	Injection (IA)	0.00	0.39	0.03	0.42	XXX	N
90784		T	Injection (IV)	0.00	0.45	0.04	0.49	XXX	N
90788		T	Injection of antibiotic	0.00	0.11	0.01	0.12	XXX	N
90799		C	Therapeutic/diag injection	0.00	0.00	0.00	0.00	XXX	N
90801		A	Psychiatric interview	2.21	0.67	0.09	2.97	XXX	N
90820		A	Diagnostic interview	2.27	0.38	0.05	2.70	XXX	N
90825		B	Evaluation of tests/records	#0.97	0.31	0.04	1.32	XXX	0
90830		D	Psychological testing	0.00	0.00	0.00	0.00	XXX	N
90835		A	Special interview	2.84	0.50	0.07	3.41	XXX	N
90841		G	Psychotherapy	0.00	0.00	0.00	0.00	XXX	0
90842		A	Psychotherapy, 75–80 min.	2.76	1.05	0.15	3.96	XXX	N
90843		A	Psychotherapy, 20–30 min.	1.11	0.35	0.05	1.51	XXX	N
90844		A	Psychotherapy, 45–50 min.	1.73	0.54	0.08	2.35	XXX	N
90845		A	Medical psychoanalysis	1.79	0.41	0.05	2.25	XXX	N
90846		R	Special family therapy	1.83	0.62	0.08	2.53	XXX	N
90847		R	Special family therapy	2.21	0.58	0.08	2.87	XXX	N
90849		R	Special family therapy	0.59	0.26	0.03	0.88	XXX	N
90853		A	Special group therapy	0.43	0.26	0.03	0.72	XXX	N
90855		A	Individual psychotherapy	1.82	0.59	0.09	2.50	XXX	N
90857		A	Special group therapy	0.43	0.15	0.02	0.60	XXX	N
90862		A	Medication management	0.95	0.37	0.05	1.37	XXX	N
90870		A	Electroconvulsive therapy	1.88	0.55	0.08	2.51	000	N
90871		A	Electroconvulsive therapy	2.72	0.83	0.13	3.68	000	N
90880		A	Medical hypnotherapy	2.19	0.64	0.07	2.90	XXX	N
90882		N	Environmental manipulation	0.00	0.00	0.00	0.00	XXX	0
90887		B	Consultation with family	#1.48	0.33	0.04	1.85	XXX	0
90889		B	Preparation of report	0.00	0.00	0.00	0.00	XXX	0
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	XXX	N
90900		A	Biofeedback, electromyogram	0.89	0.90	0.08	1.87	000	N
90902		A	Biofeedback, nerve impulse	0.89	0.63	0.05	1.57	000	N
90904		A	Biofeedback, blood pressure	0.89	0.35	0.03	1.27	000	N
90906		A	Biofeedback, blood flow	0.89	1.60	0.11	2.60	000	N
90908		A	Biofeedback, brain waves	0.89	0.86	0.06	1.81	000	N
90910		A	Biofeedback, oculogram	0.89	0.67	0.10	1.66	000	N
90911		A	Anorectal biofeedback	2.15	1.13	0.27	3.55	000	N
90915		A	Biofeedback, unspecified	0.89	0.76	0.06	1.71	000	N
90918		A	ESRD related services, month	11.18	2.19	0.14	13.51	XXX	P
90919		A	ESRD related services, month	8.54	2.19	0.14	10.87	XXX	P
90920		A	ESRD related services, month	7.27	2.19	0.14	9.60	XXX	P
90921		A	ESRD related services, month	4.47	2.19	0.14	6.80	XXX	P
90922		A	ESRD related services, day	0.37	0.07	0.01	0.45	XXX	P
90923		A	Esrd related services, day	0.28	0.07	0.01	0.36	XXX	P
90924		A	Esrd related services, day	0.24	0.07	0.01	0.32	XXX	P
90925		A	Esrd related services, day	0.15	0.07	0.01	0.23	XXX	P
90935		A	Hemodialysis, one evaluation	1.22	1.49	0.10	2.81	000	N
90937		A	Hemodialysis, repeated eval.	2.11	*2.65	0.18	4.94	000	N
90945		A	Dialysis, one evaluation	1.28	1.27	0.08	2.63	000	N
90947		A	Dialysis, repeated eval.	2.16	2.09	0.14	4.39	000	N
90989		X	Dialysis training/complete	0.00	0.00	0.00	0.00	XXX	0
90993		X	Dialysis training/incomplete	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
90997	.....	A	Hemoperfusion	1.84	*2.35	0.16	4.35	000	N
90999	.....	C	Dialysis procedure	0.00	0.00	0.00	0.00	XXX	N
91000	.....	A	Esophageal intubation	0.99	0.66	0.06	1.71	000	N
91000	26	A	Esophageal intubation	0.99	0.59	0.05	1.63	000	N
91000	TC	A	Esophageal intubation	0.00	0.07	0.01	0.08	000	N
91010	.....	A	Esophagus motility study	1.65	2.28	0.17	4.10	000	N
91010	26	A	Esophagus motility study	1.65	1.50	0.11	3.26	000	N
91010	TC	A	Esophagus motility study	0.00	0.78	0.06	0.84	000	N
91011	.....	A	Esophagus motility study	1.98	2.66	0.18	4.82	000	N
91011	26	A	Esophagus motility study	1.98	1.68	0.11	3.77	000	N
91011	TC	A	Esophagus motility study	0.00	0.98	0.07	1.05	000	N
91012	.....	A	Esophagus motility study	1.92	3.12	0.23	5.27	000	N
91012	26	A	Esophagus motility study	1.92	2.02	0.15	4.09	000	N
91012	TC	A	Esophagus motility study	0.00	1.10	0.08	1.18	000	N
91020	.....	A	Esophagogastric study	1.89	2.50	0.18	4.57	000	N
91020	26	A	Esophagogastric study	1.89	1.77	0.12	3.78	000	N
91020	TC	A	Esophagogastric study	0.00	0.73	0.06	0.79	000	N
91030	.....	A	Acid perfusion of esophagus	1.20	0.56	0.05	1.81	000	N
91030	26	A	Acid perfusion of esophagus	1.20	0.35	0.03	1.58	000	N
91030	TC	A	Acid perfusion of esophagus	0.00	0.21	0.02	0.23	000	N
91032	.....	A	Esophagus, acid reflux test	1.59	1.96	0.16	3.71	000	N
91032	26	A	Esophagus, acid reflux test	1.59	1.25	0.10	2.94	000	N
91032	TC	A	Esophagus, acid reflux test	0.00	0.71	0.06	0.77	000	N
91033	.....	A	Prolonged acid reflux test	1.71	2.97	0.25	4.93	000	N
91033	26	A	Prolonged acid reflux test	1.71	1.69	0.14	3.54	000	N
91033	TC	A	Prolonged acid reflux test	0.00	1.28	0.11	1.39	000	N
91052	.....	A	Gastric analysis test	1.71	0.82	0.07	2.60	000	N
91052	26	A	Gastric analysis test	1.71	0.50	0.04	2.25	000	N
91052	TC	A	Gastric analysis test	0.00	0.32	0.03	0.35	000	N
91055	.....	A	Gastric intubation for smear	1.28	0.80	0.06	2.14	000	N
91055	26	A	Gastric intubation for smear	1.28	0.51	0.04	1.83	000	N
91055	TC	A	Gastric intubation for smear	0.00	0.29	0.02	0.31	000	N
91060	.....	A	Gastric saline load test	0.45	0.71	0.06	1.22	000	N
91060	26	A	Gastric saline load test	0.45	0.50	0.04	0.99	000	N
91060	TC	A	Gastric saline load test	0.00	0.21	0.02	0.23	000	N
91065	.....	A	Breath hydrogen test	0.45	0.83	0.05	1.33	000	N
91065	26	A	Breath hydrogen test	0.45	0.49	0.03	0.97	000	N
91065	TC	A	Breath hydrogen test	0.00	0.34	0.02	0.36	000	N
91100	.....	A	Pass intestine bleeding tube	1.08	0.56	0.05	1.69	000	N
91105	.....	A	Gastric intubation treatment	0.37	*0.46	0.04	0.87	000	N
91122	.....	A	Anal pressure record	1.77	1.73	0.22	3.72	000	S
91122	26	A	Anal pressure record	1.77	1.06	0.13	2.96	000	S
91122	TC	A	Anal pressure record	0.00	0.67	0.09	0.76	000	S
91299	.....	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	XXX	N
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	XXX	N
91299	TC	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	XXX	N
92002	.....	A	Eye exam, new patient	1.01	0.49	0.02	1.52	XXX	P
92004	.....	A	Eye exam, new patient	1.61	0.57	0.02	2.20	XXX	P
92012	.....	A	Eye exam established pt	0.82	0.44	0.02	1.28	XXX	N
92014	.....	A	Eye exam & treatment	1.06	0.54	0.02	1.62	XXX	N
92015	.....	N	Refraction	#0.38	0.32	0.02	0.72	XXX	O
92018	.....	A	New eye exam & treatment	1.51	0.47	0.03	2.01	XXX	N
92019	.....	A	Eye exam & treatment	1.31	0.47	0.03	1.81	XXX	N
92020	.....	A	Special eye evaluation	0.37	0.29	0.01	0.67	XXX	N
92060	.....	A	Special eye evaluation	0.50	0.39	0.02	0.91	XXX	N
92060	26	A	Special eye evaluation	0.50	0.21	0.01	0.72	XXX	N
92060	TC	A	Special eye evaluation	0.00	0.18	0.01	0.19	XXX	N
92065	.....	A	Orthoptic/pleoptic training	0.37	0.36	0.01	0.74	XXX	N
92065	26	A	Orthoptic/pleoptic training	0.37	0.20	0.01	0.58	XXX	N
92065	TC	A	Orthoptic/pleoptic training	0.00	0.16	0.00	0.16	XXX	N
92070	.....	A	Fitting of contact lens	0.70	1.20	0.06	1.96	XXX	N
92081	.....	A	Visual field examination(s)	0.36	0.32	0.01	0.69	XXX	N
92081	26	A	Visual field examination(s)	0.36	0.17	0.01	0.54	XXX	N
92081	TC	A	Visual field examination(s)	0.00	0.15	0.00	0.15	XXX	N
92082	.....	A	Visual field examination(s)	0.44	0.49	0.02	0.95	XXX	N
92082	26	A	Visual field examination(s)	0.44	0.30	0.01	0.75	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
92082	TC	A	Visual field examination(s)	0.00	0.19	0.01	0.20	XXX	N
92083	.....	A	Visual field examination(s)	0.50	0.83	0.04	1.37	XXX	N
92083	26	A	Visual field examination(s)	0.50	0.55	0.03	1.08	XXX	N
92083	TC	A	Visual field examination(s)	0.00	0.28	0.01	0.29	XXX	N
92100	.....	A	Serial tonometry exam(s)	0.92	0.25	0.01	1.18	XXX	N
92120	.....	A	Tonography & eye evaluation	0.81	0.31	0.02	1.14	XXX	N
92130	.....	A	Water provocation tonography	0.81	0.49	0.02	1.32	XXX	N
92140	.....	A	Glaucoma provocative tests	0.50	0.30	0.01	0.81	XXX	N
92225	.....	A	Special eye exam, initial	0.58	0.45	0.02	1.05	XXX	N
92226	.....	A	Special eye exam, subsequent	0.50	0.40	0.02	0.92	XXX	N
92230	.....	A	Eye exam with photos	0.60	0.69	0.04	1.33	XXX	N
92235	.....	A	Eye exam with photos	0.81	1.58	0.09	2.48	XXX	N
92235	26	A	Eye exam with photos	0.81	0.59	0.03	1.43	XXX	N
92235	TC	A	Eye exam with photos	0.00	0.99	0.06	1.05	XXX	N
92250	.....	A	Eye exam with photos	0.44	0.42	0.02	0.88	XXX	N
92250	26	A	Eye exam with photos	0.44	0.25	0.01	0.70	XXX	N
92250	TC	A	Eye exam with photos	0.00	0.17	0.01	0.18	XXX	N
92260	.....	A	Ophthalmoscopy/dynamometry	0.50	0.54	0.03	1.07	XXX	N
92265	.....	A	Eye muscle evaluation	0.81	0.29	0.02	1.12	XXX	N
92265	26	A	Eye muscle evaluation	0.81	0.07	0.00	0.88	XXX	N
92265	TC	A	Eye muscle evaluation	0.00	0.22	0.02	0.24	XXX	N
92270	.....	A	Electro-oculography	0.81	0.67	0.05	1.53	XXX	N
92270	26	A	Electro-oculography	0.81	0.37	0.03	1.21	XXX	N
92270	TC	A	Electro-oculography	0.00	0.30	0.02	0.32	XXX	N
92275	.....	A	Electroretinography	1.01	0.90	0.05	1.96	XXX	N
92275	26	A	Electroretinography	1.01	0.51	0.03	1.55	XXX	N
92275	TC	A	Electroretinography	0.00	0.39	0.02	0.41	XXX	N
92280	.....	D	Special eye evaluation	0.00	0.00	0.00	0.00	XXX	N
92280	26	D	Special eye evaluation	0.00	0.00	0.00	0.00	XXX	N
92280	TC	D	Special eye evaluation	0.00	0.00	0.00	0.00	XXX	N
92283	.....	A	Color vision examination	0.26	0.29	0.01	0.56	XXX	N
92283	26	A	Color vision examination	0.26	0.17	0.01	0.44	XXX	N
92283	TC	A	Color vision examination	0.00	0.12	0.00	0.12	XXX	N
92284	.....	A	Dark adaptation eye exam	0.37	0.45	0.02	0.84	XXX	N
92284	26	A	Dark adaptation eye exam	0.37	0.28	0.01	0.66	XXX	N
92284	TC	A	Dark adaptation eye exam	0.00	0.17	0.01	0.18	XXX	N
92285	.....	A	Eye photography	0.20	0.29	0.01	0.50	XXX	N
92285	26	A	Eye photography	0.20	0.18	0.01	0.39	XXX	N
92285	TC	A	Eye photography	0.00	0.11	0.00	0.11	XXX	N
92286	.....	A	Internal eye photography	0.66	1.22	0.07	1.95	XXX	N
92286	26	A	Internal eye photography	0.66	0.83	0.05	1.54	XXX	N
92286	TC	A	Internal eye photography	0.00	0.39	0.02	0.41	XXX	N
92287	.....	A	Internal eye photography	0.81	1.52	0.08	2.41	XXX	N
92310	.....	N	Contact lens fitting	#1.17	1.32	0.00	2.49	XXX	0
92311	.....	A	Contact lens fitting	1.08	0.90	0.03	2.01	XXX	N
92312	.....	A	Contact lens fitting	1.26	1.16	0.03	2.45	XXX	N
92313	.....	A	Contact lens fitting	0.92	0.88	0.03	1.83	XXX	N
92314	.....	N	Prescription of contact lens	#0.69	0.78	0.00	1.47	XXX	0
92315	.....	A	Prescription of contact lens	0.45	0.66	0.03	1.14	XXX	N
92316	.....	A	Prescription of contact lens	0.68	0.95	0.04	1.67	XXX	N
92317	.....	A	Prescription of contact lens	0.45	0.39	0.02	0.86	XXX	N
92325	.....	A	Modification of contact lens	0.00	0.38	0.01	0.39	XXX	N
92326	.....	A	Replacement of contact lens	0.00	1.56	0.06	1.62	XXX	N
92330	.....	A	Fitting of artificial eye	1.08	1.13	0.09	2.30	XXX	N
92335	.....	A	Fitting of artificial eye	0.45	1.97	0.11	2.53	XXX	N
92340	.....	N	Fitting of spectacles	#0.37	0.42	0.00	0.79	XXX	0
92341	.....	N	Fitting of spectacles	#0.47	0.53	0.00	1.00	XXX	0
92342	.....	N	Fitting of spectacles	#0.53	0.60	0.00	1.13	XXX	0
92352	.....	B	Special spectacles fitting	#0.37	0.30	0.01	0.68	XXX	0
92353	.....	B	Special spectacles fitting	#0.50	0.40	0.01	0.91	XXX	0
92354	.....	B	Special spectacles fitting	#0.00	8.44	0.10	8.54	XXX	0
92355	.....	B	Special spectacles fitting	#0.00	4.13	0.01	4.14	XXX	0
92358	.....	B	Eye prosthesis service	#0.00	0.92	0.05	0.97	XXX	0
92370	.....	N	Repair & adjust spectacles	#0.32	0.36	0.00	0.68	XXX	0
92371	.....	B	Repair & adjust spectacles	#0.00	0.59	0.02	0.61	XXX	0
92390	.....	N	Supply of spectacles	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
92391	.....	N	Supply of contact lenses	0.00	0.00	0.00	0.00	XXX	0
92392	.....	G	Supply of low vision aids	#0.00	3.85	0.02	3.87	XXX	0
92393	.....	G	Supply of artificial eye	#0.00	11.96	0.67	12.63	XXX	0
92395	.....	G	Supply of spectacles	#0.00	1.31	0.10	1.41	XXX	0
92396	.....	G	Supply of contact lenses	#0.00	2.19	0.08	2.27	XXX	0
92499	.....	C	Eye service or procedure	0.00	0.00	0.00	0.00	XXX	N
92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	XXX	N
92499	TC	C	Eye service or procedure	0.00	0.00	0.00	0.00	XXX	N
92502	.....	A	Ear and throat examination	1.51	1.12	0.12	2.75	000	N
92504	.....	A	Ear microscopy examination	0.18	0.26	0.02	0.46	XXX	N
92506	.....	A	Speech & hearing evaluation	0.86	0.52	0.05	1.43	XXX	N
92507	.....	A	Speech/hearing therapy	0.52	0.33	0.03	0.88	XXX	N
92508	.....	A	Speech/hearing therapy	0.26	0.18	0.02	0.46	XXX	N
92510	.....	A	Rehab for ear implant	1.50	1.36	0.15	3.01	XXX	N
92511	.....	A	Nasopharyngoscopy	0.84	0.85	0.09	1.78	000	S
92512	.....	A	Nasal function studies	0.55	0.47	0.05	1.07	XXX	N
92516	.....	A	Facial nerve function test	0.43	0.39	0.04	0.86	XXX	N
92520	.....	A	Laryngeal function studies	0.76	0.53	0.05	1.34	XXX	N
92525	.....	A	Oral function evaluation	1.13	1.02	0.11	2.26	XXX	N
92526	.....	A	Oral function therapy	0.52	0.47	0.05	1.04	XXX	N
92531	.....	B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	XXX	0
92532	.....	B	Positional nystagmus study	0.00	0.00	0.00	0.00	XXX	0
92533	.....	B	Caloric vestibular test	0.00	0.00	0.00	0.00	XXX	0
92534	.....	B	Optokinetic nystagmus	0.00	0.00	0.00	0.00	XXX	0
92541	.....	A	Spontaneous nystagmus test	0.40	0.67	0.07	1.14	XXX	N
92541	26	A	Spontaneous nystagmus test	0.40	0.45	0.05	0.90	XXX	N
92541	TC	A	Spontaneous nystagmus test	0.00	0.22	0.02	0.24	XXX	N
92542	.....	A	Positional nystagmus test	0.33	0.61	0.07	1.01	XXX	N
92542	26	A	Positional nystagmus test	0.33	0.36	0.04	0.73	XXX	N
92542	TC	A	Positional nystagmus test	0.00	0.25	0.03	0.28	XXX	N
92543	.....	A	Caloric vestibular test	0.38	0.82	0.09	1.29	XXX	N
92543	26	A	Caloric vestibular test	0.38	0.42	0.05	0.85	XXX	N
92543	TC	A	Caloric vestibular test	0.00	0.40	0.04	0.44	XXX	N
92544	.....	A	Optokinetic nystagmus test	0.26	0.47	0.05	0.78	XXX	N
92544	26	A	Optokinetic nystagmus test	0.26	0.27	0.03	0.56	XXX	N
92544	TC	A	Optokinetic nystagmus test	0.00	0.20	0.02	0.22	XXX	N
92545	.....	A	Oscillating tracking test	0.23	0.40	0.04	0.67	XXX	N
92545	26	A	Oscillating tracking test	0.23	0.20	0.02	0.45	XXX	N
92545	TC	A	Oscillating tracking test	0.00	0.20	0.02	0.22	XXX	N
92546	.....	A	Sinusoidal rotational test	0.29	0.53	0.05	0.87	XXX	N
92546	26	A	Sinusoidal rotational test	0.29	0.30	0.03	0.62	XXX	N
92546	TC	A	Sinusoidal rotational test	0.00	0.23	0.02	0.25	XXX	N
92547	.....	A	Supplemental electrical test	0.00	0.53	0.06	0.59	XXX	N
92551	.....	N	Pure tone hearing test, air	0.00	0.00	0.00	0.00	XXX	0
92552	.....	A	Pure tone audiometry, air	0.00	0.42	0.04	0.46	XXX	N
92553	.....	A	Audiometry, air & bone	0.00	0.63	0.07	0.70	XXX	N
92555	.....	A	Speech threshold audiometry	0.00	0.36	0.04	0.40	XXX	N
92556	.....	A	Speech audiometry, complete	0.00	0.54	0.06	0.60	XXX	N
92557	.....	A	Comprehensive hearing test	0.00	1.13	0.13	1.26	XXX	N
92559	.....	N	Group audiometric testing	0.00	0.00	0.00	0.00	XXX	0
92560	.....	N	Bekesy audiometry, screen	0.00	0.00	0.00	0.00	XXX	0
92561	.....	A	Bekesy audiometry, diagnosis	0.00	0.68	0.07	0.75	XXX	N
92562	.....	A	Loudness balance test	0.00	0.39	0.04	0.43	XXX	N
92563	.....	A	Tone decay hearing test	0.00	0.36	0.04	0.40	XXX	N
92564	.....	A	Sisi hearing test	0.00	0.45	0.05	0.50	XXX	N
92565	.....	A	Stenger test, pure tone	0.00	0.38	0.04	0.42	XXX	N
92567	.....	A	Tympanometry	0.00	0.50	0.06	0.56	XXX	N
92568	.....	A	Acoustic reflex testing	0.00	0.36	0.04	0.40	XXX	N
92569	.....	A	Acoustic reflex decay test	0.00	0.39	0.04	0.43	XXX	N
92571	.....	A	Filtered speech hearing test	0.00	0.37	0.04	0.41	XXX	N
92572	.....	A	Staggered spondaic word test	0.00	0.08	0.01	0.09	XXX	N
92573	.....	A	Lombard test	0.00	0.33	0.04	0.37	XXX	N
92574	.....	D	Swinging story test	0.00	0.00	0.00	0.00	XXX	N
92575	.....	A	Sensorineural acuity test	0.00	0.29	0.03	0.32	XXX	N
92576	.....	A	Synthetic sentence test	0.00	0.42	0.05	0.47	XXX	N
92577	.....	A	Stenger test, speech	0.00	0.68	0.08	0.76	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
92578		D	Delayed auditory feedback	0.00	0.00	0.00	0.00	XXX	N
92579		A	Visual audiometry (vra)	0.00	0.69	0.07	0.76	XXX	N
92580		D	Electrodermal audiometry	0.00	0.00	0.00	0.00	XXX	N
92582		A	Conditioning play audiometry	0.00	0.69	0.07	0.76	XXX	N
92583		A	Select picture audiometry	0.00	0.85	0.09	0.94	XXX	N
92584		A	Electrocochleography	0.00	2.36	0.25	2.61	XXX	N
92585		A	Auditory evoked potential	0.50	3.25	0.31	4.06	XXX	N
92585	26	A	Auditory evoked potential	0.50	1.49	0.14	2.13	XXX	N
92585	TC	A	Auditory evoked potential	0.00	1.76	0.17	1.93	XXX	N
92587		A	Evoked auditory test	0.13	1.35	0.13	1.61	XXX	N
92587	26	A	Evoked auditory test	0.13	0.11	0.01	0.25	XXX	N
92587	TC	A	Evoked auditory test	0.00	1.24	0.12	1.36	XXX	N
92588		A	Evoked auditory test	0.36	1.70	0.16	2.22	XXX	N
92588	26	A	Evoked auditory test	0.36	0.30	0.02	0.68	XXX	N
92588	TC	A	Evoked auditory test	0.00	1.40	0.14	1.54	XXX	N
92589		A	Auditory function test(s)	0.00	0.51	0.06	0.57	XXX	N
92590		N	Hearing aid exam, one ear	0.00	0.00	0.00	0.00	XXX	O
92591		N	Hearing aid exam, both ears	0.00	0.00	0.00	0.00	XXX	O
92592		N	Hearing aid check, one ear	0.00	0.00	0.00	0.00	XXX	O
92593		N	Hearing aid check, both ears	0.00	0.00	0.00	0.00	XXX	O
92594		N	Electro hearing aid test, one	0.00	0.00	0.00	0.00	XXX	O
92595		N	Electro hearingaid test, both	0.00	0.00	0.00	0.00	XXX	O
92596		A	Ear protector evaluation	0.00	0.56	0.06	0.62	XXX	N
92597		A	Oral speech device eval	1.11	1.01	0.11	2.23	XXX	N
92598		A	Modify oral speech device	0.73	0.66	0.07	1.46	XXX	N
92599		C	ENT procedure/service	0.00	0.00	0.00	0.00	XXX	N
92599	26	C	ENT procedure/service	0.00	0.00	0.00	0.00	XXX	N
92599	TC	C	ENT procedure/service	0.00	0.00	0.00	0.00	XXX	N
92950		A	Heart/lung resuscitation (CPR)	3.80	2.27	0.17	6.24	000	N
92953		A	Temporary external pacing	0.23	*0.66	0.15	1.04	000	N
92960		A	Heart electroconversion	2.25	1.88	0.16	4.29	000	N
92970		A	Cardioassist, internal	3.52	3.47	0.41	7.40	000	N
92971		A	Cardioassist, external	1.77	1.11	0.08	2.96	000	N
92975		A	Dissolve clot, heart vessel	7.25	5.71	0.42	13.38	000	N
92977		A	Dissolve clot, heart vessel	0.00	7.68	0.54	8.22	XXX	N
92980		A	Insert intracoronary stent	14.84	16.41	1.22	32.47	000	N
92981		A	Insert intracoronary stent	4.17	*5.42	0.44	10.03	ZZZ	N
92982		A	Coronary artery dilation	10.98	*14.05	1.22	26.25	000	N
92984		A	Coronary artery dilation	2.97	*3.80	0.44	7.21	ZZZ	N
92986		A	Revision of aortic valve	20.34	12.04	0.90	33.28	090	N
92987		A	Revision of mitral valve	20.69	12.20	0.91	33.80	090	N
92990		A	Revision of pulmonary valve	16.22	9.59	0.71	26.52	090	N
92992		C	Revision of heart chamber	0.00	0.00	0.00	0.00	090	S
92993		C	Revision of heart chamber	0.00	0.00	0.00	0.00	090	S
92995		A	Coronary atherectomy	12.09	*15.47	1.22	28.78	000	N
92996		A	Coronary atherectomy	3.26	*4.17	0.44	7.87	ZZZ	N
93000		A	Electrocardiogram, complete	0.17	0.59	0.04	0.80	XXX	N
93005		A	Electrocardiogram, tracing	0.00	0.43	0.03	0.46	XXX	N
93010		A	Electrocardiogram report	0.17	0.16	0.01	0.34	XXX	N
93012		A	Transmission of ecg	0.00	2.25	0.22	2.47	XXX	N
93014		A	Report on transmitted ecg	0.52	0.40	0.05	0.97	XXX	N
93015		A	Cardiovascular stress test	0.75	2.37	0.18	3.30	XXX	N
93016		A	Cardiovascular stress test	0.45	0.39	0.03	0.87	XXX	N
93017		A	Cardiovascular stress test	0.00	1.60	0.12	1.72	XXX	N
93018		A	Cardiovascular stress test	0.30	0.38	0.03	0.71	XXX	N
93024		A	Cardiac drug stress test	1.17	*2.56	0.23	3.96	XXX	N
93024	26	A	Cardiac drug stress test	1.17	*1.49	0.14	2.80	XXX	N
93024	TC	A	Cardiac drug stress test	0.00	1.07	0.09	1.16	XXX	N
93040		A	Rhythm ECG with report	0.16	0.26	0.02	0.44	XXX	N
93041		A	Rhythm ECG, tracing	0.00	0.14	0.01	0.15	XXX	N
93042		A	Rhythm ECG, report	0.16	0.12	0.01	0.29	XXX	N
93201		A	Phonocardiogram & ECG lead	0.42	1.03	0.09	1.54	XXX	N
93202		A	Phonocardiogram & ECG lead	0.00	0.75	0.07	0.82	XXX	N
93204		A	Phonocardiogram & ECG lead	0.42	0.28	0.02	0.72	XXX	N
93205		A	Special phonocardiogram	0.46	0.88	0.07	1.41	XXX	N
93208		A	Special phonocardiogram	0.00	0.33	0.03	0.36	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
93209	.....	A	Special phonocardiogram	0.46	0.55	0.04	1.05	XXX	N
93210	.....	A	Intracardiac phonocardiogram	0.92	1.73	0.13	2.78	XXX	N
93210	26	A	Intracardiac phonocardiogram	0.92	0.82	0.06	1.80	XXX	N
93210	TC	A	Intracardiac phonocardiogram	0.00	0.91	0.07	0.98	XXX	N
93220	.....	A	Vectorcardiogram	0.26	*0.91	0.07	1.24	XXX	N
93221	.....	A	Vectorcardiogram tracing	0.00	0.58	0.04	0.62	XXX	N
93222	.....	A	Vectorcardiogram report	0.26	*0.33	0.03	0.62	XXX	N
93224	.....	A	ECG monitor/report, 24 hrs	0.52	*3.93	0.31	4.76	XXX	N
93225	.....	A	ECG monitor/record, 24 hrs	0.00	1.18	0.09	1.27	XXX	N
93226	.....	A	ECG monitor/report, 24 hrs	0.00	2.08	0.16	2.24	XXX	N
93227	.....	A	ECG monitor/review, 24 hrs	0.52	*0.67	0.06	1.25	XXX	N
93230	.....	A	ECG monitor/report, 24 hrs	0.52	*4.19	0.34	5.05	XXX	N
93231	.....	A	ECG monitor/record, 24 hrs	0.00	1.45	0.11	1.56	XXX	N
93232	.....	A	ECG monitor/report, 24 hrs	0.00	2.07	0.15	2.22	XXX	N
93233	.....	A	ECG monitor/review, 24 hrs	0.52	*0.67	0.08	1.27	XXX	N
93235	.....	A	ECG monitor/report, 24 hrs	0.45	*3.07	0.23	3.75	XXX	N
93236	.....	A	ECG monitor/report, 24 hrs	0.00	2.50	0.17	2.67	XXX	N
93237	.....	A	ECG monitor/review, 24 hrs	0.45	*0.57	0.06	1.08	XXX	N
93268	.....	A	ECG record/review	0.52	3.83	0.36	4.71	XXX	N
93270	.....	A	ECG recording	0.00	1.18	0.09	1.27	XXX	N
93271	.....	A	ECG/monitoring and analysis	0.00	2.25	0.22	2.47	XXX	N
93272	.....	A	ECG/review, interpret only	0.52	0.40	0.05	0.97	XXX	N
93278	.....	A	ECG/signal-averaged	0.35	*1.55	0.18	2.08	XXX	N
93278	26	A	ECG/signal-averaged	0.35	*0.45	0.06	0.86	XXX	N
93278	TC	A	ECG/signal-averaged	0.00	1.10	0.12	1.22	XXX	N
93307	.....	A	Echo exam of heart	0.78	*4.68	0.36	5.82	XXX	N
93307	26	A	Echo exam of heart	0.78	*1.00	0.09	1.87	XXX	N
93307	TC	A	Echo exam of heart	0.00	3.68	0.27	3.95	XXX	N
93308	.....	A	Echo exam of heart	0.53	2.53	0.19	3.25	XXX	N
93308	26	A	Echo exam of heart	0.53	0.68	0.05	1.26	XXX	N
93308	TC	A	Echo exam of heart	0.00	1.85	0.14	1.99	XXX	N
93312	.....	A	Echo exam of heart	1.57	4.95	0.45	6.97	XXX	N
93312	26	A	Echo exam of heart	1.57	1.35	0.12	3.04	XXX	N
93312	TC	A	Echo exam of heart	0.00	3.60	0.33	3.93	XXX	N
93313	.....	A	Echo exam of heart	0.95	0.67	0.06	1.68	XXX	N
93314	.....	A	Echo exam of heart	0.95	4.27	0.39	5.61	XXX	N
93314	26	A	Echo exam of heart	0.95	0.67	0.06	1.68	XXX	N
93314	TC	A	Echo exam of heart	0.00	3.60	0.33	3.93	XXX	N
93320	.....	A	Doppler echo exam, heart	0.38	*2.11	0.18	2.67	XXX	N
93320	26	A	Doppler echo exam, heart	0.38	*0.48	0.05	0.91	XXX	N
93320	TC	A	Doppler echo exam, heart	0.00	1.63	0.13	1.76	XXX	N
93321	.....	A	Doppler echo exam, heart	0.15	*1.25	0.11	1.51	XXX	N
93321	26	A	Doppler echo exam, heart	0.15	*0.19	0.02	0.36	XXX	N
93321	TC	A	Doppler echo exam, heart	0.00	1.06	0.09	1.15	XXX	N
93325	.....	A	Doppler color flow	0.07	2.80	0.25	3.12	XXX	N
93325	26	A	Doppler color flow	0.07	0.04	0.01	0.12	XXX	N
93325	TC	A	Doppler color flow	0.00	2.76	0.24	3.00	XXX	N
93350	.....	A	Echo exam of heart	0.78	*3.63	0.24	4.65	XXX	N
93350	26	A	Echo exam of heart	0.78	*1.95	0.10	2.83	XXX	N
93350	TC	A	Echo exam of heart	0.00	1.68	0.14	1.82	XXX	N
93501	.....	A	Right heart catheterization	3.02	19.72	1.54	24.28	000	N
93501	26	A	Right heart catheterization	3.02	3.61	0.34	6.97	000	N
93501	TC	A	Right heart catheterization	0.00	16.11	1.20	17.31	000	N
93503	.....	A	Insert/place heart catheter	2.43	2.37	0.36	5.16	000	N
93505	.....	A	Biopsy of heart lining	4.56	4.92	0.46	9.94	000	N
93505	26	A	Biopsy of heart lining	4.56	3.03	0.28	7.87	000	N
93505	TC	A	Biopsy of heart lining	0.00	1.89	0.18	2.07	000	N
93510	.....	A	Left heart catheterization	4.33	38.28	2.86	45.47	000	N
93510	26	A	Left heart catheterization	4.33	3.06	0.23	7.62	000	N
93510	TC	A	Left heart catheterization	0.00	35.22	2.63	37.85	000	N
93511	.....	A	Left heart catheterization	5.03	36.91	2.76	44.70	000	N
93511	26	A	Left heart catheterization	5.03	2.62	0.20	7.85	000	N
93511	TC	A	Left heart catheterization	0.00	34.29	2.56	36.85	000	N
93514	.....	A	Left heart catheterization	7.05	38.84	2.94	48.83	000	S
93514	26	A	Left heart catheterization	7.05	4.55	0.38	11.98	000	S
93514	TC	A	Left heart catheterization	0.00	34.29	2.56	36.85	000	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
93524		A	Left heart catheterization	6.95	49.45	3.69	60.09	000	N
93524	26	A	Left heart catheterization	6.95	4.65	0.34	11.94	000	N
93524	TC	A	Left heart catheterization	0.00	44.80	3.35	48.15	000	N
93526		A	Rt & Lt heart catheters	5.99	51.48	3.83	61.30	000	N
93526	26	A	Rt & Lt heart catheters	5.99	5.45	0.39	11.83	000	N
93526	TC	A	Rt & Lt heart catheters	0.00	46.03	3.44	49.47	000	N
93527		A	Rt & Lt heart catheters	7.28	51.94	3.85	63.07	000	N
93527	26	A	Rt & Lt heart catheters	7.28	7.14	0.50	14.92	000	N
93527	TC	A	Rt & Lt heart catheters	0.00	44.80	3.35	48.15	000	N
93528		A	Rt & Lt heart catheters	9.00	49.23	3.68	61.91	000	N
93528	26	A	Rt & Lt heart catheters	9.00	4.43	0.33	13.76	000	N
93528	TC	A	Rt & Lt heart catheters	0.00	44.80	3.35	48.15	000	N
93529		A	Rt, Lt heart catheterization	4.80	47.73	3.57	56.10	000	N
93529	26	A	Rt, Lt heart catheterization	4.80	2.93	0.22	7.95	000	N
93529	TC	A	Rt, Lt heart catheterization	0.00	44.80	3.35	48.15	000	N
93536		A	Insert circulation assi	4.85	*6.20	0.71	11.76	000	N
93539		A	Injection, cardiac cath	0.29	*0.88	0.20	1.37	000	N
93540		A	Injection, cardiac cath	0.43	*0.88	0.20	1.51	000	N
93541		A	Injection for lung angiogram	0.29	*0.73	0.16	1.18	000	N
93542		A	Injection for heart x-rays	0.29	*0.72	0.16	1.17	000	N
93543		A	Injection for heart x-rays	0.29	*0.57	0.11	0.97	000	N
93544		A	Injection for aortography	0.29	*0.57	0.11	0.97	000	N
93545		A	Injection for coronary xrays	0.29	*1.03	0.24	1.56	000	N
93555		A	Imaging, cardiac cath	0.81	6.25	0.42	7.48	XXX	N
93555	26	A	Imaging, cardiac cath	0.81	0.27	0.04	1.12	XXX	N
93555	TC	A	Imaging, cardiac cath	0.00	5.98	0.38	6.36	XXX	N
93556		A	Imaging, cardiac cath	0.83	9.88	0.65	11.36	XXX	N
93556	26	A	Imaging, cardiac cath	0.83	0.45	0.07	1.35	XXX	N
93556	TC	A	Imaging, cardiac cath	0.00	9.43	0.58	10.01	XXX	N
93561		A	Cardiac output measurement	1.15	1.25	0.16	2.56	000	N
93561	26	A	Cardiac output measurement	1.15	0.75	0.09	1.99	000	N
93561	TC	A	Cardiac output measurement	0.00	0.50	0.07	0.57	000	N
93562		A	Cardiac output measurement	0.37	*0.76	0.10	1.23	000	N
93562	26	A	Cardiac output measurement	0.37	*0.46	0.06	0.89	000	N
93562	TC	A	Cardiac output measurement	0.00	0.30	0.04	0.34	000	N
93600		A	Bundle of His recording	2.12	*4.57	0.38	7.07	000	N
93600	26	A	Bundle of His recording	2.12	*2.71	0.24	5.07	000	N
93600	TC	A	Bundle of His recording	0.00	1.86	0.14	2.00	000	N
93602		A	Intra-atrial recording	2.12	2.83	0.22	5.17	000	N
93602	26	A	Intra-atrial recording	2.12	1.77	0.14	4.03	000	N
93602	TC	A	Intra-atrial recording	0.00	1.06	0.08	1.14	000	N
93603		A	Right ventricular recording	2.12	3.79	0.28	6.19	000	N
93603	26	A	Right ventricular recording	2.12	2.19	0.16	4.47	000	N
93603	TC	A	Right ventricular recording	0.00	1.60	0.12	1.72	000	N
93607		A	Right ventricular recording	3.26	3.63	0.28	7.17	000	N
93607	26	A	Right ventricular recording	3.26	2.21	0.17	5.64	000	N
93607	TC	A	Right ventricular recording	0.00	1.42	0.11	1.53	000	N
93609		A	Mapping of tachycardia	10.07	6.43	0.47	16.97	000	N
93609	26	A	Mapping of tachycardia	10.07	3.84	0.28	14.19	000	N
93609	TC	A	Mapping of tachycardia	0.00	2.59	0.19	2.78	000	N
93610		A	Intra-atrial pacing	3.02	3.60	0.27	6.89	000	N
93610	26	A	Intra-atrial pacing	3.02	2.31	0.17	5.50	000	N
93610	TC	A	Intra-atrial pacing	0.00	1.29	0.10	1.39	000	N
93612		A	Intraventricular pacing	3.02	3.88	0.29	7.19	000	N
93612	26	A	Intraventricular pacing	3.02	2.34	0.17	5.53	000	N
93612	TC	A	Intraventricular pacing	0.00	1.54	0.12	1.66	000	N
93615		A	Esophageal recording	0.99	0.65	0.04	1.68	000	N
93615	26	A	Esophageal recording	0.99	0.35	0.02	1.36	000	N
93615	TC	A	Esophageal recording	0.00	0.30	0.02	0.32	000	N
93616		A	Esophageal recording	1.49	1.66	0.10	3.25	000	N
93616	26	A	Esophageal recording	1.49	1.36	0.08	2.93	000	N
93616	TC	A	Esophageal recording	0.00	0.30	0.02	0.32	000	N
93618		A	Heart rhythm pacing	4.26	*9.24	0.72	14.22	000	N
93618	26	A	Heart rhythm pacing	4.26	*5.46	0.44	10.16	000	N
93618	TC	A	Heart rhythm pacing	0.00	3.78	0.28	4.06	000	N
93619		A	Electrophysiology evaluation	7.32	*16.71	1.40	25.43	000	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
93619	26	A	Electrophysiology evaluation	7.32	*9.37	0.86	17.55	000	N
93619	TC	A	Electrophysiology evaluation	0.00	7.34	0.54	7.88	000	N
93620	.....	A	Electrophysiology evaluation	11.59	22.07	1.55	35.21	000	N
93620	26	A	Electrophysiology evaluation	11.59	13.53	0.95	26.07	000	N
93620	TC	A	Electrophysiology evaluation	0.00	8.54	0.60	9.14	000	N
93621	.....	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	000	N
93621	26	A	Electrophysiology evaluation	12.66	14.94	1.11	28.71	000	N
93621	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	000	N
93622	.....	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	000	N
93622	26	A	Electrophysiology evaluation	12.74	14.74	1.07	28.55	000	N
93622	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	000	N
93623	.....	C	Stimulation, pacing heart	0.00	0.00	0.00	0.00	000	N
93623	26	A	Stimulation, pacing heart	2.85	2.78	0.20	5.83	000	N
93623	TC	C	Stimulation, pacing heart	0.00	0.00	0.00	0.00	000	N
93624	.....	A	Electrophysiologic study	4.81	4.88	0.35	10.04	000	N
93624	26	A	Electrophysiologic study	4.81	2.99	0.21	8.01	000	N
93624	TC	A	Electrophysiologic study	0.00	1.89	0.14	2.03	000	N
93631	.....	A	Heart pacing, mapping	7.60	11.62	1.37	20.59	000	N
93631	26	A	Heart pacing, mapping	7.60	5.76	0.67	14.03	000	N
93631	TC	A	Heart pacing, mapping	0.00	5.86	0.70	6.56	000	N
93640	.....	A	Evaluation heart device	3.52	*11.51	1.09	16.12	000	N
93640	26	A	Evaluation heart device	3.52	*4.67	0.61	8.80	000	N
93640	TC	A	Evaluation heart device	0.00	6.84	0.48	7.32	000	N
93641	.....	A	Electrophysiology evaluation	5.93	*13.85	1.09	20.87	000	N
93641	26	A	Electrophysiology evaluation	5.93	*7.01	0.61	13.55	000	N
93641	TC	A	Electrophysiology evaluation	0.00	6.84	0.48	7.32	000	N
93642	.....	A	Electrophysiology evaluation	4.89	*13.09	1.09	19.07	000	N
93642	26	A	Electrophysiology evaluation	4.89	*6.25	0.61	11.75	000	N
93642	TC	A	Electrophysiology evaluation	0.00	6.84	0.48	7.32	000	N
93650	.....	A	Ablate heart dysrhythm focus	10.51	*13.46	1.34	25.31	000	N
93651	.....	A	Ablate heart dysrhythm focus	16.25	17.83	1.34	35.42	000	N
93652	.....	A	Ablate heart dysrhythm focus	17.68	17.83	1.34	36.85	000	N
93660	.....	C	Tilt table evaluation	0.00	0.00	0.00	0.00	000	N
93660	26	A	Tilt table evaluation	1.89	1.44	0.17	3.50	000	N
93660	TC	C	Tilt table evaluation	0.00	0.00	0.00	0.00	000	N
93720	.....	A	Total body plethysmography	0.17	*0.89	0.10	1.16	XXX	N
93721	.....	A	Plethysmography tracing	0.00	0.67	0.07	0.74	XXX	N
93722	.....	A	Plethysmography report	0.17	*0.22	0.03	0.42	XXX	N
93724	.....	A	Analyze pacemaker system	4.89	6.66	0.50	12.05	000	N
93724	26	A	Analyze pacemaker system	4.89	2.88	0.22	7.99	000	N
93724	TC	A	Analyze pacemaker system	0.00	3.78	0.28	4.06	000	N
93731	.....	A	Analyze pacemaker system	0.45	0.79	0.07	1.31	XXX	N
93731	26	A	Analyze pacemaker system	0.45	0.32	0.03	0.80	XXX	N
93731	TC	A	Analyze pacemaker system	0.00	0.47	0.04	0.51	XXX	N
93732	.....	A	Analyze pacemaker system	0.92	0.91	0.08	1.91	XXX	N
93732	26	A	Analyze pacemaker system	0.92	0.42	0.04	1.38	XXX	N
93732	TC	A	Analyze pacemaker system	0.00	0.49	0.04	0.53	XXX	N
93733	.....	A	Telephone analysis, pacemaker	0.17	*0.91	0.08	1.16	XXX	N
93733	26	A	Telephone analysis, pacemaker	0.17	*0.22	0.02	0.41	XXX	N
93733	TC	A	Telephone analysis, pacemaker	0.00	0.69	0.06	0.75	XXX	N
93734	.....	A	Analyze pacemaker system	0.38	0.64	0.06	1.08	XXX	N
93734	26	A	Analyze pacemaker system	0.38	0.31	0.03	0.72	XXX	N
93734	TC	A	Analyze pacemaker system	0.00	0.33	0.03	0.36	XXX	N
93735	.....	A	Analyze pacemaker system	0.74	0.85	0.08	1.67	XXX	N
93735	26	A	Analyze pacemaker system	0.74	0.43	0.04	1.21	XXX	N
93735	TC	A	Analyze pacemaker system	0.00	0.42	0.04	0.46	XXX	N
93736	.....	A	Telephone analysis, pacemaker	0.15	*0.79	0.09	1.03	XXX	N
93736	26	A	Telephone analysis, pacemaker	0.15	*0.19	0.03	0.37	XXX	N
93736	TC	A	Telephone analysis, pacemaker	0.00	0.60	0.06	0.66	XXX	N
93737	.....	A	Analyze cardio/defibrillator	0.45	0.74	0.06	1.25	XXX	N
93737	26	A	Analyze cardio/defibrillator	0.45	0.27	0.02	0.74	XXX	N
93737	TC	A	Analyze cardio/defibrillator	0.00	0.47	0.04	0.51	XXX	N
93738	.....	A	Analyze cardio/defibrillator	0.92	0.88	0.07	1.87	XXX	N
93738	26	A	Analyze cardio/defibrillator	0.92	0.39	0.03	1.34	XXX	N
93738	TC	A	Analyze cardio/defibrillator	0.00	0.49	0.04	0.53	XXX	N
93740	.....	A	Temperature gradient studies	0.16	0.45	0.04	0.65	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
93740	26	A	Temperature gradient studies	0.16	0.30	0.03	0.49	XXX	N
93740	TC	A	Temperature gradient studies	0.00	0.15	0.01	0.16	XXX	N
93760	.....	N	Cephalic thermogram	0.00	0.00	0.00	0.00	XXX	0
93762	.....	N	Peripheral thermogram	0.00	0.00	0.00	0.00	XXX	0
93770	.....	A	Measure venous pressure	0.16	0.20	0.02	0.38	XXX	N
93770	26	A	Measure venous pressure	0.16	0.17	0.02	0.35	XXX	N
93770	TC	A	Measure venous pressure	0.00	0.03	0.00	0.03	XXX	N
93784	.....	N	Ambulatory BP monitoring	0.00	0.00	0.00	0.00	XXX	0
93786	.....	N	Ambulatory BP recording	0.00	0.00	0.00	0.00	XXX	0
93788	.....	N	Ambulatory BP analysis	0.00	0.00	0.00	0.00	XXX	0
93790	.....	N	Review/report BP recording	0.00	0.00	0.00	0.00	XXX	0
93797	.....	A	Cardiac rehab	0.18	0.30	0.02	0.50	000	N
93798	.....	A	Cardiac rehab/monitor	0.28	0.47	0.04	0.79	000	N
93799	.....	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	XXX	N
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	XXX	N
93799	TC	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	XXX	N
93875	.....	A	Extracranial study	0.22	*1.36	0.18	1.76	XXX	N
93875	26	A	Extracranial study	0.22	*0.31	0.06	0.59	XXX	N
93875	TC	A	Extracranial study	0.00	1.05	0.12	1.17	XXX	N
93880	.....	A	Extracranial study	0.60	3.94	0.44	4.98	XXX	N
93880	26	A	Extracranial study	0.60	0.39	0.04	1.03	XXX	N
93880	TC	A	Extracranial study	0.00	3.55	0.40	3.95	XXX	N
93882	.....	A	Extracranial study	0.40	2.62	0.29	3.31	XXX	N
93882	26	A	Extracranial study	0.40	0.26	0.03	0.69	XXX	N
93882	TC	A	Extracranial study	0.00	2.36	0.26	2.62	XXX	N
93886	.....	A	Intracranial study	0.94	4.44	0.50	5.88	XXX	N
93886	26	A	Intracranial study	0.94	0.42	0.05	1.41	XXX	N
93886	TC	A	Intracranial study	0.00	4.02	0.45	4.47	XXX	N
93888	.....	A	Intracranial study	0.62	2.96	0.34	3.92	XXX	N
93888	26	A	Intracranial study	0.62	0.28	0.03	0.93	XXX	N
93888	TC	A	Intracranial study	0.00	2.68	0.31	2.99	XXX	N
93922	.....	A	Extremity study	0.25	*1.38	0.19	1.82	XXX	N
93922	26	A	Extremity study	0.25	*0.28	0.05	0.58	XXX	N
93922	TC	A	Extremity study	0.00	1.10	0.14	1.24	XXX	N
93923	.....	A	Extremity study	0.45	*2.59	0.35	3.39	XXX	N
93923	26	A	Extremity study	0.45	*0.51	0.09	1.05	XXX	N
93923	TC	A	Extremity study	0.00	2.08	0.26	2.34	XXX	N
93924	.....	A	Extremity study	0.50	*2.83	0.39	3.72	XXX	N
93924	26	A	Extremity study	0.50	*0.57	0.10	1.17	XXX	N
93924	TC	A	Extremity study	0.00	2.26	0.29	2.55	XXX	N
93925	.....	A	Lower extremity study	0.58	3.96	0.44	4.98	XXX	N
93925	26	A	Lower extremity study	0.58	0.39	0.04	1.01	XXX	N
93925	TC	A	Lower extremity study	0.00	3.57	0.40	3.97	XXX	N
93926	.....	A	Lower extremity study	0.39	2.64	0.30	3.33	XXX	N
93926	26	A	Lower extremity study	0.39	0.26	0.03	0.68	XXX	N
93926	TC	A	Lower extremity study	0.00	2.38	0.27	2.65	XXX	N
93930	.....	A	Upper extremity study	0.46	4.18	0.47	5.11	XXX	N
93930	26	A	Upper extremity study	0.46	0.39	0.05	0.90	XXX	N
93930	TC	A	Upper extremity study	0.00	3.79	0.42	4.21	XXX	N
93931	.....	A	Upper extremity study	0.31	2.78	0.31	3.40	XXX	N
93931	26	A	Upper extremity study	0.31	0.26	0.03	0.60	XXX	N
93931	TC	A	Upper extremity study	0.00	2.52	0.28	2.80	XXX	N
93965	.....	A	Extremity study	0.35	*1.49	0.19	2.03	XXX	N
93965	26	A	Extremity study	0.35	*0.45	0.06	0.86	XXX	N
93965	TC	A	Extremity study	0.00	1.04	0.13	1.17	XXX	N
93970	.....	A	Extremity study	0.68	4.33	0.51	5.52	XXX	N
93970	26	A	Extremity study	0.68	0.40	0.05	1.13	XXX	N
93970	TC	A	Extremity study	0.00	3.93	0.46	4.39	XXX	N
93971	.....	A	Extremity study	0.45	2.89	0.34	3.68	XXX	N
93971	26	A	Extremity study	0.45	0.27	0.03	0.75	XXX	N
93971	TC	A	Extremity study	0.00	2.62	0.31	2.93	XXX	N
93975	.....	A	Vascular study	1.80	4.90	0.55	7.25	XXX	N
93975	26	A	Vascular study	1.80	0.42	0.05	2.27	XXX	N
93975	TC	A	Vascular study	0.00	4.48	0.50	4.98	XXX	N
93976	.....	A	Vascular study	1.21	3.27	0.37	4.85	XXX	N
93976	26	A	Vascular study	1.21	0.28	0.03	1.52	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
93976	TC	A	Vascular study	0.00	2.99	0.34	3.33	XXX	N
93978	.....	A	Vascular study	0.65	4.06	0.47	5.18	XXX	N
93978	26	A	Vascular study	0.65	0.39	0.05	1.09	XXX	N
93978	TC	A	Vascular study	0.00	3.67	0.42	4.09	XXX	N
93979	.....	A	Vascular study	0.44	2.70	0.31	3.45	XXX	N
93979	26	A	Vascular study	0.44	0.26	0.03	0.73	XXX	N
93979	TC	A	Vascular study	0.00	2.44	0.28	2.72	XXX	N
93980	.....	A	Penile vascular study	1.82	4.15	0.45	6.42	XXX	N
93980	26	A	Penile vascular study	1.82	0.82	0.07	2.71	XXX	N
93980	TC	A	Penile vascular study	0.00	3.33	0.38	3.71	XXX	N
93981	.....	A	Penile vascular study	0.64	3.47	0.39	4.50	XXX	N
93981	26	A	Penile vascular study	0.64	0.40	0.03	1.07	XXX	N
93981	TC	A	Penile vascular study	0.00	3.07	0.36	3.43	XXX	N
93990	.....	A	Doppler flow testing	0.25	2.57	0.29	3.11	XXX	N
93990	26	A	Doppler flow testing	0.25	0.19	0.02	0.46	XXX	N
93990	TC	A	Doppler flow testing	0.00	2.38	0.27	2.65	XXX	N
94010	.....	A	Breathing capacity test	0.17	0.68	0.05	0.90	XXX	N
94010	26	A	Breathing capacity test	0.17	0.28	0.02	0.47	XXX	N
94010	TC	A	Breathing capacity test	0.00	0.40	0.03	0.43	XXX	N
94060	.....	A	Evaluation of wheezing	0.31	1.27	0.09	1.67	XXX	N
94060	26	A	Evaluation of wheezing	0.31	0.38	0.03	0.72	XXX	N
94060	TC	A	Evaluation of wheezing	0.00	0.89	0.06	0.95	XXX	N
94070	.....	A	Evaluation of wheezing	0.60	1.77	0.13	2.50	XXX	N
94070	26	A	Evaluation of wheezing	0.60	0.38	0.03	1.01	XXX	N
94070	TC	A	Evaluation of wheezing	0.00	1.39	0.10	1.49	XXX	N
94150	.....	A	Vital capacity test	0.11	0.20	0.02	0.33	XXX	N
94150	26	A	Vital capacity test	0.11	0.12	0.01	0.24	XXX	N
94150	TC	A	Vital capacity test	0.00	0.08	0.01	0.09	XXX	N
94160	.....	A	Vital capacity screening	0.18	0.37	0.02	0.57	XXX	N
94160	26	A	Vital capacity screening	0.18	0.19	0.01	0.38	XXX	N
94160	TC	A	Vital capacity screening	0.00	0.18	0.01	0.19	XXX	N
94200	.....	A	Lung function test (MBC/MVV)	0.11	*0.38	0.03	0.52	XXX	N
94200	26	A	Lung function test (MBC/MVV)	0.11	*0.14	0.01	0.26	XXX	N
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.24	0.02	0.26	XXX	N
94240	.....	A	Residual lung capacity	0.26	0.88	0.07	1.21	XXX	N
94240	26	A	Residual lung capacity	0.26	0.23	0.02	0.51	XXX	N
94240	TC	A	Residual lung capacity	0.00	0.65	0.05	0.70	XXX	N
94250	.....	A	Expired gas collection	0.11	*0.27	0.02	0.40	XXX	N
94250	26	A	Expired gas collection	0.11	*0.14	0.01	0.26	XXX	N
94250	TC	A	Expired gas collection	0.00	0.13	0.01	0.14	XXX	N
94260	.....	A	Thoracic gas volume	0.13	*0.69	0.06	0.88	XXX	N
94260	26	A	Thoracic gas volume	0.13	*0.17	0.02	0.32	XXX	N
94260	TC	A	Thoracic gas volume	0.00	0.52	0.04	0.56	XXX	N
94350	.....	A	Lung nitrogen washout curve	0.26	0.73	0.05	1.04	XXX	N
94350	26	A	Lung nitrogen washout curve	0.26	0.21	0.01	0.48	XXX	N
94350	TC	A	Lung nitrogen washout curve	0.00	0.52	0.04	0.56	XXX	N
94360	.....	A	Measure airflow resistance	0.26	1.11	0.07	1.44	XXX	N
94360	26	A	Measure airflow resistance	0.26	0.19	0.01	0.46	XXX	N
94360	TC	A	Measure airflow resistance	0.00	0.92	0.06	0.98	XXX	N
94370	.....	A	Breath airway closing volume	0.26	0.40	0.03	0.69	XXX	N
94370	26	A	Breath airway closing volume	0.26	0.14	0.01	0.41	XXX	N
94370	TC	A	Breath airway closing volume	0.00	0.26	0.02	0.28	XXX	N
94375	.....	A	Respiratory flow volume loop	0.31	0.67	0.04	1.02	XXX	N
94375	26	A	Respiratory flow volume loop	0.31	0.21	0.01	0.53	XXX	N
94375	TC	A	Respiratory flow volume loop	0.00	0.46	0.03	0.49	XXX	N
94400	.....	A	CO2 breathing response curve	0.40	0.77	0.19	1.36	XXX	N
94400	26	A	CO2 breathing response curve	0.40	0.47	0.13	1.00	XXX	N
94400	TC	A	CO2 breathing response curve	0.00	0.30	0.06	0.36	XXX	N
94450	.....	A	Hypoxia response curve	0.40	0.61	0.05	1.06	XXX	N
94450	26	A	Hypoxia response curve	0.40	0.24	0.02	0.66	XXX	N
94450	TC	A	Hypoxia response curve	0.00	0.37	0.03	0.40	XXX	N
94620	.....	A	Pulmonary stress testing	0.88	2.05	0.15	3.08	XXX	N
94620	26	A	Pulmonary stress testing	0.88	0.70	0.05	1.63	XXX	N
94620	TC	A	Pulmonary stress testing	0.00	1.35	0.10	1.45	XXX	N
94640	.....	A	Airway inhalation treatment	0.00	0.39	0.03	0.42	XXX	N
94642	.....	C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
94650	.....	A	Pressure breathing (IPPB)	0.00	0.37	0.03	0.40	XXX	N
94651	.....	A	Pressure breathing (IPPB)	0.00	0.36	0.03	0.39	XXX	N
94652	.....	A	Pressure breathing (IPPB)	0.00	0.41	0.08	0.49	XXX	N
94656	.....	A	Initial ventilator mgmt	1.22	1.13	0.12	2.47	XXX	N
94657	.....	A	Cont. ventilator	0.83	0.62	0.05	1.50	XXX	N
94660	.....	A	Pos airway pressure, CPAP	0.76	0.71	0.06	1.53	XXX	N
94662	.....	A	Neg pressure ventilation, cnp	0.76	0.30	0.02	1.08	XXX	N
94664	.....	A	Aerosol or vapor inhalations	0.00	0.50	0.04	0.54	XXX	N
94665	.....	A	Aerosol or vapor inhalations	0.00	0.46	0.05	0.51	XXX	N
94667	.....	A	Chest wall manipulation	0.00	0.55	0.05	0.60	XXX	N
94668	.....	A	Chest wall manipulation	0.00	0.34	0.03	0.37	XXX	N
94680	.....	A	Exhaled air analysis: O2	0.26	0.82	0.10	1.18	XXX	N
94680	26	A	Exhaled air analysis: O2	0.26	0.33	0.03	0.62	XXX	N
94680	TC	A	Exhaled air analysis: O2	0.00	0.49	0.07	0.56	XXX	N
94681	.....	A	Exhaled air analysis: O2, CO2	0.20	*1.58	0.17	1.95	XXX	N
94681	26	A	Exhaled air analysis: O2, CO2	0.20	*0.26	0.04	0.50	XXX	N
94681	TC	A	Exhaled air analysis: O2, CO2	0.00	1.32	0.13	1.45	XXX	N
94690	.....	A	Exhaled air analysis	0.07	0.56	0.04	0.67	XXX	N
94690	26	A	Exhaled air analysis	0.07	0.05	0.00	0.12	XXX	N
94690	TC	A	Exhaled air analysis	0.00	0.51	0.04	0.55	XXX	N
94720	.....	A	Monoxide diffusing capacity	0.26	1.03	0.08	1.37	XXX	N
94720	26	A	Monoxide diffusing capacity	0.26	0.23	0.02	0.51	XXX	N
94720	TC	A	Monoxide diffusing capacity	0.00	0.80	0.06	0.86	XXX	N
94725	.....	A	Membrane diffusion capacity	0.26	1.84	0.14	2.24	XXX	N
94725	26	A	Membrane diffusion capacity	0.26	0.18	0.01	0.45	XXX	N
94725	TC	A	Membrane diffusion capacity	0.00	1.66	0.13	1.79	XXX	N
94750	.....	A	Pulmonary compliance study	0.23	0.83	0.06	1.12	XXX	N
94750	26	A	Pulmonary compliance study	0.23	0.28	0.02	0.53	XXX	N
94750	TC	A	Pulmonary compliance study	0.00	0.55	0.04	0.59	XXX	N
94760	.....	A	Measure blood oxygen level	0.00	0.25	0.02	0.27	XXX	N
94761	.....	A	Measure blood oxygen level	0.00	0.64	0.06	0.70	XXX	N
94762	.....	A	Measure blood oxygen level	0.00	1.08	0.10	1.18	XXX	N
94770	.....	A	Exhaled carbon dioxide test	0.20	0.40	0.11	0.71	XXX	N
94770	26	A	Exhaled carbon dioxide test	0.20	0.11	0.03	0.34	XXX	N
94770	TC	A	Exhaled carbon dioxide test	0.00	0.29	0.08	0.37	XXX	N
94772	.....	C	Breath recording, infant	0.00	0.00	0.00	0.00	XXX	N
94772	26	C	Breath recording, infant	0.00	0.00	0.00	0.00	XXX	N
94772	TC	C	Breath recording, infant	0.00	0.00	0.00	0.00	XXX	N
94799	.....	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	XXX	N
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	XXX	N
94799	TC	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	XXX	N
95004	.....	A	Allergy skin tests	0.00	0.09	0.01	0.10	XXX	N
95010	.....	A	Sensitivity skin tests	0.15	0.11	0.01	0.27	XXX	N
95015	.....	A	Sensitivity skin tests	0.15	0.11	0.01	0.27	XXX	N
95024	.....	A	Allergy skin tests	0.00	0.14	0.01	0.15	XXX	N
95027	.....	A	Skin end point titration	0.00	0.14	0.01	0.15	XXX	N
95028	.....	A	Allergy skin tests	0.00	0.22	0.01	0.23	XXX	N
95044	.....	A	Allergy patch tests	0.00	0.19	0.01	0.20	XXX	N
95052	.....	A	Photo patch test	0.00	0.24	0.01	0.25	XXX	N
95056	.....	A	Photosensitivity tests	0.00	0.17	0.01	0.18	XXX	N
95060	.....	A	Eye allergy tests	0.00	0.33	0.02	0.35	XXX	N
95065	.....	A	Nose allergy test	0.00	0.19	0.01	0.20	XXX	N
95070	.....	A	Bronchial allergy tests	0.00	2.17	0.02	2.19	XXX	N
95071	.....	A	Bronchial allergy tests	0.00	2.78	0.02	2.80	XXX	N
95075	.....	A	Ingestion challenge test	0.95	1.97	0.02	2.94	XXX	N
95078	.....	A	Provocative testing	0.00	0.24	0.02	0.26	XXX	N
95115	.....	A	Immunotherapy, one injection	0.00	0.37	0.02	0.39	000	N
95117	.....	A	Immunotherapy injections	0.00	0.48	0.02	0.50	000	N
95120	.....	G	Immunotherapy, one injection	0.00	0.00	0.00	0.00	XXX	0
95125	.....	G	Immunotherapy, many antigens	0.00	0.00	0.00	0.00	XXX	0
95130	.....	G	Immunotherapy, insect venom	0.00	0.00	0.00	0.00	XXX	0
95131	.....	G	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX	0
95132	.....	G	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX	0
95133	.....	G	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX	0
95134	.....	G	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX	0
95144	.....	A	Antigen therapy services	0.06	0.13	0.01	0.20	000	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
95145	.....	A	Antigen therapy services	0.06	0.34	0.03	0.43	000	N
95146	.....	A	Antigen therapy services	0.06	0.61	0.03	0.70	000	N
95147	.....	A	Antigen therapy services	0.06	0.91	0.03	1.00	000	N
95148	.....	A	Antigen therapy services	0.06	0.91	0.03	1.00	000	N
95149	.....	A	Antigen therapy services	0.06	1.14	0.03	1.23	000	N
95165	.....	A	Antigen therapy services	0.06	0.10	0.01	0.17	000	N
95170	.....	A	Antigen therapy services	0.06	0.35	0.03	0.44	000	N
95180	.....	A	Rapid desensitization	2.01	0.14	0.01	2.16	000	N
95199	.....	C	Allergy immunology services	0.00	0.00	0.00	0.00	000	N
95805	.....	A	Multiple sleep latency test	1.88	5.51	0.45	7.84	XXX	N
95805	26	A	Multiple sleep latency test	1.88	0.56	0.07	2.51	XXX	N
95805	TC	A	Multiple sleep latency test	0.00	4.95	0.38	5.33	XXX	N
95807	.....	A	Sleep study	1.66	8.75	0.67	11.08	XXX	N
95807	26	A	Sleep study	1.66	2.45	0.19	4.30	XXX	N
95807	TC	A	Sleep study	0.00	6.30	0.48	6.78	XXX	N
95808	.....	A	Polysomnography, 1–3	2.65	8.75	0.67	12.07	XXX	N
95808	26	A	Polysomnography, 1–3	2.65	2.45	0.19	5.29	XXX	N
95808	TC	A	Polysomnography, 1–3	0.00	6.30	0.48	6.78	XXX	N
95810	.....	A	Polysomnography, 4 or more	3.53	8.75	0.67	12.95	XXX	N
95810	26	A	Polysomnography, 4 or more	3.53	2.45	0.19	6.17	XXX	N
95810	TC	A	Polysomnography, 4 or more	0.00	6.30	0.48	6.78	XXX	N
95812	.....	A	Electroencephalogram (EEG)	1.08	1.85	0.15	3.08	XXX	N
95812	26	A	Electroencephalogram (EEG)	1.08	0.50	0.04	1.62	XXX	N
95812	TC	A	Electroencephalogram (EEG)	0.00	1.35	0.11	1.46	XXX	N
95813	.....	A	Electroencephalogram (EEG)	1.73	1.85	0.15	3.73	XXX	N
95813	26	A	Electroencephalogram (EEG)	1.73	0.50	0.04	2.27	XXX	N
95813	TC	A	Electroencephalogram (EEG)	0.00	1.35	0.11	1.46	XXX	N
95816	.....	A	Electroencephalogram (EEG)	1.08	1.54	0.13	2.75	XXX	N
95816	26	A	Electroencephalogram (EEG)	1.08	0.28	0.03	1.39	XXX	N
95816	TC	A	Electroencephalogram (EEG)	0.00	1.26	0.10	1.36	XXX	N
95819	.....	A	Electroencephalogram (EEG)	1.08	1.80	0.14	3.02	XXX	N
95819	26	A	Electroencephalogram (EEG)	1.08	0.50	0.04	1.62	XXX	N
95819	TC	A	Electroencephalogram (EEG)	0.00	1.30	0.10	1.40	XXX	N
95822	.....	A	Sleep electroencephalogram	1.08	2.28	0.18	3.54	XXX	N
95822	26	A	Sleep electroencephalogram	1.08	0.56	0.04	1.68	XXX	N
95822	TC	A	Sleep electroencephalogram	0.00	1.72	0.14	1.86	XXX	N
95824	.....	A	Electroencephalography	0.74	0.98	0.07	1.79	XXX	N
95824	26	A	Electroencephalography	0.74	0.58	0.04	1.36	XXX	N
95824	TC	A	Electroencephalography	0.00	0.40	0.03	0.43	XXX	N
95827	.....	A	Night electroencephalogram	1.08	3.06	0.24	4.38	XXX	N
95827	26	A	Night electroencephalogram	1.08	0.88	0.07	2.03	XXX	N
95827	TC	A	Night electroencephalogram	0.00	2.18	0.17	2.35	XXX	N
95829	.....	A	Surgery electrocorticogram	6.21	0.59	0.05	6.85	XXX	N
95829	26	A	Surgery electrocorticogram	6.21	0.45	0.03	6.69	XXX	N
95829	TC	A	Surgery electrocorticogram	0.00	0.14	0.02	0.16	XXX	N
95830	.....	A	Insert electrodes for EEG	1.70	0.78	0.07	2.55	XXX	N
95831	.....	A	Limb muscle testing, manual	0.28	0.29	0.03	0.60	XXX	N
95832	.....	A	Hand muscle testing, manual	0.29	0.25	0.02	0.56	XXX	N
95833	.....	A	Body muscle testing, manual	0.47	0.38	0.05	0.90	XXX	N
95834	.....	A	Body muscle testing, manual	0.60	0.61	0.06	1.27	XXX	N
95851	.....	A	Range of motion measurements	0.28	0.24	0.02	0.54	XXX	N
95852	.....	A	Range of motion measurements	0.19	0.15	0.02	0.36	XXX	N
95857	.....	A	Tensilon test	0.53	0.50	0.04	1.07	XXX	N
95858	.....	A	Tensilon test & myogram	1.56	1.02	0.09	2.67	XXX	N
95858	26	A	Tensilon test & myogram	1.56	0.64	0.05	2.25	XXX	N
95858	TC	A	Tensilon test & myogram	0.00	0.38	0.04	0.42	XXX	N
95860	.....	A	Muscle test, one limb	0.96	1.09	0.09	2.14	XXX	N
95860	26	A	Muscle test, one limb	0.96	0.73	0.06	1.75	XXX	N
95860	TC	A	Muscle test, one limb	0.00	0.36	0.03	0.39	XXX	N
95861	.....	A	Muscle test, two limbs	1.54	1.97	0.16	3.67	XXX	N
95861	26	A	Muscle test, two limbs	1.54	1.27	0.10	2.91	XXX	N
95861	TC	A	Muscle test, two limbs	0.00	0.70	0.06	0.76	XXX	N
95863	.....	A	Muscle test, 3 limbs	1.87	2.30	0.18	4.35	XXX	N
95863	26	A	Muscle test, 3 limbs	1.87	1.41	0.11	3.39	XXX	N
95863	TC	A	Muscle test, 3 limbs	0.00	0.89	0.07	0.96	XXX	N
95864	.....	A	Muscle test, 4 limbs	1.99	3.45	0.27	5.71	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
95864	26	A	Muscle test, 4 limbs	1.99	1.75	0.14	3.88	XXX	N
95864	TC	A	Muscle test, 4 limbs	0.00	1.70	0.13	1.83	XXX	N
95867	.....	A	Muscle test, head or neck	0.62	1.13	0.09	1.84	XXX	N
95867	26	A	Muscle test, head or neck	0.62	0.58	0.05	1.25	XXX	N
95867	TC	A	Muscle test, head or neck	0.00	0.55	0.04	0.59	XXX	N
95868	.....	A	Muscle test, head or neck	1.50	1.92	0.15	3.57	XXX	N
95868	26	A	Muscle test, head or neck	1.50	1.26	0.10	2.86	XXX	N
95868	TC	A	Muscle test, head or neck	0.00	0.66	0.05	0.71	XXX	N
95869	.....	A	Muscle test, limited	0.37	0.53	0.05	0.95	XXX	N
95869	26	A	Muscle test, limited	0.37	0.33	0.03	0.73	XXX	N
95869	TC	A	Muscle test, limited	0.00	0.20	0.02	0.22	XXX	N
95872	.....	A	Muscle test, one fiber	1.50	1.25	0.11	2.86	XXX	N
95872	26	A	Muscle test, one fiber	1.50	0.68	0.06	2.24	XXX	N
95872	TC	A	Muscle test, one fiber	0.00	0.57	0.05	0.62	XXX	N
95875	.....	A	Limb exercise test	1.34	0.60	0.10	2.04	XXX	N
95875	26	A	Limb exercise test	1.34	0.22	0.04	1.60	XXX	N
95875	TC	A	Limb exercise test	0.00	0.38	0.06	0.44	XXX	N
95880	.....	D	Cerebral aphasia testing	0.00	0.00	0.00	0.00	XXX	N
95881	.....	D	Cerebral developmental test	0.00	0.00	0.00	0.00	XXX	N
95882	.....	D	Cognitive function testing	0.00	0.00	0.00	0.00	XXX	N
95883	.....	D	Neuropsychological testing	0.00	0.00	0.00	0.00	XXX	N
95900	.....	A	Motor nerve conduction test	0.42	0.62	0.05	1.09	XXX	N
95900	26	A	Motor nerve conduction test	0.42	0.35	0.03	0.80	XXX	N
95900	TC	A	Motor nerve conduction test	0.00	0.27	0.02	0.29	XXX	N
95903	.....	A	Motor nerve conduction test	0.60	0.59	0.05	1.24	XXX	N
95903	26	A	Motor nerve conduction test	0.60	0.35	0.03	0.98	XXX	N
95903	TC	A	Motor nerve conduction test	0.00	0.24	0.02	0.26	XXX	N
95904	.....	A	Sense nerve conduction test	0.34	0.55	0.05	0.94	XXX	N
95904	26	A	Sense nerve conduction test	0.34	0.34	0.03	0.71	XXX	N
95904	TC	A	Sense nerve conduction test	0.00	0.21	0.02	0.23	XXX	N
95920	.....	A	Intraoperative nerve testing	2.11	2.67	0.20	4.98	XXX	N
95920	26	A	Intraoperative nerve testing	2.11	1.43	0.12	3.66	XXX	N
95920	TC	A	Intraoperative nerve testing	0.00	1.24	0.08	1.32	XXX	N
95925	.....	A	Somatosensory testing	0.54	1.51	0.12	2.17	XXX	N
95925	26	A	Somatosensory testing	0.54	0.64	0.05	1.23	XXX	N
95925	TC	A	Somatosensory testing	0.00	0.87	0.07	0.94	XXX	N
95926	.....	A	Somatosensory testing	0.54	1.51	0.12	2.17	XXX	N
95926	26	A	Somatosensory testing	0.54	0.64	0.05	1.23	XXX	N
95926	TC	A	Somatosensory testing	0.00	0.87	0.07	0.94	XXX	N
95927	.....	A	Somatosensory testing	0.54	1.51	0.12	2.17	XXX	N
95927	26	A	Somatosensory testing	0.54	0.64	0.05	1.23	XXX	N
95927	TC	A	Somatosensory testing	0.00	0.87	0.07	0.94	XXX	N
95930	.....	A	Visual evoked potential test	0.35	0.83	0.05	1.23	XXX	N
95930	26	A	Visual evoked potential test	0.35	0.58	0.04	0.97	XXX	N
95930	TC	A	Visual evoked potential test	0.00	0.25	0.01	0.26	XXX	N
95933	.....	A	Blink reflex test	0.59	1.25	0.10	1.94	XXX	N
95933	26	A	Blink reflex test	0.59	0.50	0.04	1.13	XXX	N
95933	TC	A	Blink reflex test	0.00	0.75	0.06	0.81	XXX	N
95934	.....	A	'H' reflex test	0.51	0.54	0.05	1.10	XXX	N
95934	26	A	'H' reflex test	0.51	0.34	0.03	0.88	XXX	N
95934	TC	A	'H' reflex test	0.00	0.20	0.02	0.22	XXX	N
95935	.....	D	'H' or 'F' reflex study	0.00	0.00	0.00	0.00	XXX	N
95935	26	D	'H' or 'F' reflex study	0.00	0.00	0.00	0.00	XXX	N
95935	TC	D	'H' or 'F' reflex study	0.00	0.00	0.00	0.00	XXX	N
95936	.....	A	'H' reflex test	0.55	0.54	0.05	1.14	XXX	N
95936	26	A	'H' reflex test	0.55	0.34	0.03	0.92	XXX	N
95936	TC	A	'H' reflex test	0.00	0.20	0.02	0.22	XXX	N
95937	.....	A	Neuromuscular junction test	0.60	0.77	0.07	1.44	XXX	N
95937	26	A	Neuromuscular junction test	0.60	0.45	0.04	1.09	XXX	N
95937	TC	A	Neuromuscular junction test	0.00	0.32	0.03	0.35	XXX	N
95950	.....	A	Ambulatory eeg monitoring	1.51	7.25	0.60	9.36	XXX	N
95950	26	A	Ambulatory eeg monitoring	1.51	1.21	0.10	2.82	XXX	N
95950	TC	A	Ambulatory eeg monitoring	0.00	6.04	0.50	6.54	XXX	N
95951	.....	A	EEG monitoring/videorecord	3.80	8.83	0.64	13.27	XXX	N
95951	26	A	EEG monitoring/videorecord	3.80	1.50	0.11	5.41	XXX	N
95951	TC	A	EEG monitoring/videorecord	0.00	7.33	0.53	7.86	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110—D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
95953	.....	A	EEG monitoring/computer	3.08	7.25	0.60	10.93	XXX	N
95953	26	A	EEG monitoring/computer	3.08	1.21	0.10	4.39	XXX	N
95953	TC	A	EEG monitoring/computer	0.00	6.04	0.50	6.54	XXX	N
95954	.....	A	EEG monitoring/giving drugs	2.45	2.32	0.28	5.05	XXX	N
95954	26	A	EEG monitoring/giving drugs	2.45	1.87	0.22	4.54	XXX	N
95954	TC	A	EEG monitoring/giving drugs	0.00	0.45	0.06	0.51	XXX	N
95955	.....	A	EEG during surgery	1.01	2.90	0.30	4.21	XXX	N
95955	26	A	EEG during surgery	1.01	1.03	0.11	2.15	XXX	N
95955	TC	A	EEG during surgery	0.00	1.87	0.19	2.06	XXX	N
95956	.....	A	EEG monitoring/cable/radio	3.08	7.54	0.61	11.23	XXX	N
95956	26	A	EEG monitoring/cable/radio	3.08	1.50	0.11	4.69	XXX	N
95956	TC	A	EEG monitoring/cable/radio	0.00	6.04	0.50	6.54	XXX	N
95957	.....	A	EEG digital analysis	1.98	2.25	0.18	4.41	XXX	N
95957	26	A	EEG digital analysis	1.98	0.63	0.05	2.66	XXX	N
95957	TC	A	EEG digital analysis	0.00	1.62	0.13	1.75	XXX	N
95958	.....	A	EEG monitoring/function test	4.25	4.89	0.52	9.66	XXX	N
95958	26	A	EEG monitoring/function test	4.25	3.23	0.38	7.86	XXX	N
95958	TC	A	EEG monitoring/function test	0.00	1.66	0.14	1.80	XXX	N
95961	.....	A	Electrode stimulation, brain	2.97	2.67	0.20	5.84	XXX	N
95961	26	A	Electrode stimulation, brain	2.97	1.43	0.12	4.52	XXX	N
95961	TC	A	Electrode stimulation, brain	0.00	1.24	0.08	1.32	XXX	N
95962	.....	A	Electrode stimulation, brain	3.21	2.67	0.20	6.08	XXX	N
95962	26	A	Electrode stimulation, brain	3.21	1.43	0.12	4.76	XXX	N
95962	TC	A	Electrode stimulation, brain	0.00	1.24	0.08	1.32	XXX	N
95999	.....	C	Neurological procedure	0.00	0.00	0.00	0.00	XXX	N
96100	.....	A	Psychological testing	0.00	1.68	0.20	1.88	XXX	N
96105	.....	A	Assessment of aphasia	0.00	1.68	0.20	1.88	XXX	N
96110	.....	C	Developmental test, lim	0.00	0.00	0.00	0.00	XXX	N
96111	.....	A	Developmental test, extend	0.00	1.68	0.20	1.88	XXX	N
96115	.....	A	Neurobehavior status exam	0.00	1.68	0.20	1.88	XXX	N
96117	.....	A	Neuropsych test battery	0.00	1.68	0.20	1.88	XXX	N
96400	.....	A	Chemotherapy, (SC)/(IM)	0.00	0.13	0.01	0.14	XXX	N
96405	.....	A	Intralesional chemo admin	0.52	0.38	0.03	0.93	000	S
96406	.....	A	Intralesional chemo admin	0.80	0.56	0.04	1.40	000	S
96408	.....	A	Chemotherapy, push technique	0.00	0.92	0.06	0.98	XXX	N
96410	.....	A	Chemotherapy, infusion method	0.00	1.47	0.09	1.56	XXX	N
96412	.....	A	Chemotherapy, infusion method	0.00	1.10	0.08	1.18	XXX	N
96414	.....	A	Chemotherapy, infusion method	0.00	1.27	0.09	1.36	XXX	N
96420	.....	A	Chemotherapy, push technique	0.00	1.19	0.09	1.28	XXX	N
96422	.....	A	Chemotherapy, infusion method	0.00	1.17	0.09	1.26	XXX	N
96423	.....	A	Chemotherapy, infusion method	0.00	0.46	0.03	0.49	XXX	N
96425	.....	A	Chemotherapy, infusion method	0.00	1.36	0.09	1.45	XXX	N
96440	.....	A	Chemotherapy, intracavitary	2.37	0.81	0.06	3.24	000	N
96445	.....	A	Chemotherapy, intracavitary	2.20	0.98	0.09	3.27	000	N
96450	.....	A	Chemotherapy, into CNS	1.89	0.87	0.06	2.82	000	N
96520	.....	A	Pump refilling, maintenance	0.00	0.85	0.06	0.91	XXX	N
96530	.....	A	Pump refilling, maintenance	0.00	1.01	0.07	1.08	XXX	N
96542	.....	A	Chemotherapy injection	1.42	1.09	0.13	2.64	XXX	N
96545	.....	B	Provide chemotherapy agent	0.00	0.00	0.00	0.00	XXX	O
96549	.....	C	Chemotherapy, unspecified	0.00	0.00	0.00	0.00	XXX	N
96900	.....	A	Ultraviolet light therapy	0.00	0.38	0.03	0.41	XXX	N
96910	.....	A	Photochemotherapy with UV-B	0.00	0.55	0.04	0.59	XXX	N
96912	.....	A	Photochemotherapy with UV-A	0.00	0.63	0.05	0.68	XXX	N
96913	.....	A	Photochemotherapy, UV-A or B	0.00	1.29	0.10	1.39	XXX	N
96999	.....	C	Dermatological procedure	0.00	0.00	0.00	0.00	XXX	N
97010	.....	A	Hot or cold packs therapy	0.11	0.21	0.02	0.34	XXX	N
97012	.....	A	Mechanical traction therapy	0.25	0.19	0.02	0.46	XXX	N
97014	.....	A	Electric stimulation therapy	0.18	0.20	0.02	0.40	XXX	N
97016	.....	A	Vasopneumatic device therapy	0.18	0.25	0.02	0.45	XXX	N
97018	.....	A	Paraffin bath therapy	0.11	0.24	0.03	0.38	XXX	N
97020	.....	A	Microwave therapy	0.11	0.20	0.02	0.33	XXX	N
97022	.....	A	Whirlpool therapy	0.25	0.19	0.02	0.46	XXX	N
97024	.....	A	Diathermy treatment	0.11	0.21	0.02	0.34	XXX	N
97026	.....	A	Infrared therapy	0.11	0.19	0.02	0.32	XXX	N
97028	.....	A	Ultraviolet therapy	0.20	0.19	0.01	0.40	XXX	N
97032	.....	A	Electrical stimulation	0.25	0.14	0.01	0.40	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
97033		A	Electric current therapy	0.26	0.14	0.02	0.42	XXX	N
97034		A	Contrast bath therapy	0.21	0.10	0.01	0.32	XXX	N
97035		A	Ultrasound therapy	0.21	0.11	0.01	0.33	XXX	N
97036		A	Hydrotherapy	0.38	0.21	0.02	0.61	XXX	N
97039		A	Physical therapy treatment	0.29	0.24	0.03	0.56	XXX	N
97110		A	Therapeutic exercises	0.45	0.13	0.02	0.60	XXX	N
97112		A	Neuromuscular reeducation	0.45	0.13	0.01	0.59	XXX	N
97113		A	Aquatic therapy/exercises	0.44	0.20	0.02	0.66	XXX	N
97116		A	Gait training therapy	0.40	0.11	0.01	0.52	XXX	N
97122		A	Manual traction therapy	0.45	0.11	0.01	0.57	XXX	N
97124		A	Massage therapy	0.35	0.11	0.01	0.47	XXX	N
97139		A	Physical medicine procedure	0.21	0.16	0.02	0.39	XXX	N
97150		A	Group therapeutic procedures	0.27	0.20	0.02	0.49	XXX	N
97250		A	Myofascial release	0.45	0.35	0.04	0.84	000	N
97260		A	Regional manipulation	0.19	0.20	0.02	0.41	000	N
97261		A	Supplemental manipulations	0.12	0.11	0.01	0.24	000	N
97265		A	Joint mobilization	0.45	0.35	0.04	0.84	XXX	N
97500		A	Orthotics training	0.31	0.27	0.04	0.62	XXX	N
97501		A	Supplemental training	0.17	0.15	0.02	0.34	XXX	N
97520		A	Prosthetic training	0.37	0.30	0.04	0.71	XXX	N
97521		A	Supplemental training	0.22	0.17	0.02	0.41	XXX	N
97530		A	Therapeutic activities	0.44	0.17	0.02	0.63	XXX	N
97535		A	Self care mngment training	0.33	0.17	0.02	0.52	XXX	N
97537		A	Community/work reintegration	0.33	0.17	0.02	0.52	XXX	N
97540		D	Training for daily living	0.00	0.00	0.00	0.00	XXX	N
97541		D	Supplemental training	0.00	0.00	0.00	0.00	XXX	N
97542		A	Wheelchair mngement training	0.25	0.17	0.02	0.44	XXX	N
97545		R	Work hardening	0.00	0.00	0.00	0.00	XXX	N
97546		R	Work hardening	0.00	0.00	0.00	0.00	XXX	N
97700		D	Training checkout	0.00	0.00	0.00	0.00	XXX	N
97701		D	Supplemental checkout	0.00	0.00	0.00	0.00	XXX	N
97703		A	Prosthetic checkout	0.25	0.18	0.03	0.46	XXX	N
97750		A	Physical performance test	0.45	0.24	0.03	0.72	XXX	N
97770		A	Cognitive skills development	0.44	0.28	0.03	0.75	XXX	N
97799		C	Physical medicine procedure	0.00	0.00	0.00	0.00	XXX	N
98925		A	Osteopathic manipulation	0.45	0.25	0.02	0.72	000	N
98926		A	Osteopathic manipulation	0.65	0.40	0.03	1.08	000	N
98927		A	Osteopathic manipulation	0.87	0.38	0.03	1.28	000	N
98928		A	Osteopathic manipulation	1.03	0.42	0.04	1.49	000	N
98929		A	Osteopathic manipulation	1.19	0.39	0.03	1.61	000	N
99000		B	Specimen handling	0.00	0.00	0.00	0.00	XXX	0
99001		B	Specimen handling	0.00	0.00	0.00	0.00	XXX	0
99002		B	Device handling	0.00	0.00	0.00	0.00	XXX	0
99024		B	Post-op follow-up visit	0.00	0.00	0.00	0.00	XXX	0
99025		B	Initial surgical evaluation	0.00	0.00	0.00	0.00	XXX	0
99050		B	Medical services after hrs	0.00	0.00	0.00	0.00	XXX	0
99052		B	Medical services at night	0.00	0.00	0.00	0.00	XXX	0
99054		B	Medical services, unusual hrs	0.00	0.00	0.00	0.00	XXX	0
99056		B	Non-office medical services	0.00	0.00	0.00	0.00	XXX	0
99058		B	Office emergency care	0.00	0.00	0.00	0.00	XXX	0
99070		B	Special supplies	0.00	0.00	0.00	0.00	XXX	0
99071		B	Patient education materials	0.00	0.00	0.00	0.00	XXX	0
99075		N	Medical testimony	0.00	0.00	0.00	0.00	XXX	0
99078		B	Group health education	0.00	0.00	0.00	0.00	XXX	0
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	XXX	0
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	XXX	N
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	XXX	0
99100		B	Special anesthesia service	0.00	0.00	0.00	0.00	XXX	0
99116		B	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	XXX	0
99135		B	Special anesthesia procedure	0.00	0.00	0.00	0.00	XXX	0
99140		B	Emergency anesthesia	0.00	0.00	0.00	0.00	XXX	0
99175		A	Induction of vomiting	0.00	1.33	0.10	1.43	XXX	N
99178		D	Development evaluation tests	0.00	0.00	0.00	0.00	XXX	N
99183		A	Hyperbaric oxygen therapy	2.34	1.67	0.11	4.12	XXX	N
99185		A	Regional hypothermia	0.00	0.61	0.04	0.65	XXX	N
99186		A	Total body hypothermia	0.00	1.70	0.52	2.22	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
99190		X	Special pump services	0.00	0.00	0.00	0.00	XXX	0
99191		X	Special pump services	0.00	0.00	0.00	0.00	XXX	0
99192		X	Special pump services	0.00	0.00	0.00	0.00	XXX	0
99195		A	Phlebotomy	0.00	0.42	0.03	0.45	XXX	N
99199		C	Special service or report	0.00	0.00	0.00	0.00	XXX	N
99201		A	Office/outpatient visit, new	0.38	0.37	0.04	0.79	XXX	P
99202		A	Office/outpatient visit, new	0.75	0.45	0.05	1.25	XXX	P
99203		A	Office/outpatient visit, new	1.14	0.52	0.06	1.72	XXX	P
99204		A	Office/outpatient visit, new	1.71	0.78	0.08	2.57	XXX	P
99205		A	Office/outpatient visit, new	2.28	0.85	0.09	3.22	XXX	P
99211		A	Office/outpatient visit, est	0.17	0.19	0.02	0.38	XXX	P
99212		A	Office/outpatient visit, est	0.38	0.28	0.02	0.68	XXX	P
99213		A	Office/outpatient visit, est	0.55	0.38	0.03	0.96	XXX	P
99214		A	Office/outpatient visit, est	0.94	0.50	0.04	1.48	XXX	P
99215		A	Office/outpatient visit, est	1.51	0.76	0.07	2.34	XXX	P
99217		A	Observation care discharge	1.09	0.52	0.04	1.65	XXX	N
99218		A	Observation care	1.08	0.68	0.06	1.82	XXX	N
99219		A	Observation care	1.75	1.05	0.09	2.89	XXX	N
99220		A	Observation care	2.41	1.14	0.09	3.64	XXX	N
99221		A	Initial hospital care	1.06	0.67	0.06	1.79	XXX	N
99222		A	Initial hospital care	1.84	1.04	0.09	2.97	XXX	N
99223		A	Initial hospital care	2.57	1.13	0.08	3.78	XXX	N
99231		A	Subsequent hospital care	0.51	0.38	0.03	0.92	XXX	N
99232		A	Subsequent hospital care	0.88	0.45	0.04	1.37	XXX	N
99233		A	Subsequent hospital care	1.25	0.60	0.05	1.90	XXX	N
99238		A	Hospital discharge day	1.06	0.51	0.04	1.61	XXX	N
99239		A	Hospital discharge day	1.75	0.51	0.04	2.30	XXX	N
99241		A	Office consultation	0.54	0.64	0.08	1.26	XXX	N
99242		A	Office consultation	1.11	0.77	0.09	1.97	XXX	N
99243		A	Office consultation	1.47	0.97	0.10	2.54	XXX	N
99244		A	Office consultation	2.23	1.23	0.11	3.57	XXX	N
99245		A	Office consultation	2.96	1.69	0.16	4.81	XXX	N
99251		A	Initial inpatient consult	0.54	0.67	0.08	1.29	XXX	N
99252		A	Initial inpatient consult	1.13	0.76	0.09	1.98	XXX	N
99253		A	Initial inpatient consult	1.56	0.95	0.10	2.61	XXX	N
99254		A	Initial inpatient consult	2.27	1.20	0.11	3.58	XXX	N
99255		A	Initial inpatient consult	3.14	1.57	0.14	4.85	XXX	N
99261		A	Follow-up inpatient consult	0.36	0.33	0.03	0.72	XXX	N
99262		A	Follow-up inpatient consult	0.74	0.46	0.04	1.24	XXX	N
99263		A	Follow-up inpatient consult	1.16	0.67	0.04	1.87	XXX	N
99271		A	Confirmatory consultation	0.45	*0.58	0.07	1.10	XXX	N
99272		A	Confirmatory consultation	0.84	0.71	0.09	1.64	XXX	N
99273		A	Confirmatory consultation	1.19	1.02	0.11	2.32	XXX	N
99274		A	Confirmatory consultation	1.73	1.22	0.11	3.06	XXX	N
99275		A	Confirmatory consultation	2.31	1.74	0.17	4.22	XXX	N
99281		A	Emergency dept visit	0.28	0.28	0.01	0.57	XXX	P
99282		A	Emergency dept visit	0.47	0.38	0.03	0.88	XXX	P
99283		A	Emergency dept visit	1.07	0.49	0.04	1.60	XXX	P
99284		A	Emergency dept visit	1.68	0.70	0.06	2.44	XXX	P
99285		A	Emergency dept visit	2.63	1.13	0.08	3.84	XXX	P
99288		B	Direct advanced life support	0.00	0.00	0.00	0.00	XXX	0
99291		A	Critical care, first hour	3.64	1.43	0.11	5.18	XXX	N
99292		A	Critical care, addl 30 min	1.84	0.63	0.04	2.51	XXX	N
99295		A	Neonatal critical care	16.03	5.08	1.55	22.66	XXX	N
99296		A	Neonatal critical care	7.40	2.46	0.77	10.63	XXX	N
99297		A	Neonatal critical care	3.84	1.23	0.38	5.45	XXX	N
99301		A	Nursing facility care	1.07	0.45	0.03	1.55	XXX	P
99302		A	Nursing facility care	1.67	0.50	0.04	2.21	XXX	P
99303		A	Nursing facility care	2.29	0.95	0.07	3.31	XXX	P
99311		A	Nursing facility care, subseq	0.54	0.34	0.03	0.91	XXX	P
99312		A	Nursing facility care, subseq	0.89	0.41	0.03	1.33	XXX	P
99313		A	Nursing facility care, subseq	1.19	0.46	0.04	1.69	XXX	P
99321		A	Rest home visit, new patient	0.71	0.37	0.03	1.11	XXX	P
99322		A	Rest home visit, new patient	1.01	0.51	0.05	1.57	XXX	P
99323		A	Rest home visit, new patient	1.28	0.73	0.06	2.07	XXX	P
99331		A	Rest home visit, estab pat	0.60	0.28	0.02	0.90	XXX	P

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
99332		A	Rest home visit, estab pat	0.80	0.36	0.03	1.19	XXX	P
99333		A	Rest home visit, estab pat	1.00	0.44	0.02	1.46	XXX	P
99341		A	Home visit, new patient	1.12	0.53	0.05	1.70	XXX	P
99342		A	Home visit, new patient	1.58	0.60	0.05	2.23	XXX	P
99343		A	Home visit, new patient	2.09	0.77	0.06	2.92	XXX	P
99351		A	Home visit, estab patient	0.83	0.45	0.04	1.32	XXX	P
99352		A	Home visit, estab patient	1.12	0.53	0.04	1.69	XXX	P
99353		A	Home visit, estab patient	1.48	0.61	0.05	2.14	XXX	P
99354		A	Prolonged service, office	1.51	0.76	0.07	2.34	XXX	P
99355		A	Prolonged service, office	1.51	0.76	0.07	2.34	XXX	P
99356		A	Prolonged service, inpatient	1.44	0.85	0.08	2.37	XXX	N
99357		A	Prolonged service, inpatient	1.44	0.85	0.08	2.37	XXX	N
99358		B	Prolonged serv, w/o contact	0.00	0.00	0.00	0.00	XXX	0
99359		B	Prolonged serv, w/o contact	0.00	0.00	0.00	0.00	XXX	0
99360		X	Physician standby services	0.00	0.00	0.00	0.00	XXX	0
99361		B	Physician/team conference	0.00	0.00	0.00	0.00	XXX	0
99362		B	Physician/team conference	0.00	0.00	0.00	0.00	XXX	0
99371		B	Physician phone consultation	0.00	0.00	0.00	0.00	XXX	0
99372		B	Physician phone consultation	0.00	0.00	0.00	0.00	XXX	0
99373		B	Physician phone consultation	0.00	0.00	0.00	0.00	XXX	0
99375		A	Care plan oversight/30–60	1.73	0.51	0.04	2.28	XXX	P
99376		B	Care plan oversight/over 60	0.00	0.00	0.00	0.00	XXX	0
99381		N	Preventive visit, new, infant	#1.19	1.23	0.08	2.50	XXX	0
99382		N	Preventive visit, new, age 1–4	#1.36	1.41	0.09	2.86	XXX	0
99383		N	Preventive visit, new, age 5–11	#1.36	1.41	0.09	2.86	XXX	0
99384		N	Preventive visit, new, 12–17	#1.53	1.59	0.10	3.22	XXX	0
99385		N	Preventive visit, new, 18–39	#1.53	1.40	0.09	3.02	XXX	0
99386		N	Preventive visit, new, 40–64	#1.88	1.72	0.10	3.70	XXX	0
99387		N	Preventive visit, new, 65 & over	#2.06	1.88	0.11	4.05	XXX	0
99391		N	Preventive visit, est, infant	#1.02	1.06	0.07	2.15	XXX	0
99392		N	Preventive visit, est, age 1–4	#1.19	1.23	0.08	2.50	XXX	0
99393		N	Preventive visit, est, age 5–11	#1.19	1.23	0.08	2.50	XXX	0
99394		N	Preventive visit, est, 12–17	#1.36	1.41	0.09	2.86	XXX	0
99395		N	Preventive visit, est, 18–39	#1.36	1.25	0.08	2.69	XXX	0
99396		N	Preventive visit, est, 40–64	#1.53	1.40	0.09	3.02	XXX	0
99397		N	Preventive visit, est, 65 & over	#1.71	1.56	0.10	3.37	XXX	0
99401		N	Preventive counseling, indiv	#0.48	0.45	0.03	0.96	XXX	0
99402		N	Preventive counseling, indiv	#0.98	0.89	0.05	1.92	XXX	0
99403		N	Preventive counseling, indiv	#1.46	1.34	0.08	2.88	XXX	0
99404		N	Preventive counseling, indiv	#1.95	1.78	0.11	3.84	XXX	0
99411		N	Preventive counseling, group	#0.15	0.14	0.01	0.30	XXX	0
99412		N	Preventive counseling, group	#0.25	0.23	0.01	0.49	XXX	0
99420		N	Health risk assessment test	0.00	0.00	0.00	0.00	XXX	0
99429		N	Unlisted preventive service	0.00	0.00	0.00	0.00	XXX	0
99431		A	Initial care, normal newborn	1.17	1.21	0.08	2.46	XXX	N
99432		A	Newborn care not in hospital	1.26	1.31	0.08	2.65	XXX	N
99433		A	Normal newborn care, hospital	0.62	0.64	0.04	1.30	XXX	N
99435		A	Hospital NB discharge day	1.50	1.55	0.10	3.15	XXX	P
99440		A	Newborn resuscitation	2.93	3.04	0.19	6.16	XXX	N
99450		N	Life/disability evaluation	0.00	0.00	0.00	0.00	XXX	0
99455		R	Disability examination	0.00	0.00	0.00	0.00	XXX	N
99456		R	Disability examination	0.00	0.00	0.00	0.00	XXX	N
99499		C	Unlisted E/M service	0.00	0.00	0.00	0.00	XXX	N
A0021		G	Outside state ambulance serv	0.00	0.00	0.00	0.00	XXX	0
A0030		X	Air ambulance service	0.00	0.00	0.00	0.00	XXX	0
A0040		X	Helicopter ambulance service	0.00	0.00	0.00	0.00	XXX	0
A0050		X	Water amb service emergency	0.00	0.00	0.00	0.00	XXX	0
A0080		G	Noninterest escort in non er	0.00	0.00	0.00	0.00	XXX	0
A0090		G	Interest escort in non er	0.00	0.00	0.00	0.00	XXX	0
A0100		G	Nonemergency transport taxi	0.00	0.00	0.00	0.00	XXX	0
A0110		G	Nonemergency transport bus	0.00	0.00	0.00	0.00	XXX	0
A0120		G	Noner transport mini-bus	0.00	0.00	0.00	0.00	XXX	0
A0130		G	Noner transport wheelch van	0.00	0.00	0.00	0.00	XXX	0
A0140		G	Nonemergency transport air	0.00	0.00	0.00	0.00	XXX	0
A0160		G	Noner transport case worker	0.00	0.00	0.00	0.00	XXX	0
A0170		G	Noner transport parking fees	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
A0180		G	Noner transport lodgng recip	0.00	0.00	0.00	0.00	XXX	0
A0190		G	Noner transport meals recip	0.00	0.00	0.00	0.00	XXX	0
A0200		G	Noner transport lodgng escrt	0.00	0.00	0.00	0.00	XXX	0
A0210		G	Noner transport meals escort	0.00	0.00	0.00	0.00	XXX	0
A0225		X	Neonatal emergency transport	0.00	0.00	0.00	0.00	XXX	0
A0300		X	Ambulance basic non-emer all	0.00	0.00	0.00	0.00	XXX	0
A0302		X	Ambulance basic emergency all	0.00	0.00	0.00	0.00	XXX	0
A0304		X	Amb adv non-er no serv all	0.00	0.00	0.00	0.00	XXX	0
A0306		X	Amb adv non-er spec serv all	0.00	0.00	0.00	0.00	XXX	0
A0308		X	Amb adv er no spec serv all	0.00	0.00	0.00	0.00	XXX	0
A0310		X	Amb adv er spec serv all	0.00	0.00	0.00	0.00	XXX	0
A0320		X	Amb basic non-er + supplies	0.00	0.00	0.00	0.00	XXX	0
A0322		X	Amb basic emerg + supplies	0.00	0.00	0.00	0.00	XXX	0
A0324		X	Adv non-er serv sep mileage	0.00	0.00	0.00	0.00	XXX	0
A0326		X	Adv non-er no serv sep mile	0.00	0.00	0.00	0.00	XXX	0
A0328		X	Adv er no serv sep mileage	0.00	0.00	0.00	0.00	XXX	0
A0330		X	Adv er spec serv sep mile	0.00	0.00	0.00	0.00	XXX	0
A0340		X	Amb basic non-er + mileage	0.00	0.00	0.00	0.00	XXX	0
A0342		X	Ambul basic emer + mileage	0.00	0.00	0.00	0.00	XXX	0
A0344		X	Amb adv non-er no serv + mile	0.00	0.00	0.00	0.00	XXX	0
A0346		X	Amb adv non-er serv + mile	0.00	0.00	0.00	0.00	XXX	0
A0348		X	Adv emer no spec serv + mile	0.00	0.00	0.00	0.00	XXX	0
A0350		X	Adv emer spec serv + mileage	0.00	0.00	0.00	0.00	XXX	0
A0360		X	Basic non-er sep mile & supp	0.00	0.00	0.00	0.00	XXX	0
A0362		X	Basic emer sep mile & supply	0.00	0.00	0.00	0.00	XXX	0
A0364		X	Adv non-er no serv sep mi&su	0.00	0.00	0.00	0.00	XXX	0
A0366		X	Adv non-er serv sep mil&supp	0.00	0.00	0.00	0.00	XXX	0
A0368		X	Adv er no serv sep mile&supp	0.00	0.00	0.00	0.00	XXX	0
A0370		X	Adv er spec serv sep mi&supp	0.00	0.00	0.00	0.00	XXX	0
A0380		X	Basic life support mileage	0.00	0.00	0.00	0.00	XXX	0
A0382		X	Basic support routine suppl	0.00	0.00	0.00	0.00	XXX	0
A0384		X	Bls defibrillation supplies	0.00	0.00	0.00	0.00	XXX	0
A0390		X	Advanced life support mileag	0.00	0.00	0.00	0.00	XXX	0
A0392		X	Als defibrillation supplies	0.00	0.00	0.00	0.00	XXX	0
A0394		X	Als IV drug therapy supplies	0.00	0.00	0.00	0.00	XXX	0
A0396		X	Als esophageal intub suppl	0.00	0.00	0.00	0.00	XXX	0
A0398		X	Als routine dispoible suppl	0.00	0.00	0.00	0.00	XXX	0
A0420		X	Ambulance waiting 1/2 hr	0.00	0.00	0.00	0.00	XXX	0
A0422		X	Ambulance 02 life sustaining	0.00	0.00	0.00	0.00	XXX	0
A0424		X	Extra ambulance attendant	0.00	0.00	0.00	0.00	XXX	0
A0888		N	Noncovered ambulance mileage	0.00	0.00	0.00	0.00	XXX	0
A0999		X	Unlisted ambulance service	0.00	0.00	0.00	0.00	XXX	0
A2000		A	Chiropractor manip of spine	0.45	0.29	0.01	0.75	XXX	N
A4190		P	Transparent film each	0.00	0.00	0.00	0.00	XXX	0
A4200		P	Gauze pad medicated/non-med	0.00	0.00	0.00	0.00	XXX	0
A4202		P	Elastic gauze roll	0.00	0.00	0.00	0.00	XXX	0
A4203		P	Non-elastic gauze roll	0.00	0.00	0.00	0.00	XXX	0
A4204		P	Absorptive dressing	0.00	0.00	0.00	0.00	XXX	0
A4205		P	Nonabsorptive dressing	0.00	0.00	0.00	0.00	XXX	0
A4206		P	1 CC sterile syringe & needle	0.00	0.00	0.00	0.00	XXX	0
A4207		P	2 CC sterile syringe & needle	0.00	0.00	0.00	0.00	XXX	0
A4208		P	3 CC sterile syringe & needle	0.00	0.00	0.00	0.00	XXX	0
A4209		P	5+ CC sterile syringe & needle	0.00	0.00	0.00	0.00	XXX	0
A4210		N	Nonneedle injection device	0.00	0.00	0.00	0.00	XXX	0
A4211		P	Supp for self-adm injections	0.00	0.00	0.00	0.00	XXX	0
A4212		P	Non coring needle or stylet	0.00	0.00	0.00	0.00	XXX	0
A4213		P	20+ CC syringe only	0.00	0.00	0.00	0.00	XXX	0
A4214		P	30 CC sterile water/saline	0.00	0.00	0.00	0.00	XXX	0
A4215		P	Sterile needle	0.00	0.00	0.00	0.00	XXX	0
A4220		P	Infusion pump refill kit	0.00	0.00	0.00	0.00	XXX	0
A4230		N	Infus insulin pump non needle	0.00	0.00	0.00	0.00	XXX	0
A4231		N	Infusion insulin pump needle	0.00	0.00	0.00	0.00	XXX	0
A4232		N	Syringe w/needle insulin 3cc	0.00	0.00	0.00	0.00	XXX	0
A4244		P	Alcohol or peroxide per pint	0.00	0.00	0.00	0.00	XXX	0
A4245		P	Alcohol wipes per box	0.00	0.00	0.00	0.00	XXX	0
A4246		P	Betadine/phisohex solution	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110—D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
A4247		P	Betadine/iodine swabs/wipes	0.00	0.00	0.00	0.00	XXX	0
A4250		R	Urine reagent strips/tablets	0.00	0.00	0.00	0.00	XXX	N
A4253		P	Blood glucose/reagent strips	0.00	0.00	0.00	0.00	XXX	0
A4254		X	Battery for glucose monitor	0.00	0.00	0.00	0.00	XXX	0
A4256		P	Calibrator solution/chips	0.00	0.00	0.00	0.00	XXX	0
A4258		P	Lancet device each	0.00	0.00	0.00	0.00	XXX	0
A4259		P	Lancets per box	0.00	0.00	0.00	0.00	XXX	0
A4260		N	Levonorgestrel implant	0.00	0.00	0.00	0.00	XXX	0
A4262		B	Temporary tear duct plug	0.00	0.00	0.00	0.00	XXX	0
A4263		A	Permanent tear duct plug	0.00	0.95	0.00	0.95	XXX	N
A4265		P	Paraffin	0.00	0.00	0.00	0.00	XXX	0
A4270		B	Disposable endoscope sheath	0.00	0.00	0.00	0.00	XXX	0
A4300		A	Cath impl vasc access portal	0.00	0.95	0.00	0.95	XXX	N
A4301		P	Implantable access syst perc	0.00	0.00	0.00	0.00	XXX	0
A4305		P	Drug delivery system >=50 ML	0.00	0.00	0.00	0.00	XXX	0
A4306		P	Drug delivery system <=5 ML	0.00	0.00	0.00	0.00	XXX	0
A4310		P	Insert tray w/o bag/cath	0.00	0.00	0.00	0.00	XXX	0
A4311		P	Catheter w/o bag 2-way latex	0.00	0.00	0.00	0.00	XXX	0
A4312		P	Cath w/o bag 2-way silicone	0.00	0.00	0.00	0.00	XXX	0
A4313		P	Catheter w/bag 3-way	0.00	0.00	0.00	0.00	XXX	0
A4314		P	Cath w/drainage 2-way latex	0.00	0.00	0.00	0.00	XXX	0
A4315		P	Cath w/drainage 2-way silcne	0.00	0.00	0.00	0.00	XXX	0
A4316		P	Cath w/drainage 3-way	0.00	0.00	0.00	0.00	XXX	0
A4320		P	Irrigation tray	0.00	0.00	0.00	0.00	XXX	0
A4322		P	Irrigation syringe	0.00	0.00	0.00	0.00	XXX	0
A4323		P	Saline irrigation solution	0.00	0.00	0.00	0.00	XXX	0
A4326		P	Male external catheter	0.00	0.00	0.00	0.00	XXX	0
A4327		P	Fem urinary collect dev cup	0.00	0.00	0.00	0.00	XXX	0
A4328		P	Fem urinary collect pouch	0.00	0.00	0.00	0.00	XXX	0
A4329		P	External catheter start set	0.00	0.00	0.00	0.00	XXX	0
A4330		P	Stool collection pouch	0.00	0.00	0.00	0.00	XXX	0
A4335		P	Incontinence supply	0.00	0.00	0.00	0.00	XXX	0
A4338		P	Indwelling catheter latex	0.00	0.00	0.00	0.00	XXX	0
A4340		P	Indwelling catheter special	0.00	0.00	0.00	0.00	XXX	0
A4344		P	Cath indw foley 2 way silicn	0.00	0.00	0.00	0.00	XXX	0
A4346		P	Cath indw foley 3 way	0.00	0.00	0.00	0.00	XXX	0
A4347		P	Male external catheter	0.00	0.00	0.00	0.00	XXX	0
A4351		P	Straight tip urine catheter	0.00	0.00	0.00	0.00	XXX	0
A4352		P	Coude tip urinary catheter	0.00	0.00	0.00	0.00	XXX	0
A4354		P	Cath insertion tray w/bag	0.00	0.00	0.00	0.00	XXX	0
A4355		P	Bladder irrigation tubing	0.00	0.00	0.00	0.00	XXX	0
A4356		P	Ext ureth clmp or compr dvc	0.00	0.00	0.00	0.00	XXX	0
A4357		P	Bedside drainage bag	0.00	0.00	0.00	0.00	XXX	0
A4358		P	Urinary leg bag	0.00	0.00	0.00	0.00	XXX	0
A4359		P	Urinary suspensory w/o leg bag	0.00	0.00	0.00	0.00	XXX	0
A4361		P	Ostomy face plate	0.00	0.00	0.00	0.00	XXX	0
A4362		P	Solid skin barrier	0.00	0.00	0.00	0.00	XXX	0
A4363		P	Liquid skin barrier	0.00	0.00	0.00	0.00	XXX	0
A4364		P	Ostomy/cath adhesive	0.00	0.00	0.00	0.00	XXX	0
A4367		P	Ostomy belt	0.00	0.00	0.00	0.00	XXX	0
A4397		P	Irrigation supply sleeve	0.00	0.00	0.00	0.00	XXX	0
A4398		P	Irrigation supply bags	0.00	0.00	0.00	0.00	XXX	0
A4399		P	Irrigation supply cone/cathe	0.00	0.00	0.00	0.00	XXX	0
A4400		P	Ostomy irrigation set	0.00	0.00	0.00	0.00	XXX	0
A4402		P	Lubricant per ounce	0.00	0.00	0.00	0.00	XXX	0
A4404		P	Ostomy ring each	0.00	0.00	0.00	0.00	XXX	0
A4421		P	Ostomy supply misc	0.00	0.00	0.00	0.00	XXX	0
A4454		P	Tape all types all sizes	0.00	0.00	0.00	0.00	XXX	0
A4455		P	Adhesive remover per ounce	0.00	0.00	0.00	0.00	XXX	0
A4460		P	Elastic compression bandage	0.00	0.00	0.00	0.00	XXX	0
A4465		P	Non-elastic extremity binder	0.00	0.00	0.00	0.00	XXX	0
A4470		P	Gravlee jet washer	0.00	0.00	0.00	0.00	XXX	0
A4480		P	Vabra aspirator	0.00	0.00	0.00	0.00	XXX	0
A4490		N	Above knee surgical stocking	0.00	0.00	0.00	0.00	XXX	0
A4495		N	Thigh length surg stocking	0.00	0.00	0.00	0.00	XXX	0
A4500		N	Below knee surgical stocking	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
A4510		N	Full length surg stocking	0.00	0.00	0.00	0.00	XXX	0
A4550		A	Surgical trays	0.00	0.95	0.00	0.95	XXX	N
A4554		N	Disposable underpads	0.00	0.00	0.00	0.00	XXX	0
A4556		P	Electrodes	0.00	0.00	0.00	0.00	XXX	0
A4557		P	Lead wires	0.00	0.00	0.00	0.00	XXX	0
A4558		P	Conductive paste or gel	0.00	0.00	0.00	0.00	XXX	0
A4560		X	Pessary	0.00	0.00	0.00	0.00	XXX	0
A4565		X	Slings	0.00	0.00	0.00	0.00	XXX	0
A4570		X	Splint	0.00	0.00	0.00	0.00	XXX	0
A4572		X	Rib belt	0.00	0.00	0.00	0.00	XXX	0
A4575		N	Hyperbaric O2 chamber disps	0.00	0.00	0.00	0.00	XXX	0
A4580		X	Cast supplies (plaster)	0.00	0.00	0.00	0.00	XXX	0
A4581		X	Risser jacket supplies	0.00	0.00	0.00	0.00	XXX	0
A4590		X	Special casting material	0.00	0.00	0.00	0.00	XXX	0
A4595		X	TENS suppl 2 lead per month	0.00	0.00	0.00	0.00	XXX	0
A4610		X	Med supplies for use in DME	0.00	0.00	0.00	0.00	XXX	0
A4611		X	Heavy duty battery	0.00	0.00	0.00	0.00	XXX	0
A4612		X	Battery cables	0.00	0.00	0.00	0.00	XXX	0
A4613		X	Battery charger	0.00	0.00	0.00	0.00	XXX	0
A4615		X	Cannula nasal	0.00	0.00	0.00	0.00	XXX	0
A4616		X	Tubing (oxygen) per foot	0.00	0.00	0.00	0.00	XXX	0
A4617		X	Mouth piece	0.00	0.00	0.00	0.00	XXX	0
A4618		X	Breathing circuits	0.00	0.00	0.00	0.00	XXX	0
A4619		X	Face tent	0.00	0.00	0.00	0.00	XXX	0
A4620		X	Variable concentration mask	0.00	0.00	0.00	0.00	XXX	0
A4621		X	Tracheotomy mask or collar	0.00	0.00	0.00	0.00	XXX	0
A4622		X	Tracheostomy or laryngectomy	0.00	0.00	0.00	0.00	XXX	0
A4623		X	Tracheostomy inner cannula	0.00	0.00	0.00	0.00	XXX	0
A4624		X	Tracheal suction tube	0.00	0.00	0.00	0.00	XXX	0
A4625		X	Trach care kit for new trach	0.00	0.00	0.00	0.00	XXX	0
A4626		X	Tracheostomy cleaning brush	0.00	0.00	0.00	0.00	XXX	0
A4627		X	Spacer bag/reservoir	0.00	0.00	0.00	0.00	XXX	0
A4628		X	Oropharyngeal suction cath	0.00	0.00	0.00	0.00	XXX	0
A4629		X	Tracheostomy care kit	0.00	0.00	0.00	0.00	XXX	0
A4630		X	Repl bat t.e.n.s. own by pt	0.00	0.00	0.00	0.00	XXX	0
A4631		X	Wheelchair battery	0.00	0.00	0.00	0.00	XXX	0
A4635		X	Underarm crutch pad	0.00	0.00	0.00	0.00	XXX	0
A4636		X	Handgrip for cane etc	0.00	0.00	0.00	0.00	XXX	0
A4637		X	Repl tip cane/crutch/walker	0.00	0.00	0.00	0.00	XXX	0
A4640		X	Alternating pressure pad	0.00	0.00	0.00	0.00	XXX	0
A4641		E	Diagnostic imaging agent	0.00	0.00	0.00	0.00	XXX	0
A4642		E	Satumomab pendetide per dose	0.00	0.00	0.00	0.00	XXX	0
A4643		E	High dose contrast MRI	0.00	0.00	0.00	0.00	XXX	0
A4644		E	Contrast 100–199 MGs iodine	0.00	0.00	0.00	0.00	XXX	0
A4645		E	Contrast 200–299 MGs iodine	0.00	0.00	0.00	0.00	XXX	0
A4646		E	Contrast 300–399 MGs iodine	0.00	0.00	0.00	0.00	XXX	0
A4647		B	Supp- paramagnetic contr mat	0.00	0.00	0.00	0.00	XXX	0
A4649		B	Surgical supplies	0.00	0.00	0.00	0.00	XXX	0
A4650		X	Supp esrd centrifuge	0.00	0.00	0.00	0.00	XXX	0
A4655		X	Esrd syringe/needle	0.00	0.00	0.00	0.00	XXX	0
A4660		X	Esrd blood pressure device	0.00	0.00	0.00	0.00	XXX	0
A4663		X	Esrd blood pressure cuff	0.00	0.00	0.00	0.00	XXX	0
A4670		N	Auto blood pressure monitor	0.00	0.00	0.00	0.00	XXX	0
A4680		X	Activated carbon filters	0.00	0.00	0.00	0.00	XXX	0
A4690		X	Dialyzers	0.00	0.00	0.00	0.00	XXX	0
A4700		X	Standard dialysate solution	0.00	0.00	0.00	0.00	XXX	0
A4705		X	Bicarb dialysate solution	0.00	0.00	0.00	0.00	XXX	0
A4712		X	Sterile water	0.00	0.00	0.00	0.00	XXX	0
A4714		X	Treated water for dialysis	0.00	0.00	0.00	0.00	XXX	0
A4730		X	Fistula cannulation set dial	0.00	0.00	0.00	0.00	XXX	0
A4735		X	Local/topical anesthetics	0.00	0.00	0.00	0.00	XXX	0
A4740		X	Esrd shunt accessory	0.00	0.00	0.00	0.00	XXX	0
A4750		X	Arterial or venous tubing	0.00	0.00	0.00	0.00	XXX	0
A4755		X	Arterial and venous tubing	0.00	0.00	0.00	0.00	XXX	0
A4760		X	Standard testing solution	0.00	0.00	0.00	0.00	XXX	0
A4765		X	Dialysate concentrate	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
A4770		X	Blood testing supplies	0.00	0.00	0.00	0.00	XXX	0
A4771		X	Blood clotting time tube	0.00	0.00	0.00	0.00	XXX	0
A4772		X	Dextrostick/glucose strips	0.00	0.00	0.00	0.00	XXX	0
A4773		X	Hemostix	0.00	0.00	0.00	0.00	XXX	0
A4774		X	Ammonia test paper	0.00	0.00	0.00	0.00	XXX	0
A4780		X	Esrd sterilizing agent	0.00	0.00	0.00	0.00	XXX	0
A4790		X	Esrd cleansing agents	0.00	0.00	0.00	0.00	XXX	0
A4800		X	Heparin/antidote dialysis	0.00	0.00	0.00	0.00	XXX	0
A4820		X	Supplies hemodialysis kit	0.00	0.00	0.00	0.00	XXX	0
A4850		X	Rubber tipped hemostats	0.00	0.00	0.00	0.00	XXX	0
A4860		X	Disposable catheter caps	0.00	0.00	0.00	0.00	XXX	0
A4870		X	Plumbing/electrical work	0.00	0.00	0.00	0.00	XXX	0
A4880		X	Water storage tanks	0.00	0.00	0.00	0.00	XXX	0
A4890		N	Contracts/repair/maintenance	0.00	0.00	0.00	0.00	XXX	0
A4900		X	Capd supply kit	0.00	0.00	0.00	0.00	XXX	0
A4901		X	Ccpd supply kit	0.00	0.00	0.00	0.00	XXX	0
A4905		X	Ipdc supply kit	0.00	0.00	0.00	0.00	XXX	0
A4910		X	Esrd nonmedical supplies	0.00	0.00	0.00	0.00	XXX	0
A4912		X	Gomco drain bottle	0.00	0.00	0.00	0.00	XXX	0
A4913		X	Esrd supply	0.00	0.00	0.00	0.00	XXX	0
A4914		X	Preparation kit	0.00	0.00	0.00	0.00	XXX	0
A4918		X	Venous pressure clamp	0.00	0.00	0.00	0.00	XXX	0
A4919		X	Supp dialysis dialyzer holde	0.00	0.00	0.00	0.00	XXX	0
A4920		X	Harvard pressure clamp	0.00	0.00	0.00	0.00	XXX	0
A4921		X	Measuring cylinder	0.00	0.00	0.00	0.00	XXX	0
A4927		X	Gloves	0.00	0.00	0.00	0.00	XXX	0
A5051		P	Pouch clsd w barr attached	0.00	0.00	0.00	0.00	XXX	0
A5052		P	Clsd ostomy pouch w/o barr	0.00	0.00	0.00	0.00	XXX	0
A5053		P	Clsd ostomy pouch faceplate	0.00	0.00	0.00	0.00	XXX	0
A5054		P	Clsd ostomy pouch w/flange	0.00	0.00	0.00	0.00	XXX	0
A5055		P	Stoma cap	0.00	0.00	0.00	0.00	XXX	0
A5061		P	Pouch drainable w barrier at	0.00	0.00	0.00	0.00	XXX	0
A5062		P	Drnble ostomy pouch w/o barr	0.00	0.00	0.00	0.00	XXX	0
A5063		P	Drain ostomy pouch w/flange	0.00	0.00	0.00	0.00	XXX	0
A5064		P	Drain ostomy pouch w/fceplte	0.00	0.00	0.00	0.00	XXX	0
A5065		P	Drain ostomy pouch on fceplte	0.00	0.00	0.00	0.00	XXX	0
A5071		P	Urinary pouch w/barrier	0.00	0.00	0.00	0.00	XXX	0
A5072		P	Urinary pouch w/o barrier	0.00	0.00	0.00	0.00	XXX	0
A5073		P	Urinary pouch on barr w/flng	0.00	0.00	0.00	0.00	XXX	0
A5074		P	Urinary pouch w/faceplate	0.00	0.00	0.00	0.00	XXX	0
A5075		P	Urinary pouch on faceplate	0.00	0.00	0.00	0.00	XXX	0
A5081		P	Continent stoma plug	0.00	0.00	0.00	0.00	XXX	0
A5082		P	Continent stoma catheter	0.00	0.00	0.00	0.00	XXX	0
A5093		P	Ostomy accessory convex inse	0.00	0.00	0.00	0.00	XXX	0
A5102		P	Bedside btle rigid/expansible	0.00	0.00	0.00	0.00	XXX	0
A5105		P	Urinary suspensory	0.00	0.00	0.00	0.00	XXX	0
A5112		P	Urinary leg bag	0.00	0.00	0.00	0.00	XXX	0
A5113		P	Latex leg strap	0.00	0.00	0.00	0.00	XXX	0
A5114		P	Foam/fabric leg strap	0.00	0.00	0.00	0.00	XXX	0
A5119		P	Skin barrier wipes box pr 50	0.00	0.00	0.00	0.00	XXX	0
A5121		P	Solid skin barrier 6x6	0.00	0.00	0.00	0.00	XXX	0
A5122		P	Solid skin barrier 8x8	0.00	0.00	0.00	0.00	XXX	0
A5123		P	Skin barrier with flange	0.00	0.00	0.00	0.00	XXX	0
A5126		P	Adhesive disc/foam pad	0.00	0.00	0.00	0.00	XXX	0
A5131		P	Appliance cleaner	0.00	0.00	0.00	0.00	XXX	0
A5149		P	Incontinence/ostomy supply	0.00	0.00	0.00	0.00	XXX	0
A5500		X	Diab shoe for density insert	0.00	0.00	0.00	0.00	XXX	0
A5501		X	Diabetic custom molded shoe	0.00	0.00	0.00	0.00	XXX	0
A5502		X	Diabetic shoe density insert	0.00	0.00	0.00	0.00	XXX	0
A5503		X	Diabetic shoe w/roller/rockr	0.00	0.00	0.00	0.00	XXX	0
A5504		X	Diabetic shoe with wedge	0.00	0.00	0.00	0.00	XXX	0
A5505		X	Diab shoe w/metatarsal bar	0.00	0.00	0.00	0.00	XXX	0
A5506		X	Diabetic shoe w/off set heel	0.00	0.00	0.00	0.00	XXX	0
A5507		X	Modification diabetic shoe	0.00	0.00	0.00	0.00	XXX	0
A6020		P	Collagen dressing cover ea	0.00	0.00	0.00	0.00	XXX	0
A9150		E	Misc/exper non-prescript dru	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110-D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
A9160		N	Podiatrist non-covered servi	0.00	0.00	0.00	0.00	XXX	0
A9170		N	Chiropractor non-covered ser	0.00	0.00	0.00	0.00	XXX	0
A9190		N	Misc/expe personal comfort i	0.00	0.00	0.00	0.00	XXX	0
A9270		N	Non-covered item or service	0.00	0.00	0.00	0.00	XXX	0
A9300		N	Exercise equipment	0.00	0.00	0.00	0.00	XXX	0
A9500		E	Technetium TC 99m sestamibi	0.00	0.00	0.00	0.00	XXX	0
A9505		E	Thallous chloride TL 201/mci	0.00	0.00	0.00	0.00	XXX	0
D0110		D	Initial oral examination	0.00	0.00	0.00	0.00	YYY	N
D0120		N	Periodic oral evaluation	0.00	0.00	0.00	0.00	XXX	0
D0130		D	Emergency oral examination	0.00	0.00	0.00	0.00	YYY	N
D0140		N	Limit oral eval probm focus	0.00	0.00	0.00	0.00	XXX	0
D0150		R	Comprehensve oral evaluation	0.00	0.00	0.00	0.00	YYY	N
D0160		N	Extensv oral eval prob focus	0.00	0.00	0.00	0.00	XXX	0
D0210		G	Intraor complete film series	0.00	0.00	0.00	0.00	XXX	0
D0220		G	Intraoral periapical first f	0.00	0.00	0.00	0.00	XXX	0
D0230		G	Intraoral periapical ea add	0.00	0.00	0.00	0.00	XXX	0
D0240		R	Intraoral occlusal film	0.00	0.00	0.00	0.00	YYY	N
D0250		R	Extraoral first film	0.00	0.00	0.00	0.00	YYY	N
D0260		R	Extraoral ea additional film	0.00	0.00	0.00	0.00	YYY	N
D0270		R	Dental bitewing single film	0.00	0.00	0.00	0.00	YYY	N
D0272		R	Dental bitewings two films	0.00	0.00	0.00	0.00	YYY	N
D0274		R	Dental bitewings four films	0.00	0.00	0.00	0.00	YYY	N
D0290		G	Dental film skull/facial bon	0.00	0.00	0.00	0.00	XXX	0
D0310		G	Dental saligraphy	0.00	0.00	0.00	0.00	XXX	0
D0320		G	Dental tmj arthrogram incl i	0.00	0.00	0.00	0.00	XXX	0
D0321		G	Dental other tmj films	0.00	0.00	0.00	0.00	XXX	0
D0322		G	Dental tomographic survey	0.00	0.00	0.00	0.00	XXX	0
D0330		G	Dental panoramic film	0.00	0.00	0.00	0.00	XXX	0
D0340		G	Dental cephalometric film	0.00	0.00	0.00	0.00	XXX	0
D0415		N	Bacteriologic study	0.00	0.00	0.00	0.00	XXX	0
D0425		N	Caries susceptibility test	0.00	0.00	0.00	0.00	XXX	0
D0460		R	Pulp vitality test	0.00	0.00	0.00	0.00	YYY	N
D0470		N	Diagnostic casts	0.00	0.00	0.00	0.00	XXX	0
D0471		R	Diagnostic photographs	0.00	0.00	0.00	0.00	YYY	N
D0501		R	Histopathologic examinations	0.00	0.00	0.00	0.00	YYY	N
D0502		R	Other oral pathology procedu	0.00	0.00	0.00	0.00	YYY	N
D0999		R	Unspecified diagnostic proce	0.00	0.00	0.00	0.00	YYY	N
D1110		N	Dental prophylaxis adult	0.00	0.00	0.00	0.00	XXX	0
D1120		N	Dental prophylaxis child	0.00	0.00	0.00	0.00	XXX	0
D1201		N	Topical fluor w prophy child	0.00	0.00	0.00	0.00	XXX	0
D1203		N	Topical fluor w/o prophy chi	0.00	0.00	0.00	0.00	XXX	0
D1204		N	Topical fluor w/o prophy adu	0.00	0.00	0.00	0.00	XXX	0
D1205		N	Topical fluoride w/ prophy a	0.00	0.00	0.00	0.00	XXX	0
D1310		N	Nutri counsel-control caries	0.00	0.00	0.00	0.00	XXX	0
D1320		N	Tobacco counseling	0.00	0.00	0.00	0.00	XXX	0
D1330		N	Oral hygiene instruction	0.00	0.00	0.00	0.00	XXX	0
D1351		N	Dental sealant per tooth	0.00	0.00	0.00	0.00	XXX	0
D1510		R	Space maintainer fxd unilat	0.00	0.00	0.00	0.00	YYY	N
D1515		R	Fixed bilat space maintainer	0.00	0.00	0.00	0.00	YYY	N
D1520		R	Remove unilat space maintain	0.00	0.00	0.00	0.00	YYY	N
D1515		R	Fixed bilat space maintainer	0.00	0.00	0.00	0.00	YYY	N
D1520		R	Remove unilat space maintain	0.00	0.00	0.00	0.00	YYY	N
D1525		R	Remove bilat space maintain	0.00	0.00	0.00	0.00	YYY	N
D1550		R	Recement space maintainer	0.00	0.00	0.00	0.00	YYY	N
D2110		N	Amalgam one surface primary	0.00	0.00	0.00	0.00	XXX	0
D2120		N	Amalgam two surfaces primary	0.00	0.00	0.00	0.00	XXX	0
D2130		N	Amalgam three surfaces prima	0.00	0.00	0.00	0.00	XXX	0
D2131		N	Amalgam four/more surf prima	0.00	0.00	0.00	0.00	XXX	0
D2140		N	Amalgam one surface permanen	0.00	0.00	0.00	0.00	XXX	0
D2150		N	Amalgam two surfaces permane	0.00	0.00	0.00	0.00	XXX	0
D2160		N	Amalgam three surfaces perma	0.00	0.00	0.00	0.00	XXX	0
D2161		N	Amalgam 4 or > surfaces perm	0.00	0.00	0.00	0.00	XXX	0
D2210		N	Silcate cement per restorat	0.00	0.00	0.00	0.00	XXX	0
D2330		N	Resin one surface-anterior	0.00	0.00	0.00	0.00	XXX	0
D2331		N	Resin two surfaces-anterior	0.00	0.00	0.00	0.00	XXX	0
D2332		N	Resin three surfaces-anterio	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
D2335		N	Resin 4/> surf or w incis an	0.00	0.00	0.00	0.00	XXX	0
D2336		N	Composite resin crown	0.00	0.00	0.00	0.00	XXX	0
D2380		N	Resin one surf poster primar	0.00	0.00	0.00	0.00	XXX	0
D2381		N	Resin two surf poster primar	0.00	0.00	0.00	0.00	XXX	0
D2382		N	Resin three/more surf post p	0.00	0.00	0.00	0.00	XXX	0
D2385		N	Resin one surf poster perman	0.00	0.00	0.00	0.00	XXX	0
D2386		N	Resin two surf poster perman	0.00	0.00	0.00	0.00	XXX	0
D2387		N	Resin three/more surf post p	0.00	0.00	0.00	0.00	XXX	0
D2410		N	Dental gold foil one surface	0.00	0.00	0.00	0.00	XXX	0
D2420		N	Dental gold foil two surface	0.00	0.00	0.00	0.00	XXX	0
D2430		N	Dental gold foil three surfa	0.00	0.00	0.00	0.00	XXX	0
D2510		N	Dental inlay metallic 1 surf	0.00	0.00	0.00	0.00	XXX	0
D2520		N	Dental inlay metallic 2 surf	0.00	0.00	0.00	0.00	XXX	0
D2530		N	Dental inlay metl 3/more sur	0.00	0.00	0.00	0.00	XXX	0
D2540		D	Dental onlay metallic	0.00	0.00	0.00	0.00	YYY	N
D2543		N	Dental onlay metallic 3 surf	0.00	0.00	0.00	0.00	XXX	0
D2544		N	Dental onlay metl 4/more sur	0.00	0.00	0.00	0.00	XXX	0
D2610		N	Inlay porcelain/ceramic 1 su	0.00	0.00	0.00	0.00	XXX	0
D2620		N	Inlay porcelain/ceramic 2 su	0.00	0.00	0.00	0.00	XXX	0
D2630		N	Dental onlay porc 3/more sur	0.00	0.00	0.00	0.00	XXX	0
D2640		D	Onlay w inlay porcelain/cera	0.00	0.00	0.00	0.00	YYY	N
D2642		N	Dental onlay porcelin 2 surf	0.00	0.00	0.00	0.00	XXX	0
D2643		N	Dental onlay porcelin 3 surf	0.00	0.00	0.00	0.00	XXX	0
D2644		N	Dental onlay porc 4/more sur	0.00	0.00	0.00	0.00	XXX	0
D2650		N	Inlay composite/resin one su	0.00	0.00	0.00	0.00	XXX	0
D2651		N	Inlay composite/resin two su	0.00	0.00	0.00	0.00	XXX	0
D2652		N	Dental inlay resin 3/mre sur	0.00	0.00	0.00	0.00	XXX	0
D2660		D	Onlay w inlay composite/resi	0.00	0.00	0.00	0.00	YYY	N
D2662		N	Dental onlay resin 2 surface	0.00	0.00	0.00	0.00	XXX	0
D2663		N	Dental onlay resin 3 surface	0.00	0.00	0.00	0.00	XXX	0
D2664		N	Dental onlay resin 4/mre sur	0.00	0.00	0.00	0.00	XXX	0
D2710		N	Crown resin laboratory	0.00	0.00	0.00	0.00	XXX	0
D2720		N	Crown resin w/ high noble me	0.00	0.00	0.00	0.00	XXX	0
D2721		N	Crown resin w/ base metal	0.00	0.00	0.00	0.00	XXX	0
D2722		N	Crown resin w/ noble metal	0.00	0.00	0.00	0.00	XXX	0
D2740		N	Crown porcelain/ceramic subs	0.00	0.00	0.00	0.00	XXX	0
D2750		N	Crown porcelain w/ h noble m	0.00	0.00	0.00	0.00	XXX	0
D2751		N	Crown porcelain fused base m	0.00	0.00	0.00	0.00	XXX	0
D2752		N	Crown porcelain w/ noble met	0.00	0.00	0.00	0.00	XXX	0
D2790		N	Crown full cast high noble m	0.00	0.00	0.00	0.00	XXX	0
D2791		N	Crown full cast base metal	0.00	0.00	0.00	0.00	XXX	0
D2792		N	Crown full cast noble metal	0.00	0.00	0.00	0.00	XXX	0
D2810		N	Crown 3/4 cast metallic	0.00	0.00	0.00	0.00	XXX	0
D2910		N	Dental recement inlay	0.00	0.00	0.00	0.00	XXX	0
D2920		N	Dental recement crown	0.00	0.00	0.00	0.00	XXX	0
D2930		N	Prefab stnlss steel crwn pri	0.00	0.00	0.00	0.00	XXX	0
D2931		N	Prefab stnlss steel crown pe	0.00	0.00	0.00	0.00	XXX	0
D2932		N	Prefabricated resin crown	0.00	0.00	0.00	0.00	XXX	0
D2933		N	Prefab stainless steel crown	0.00	0.00	0.00	0.00	XXX	0
D2940		N	Dental sedative filling	0.00	0.00	0.00	0.00	XXX	0
D2950		N	Core build-up incl any pins	0.00	0.00	0.00	0.00	XXX	0
D2951		N	Tooth pin retention	0.00	0.00	0.00	0.00	XXX	0
D2952		N	Post and core cast + crown	0.00	0.00	0.00	0.00	XXX	0
D2954		N	Prefab post/core + crown	0.00	0.00	0.00	0.00	XXX	0
D2955		N	Post removal	0.00	0.00	0.00	0.00	XXX	0
D2960		N	Laminate labial veneer	0.00	0.00	0.00	0.00	XXX	0
D2961		N	Lab labial veneer resin	0.00	0.00	0.00	0.00	XXX	0
D2962		N	Lab labial veneer porcelain	0.00	0.00	0.00	0.00	XXX	0
D2970		R	Temporary- fractured tooth	0.00	0.00	0.00	0.00	YYY	N
D2980		N	Crown repair	0.00	0.00	0.00	0.00	XXX	0
D2999		R	Dental unspec restorative pr	0.00	0.00	0.00	0.00	YYY	N
D3110		N	Pulp cap direct	0.00	0.00	0.00	0.00	XXX	0
D3120		N	Pulp cap indirect	0.00	0.00	0.00	0.00	XXX	0
D3220		N	Therapeutic pulpotomy	0.00	0.00	0.00	0.00	XXX	0
D3230		N	Pulpal therapy anterior prim	0.00	0.00	0.00	0.00	XXX	0
D3240		N	Pulpal therapy posterior pri	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
D3310		N	Anterior	0.00	0.00	0.00	0.00	XXX	0
D3320		N	Root canal therapy 2 canals	0.00	0.00	0.00	0.00	XXX	0
D3330		N	Root canal therapy 3 canals	0.00	0.00	0.00	0.00	XXX	0
D3346		N	Retreat root canal anterior	0.00	0.00	0.00	0.00	XXX	0
D3347		N	Retreat root canal bicuspid	0.00	0.00	0.00	0.00	XXX	0
D3348		N	Retreat root canal molar	0.00	0.00	0.00	0.00	XXX	0
D3351		N	Apexification/recalc initial	0.00	0.00	0.00	0.00	XXX	0
D3352		N	Apexification/recalc interim	0.00	0.00	0.00	0.00	XXX	0
D3353		N	Apexification/recalc final	0.00	0.00	0.00	0.00	XXX	0
D3410		N	Apicoect/perirad surg anter	0.00	0.00	0.00	0.00	XXX	0
D3421		N	Root surgery bicuspid	0.00	0.00	0.00	0.00	XXX	0
D3425		N	Root surgery molar	0.00	0.00	0.00	0.00	XXX	0
D3426		N	Root surgery ea add root	0.00	0.00	0.00	0.00	XXX	0
D3430		N	Retrograde filling	0.00	0.00	0.00	0.00	XXX	0
D3450		N	Root amputation	0.00	0.00	0.00	0.00	XXX	0
D3460		R	Endodontic endosseous implan	0.00	0.00	0.00	0.00	YYY	N
D3470		N	Intentional replantation	0.00	0.00	0.00	0.00	XXX	0
D3910		N	Isolation- tooth w rubb dam	0.00	0.00	0.00	0.00	XXX	0
D3920		N	Tooth splitting	0.00	0.00	0.00	0.00	XXX	0
D3950		N	Canal prep/fitting of dowel	0.00	0.00	0.00	0.00	XXX	0
D3960		N	Bleaching of discolored toot	0.00	0.00	0.00	0.00	XXX	0
D3999		R	Endodontic procedure	0.00	0.00	0.00	0.00	YYY	N
D4210		G	Gingivectomy/plasty per quad	0.00	0.00	0.00	0.00	XXX	0
D4211		G	Gingivectomy/plasty per toot	0.00	0.00	0.00	0.00	XXX	0
D4220		N	Gingival curettage per quadr	0.00	0.00	0.00	0.00	XXX	0
D4240		N	Gingival flap proc w/ planin	0.00	0.00	0.00	0.00	XXX	0
D4249		N	Crown lengthen hard tissue	0.00	0.00	0.00	0.00	XXX	0
D4250		R	Mucogingival surg per quadra	0.00	0.00	0.00	0.00	YYY	N
D4260		R	Osseous surgery per quadrant	0.00	0.00	0.00	0.00	YYY	S
D4261		D	Bone replace graft single si	0.00	0.00	0.00	0.00	YYY	S
D4262		D	Bone replace graft mult site	0.00	0.00	0.00	0.00	YYY	N
D4263		R	Bone replce graft first site	0.00	0.00	0.00	0.00	YYY	N
D4264		R	Bone replce graft each add	0.00	0.00	0.00	0.00	YYY	N
D4266		N	Guided tiss regen resorb	0.00	0.00	0.00	0.00	XXX	0
D4267		N	Guided tiss regen nonresorb	0.00	0.00	0.00	0.00	XXX	0
D4268		D	Guided tissue regeneration	0.00	0.00	0.00	0.00	YYY	N
D4270		R	Pedicle soft tissue graft pr	0.00	0.00	0.00	0.00	YYY	S
D4271		R	Free soft tissue graft proc	0.00	0.00	0.00	0.00	YYY	S
D4273		R	Subepithelial tissue graft	0.00	0.00	0.00	0.00	YYY	N
D4274		N	Distal/proximal wedge proc	0.00	0.00	0.00	0.00	XXX	0
D4320		N	Provision splnt intracoronal	0.00	0.00	0.00	0.00	XXX	0
D4321		N	Provisional splint extracoro	0.00	0.00	0.00	0.00	XXX	0
D4341		N	Periodontal scaling & root	0.00	0.00	0.00	0.00	XXX	0
D4345		D	Periodontal scaling w/inflam	0.00	0.00	0.00	0.00	YYY	N
D4355		R	Full mouth debridement	0.00	0.00	0.00	0.00	YYY	N
D4381		R	Localized chemo delivery	0.00	0.00	0.00	0.00	YYY	N
D4910		N	Periodontal maint procedures	0.00	0.00	0.00	0.00	XXX	0
D4920		N	Unscheduled dressing change	0.00	0.00	0.00	0.00	XXX	0
D4999		N	Unspecified periodontal proc	0.00	0.00	0.00	0.00	XXX	0
D5110		N	Dentures complete maxillary	0.00	0.00	0.00	0.00	XXX	0
D5120		N	Dentures complete mandible	0.00	0.00	0.00	0.00	XXX	0
D5130		N	Dentures immediat maxillary	0.00	0.00	0.00	0.00	XXX	0
D5140		N	Dentures immediat mandible	0.00	0.00	0.00	0.00	XXX	0
D5211		N	Dentures maxill part resin	0.00	0.00	0.00	0.00	XXX	0
D5212		N	Dentures mand part resin	0.00	0.00	0.00	0.00	XXX	0
D5213		N	Dentures maxill part metal	0.00	0.00	0.00	0.00	XXX	0
D5214		N	Dentures mandibl part metal	0.00	0.00	0.00	0.00	XXX	0
D5281		N	Removable partial denture	0.00	0.00	0.00	0.00	XXX	0
D5410		N	Dentures adjust cmplt maxil	0.00	0.00	0.00	0.00	XXX	0
D5411		N	Dentures adjust cmplt mand	0.00	0.00	0.00	0.00	XXX	0
D5421		N	Dentures adjust part maxill	0.00	0.00	0.00	0.00	XXX	0
D5422		N	Dentures adjust part mandbl	0.00	0.00	0.00	0.00	XXX	0
D5510		N	Dentur repr broken compl bas	0.00	0.00	0.00	0.00	XXX	0
D5520		N	Replace denture teeth complt	0.00	0.00	0.00	0.00	XXX	0
D5610		N	Dentures repair resin base	0.00	0.00	0.00	0.00	XXX	0
D5620		N	Rep part denture cast frame	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
D5630		N	Rep partial denture clasp	0.00	0.00	0.00	0.00	XXX	0
D5640		N	Replace part denture teeth	0.00	0.00	0.00	0.00	XXX	0
D5650		N	Add tooth to partial denture	0.00	0.00	0.00	0.00	XXX	0
D5660		N	Add clasp to partial denture	0.00	0.00	0.00	0.00	XXX	0
D5710		N	Dentures rebase cmplt maxil	0.00	0.00	0.00	0.00	XXX	0
D5711		N	Dentures rebase cmplt mand	0.00	0.00	0.00	0.00	XXX	0
D5720		N	Dentures rebase part maxill	0.00	0.00	0.00	0.00	XXX	0
D5721		N	Dentures rebase part mandbl	0.00	0.00	0.00	0.00	XXX	0
D5730		N	Denture reln cmplt maxil ch	0.00	0.00	0.00	0.00	XXX	0
D5731		N	Denture reln cmplt mand chr	0.00	0.00	0.00	0.00	XXX	0
D5740		N	Denture reln part maxil lab	0.00	0.00	0.00	0.00	XXX	0
D5741		N	Denture reln part mand chr	0.00	0.00	0.00	0.00	XXX	0
D5750		N	Denture reln cmplt max lab	0.00	0.00	0.00	0.00	XXX	0
D5751		N	Denture reln cmplt mand lab	0.00	0.00	0.00	0.00	XXX	0
D5760		N	Denture reln part maxil lab	0.00	0.00	0.00	0.00	XXX	0
D5761		N	Denture reln part mand lab	0.00	0.00	0.00	0.00	XXX	0
D5810		N	Denture interm cmplt maxill	0.00	0.00	0.00	0.00	XXX	0
D5811		N	Denture interm cmplt mandbl	0.00	0.00	0.00	0.00	XXX	0
D5820		N	Denture interm part maxill	0.00	0.00	0.00	0.00	XXX	0
D5821		N	Denture interm part mandbl	0.00	0.00	0.00	0.00	XXX	0
D5850		N	Denture tiss conditn maxill	0.00	0.00	0.00	0.00	XXX	0
D5851		N	Denture tiss conditn mandbl	0.00	0.00	0.00	0.00	XXX	0
D5860		N	Overdenture complete	0.00	0.00	0.00	0.00	XXX	0
D5861		N	Overdenture partial	0.00	0.00	0.00	0.00	XXX	0
D5862		N	Precision attachment	0.00	0.00	0.00	0.00	XXX	0
D5899		N	Removable prosthodontic proc	0.00	0.00	0.00	0.00	XXX	0
D5911		R	Facial moulage sectional	0.00	0.00	0.00	0.00	YYY	N
D5912		R	Facial moulage complete	0.00	0.00	0.00	0.00	YYY	N
D5913		G	Nasal prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5914		G	Auricular prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5915		G	Orbital prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5916		G	Ocular prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5919		G	Facial prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5922		G	Nasal septal prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5923		G	Ocular prosthesis interim	0.00	0.00	0.00	0.00	XXX	0
D5924		G	Cranial prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5925		G	Facial augmentation implant	0.00	0.00	0.00	0.00	XXX	0
D5926		G	Replacement nasal prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5927		G	Auricular replacement	0.00	0.00	0.00	0.00	XXX	0
D5928		G	Orbital replacement	0.00	0.00	0.00	0.00	XXX	0
D5929		G	Facial replacement	0.00	0.00	0.00	0.00	XXX	0
D5931		G	Surgical obturator	0.00	0.00	0.00	0.00	XXX	0
D5932		G	Postsurgical obturator	0.00	0.00	0.00	0.00	XXX	0
D5933		G	Refitting of obturator	0.00	0.00	0.00	0.00	XXX	0
D5934		G	Mandibular flange prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5935		G	Mandibular denture prosth	0.00	0.00	0.00	0.00	XXX	0
D5936		G	Temp obturator prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5937		G	Trismus appliance	0.00	0.00	0.00	0.00	XXX	0
D5951		R	Feeding aid	0.00	0.00	0.00	0.00	YYY	N
D5952		G	Pediatric speech aid	0.00	0.00	0.00	0.00	XXX	0
D5953		G	Adult speech aid	0.00	0.00	0.00	0.00	XXX	0
D5954		G	Superimposed prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5955		G	Palatal lift prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5958		G	Intraoral con def inter plt	0.00	0.00	0.00	0.00	XXX	0
D5959		G	Intraoral con def mod palat	0.00	0.00	0.00	0.00	XXX	0
D5960		G	Modify speech aid prosthesis	0.00	0.00	0.00	0.00	XXX	0
D5982		G	Surgical stent	0.00	0.00	0.00	0.00	XXX	0
D5983		R	Radiation applicator	0.00	0.00	0.00	0.00	YYY	N
D5984		R	Radiation shield	0.00	0.00	0.00	0.00	YYY	N
D5985		R	Radiation cone locator	0.00	0.00	0.00	0.00	YYY	N
D5986		N	Fluoride applicator	0.00	0.00	0.00	0.00	XXX	0
D5987		R	Commissure splint	0.00	0.00	0.00	0.00	YYY	N
D5988		R	Surgical splint	0.00	0.00	0.00	0.00	YYY	N
D5999		G	Maxillofacial prosthesis	0.00	0.00	0.00	0.00	XXX	0
D6010		G	Odontics endosteal implant	0.00	0.00	0.00	0.00	XXX	0
D6020		G	Odontics abutment placement	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
D6030		D	Prosthodont endosseous impl	0.00	0.00	0.00	0.00	YYY	N
D6040		G	Odontics epostea implant	0.00	0.00	0.00	0.00	XXX	0
D6050		G	Odontics transosteal implnt	0.00	0.00	0.00	0.00	XXX	0
D6055		G	Implant connecting bar	0.00	0.00	0.00	0.00	XXX	0
D6080		G	Implant maintenance	0.00	0.00	0.00	0.00	XXX	0
D6090		G	Repair implant	0.00	0.00	0.00	0.00	XXX	0
D6095		G	Odontics repr abutment	0.00	0.00	0.00	0.00	XXX	0
D6100		G	Removal of implant	0.00	0.00	0.00	0.00	XXX	0
D6199		G	Implant procedure	0.00	0.00	0.00	0.00	XXX	0
D6210		N	Prosthodont high noble metal	0.00	0.00	0.00	0.00	XXX	0
D6211		N	Bridge base metal cast	0.00	0.00	0.00	0.00	XXX	0
D6212		N	Bridge noble metal cast	0.00	0.00	0.00	0.00	XXX	0
D6240		N	Bridge porcelain high noble	0.00	0.00	0.00	0.00	XXX	0
D6241		N	Bridge porcelain base metal	0.00	0.00	0.00	0.00	XXX	0
D6242		N	Bridge porcelain nobel metal	0.00	0.00	0.00	0.00	XXX	0
D6250		N	Bridge resin w/high noble	0.00	0.00	0.00	0.00	XXX	0
D6251		N	Bridge resin base metal	0.00	0.00	0.00	0.00	XXX	0
D6252		N	Bridge resin w/noble metal	0.00	0.00	0.00	0.00	XXX	0
D6520		N	Dental retainer two surfaces	0.00	0.00	0.00	0.00	XXX	0
D6530		N	Retainer metallic 3+ surface	0.00	0.00	0.00	0.00	XXX	0
D6540		D	Retainer metallic cusps	0.00	0.00	0.00	0.00	YYY	N
D6543		N	Dental retainr onlay 3 surf	0.00	0.00	0.00	0.00	XXX	0
D6544		N	Dental retainr onlay 4/more	0.00	0.00	0.00	0.00	XXX	0
D6545		N	Dental retainr cast metl	0.00	0.00	0.00	0.00	XXX	0
D6720		N	Retain crown resin w hi noble	0.00	0.00	0.00	0.00	XXX	0
D6721		N	Crown resin w/base metal	0.00	0.00	0.00	0.00	XXX	0
D6722		N	Crown resin w/noble metal	0.00	0.00	0.00	0.00	XXX	0
D6750		N	Crown porcelain high noble	0.00	0.00	0.00	0.00	XXX	0
D6751		N	Crown porcelain base metal	0.00	0.00	0.00	0.00	XXX	0
D6752		N	Crown porcelain noble metal	0.00	0.00	0.00	0.00	XXX	0
D6780		N	Crown 3/4 high noble metal	0.00	0.00	0.00	0.00	XXX	0
D6790		N	Crown full high noble metal	0.00	0.00	0.00	0.00	XXX	0
D6791		N	Crown full base metal cast	0.00	0.00	0.00	0.00	XXX	0
D6792		N	Crown full noble metal cast	0.00	0.00	0.00	0.00	XXX	0
D6920		R	Dental connector bar	0.00	0.00	0.00	0.00	YYY	N
D6930		N	Dental recement bridge	0.00	0.00	0.00	0.00	XXX	0
D6940		N	Stress breaker	0.00	0.00	0.00	0.00	XXX	0
D6950		N	Precision attachment	0.00	0.00	0.00	0.00	XXX	0
D6970		N	Post & core plus retainer	0.00	0.00	0.00	0.00	XXX	0
D6971		N	Cast post bridge retainer	0.00	0.00	0.00	0.00	XXX	0
D6972		N	Prefab post & core plus reta	0.00	0.00	0.00	0.00	XXX	0
D6973		N	Core build up for retainer	0.00	0.00	0.00	0.00	XXX	0
D6975		N	Coping metal	0.00	0.00	0.00	0.00	XXX	0
D6980		N	Bridge repair	0.00	0.00	0.00	0.00	XXX	0
D6999		N	Fixed prosthodontic proc	0.00	0.00	0.00	0.00	XXX	0
D7110		R	Oral surgery single tooth	0.00	0.00	0.00	0.00	YYY	S
D7120		R	Each add tooth extraction	0.00	0.00	0.00	0.00	YYY	S
D7130		R	Tooth root removal	0.00	0.00	0.00	0.00	YYY	S
D7210		R	Rem imp tooth w mucoper flip	0.00	0.00	0.00	0.00	YYY	S
D7220		R	Impact tooth remov soft tiss	0.00	0.00	0.00	0.00	YYY	S
D7230		R	Impact tooth remov part bony	0.00	0.00	0.00	0.00	YYY	S
D7240		R	Impact tooth remov comp bony	0.00	0.00	0.00	0.00	YYY	S
D7241		R	Impact tooth rem bony w/comp	0.00	0.00	0.00	0.00	YYY	S
D7250		R	Tooth root removal	0.00	0.00	0.00	0.00	YYY	S
D7260		R	Oral antral fistula closure	0.00	0.00	0.00	0.00	YYY	S
D7270		N	Tooth reimplantation	0.00	0.00	0.00	0.00	XXX	0
D7271		D	Tooth implantation	0.00	0.00	0.00	0.00	YYY	N
D7272		N	Tooth transplantation	0.00	0.00	0.00	0.00	XXX	0
D7280		N	Exposure impact tooth orthod	0.00	0.00	0.00	0.00	XXX	0
D7281		N	Exposure tooth aid eruption	0.00	0.00	0.00	0.00	XXX	0
D7285		G	Biopsy of oral tissue hard	0.00	0.00	0.00	0.00	XXX	0
D7286		G	Biopsy of oral tissue soft	0.00	0.00	0.00	0.00	XXX	0
D7290		N	Repositioning of teeth	0.00	0.00	0.00	0.00	XXX	0
D7291		R	Transseptal fiberotomy	0.00	0.00	0.00	0.00	YYY	N
D7310		G	Alveoplasty w/ extraction	0.00	0.00	0.00	0.00	XXX	0
D7320		G	Alveoplasty w/o extraction	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
D7340		G	Vestibuloplasty ridge extens	0.00	0.00	0.00	0.00	XXX	0
D7350		G	Vestibuloplasty exten graft	0.00	0.00	0.00	0.00	XXX	0
D7410		G	Rad exc lesion up to 1.25 cm	0.00	0.00	0.00	0.00	XXX	0
D7420		G	Lesion > 1.25 cm	0.00	0.00	0.00	0.00	XXX	0
D7430		G	Exc benign tumor to 1.25 cm	0.00	0.00	0.00	0.00	XXX	0
D7431		G	Benign tumor exc > 1.25 cm	0.00	0.00	0.00	0.00	XXX	0
D7440		G	Malig tumor exc to 1.25 cm	0.00	0.00	0.00	0.00	XXX	0
D7441		G	Malig tumor > 1.25 cm	0.00	0.00	0.00	0.00	XXX	0
D7450		G	Rem odontogen cyst to 1.25cm	0.00	0.00	0.00	0.00	XXX	0
D7451		G	Rem odontogen cyst > 1.25 cm	0.00	0.00	0.00	0.00	XXX	0
D7460		G	Rem nonodonto cyst to 1.25cm	0.00	0.00	0.00	0.00	XXX	0
D7461		G	Rem nonodonto cyst > 1.25 cm	0.00	0.00	0.00	0.00	XXX	0
D7465		G	Lesion destruction	0.00	0.00	0.00	0.00	XXX	0
D7470		G	Rem exostosis maxilla/mandib	0.00	0.00	0.00	0.00	XXX	0
D7480		G	Partial osteotomy	0.00	0.00	0.00	0.00	XXX	0
D7490		G	Mandible resection	0.00	0.00	0.00	0.00	XXX	0
D7510		G	I&d abscc intraoral soft tiss	0.00	0.00	0.00	0.00	XXX	0
D7520		G	I&d abscess extraoral	0.00	0.00	0.00	0.00	XXX	0
D7530		G	Removal fb skin/areolar tiss	0.00	0.00	0.00	0.00	XXX	0
D7540		G	Removal of fb reaction	0.00	0.00	0.00	0.00	XXX	0
D7550		G	Removal of sloughed off bone	0.00	0.00	0.00	0.00	XXX	0
D7560		G	Maxillary sinusotomy	0.00	0.00	0.00	0.00	XXX	0
D7610		G	Maxilla open reduct simple	0.00	0.00	0.00	0.00	XXX	0
D7620		G	Clsd reduct simpl maxilla fx	0.00	0.00	0.00	0.00	XXX	0
D7630		G	Open red simpl mandible fx	0.00	0.00	0.00	0.00	XXX	0
D7640		G	Clsd red simpl mandible fx	0.00	0.00	0.00	0.00	XXX	0
D7650		G	Open red simp malar/zygom fx	0.00	0.00	0.00	0.00	XXX	0
D7660		G	Clsd red simp malar/zygom fx	0.00	0.00	0.00	0.00	XXX	0
D7670		G	Open red simple alveolus fx	0.00	0.00	0.00	0.00	XXX	0
D7680		G	Reduct simple facial bone fx	0.00	0.00	0.00	0.00	XXX	0
D7710		G	Maxilla open reduct compound	0.00	0.00	0.00	0.00	XXX	0
D7720		G	Clsd reduct compd maxilla fx	0.00	0.00	0.00	0.00	XXX	0
D7730		G	Open reduct compd mandble fx	0.00	0.00	0.00	0.00	XXX	0
D7740		G	Clsd reduct compd mandble fx	0.00	0.00	0.00	0.00	XXX	0
D7750		G	Open red comp malar/zygma fx	0.00	0.00	0.00	0.00	XXX	0
D7760		G	Clsd red comp malar/zygma fx	0.00	0.00	0.00	0.00	XXX	0
D7770		G	Open reduc compd alveolus fx	0.00	0.00	0.00	0.00	XXX	0
D7780		G	Reduct compnd facial bone fx	0.00	0.00	0.00	0.00	XXX	0
D7810		G	Tmj open reduct-dislocation	0.00	0.00	0.00	0.00	XXX	0
D7820		G	Closed tmp manipulation	0.00	0.00	0.00	0.00	XXX	0
D7830		G	Tmj manipulation under anest	0.00	0.00	0.00	0.00	XXX	0
D7840		G	Removal of tmj condyle	0.00	0.00	0.00	0.00	XXX	0
D7850		G	Tmj meniscectomy	0.00	0.00	0.00	0.00	XXX	0
D7852		G	Tmj repair of joint disc	0.00	0.00	0.00	0.00	XXX	0
D7854		G	Tmj excisn of joint membrane	0.00	0.00	0.00	0.00	XXX	0
D7856		G	Tmj cutting of a muscle	0.00	0.00	0.00	0.00	XXX	0
D7858		G	Tmj reconstruction	0.00	0.00	0.00	0.00	XXX	0
D7860		G	Tmj cutting into joint	0.00	0.00	0.00	0.00	XXX	0
D7865		G	Tmj reshaping components	0.00	0.00	0.00	0.00	XXX	0
D7870		G	Tmj aspiration joint fluid	0.00	0.00	0.00	0.00	XXX	0
D7872		G	Tmj diagnostic arthroscopy	0.00	0.00	0.00	0.00	XXX	0
D7873		G	Tmj arthroscopy lysis adhesn	0.00	0.00	0.00	0.00	XXX	0
D7874		G	Tmj arthroscopy disc reposit	0.00	0.00	0.00	0.00	XXX	0
D7875		G	Tmj arthroscopy synovectomy	0.00	0.00	0.00	0.00	XXX	0
D7876		G	Tmj arthroscopy discectomy	0.00	0.00	0.00	0.00	XXX	0
D7877		G	Tmj arthroscopy debridement	0.00	0.00	0.00	0.00	XXX	0
D7880		G	Occlusal orthotic appliance	0.00	0.00	0.00	0.00	XXX	0
D7899		G	Tmj unspecified therapy	0.00	0.00	0.00	0.00	XXX	0
D7910		G	Dent sutur recent wnd to 5cm	0.00	0.00	0.00	0.00	XXX	0
D7911		G	Dental suture wound to 5 cm	0.00	0.00	0.00	0.00	XXX	0
D7912		G	Suture complicate wnd > 5 cm	0.00	0.00	0.00	0.00	XXX	0
D7920		G	Dental skin graft	0.00	0.00	0.00	0.00	XXX	0
D7940		R	Reshaping bone orthognathic	0.00	0.00	0.00	0.00	YYY	S
D7941		G	Bone cutting ramus closed	0.00	0.00	0.00	0.00	XXX	0
D7942		G	Bone cutting ramus open	0.00	0.00	0.00	0.00	XXX	0
D7943		G	Cutting ramus open w/graft	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
D7944		G	Bone cutting segmented	0.00	0.00	0.00	0.00	XXX	0
D7945		G	Bone cutting body mandible	0.00	0.00	0.00	0.00	XXX	0
D7946		G	Reconstruction maxilla total	0.00	0.00	0.00	0.00	XXX	0
D7947		G	Reconstruct maxilla segment	0.00	0.00	0.00	0.00	XXX	0
D7948		G	Reconstruct midface no graft	0.00	0.00	0.00	0.00	XXX	0
D7949		G	Reconstruct midface w/graft	0.00	0.00	0.00	0.00	XXX	0
D7950		G	Mandible graft	0.00	0.00	0.00	0.00	XXX	0
D7955		G	Repair maxillofacial defects	0.00	0.00	0.00	0.00	XXX	0
D7960		G	Frenulectomy/frenulotomy	0.00	0.00	0.00	0.00	XXX	0
D7970		G	Excision hyperplastic tissue	0.00	0.00	0.00	0.00	XXX	0
D7971		G	Excision pericoronal gingiva	0.00	0.00	0.00	0.00	XXX	0
D7980		G	Sialolithotomy	0.00	0.00	0.00	0.00	XXX	0
D7981		G	Excision of salivary gland	0.00	0.00	0.00	0.00	XXX	0
D7982		G	Sialodochoplasty	0.00	0.00	0.00	0.00	XXX	0
D7983		G	Closure of salivary fistula	0.00	0.00	0.00	0.00	XXX	0
D7990		G	Emergency tracheotomy	0.00	0.00	0.00	0.00	XXX	0
D7991		G	Dental coronoidectomy	0.00	0.00	0.00	0.00	XXX	0
D7993		D	Implant facial bones	0.00	0.00	0.00	0.00	YYY	N
D7994		D	Implant chin	0.00	0.00	0.00	0.00	YYY	N
D7995		G	Synthetic graft facial bones	0.00	0.00	0.00	0.00	XXX	0
D7996		G	Implant mandible for augment	0.00	0.00	0.00	0.00	XXX	0
D7999		G	Oral surgery procedure	0.00	0.00	0.00	0.00	XXX	0
D8010		N	Limited dental tx primary	0.00	0.00	0.00	0.00	XXX	0
D8020		N	Limited dental tx transition	0.00	0.00	0.00	0.00	XXX	0
D8030		N	Limited dental tx adolescent	0.00	0.00	0.00	0.00	XXX	0
D8040		N	Limited dental tx adult	0.00	0.00	0.00	0.00	XXX	0
D8050		N	Intercep dental tx primary	0.00	0.00	0.00	0.00	XXX	0
D8060		N	Intercep dental tx transiti	0.00	0.00	0.00	0.00	XXX	0
D8070		N	Compre dental tx transition	0.00	0.00	0.00	0.00	XXX	0
D8080		N	Compre dental tx adolescent	0.00	0.00	0.00	0.00	XXX	0
D8090		N	Compre dental tx adult	0.00	0.00	0.00	0.00	XXX	0
D8110		D	Orthodontic rem appliance tx	0.00	0.00	0.00	0.00	YYY	N
D8120		D	Fixed appliance therapy guid	0.00	0.00	0.00	0.00	YYY	N
D8210		N	Orthodontic rem appliance tx	0.00	0.00	0.00	0.00	XXX	0
D8220		N	Fixed appliance therapy habt	0.00	0.00	0.00	0.00	XXX	0
D8360		D	Orthodontic rem appliance tx	0.00	0.00	0.00	0.00	YYY	N
D8370		D	Fixed appliance interceptive	0.00	0.00	0.00	0.00	YYY	N
D8460		D	Trans dentit class 1 maloccl	0.00	0.00	0.00	0.00	YYY	N
D8470		D	Class ii malocclusion trnstn	0.00	0.00	0.00	0.00	YYY	N
D8480		D	Class iii malocclusion trnst	0.00	0.00	0.00	0.00	YYY	N
D8560		D	Class i tx atyp/ext skel cas	0.00	0.00	0.00	0.00	YYY	N
D8570		D	Class ii malocclusion perman	0.00	0.00	0.00	0.00	YYY	N
D8580		D	Class iii malocclusion perman	0.00	0.00	0.00	0.00	YYY	N
D8650		D	Tx atypical/extend skel case	0.00	0.00	0.00	0.00	YYY	N
D8660		N	Preorthodontic tx visit	0.00	0.00	0.00	0.00	XXX	0
D8670		N	Periodic orthodontc tx visit	0.00	0.00	0.00	0.00	XXX	0
D8680		N	Orthodontic retention	0.00	0.00	0.00	0.00	XXX	0
D8690		N	Orthodontic treatment	0.00	0.00	0.00	0.00	XXX	0
D8750		D	Post-treatment stabilization	0.00	0.00	0.00	0.00	YYY	N
D8999		N	Orthodontic procedure	0.00	0.00	0.00	0.00	XXX	0
D9110		R	Tx dental pain minor proc	0.00	0.00	0.00	0.00	YYY	N
D9210		G	Dent anesthesia w/o surgery	0.00	0.00	0.00	0.00	XXX	0
D9211		G	Regional block anesthesia	0.00	0.00	0.00	0.00	XXX	0
D9212		G	Trigeminal block anesthesia	0.00	0.00	0.00	0.00	XXX	0
D9215		G	Local anesthesia	0.00	0.00	0.00	0.00	XXX	0
D9220		G	General anesthesia	0.00	0.00	0.00	0.00	XXX	0
D9221		G	General anesthesia ea ad 15m	0.00	0.00	0.00	0.00	XXX	0
D9230		R	Analgesia	0.00	0.00	0.00	0.00	YYY	N
D9240		G	Intravenous sedation	0.00	0.00	0.00	0.00	XXX	0
D9310		G	Dental consultation	0.00	0.00	0.00	0.00	XXX	0
D9410		G	Dental house call	0.00	0.00	0.00	0.00	XXX	0
D9420		G	Hospital call	0.00	0.00	0.00	0.00	XXX	0
D9430		G	Office visit during hours	0.00	0.00	0.00	0.00	XXX	0
D9440		G	Office visit after hours	0.00	0.00	0.00	0.00	XXX	0
D9610		G	Dent therapeutic drug inject	0.00	0.00	0.00	0.00	XXX	0
D9630		R	Other drugs/medicaments	0.00	0.00	0.00	0.00	YYY	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
D9910	.....	N	Dent appl desensitizing med	0.00	0.00	0.00	0.00	XXX	0
D9920	.....	N	Behavior management	0.00	0.00	0.00	0.00	XXX	0
D9930	.....	R	Treatment of complications	0.00	0.00	0.00	0.00	YYY	N
D9940	.....	R	Dental occlusal guard	0.00	0.00	0.00	0.00	YYY	N
D9941	.....	N	Fabrication athletic guard	0.00	0.00	0.00	0.00	XXX	0
D9950	.....	R	Occlusion analysis	0.00	0.00	0.00	0.00	YYY	N
D9951	.....	R	Limited occlusal adjustment	0.00	0.00	0.00	0.00	YYY	N
D9952	.....	R	Complete occlusal adjustment	0.00	0.00	0.00	0.00	YYY	N
D9970	.....	N	Enamel microabrasion	0.00	0.00	0.00	0.00	XXX	0
D9999	.....	G	Adjunctive procedure	0.00	0.00	0.00	0.00	XXX	0
G0001	.....	X	Drawing blood for specimen	0.00	0.00	0.00	0.00	XXX	0
G0002	.....	A	Temporary urinary catheter	0.50	0.70	0.02	1.22	000	S
G0004	.....	A	ECG transm phys review & int	0.52	7.31	0.65	8.48	XXX	N
G0005	.....	A	ECG 24 hour recording	0.00	1.18	0.09	1.27	XXX	N
G0006	.....	A	ECG transmission & analysis	0.00	5.73	0.51	6.24	XXX	N
G0007	.....	A	ECG phy review & interpret	0.52	0.40	0.05	0.97	XXX	N
G0008	.....	X	Admin influenza virus vac	0.00	0.00	0.00	0.00	XXX	0
G0009	.....	X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	XXX	0
G0010	.....	X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	XXX	0
G0015	.....	A	Post symptom ECG tracing	0.00	5.73	0.51	6.24	XXX	N
G0016	.....	A	Post symptom ECG md review	0.52	0.40	0.05	0.97	XXX	N
G0020	.....	D	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	010	S
G0021	.....	D	Prepare orbital prosthesis	0.00	0.00	0.00	0.00	090	S
G0025	.....	A	Collagen skin test kit	0.00	0.95	0.00	0.95	XXX	N
G0026	.....	X	Fecal leukocyte examination	0.00	0.00	0.00	0.00	XXX	0
G0027	.....	X	Semen analysis	0.00	0.00	0.00	0.00	XXX	0
G0030	.....	C	PET imaging prev PET single	0.00	0.00	0.00	0.00	XXX	N
G0030	26	A	PET imaging prev PET single	1.09	0.48	0.07	1.64	XXX	N
G0030	TC	C	PET imaging prev PET single	0.00	0.00	0.00	0.00	XXX	N
G0031	.....	C	PET imaging prev PET multiple	0.00	0.00	0.00	0.00	XXX	N
G0031	26	A	PET imaging prev PET multiple	1.46	0.65	0.10	2.21	XXX	N
G0031	TC	C	PET imaging prev PET multiple	0.00	0.00	0.00	0.00	XXX	N
G0032	.....	C	PET follow SPECT 78464 singl	0.00	0.00	0.00	0.00	XXX	N
G0032	26	A	PET follow SPECT 78464 singl	1.09	0.48	0.07	1.64	XXX	N
G0032	TC	C	PET follow SPECT 78464 singl	0.00	0.00	0.00	0.00	XXX	N
G0033	.....	C	PET follow SPECT 78464 mult	0.00	0.00	0.00	0.00	XXX	N
G0033	26	A	PET follow SPECT 78464 mult	1.46	0.65	0.10	2.21	XXX	N
G0033	TC	C	PET follow SPECT 78464 mult	0.00	0.00	0.00	0.00	XXX	N
G0034	.....	C	PET follow SPECT 76865 singl	0.00	0.00	0.00	0.00	XXX	N
G0034	26	A	PET follow SPECT 76865 singl	1.09	0.48	0.07	1.64	XXX	N
G0034	TC	C	PET follow SPECT 76865 singl	0.00	0.00	0.00	0.00	XXX	N
G0035	.....	C	PET follow SPECT 78465 mult	0.00	0.00	0.00	0.00	XXX	N
G0035	26	A	PET follow SPECT 78465 mult	1.46	0.65	0.10	2.21	XXX	N
G0035	TC	C	PET follow SPECT 78465 mult	0.00	0.00	0.00	0.00	XXX	N
G0036	.....	C	PET follow cornry angio sing	0.00	0.00	0.00	0.00	XXX	N
G0036	26	A	PET follow cornry angio sing	1.09	0.48	0.07	1.64	XXX	N
G0036	TC	C	PET follow cornry angio sing	0.00	0.00	0.00	0.00	XXX	N
G0037	.....	C	PET follow cornry angio mult	0.00	0.00	0.00	0.00	XXX	N
G0037	26	A	PET follow cornry angio mult	1.46	0.65	0.10	2.21	XXX	N
G0037	TC	C	PET follow cornry angio mult	0.00	0.00	0.00	0.00	XXX	N
G0038	.....	C	PET follow myocard perf sing	0.00	0.00	0.00	0.00	XXX	N
G0038	26	A	PET follow myocard perf sing	1.09	0.48	0.07	1.64	XXX	N
G0038	TC	C	PET follow myocard perf sing	0.00	0.00	0.00	0.00	XXX	N
G0039	.....	C	PET follow myocard perf mult	0.00	0.00	0.00	0.00	XXX	N
G0039	26	A	PET follow myocard perf mult	1.46	0.65	0.10	2.21	XXX	N
G0039	TC	C	PET follow myocard perf mult	0.00	0.00	0.00	0.00	XXX	N
G0040	.....	C	PET follow stress echo singl	0.00	0.00	0.00	0.00	XXX	N
G0040	26	A	PET follow stress echo singl	1.09	0.48	0.07	1.64	XXX	N
G0040	TC	C	PET follow stress echo singl	0.00	0.00	0.00	0.00	XXX	N
G0041	.....	C	PET follow stress echo mult	0.00	0.00	0.00	0.00	XXX	N
G0041	26	A	PET follow stress echo mult	1.46	0.65	0.10	2.21	XXX	N
G0041	TC	C	PET follow stress echo mult	0.00	0.00	0.00	0.00	XXX	N
G0042	.....	C	PET follow ventriculogm sing	0.00	0.00	0.00	0.00	XXX	N
G0042	26	A	PET follow ventriculogm sing	1.09	0.48	0.07	1.64	XXX	N
G0042	TC	C	PET follow ventriculogm sing	0.00	0.00	0.00	0.00	XXX	N
G0043	.....	C	PET follow ventriculogm mult	0.00	0.00	0.00	0.00	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
G0043	26	A	PET follow ventriculogm mult	1.46	0.65	0.10	2.21	XXX	N
G0043	TC	C	PET follow ventriculogm mult	0.00	0.00	0.00	0.00	XXX	N
G0044		C	PET following rest ECG singl	0.00	0.00	0.00	0.00	XXX	N
G0044	26	A	PET following rest ECG singl	1.09	0.48	0.07	1.64	XXX	N
G0044	TC	C	PET following rest ECG singl	0.00	0.00	0.00	0.00	XXX	N
G0045		C	PET following rest ECG mult	0.00	0.00	0.00	0.00	XXX	N
G0045	26	A	PET following rest ECG mult	1.46	0.65	0.10	2.21	XXX	N
G0045	TC	C	PET following rest ECG mult	0.00	0.00	0.00	0.00	XXX	N
G0046		C	PET follow stress ECG singl	0.00	0.00	0.00	0.00	XXX	N
G0046	26	A	PET follow stress ECG singl	1.09	0.48	0.07	1.64	XXX	N
G0046	TC	C	PET follow stress ECG singl	0.00	0.00	0.00	0.00	XXX	N
G0047		C	PET follow stress ECG mult	0.00	0.00	0.00	0.00	XXX	N
G0047	26	A	PET follow stress ECG mult	1.46	0.65	0.10	2.21	XXX	N
G0047	TC	C	PET follow stress ECG mult	0.00	0.00	0.00	0.00	XXX	N
G0050		A	Residual urine by ultrasound	0.00	0.81	0.05	0.86	XXX	N
G0054		X	Blood cholesterol test	0.00	0.00	0.00	0.00	XXX	0
G0055		X	Glucose post dose measure	0.00	0.00	0.00	0.00	XXX	0
G0056		X	Glucose tolerance 3 specimen	0.00	0.00	0.00	0.00	XXX	0
G0057		X	Glucose tolerance>3 specimen	0.00	0.00	0.00	0.00	XXX	0
G0058		X	Auto multichannel 20 tests	0.00	0.00	0.00	0.00	XXX	0
G0059		X	Auto multichannel 21 tests	0.00	0.00	0.00	0.00	XXX	0
G0060		X	Auto multichannel 22 tests	0.00	0.00	0.00	0.00	XXX	0
G0061		N	Lung volume reduction surg	#17.62	15.81	3.01	36.44	XXX	0
H5300		G	Occupational therapy	#0.32	0.24	0.03	0.59	XXX	0
J0110		D	Administration injection	0.00	0.00	0.00	0.00	XXX	0
J0120		E	Tetracyclin injection	0.00	0.00	0.00	0.00	XXX	0
J0150		E	Injection adenosine 6 MG	0.00	0.00	0.00	0.00	XXX	0
J0170		E	Adrenalin epinephrin inject	0.00	0.00	0.00	0.00	XXX	0
J0190		E	Inj biperiden lactate/5 mg	0.00	0.00	0.00	0.00	XXX	0
J0205		E	Alglucerase injection	0.00	0.00	0.00	0.00	XXX	0
J0210		E	Methyldopate hcl injection	0.00	0.00	0.00	0.00	XXX	0
J0256		E	Alpha 1-proteinase 500 MG	0.00	0.00	0.00	0.00	XXX	0
J0280		E	Aminophyllin 250 MG inj	0.00	0.00	0.00	0.00	XXX	0
J0290		E	Ampicillin 500 MG inj	0.00	0.00	0.00	0.00	XXX	0
J0295		E	Ampicillin sodium per 1.5 gm	0.00	0.00	0.00	0.00	XXX	0
J0300		E	Amobarbital 125 MG inj	0.00	0.00	0.00	0.00	XXX	0
J0330		E	Succinylcholine chloride inj	0.00	0.00	0.00	0.00	XXX	0
J0340		E	Nandrolon phenpropionate inj	0.00	0.00	0.00	0.00	XXX	0
J0350		E	Injection anistreplase 30 u	0.00	0.00	0.00	0.00	XXX	0
J0360		E	Hydralazine hcl injection	0.00	0.00	0.00	0.00	XXX	0
J0380		E	Inj metaraminol bitartrate	0.00	0.00	0.00	0.00	XXX	0
J0390		E	Chloroquine injection	0.00	0.00	0.00	0.00	XXX	0
J0400		E	Inj trimethaphan camsylate	0.00	0.00	0.00	0.00	XXX	0
J0460		E	Atropine sulfate injection	0.00	0.00	0.00	0.00	XXX	0
J0470		E	Dimecaprol injection	0.00	0.00	0.00	0.00	XXX	0
J0475		E	Baclofen 10 MG injection	0.00	0.00	0.00	0.00	XXX	0
J0500		E	Dicyclomine injection	0.00	0.00	0.00	0.00	XXX	0
J0510		E	Benzquinamide injection	0.00	0.00	0.00	0.00	XXX	0
J0515		E	Inj benztropine mesylate	0.00	0.00	0.00	0.00	XXX	0
J0520		E	Bethanechol chloride inject	0.00	0.00	0.00	0.00	XXX	0
J0530		E	Penicillin g benzathine inj	0.00	0.00	0.00	0.00	XXX	0
J0540		E	Penicillin g benzathine inj	0.00	0.00	0.00	0.00	XXX	0
J0550		E	Penicillin g benzathine inj	0.00	0.00	0.00	0.00	XXX	0
J0560		E	Penicillin g benzathine inj	0.00	0.00	0.00	0.00	XXX	0
J0570		E	Penicillin g benzathine inj	0.00	0.00	0.00	0.00	XXX	0
J0580		E	Penicillin g benzathine inj	0.00	0.00	0.00	0.00	XXX	0
J0585		E	Botulinum toxin a per 100 u	0.00	0.00	0.00	0.00	XXX	0
J0590		E	Ethylnorepinephrine hcl inj	0.00	0.00	0.00	0.00	XXX	0
J0600		E	Edetate calcium disodium inj	0.00	0.00	0.00	0.00	XXX	0
J0610		E	Calcium gluconate injection	0.00	0.00	0.00	0.00	XXX	0
J0620		E	Calcium glycer & lact/10 ML	0.00	0.00	0.00	0.00	XXX	0
J0630		E	Calcitonin salmon injection	0.00	0.00	0.00	0.00	XXX	0
J0635		E	Calcitriol injection	0.00	0.00	0.00	0.00	XXX	0
J0640		E	Leucovorin calcium injection	0.00	0.00	0.00	0.00	XXX	0
J0670		E	Inj mepivacaine HCL/10 ml	0.00	0.00	0.00	0.00	XXX	0
J0680		D	Deslanoside injection	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
J0690		E	Cefazolin sodium injection	0.00	0.00	0.00	0.00	XXX	0
J0694		E	Cefoxitin sodium injection	0.00	0.00	0.00	0.00	XXX	0
J0695		E	Cefonocid sodium injection	0.00	0.00	0.00	0.00	XXX	0
J0696		E	Ceftriaxone sodium injection	0.00	0.00	0.00	0.00	XXX	0
J0697		E	Sterile cefuroxime injection	0.00	0.00	0.00	0.00	XXX	0
J0698		E	Cefotaxime sodium injection	0.00	0.00	0.00	0.00	XXX	0
J0702		E	Betamethasone acet&sod phosp	0.00	0.00	0.00	0.00	XXX	0
J0704		E	Betamethasone sod phosp/4 MG	0.00	0.00	0.00	0.00	XXX	0
J0710		E	Cephapirin sodium injection	0.00	0.00	0.00	0.00	XXX	0
J0713		E	Inj ceftazidime per 500 mg	0.00	0.00	0.00	0.00	XXX	0
J0715		E	Ceftizoxime sodium / 500 MG	0.00	0.00	0.00	0.00	XXX	0
J0720		E	Chloramphenicol sodium injec	0.00	0.00	0.00	0.00	XXX	0
J0725		E	Chorionic gonadotropin/1000u	0.00	0.00	0.00	0.00	XXX	0
J0730		E	Chlorpheniramin maleate inj	0.00	0.00	0.00	0.00	XXX	0
J0743		E	Cilastatin sodium injection	0.00	0.00	0.00	0.00	XXX	0
J0745		E	Inj codeine phosphate /30 MG	0.00	0.00	0.00	0.00	XXX	0
J0760		E	Colchicine injection	0.00	0.00	0.00	0.00	XXX	0
J0770		E	Colistimethate sodium inj	0.00	0.00	0.00	0.00	XXX	0
J0780		E	Prochlorperazine injection	0.00	0.00	0.00	0.00	XXX	0
J0800		E	Corticotropin injection	0.00	0.00	0.00	0.00	XXX	0
J0810		E	Cortisone injection	0.00	0.00	0.00	0.00	XXX	0
J0820		D	Cortigel 40 injection	0.00	0.00	0.00	0.00	XXX	0
J0835		E	Inj cosyntropin per 0.25 MG	0.00	0.00	0.00	0.00	XXX	0
J0850		E	Cytomegalovirus imm IV /vial	0.00	0.00	0.00	0.00	XXX	0
J0895		E	Deferoxamine mesylate inj	0.00	0.00	0.00	0.00	XXX	0
J0900		E	Testosterone enanthate inj	0.00	0.00	0.00	0.00	XXX	0
J0945		E	Brompheniramine maleate inj	0.00	0.00	0.00	0.00	XXX	0
J0970		E	Estradiol valerate injection	0.00	0.00	0.00	0.00	XXX	0
J1000		E	Depo-estradiol cypionate inj	0.00	0.00	0.00	0.00	XXX	0
J1020		E	Methylprednisolone 20 MG inj	0.00	0.00	0.00	0.00	XXX	0
J1030		E	Methylprednisolone 40 MG inj	0.00	0.00	0.00	0.00	XXX	0
J1040		E	Methylprednisolone 80 MG inj	0.00	0.00	0.00	0.00	XXX	0
J1050		E	Medroxyprogesterone inj	0.00	0.00	0.00	0.00	XXX	0
J1055		E	Medrxyprogester acetate inj	0.00	0.00	0.00	0.00	XXX	0
J1060		E	Testosterone cypionate 1 ML	0.00	0.00	0.00	0.00	XXX	0
J1070		E	Testosterone cypionat 100 MG	0.00	0.00	0.00	0.00	XXX	0
J1080		E	Testosterone cypionat 200 MG	0.00	0.00	0.00	0.00	XXX	0
J1090		E	Testosterone cypionate 50 MG	0.00	0.00	0.00	0.00	XXX	0
J1095		E	Inj dexamethasone acetate	0.00	0.00	0.00	0.00	XXX	0
J1100		E	Dexamethosone sodium phos	0.00	0.00	0.00	0.00	XXX	0
J1110		E	Inj dihydroergotamine mesylt	0.00	0.00	0.00	0.00	XXX	0
J1120		E	Acetazolamid sodium injectio	0.00	0.00	0.00	0.00	XXX	0
J1160		E	Digoxin injection	0.00	0.00	0.00	0.00	XXX	0
J1165		E	Phenytoin sodium injection	0.00	0.00	0.00	0.00	XXX	0
J1170		E	Hydromorphone injection	0.00	0.00	0.00	0.00	XXX	0
J1180		E	Dyphylline injection	0.00	0.00	0.00	0.00	XXX	0
J1200		E	Diphenhydramine hcl injectio	0.00	0.00	0.00	0.00	XXX	0
J1205		E	Chlorothiazide sodium inj	0.00	0.00	0.00	0.00	XXX	0
J1212		E	Dimethyl sulfoxide 50% 50 ML	0.00	0.00	0.00	0.00	XXX	0
J1230		E	Methadone injection	0.00	0.00	0.00	0.00	XXX	0
J1240		E	Dimenhydrinate injection	0.00	0.00	0.00	0.00	XXX	0
J1245		E	Dipyridamole injection	0.00	0.00	0.00	0.00	XXX	0
J1250		E	Inj dobutamine HCL/250 mg	0.00	0.00	0.00	0.00	XXX	0
J1320		E	Amitriptyline injection	0.00	0.00	0.00	0.00	XXX	0
J1330		E	Ergonovine maleate injection	0.00	0.00	0.00	0.00	XXX	0
J1340		D	Aqueous/saline placebo inj	0.00	0.00	0.00	0.00	XXX	0
J1362		E	Erythromycin glucap / 250 MG	0.00	0.00	0.00	0.00	XXX	0
J1364		E	Erythro lactobionate /500 MG	0.00	0.00	0.00	0.00	XXX	0
J1380		E	Estradiol valerate 10 MG inj	0.00	0.00	0.00	0.00	XXX	0
J1390		E	Estradiol valerate 20 MG inj	0.00	0.00	0.00	0.00	XXX	0
J1410		E	Inj estrogen conjugate 25 MG	0.00	0.00	0.00	0.00	XXX	0
J1435		E	Injection estrone per 1 MG	0.00	0.00	0.00	0.00	XXX	0
J1436		E	Etidronate disodium inj	0.00	0.00	0.00	0.00	XXX	0
J1440		E	Filgrastim 300 mcg injection	0.00	0.00	0.00	0.00	XXX	0
J1441		E	Filgrastim 480 mcg injection	0.00	0.00	0.00	0.00	XXX	0
J1455		E	Foscarnet sodium injection	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
J1460		E	Gamma globulin 1 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1470		E	Gamma globulin 2 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1480		E	Gamma globulin 3 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1490		E	Gamma globulin 4 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1500		E	Gamma globulin 5 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1510		E	Gamma globulin 6 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1520		E	Gamma globulin 7 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1530		E	Gamma globulin 8 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1540		E	Gamma globulin 9 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1550		E	Gamma globulin 10 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1560		E	Gamma globulin > 10 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1561		E	Immune globulin injection	0.00	0.00	0.00	0.00	XXX	0
J1562		E	Immune globulin 10% /5 grams	0.00	0.00	0.00	0.00	XXX	0
J1570		E	Ganciclovir sodium injection	0.00	0.00	0.00	0.00	XXX	0
J1580		E	Garamycin gentamicin inj	0.00	0.00	0.00	0.00	XXX	0
J1600		E	Gold sodium thiomaleate inj	0.00	0.00	0.00	0.00	XXX	0
J1610		E	Glucagon hydrochloride/1 MG	0.00	0.00	0.00	0.00	XXX	0
J1620		E	Gonadorelin hydroch/ 100 mcg	0.00	0.00	0.00	0.00	XXX	0
J1625		E	Granisetron hydrochlor/1 MG	0.00	0.00	0.00	0.00	XXX	0
J1630		E	Haloperidol injection	0.00	0.00	0.00	0.00	XXX	0
J1631		E	Haloperidol decanoate inj	0.00	0.00	0.00	0.00	XXX	0
J1642		E	Inj heparin sodium per 10 u	0.00	0.00	0.00	0.00	XXX	0
J1644		E	Inj heparin sodium per 1000u	0.00	0.00	0.00	0.00	XXX	0
J1650		E	Inj enoxaparin sodium 30 mg	0.00	0.00	0.00	0.00	XXX	0
J1660		D	Histamine injection	0.00	0.00	0.00	0.00	XXX	0
J1670		E	Tetanus immune globulin inj	0.00	0.00	0.00	0.00	XXX	0
J1690		E	Prednisolone tebutate inj	0.00	0.00	0.00	0.00	XXX	0
J1700		E	Hydrocortisone acetate inj	0.00	0.00	0.00	0.00	XXX	0
J1710		E	Hydrocortisone sodium ph inj	0.00	0.00	0.00	0.00	XXX	0
J1720		E	Hydrocortisone sodium succ i	0.00	0.00	0.00	0.00	XXX	0
J1730		E	Diazoxide injection	0.00	0.00	0.00	0.00	XXX	0
J1739		E	Hydroxyprogesterone cap 125	0.00	0.00	0.00	0.00	XXX	0
J1741		E	Hydroxyprogesterone cap 250	0.00	0.00	0.00	0.00	XXX	0
J1760		E	Iron dextran 2 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1770		E	Iron dextran 5 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1780		E	Iron dextran 10 CC inj	0.00	0.00	0.00	0.00	XXX	0
J1785		E	Injection imiglucerase /unit	0.00	0.00	0.00	0.00	XXX	0
J1790		E	Droperidol injection	0.00	0.00	0.00	0.00	XXX	0
J1800		E	Propranolol injection	0.00	0.00	0.00	0.00	XXX	0
J1810		E	Droperidol/fentanyl inj	0.00	0.00	0.00	0.00	XXX	0
J1820		E	Insulin injection	0.00	0.00	0.00	0.00	XXX	0
J1830		E	Interferon beta-1b / .25 MG	0.00	0.00	0.00	0.00	XXX	0
J1840		E	Kanamycin sulfate 500 MG inj	0.00	0.00	0.00	0.00	XXX	0
J1850		E	Kanamycin sulfate 75 MG inj	0.00	0.00	0.00	0.00	XXX	0
J1885		E	Ketorolac tromethamine inj	0.00	0.00	0.00	0.00	XXX	0
J1890		E	Cephalothin sodium injection	0.00	0.00	0.00	0.00	XXX	0
J1910		E	Kutapressin injection	0.00	0.00	0.00	0.00	XXX	0
J1930		E	Propiomazine injection	0.00	0.00	0.00	0.00	XXX	0
J1940		E	Furosemide injection	0.00	0.00	0.00	0.00	XXX	0
J1950		E	Leuprolide acetate /3.75 MG	0.00	0.00	0.00	0.00	XXX	0
J1955		E	Inj levocarnitine per 1 gm	0.00	0.00	0.00	0.00	XXX	0
J1960		E	Levorphanol tartrate inj	0.00	0.00	0.00	0.00	XXX	0
J1970		E	Methotrimeprazine injection	0.00	0.00	0.00	0.00	XXX	0
J1980		E	Hyoscyamine sulfate inj	0.00	0.00	0.00	0.00	XXX	0
J1990		E	Chlordiazepoxide injection	0.00	0.00	0.00	0.00	XXX	0
J2000		E	Lidocaine injection	0.00	0.00	0.00	0.00	XXX	0
J2010		E	Lincomycin injection	0.00	0.00	0.00	0.00	XXX	0
J2050		E	Liver injection	0.00	0.00	0.00	0.00	XXX	0
J2060		E	Lorazepam injection	0.00	0.00	0.00	0.00	XXX	0
J2100		D	Luminal sodium injection	0.00	0.00	0.00	0.00	XXX	0
J2150		E	Mannitol injection	0.00	0.00	0.00	0.00	XXX	0
J2175		E	Meperidine hydrochl /100 MG	0.00	0.00	0.00	0.00	XXX	0
J2180		E	Meperidine/promethazine inj	0.00	0.00	0.00	0.00	XXX	0
J2190		D	Mersalyl & theophylline inj	0.00	0.00	0.00	0.00	XXX	0
J2210		E	Methylethergonovin maleate inj	0.00	0.00	0.00	0.00	XXX	0
J2240		E	Metocurine iodide injection	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110—D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
J2250		E	Inj midazolam hydrochloride	0.00	0.00	0.00	0.00	XXX	0
J2260		E	Inj milrinone lactate / 5 ML	0.00	0.00	0.00	0.00	XXX	0
J2270		E	Morphine sulfate injection	0.00	0.00	0.00	0.00	XXX	0
J2275		E	Morphine sulfate injection	0.00	0.00	0.00	0.00	XXX	0
J2300		E	Inj nalbuphine hydrochloride	0.00	0.00	0.00	0.00	XXX	0
J2310		E	Inj naloxone hydrochloride	0.00	0.00	0.00	0.00	XXX	0
J2320		E	Nandrolone decanoate 50 MG	0.00	0.00	0.00	0.00	XXX	0
J2321		E	Nandrolone decanoate 100 MG	0.00	0.00	0.00	0.00	XXX	0
J2322		E	Nandrolone decanoate 200 MG	0.00	0.00	0.00	0.00	XXX	0
J2330		E	Thiothixene injection	0.00	0.00	0.00	0.00	XXX	0
J2350		E	Niacinamide/niacin injection	0.00	0.00	0.00	0.00	XXX	0
J2360		E	Orphenadrine injection	0.00	0.00	0.00	0.00	XXX	0
J2370		E	Phenylephrine hcl injection	0.00	0.00	0.00	0.00	XXX	0
J2400		E	Chloroprocaine hcl injection	0.00	0.00	0.00	0.00	XXX	0
J2405		E	Ondansetron hcl injection	0.00	0.00	0.00	0.00	XXX	0
J2410		E	Oxymorphone hcl injection	0.00	0.00	0.00	0.00	XXX	0
J2430		E	Pamidronate disodium /30 MG	0.00	0.00	0.00	0.00	XXX	0
J2440		E	Papaverin hcl injection	0.00	0.00	0.00	0.00	XXX	0
J2460		E	Oxytetracycline injection	0.00	0.00	0.00	0.00	XXX	0
J2480		E	Hydrochlorides of opium inj	0.00	0.00	0.00	0.00	XXX	0
J2495		D	Tridihexethyl chloride inj	0.00	0.00	0.00	0.00	XXX	0
J2510		E	Penicillin g procaine inj	0.00	0.00	0.00	0.00	XXX	0
J2512		E	Inj pentagastrin per 2 ML	0.00	0.00	0.00	0.00	XXX	0
J2515		E	Pentobarbital sodium inj	0.00	0.00	0.00	0.00	XXX	0
J2540		E	Penicillin g potassium inj	0.00	0.00	0.00	0.00	XXX	0
J2545		E	Pentamidine isethionate/300mg	0.00	0.00	0.00	0.00	XXX	0
J2550		E	Promethazine hcl injection	0.00	0.00	0.00	0.00	XXX	0
J2560		E	Phenobarbital sodium inj	0.00	0.00	0.00	0.00	XXX	0
J2590		E	Oxytocin injection	0.00	0.00	0.00	0.00	XXX	0
J2597		E	Inj desmopressin acetate	0.00	0.00	0.00	0.00	XXX	0
J2640		E	Prednisolone sodium ph inj	0.00	0.00	0.00	0.00	XXX	0
J2650		E	Prednisolone acetate inj	0.00	0.00	0.00	0.00	XXX	0
J2670		E	Totazoline hcl injection	0.00	0.00	0.00	0.00	XXX	0
J2675		E	Inj progesterone per 50 MG	0.00	0.00	0.00	0.00	XXX	0
J2680		E	Fluphenazine decanoate 25 MG	0.00	0.00	0.00	0.00	XXX	0
J2690		E	Procainamide hcl injection	0.00	0.00	0.00	0.00	XXX	0
J2700		E	Oxacillin sodium injection	0.00	0.00	0.00	0.00	XXX	0
J2710		E	Neostigmine methylsulfate inj	0.00	0.00	0.00	0.00	XXX	0
J2720		E	Inj protamine sulfate/10 MG	0.00	0.00	0.00	0.00	XXX	0
J2725		E	Inj protirelin per 250 mcg	0.00	0.00	0.00	0.00	XXX	0
J2730		E	Pralidoxime chloride inj	0.00	0.00	0.00	0.00	XXX	0
J2760		E	Phentolamine mesylate inj	0.00	0.00	0.00	0.00	XXX	0
J2765		E	Metoclopramide hcl injection	0.00	0.00	0.00	0.00	XXX	0
J2790		E	Rho d immune globulin inj	0.00	0.00	0.00	0.00	XXX	0
J2800		E	Methocarbamol injection	0.00	0.00	0.00	0.00	XXX	0
J2810		E	Inj theophylline per 40 MG	0.00	0.00	0.00	0.00	XXX	0
J2820		E	Sargramostim injection	0.00	0.00	0.00	0.00	XXX	0
J2860		E	Secobarbital sodium inj	0.00	0.00	0.00	0.00	XXX	0
J2910		E	Aurothioglucose injection	0.00	0.00	0.00	0.00	XXX	0
J2912		E	Sodium chloride injection	0.00	0.00	0.00	0.00	XXX	0
J2914		D	Sodium salicylate injection	0.00	0.00	0.00	0.00	XXX	0
J2920		E	Methylprednisolone injection	0.00	0.00	0.00	0.00	XXX	0
J2930		E	Methylprednisolone injection	0.00	0.00	0.00	0.00	XXX	0
J2950		E	Promazine hcl injection	0.00	0.00	0.00	0.00	XXX	0
J2970		E	Methicillin sodium injection	0.00	0.00	0.00	0.00	XXX	0
J2995		E	Inj streptokinase /250000 IU	0.00	0.00	0.00	0.00	XXX	0
J2996		E	Alteplase recombinant inj	0.00	0.00	0.00	0.00	XXX	0
J3000		E	Streptomycin injection	0.00	0.00	0.00	0.00	XXX	0
J3005		E	Strontium-89 chloride /10 ML	0.00	0.00	0.00	0.00	XXX	0
J3010		E	Fentanyl citrate injection	0.00	0.00	0.00	0.00	XXX	0
J3030		E	Sumatriptan succinate / 6 MG	0.00	0.00	0.00	0.00	XXX	0
J3070		E	Pentazocine hcl injection	0.00	0.00	0.00	0.00	XXX	0
J3080		E	Chlorprothixene injection	0.00	0.00	0.00	0.00	XXX	0
J3105		E	Terbutaline sulfate inj	0.00	0.00	0.00	0.00	XXX	0
J3120		E	Testosterone enanthate inj	0.00	0.00	0.00	0.00	XXX	0
J3130		E	Testosterone enanthate inj	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110-D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
J3140		E	Testosterone suspension inj	0.00	0.00	0.00	0.00	XXX	0
J3150		E	Testosterone propionate inj	0.00	0.00	0.00	0.00	XXX	0
J3230		E	Chlorpromazine hcl injection	0.00	0.00	0.00	0.00	XXX	0
J3240		E	Thyrotropin injection	0.00	0.00	0.00	0.00	XXX	0
J3250		E	Trimethobenzamide hcl inj	0.00	0.00	0.00	0.00	XXX	0
J3260		E	Tobramycin sulfate injection	0.00	0.00	0.00	0.00	XXX	0
J3265		E	Injection torsemide 10 mg/ml	0.00	0.00	0.00	0.00	XXX	0
J3270		E	Imipramine hcl injection	0.00	0.00	0.00	0.00	XXX	0
J3280		E	Thiethylperazine maleate inj	0.00	0.00	0.00	0.00	XXX	0
J3301		E	Triamcinolone acetonide inj	0.00	0.00	0.00	0.00	XXX	0
J3302		E	Triamcinolone diacetate inj	0.00	0.00	0.00	0.00	XXX	0
J3303		E	Triamcinolone hexacetonl inj	0.00	0.00	0.00	0.00	XXX	0
J3305		E	Inj trimetrexate glucuronate	0.00	0.00	0.00	0.00	XXX	0
J3310		E	Perphenazine injection	0.00	0.00	0.00	0.00	XXX	0
J3320		E	Spectinomycin di-hcl inj	0.00	0.00	0.00	0.00	XXX	0
J3340		D	Cryptenamine acetate inj	0.00	0.00	0.00	0.00	XXX	0
J3350		E	Urea injection	0.00	0.00	0.00	0.00	XXX	0
J3360		E	Diazepam injection	0.00	0.00	0.00	0.00	XXX	0
J3364		E	Urokinase 5000 IU injection	0.00	0.00	0.00	0.00	XXX	0
J3365		E	Urokinase 250,000 IU inj	0.00	0.00	0.00	0.00	XXX	0
J3370		E	Vancomycin hcl injection	0.00	0.00	0.00	0.00	XXX	0
J3380		D	Isoxsuprine hcl injection	0.00	0.00	0.00	0.00	XXX	0
J3390		E	Methoxamine injection	0.00	0.00	0.00	0.00	XXX	0
J3400		E	Triflupromazine hcl inj	0.00	0.00	0.00	0.00	XXX	0
J3410		E	Hydroxyzine hcl injection	0.00	0.00	0.00	0.00	XXX	0
J3420		E	Vitamin b12 injection	0.00	0.00	0.00	0.00	XXX	0
J3430		E	Vitamin k phytionadione inj	0.00	0.00	0.00	0.00	XXX	0
J3450		E	Mephentermine sulfate inj	0.00	0.00	0.00	0.00	XXX	0
J3470		E	Hyaluronidase injection	0.00	0.00	0.00	0.00	XXX	0
J3475		E	Inj magnesium sulfate	0.00	0.00	0.00	0.00	XXX	0
J3480		E	Inj potassium chloride	0.00	0.00	0.00	0.00	XXX	0
J3490		E	Drugs unclassified injection	0.00	0.00	0.00	0.00	XXX	0
J3500		D	Vitamin therapy	0.00	0.00	0.00	0.00	XXX	0
J3520		N	Edetate disodium per 150 mg	0.00	0.00	0.00	0.00	XXX	0
J3530		E	Nasal vaccine inhalation	0.00	0.00	0.00	0.00	XXX	0
J3535		E	Metered dose inhaler drug	0.00	0.00	0.00	0.00	XXX	0
J3540		D	Autogenous blood extract	0.00	0.00	0.00	0.00	XXX	0
J3550		D	Intra-arterial oxygen inj	0.00	0.00	0.00	0.00	XXX	0
J3560		D	Adrenal cortex extract	0.00	0.00	0.00	0.00	XXX	0
J3570		N	Laetrile amygdalin vit B17	0.00	0.00	0.00	0.00	XXX	0
J6015		D	Typhus immun/injection	0.00	0.00	0.00	0.00	XXX	0
J7030		E	Normal saline solution infus	0.00	0.00	0.00	0.00	XXX	0
J7040		E	Normal saline solution infus	0.00	0.00	0.00	0.00	XXX	0
J7042		E	5% dextrose/normal saline	0.00	0.00	0.00	0.00	XXX	0
J7050		E	Normal saline solution infus	0.00	0.00	0.00	0.00	XXX	0
J7051		E	Sterile saline/water	0.00	0.00	0.00	0.00	XXX	0
J7060		E	5% dextrose/water	0.00	0.00	0.00	0.00	XXX	0
J7070		E	D5w infusion	0.00	0.00	0.00	0.00	XXX	0
J7080		D	5% albumisol infusion	0.00	0.00	0.00	0.00	XXX	0
J7090		D	25% albumisol infusion	0.00	0.00	0.00	0.00	XXX	0
J7100		E	Dextran 40 infusion	0.00	0.00	0.00	0.00	XXX	0
J7110		E	Dextran 75 infusion	0.00	0.00	0.00	0.00	XXX	0
J7120		E	Ringers lactate infusion	0.00	0.00	0.00	0.00	XXX	0
J7130		E	Hypertonic saline solution	0.00	0.00	0.00	0.00	XXX	0
J7140		N	Prescription oral drug	0.00	0.00	0.00	0.00	XXX	0
J7150		N	Prescription oral chemo drug	0.00	0.00	0.00	0.00	XXX	0
J7190		X	Factor viii	0.00	0.00	0.00	0.00	XXX	0
J7191		X	Factor VIII (porcine)	0.00	0.00	0.00	0.00	XXX	0
J7192		X	Factor viii recombinant	0.00	0.00	0.00	0.00	XXX	0
J7194		X	Factor ix complex	0.00	0.00	0.00	0.00	XXX	0
J7196		X	Othr hemophilia clot factors	0.00	0.00	0.00	0.00	XXX	0
J7197		X	Antithrombin iii injection	0.00	0.00	0.00	0.00	XXX	0
J7300		N	Intraut copper contraceptive	0.00	0.00	0.00	0.00	XXX	0
J7500		X	Azathiop po tab 50mg 100s ea	0.00	0.00	0.00	0.00	XXX	0
J7501		X	Azathioprine parenteral	0.00	0.00	0.00	0.00	XXX	0
J7502		X	Cyclosporine oral solution	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
J7503		X	Cyclosporine parenteral	0.00	0.00	0.00	0.00	XXX	0
J7504		X	Lymphocyte immune globulin	0.00	0.00	0.00	0.00	XXX	0
J7505		X	Monoclonal antibodies	0.00	0.00	0.00	0.00	XXX	0
J7506		X	Prednisone	0.00	0.00	0.00	0.00	XXX	0
J7507		E	Tacrolimus oral per 1 MG	0.00	0.00	0.00	0.00	XXX	0
J7508		E	Tacrolimus oral per 5 MG	0.00	0.00	0.00	0.00	XXX	0
J7509		X	Methylprednisolone oral	0.00	0.00	0.00	0.00	XXX	0
J7510		X	Prednisolone oral per 5 mg	0.00	0.00	0.00	0.00	XXX	0
J7599		X	Immunosuppressive drug noc	0.00	0.00	0.00	0.00	XXX	0
J7610		E	Acetylcysteine 10% injection	0.00	0.00	0.00	0.00	XXX	0
J7615		E	Acetylcysteine 20% injection	0.00	0.00	0.00	0.00	XXX	0
J7620		E	Albuterol sulfate .083% inj	0.00	0.00	0.00	0.00	XXX	0
J7625		E	Albuterol sulfate .5% inj	0.00	0.00	0.00	0.00	XXX	0
J7627		E	Bitolterolmesylate inhal sol	0.00	0.00	0.00	0.00	XXX	0
J7630		E	Cromolyn sodium injection	0.00	0.00	0.00	0.00	XXX	0
J7640		E	Epinephrine injection	0.00	0.00	0.00	0.00	XXX	0
J7645		E	Ipratropium bromide .02%/ml	0.00	0.00	0.00	0.00	XXX	0
J7650		E	Isoetharine hcl .1% inj	0.00	0.00	0.00	0.00	XXX	0
J7651		E	Isoetharine hcl .125% inj	0.00	0.00	0.00	0.00	XXX	0
J7652		E	Isoetharine hcl .167% inj	0.00	0.00	0.00	0.00	XXX	0
J7653		E	Isoetharine hcl .2%/ inj	0.00	0.00	0.00	0.00	XXX	0
J7654		E	Isoetharine hcl .25% inj	0.00	0.00	0.00	0.00	XXX	0
J7655		E	Isoetharine hcl 1% inj	0.00	0.00	0.00	0.00	XXX	0
J7660		E	Isoproterenol hcl .5% inj	0.00	0.00	0.00	0.00	XXX	0
J7665		E	Isoproterenol hcl 1% inj	0.00	0.00	0.00	0.00	XXX	0
J7670		E	Metaproterenol sulfate .4%	0.00	0.00	0.00	0.00	XXX	0
J7672		E	Metaproterenol sulfate .6%	0.00	0.00	0.00	0.00	XXX	0
J7675		E	Metaproterenol sulfate 5%	0.00	0.00	0.00	0.00	XXX	0
J7699		E	Inhalation solution for DME	0.00	0.00	0.00	0.00	XXX	0
J7799		E	Non-inhalation drug for DME	0.00	0.00	0.00	0.00	XXX	0
J8499		N	Oral prescrip drug non chemo	0.00	0.00	0.00	0.00	XXX	0
J8530		E	Cyclophosphamide oral 25 MG	0.00	0.00	0.00	0.00	XXX	0
J8560		E	Etoposide oral 50 MG	0.00	0.00	0.00	0.00	XXX	0
J8600		E	Melphalan oral 2 MG	0.00	0.00	0.00	0.00	XXX	0
J8610		E	Methotrexate oral 2.5 MG	0.00	0.00	0.00	0.00	XXX	0
J8999		E	Oral prescription drug chemo	0.00	0.00	0.00	0.00	XXX	0
J9000		E	Doxorubic hcl 10 MG vl chemo	0.00	0.00	0.00	0.00	XXX	0
J9010		E	Doxorubicin hcl 50 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9015		E	Aldesleukin/single use vial	0.00	0.00	0.00	0.00	XXX	0
J9020		E	Asparaginase injection	0.00	0.00	0.00	0.00	XXX	0
J9031		E	Bcg live intravesical vac	0.00	0.00	0.00	0.00	XXX	0
J9040		E	Bleomycin sulfate injection	0.00	0.00	0.00	0.00	XXX	0
J9045		E	Carboplatin injection	0.00	0.00	0.00	0.00	XXX	0
J9050		E	Carmus bischl nitro inj	0.00	0.00	0.00	0.00	XXX	0
J9060		E	Cisplatin 10 MG injection	0.00	0.00	0.00	0.00	XXX	0
J9062		E	Cisplatin 50 MG injection	0.00	0.00	0.00	0.00	XXX	0
J9065		E	Inj cladribine per 1 MG	0.00	0.00	0.00	0.00	XXX	0
J9070		E	Cyclophosphamide 100 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9080		E	Cyclophosphamide 200 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9090		E	Cyclophosphamide 500 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9091		E	Cyclophosphamide 1.0 grm inj	0.00	0.00	0.00	0.00	XXX	0
J9092		E	Cyclophosphamide 2.0 grm inj	0.00	0.00	0.00	0.00	XXX	0
J9093		E	Cyclophosphamide lyophilized	0.00	0.00	0.00	0.00	XXX	0
J9094		E	Cyclophosphamide lyophilized	0.00	0.00	0.00	0.00	XXX	0
J9095		E	Cyclophosphamide lyophilized	0.00	0.00	0.00	0.00	XXX	0
J9096		E	Cyclophosphamide lyophilized	0.00	0.00	0.00	0.00	XXX	0
J9097		E	Cyclophosphamide lyophilized	0.00	0.00	0.00	0.00	XXX	0
J9100		E	Cytarabine hcl 100 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9110		E	Cytarabine hcl 500 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9120		E	Dactinomycin actinomycin d	0.00	0.00	0.00	0.00	XXX	0
J9130		E	Dacarbazine 10 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9140		E	Dacarbazine 200 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9150		E	Daunorubicin hcl injection	0.00	0.00	0.00	0.00	XXX	0
J9165		E	Diethylstilbestrol injection	0.00	0.00	0.00	0.00	XXX	0
J9181		E	Etoposide 10 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9182		E	Etoposide 100 MG inj	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
J9185		E	Fludarabine phosphate inj	0.00	0.00	0.00	0.00	XXX	0
J9190		E	Fluorouracil injection	0.00	0.00	0.00	0.00	XXX	0
J9200		E	Floxuridine injection	0.00	0.00	0.00	0.00	XXX	0
J9202		E	Goserelin acetate implant	0.00	0.00	0.00	0.00	XXX	0
J9208		E	Ifosfomide injection	0.00	0.00	0.00	0.00	XXX	0
J9209		E	Mesna injection	0.00	0.00	0.00	0.00	XXX	0
J9211		E	Idarubicin hcl injection	0.00	0.00	0.00	0.00	XXX	0
J9213		E	Interferon alfa-2a inj	0.00	0.00	0.00	0.00	XXX	0
J9214		E	Interferon alfa-2b inj	0.00	0.00	0.00	0.00	XXX	0
J9215		E	Interferon alfa-n3 inj	0.00	0.00	0.00	0.00	XXX	0
J9216		E	Interferon gamma 1-b inj	0.00	0.00	0.00	0.00	XXX	0
J9217		E	Leuprolide acetate suspnsion	0.00	0.00	0.00	0.00	XXX	0
J9218		E	Leuprolide acetate injection	0.00	0.00	0.00	0.00	XXX	0
J9230		E	Mechlorethamine hcl inj	0.00	0.00	0.00	0.00	XXX	0
J9245		E	Inj melphalan hydrochl 50 MG	0.00	0.00	0.00	0.00	XXX	0
J9250		E	Methotrexate sodium inj	0.00	0.00	0.00	0.00	XXX	0
J9260		E	Methotrexate sodium inj	0.00	0.00	0.00	0.00	XXX	0
J9265		E	Paclitaxel injection	0.00	0.00	0.00	0.00	XXX	0
J9266		E	Pegaspargase/singl dose vial	0.00	0.00	0.00	0.00	XXX	0
J9268		E	Pentostatin injection	0.00	0.00	0.00	0.00	XXX	0
J9270		E	Plicamycin (mithramycin) inj	0.00	0.00	0.00	0.00	XXX	0
J9280		E	Mitomycin 5 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9290		E	Mitomycin 20 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9291		E	Mitomycin 40 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9293		E	Mitoxantrone hydrochl / 5 MG	0.00	0.00	0.00	0.00	XXX	0
J9295		D	Polyestradiol phosphate inj	0.00	0.00	0.00	0.00	XXX	0
J9320		E	Streptozocin injection	0.00	0.00	0.00	0.00	XXX	0
J9340		E	Thiotepa injection	0.00	0.00	0.00	0.00	XXX	0
J9360		E	Vinblastine sulfate inj	0.00	0.00	0.00	0.00	XXX	0
J9370		E	Vincristine sulfate 1 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9375		E	Vincristine sulfate 2 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9380		E	Vincristine sulfate 5 MG inj	0.00	0.00	0.00	0.00	XXX	0
J9390		E	Vinorelbine tartrate/10 mg	0.00	0.00	0.00	0.00	XXX	0
J9999		E	Chemotherapy drug	0.00	0.00	0.00	0.00	XXX	0
M0005		G	Off visit 2/more modalities	#0.76	0.31	0.03	1.10	XXX	0
M0006		G	One phys therapy modality	#0.50	0.15	0.02	0.67	XXX	0
M0007		G	Combined phys ther mod & tx	#1.01	0.35	0.04	1.40	XXX	0
M0008		G	Combined phys ther mod & tx	#0.50	0.11	0.01	0.62	XXX	0
M0064		A	Visit for drug monitoring	0.37	0.19	0.03	0.59	XXX	N
M0075		N	Cellular therapy	0.00	0.00	0.00	0.00	XXX	0
M0076		N	Prolotherapy	0.00	0.00	0.00	0.00	XXX	0
M0100		N	Intragastric hypothermia	0.00	0.00	0.00	0.00	XXX	0
M0101		A	Cutting or removal of corns	0.37	0.35	0.03	0.75	XXX	S
M0300		N	IV chelation therapy	0.00	0.00	0.00	0.00	XXX	0
M0301		N	Fabric wrapping of aneurysm	0.00	0.00	0.00	0.00	XXX	0
M0302		N	Assessment of cardiac output	0.00	0.00	0.00	0.00	XXX	0
P2028		X	Cephalin flocculation test	0.00	0.00	0.00	0.00	XXX	0
P2029		X	Congo red blood test	0.00	0.00	0.00	0.00	XXX	0
P2031		N	Hair analysis	0.00	0.00	0.00	0.00	XXX	0
P2033		X	Blood thymol turbidity	0.00	0.00	0.00	0.00	XXX	0
P2038		X	Blood mucoprotein	0.00	0.00	0.00	0.00	XXX	0
P3000		X	Screen pap by tech w md supv	0.00	0.00	0.00	0.00	XXX	0
P3001		X	Screening pap smear by phys	0.00	0.00	0.00	0.00	XXX	0
P3001	26	A	Screening pap smear by phys	0.42	0.32	0.04	0.78	XXX	N
P7001		G	Culture bacterial urine	0.00	0.00	0.00	0.00	XXX	0
P9010		E	Whole blood for transfusion	0.00	0.00	0.00	0.00	XXX	0
P9011		E	Blood split unit	0.00	0.00	0.00	0.00	XXX	0
P9012		E	Cryoprecipitate each unit	0.00	0.00	0.00	0.00	XXX	0
P9013		E	Unit/s blood fibrinogen	0.00	0.00	0.00	0.00	XXX	0
P9014		E	Gamma globulin 1 ML	0.00	0.00	0.00	0.00	XXX	0
P9015		E	Rh immune globulin 1 ML	0.00	0.00	0.00	0.00	XXX	0
P9016		E	Leukocyte poor blood, unit	0.00	0.00	0.00	0.00	XXX	0
P9017		E	One donor fresh frozen plasma	0.00	0.00	0.00	0.00	XXX	0
P9018		E	Plasma protein fract, unit	0.00	0.00	0.00	0.00	XXX	0
P9019		E	Platelet concentrate unit	0.00	0.00	0.00	0.00	XXX	0
P9020		E	Platelet rich plasma unit	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
P9021		E	Red blood cells unit	0.00	0.00	0.00	0.00	XXX	0
P9022		E	Washed red blood cells unit	0.00	0.00	0.00	0.00	XXX	0
P9603		X	One-way allow prorated miles	0.00	0.00	0.00	0.00	XXX	0
P9604		X	One-way allow prorated trip	0.00	0.00	0.00	0.00	XXX	0
P9605		D	Routine venipuncture	0.00	0.00	0.00	0.00	XXX	0
P9610		X	Urine specimen collect singl	0.00	0.00	0.00	0.00	XXX	0
P9615		X	Urine specimen collect mult	0.00	0.00	0.00	0.00	XXX	0
Q0034		X	Admin of influenza vaccine	0.00	0.00	0.00	0.00	XXX	0
Q0035		A	Cardiokymography	0.17	0.49	0.04	0.70	XXX	N
Q0035	26	A	Cardiokymography	0.17	0.12	0.01	0.30	XXX	N
Q0035	TC	A	Cardiokymography	0.00	0.37	0.03	0.40	XXX	N
Q0068		A	Extracorporeal plasmapheresis	1.67	1.27	0.16	3.10	000	N
Q0091		A	Obtaining screen pap smear	0.37	0.28	0.03	0.68	XXX	N
Q0092		A	Set up port xray equipment	0.00	0.30	0.01	0.31	XXX	N
Q0103		A	Physical therapy evaluation	1.01	0.35	0.11	1.47	XXX	N
Q0104		A	Phys therapy re-evaluation	0.50	0.04	0.01	0.55	XXX	N
Q0109		A	Occupational therapy eval	1.01	0.35	0.11	1.47	XXX	N
Q0110		A	Occupational therap re-eval	0.50	0.04	0.01	0.55	XXX	N
Q0111		X	Wet mounts/ w preparations	0.00	0.00	0.00	0.00	XXX	0
Q0112		X	Potassium hydroxide preps	0.00	0.00	0.00	0.00	XXX	0
Q0113		X	Pinworm examinations	0.00	0.00	0.00	0.00	XXX	0
Q0114		X	Fern test	0.00	0.00	0.00	0.00	XXX	0
Q0115		X	Post-coital mucous exam	0.00	0.00	0.00	0.00	XXX	0
Q0116		X	Hemoglb n single analyte exam	0.00	0.00	0.00	0.00	XXX	0
Q0132		X	Dispensing fee DME neb drug	0.00	0.00	0.00	0.00	XXX	0
Q0136		X	Non esrd epoetin alpha inj	0.00	0.00	0.00	0.00	XXX	0
Q0137		D	Dexamethasone acetate 8MG/ML	0.00	0.00	0.00	0.00	XXX	0
Q0138		D	Dexamethasone acetat 16MG/ML	0.00	0.00	0.00	0.00	XXX	0
Q0139		D	Inj desmopressin acetat 4mcg	0.00	0.00	0.00	0.00	XXX	N
Q0140		D	Inj potassium chloride, 2meg	0.00	0.00	0.00	0.00	XXX	0
Q0141		D	Inj magnesium sulfate, 500 mg	0.00	0.00	0.00	0.00	XXX	N
Q0142		D	Sup thallous chloride tl 201	0.00	0.00	0.00	0.00	XXX	N
Q0143		D	Sup technetium tc sestamibi	0.00	0.00	0.00	0.00	XXX	0
Q9920		E	Epoetin with hct <= 20	0.00	0.00	0.00	0.00	XXX	0
Q9921		E	Epoetin with hct = 21	0.00	0.00	0.00	0.00	XXX	0
Q9922		E	Epoetin with hct = 22	0.00	0.00	0.00	0.00	XXX	0
Q9923		E	Epoetin with hct = 23	0.00	0.00	0.00	0.00	XXX	0
Q9924		E	Epoetin with hct = 24	0.00	0.00	0.00	0.00	XXX	0
Q9925		E	Epoetin with hct = 25	0.00	0.00	0.00	0.00	XXX	0
Q9926		E	Epoetin with hct = 26	0.00	0.00	0.00	0.00	XXX	0
Q9927		E	Epoetin with hct = 27	0.00	0.00	0.00	0.00	XXX	0
Q9928		E	Epoetin with hct = 28	0.00	0.00	0.00	0.00	XXX	0
Q9929		E	Epoetin with hct = 29	0.00	0.00	0.00	0.00	XXX	0
Q9930		E	Epoetin with hct = 30	0.00	0.00	0.00	0.00	XXX	0
Q9931		E	Epoetin with hct = 31	0.00	0.00	0.00	0.00	XXX	0
Q9932		E	Epoetin with hct = 32	0.00	0.00	0.00	0.00	XXX	0
Q9933		E	Epoetin with hct = 33	0.00	0.00	0.00	0.00	XXX	0
Q9934		E	Epoetin with hct = 34	0.00	0.00	0.00	0.00	XXX	0
Q9935		E	Epoetin with hct = 35	0.00	0.00	0.00	0.00	XXX	0
Q9936		E	Epoetin with hct = 36	0.00	0.00	0.00	0.00	XXX	0
Q9937		E	Epoetin with hct = 37	0.00	0.00	0.00	0.00	XXX	0
Q9938		E	Epoetin with hct = 38	0.00	0.00	0.00	0.00	XXX	0
Q9939		E	Epoetin with hct = 39	0.00	0.00	0.00	0.00	XXX	0
Q9940		E	Epoetin with hct >= 40	0.00	0.00	0.00	0.00	XXX	0
R0070		C	Transport portable x-ray	0.00	0.00	0.00	0.00	XXX	N
R0075		C	Transport port x-ray multipl	0.00	0.00	0.00	0.00	XXX	N
R0076		C	Transport portable EKG	0.00	0.00	0.00	0.00	XXX	N
V2020		X	Vision svcs frames purchases	0.00	0.00	0.00	0.00	XXX	0
V2025		N	Eyeglasses delux frames	0.00	0.00	0.00	0.00	XXX	0
V2100		X	Lens spher single plano 4.00	0.00	0.00	0.00	0.00	XXX	0
V2101		X	Single visn sphere 4.12-7.00	0.00	0.00	0.00	0.00	XXX	0
V2102		X	Singl visn sphere 7.12-20.00	0.00	0.00	0.00	0.00	XXX	0
V2103		X	Spherocylindr 4.00d/12-2.00d	0.00	0.00	0.00	0.00	XXX	0
V2104		X	Spherocylindr 4.00d/2.12-4d	0.00	0.00	0.00	0.00	XXX	0
V2105		X	Spherocylinder 4.00d/4.25-6d	0.00	0.00	0.00	0.00	XXX	0
V2106		X	Spherocylinder 4.00d/>6.00d	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110-D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
V2107		X	Spherocylinder 4.25d/12–2d	0.00	0.00	0.00	0.00	XXX	0
V2108		X	Spherocylinder 4.25d/2.12–4d	0.00	0.00	0.00	0.00	XXX	0
V2109		X	Spherocylinder 4.25d/4.25–6d	0.00	0.00	0.00	0.00	XXX	0
V2110		X	Spherocylinder 4.25d/over 6d	0.00	0.00	0.00	0.00	XXX	0
V2111		X	Spherocylindr 7.25d/.25–2.25	0.00	0.00	0.00	0.00	XXX	0
V2112		X	Spherocylindr 7.25d/2.25–4d	0.00	0.00	0.00	0.00	XXX	0
V2113		X	Spherocylindr 7.25d/4.25–6d	0.00	0.00	0.00	0.00	XXX	0
V2114		X	Spherocylinder over 12.00d	0.00	0.00	0.00	0.00	XXX	0
V2115		X	Lens lenticular bifocal	0.00	0.00	0.00	0.00	XXX	0
V2116		X	Nonaspheric lens bifocal	0.00	0.00	0.00	0.00	XXX	0
V2117		X	Aspheric lens bifocal	0.00	0.00	0.00	0.00	XXX	0
V2118		X	Lens aniseikonic single	0.00	0.00	0.00	0.00	XXX	0
V2199		X	Lens single vision not oth c	0.00	0.00	0.00	0.00	XXX	0
V2200		X	Lens sphr bifoc plano 4.00d	0.00	0.00	0.00	0.00	XXX	0
V2201		X	Lens sphere bifocal 4.12–7.0	0.00	0.00	0.00	0.00	XXX	0
V2202		X	Lens sphere bifocal 7.12–20.	0.00	0.00	0.00	0.00	XXX	0
V2203		X	Lens sphcyl bifocal 4.00d/.1	0.00	0.00	0.00	0.00	XXX	0
V2204		X	Lens sphcy bifocal 4.00d/2.1	0.00	0.00	0.00	0.00	XXX	0
V2205		X	Lens sphcy bifocal 4.00d/4.2	0.00	0.00	0.00	0.00	XXX	0
V2206		X	Lens sphcy bifocal 4.00d/ove	0.00	0.00	0.00	0.00	XXX	0
V2207		X	Lens sphcy bifocal 4.25–7d/.	0.00	0.00	0.00	0.00	XXX	0
V2208		X	Lens sphcy bifocal 4.25–7/2.	0.00	0.00	0.00	0.00	XXX	0
V2209		X	Lens sphcy bifocal 4.25–7/4.	0.00	0.00	0.00	0.00	XXX	0
V2210		X	Lens sphcy bifocal 4.25–7/ov	0.00	0.00	0.00	0.00	XXX	0
V2211		X	Lens sphcy bifo 7.25–12/.25-	0.00	0.00	0.00	0.00	XXX	0
V2212		X	Lens sphcyl bifo 7.25–12/2.2	0.00	0.00	0.00	0.00	XXX	0
V2213		X	Lens sphcyl bifo 7.25–12/4.2	0.00	0.00	0.00	0.00	XXX	0
V2214		X	Lens sphcyl bifocal over 12.	0.00	0.00	0.00	0.00	XXX	0
V2215		X	Lens lenticular bifocal	0.00	0.00	0.00	0.00	XXX	0
V2216		X	Lens lenticular nonaspheric	0.00	0.00	0.00	0.00	XXX	0
V2217		X	Lens lenticular aspheric bif	0.00	0.00	0.00	0.00	XXX	0
V2218		X	Lens aniseikonic bifocal	0.00	0.00	0.00	0.00	XXX	0
V2219		X	Lens bifocal seg width over	0.00	0.00	0.00	0.00	XXX	0
V2220		X	Lens bifocal add over 3.25d	0.00	0.00	0.00	0.00	XXX	0
V2299		X	Lens bifocal speciality	0.00	0.00	0.00	0.00	XXX	0
V2300		X	Lens sphere trifocal 4.00d	0.00	0.00	0.00	0.00	XXX	0
V2301		X	Lens sphere trifocal 4.12–7.	0.00	0.00	0.00	0.00	XXX	0
V2302		X	Lens sphere trifocal 7.12–20	0.00	0.00	0.00	0.00	XXX	0
V2303		X	Lens sphcy trifocal 4.0/.12-	0.00	0.00	0.00	0.00	XXX	0
V2304		X	Lens sphcy trifocal 4.0/2.25	0.00	0.00	0.00	0.00	XXX	0
V2305		X	Lens sphcy trifocal 4.0/4.25	0.00	0.00	0.00	0.00	XXX	0
V2306		X	Lens sphcyl trifocal 4.00/>6	0.00	0.00	0.00	0.00	XXX	0
V2307		X	Lens sphcy trifocal 4.25–7/.	0.00	0.00	0.00	0.00	XXX	0
V2308		X	Lens sphc trifocal 4.25–7/2.	0.00	0.00	0.00	0.00	XXX	0
V2309		X	Lens sphc trifocal 4.25–7/4.	0.00	0.00	0.00	0.00	XXX	0
V2310		X	Lens sphc trifocal 4.25–7/>6	0.00	0.00	0.00	0.00	XXX	0
V2311		X	Lens sphc trifo 7.25–12/.25-	0.00	0.00	0.00	0.00	XXX	0
V2312		X	Lens sphc trifo 7.25–12/2.25	0.00	0.00	0.00	0.00	XXX	0
V2313		X	Lens sphc trifo 7.25–12/4.25	0.00	0.00	0.00	0.00	XXX	0
V2314		X	Lens sphcyl trifocal over 12	0.00	0.00	0.00	0.00	XXX	0
V2315		X	Lens lenticular trifocal	0.00	0.00	0.00	0.00	XXX	0
V2316		X	Lens lenticular nonaspheric	0.00	0.00	0.00	0.00	XXX	0
V2317		X	Lens lenticular aspheric tri	0.00	0.00	0.00	0.00	XXX	0
V2318		X	Lens aniseikonic trifocal	0.00	0.00	0.00	0.00	XXX	0
V2319		X	Lens trifocal seg width > 28	0.00	0.00	0.00	0.00	XXX	0
V2320		X	Lens trifocal add over 3.25d	0.00	0.00	0.00	0.00	XXX	0
V2399		X	Lens trifocal speciality	0.00	0.00	0.00	0.00	XXX	0
V2410		X	Lens variab asphericity sing	0.00	0.00	0.00	0.00	XXX	0
V2430		X	Lens variable asphericity bi	0.00	0.00	0.00	0.00	XXX	0
V2499		X	Variable asphericity lens	0.00	0.00	0.00	0.00	XXX	0
V2500		X	Contact lens pmma spherical	0.00	0.00	0.00	0.00	XXX	0
V2501		X	Cntct lens pmma-toric/prism	0.00	0.00	0.00	0.00	XXX	0
V2502		X	Contact lens pmma bifocal	0.00	0.00	0.00	0.00	XXX	0
V2503		X	Cntct lens pmma color vision	0.00	0.00	0.00	0.00	XXX	0
V2510		X	Cntct gas permeable sphericl	0.00	0.00	0.00	0.00	XXX	0
V2511		X	Cntct toric prism ballast	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110–D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
V2512		X	Cntct lens gas permbl bifocl	0.00	0.00	0.00	0.00	XXX	0
V2513		X	Contact lens extended wear	0.00	0.00	0.00	0.00	XXX	0
V2520		P	Contact lens hydrophilic	0.00	0.00	0.00	0.00	XXX	0
V2521		X	Cntct lens hydrophilic toric	0.00	0.00	0.00	0.00	XXX	0
V2522		X	Cntct lens hydrophil bifocl	0.00	0.00	0.00	0.00	XXX	0
V2523		X	Cntct lens hydrophil extend	0.00	0.00	0.00	0.00	XXX	0
V2530		X	Contact lens gas impermeable	0.00	0.00	0.00	0.00	XXX	0
V2531		X	Contact lens gas permeable	0.00	0.00	0.00	0.00	XXX	0
V2599		X	Contact lens/es other type	0.00	0.00	0.00	0.00	XXX	0
V2600		X	Hand held low vision aids	0.00	0.00	0.00	0.00	XXX	0
V2610		X	Single lens spectacle mount	0.00	0.00	0.00	0.00	XXX	0
V2615		X	Telescop/othr compound lens	0.00	0.00	0.00	0.00	XXX	0
V2623		X	Plastic eye prosth custom	0.00	0.00	0.00	0.00	XXX	0
V2624		X	Polishing artifical eye	0.00	0.00	0.00	0.00	XXX	0
V2625		X	Enlargemnt of eye prosthesis	0.00	0.00	0.00	0.00	XXX	0
V2626		X	Reduction of eye prosthesis	0.00	0.00	0.00	0.00	XXX	0
V2627		X	Scleral cover shell	0.00	0.00	0.00	0.00	XXX	0
V2628		X	Fabrication & fitting	0.00	0.00	0.00	0.00	XXX	0
V2629		X	Prosthetic eye other type	0.00	0.00	0.00	0.00	XXX	0
V2630		X	Anter chamber intraocul lens	0.00	0.00	0.00	0.00	XXX	0
V2631		X	Iris support intraoclr lens	0.00	0.00	0.00	0.00	XXX	0
V2632		X	Post chmbr intraocular lens	0.00	0.00	0.00	0.00	XXX	0
V2700		X	Balance lens	0.00	0.00	0.00	0.00	XXX	0
V2710		X	Glass/plastic slab off prism	0.00	0.00	0.00	0.00	XXX	0
V2715		X	Prism lens/es	0.00	0.00	0.00	0.00	XXX	0
V2718		X	Fresnell prism press-on lens	0.00	0.00	0.00	0.00	XXX	0
V2730		X	Special base curve	0.00	0.00	0.00	0.00	XXX	0
V2740		X	Rose tint plastic	0.00	0.00	0.00	0.00	XXX	0
V2741		X	Non-rose tint plastic	0.00	0.00	0.00	0.00	XXX	0
V2742		X	Rose tint glass	0.00	0.00	0.00	0.00	XXX	0
V2743		X	Non-rose tint glass	0.00	0.00	0.00	0.00	XXX	0
V2744		X	Tint photochromatic lens/es	0.00	0.00	0.00	0.00	XXX	0
V2750		X	Anti-reflective coating	0.00	0.00	0.00	0.00	XXX	0
V2755		X	UV lens/es	0.00	0.00	0.00	0.00	XXX	0
V2760		X	Scratch resistant coating	0.00	0.00	0.00	0.00	XXX	0
V2770		X	Occluder lens/es	0.00	0.00	0.00	0.00	XXX	0
V2780		X	Oversize lens/es	0.00	0.00	0.00	0.00	XXX	0
V2781		X	Progressive lens per lens	0.00	0.00	0.00	0.00	XXX	0
V2785		X	Corneal tissue processing	0.00	0.00	0.00	0.00	XXX	0
V2799		X	Miscellaneous vision service	0.00	0.00	0.00	0.00	XXX	0
V5008		N	Hearing screening	0.00	0.00	0.00	0.00	XXX	0
V5010		N	Assessment for hearing aid	0.00	0.00	0.00	0.00	XXX	0
V5011		N	Hearing aid fitting/checking	0.00	0.00	0.00	0.00	XXX	0
V5014		N	Hearing aid repair/modifying	0.00	0.00	0.00	0.00	XXX	0
V5020		N	Conformity evaluation	0.00	0.00	0.00	0.00	XXX	0
V5030		N	Body-worn hearing aid air	0.00	0.00	0.00	0.00	XXX	0
V5040		N	Body-worn hearing aid bone	0.00	0.00	0.00	0.00	XXX	0
V5050		N	Body-worn hearing aid in ear	0.00	0.00	0.00	0.00	XXX	0
V5060		N	Behind ear hearing aid	0.00	0.00	0.00	0.00	XXX	0
V5070		N	Glasses air conduction	0.00	0.00	0.00	0.00	XXX	0
V5080		N	Glasses bone conduction	0.00	0.00	0.00	0.00	XXX	0
V5090		N	Hearing aid dispensing fee	0.00	0.00	0.00	0.00	XXX	0
V5100		N	Body-worn bilat hearing aid	0.00	0.00	0.00	0.00	XXX	0
V5110		N	Hearing aid dispensing fee	0.00	0.00	0.00	0.00	XXX	0
V5120		N	Body-worn binaur hearing aid	0.00	0.00	0.00	0.00	XXX	0
V5130		N	In ear binaural hearing aid	0.00	0.00	0.00	0.00	XXX	0
V5140		N	Behind ear binaur hearing aid	0.00	0.00	0.00	0.00	XXX	0
V5150		N	Glasses binaural hearing aid	0.00	0.00	0.00	0.00	XXX	0
V5160		N	Dispensing fee binaural	0.00	0.00	0.00	0.00	XXX	0
V5170		N	Within ear cros hearing aid	0.00	0.00	0.00	0.00	XXX	0
V5180		N	Behind ear cros hearing aid	0.00	0.00	0.00	0.00	XXX	0
V5190		N	Glasses cros hearing aid	0.00	0.00	0.00	0.00	XXX	0
V5200		N	Cros hearing aid dispens fee	0.00	0.00	0.00	0.00	XXX	0
V5210		N	In ear bicros hearing aid	0.00	0.00	0.00	0.00	XXX	0
V5220		N	Behind ear bicros hearing aid	0.00	0.00	0.00	0.00	XXX	0
V5230		N	Glasses bicros hearing aid	0.00	0.00	0.00	0.00	XXX	0

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² Copyright 1994 American Dental Association. All rights reserved (D0110-D9999).³ # Indicates RVUs are not used for Medicare payment.⁴ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

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

CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
V5240		N	Dispensing fee bicros	0.00	0.00	0.00	0.00	XXX	0
V5299		R	Hearing service	0.00	0.00	0.00	0.00	XXX	N
V5336		N	Repair communication device	0.00	0.00	0.00	0.00	XXX	0
V5362		R	Speech screening	0.00	0.00	0.00	0.00	XXX	N
V5363		R	Language screening	0.00	0.00	0.00	0.00	XXX	N
V5364		R	Dysphagia screening	0.00	0.00	0.00	0.00	XXX	N

Addendum C—Codes With Interim Relative Value Units

Addendum C lists the codes for which interim RVUs have been established. Because these RVUs are interim, public comments on these codes will be considered if they are received by 5 p.m., February 6, 1996. Any revisions to the interim RVUs will be announced in a document to be published in 1996 that provides our analysis of and responses to public comments. These revisions will apply to services furnished beginning January 1, 1997.

Addendum C contains the following information:

1. *CPT/HCPCS code.* This is either a CPT or alphanumeric HCPCS code for the service in question. CPT codes are listed first, followed by alphanumeric HCPCS codes.

2. *Modifier.* A modifier is shown if there is TC (modifier TC) and a PC (modifier -26) for the service. If there is a PC and a TC for the service, Addendum C contains three entries for the code: One for the global values

(both professional and technical); one for modifier -26 (PC); and one for modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PCs and the TCs of the service.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the fee schedule and whether it is separately payable if the service is covered. See Addendum B for a description of the status indicators.

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

5. *Physician work RVUs.* These are the interim RVUs for the physician work for this service.

6. *Practice expense RVUs.* These are the interim RVUs for the practice expense for the service.

7. *Malpractice expense RVUs.* These are the interim RVUs for the malpractice expense for the service.

8. *Total RVUs.* This is the sum of the work, practice expense, and malpractice expense RVUs.

9. *Global period.* This indicator shows the number of days in the global period for the code (0, 10, or 90 days). See Addendum B for explanations of the alpha codes.

10. *Update.* This column indicates whether the update for surgical procedures, primary care services, or other nonsurgical services applies to the CPT/HCPCS code in column 1. A "0" appears in this field for codes that are deleted in 1996 or are not paid under the physician fee schedule. A "P" in this column indicates that the update and CF for primary care services applies to this code. An "N" in this column indicates that the update and CF for other nonsurgical services applies to this code. An "S" in this column indicates that the separate update and CF for surgical procedures applies.

ADDENDUM C.—CODES WITH INTERIM RVUS

CPT/ HCPCS ¹	MOD	Status	Description	Physi- cian work RVUs ²	Practice expense RVUs ³	Mal- practice RVUs	Total	Global period	Update
17110		A	Destruction of skin lesions	0.55	0.40	0.03	0.98	010	S
20100		A	Explore wound, neck	9.50	4.97	1.16	15.63	010	S
20101		A	Explore wound, chest	3.00	1.57	0.37	4.94	010	S
20102		A	Explore wound, abdomen	3.68	1.92	0.45	6.05	010	S
20103		A	Explore wound, extremity	4.95	2.59	0.60	8.14	010	S
20930		B	Spinal bone allograft	0.00	0.00	0.00	0.00	XXX	0
20931		A	Spinal bone allograft	1.81	1.73	0.28	3.82	ZZZ	S
20936		B	Spinal bone autograft	0.00	0.00	0.00	0.00	XXX	0
20937		A	Spinal bone autograft	2.79	2.66	0.44	5.89	ZZZ	S
20938		A	Spinal bone autograft	3.02	2.88	0.47	6.37	ZZZ	S
21076		A	Prepare face/oral prosthesis	12.54	16.77	1.35	30.66	010	S
21077		A	Prepare face/oral prosthesis	31.54	42.18	3.39	77.11	090	S
21141		A	Reconstruct midface, left	16.92	14.34	1.68	32.94	090	S
21142		A	Reconstruct midface, left	17.58	14.84	1.74	34.16	090	S
21143		A	Reconstruct midface, left	18.30	15.40	1.81	35.51	090	S
21145		A	Reconstruct midface, left	18.92	14.34	1.68	34.94	090	S
21146		A	Reconstruct midface, left	19.58	14.84	1.74	36.16	090	S
21147		A	Reconstruct midface, left	20.30	15.40	1.81	37.51	090	S
22100		A	Remove part of neck vertebra	9.05	7.64	1.09	17.78	090	S
22101		A	Remove part, thorax vertebra	9.00	8.01	1.38	18.39	090	S
22102		A	Remove part, lumbar vertebra	9.00	4.50	0.67	14.17	090	S
22103		A	Remove extra spine segment	2.34	2.23	0.37	4.94	ZZZ	S
22110		A	Remove part of neck vertebra	11.59	9.72	1.64	22.95	090	S
22112		A	Remove part, thorax vertebra	11.59	9.90	1.63	23.12	090	S
22114		A	Remove part, lumbar vertebra	11.59	7.25	1.17	20.01	090	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.

² # Indicates RVUs are not used for Medicare payment.

³ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

ADDENDUM C.—CODES WITH INTERIM RVUS—Continued

CPT/ HCPCS ¹	MOD	Status	Description	Physi- cian work RVUs ²	Practice expense RVUs ³	Mal- practice RVUs	Total	Global period	Update
22116		A	Remove extra spine segment	2.32	2.21	0.36	4.89	ZZZ	S
22210		A	Revision of neck spine	22.51	13.83	2.43	38.77	090	S
22212		A	Revision of thorax spine	18.14	17.29	2.83	38.26	090	S
22214		A	Revision of lumbar spine	18.14	15.11	2.68	35.93	090	S
22216		A	Revise, extra spine segment	6.04	5.07	0.89	12.00	ZZZ	S
22220		A	Revision of neck spine	20.15	16.64	2.63	39.42	090	S
22222		A	Revision of thorax spine	20.15	13.61	1.58	35.34	090	S
22224		A	Revision of lumbar spine	20.15	14.68	2.66	37.49	090	S
22226		A	Revise, extra spine segment	6.04	5.07	0.89	12.00	ZZZ	S
22305		A	Treat spine process fracture	1.86	*2.38	0.37	4.61	090	S
22310		A	Treat spine fracture	1.86	*2.52	0.69	5.07	090	S
22315		A	Treat spine fracture	8.36	5.51	0.86	14.73	090	S
22325		A	Repair of spine fracture	17.19	8.32	1.34	26.85	090	S
22326		A	Repair neck spine fracture	18.43	15.93	2.74	37.10	090	S
22327		A	Repair thorax spine fracture	17.56	15.95	2.35	35.86	090	S
22328		A	Repair each add spine fx	4.61	4.40	0.72	9.73	ZZZ	S
22548		A	Neck spine fusion	24.08	22.74	3.82	50.64	090	S
22554		A	Neck spine fusion	17.24	19.81	3.52	40.57	090	S
22556		A	Thorax spine fusion	22.27	21.68	3.58	47.53	090	S
22558		A	Lumbar spine fusion	21.22	20.17	3.38	44.77	090	S
22585		A	Additional spinal fusion	5.53	5.40	0.93	11.86	ZZZ	S
22590		A	Spine & skull spinal fusion	19.50	21.57	3.44	44.51	090	S
22595		A	Neck spinal fusion	18.19	22.46	3.87	44.52	090	S
22600		A	Neck spine fusion	14.74	19.36	3.32	37.42	090	S
22610		A	Thorax spine fusion	14.62	17.87	2.75	35.24	090	S
22612		A	Lumbar spine fusion	20.19	20.60	3.33	44.12	090	S
22614		A	Spine fusion, extra segment	6.44	5.65	0.92	13.01	ZZZ	S
22630		A	Lumbar spine fusion	20.03	18.44	3.15	41.62	090	S
22632		A	Spine fusion, extra segment	5.23	4.99	0.82	11.04	ZZZ	S
22800		A	Fusion of spine	16.92	*21.66	3.58	42.16	090	S
22802		A	Fusion of spine	29.74	28.32	4.61	62.67	090	S
22804		A	Fusion of spine	35.00	28.32	4.61	67.93	090	S
22808		A	Fusion of spine	25.00	18.41	3.15	46.56	090	S
22810		A	Fusion of spine	29.00	18.41	3.15	50.56	090	S
22812		A	Fusion of spine	31.00	25.93	4.24	61.17	090	S
22830		A	Exploration of spinal fusion	10.22	*13.07	2.18	25.47	090	S
22840		A	Insert spine fixation device	6.27	5.98	0.98	13.23	ZZZ	S
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	XXX	0
22842		A	Insert spine fixation device	7.19	6.86	1.12	15.17	ZZZ	S
22843		A	Insert spine fixation device	8.97	8.55	1.40	18.92	ZZZ	S
22844		A	Insert spine fixation device	10.96	10.45	1.71	23.12	ZZZ	S
22845		A	Insert spine fixation device	5.98	5.70	0.93	12.61	ZZZ	S
22846		A	Insert spine fixation device	8.28	7.90	1.29	17.47	ZZZ	S
22847		A	Insert spine fixation device	9.20	8.77	1.44	19.41	ZZZ	S
22848		A	Insert pelvic fixation device	6.00	5.72	0.94	12.66	ZZZ	S
22851		A	Apply spine prosth device	6.71	6.40	1.05	14.16	ZZZ	S
32095		A	Biopsy through chest wall	7.13	8.25	1.45	16.83	090	S
32501		A	Repair bronchus (add-on)	4.69	4.31	0.70	9.70	ZZZ	S
33253		A	Reconstruct atria	30.00	21.81	4.26	56.07	090	S
33924		A	Remove pulmonary shunt	5.50	4.00	0.78	10.28	ZZZ	S
38231		A	Stem cell collection	1.50	1.37	0.08	2.95	000	N
38240		A	Bone marrow/stem transplant	2.24	2.08	0.14	4.46	XXX	N
38241		A	Bone marrow/stem transplant	2.24	2.04	0.13	4.41	XXX	N
47350		A	Repair liver wound	11.29	7.46	1.49	20.24	090	S
47360		A	Repair liver wound	15.34	10.93	2.18	28.45	090	S
47361		A	Repair liver wound	28.00	14.64	3.41	46.05	090	S
47362		A	Repair liver wound	10.00	5.23	1.22	16.45	090	S
49000		A	Exploration of abdomen	8.99	6.79	1.40	17.18	090	S
49002		A	Reopening of abdomen	9.40	6.05	1.21	16.66	090	S
49010		A	Exploration behind abdomen	11.19	6.95	1.31	19.45	090	S
55859		A	Percut/needle insert, pros	8.29	5.89	0.58	14.76	090	S
56343		A	Laparoscopic salpingostomy	6.96	5.28	1.11	13.35	090	S
56344		A	Laparoscopic fimbrioplasty	7.16	5.11	1.19	13.46	090	S
57284		A	Repair paravaginal defect	12.10	8.59	0.84	21.53	090	S
59610		A	Vbac delivery	22.55	14.99	3.47	41.01	MMM	S
59612		A	Vbac delivery only	14.84	9.48	2.20	26.52	MMM	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² # Indicates RVUs are not used for Medicare payment.³ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

ADDENDUM C.—CODES WITH INTERIM RVUS—Continued

CPT/ HCPCS ¹	MOD	Status	Description	Physi- cian work RVUs ²	Practice expense RVUs ³	Mal- practice RVUs	Total	Global period	Update
59614	.....	A	Vbac care after delivery	15.96	10.31	2.39	28.66	MMM	S
59618	.....	A	Attempted vbac delivery	25.23	16.90	3.92	46.05	MMM	S
59620	.....	A	Attempted vbac delivery only	16.95	10.99	2.55	30.49	MMM	S
59622	.....	A	Attempted vbac after care	18.11	11.82	2.73	32.66	MMM	S
62274	.....	A	Inject spinal anesthetic	1.78	0.74	0.17	2.69	000	N
62288	.....	A	Injection into spinal canal	1.74	1.12	0.24	3.10	000	N
62350	.....	A	Implant spinal catheter	6.25	3.49	1.02	10.76	090	S
62351	.....	A	Implant spinal catheter	9.25	5.16	1.50	15.91	090	S
62355	.....	A	Remove spinal canal catheter	4.80	3.49	0.68	8.97	090	S
62360	.....	A	Insert spine infusion device	2.00	1.12	0.33	3.45	090	S
62361	.....	A	Implant spine infusion pump	4.80	2.68	0.78	8.26	090	S
62362	.....	A	Implant spine infusion pump	6.29	3.51	1.02	10.82	090	S
62365	.....	A	Remove spine infusion device	4.77	3.47	0.68	8.92	090	S
62367	26	A	Analyze spine infusion pump	0.48	0.35	0.07	0.90	XXX	N
62368	26	A	Analyze spine infusion pump	0.75	0.55	0.11	1.41	XXX	N
67107	.....	A	Repair detached retina	13.99	*17.91	1.10	33.00	090	S
67108	.....	A	Repair detached retina	19.90	*25.47	1.76	47.13	090	S
67112	.....	A	Re-repair detached retina	16.15	16.51	0.86	33.52	090	S
76965	26	A	Echo guidance radiotherapy	1.34	2.07	0.19	3.60	XXX	N
78459	26	G	Heart muscle imaging (PET)	#1.88	1.34	0.10	3.32	XXX	O
78810	26	N	Tumor imaging (PET)	#1.93	1.37	0.10	3.40	XXX	O
92506	.....	A	Speech & hearing evaluation	0.86	0.52	0.05	1.43	XXX	N
92507	.....	A	Speech/hearing therapy	0.52	0.33	0.03	0.88	XXX	N
92508	.....	A	Speech/hearing therapy	0.26	0.18	0.02	0.46	XXX	N
92510	.....	A	Rehab for ear implant	1.50	1.36	0.15	3.01	XXX	N
92516	.....	A	Facial nerve function test	0.43	0.39	0.04	0.86	XXX	N
92525	.....	A	Oral function evaluation	1.13	1.02	0.11	2.26	XXX	N
92526	.....	A	Oral function therapy	0.52	0.47	0.05	1.04	XXX	N
92546	26	A	Sinusoidal rotational test	0.29	0.30	0.03	0.62	XXX	N
92579	.....	A	Visual audiometry (vra)	0.00	0.69	0.07	0.76	XXX	N
92597	.....	A	Oral speech device eval	1.11	1.01	0.11	2.23	XXX	N
92598	.....	A	Modify oral speech device	0.73	0.66	0.07	1.46	XXX	N
92987	.....	A	Revision of mitral valve	20.69	12.20	0.91	33.80	090	N
95872	26	A	Muscle test, one fiber	1.50	0.68	0.06	2.24	XXX	N
95900	26	A	Motor nerve conduction test	0.42	0.35	0.03	0.80	XXX	N
95903	26	A	Motor nerve conduction test	0.60	0.35	0.03	0.98	XXX	N
95904	26	A	Sense nerve conduction test	0.34	0.34	0.03	0.71	XXX	N
95925	26	A	Somatosensory testing	0.54	0.64	0.05	1.23	XXX	N
95926	26	A	Somatosensory testing	0.54	0.64	0.05	1.23	XXX	N
95927	26	A	Somatosensory testing	0.54	0.64	0.05	1.23	XXX	N
95930	26	A	Visual evoked potential test	0.35	0.58	0.04	0.97	XXX	N
95934	26	A	'H' reflex test	0.51	0.34	0.03	0.88	XXX	N
95936	26	A	'H' reflex test	0.55	0.34	0.03	0.92	XXX	N
97010	.....	A	Hot or cold packs therapy	0.11	0.21	0.02	0.34	XXX	N
97012	.....	A	Mechanical traction therapy	0.25	0.19	0.02	0.46	XXX	N
97014	.....	A	Electric stimulation therapy	0.18	0.20	0.02	0.40	XXX	N
97016	.....	A	Vasopneumatic device therapy	0.18	0.25	0.02	0.45	XXX	N
97018	.....	A	Paraffin bath therapy	0.11	0.24	0.03	0.38	XXX	N
97020	.....	A	Microwave therapy	0.11	0.20	0.02	0.33	XXX	N
97022	.....	A	Whirlpool therapy	0.25	0.19	0.02	0.46	XXX	N
97024	.....	A	Diathermy treatment	0.11	0.21	0.02	0.34	XXX	N
97026	.....	A	Infrared therapy	0.11	0.19	0.02	0.32	XXX	N
97028	.....	A	Ultraviolet therapy	0.20	0.19	0.01	0.40	XXX	N
97032	.....	A	Electrical stimulation	0.25	0.14	0.01	0.40	XXX	N
97033	.....	A	Electric current therapy	0.26	0.14	0.02	0.42	XXX	N
97034	.....	A	Contrast bath therapy	0.21	0.10	0.01	0.32	XXX	N
97035	.....	A	Ultrasound therapy	0.21	0.11	0.01	0.33	XXX	N
97036	.....	A	Hydrotherapy	0.38	0.21	0.02	0.61	XXX	N
97039	.....	A	Physical therapy treatment	0.29	0.24	0.03	0.56	XXX	N
97110	.....	A	Therapeutic exercises	0.45	0.13	0.02	0.60	XXX	N
97112	.....	A	Neuromuscular reeducation	0.45	0.13	0.01	0.59	XXX	N
97113	.....	A	Aquatic therapy/exercises	0.44	0.20	0.02	0.66	XXX	N
97116	.....	A	Gait training therapy	0.40	0.11	0.01	0.52	XXX	N
97122	.....	A	Manual traction therapy	0.45	0.11	0.01	0.57	XXX	N
97124	.....	A	Massage therapy	0.35	0.11	0.01	0.47	XXX	N
97139	.....	A	Physical medicine procedure	0.21	0.16	0.02	0.39	XXX	N

¹ All CPT codes and descriptors copyright 1995 American Medical Association.² # Indicates RVUs are not used for Medicare payment.³ * Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.

ADDENDUM C.—CODES WITH INTERIM RVUS—Continued

CPT/ HCPCS ¹	MOD	Status	Description	Physi- cian work RVUs ²	Practice expense RVUs ³	Mal- practice RVUs	Total	Global period	Update
97150	.....	A	Group therapeutic procedures	0.27	0.20	0.02	0.49	XXX	N
97250	.....	A	Myofascial release	0.45	0.35	0.04	0.84	000	N
97260	.....	A	Regional manipulation	0.19	0.20	0.02	0.41	000	N
97261	.....	A	Supplemental manipulations	0.12	0.11	0.01	0.24	000	N
97265	.....	A	Joint mobilization	0.45	0.35	0.04	0.84	XXX	N
97500	.....	A	Orthotics training	0.31	0.27	0.04	0.62	XXX	N
97501	.....	A	Supplemental training	0.17	0.15	0.02	0.34	XXX	N
97520	.....	A	Prosthetic training	0.37	0.30	0.04	0.71	XXX	N
97521	.....	A	Supplemental training	0.22	0.17	0.02	0.41	XXX	N
97530	.....	A	Therapeutic activities	0.44	0.17	0.02	0.63	XXX	N
97535	.....	A	Self care mngment training	0.33	0.17	0.02	0.52	XXX	N
97537	.....	A	Community/work reintegration	0.33	0.17	0.02	0.52	XXX	N
97542	.....	A	Wheelchair mngement training	0.25	0.17	0.02	0.44	XXX	N
97703	.....	A	Prosthetic checkout	0.25	0.18	0.03	0.46	XXX	N
97750	.....	A	Physical performance test	0.45	0.24	0.03	0.72	XXX	N
97770	.....	A	Cognitive skills development	0.44	0.28	0.03	0.75	XXX	N
99238	.....	A	Hospital discharge day	1.06	0.51	0.04	1.61	XXX	N
99239	.....	A	Hospital discharge day	1.75	0.51	0.04	2.30	XXX	N
99435	.....	A	Hospital NB discharge day	1.50	1.55	0.10	3.15	XXX	P
G0030	26	A	PET imaging prev PET single	1.09	0.48	0.07	1.64	XXX	N
G0031	26	A	PET imaging prev PET multiple	1.46	0.65	0.10	2.21	XXX	N
G0032	26	A	PET follow SPECT 78464 singl	1.09	0.48	0.07	1.64	XXX	N
G0033	26	A	PET follow SPECT 78464 mult	1.46	0.65	0.10	2.21	XXX	N
G0034	26	A	PET follow SPECT 76865 singl	1.09	0.48	0.07	1.64	XXX	N
G0035	26	A	PET follow SPECT 78465 mult	1.46	0.65	0.10	2.21	XXX	N
G0036	26	A	PET follow cornry angio sing	1.09	0.48	0.07	1.64	XXX	N
G0037	26	A	PET follow cornry angio mult	1.46	0.65	0.10	2.21	XXX	N
G0038	26	A	PET follow myocard perf sing	1.09	0.48	0.07	1.64	XXX	N
G0039	26	A	PET follow myocard perf mult	1.46	0.65	0.10	2.21	XXX	N
G0040	26	A	PET follow stress echo singl	1.09	0.48	0.07	1.64	XXX	N
G0041	26	A	PET follow stress echo mult	1.46	0.65	0.10	2.21	XXX	N
G0042	26	A	PET follow ventriculogm sing	1.09	0.48	0.07	1.64	XXX	N
G0043	26	A	PET follow ventriculogm mult	1.46	0.65	0.10	2.21	XXX	N
G0044	26	A	PET following rest ECG singl	1.09	0.48	0.07	1.64	XXX	N
G0045	26	A	PET following rest ECG mult	1.46	0.65	0.10	2.21	XXX	N
G0046	26	A	PET follow stress ECG singl	1.09	0.48	0.07	1.64	XXX	N
G0047	26	A	PET follow stress ECG mult	1.46	0.65	0.10	2.21	XXX	N

ADDENDUM D.—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier number	Locality number	Locality name	Work	Practice expense	Mal- practice
00510	05	Birmingham, AL	0.994	0.912	0.927
00510	04	Mobile, AL	0.975	0.858	0.927
00510	02	North Central AL	0.973	0.850	0.927
00510	01	Northwest AL	0.990	0.873	0.927
00510	06	Rest Of AL	0.964	0.818	0.927
00510	03	Southeast AL	0.970	0.858	0.927
01020	01	Alaska	1.064	1.155	1.617
01030	05	Flagstaff, AZ	0.971	0.936	1.321
01030	01	Phoenix, AZ	1.004	0.963	1.321
01030	07	Prescott, AZ	0.971	0.912	1.321
01030	99	Rest Of AZ	0.989	0.948	1.321
01030	02	Tucson, AZ	0.978	0.942	1.321
01030	08	Yuma, AZ	0.984	0.925	1.321
00520	13	Arkansas	0.954	0.853	0.427
02050	26	Anaheim/Santa Ana, CA	1.037	1.205	0.752
00542	14	Bakersfield, CA	1.023	0.992	0.686
00542	11	Fresno/Madera, CA	1.000	0.977	0.596
00542	13	Kings/Tulare, CA	0.987	0.954	0.596
02050	18	Los Angeles (1st Of 8)	1.056	1.207	0.752
02050	19	Los Angeles (2nd Of 8)	1.056	1.207	0.752
02050	20	Los Angeles (3rd Of 8)	1.056	1.207	0.752
02050	21	Los Angeles (4th Of 8)	1.056	1.207	0.752
02050	22	Los Angeles (5th Of 8)	1.056	1.207	0.752

Note: Work GPCI is the 1/4 work GPCI required by Section 1848(e)(1)(A)(iii) of the Social Security Act.

ADDENDUM D.—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier number	Locality number	Locality name	Work	Practice expense	Mal-practice
02050	23	Los Angeles (6th Of 8)	1.056	1.207	0.752
02050	24	Los Angeles (7th Of 8)	1.056	1.207	0.752
02050	25	Los Angeles (8th Of 8)	1.056	1.207	0.752
00542	03	Marin/Napa/Solano, CA	1.015	1.180	0.596
00542	10	Merced/Surr.Cntys, CA	1.002	0.988	0.596
00542	12	Monterey/Santa Cruz, CA	1.008	1.143	0.596
00542	01	N. Coastal Cntys, CA	1.003	1.090	0.596
00542	02	Ne Rural, CA	0.982	0.953	0.596
00542	07	Oakland/Berkeley, CA	1.042	1.215	0.596
00542	27	Riverside, CA	1.011	1.059	0.667
00542	04	Sacramento/Surr. Cntys, CA	1.020	1.069	0.596
00542	15	San Bernadino/E.Ctrl Cntys	1.015	1.056	0.749
02050	28	San Diego/Imperial, CA	1.017	1.077	0.618
00542	05	San Francisco, CA	1.068	1.330	0.596
00542	06	San Mateo, CA	1.049	1.300	0.596
02050	16	Santa Barbara, CA	1.016	1.119	0.686
00542	09	Santa Clara, CA	1.064	1.289	0.596
00542	08	Stockton/Surr. Cntys., CA	1.001	1.041	0.596
02050	17	Ventura, CA	1.028	1.192	0.686
00824	01	Colorado	0.989	0.951	0.827
10230	04	Eastern CT	1.033	1.132	1.001
10230	01	Nw And N. Cntrl CT	1.049	1.159	1.001
10230	03	S. Cntrl CT	1.056	1.226	1.001
10230	02	Sw CT	1.055	1.275	1.001
00570	01	Delaware	1.021	1.032	0.792
00580	01	DC+MD/VA Suburbs	1.051	1.192	0.980
00590	03	Fort Lauderdale, FL	0.998	1.036	1.867
00590	04	Miami, FL	1.016	1.087	2.456
00590	02	N/Nc FL Cities	0.978	0.952	1.417
00590	01	Rest Of Florida	0.971	0.914	1.417
01040	01	Atlanta, GA	1.007	1.030	0.902
01040	04	Rest Of GA	0.965	0.856	0.902
01040	02	Small GA Cities 02	0.981	0.917	0.902
01040	03	Small GA Cities 03	0.966	0.884	0.902
01120	01	Hawaii/Guam	0.999	1.220	0.921
05130	12	North Idaho	0.957	0.864	0.588
05130	11	South Idaho	0.963	0.887	0.588
00621	10	Champaign-Urbana, IL	0.952	0.884	1.008
00621	16	Chicago, IL	1.028	1.080	1.382
00621	03	De Kalb, IL	0.953	0.873	0.780
00621	11	Decatur, IL	0.962	0.864	0.880
00621	12	East St. Louis, IL	0.988	0.929	1.202
00621	06	Kankakee, IL	0.959	0.881	0.901
00621	08	Normal, IL	0.969	0.893	0.731
00621	01	Northwest, IL	0.951	0.842	0.731
00621	05	Peoria, IL	0.980	0.906	0.731
00621	07	Quincy, IL	0.946	0.824	0.731
00621	04	Rock Island, IL	0.972	0.858	0.731
00621	02	Rockford, IL	0.978	0.941	0.813
00621	13	Southeast IL	0.946	0.814	0.731
00621	14	Southern IL	0.946	0.822	0.822
00621	09	Springfield, IL	0.981	0.936	0.946
00621	15	Suburban Chicago, IL	1.007	1.093	1.159
00630	01	Metropolitan IN	0.989	0.937	0.363
00630	03	Rest Of IN	0.973	0.872	0.346
00630	02	Urban IN	0.974	0.896	0.346
00640	00	Iowa	0.960	0.877	0.679
00740	05	Kansas City, Kansas	0.989	0.949	1.191
00650	01	Rest Of Kansas	0.958	0.877	1.191
00740	04	Suburban Kansas City, Kans	0.989	0.949	1.191
00660	01	Lexington & Louisville, KY	0.989	0.904	0.819
00660	03	Rest Of Kentucky	0.957	0.821	0.819
00660	02	Sm Cities (City Limits), KY	0.960	0.850	0.819
00528	07	Alexandria, LA	0.958	0.864	0.911
00528	03	Baton Rouge, LA	0.984	0.894	0.911
00528	06	Lafayette, LA	0.971	0.857	0.911
00528	04	Lake Charles, LA	0.974	0.901	0.911
00528	05	Monroe, LA	0.958	0.867	0.911

Note: Work GPCI is the 1/4 work GPCI required by Section 1848(e)(1)(A)(iii) of the Social Security Act.

ADDENDUM D.—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier number	Locality number	Locality name	Work	Practice expense	Mal-practice
00528	01	New Orleans, LA	0.999	0.946	0.997
00528	50	Rest Of LA	0.965	0.850	0.913
00528	02	Shreveport, LA	0.971	0.889	0.911
21200	02	Central Maine	0.961	0.929	0.759
21200	01	Northern Maine	0.964	0.920	0.759
21200	03	Southern Maine	0.980	1.034	0.759
00901	01	Baltimore/Surr. Cntys, MD	1.021	1.036	1.115
00901	03	South & E. Shore MD	0.985	0.972	0.862
00901	02	Western MD	0.982	0.930	0.862
00700	02	MA Suburbs/Rural Cities	1.015	1.101	0.978
00700	01	Urban MA	1.030	1.167	0.978
00623	01	Detroit, MI	1.043	1.038	3.051
00623	02	Michigan, Not Detroit	0.998	0.935	1.844
00720	00	Minnesota (Blue Shield)	0.990	0.965	0.594
10240	00	Minnesota (Travelers)	0.990	0.965	0.594
10250	01	Rest Of Mississippi	0.950	0.813	0.726
10250	02	Urban Mississippi	0.964	0.868	0.726
00740	03	K.C. (Jackson Cnty), MO	0.989	0.949	1.207
00740	02	N K.C. (Clay/Platte), MO	0.989	0.949	1.204
11260	03	Rest Of MO	0.944	0.810	1.159
00740	06	Rural Nw Counties, MO	0.950	0.835	1.159
11260	02	Sm E. Cities, MO	0.940	0.809	1.159
00740	01	St Joseph, MO	0.952	0.850	1.159
11260	01	St. Louis/Lg E. Cities, MO	0.983	0.921	1.193
00751	01	Montana	0.952	0.864	0.756
00655	00	Nebraska	0.951	0.872	0.444
01290	03	Elko & Ely (Cities), NV	0.984	0.986	0.887
01290	01	Las Vegas, Et Al. (Cities), NV	1.012	1.022	0.887
01290	02	Reno, Et Al. (Cities), NV	0.997	1.049	0.887
01290	99	Rest Of Nevada	0.997	1.013	0.887
00780	40	New Hampshire	0.988	1.034	0.916
00860	02	Middle NJ	1.032	1.137	0.762
00860	01	Northern NJ	1.059	1.215	0.762
00860	03	Southern NJ	1.024	1.082	0.762
01360	05	New Mexico	0.975	0.903	0.792
00801	01	Buffalo/Surr. Cntys, NY	1.003	0.936	0.821
00803	01	Manhattan, NY	1.095	1.359	1.546
00801	03	N. Central Cities, NY	1.005	0.967	0.821
00803	02	Nyc Suburbs/Long I., NY	1.068	1.235	1.759
00803	03	Poughkpsie/N Nyc Suburbs, NY	1.011	1.081	1.218
14330	04	Queens, NY	1.058	1.240	1.686
00801	04	Rest Of New York	0.989	0.937	0.821
00801	02	Rochester/Surr. Cntys, NY	1.012	0.992	0.821
05535	00	North Carolina	0.971	0.918	0.435
00820	01	North Dakota	0.951	0.860	0.617
16360	00	Ohio	0.991	0.940	1.049
01370	00	Oklahoma	0.970	0.882	0.481
01380	02	Eugene, et al. (Cities), OR	0.959	0.938	0.637
01380	01	Portland, et al. (Cities), OR	0.997	1.000	0.637
01380	99	Rest Of Oregon	0.962	0.907	0.637
01380	03	Salem, et al. (Cities), OR	0.965	0.929	0.637
01380	12	Sw Cities (City Limits), OR	0.967	0.954	0.637
00865	02	Lg PA Cities	1.006	1.002	0.936
00865	01	Philly/Pitt Med Shcls/Hosps, PA	1.027	1.040	1.213
00865	04	Rest Of PA	0.973	0.899	0.719
00865	03	Sm PA Cities	0.983	0.917	0.736
00973	20	Puerto Rico	0.883	0.739	0.268
00870	01	Rhode Island	1.019	1.074	1.569
00880	01	South Carolina	0.976	0.899	0.361
00820	02	South Dakota	0.936	0.856	0.443
05440	35	Tennessee	0.976	0.899	0.524
00900	29	Abilene, TX	0.960	0.851	0.827
00900	26	Amarillo, TX	0.975	0.883	0.827
00900	31	Austin, TX	0.987	0.986	0.827
00900	20	Beaumont, TX	0.993	0.893	1.428
00900	09	Brazoria, TX	0.993	0.966	1.428
00900	10	Brownsville, TX	0.955	0.848	0.827
00900	24	Corpus Christi, TX	0.983	0.898	0.827

Note: Work GPCI is the 1/4 work GPCI required by Section 1848(e)(1)(A)(iii) of the Social Security Act.

ADDENDUM D.—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier number	Locality number	Locality name	Work	Practice expense	Mal-practice
00900	11	Dallas, TX	1.012	1.012	0.893
00900	12	Denton, TX	0.968	0.952	0.827
00900	14	El Paso, TX	0.973	0.893	0.893
00900	28	Fort Worth, TX	0.989	0.972	0.893
00900	15	Galveston, TX	0.989	0.966	1.428
00900	16	Grayson, TX	0.959	0.874	0.827
00900	18	Houston, TX	1.021	1.005	1.428
00900	33	Laredo, TX	0.957	0.851	0.827
00900	17	Longview, TX	0.973	0.863	0.827
00900	21	Lubbock, TX	0.955	0.894	0.827
00900	19	McAllen, TX	0.961	0.837	0.827
00900	23	Midland, TX	0.991	0.900	0.827
00900	02	Northeast Rural TX	0.960	0.857	0.827
00900	13	Odessa, TX	0.991	0.900	0.827
00900	25	Orange, TX	0.993	0.893	0.827
00900	30	San Angelo, TX	0.948	0.844	0.827
00900	07	San Antonio, TX	0.978	0.926	0.827
00900	03	Southeast Rural TX	0.963	0.872	0.889
00900	06	Temple, TX	0.968	0.884	0.827
00900	08	Texarkana, TX	0.955	0.872	0.827
00900	27	Tyler, TX	0.971	0.894	0.827
00900	32	Victoria, TX	0.983	0.868	0.827
00900	22	Waco, TX	0.966	0.877	0.827
00900	04	Western TX	0.956	0.818	0.827
00900	34	Wichita Falls, TX	0.950	0.857	0.827
00910	09	Utah	0.978	0.891	0.644
00780	50	Vermont	0.974	0.988	0.452
00973	50	Virgin Islands	0.966	0.978	1.023
10490	04	Rest Of VA	0.976	0.876	0.504
10490	01	Richmond & Charlottesville, VA	1.004	0.991	0.511
10490	03	Sm Town/Industrial VA	0.974	0.897	0.517
10490	02	Tidewater & N VA Cntys	0.990	0.965	0.530
01390	03	E Cntrl & Ne WA	0.985	0.943	0.748
01390	02	Seattle (King Cnty), WA	1.006	1.077	0.748
01390	01	W & Se WA (Excl Seattle)	0.982	0.968	0.748
16510	16	Charleston, WV	0.980	0.881	1.004
16510	18	Eastern Valley, WV	0.960	0.899	1.004
16510	19	Ohio River Valley, WV	0.959	0.833	1.004
16510	20	Southern Valley, WV	0.952	0.815	1.004
16510	17	Wheeling, WV	0.957	0.840	1.004
00951	13	Central WI	0.959	0.849	1.160
00951	40	Green Bay (Northeast), WI	0.976	0.894	1.160
00951	54	Janesville (S Cntrl), WI	0.966	0.895	1.160
00951	19	La Crosse (W Cntrl), WI	0.972	0.879	1.160
00951	15	Madison (Dane Cnty), WI	0.990	1.000	1.160
00951	46	Milwaukee Suburbs (Se), WI	0.990	0.959	1.160
00951	04	Milwaukee, WI	1.001	0.978	1.160
00951	12	Northwest WI	0.961	0.850	1.160
00951	60	Oshkosh (E Cntrl), WI	0.973	0.886	1.160
00951	14	Southwest WI	0.959	0.850	1.160
00951	36	Wausau (N Cntrl), WI	0.962	0.866	1.160
00825	21	Wyoming	0.968	0.881	0.811

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL

CPT/ HCPCS #	Description
10040	Acne surgery.
10060	Drainage of skin abscess.
10061	Drainage of skin abscess.
10080	Drainage of pilonidal cyst.
10081	Drainage of pilonidal cyst.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
10120	Remove foreign body.
10121	Remove foreign body.
10140	Drainage of hematoma/fluid.
10160	Puncture drainage of lesion.
11000	Surgical cleansing of skin.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
11001	Additional cleansing of skin.
11040	Surgical cleansing, abrasion.
11041	Surgical cleansing of skin.
* 11042	Cleansing of skin/tissue.
11050	Trim skin lesion.

* Added to the list as of 1/1/96.

All CPT codes and descriptors copyright 1995 American Medical Association.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
11051	Trim 2 to 4 skin lesions.
11052	Trim over 4 skin lesions.
11100	Biopsy of skin lesion.
11101	Biopsy, each added lesion.
11200	Removal of skin tags.
11201	Removal of added skin tags.
11300	Shave skin lesion.
11301	Shave skin lesion.
11302	Shave skin lesion.
11303	Shave skin lesion.
11305	Shave skin lesion.
11306	Shave skin lesion.
11307	Shave skin lesion.
11308	Shave skin lesion.
11310	Shave skin lesion.
11311	Shave skin lesion.
11312	Shave skin lesion.
11313	Shave skin lesion.
11400	Removal of skin lesion.
11401	Removal of skin lesion.
11402	Removal of skin lesion.
11403	Removal of skin lesion.
* 11404	Removal of skin lesion.
11420	Removal of skin lesion.
11421	Removal of skin lesion.
11422	Removal of skin lesion.
11423	Removal of skin lesion.
* 11424	Removal of skin lesion.
11440	Removal of skin lesion.
11441	Removal of skin lesion.
11442	Removal of skin lesion.
11443	Removal of skin lesion.
* 11444	Removal of skin lesion.
* 11446	Removal of skin lesion.
11600	Removal of skin lesion.
11601	Removal of skin lesion.
11602	Removal of skin lesion.
11603	Removal of skin lesion.
* 11604	Removal of skin lesion.
11620	Removal of skin lesion.
11621	Removal of skin lesion.
11622	Removal of skin lesion.
11623	Removal of skin lesion.
* 11624	Removal of skin lesion.
11640	Removal of skin lesion.
11641	Removal of skin lesion.
11642	Removal of skin lesion.
11643	Removal of skin lesion.
* 11644	Removal of skin lesion.
11700	Scraping of 1-5 nails.
11701	Scraping of additional nails.
11710	Scraping of 1-5 nails.
11711	Scraping of additional nails.
11730	Removal of nail plate.
11731	Removal of second nail plate.
11732	Remove additional nail plate.
11740	Drain blood from under nail.
11750	Removal of nail bed.
11752	Remove nail bed/finger tip.
11760	Reconstruction of nail bed.
11762	Reconstruction of nail bed.
11765	Excision of nail fold, toe.
11900	Injection into skin lesions.
11901	Added skin lesion injections.
* 12021	Closure of split wound.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
12031	Layer closure of wound(s).
12032	Layer closure of wound(s).
12041	Layer closure of wound(s).
12042	Layer closure of wound(s).
12051	Layer closure of wound(s).
12052	Layer closure of wound(s).
* 13100	Repair of wound or lesion.
* 13101	Repair of wound or lesion.
* 13120	Repair of wound or lesion.
* 13121	Repair of wound or lesion.
* 13131	Repair of wound or lesion.
* 13132	Repair of wound or lesion.
* 13151	Repair of wound or lesion.
* 13152	Repair of wound or lesion.
* 14000	Skin tissue rearrangement.
* 14040	Skin tissue rearrangement.
* 14041	Skin tissue rearrangement.
* 14061	Skin tissue rearrangement.
15780	Abrasion treatment of skin.
15781	Abrasion treatment of skin.
15782	Abrasion treatment of skin.
15783	Abrasion treatment of skin.
15786	Abrasion treatment of lesion.
15787	Abrasion, added skin lesions.
15851	Removal of sutures.
15852	Dressing change, not for burn.
16000	Initial treatment of burn(s).
16010	Treatment of burn(s).
16020	Treatment of burn(s).
16025	Treatment of burn(s).
17000	Destroy benign/premalignant lesion.
17001	Destruction of add'l lesions.
17002	Destruction of add'l lesions.
17010	Destruction skin lesion(s).
17100	Destruction of skin lesion.
17101	Destruction of 2nd lesion.
17102	Destruction of add'l lesions.
17104	Destruction of skin lesions.
17105	Destruction of skin lesions.
17106	Destruction of skin lesions.
17107	Destruction of skin lesions.
17110	Destruction of skin lesions.
17200	Electrocautery of skin tags.
17201	Electrocautery added lesions.
17250	Chemical cautery, tissue.
17260	Destruction of skin lesions.
17261	Destruction of skin lesions.
17262	Destruction of skin lesions.
17263	Destruction of skin lesions.
17264	Destruction of skin lesions.
17266	Destruction of skin lesions.
17270	Destruction of skin lesions.
17271	Destruction of skin lesions.
17272	Destruction of skin lesions.
17273	Destruction of skin lesions.
17274	Destruction of skin lesions.
17276	Destruction of skin lesions.
17280	Destruction of skin lesions.
17281	Destruction of skin lesions.
17282	Destruction of skin lesions.
17283	Destruction of skin lesions.
17284	Destruction of skin lesions.
17286	Destruction of skin lesions.
17304	Chemosurgery of skin lesion.
17305	2nd stage chemosurgery.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
17306	3rd stage chemosurgery.
17307	Followup skin lesion therapy.
17310	Extensive skin chemosurgery.
17340	Cryotherapy of skin.
17360	Skin peel therapy.
19000	Drainage of breast lesion.
19001	Drain added breast lesion.
* 19100	Biopsy of breast.
20000	Incision of abscess.
20500	Injection of sinus tract.
20520	Removal of foreign body.
20550	Inj tendon/ligament/cyst.
20600	Drain/inject joint/bursa.
20605	Drain/inject joint/bursa.
20610	Drain/inject joint/bursa.
20615	Treatment of bone cyst.
* 20670	Removal of support implant.
20974	Electrical bone stimulation.
* 21025	Excision of bone, lower jaw.
* 21026	Excision of facial bone(s).
21029	Contour of face bone lesion.
21030	Removal of face bone lesion.
21031	Remove exostosis, mandible.
21032	Remove exostosis, maxilla.
* 21040	Removal of jaw bone lesion.
* 21041	Removal of jaw bone lesion.
21079	Prepare face/oral prosthesis.
21080	Prepare face/oral prosthesis.
21081	Prepare face/oral prosthesis.
21082	Prepare face/oral prosthesis.
21083	Prepare face/oral prosthesis.
21084	Prepare face/oral prosthesis.
21085	Prepare face/oral prosthesis.
21086	Prepare face/oral prosthesis.
21087	Prepare face/oral prosthesis.
21088	Prepare face/oral prosthesis.
21089	Prepare face/oral prosthesis.
21110	Interdental fixation.
* 21210	Face bone graft.
* 21215	Lower jaw bone graft.
* 21248	Reconstruction of jaw.
* 21249	Reconstruction of jaw.
* 21485	Reset dislocated jaw.
* 21550	Biopsy of neck/chest.
* 21920	Biopsy soft tissue of back.
23031	Drain shoulder bursa.
* 23330	Remove shoulder foreign body.
* 23620	Treat humerus fracture.
* 23931	Drainage of arm bursa.
* 24065	Biopsy arm/elbow soft tissue.
24200	Removal of arm foreign body.
* 24362	Reconstruct elbow joint.
24650	Treat radius fracture.
* 25065	Biopsy forearm soft tissues.
25500	Treat fracture of radius.
25530	Treat fracture of ulna.
25600	Treat fracture radius/ulna.
25622	Treat wrist bone fracture.
* 25624	Treat wrist bone fracture.
25630	Treat wrist bone fracture.
* 25635	Treat wrist bone fracture.
25650	Repair wrist bone fracture.
26010	Drainage of finger abscess.
* 26070	Explore/treat hand joint.
* 26432	Repair finger tendon.

* Added to the list as of 1/1/96.

All CPT codes and descriptors copyright 1995 American Medical Association.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
26600	Treat metacarpal fracture.
* 26605	Treat metacarpal fracture.
26720	Treat finger fracture, each.
26725	Treat finger fracture, each.
26740	Treat finger fracture, each.
* 27086	Remove hip foreign body.
* 27323	Biopsy thigh soft tissues.
* 27520	Treat kneecap fracture.
* 27604	Drain lower leg bursa.
* 27613	Biopsy lower leg soft tissue.
* 27760	Treatment of ankle fracture.
* 27780	Treatment of fibula fracture.
* 27786	Treatment of ankle fracture.
* 27788	Treatment of ankle fracture.
28001	Drainage of bursa of foot.
* 28003	Treatment of foot infection.
28010	Incision of toe tendon.
28011	Incision of toe tendons.
28022	Exploration of a foot joint.
28024	Exploration of a toe joint.
28052	Biopsy of foot joint lining.
28108	Removal of toe lesions.
28124	Partial removal of toe.
28126	Partial removal of toe.
28153	Partial removal of toe.
28160	Partial removal of toe.
28190	Removal of foot foreign body.
28220	Release of foot tendon.
* 28222	Release of foot tendons.
28230	Incision of foot tendon(s).
28232	Incision of toe tendon.
28234	Incision of foot tendon.
28270	Release of foot contracture.
28272	Release of toe joint, each.
* 28313	Repair of demormity of toe.
* 28400	Treatment of heal fracture.
28430	Treatment of ankle fracture.
28450	Treat midfoot fracture, each.
28455	Treat midfoot fracture, each.
28470	Treat metatarsal fracture.
28475	Treat metatarsal fracture.
28490	Treat big toe fracture.
28495	Treat big toe fracture.
28510	Treatment of toe fracture.
28515	Treatment of toe fracture.
28530	Treat sesamoid bone fracture.
28540	Treat foot dislocation.
28570	Treat foot dislocation.
28600	Treat foot dislocation.
28630	Treat toe dislocation.
* 28635	Treat toe dislocation.
* 28665	Treat toe dislocation.
29015	Application of body cast.
29020	Application of body cast.
29025	Application of body cast.
29035	Application of body cast.
29049	Application of shoulder cast.
29065	Application of long arm cast.
29075	Application of forearm cast.
29085	Apply hand/wrist cast.
29105	Apply long arm splint.
29125	Apply forearm splint.
29126	Apply forearm splint.
29130	Application of finger splint.
29131	Application of finger splint.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
29200	Strapping of chest.
29220	Strapping of low back.
29260	Strapping of elbow or wrist.
29280	Strapping of hand or finger.
29345	Application of long leg cast.
29355	Application of long leg cast.
29358	Apply long leg cast brace.
29365	Application of long leg cast.
29405	Apply short leg cast.
29425	Apply short leg cast.
29435	Apply short leg cast.
29440	Addition of walker to cast.
29450	Application of leg cast.
29515	Application of lower leg splint.
29520	Strapping of hip.
29530	Strapping of knee.
29540	Strapping of ankle.
29550	Strapping of toes.
29580	Application of paste boot.
29590	Application of foot splint.
29700	Removal/revision of cast.
29705	Removal/revision of cast.
29710	Removal/revision of cast.
29715	Removal/revision of cast.
29720	Repair of body cast.
29730	Windowing of cast.
29740	Wedging of cast.
29750	Wedging of clubfoot cast.
29850	Knee arthroscopy/surgery.
30000	Drainage of nose lesion.
30020	Drainage of nose lesion.
30100	Intranasal biopsy.
30110	Removal of nose polyp(s).
* 30124	Removal of nose lesion.
30200	Injection treatment of nose.
30210	Nasal sinus therapy.
30220	Insert nasal septal button.
30300	Remove nasal foreign body.
* 30560	Release of nasal adhesions.
* 30580	Repair upper jaw fistula.
* 30801	Cauterization inner nose.
30901	Control of nosebleed.
31000	Irrigation maxillary sinus.
31002	Irrigation sphenoid sinus.
* 31233	Nasal/sinus endoscopy, dx.
* 31235	Nasal/sinus endoscopy, dx.
* 31237	Nasal/sinus endoscopy, surg.
* 31238	Nasal/sinus endoscopy, surg.
31505	Diagnostic laryngoscopy.
* 31525	Diagnostic laryngoscopy.
* 31570	Laryngoscopy with injection.
31575	Diagnostic laryngoscopy.
31579	Diagnostic laryngoscopy.
* 33011	Repeat drainage of heart sac.
36000	Place needle in vein.
36400	Drawing blood.
36405	Drawing blood.
36406	Drawing blood.
36410	Drawing blood.
36430	Blood transfusion service.
36450	Exchange transfusion service.
36470	Injection therapy of vein.
36471	Injection therapy of veins.
36510	Insertion of catheter, vein.
* 38300	Drainage lymph node lesion.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
* 38505	Needle biopsy, lymph node(s).
40490	Biopsy of lip.
40800	Drainage of mouth lesion.
* 40801	Drainage of mouth lesion.
40804	Removal foreign body, mouth.
40808	Biopsy of mouth lesion.
40810	Excision of mouth lesion.
40812	Excise/repair mouth lesion.
* 40814	Excise/repair mouth lesion.
* 40816	Excision of mouth lesion.
* 40819	Excise lip or cheek fold.
* 40820	Treatment of mouth lesion.
* 41000	Drainage of mouth lesion.
* 41008	Drainage of mouth lesion.
41100	Biopsy of tongue.
* 41105	Biopsy of tongue.
41108	Biopsy of floor of mouth.
* 41110	Excision of tongue lesion.
* 41112	Excision of tongue lesion.
* 41113	Excision of tongue lesion.
* 41800	Drainage of gum lesion.
* 41806	Removal of foreign body, jawbone.
41825	Excision of gum lesion.
41826	Excision of gum lesion.
* 41827	Excision of gum lesion.
* 42000	Drainage mouth roof lesion.
42100	Biopsy roof of mouth.
* 42104	Excision lesion, mouth roof.
* 42106	Excision lesion, mouth roof.
* 42107	Excision lesion, mouth roof.
* 42160	Treatment mouth roof lesion.
* 42300	Drainage of salivary gland.
* 42310	Drainage of salivary gland.
42330	Removal of salivary stone.
* 42335	Removal of salivary stone.
* 42340	Removal of salivary stone.
42400	Biopsy of salivary gland.
* 42405	Biopsy of salivary gland.
42650	Dilation of salivary duct.
42660	Dilation of salivary duct.
* 42700	Drainage of tonsil abscess.
42800	Biopsy of throat.
45300	Proctosigmoidoscopy.
45303	Proctosigmoidoscopy.
* 45305	Proctosigmoidoscopy; biopsy.
* 45308	Proctosigmoidoscopy.
* 45309	Proctosigmoidoscopy.
45330	Sigmoidoscopy, diagnostic.
45520	Treatment of rectal prolapse.
* 46050	Incision of anal abscess.
46083	Incise external hemorrhoid.
46221	Ligation of hemorrhoid(s).
46230	Removal of anal tabs.
46320	Removal of hemorrhoid clot.
46500	Injection into hemorrhoids.
46600	Diagnostic anoscopy.
46604	Anoscopy and dilation.
46606	Anoscopy and biopsy.
* 46611	Anoscopy.
46614	Anoscopy; control bleeding.
46615	Anoscopy.
46900	Destruction, anal lesion(s).
46910	Destruction, anal lesion(s).
46916	Cryosurgery, anal lesion(s).
46917	Laser surgery, anal lesion(s).

* Added to the list as of 1/1/96.

All CPT codes and descriptors copyright 1995 American Medical Association.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
46934	Destruction of hemorrhoids.
46935	Destruction of hemorrhoids.
46936	Destruction of hemorrhoids.
46940	Treatment of anal fissure.
46942	Treatment of anal fissure.
46945	Ligation of hemorrhoids.
46946	Ligation of hemorrhoids.
51700	Irrigation of bladder.
51705	Change of bladder tube.
*51710	Change of bladder tube.
51720	Treatment of bladder lesion.
*52000	Cystoscopy.
*52010	Cystoscopy & duct catheter.
52265	Cystoscopy & treatment.
*52281	Cystoscopy & treatment.
*52285	Cystoscopy & treatment.
53270	Removal of urethra gland.
*53420	Reconstruct urethra, stage 1.
53600	Dilate urethra stricture.
53601	Dilate urethra stricture.
53620	Dilate urethra stricture.
53621	Dilate urethra stricture.
53660	Dilation of urethra.
53661	Dilation of urethra.
53670	Insert urinary catheter.
54050	Destruction, penis lesion(s).
54055	Destruction, penis lesion(s).
54056	Cryosurgery, penis lesion(s).
*54065	Destruction, penis lesion(s).
54200	Treatment of penis lesion.
54230	Prepare penis study.
54235	Penile injection.
55000	Drainage of hydrocele.
55250	Removal of sperm duct(s).
*55700	Biopsy of prostate.
*56405	I & D of vulva/perineum.
56420	Drainage of gland abscess.
56501	Destruction, vulva lesion(s).
*56605	Biopsy of vulva/perineum.
56606	Biopsy of vulva/perineum.
57061	Destruction vagina lesion(s).
57100	Biopsy of vagina.
57150	Treat vagina infection.
57160	Insertion of pessary.
57170	Fitting of diaphragm/cap.
*57180	Treat vaginal bleeding.
57452	Examination of vagina.
57454	Vagina examination & biopsy.
57460	Leep procedure.
57500	Biopsy of cervix.
57505	Endocervical curettage.
57510	Cauterization of cervix.
57511	Cryocautery of cervix.
*57800	Dilation of cervical canal.
58100	Biopsy of uterus lining.
58301	Remove intrauterine device.
59200	Insert cervical dilator.
59300	Episiotomy or vaginal repair.
59425	Antepartum care only.
59426	Antepartum care only.
59430	Care after delivery.
*60000	Drain thyroid/tongue cyst.
60100	Biopsy of thyroid.
61001	Remove cranial cavity fluid.
*61070	Brain canal shunt procedure.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
63690	Analysis of neuroreceiver.
63691	Analysis of neuroreceiver.
64400	Injection for nerve block.
64405	Injection for nerve block.
64408	Injection for nerve block.
64412	Injection for nerve block.
64413	Injection for nerve block.
64418	Injection for nerve block.
64435	Injection for nerve block.
64440	Injection for nerve block.
64441	Injection for nerve block.
64445	Injection for nerve block.
64450	Injection for nerve block.
64505	Injection for nerve block.
64508	Injection for nerve block.
64550	Apply neurostimulator.
64553	Implant neuroelectrodes.
64555	Implant neuroelectrodes.
64560	Implant neuroelectrodes.
64565	Implant neuroelectrodes.
64612	Destroy nerve, face muscle.
64613	Destroy nerve, spine muscle.
65205	Remove foreign body from eye.
65210	Remove foreign body from eye.
65220	Remove foreign body from eye.
65222	Remove foreign body from eye.
65286	Repair of eye wound.
65430	Corneal smear.
65435	Curette/treat cornea.
65436	Curette/treat cornea.
65600	Revision of cornea.
65772	Correction of astigmatism.
*65805	Drainage of eye.
65855	Laser surgery of eye.
65860	Incise inner eye adhesions.
*66030	Injection treatment of eye.
66761	Revision of iris.
*66762	Revision of iris.
66770	Removal of inner eye lesion.
*67031	Laser surgery, eye strands.
*67101	Repair detached retina.
*67105	Repair detached retina.
*67141	Treatment of retina.
67145	Treatment of retina.
*67208	Treatment of retinal lesion.
67210	Treatment of retinal lesion.
67228	Treatment of retinal lesion.
67345	Destroy nerve of eye muscle.
67505	Inject/treat eye socket.
67515	Inject/treat eye socket.
67700	Drainage of eyelid abscess.
67710	Incision of eyelid.
67800	Remove eyelid lesion.
67801	Remove eyelid lesions.
67805	Remove eyelid lesions.
67810	Biopsy of eyelid.
67820	Revise eyelashes.
67825	Revise eyelashes.
67840	Remove eyelid lesion.
67850	Treat eyelid lesion.
67915	Repair eyelid defect.
67922	Repair eyelid defect.
67930	Repair eyelid wound.
67938	Remove eyelid foreign body.
68020	Incise/drain eyelid lining.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
68040	Treatment of eyelid lesions.
68100	Biopsy of eyelid lining.
68110	Remove eyelid lining lesion.
68135	Remove eyelid lining lesion.
68200	Treat eyelid by injection.
68400	Incise/drain tear gland.
68420	Incise/drain tear sac.
68440	Incise tear duct opening.
68530	Clearance of tear duct.
68705	Revise tear duct opening.
68760	Close tear duct opening.
68761	Close tear duct opening.
68770	Close tear system fistula.
68800	Dilate tear duct opening(s).
68820	Explore tear duct system.
68830	Reopen tear duct channel.
68840	Explore/irrigate tear ducts.
69000	Drain external ear lesion.
69005	Drain external ear lesion.
69020	Drain outer ear canal lesion.
69100	Biopsy of external ear.
69105	Biopsy of external ear canal.
69200	Clear outer ear canal.
69210	Remove impacted ear wax.
69220	Clean out mastoid cavity.
69222	Clean out mastoid cavity.
69400	Inflate middle ear canal.
69401	Inflate middle ear canal.
69405	Catheterize middle ear canal.
69410	Inset middle ear baffle.
69420	Incision of eardrum.
*69424	Remove ventilating tube.
69433	Create eardrum opening.
69540	Remove ear lesion.
69610	Repair of eardrum.
92002	Eye exam, new patient.
92004	Eye exam, new patient.
92012	Eye exam established pt.
92014	Eye exam & treatment.
92019	Eye exam & treatment.
92020	Special eye evaluation.
92070	Fitting of contact lens.
92100	Serial tonometry exam(s).
92120	Tonography & eye evaluation.
92130	Water provocation tonography.
92140	Glaucoma provocative tests.
92225	Special eye exam, initial.
92226	Special eye exam, subsequent.
92230	Eye exam with photos.
92260	Ophthalmoscopy/dynamometry.
92287	Internal eye photography.
92311	Contact lens fitting.
92312	Contact lens fitting.
92313	Contact lens fitting.
92315	Prescription of contact lens.
92316	Prescription of contact lens.
92317	Prescription of contact lens.
92330	Fitting of artificial eye.
92335	Fitting of artificial eye.
92352	Special spectacles fitting.
92353	Special spectacles fitting.
92354	Special spectacles fitting.
92371	Repair & adjust spectacles.
92504	Ear microscopy examination.
92506	Speech & hearing evaluation.

* Added to the list as of 1/1/96.

All CPT codes and descriptors copyright 1995 American Medical Association.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
92507	Speech/hearing therapy.
92508	Speech/hearing therapy.
92511	Nasopharyngoscopy.
92512	Nasal function studies.
92516	Facial nerve function test.
92520	Laryngeal function studies.
92565	Stenger test, pure tone.
92571	Filtered speech hearing test.
92575	Sensorineural acuity test.
92576	Synthetic sentence test.
92577	Stenger test, speech.
92582	Conditioning play audiometry.
93205	Special phonocardiogram.
93221	Vectorcardiogram tracing.
93721	Plethysmography tracing.
93797	Cardiac rehab.
93798	Cardiac rehab/monitor.
95010	Sensitivity skin tests.
95015	Sensitivity skin tests.
95056	Photosensitivity tests.
95065	Nose allergy test.
95075	Ingestion challenge test.
95144	Antigen therapy services.
95145	Antigen therapy services.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
95146	Antigen therapy services.
95147	Antigen therapy services.
95148	Antigen therapy services.
95149	Antigen therapy services.
95165	Antigen therapy services.
95170	Antigen therapy services.
95180	Rapid desensitization.
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.
95857	Tensilon test.
96405	Intralesional chemo admin.
96406	Intralesional chemo admin.
96445	Chemotherapy, intracavitary.
96450	Chemotherapy, into cns.
96542	Chemotherapy injection.
99201	Office/outpatient visit, new.
99202	Office/outpatient visit, new.
99203	Office/outpatient visit, new.
99204	Office/outpatient visit, new.
99205	Office/outpatient visit, new.

ADDENDUM E.—PROCEDURE CODES
SUBJECT TO THE SITE-OF-SERVICE
DIFFERENTIAL—Continued

CPT/ HCPCS #	Description
99211	Office/outpatient visit, est.
99212	Office/outpatient visit, est.
99213	Office/outpatient visit, est.
99214	Office/outpatient visit, est.
99215	Office/outpatient visit, est.
99241	Office consultation.
99242	Office consultation.
99243	Office consultation.
99244	Office consultation.
99245	Office consultation.
99271	Confirmatory consultation.
99272	Confirmatory consultation.
99273	Confirmatory consultation.
99274	Confirmatory consultation.
99354	Prolonged service, office.
99355	Prolonged service, office.
A2000	Chiropractor manip of spine.
G0020	Prepare face/oral prosthesis.
G0021	Prepare face/oral prosthesis.
H5300	Occupational therapy.
M0101	Cutting/remove corns/calluses.

* Added to the list as of 1/1/96.

All CPT codes and descriptors copyright 1995 American Medical Association.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[BPD-828-FN]

RIN 0938-AH03

Medicare Program; Physician Fee Schedule Update For Calendar Year 1996 and Physician Volume Performance Standard Rates of Increase for Federal Fiscal Year 1996

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final notice.

SUMMARY: This final notice announces the calendar year 1996 updates to the Medicare physician fee schedule and the Federal fiscal year 1996 volume performance standard rates of increase for expenditures for physicians' services under the Medicare Supplementary Medical Insurance (Part B) program as required by sections 1848 (d) and (f), respectively, of the Social Security Act. The fee schedule update for calendar year 1996 is 3.8 percent for surgical services, -2.3 percent for primary care services, and 0.4 percent for other nonsurgical services. While it does not affect payment for any particular service, there was a 0.8 percent increase in the update for all physicians' services for 1996. The physician volume performance standard rates of increase for Federal fiscal year 1996 are -0.5 percent for surgical services, 9.3 percent for primary care services, 0.6 percent for other nonsurgical services, and a weighted average of 1.8 percent for all physicians' services.

In our July 26, 1995 proposed rule concerning revisions to payment policies under the Medicare physician fee schedule for calendar year 1996, we proposed using category-specific volume and intensity growth allowances in calculating the default Medicare Volume Performance Standard (MVPS). We received 20 comments on this proposal. Since this proposal is related to the MVPS and this notice deals with MVPS issues, we are responding to those comments in this notice instead of in the final rule for the fee schedule entitled "Medicare Program; Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1996" published elsewhere in this Federal Register issue.

EFFECTIVE DATE: The volume performance standard rates of increase are effective on October 1, 1995. The Medicare physician fee schedule update is effective on January 1, 1996.

ADDRESSES: *Copies:* To order paper copies of the Federal Register containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify Stock Number 069-001-00090-4 and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each paper copy is \$8. As an alternative, you can view and photocopy the Federal Register document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the Federal Register.

To order copies of the source files for this document on high density 3.5 inch personal computer diskettes, send your request to: Superintendent of Documents, Attention: Electronic Products, P.O. Box 37082, Washington, DC 20013-7082. Enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512-1530 or by faxing to (202) 512-1262. The cost for the diskettes is \$20. The file format on the diskettes is comma delimited ASCII.

FOR FURTHER INFORMATION CONTACT:
Ordering information: See **ADDRESSES** section.

Content information: Contact either Don Thompson, (410) 786-4586, or Rick Ensor, (410) 786-5617.

SUPPLEMENTARY INFORMATION:

I. Background and Summary of Legislation

A. The Physician Fee Schedule Update and Medicare Volume Performance Standard

Section 1848 of the Social Security Act (the Act) requires the Secretary of Health and Human Services to—

- Establish annual updates to payment rates under the Medicare physician fee schedule, and
- Establish volume performance standard rates of increase to help control the rate of growth in expenditures for physicians' services.

Under section 1848(b)(1) of the Act, payment for physicians' services, except for anesthesia services, equals the product of the relative value units (RVUs) for a service, a geographic adjustment factor, and a conversion factor. Anesthesia services are paid

under a different relative value system, and payment is equal to the sum of the base and time units for the service multiplied by a geographically adjusted anesthesia-specific conversion factor. The RVUs and anesthesia base units reflect the relative amount of resources used by physicians to furnish the service, and the geographic adjustment factor measures practice cost differences between areas. The geographically adjusted RVUs are multiplied by a conversion factor to obtain the physician fee schedule payment amounts. The 1996 conversion factors are \$15.28 for anesthesia services, \$40.7986 for surgical services, \$35.4173 for primary care services, and \$34.6293 for other nonsurgical services.

1. Physician Fee Schedule Update

Section 1848(d) of the Act requires the Secretary to provide the Congress with her recommendation of a physician fee schedule update by April 15 of each year. Under section 1848(d)(2)(A) of the Act, the Secretary is required to consider a number of factors, including the following:

- The percentage change in the Medicare economic index (MEI), a measure of the change in the cost of operating a medical practice.
- The growth in actual expenditures for physicians' services in the prior fiscal year.
- The relationship between that growth and the volume performance standard rate of increase.
- Changes in the volume and intensity of services.
- Access to services.
- Other factors that may contribute to changes in the volume and intensity of services or access to services.

If the Congress does not set the update, section 1848(d)(3) of the Act establishes the process for updating the physician fee schedule. Under section 1848(d)(3), unless otherwise specified by the Congress, the fee schedule update for a category of physicians' services equals the appropriate update index (the MEI) adjusted by the number of percentage points by which expenditure growth exceeded or was less than the volume performance standard rates of increase for the second preceding year for that category of physicians' services. That is, the calendar year 1996 update would equal the 1996 MEI increased or decreased by the difference between the rate of increase in expenditures for fiscal year 1994 and the volume performance standard for that year. However, section 1848(d)(3)(B) of the Act limits the maximum downward adjustment for 1995 and any succeeding year to 5.0 percentage points. There is

no restriction on upward adjustments to the MEI.

Section 1848(d)(1)(C) of the Act requires the Secretary to publish in the Federal Register, within the last 15 days of October, the updates for the following calendar year.

The updates are required by the Medicare statute, and any budget implications associated with them are due to the requirements of the law and not this notice.

2. Medicare Volume Performance Standard Rates of Increase Section 1848(f) of the Act requires the Secretary to establish volume performance standard rates of increase for Medicare expenditures for physicians' services. The use of volume performance standard rates of increase is intended to control the rate of increase in expenditures for physicians' services.

The volume performance standard rates of increase are not limits on expenditures. Payments for services are not withheld if volume performance standard rates of increase are exceeded. Rather, the appropriate fee schedule update, as specified in section 1848(d)(3)(A) of the Act, is adjusted to reflect the success or failure in meeting the volume performance standard rates of increase.

Section 1848(f) of the Act sets forth the process for establishing the volume performance standard rates of increase by requiring the Secretary to recommend to the Congress the physician volume performance standard rates of increase for the following Federal fiscal year by not later than April 15. The Secretary is required to recommend MVPS rates for surgical,

primary care, other nonsurgical, and all physicians' services. In making the recommendations, the Secretary is required to confer with organizations that represent physicians and to consider the following factors:

- Inflation.
- Changes in the number and age composition of Medicare enrollees under Part B (excluding risk health maintenance organization enrollees).
- Changes in technology.
- Evidence of inappropriate utilization of services.
- Evidence of lack of access to necessary physicians' services.
- Other appropriate factors as determined by the Secretary.

If the Congress does not set the volume performance standard rates of increase, section 1848(f)(2) (A) and (B) of the Act requires the Secretary to set MVPS rates for all physicians' services and each category of physicians' services equal to the product of the following four factors reduced by a performance standard factor, which for fiscal year 1996 is 4.0 percentage points:

- 1.0 plus the Secretary's estimate of the weighted-average percentage increase (divided by 100) in fees for all physicians' services or for the category of physicians' services for the portions of calendar year 1995 and calendar year 1996 contained in fiscal year 1996.
- 1.0 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of Part B enrollees (excluding risk health maintenance organization enrollees) from fiscal year 1995 to fiscal year 1996.
- 1.0 plus the Secretary's estimate of the average annual percentage growth

(divided by 100) in the volume and intensity of all physicians' services or of the category of physicians' services for fiscal year 1990 through fiscal year 1995.

- 1.0 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services or of the category of physicians' services that will result from changes in law or regulations in fiscal year 1996 as compared with expenditures for physicians' services in fiscal year 1995.

Section 1848(f)(1)(C) of the Act requires the Secretary to publish in the Federal Register within the last 15 days of October of each year the volume performance standard rates of increase for all physicians' services and for each category of physicians' services for the Federal fiscal year that began on October 1 of that year. (The MVPS for all physicians' services has no practical effect on the update. We publish it only because we are required to do so by section 1848(f) of the Act.)

3. Past Years' Medicare Volume Performance Standard Rates of Increase and Physician Fee Schedule Updates

MVPS rates have been established under section 1848 of the Act since fiscal year 1990. Calendar year 1992 was the first year in which the update was affected by expenditures under the MVPS system. The following tables illustrate the MVPS rates in each fiscal year since their inception, the actual rates of increase in expenditures, and the corresponding updates in the second subsequent calendar year.

FEE SCHEDULE UPDATE

[In percent]

Calendar year	MEI	Performance adjustment	Legislative adjustment	Update
CY 1992:				
All services	3.2	-0.9	-0.4	-1.9
CY 1993:				
Surgical	2.7	0.4	.....	3.1
Nonsurgical	2.7	-1.9	.....	0.8
CY 1994:				
Surgical	2.3	11.3	-3.6	10.0
Primary care	2.3	5.6	0.0	7.9
Other nonsurgical	2.3	5.6	-2.6	5.3
CY 1995:				
Surgical	2.1	12.8	-2.7	12.2
Primary care	2.1	5.8	0.0	7.9
Other nonsurgical	2.1	5.8	-2.7	5.2
CY 1996:				
Surgical	2.0	1.8	.....	3.8
Primary care	2.0	-4.3	.....	-2.3
Other Nonsurgical	2.0	-1.6	.....	0.4

MEDICARE VOLUME PERFORMANCE STANDARD RATES OF INCREASE
[In percent]

Fiscal year	MVPS	Actual	Difference
FY 1990:			
All services	9.1	10.0	-0.9
FY 1991:			
Surgical	3.3	2.9	0.4
Nonsurgical	8.6	10.5	-1.9
FY 1992:			
Surgical	6.5	-4.8	11.3
Nonsurgical	11.2	5.6	5.6
FY 1993:			
Surgical	8.4	-4.4	12.8
Nonsurgical	10.8	5.0	5.8
FY 1994:			
Surgical	9.1	7.3	1.8
Primary care	10.5	14.8	-4.3
Other nonsurgical	9.2	10.8	-1.6
FY 1995:			
Surgical	9.2	.....	.....
Primary care	13.8	.....	.....
Other nonsurgical	4.4	.....	.....
FY 1996:			
Surgical	-0.5	.....	.....
Primary care	9.3	.....	.....
Other nonsurgical	0.6	.....	.....

Separate MVPS rates for surgical and nonsurgical services were not required until fiscal year 1991. Separate fee schedule updates were not required until calendar year 1993. Beginning with the calendar year 1994 fee schedule update and the fiscal year 1994 MVPS, we established separate updates and MVPS rates of increase for surgical, primary care, and other nonsurgical services.

B. Physicians' Services

Section 1848(f)(5)(A) of the Act defines physicians' services for purposes of the volume performance standard rates of increase as including other items or services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed by a physician or furnished in a physician's office. Section 1861(s) of the Act defines medical and other health services covered under Part B. As provided for in the fiscal year 1990 volume performance standard rates of increase notice in the Federal Register on December 29, 1989 (54 FR 53819), we are including the following medical and other health services in section 1861(s) of the Act in the physician volume performance standard rates of increase if bills for the items are processed and paid for by Medicare carriers:

- Physicians' services.
- Services and supplies furnished incident to physicians' services.
- Outpatient physical therapy and speech therapy services, and outpatient occupational therapy services.
- Antigens prepared by or under the direct supervision of a physician.
- Services of physician assistants, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, nurse practitioners, and clinical nurse specialists.

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests.

- X-ray, radium, and radioactive isotope therapy.

- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations.

As stated in our December 8, 1994 final notice (59 FR 63638) announcing the fiscal year 1995 volume performance standard rates of increase, we are including outpatient diagnostic laboratory tests paid through intermediaries in the MVPS definition of physicians' services beginning in fiscal year 1996 (59 FR 63640).

C. Definition of Surgical, Primary Care, and Other Nonsurgical Services

As described in the December 2, 1993 notice (58 FR 63858) containing our definitions of surgical, primary care, or other nonsurgical services, we consider a procedure to be surgical if the following conditions are met:

- In the HCFA Part B data system, the service is classified under "type of service" as a "surgery."
- The service is performed by surgical specialists more than 50 percent of the time.

As also discussed in the December 1993 notice, section 1842(i)(4) of the Act defines primary care services as "office medical services, emergency department services, home medical services, skilled nursing, intermediate care, and long-

term care medical services, or nursing home, boarding home, domiciliary, or custodial care medical services." Since this language was the result of an amendment to the Act made by section 4042(b) of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) (Public Law 100-203), enacted on December 22, 1987, we rely on the conference report accompanying OBRA 1987 (H. R. Rep. No. 100-495, 100th Congress, 1st Session 594-595 (1987)) to determine the HCFA Common Procedure Coding System (HCPCS) codes to be included in the definition of primary care services. In addition, section 6102(f)(10) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) (Public Law 101-239), enacted on December 19, 1989, indicated intermediate and comprehensive office visits for eye examinations and treatments for new patients were to be considered primary care services.

We classify physicians' services not meeting the surgical or primary care definitions as nonsurgical services.

For a procedure code that is new in 1996 and does not meet the primary care definition, we do not have any data for determining how often the procedure is performed by surgical specialists and therefore whether the service should be classified as surgical or nonsurgical. We categorized these codes as surgical or nonsurgical based on the judgment of our medical staff. To

assist us in making these determinations, we considered the type-of-service classification within the Physicians' Current Procedural Terminology (CPT) and the relationship of services represented by the new codes to surgical services meeting the above-described criteria. We followed a similar process to classify codes that were new in 1995. For the 1996 classification of the new 1995 codes, however, we used 6 months of 1995 data to determine whether they meet the criteria for being considered surgical services. Based on these data, we did not need to reclassify any codes as surgical or nonsurgical.

For 1996, we have classified monthly end-stage renal disease services (HCPCS codes 90918 through 90921) as primary care services. For a full discussion of this classification, see the final rule with comment period entitled "Medicare Program; Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1996" published elsewhere in this Federal Register issue and hereafter referred to as the physician fee schedule final rule.

Also, Addendum B of the physician fee schedule final rule, published elsewhere in this Federal Register issue, lists the RVUs and related information used in determining Medicare payments for HCPCS codes. For the purposes of the physician fee schedule, we have assigned the following surgical, primary care, or other nonsurgical service update indicators to these codes:

Update indicator	Interpretation
S	Surgical services.
P	Primary care services.
N	The physician fee schedule update applies, but the code is not defined as surgical or primary care.
O	The physician fee schedule update does not apply.

The MVPS indicator for a procedure code is identical to the update indicator for codes that have a surgical, primary care, or other nonsurgical service update indicator. However, we consider some codes with an update indicator of "O" to be nonsurgical for the purposes of the MVPS, most notably the clinical diagnostic laboratory codes.

The update indicators for codes new or revised in 1996 are shown in Addendum C of the physician fee schedule final rule, published elsewhere in this Federal Register issue.

II. Analysis of and Responses to Public Comments

In our July 26, 1995 proposed rule (60 FR 38400) concerning revisions to payment policies under the Medicare physician fee schedule for calendar year 1996, we invited public comments on a proposal to use category-specific volume and intensity growth allowances in calculating the default MVPS (60 FR 38416). Since this proposal is related to the MVPS and this notice deals with MVPS issues, we are responding to those comments in this notice instead of in the physician fee schedule, published elsewhere in this Federal Register issue. Our responses to the comments follow:

Comment: Several commenters stated that the use of category-specific volume and intensity growth allowances is counter to the spirit of the MVPS since categories with higher than average volume and intensity growth receive higher MVPS targets, and categories with lower than average volume and intensity growth receive lower targets.

Response: The use of category-specific volume and intensity is more consistent with section 1848(f)(2)(A) of the Act, which describes the calculation of the volume performance standards. Section 1848(f)(2)(A) states that one of the factors in calculating the volume performance standards for all physicians' services and for each category of physicians' services shall be equal to "1 plus the Secretary's estimate of the annual percentage growth (divided by 100) in the volume and intensity of all physicians' services or of the category of physicians' services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year * * *". As stated in our July 26, 1995 proposed rule, although historically the data available to us allowed an accurate estimate of the overall growth in the volume and intensity of physicians' services, they did not allow us to estimate the volume and intensity growth for each individual category of service with the degree of accuracy required for the MVPS calculation. More recent data now allow us to do this. So while it is true that the targets move in the direction of volume and intensity growth, this is a result of the statutory volume performance standard methodology.

Comment: Several commenters stated that the proposed change in methodology does not take into account the "appropriateness" of the differential volume and intensity growth allowances.

Response: As stated in the response to the prior comment, the use of category-specific volume and intensity growth

allowances is more consistent with section 1848(f)(2)(A) of the Act. The appropriateness of the volume performance standards in any given year, or of the statutory methodology itself, can be handled through the MVPS recommendation process. Section 1848(f)(1) of the Act requires the Secretary and the Physician Payment Review Commission to provide recommendations to the Congress on the MVPS for the coming year. The Congress can choose to act on these recommendations or can set the MVPS itself.

Comment: One commenter opposed the use of category-specific volume and intensity growth allowances on the grounds that it was a "stopgap" policy and recommended a legislative change to a single conversion factor and volume performance standard.

Response: As we stated in our July 26, 1995 proposed rule, we proposed this change in our regulations to address immediate problems in the physician fee schedule. The Act does not allow us to create a single conversion factor and volume performance standard for all Medicare physician fee schedule services.

Comment: One commenter believed that we provided no justification for our proposal other than to increase payment for primary care services.

Response: As stated above, the use of category-specific volume and intensity is more consistent with section 1848(f)(2)(A) of the Act. In addition, although for fiscal year 1996 this change in methodology would result in a higher primary care MVPS, this does not necessarily mean the change would have a similar result in future years. The impact on any individual category of physicians' services is dependent on the future relationship between the average volume and intensity growth for that category and for physicians' services overall. If future growth in the volume and intensity of primary care services is lower than overall growth in physicians' services, this change would result in a lower MVPS for primary care services. Similar reasoning applies to the categories of surgical services and nonsurgical services other than primary care.

Comment: Several commenters believed that use of category-specific volume and intensity growth allowances would provide a more accurate baseline against which to compare volume and intensity growth. They also stated that the proposal was more consistent with our use of category-specific estimates of the MVPS factors for the weighted-average increase in physicians' fees and the percentage change in expenditures

resulting from changes in law or regulations.

Response: The use of category-specific volume and intensity growth will make the volume performance standards more comparable with the actual growth in allowed charges for a given category of physicians' services. In addition, we agree that the use of category-specific volume and intensity growth allowances is more consistent with our use of category-specific estimates of the MVPS factors for fees and changes in law or regulations. The language in section 1848(f)(2)(A) of the Act regarding these

two MVPS factors is similar to the language describing the volume and intensity factor.

Final decision: Beginning with fiscal year 1996, we will use category-specific volume and intensity growth allowances in calculating the default volume performance standards.

III. Provisions of This Final Notice

A. Physician Fee Schedule Update for Calendar Year 1996

Under the requirements of section 1848(d)(3) of the Act, the fee schedule

[In percent]

	Surgical services	Primary care services	Nonsurgical services
1996 MEI	2.0	2.0	2.0
MVPS Adjustment	1.8	-4.3	-1.6
1996 Update	3.8	-2.3	0.4

In our July 26, 1995 proposed rule (60 FR 38400) concerning revisions to payment policies under the Medicare physician fee schedule for calendar year 1996, we proposed applying budget-neutrality adjustments to the conversion factors rather than to the RVUs (60 FR 38401 to 38402). As discussed in the physician fee schedule final rule, published elsewhere in this Federal Register issue, the 0.36 percent budget-neutrality adjustment for 1996 will be made on the conversion factors. However, if in the future the Congress explicitly sets a conversion factor at a fixed dollar amount for a given year, we will consider establishing a separate budget-neutrality adjuster or applying the adjustment to the RVUs.

Applying the updates and budget neutrality adjustment to the 1995 conversion factors of \$39.447 for surgical services (other than anesthesia services), \$36.382 for primary care services, and \$34.616 for nonsurgical services yields 1996 conversion factors of \$40.7986 for surgical services, \$35.4173 for primary care services, and \$34.6293 for other nonsurgical services. The 1995 anesthesia conversion factor of \$14.77, which includes the effect of the 1995 RVU budget-neutrality adjustment, will be updated by the surgical update to \$15.28 for 1996, after adjusting for the 1996 budget-neutrality adjustment.

The specific calculations to determine the fee schedule updates for physicians'

[In percent]

Legislative factors	Surgical services	Primary care services	Nonsurgical services
Fees	2.1	2.1	2.3
Enrollment	-0.3	-0.3	-0.3
Volume and Intensity	2.3	5.3	5.1
Legislation	-0.6	5.7	-2.4
Performance Standard Factor	4.0	4.0	4.0
Total	-0.5	9.3	0.6

services for calendar year 1996 are explained in section IV.A. of this notice.

B. Physician Volume Performance Standard Rates of Increase for Fiscal Year 1996

Under the requirements in section 1848(f)(2) (A) and (B) of the Act, we have determined that the volume performance standard rates of increase for physicians' services for fiscal year 1996 are -0.5 percent for surgical services, 9.3 percent for primary care services, 0.6 percent for other nonsurgical services, and a weighted average of 1.8 percent for all physicians' services.

This determination is based on the following legislative factors:

The specific calculations to determine the volume performance standard rates of increase for physicians' services for fiscal year 1996 are explained in section IV.B. of this notice.

IV. Detail on Calculation of the Calendar Year 1996 Physician Fee Schedule Update and the Fiscal Year 1996 Physician Volume Performance Standard Rates of Increase

A. Physician Fee Schedule Update

1. The Percentage Change in the Medicare Economic Index

The MEI measures the weighted-average annual price change for various inputs needed to produce physicians' services. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide labor productivity. This index, which has

1989 base weights, is comprised of two broad categories: (1) Physician's own time, and (2) physician's practice expense.

The physician's own time component represents the net income portion of business receipts and primarily reflects the input of the physician's own time into the production of physicians' services in physicians' offices. This category consists of two subcomponents, wages and salaries and fringe benefits. These components are adjusted by the 10-year moving average percent change in output per man-hour for the nonfarm business sector to eliminate double counting for productivity growth in physicians' offices and the general economy.

The physician's practice expense category represents the rate of price growth in nonphysician inputs to the

production of services in physicians' offices. This category consists of wages and salaries and fringe benefits for nonphysician staff and other nonlabor inputs. Like physician's own time, the nonphysician staff categories are adjusted for productivity using the 10-year moving average percent change in output per man-hour for the nonfarm business sector. The physician's practice expense component also includes the following categories of nonlabor inputs: office expense, medical materials and supplies, professional liability insurance, medical equipment, professional car, and other expense. The table below presents a listing of the MEI cost categories with associated weights and percent changes for price proxies for the 1996 update. The calendar year 1996 MEI is 2.0 percent.

INCREASE IN THE MEDICARE ECONOMIC INDEX [Update for Calendar Year 1996 ¹]

	1989 weights ²	CY 1996 percent changes
Medicare Economic Index Total	100.0	2.0
1. Physician's Own Time ^{3 4}	54.2	1.7
a. Wages and Salaries: Average hourly earnings private nonfarm, net of productivity	45.3	1.6
b. Fringe Benefits: Employment Cost Index, benefits, private nonfarm, net of productivity	8.8	2.1
2. Physician's Practice Expense ³	45.8	2.4
a. Nonphysician Employee Compensation	16.3	1.9
1. Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation, net of productivity	13.8	1.8
2. Fringe Benefits: Employment Cost Index, fringe benefits, white collar, net of productivity	2.5	2.8
b. Office Expense: Consumer Price Index for Urban Consumers (CPI-U), housing	10.3	2.4
c. Medical Materials and Supplies: Producer Price Index (PPI), ethical drugs/PPI, surgical appliances and supplies/CPI-U, medical equipment and supplies (equally weighted)	5.2	2.8
d. Professional Liability Insurance: HCFA professional liability insurance survey ⁵	4.8	2.9
e. Medical Equipment: PPI, medical instruments and equipment	2.3	0.9
f. Other Professional Expense	6.9	3.3
1. Professional Car: CPI-U, private transportation	1.4	4.8
2. Other: CPI-U, all items less food and energy	5.5	2.9
Addendum:		
Productivity: 10-year moving average of output per man-hour, nonfarm business sector	N/A	1.2
Physician's Own Time, not productivity adjusted	54.2	2.9
Wages and salaries, not productivity adjusted	45.3	2.8
Fringe benefits, not productivity adjusted	8.8	3.3
Nonphysician Employee Compensation, not productivity adjusted	16.3	3.1
Wages and salaries, not productivity adjusted	13.8	3.0
Fringe benefits, not productivity adjusted	2.5	4.0

¹ The rates of change are for the 12-month period ending June 30, 1995, which is the period used for computing the calendar year 1996 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 1995.

² The weights shown for the MEI components are the 1989 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for calendar year 1989. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 1989 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.

³ The Physician's Own Time and Nonphysician Employee Compensation category price measures include an adjustment for productivity. The price measure for each category is divided by the 10-year moving average of output per man-hour in the nonfarm business sector. For example, the wages and salaries component of Physician's Own Time is calculated by dividing the rate of growth in average hourly earnings by the 10-year moving average rate of growth of output per man-hour for the nonfarm business sector. Dividing one plus the decimal form of the percent change in the average hourly earnings (1+.028=1.028 by one plus the decimal form of the percent change in the 10-year moving average of labor productivity (1+.012=1.012) equals one plus the change in average hourly earnings net of the change in output per man-hour (1.028/.012=1.016. All Physician's Own Time and Nonphysician Employee Compensation categories are adjusted in this way. Due to a higher level of precision the computer-calculated quotient may differ from the quotient calculated from rounded individual percent changes.

⁴ The average hourly earnings proxy, the Employment Cost Index proxies, as well as the CPI-U, housing and CPI-U, private transportation are published in the Current Labor Statistics Section of the Bureau of Labor Statistics' Monthly Labor Review. The remaining CPIs and PPIs in the revised index can be obtained from the Bureau of Labor Statistics' CPI Detailed Report or Producer Price Indexes.

⁵Derived from a HCFA survey of several major insurers (the latest available historical percent change data are for calendar year 1994). This is consistent with prior computations of the professional liability insurance component of the MEI.

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

2. Medicare Volume Performance Standard Performance Adjustment

As required by section 1848(d)(3)(B)(i) of the Act, we are increasing the update by 1.8 percentage points for surgical services and decreasing it by 4.3 percentage points for primary care and 1.6 percentage points for other nonsurgical services to reflect the percentage increase in expenditures between fiscal year 1993 and fiscal year 1994 relative to the volume performance standard rates of increase for fiscal year 1994.

Our estimate of the percentage growth in surgical services between fiscal year 1993 and fiscal year 1994 is 7.3 percent. Because the volume performance standard rate of increase for fiscal year 1994 was 9.1 percent, the rate of increase in expenditures for surgical services was less than the volume performance standard rate of increase by 1.8 percentage points. For primary care services, the rate of increase in expenditures was 14.8 percent, 4.3 percentage points greater than the volume performance standard rate of increase of 10.5 percent. For other nonsurgical services, the rate of increase in expenditures was 10.8 percent, 1.6 percentage points greater than the volume performance standard rate of increase of 9.2 percent.

B. Fiscal Year 1996 Physician Volume Performance Standard Rates of Increase

Below we explain how we determined the increases for each of the four factors used in determining the volume performance standard rates of increase for fiscal year 1996.

Factor 1—Weighted-Average Percentage Increase in Fees for Physicians' Services (Before Applying Legislative Reductions) for Months of Calendar Years 1995 and 1996 Included in Fiscal Year 1996

This factor was calculated as a weighted average of the fee increases that apply to fiscal year 1996; that is, the fee increases that apply to the last 3 months of calendar year 1995 multiplied by 25 percent plus the fee increases that apply to the first 9 months of calendar year 1996 multiplied by 75 percent. Beginning with calendar year 1992, physicians' services are updated by a physician fee schedule update factor that is based on the MEI adjusted for several statutory factors. The update factor for a category

of physicians' services for calendar year 1996 is adjusted by the number of percentage points that the rate of increase in expenditures in fiscal year 1994 compared to fiscal year 1993 was less than the volume performance standard rate of increase for the category of physicians' services in fiscal year 1994. Laboratory services are updated by increases in the Consumer Price Index for Urban Consumers (CPI-U).

Table 2 shows the updates that were used to determine the weighted-average percentage increase in physician fees.

TABLE 2.—MEDICARE ECONOMIC INDEX AND CONSUMER PRICE INDEX FOR URBAN CONSUMERS FOR CALENDAR YEARS 1995 AND 1996

	1995	1996
MEI	2.1	2.0
CPI-U	2.8	3.2

Physicians' services make up approximately 90 percent of the total expenditures in the definition of physicians' services used for purposes of the volume performance standard rates of increase; laboratory services represent approximately 10 percent.

In addition to the annual updates and individual weights of the above services, one other element has an effect on the rate of increase in physician fees. Section 1842(h)(1) of the Act provides for "participating physicians" who agree to accept Medicare payment as payment in full and to bill Medicare beneficiaries only for the 20 percent coinsurance amount and any unmet portion of the \$100 annual deductible amount. Sections 1842(b)(4)(A)(iv) and 1848(a)(3) of the Act provide that nonparticipating physicians are paid 5 percent less for their Medicare services than participating physicians. The nonparticipating physicians are given an opportunity at the end of each calendar year to enroll as participating physicians for the next calendar year. Participation rates have increased each year, and we assume that this trend will continue. The increase in the number of participating physicians and the fact that they are paid at a rate higher than nonparticipating physicians also add to the rate of increase in the weighted-average percentage increase in physician fees.

After taking into account all the elements described above, we estimate that the weighted-average increase in

fees for physicians' services in fiscal year 1996 before applying the legislative changes will be 2.1 percent for surgical services, 2.1 percent for primary care services, 2.3 percent for other nonsurgical services, and a weighted average of 2.2 percent for all physicians' services.

Factor 2—The Percentage Increase in the Average Number of Part B Enrollees from Fiscal Year 1995 to Fiscal Year 1996

We estimate that average Medicare Part B enrollment in fiscal year 1996 will be 36.2 million. Decreasing that figure by the estimated enrollment in risk health maintenance organizations of 3.1 million (those enrolled in risk health maintenance organizations whose Medicare-covered medical care is paid for through the adjusted average per capita cost mechanism and is therefore outside the scope of the MVPS) results in an estimate of 33.0 million Part B enrollees in fiscal year 1996 not in risk health maintenance organizations.

The corresponding figures for 1995 are estimated to be 35.5 million total Part B enrollees and 2.4 million risk health maintenance organization enrollees, which result in an estimate of 33.1 million Part B enrollees not in risk health maintenance organizations. We estimate that there will be 0.1 million fewer Part B enrollees not in risk health maintenance organizations in fiscal year 1996 than in fiscal year 1995, which represents a —0.3 percent decrease from fiscal year 1995 to fiscal year 1996 for surgical services, primary care services, other nonsurgical services, and the average of all physicians' services.

Factor 3—Average Annual Growth in the Volume and Intensity of Physicians' Services for Fiscal Year 1991 through Fiscal Year 1995

Section 1848(f)(2)(A)(iii) of the Act requires the Secretary to estimate the average annual percentage growth in the volume and intensity of physicians' services or of the category of physicians' services for fiscal year 1991 through fiscal year 1995. This estimate must be based upon information contained in the most recent annual report issued by the Board of Trustees of the Supplementary Medical Insurance Trust Fund (Trustees' Report).

The data on the percentage increase in the volume and intensity of services in the Trustees' Report are based on historical trends in increases in allowed

charges, which are not influenced by the Part B deductible. The volume performance standard rates of increase under this notice, however, have historically been compared to increases in expenditures, which are influenced by the Part B deductible. Section 1832(b) of the Act specifies that the Part B deductible will be \$100 for calendar year 1991 and subsequent years. The effect of the deductible remaining fixed at \$100 is that the overall annual increases in allowed charges for MVPS physicians' services are lower than the overall annual increases in expenditures. Although we believe it would be consistent with a literal interpretation of section 1848(f)(2)(A)(iii) of the Act, it would be inappropriate to base the volume and intensity component on the lower 5-year growth in allowed charges and compare the volume performance standards to the higher growth in expenditures, so we instead compare the standards to the growth in allowed charges.

Consistent with data contained in the Trustees' Report, we estimated Factor 3 using a definition of physicians' services that includes certain supplies and nonphysician services not otherwise included in computing the volume performance standard rates of increase (primarily durable medical equipment and ambulance services). We included data for these services because we were required to base the estimate on data contained in the Trustees' Report, and it was not feasible to recompute the data from the 5-year period to exclude these supplies and nonphysician services. We believe the inclusion of these nonphysician supplies and services in this component has a minimal effect on the estimate because the component measures rates of change. Since durable medical equipment and ambulance services constitute only about 10 percent of the total charges used in the Trustees' Report, the rate of change for these nonphysician services and supplies would have to be significantly different from the rate of change for physicians' services to have any measurable impact on this volume and intensity increase factor. (Factor 3 is the only component of the volume performance standard rate of increase that was estimated using data that included nonphysician services and supplies.) The volume increases for services performed in independent laboratories were included in the calculation of the physician increases, as were the volume increases for clinical laboratory tests performed in hospital outpatient departments.

As described earlier, the fiscal year 1996 volume performance standards

were calculated using category-specific volume and intensity. The 5-year average rate of increase in volume and intensity equals 2.3 percent for surgical services, 5.3 percent for primary care services, 5.1 percent for other nonsurgical services. The weighted-average increase for all physicians' services is 4.4 percent.

Factor 4—Percentage Increase in Expenditures for Physicians' Services Resulting from Changes in Law or Regulations in Fiscal Year 1996 Compared with Fiscal Year 1995

Legislative changes enacted in OBRA 1993 and changes in the regulations required by this law, as well implementation of the physician fee schedule (including refinements made in the RVUs for 1995 and 1996) will have an impact on the volume performance standard rates of increase for fiscal year 1996.

The net effect of implementing the physician fee schedule after making the RVU refinements for 1995 and 1996 will increase payment rates and, therefore, the volume performance standard for primary care services. Similarly, the net effect of refining the RVUs and implementing the fee schedule will reduce payment rates for most surgical services and many nonsurgical services other than primary care, thus, lowering the volume performance standard rates of increase for these services. Implementing the fee schedule will have no effect on the volume performance standard rates of increase for all physicians' services because the net effect of increases in payment for certain services and decreases in payment for other services will have a budget-neutral effect on payment for all physicians' services.

The net adjustments to the physician fee schedule updates will have the effect of increasing the volume performance standard rate for surgical services and decreasing the rate for primary care services. It will have no effect on the rate for other nonsurgical services. OBRA 1993 also included a provision to lower payment for practice expenses for certain services paid under the physician fee schedule, which will have the effect of lowering the MVPS for both surgical and nonsurgical services. After taking into account these provisions, this factor equals -0.6 percent for surgical services, 5.7 percent for primary care services, and -2.4 percent for other nonsurgical services, and a weighted average of -0.5 percent for all physicians' services.

V. Inapplicability of 30-Day Delay in Effective Date

We usually provide a delay of 30 days in the effective date for final Federal Register documents. In this case, however, the volume performance standard rates of increase are required by law to be published in the last 15 days of October 1995 and are effective on October 1, 1995. Thus, the Congress has clearly indicated its intent that the rates of increase be implemented without the usual 30-day delay in the effective date and has foreclosed any discretion by us in this matter. Therefore, the requirement for a 30-day delay in the effective date does not apply to this notice. With regard to the physician fee schedule, the effective date will be January 1, 1996, which is more than 30 days beyond the publication date of this notice.

VI. Regulatory Impact Statement

A. Regulatory Flexibility Act

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that a notice will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, States and individuals are not entities, but we consider all physicians to be small entities.

We are not preparing a regulatory flexibility analysis since we have determined, and the Secretary certifies, that this notice will not have a significant economic impact on a substantial number of small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a notice may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 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 50 beds.

We are not preparing a rural impact analysis since we have determined, and the Secretary certifies, that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

*B. Effects of the Proposal for Using
Category-Specific Volume and Intensity
Growth Allowances in Calculating the
Physician Volume Performance
Standard Rates of Increase*

The use of category-specific volume and intensity growth allowances in the calculation of the MVPS is budget-neutral overall, although it does have redistributive effects on the surgical,

nonsurgical, and primary care categories.

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

(Sections 1848(d) and (f) of the Social Security Act) (42 U.S.C. 1395w-4 (d) and (f)) (Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 28, 1995.

Bruce C. Vladeck,
*Administrator, Health Care Financing
Administration.*

Dated: December 1, 1995.

Donna E. Shalala,
Secretary.

[FR Doc. 95-29754 Filed 12-1-95; 4:08 pm]

BILLING CODE 4120-01-P

Registered
Trademark

Friday
December 8, 1995

Part III

Department of Agriculture

Cooperative State Research, Education,
and Extension Service

7 CFR Parts 3200 and 3411

National Cooperative Research Initiative
Grants Program: Administrative
Provisions; Requirements for Agricultural
Research Enhancement Awards; Final
Rule

DEPARTMENT OF AGRICULTURE**Cooperative State Research,
Education, and Extension Service****7 CFR Parts 3200, 3411****National Competitive Research
Initiative Grants Program (Also Known
as the National Research Initiative
Competitive Grants Program);
Administrative Provisions;
Requirements for Agricultural
Research Enhancement Awards**

AGENCY: Cooperative State Research, Education, and Extension Service, USDA.

ACTION: Final rule; amendment.

SUMMARY: This final rule amends the Cooperative State Research, Education, and Extension Service (CSREES) regulations relating to the administration of the National Research Initiative Grants Competitive Program (NRICGP) (referred to in 7 CFR Part 3200 as the National Competitive Research Initiative Grants Program) that prescribe the procedures to be followed annually in the solicitation of competitive grant proposals, the evaluation of such proposals, and the award of competitive research grants under this program. This action amends those regulations to redesignate 7 CFR Part 3200 as Part 3411, to change the legal name of the program to the National Research Initiative Competitive Grants Program, to clarify certain aspects of the program, and to add eligibility requirements for the Agricultural Research Enhancement Awards.

EFFECTIVE DATE: November 27, 1995.

FOR FURTHER INFORMATION CONTACT: Sally Rockey, Acting Deputy Administrator, CSREES, USDA, AG Box 2240, Washington, D.C. 20250-2240. Telephone: (202) 401-1761.

SUPPLEMENTARY INFORMATION:**Paperwork Reduction**

Information collection for this rule has previously been approved by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501-3520), and assigned OMB control numbers 0524-0022 and 0524-0033. This amendment does not change this information collection burden.

Classification

This rule has been reviewed under Executive Order 12866 and it has been determined that it is not a "significant regulatory action" rule because it will not have an annual effect on the

economy of \$100 million or more or adversely and materially affect a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities. This rule will not create any serious inconsistencies or otherwise interfere with any actions taken or planned by another agency. It will not materially alter the budgetary impact of entitlements, grants, user fees or loan programs and does not raise novel legal or policy issues arising out of legal mandates, the President's priorities, or principles set forth in Executive Order No. 12866.

Regulatory Flexibility Act

The Department certifies that this rule will not have a significant impact on a substantial number of small entities as defined in the Regulatory Flexibility Act, Pub. L. No. 96-534 (5 U.S.C. 601 *et seq.*).

Executive Order 12778

The following information is given in compliance with Executive Order No. 12778. All State and local laws and regulations that are in conflict with this rule are preempted. No retroactive effect is to be given to this rule. This rule does not require administrative proceedings before parties may file suit in court.

Regulatory Analysis

Not required for this rulemaking.

Environmental Impact Statement

This regulation does not significantly affect the environment. Therefore, an environmental impact statement is not required under the National Environmental Policy Act of 1969, as amended (42 U.S.C. 4321 *et seq.*).

Catalog of Federal Domestic Assistance

The NRICGP is listed in the Catalog of Federal Domestic Assistance under No. 10.206. For reasons set forth in the Final Rule-related Notice to 7 CFR Part 3015, Subpart V (48 FR 29115, June 24, 1983), this program is excluded from the scope of Executive Order 12372 which requires intergovernmental consultation with State and local officials.

Background and Purposes

Under the authority of section 2(b) of the Act of August 4, 1965, Pub. L. No. 89-106, as amended (7 U.S.C. 450i(b)) (the Act), the Secretary of Agriculture is authorized to make competitive grants to State Agricultural Experiment Stations, all colleges and universities, other research institutions and organizations, Federal agencies, private organizations or corporations, and

individuals to further the programs of the Department of Agriculture and to improve research capabilities in agricultural, food, and environmental sciences. Section 2(b) of the Act also authorizes the Secretary of Agriculture to make a variety of competitive grants to improve research capabilities in the agricultural, food, and environmental sciences.

The NRICGP was created pursuant to this authority. Pursuant to 7 CFR 2.107(a)(7), the Secretary delegated this authority to the Administrator of the Cooperative State Research Service. The Secretary of Agriculture's memorandum 1010-1 of October 20, 1994, implementing the reorganization authorities contained in the Federal Crop Insurance Reform and Department of Agriculture Reorganization Act of 1994, P.L. 103-354, redelegated this authority to the Administrator of the CSREES.

This rule moves this part from 7 CFR Chapter XXXII to 7 CFR Chapter XXXIV, changes the name of the program, adds additional definitions for "fundamental research," "mission-linked research," and "multidisciplinary research" to the NRICGP administrative provisions, and establishes eligibility requirements for the Agricultural Research Enhancement Awards program. Section 3411.3(d)(3)(ii)(C) has been changed from the proposed rule so that appointments to degree-granting institutions do not have to be full-time.

Discussion of Comments**Section 3411.2 Definitions**

One respondent suggested including the following: "All proposed research should support the mission of generating new knowledge relevant to the agricultural, food, and natural resources sector of the economy." CSREES agrees with the proposed statement, but notes that this idea is conveyed in § 3200.1 and therefore that an additional statement is unnecessary.

List of subjects in 7 CFR Part 3411

Grant Programs—Agriculture, Grants administration.

For the reasons set forth in the preamble, CSREES amends 7 CFR Chapters XXXII and XXXIV as follows:

**PART 3200—[REDESIGNATED AS
PART 3411]**

1. Part 3200 is redesignated as Part 3411 and moved from Chapter XXXII to Chapter XXXIV
2. The authority citation for newly redesignated part 3411 is revised to read as follows:

Authority: "Sec. 2(i) of the Act of August 4, 1965, as amended (7 U.S.C. 450i(i))."

3. In newly redesignated part 3411, the term "National Competitive Research Initiative Grants Program" is revised to read "National Research Initiative Competitive Grants Program" in § 3411.1(a).

4. In newly redesignated part 3411, the term "NCRIGP" is revised to read "NRICGP", each time it appears in §§ 3411.1(a) and 3411.4(c)(9)(iii).

5. In newly redesignated part 3411, the term "Grant Application Kit" is revised to read "NRICGP Application Kit" each time it appears in § 3411.4(b) introductory text, (c)(1), (8), (9) (i), (ii) and (iii).

6. Newly redesignated section 3411.2 is amended by revising the introductory text, adding new paragraphs (l)(1), (l)(2), and (l)(3) and adding new paragraphs (n) and (o) to read as follows:

§ 3411.2 Definitions

As used in this part and in annual program solicitations issued pursuant to this part:

* * * * *

(l) * * *

(1) *Fundamental research*, as referred to annually in the program solicitation, means research that tests scientific hypotheses and provides basic knowledge which allows advances in applied research and from which major conceptual breakthroughs are expected to occur.

(2) *Mission-linked research*, as referred to annually in the program solicitation, means research on specifically identified agricultural problems which, through a continuum of efforts, provides information and technology that may be transferred to users and may relate to a product, practice, or process.

(3) *Multidisciplinary research*, as referred to annually in the program solicitation, means research in which investigators from two or more disciplines are collaborating closely. These collaborations, where appropriate, may integrate the biological, physical, chemical, or social sciences.

* * * * *

(n) *Small and mid-sized institution* means an academic institution with a total enrollment of 15,000 or less. An institution in this instance is an organization that possesses a significant degree of academic and administrative autonomy, as specified in the annual program solicitation.

(o) *USDA-EPSCoR States (Experimental Program for Stimulating Competitive Research)* means States

which have had a funding level from the USDA NRICGP no higher than the 38th percentile of all States, based on a three-year rolling average, and all United States territories and possessions. A list of eligible States is published annually in the program solicitation.

7. Newly redesignated section 3411.3 is amended by adding paragraph (d) as follows:

§ 3411.3 Eligibility requirements

* * * * *

(d) *Agricultural Research Enhancement Awards*. In addition to paragraphs (a), (b), and (c) of this section, the following eligibility requirements apply to Agricultural Research Enhancement Awards (Program reserves the right to specify funding limitations and administrative requirements each year in the program solicitation):

(1) *Postdoctoral Fellowships*. In accordance with Section 2(b)(3)(D) of the Act of August 4, 1965, as amended, individuals who have recently received or will soon received their doctoral degree may submit proposals for postdoctoral fellowships. The following eligibility requirements apply:

(i) The doctoral degree of the applicant must be received not earlier than January 1 of the fiscal year three years prior to the submission of the proposal and not later than June 15 of the fiscal year during which the proposal is submitted;

(ii) The individual must be a citizen of the United States; and

(iii) The proposal must contain:

(A) documentation that arrangements have been made with an established investigator to serve as mentor;

(B) documentation that arrangements have been made for the necessary facilities, space, and materials for conduct of the research; and

(C) documentation from the host institution's authorized organizational representative indicating that the host institution concurs with these arrangements.

(2) *New Investigator Awards*. Pursuant to Section 2(b)(3)(E) of the Act of August 4, 1965, as amended, investigators or co-investigators who are beginning their research careers, do not have an extensive research publication record, and have less than 5 years of post-graduate, career-track research experience may submit proposals as new investigators. Applicants may not have received competitively-awarded Federal research funds beyond the level of pre- or postdoctoral research awards.

(3) *Strengthening Awards*. Applicants that are eligible for any grant under this part may also be eligible for Equipment

Grants, Research Career Enhancement Awards, Seed Grants, and Strengthening Standard Research Project Awards pursuant to Sections 2(b)(3) (D) and (F) of the Act of August 4, 1965, as amended, subject to the following limitations on such eligibility:

(i) *Equipment Grants*. The following organizations are ineligible to apply for Equipment grants:

(A) Institutions which are among the top 100 universities and colleges for receiving Federal funds for science and engineering research as specified in the annual program solicitation; or

(B) non-degree granting institutions.

(ii) *Research Career Enhancement Awards, Seed Grants, and Strengthening Standard Research Project Awards*. The following eligibility requirements apply to Research Career Enhancement Awards, Seed Grants, and Strengthening Standard Research Project Awards:

(A) No investigator listed on the Application For Funding (Form CSRS-661) may have received a USDA NRICGP competitive research grant within the last five years as evidenced by an investigator listing on a prior Form CSRS-661 (an investigator may have received a Seed Grant, Research Career Enhancement Award, Equipment Grant, or Postdoctoral Fellowship and still be eligible to receive a Strengthening Standard Research Project Award);

(B) All investigators listed on the Application For Funding (Form CSRS-661) must be from a small or mid-sized institution that is not among the top 100 universities and colleges for receiving Federal funds for science and engineering research as specified in the annual program solicitation or must be from an institution located in a USDA-EPSCoR state; and

(C) Every investigator listed on the Application For Funding (Form CSRS-661) must have an appointment at a degree granting institution.

8a. The heading of paragraph (c)(1) of newly redesignated § 3411.4 is revised to read as set forth below, and in paragraph (c)(1), the words "a Grant Application cover page" are revised to read "an Application for Funding form".

b. Newly redesignated § 3411.4 is further amended by revising the last sentence of paragraph (c)(4), adding three new sentences at the end of paragraph (c)(8), adding a new last sentence to paragraph (c)(9)(i), and adding a new last sentence to paragraph (c)(9)(ii), by revising the term "Institutional Review Board" to read "Institutional Committee" in paragraph (c)(9)(ii), by adding a new last sentence to paragraph (c)(9)(iii), and adding new

paragraphs (c) (13) and (14) to read as follows:

§ 3411.4 How to apply for a grant.

* * * *

(c) * * *

(1) *Application for Funding form.*

* * *

* * *

(4) *Facilities and equipment.* * * * In addition, requested items of nonexpendable equipment necessary to conduct and successfully conclude the proposed project should be listed (including dollar amounts), and, if funds are requested for their acquisition, justified on a separate sheet of paper and attached to the budget.

* * *

(8) *Budget.* * * * Equipment grants may not exceed 50 percent of the cost of the equipment to be acquired. Equipment grant funds also may not be used for installation, maintenance, warranty, or insurance expenses. Indirect costs are not permitted on Equipment grants.

(9) *Research involving special considerations.*

* * *

(i) *Recombinant DNA and RNA molecules.* * * * In the event a project involving recombinant DNA and RNA molecules results in a grant award, a qualified Institutional Biosafety Committee must approve the research before CSREES funds will be released.

(ii) *Human subjects at risk.* * * * In the event a project involving human subjects results in a grant award, funds will be released only after a qualified Institutional Committee has approved the project.

(iii) *Experimental vertebrate animal.* * * * In the event a project involving the use of living vertebrate animals results in a grant award, funds will be released only after a qualified

Institutional Animal Care and Use Committee has approved the project.

* * *

(13) *National Environmental Policy Act.* As outlined in CSREES's implementing regulations of the National Environmental Policy Act of 1969 (NEPA) at 7 CFR Part 3407, environmental data or documentation for the proposed project is to be provided to CSREES in order to assist CSREES in carrying out its responsibilities under NEPA. These responsibilities include determining whether the project requires an Environmental Assessment or an Environmental Impact Statement or whether it can be excluded from this requirement on the basis of several categorical exclusions listed in 7 CFR Part 3407. In this regard, the applicant should review the categories defined for exclusion to ascertain whether the proposed project may fall within one or more of the exclusions, and should indicate if it does so on the National Environmental Policy Act Exclusions Form (Form CSRS-1234) provided in the NRICGP Application Kit.

(14) Even though the applicant considers that a proposed project may fall within a categorical exclusion, CSREES may determine that an Environmental Assessment or an Environmental Impact Statement is necessary for a proposed project should substantial controversy on environmental grounds exist or if other extraordinary conditions or circumstances are present that may cause such activity to have a significant environmental effect.

9. Newly redesignated section 3411.6 is amended by adding paragraph (f) as follows:

§ 3411.6 Grant awards.

* * *

(f) *Current Research Information Service (CRIS).* For each project funded, CRIS Form AD-416, "Research Work Unit/Project Description-Research Resume" and CRIS Form AD-417, "Research Work Unit/Project Description-Classification of Research" and specific instructions for their completion will be sent to the grantee for completion and return. Grant funds will not be released until the completed forms are received in CSREES.

10. Newly redesignated section 3411.8 is amended by adding the following additional applicable regulation:

§ 3411.8 Other Federal statutes and regulations that apply.

* * *

7 CFR part 3051—Audits of Institutions of Higher Education and Other Nonprofit Institutions.

11. Newly redesignated section 3411.12 is amended by redesignating the current paragraph as paragraph (a) and by adding a new paragraph (b) as follows:

§ 3411.12 Conflicts of Interest.

* * *

(b) Reviewers may not review proposals submitted by institutions or other entities with which they have an affiliation or in which they have an interest. For the purposes of determining whether such a conflict exists, an institution shall be considered as an organization if it possesses a significant degree of academic and administrative autonomy, as specified in the annual program solicitation.

Done at Washington, D.C., this 1st day of December 1995.

Colien Hefferan,

Acting Administrator, Cooperative State Research, Education, and Extension Service.

[FR Doc. 95-29787 Filed 12-7-95; 8:45 am]

BILLING CODE 3410-22-M

Friday
December 8, 1995

Part IV

**Department of
Health and Human
Services**

Food and Drug Administration

**21 CFR Part 20
Public Information; Communications With
State and Foreign Government Officials;
Final Rule**

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Food and Drug Administration****21 CFR Part 20****[Docket No. 94N-0308]****Public Information; Communications With State and Foreign Government Officials****AGENCY:** Food and Drug Administration, HHS.**ACTION:** Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending its regulations governing communications with State and foreign government officials. This final rule permits FDA to receive and to disclose nonpublic safety, effectiveness, or quality information concerning FDA-regulated products to State government officials and to receive or to disclose draft proposed rules and other nonpublic, predecisional documents concerning regulatory requirements or activities to State or foreign government officials. In both cases, disclosures to or by State or foreign government officials would not require FDA to make the information or documents available to the public. This action is necessary to enhance cooperation in regulatory activities, to eliminate unwarranted contradictory regulatory requirements, and to minimize redundant application of similar requirements.

EFFECTIVE DATE: January 8, 1996.

FOR FURTHER INFORMATION CONTACT: Philip L. Chao, Office of Policy (HF-23), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-827-3380.

SUPPLEMENTARY INFORMATION:**I. Background**

In the Federal Register of January 27, 1995 (60 FR 5530), FDA published a proposed rule that would enable FDA to disclose to and receive from State government officials confidential commercial information without being compelled to make that information available to the general public. The proposed rule would also enable the agency to share and to receive nonpublic documents, such as draft rules, with State and foreign government officials. Exchanges of information, including nonpublic information, would enhance Federal-State cooperation in regulatory activities, help eliminate unwarranted contradictory regulatory requirements, and minimize redundant application of

similar requirements by domestic and foreign bodies.

The preamble to the proposed rule described the statutory and regulatory provisions that had governed FDA's communications with State and foreign government officials. Generally, FDA has always possessed both statutory and regulatory authority to withhold some information from public disclosure. For example, the Freedom of Information Act (the FOIA) (5 U.S.C. 552) establishes categories of information that are exempt from public disclosure. Such categories of information relevant to FDA records include:

1. Trade secret and confidential commercial information to protect intellectual property rights and research incentives (5 U.S.C. 552(b)(4));
2. Predecisional documents to protect the deliberative process (5 U.S.C. 552(b)(5));
3. Information whose disclosure might invade personal privacy (5 U.S.C. 552(b)(6)); and
4. Investigatory files compiled for law enforcement purposes to protect investigations into violations of the statutes and regulations FDA enforces (5 U.S.C. 552(b)(7)).

In 1974, FDA issued regulations implementing the FOIA and other laws (such as the Trade Secrets Act (18 U.S.C. 1905) and section 301(j) of the Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 331(j)) that affect public access to government records and information. These regulations included a provision, now codified in § 20.21 (21 CFR 20.21), stating that any record that is disclosed in an authorized manner to any member of the public is available for disclosure to all members of the public. When FDA issued § 20.21 in 1974, it expressly declined to make an exception for records disclosed to foreign governments, stating that:

The Commissioner concludes that the same rules will apply with respect to disclosure of [safety and effectiveness information] to foreign governments as apply to disclosure to the public. This will permit the Food and Drug Administration to provide full summaries of all safety and effectiveness data for all approved [new drug applications (NDA's)] and selected summaries for [investigational new drug applications (IND's)] and pending NDA's of which the existence of an IND has been publicly disclosed or acknowledged. The Commissioner concludes that this will adequately satisfy the need for international exchange of important regulatory information of this type. (See 39 FR 44602 at 44636 and 44637, December 24, 1974.)

However, since 1974, the regulatory environment has changed significantly. Increased international commerce and

diminishing governmental resources have prompted public health regulatory agencies, as well as the industries they regulate, to make efforts to enhance the effectiveness and efficiency of their regulatory efforts. Public health regulatory agencies have engaged in activities to harmonize regulatory requirements, minimize duplicative regulations, and cooperate in joint scientific, regulatory, and enforcement endeavors.

For example, FDA is active in a program known as the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH). ICH was organized to provide an opportunity for harmonization initiatives to be developed with input from both regulatory and industry representatives. ICH is concerned with harmonization of technical requirements for the registration of pharmaceutical products among three regions: The European Union, Japan, and the United States. The six ICH sponsors are the European Commission, the European Federation of Pharmaceutical Industry Associations, the Japanese Ministry of Health and Welfare, the Japanese Pharmaceutical Manufacturers Association, FDA, and the Pharmaceutical Research and Manufacturers of America. In addition, the ICH Secretariat, which coordinates the preparation of documentation, is provided by the International Federation of Pharmaceutical Manufacturers Associations (IFPMA). The ICH Steering Committee includes representatives from each organizing body and IFPMA, as well as observers from the World Health Organization, the Canadian Health Protection Branch, and the European Free Trade Area. The ICH expert working groups prepare guidelines on a variety of drug safety, efficacy, and quality matters, and FDA publishes these guidelines in the Federal Register.

Simultaneously, FDA's interaction with State agencies has become more important, particularly as Federal and State authorities have shared responsibilities in certain programs and new authorities have been added. For example, FDA and other Federal and State agencies regulate narcotic treatment program clinics. When new treatments become available, FDA must issue or amend its regulations regarding the new treatment's use and any special conditions on the treatment programs themselves. Yet, State government agencies may share responsibility for ensuring that the treatment programs are licensed and operate in accordance with the law and regulations. The current

degree of Federal-State cooperation was not contemplated back in 1974 when FDA first issued its public information regulations. New Federal laws enacted since 1974 have also emphasized the importance of Federal-State cooperation. Statutes such as the Prescription Drug Marketing Act of 1987, the Nutrition Labeling and Education Act of 1990, and the Mammography Quality Standards Act of 1992 have created regulatory schemes in which the Federal government establishes programs and standards and States play a major role in operations and enforcement.

This final rule is the second initiative in which FDA has amended its public information regulations to reflect its growing involvement in international activities. In the Federal Register of November 19, 1993 (58 FR 61598), FDA published a final rule amending its regulations governing communications with foreign officials (hereinafter referred to as the 1993 final rule). The 1993 final rule, which is now codified in § 20.89 (21 CFR 20.89), permits FDA, under certain safeguards, to disclose confidential commercial information concerning FDA-regulated products to foreign government officials who perform counterpart functions to FDA "as part of cooperative law enforcement or regulatory efforts." Those safeguards include: (1) A written statement from the foreign government agency establishing its authority to protect confidential commercial information from public disclosure and a written commitment not to disclose such information without the sponsor's written permission or written confirmation from FDA that the information is no longer confidential; and (2) a determination by FDA that the sponsor has provided written authorization for the disclosure, disclosure would be in the interest of public health, or disclosure is to a foreign scientist visiting FDA, on FDA's premises, as part of a joint review or long-term cooperative training effort and other safeguards. Except in the case of foreign scientists working on FDA's premises, the 1993 final rule did not authorize disclosure of trade secret information without written permission from the person that had submitted the trade secret information.

The 1993 final rule led the agency to consider whether the privileges accorded to foreign government representatives should be extended to State and local government officials. Although States carry out relatively few product approval programs, they are significant partners to FDA in such areas as bioresearch monitoring. The

agency ultimately decided that there are times when FDA needs to be able to share confidential commercial information with State and local government officials and that, when FDA grants such access, it should be subject to the same restrictions and limitations on disclosure as in cases where FDA grants foreign government officials access to confidential commercial information. Also, cooperative regulatory activities would be enhanced if FDA could provide nonpublic, predecisional documents to State and foreign counterparts.

Consequently, FDA published a proposed rule (60 FR 5530) to amend § 20.88 (21 CFR 20.88) to: (1) Permit the agency to disclose confidential commercial information submitted to FDA or incorporated into FDA-prepared records to State government officials, and (2) disclose to or receive from State government officials nonpublic predecisional documents concerning FDA's or the State agency's regulations, regulatory requirements, or other nonpublic information. In both cases, disclosure would be subject to certain conditions or restrictions, and the information exchanges would not require disclosure to the public. For example, under proposed § 20.88(d), FDA would be authorized to disclose confidential commercial information to State government officials provided that: (1) The State government agency has provided a written statement establishing its authority to protect confidential commercial information and a written commitment not to disclose such information without written permission from FDA or the sponsor of the confidential commercial information; and (2) the agency found that the sponsor has provided written permission for the disclosure, disclosure would be in the interest of the public health, or disclosure would be to a visiting State government scientist on FDA's premises. (See 60 FR 5530 at 5539.)

The proposed rule would also amend § 20.89 to permit FDA to disclose to or receive from foreign government officials nonpublic predecisional documents, provided that certain conditions (such as provision of a written statement establishing the foreign government's authority to protect nonpublic documents from public disclosure) are observed and that certain findings (such as a finding that the exchange is "reasonably necessary to facilitate global harmonization of regulatory requirements, cooperative regulatory activities, or implementation of international agreements") are made.

II. Analysis of the Comments on the Proposed Rule

FDA received 20 comments on the proposed rule. Ten comments, consisting of letters from nine States and one foreign country, expressed strong support for the proposed rule. In general, these comments indicated that the proposed rule would enhance intergovernmental relations, help eliminate redundant regulatory requirements, permit Federal and State agencies to respond more quickly to potential public health problems, and aid efforts to combat health fraud.

The remaining 10 comments were sent by individual citizens and firms and opposed the proposed rule for the reasons described below. In brief, five comments opposed withholding information from the general public because they saw the proposed rule as undercutting openness in government, whereas the other five comments opposed disclosures because they felt the proposed rule lacked sufficient safeguards to prevent State and foreign government officials from disclosing confidential commercial information or trade secrets to third parties.

A. General Comments

1. Two comments commended FDA for trying to increase intergovernmental cooperation, but argued that, as FDA is not involved in matters of national security or defense, it should not keep any communications from the public. The comments asserted that withholding information from public disclosure would not benefit the public and might diminish public and industry respect for the agency. Similarly, two other comments argued that the proposed rule violated the First Amendment to the U.S. Constitution because it limited the amount of information that the public could examine. The comments stated that the agency had not justified or shown that its interest in denying public access to information exchanged with State and foreign governments exceeds the public's interest in access to that information.

The agency disagrees with the comments. The final rule does not in any way reduce the information in FDA records that the public can examine. Section 20.88(d) permits FDA to provide confidential commercial information to State government officials. Confidential commercial information has historically been exempt from public disclosure requirements, so FDA's providing such information to State government officials while withholding such information from the public will not decrease the amount of information

available to the public. Sections 20.88(e) and 20.89(d) pertain to exchanges of nonpublic, predecisional documents with State and foreign government officials. Historically, FDA has generally withheld these documents from public disclosure as well.

The agency also disagrees with any assertion that the final rule violates the First Amendment. While courts have construed the First Amendment as giving the public access to government proceedings, they have declined to provide access to all government operations. Indeed, as the Supreme Court stated in *Press-Enterprise Co. v. Superior Court of California*, 478 U.S. 1, 9 (1986):

Although many governmental processes operate best under public scrutiny, it takes little imagination to recognize that there are some kinds of government operations that would be totally frustrated if conducted openly.

In the present case, requiring FDA to publicly disclose confidential commercial information and predecisional documents that it provides to or receives from State and foreign governments would frustrate the final rule's fundamental purposes. The final rule is intended to encourage information exchanges between governments by assuring State and foreign governments that the information or documents they receive or provide will not be publicly available. The final rule also reassures those who submit confidential commercial information to FDA or to State or foreign governments that such information will be protected. If public access to confidential commercial information were required whenever FDA exchanged such information with a State or foreign government, as the comments suggest, firms would then be obliged to refuse requests for intergovernmental disclosure by FDA, State governments, or foreign governments or even refuse to submit confidential commercial information in order to protect it.

Additionally, courts have established a two-part test of "experience" and "logic" to determine whether the First Amendment requires the governmental proceeding to be open to the public. The first part, "experience," asks whether the proceeding is one that has historically been open to the public. The second part, "logic," asks whether public access would play a significant, positive role in the governmental process. If the government process passes these tests, then a qualified First Amendment right of public access exists; in other words, the right of public access is not absolute or

unconditional. (See *Press-Enterprise Co.*, 478 U.S. 8 and 9; *United States v. Simone*, 14 F.3d 833, 837-839 (3d Cir. 1994).)

Applying the two-part test to the final rule leads to the conclusion that the First Amendment does not require these exchanges of information to be open to the public. Historically, the agency has always protected confidential commercial information and indicated that predecisional documents prepared by the agency are either not available to the general public or available under limited conditions. (See, e.g., 21 CFR 20.61 and 21 CFR 20.62 (nondisclosure of inter- or intra-agency memoranda or letters); 21 CFR 20.64 (nondisclosure of records or information compiled for law enforcement purposes); 21 CFR 10.80 (establishing conditions for release of draft notices and regulations).)

Additionally, under the second prong, it is questionable whether public access would play a significant, positive role in the governmental process. For example, intergovernmental exchanges of confidential commercial information will enable governments to learn more about specific products and, as a result, to develop better and more efficient regulatory or enforcement actions. At the same time, disclosure of such confidential commercial information to the general public does not further any regulatory process, and in any event, is prohibited by 18 U.S.C. 1905. The law recognizes that public disclosure of confidential commercial information may have a detrimental effect on product development; providing a firm's competitors with access to valuable information may create a disincentive for firms to develop innovations or improve their products or methods. The result would be diminished availability of useful products.

Furthermore, intergovernmental exchanges of nonpublic, predecisional documents may help the agency decide whether a regulatory approach it is considering is appropriate or even necessary. While the agency may, in many cases, make draft documents available to the general public (for example, in the Federal Register of July 24, 1995 (60 FR 37856), FDA published a notice announcing the availability of a draft final rule on medical device good manufacturing practices to members of the public as well as to State and foreign regulators), in other cases, providing public access to predecisional documents during the deliberative process could interfere with that process or create misleading impressions about the agency's intentions.

In some cases, premature public disclosure of draft documents can

unnecessarily complicate regulatory actions and undermine public health and safety. For example, if the agency developed a proposal on a particular form of tamper evident packaging, such information could be helpful to other foreign governments. However, premature disclosure of that same information could ultimately prove harmful to the general public if its disclosure would enable those who tamper with products to alter their methods in order to evade detection or to defeat the proposed solution.

FDA further emphasizes that, as stated in the preamble to the proposed rule, if any State or foreign government official provides information that the agency wishes to rely on in its published proposals or the administrative record, the agency will include that information unless inclusion would harm private or governmental interests (see 60 FR 5530 at 5538). When a proposed rule is published, therefore, the general public would be fully informed and have an opportunity to comment on the substance of any advice from State or foreign officials that FDA incorporated into the proposed rule.

The agency reiterates that nonpublic exchanges of information with State and foreign government officials will not be a routine occurrence and that FDA does not intend to prohibit public disclosure of information received from State and foreign government officials if such information can be disclosed without harm to any private or governmental interests.

More importantly, the agency believes that the final rule will result in significant public benefits because the final rule facilitates FDA's access to information and expertise within State and foreign governments and should result in better regulatory proposals and actions. For example, if FDA and a State are considering whether to issue proposed regulations on the same or similar subjects, exchanging nonpublic, predecisional documents might lead both parties to reexamine, modify, or harmonize their proposed regulatory strategy. Preventing the issuance of redundant or unnecessary regulations should benefit the public and the affected industries.

2. One comment claimed that the proposed rule violated the Tenth Amendment to the Constitution. The Tenth Amendment states that, "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." The comment argued that the proposed rule violated the Tenth

Amendment because citizens had not yielded to the Federal government their "rights of access to the information generated by our public servants."

The agency disagrees with the comment. The final rule concerns FDA's ability to exchange certain confidential commercial information or nonpublic, predecisional documents with State or foreign government officials. Thus, the final rule pertains to information exchange and access to FDA records and implements Federal authority without impairing State or popular power. Indeed, the final rule can strengthen States' regulatory roles.

3. Two comments said that the proposed rule violated procedural due process because it would give State and foreign government officials "preferential access" to predecisional documents, such as draft regulations, thereby giving those officials "far greater influence over the deliberative process by imparting selected information and opinion" to FDA.

The agency disagrees with the comments' assertion. As the Supreme Court said in *Mathews v. Eldridge*, 424 U.S. 319, 332 (1976), procedural due process "imposes constraints on governmental decisions which deprive individuals of 'liberty' or property' interests within the meaning of the Due Process Clause of the Fifth or Fourteenth Amendment." However, "[d]ue process, unlike some legal rules, is not a technical conception with a fixed content unrelated to time, place and circumstances * * * [d]ue process is flexible and calls for such procedural protections as the particular situation demands." Id. p. 334 (citations omitted).

Here, the final rule does not impose any constraints or sanctions nor does it deprive individuals of any liberty or property interest. The final rule does not "deprive" the public of its access to confidential commercial information or predecisional documents because such information has always been protected from disclosure. Neither does the final rule deprive the public of the opportunity to comment on rulemaking. As stated in the preamble to the proposed rule:

* * * any information provided by State or foreign government officials upon which FDA is relying will be included in published proposals. At that time, the general public will be fully informed and have an opportunity to comment on the substance of any advice from foreign or State officials that is incorporated into agency proposals or initiatives.

(See 60 FR 5530 at 5538.) This approach is consistent with due process because "[t]he fundamental requirement of due process is the opportunity to be heard 'at a meaningful time and in a

meaningful manner,'" *Mathews*, 424 U.S. 333 (citations omitted).

Moreover, judicial opinions concerning informal rulemaking have focused on the need to ensure that ex parte contacts do not frustrate judicial review or raise serious questions of fairness. (See *Home Box Office, Inc. v. FCC*, 567 F.2d 9 (D.C. Cir. 1977), cert. denied 434 U.S. 829, rehearing denied 434 U.S. 988 (1977).) There is no *per se* prohibition on ex parte contacts. (See *Action for Children's Television v. FCC*, 564 F.2d 458, 475 n.28 (D.C. Cir. 1977).)

FDA reiterates that it will include in its published proposals any information provided by State or foreign government officials upon which FDA is relying. The agency will make such information available at the time of publication. Thus, the general public will be fully informed and have an opportunity to comment on the substance of any advice from foreign or State officials that is incorporated into agency proposals or initiatives. FDA believes this is consistent with all applicable legal requirements.

4. Two comments claimed that the proposed rule violated rights of privacy and confidentiality because information supplied to FDA, with the expectation that the information would remain confidential, would be eligible for disclosure to officials outside FDA. The comments noted that non-FDA officials may have interests and obligations that differ from those of FDA, the public, or the regulated industry. The comments said that requiring the State or foreign government to provide a written statement establishing its authority to protect confidential commercial information or nonpublic documents from public disclosure was "wholly inadequate" because State and foreign officials are not subject to FDA's management or control. The comments further asserted that much information given to FDA is unreliable, fraudulent, or defamatory and could be used by outside parties for ulterior purposes and that the proposed rule would dissuade submission of confidential information to FDA and encourage submission of false information.

Four other comments expressed similar objections to the proposed rule, stating that foreign governments might use confidential commercial information to benefit their own industries.

The agency has given serious attention to the concerns expressed in the comments, but disagrees that the safeguards are inadequate. As stated earlier, FDA issued a final rule on November 19, 1993, to permit the agency to disclose confidential

commercial information to foreign government officials, subject to certain conditions and safeguards to protect the confidentiality of the information. Since issuing that final rule, the agency is unaware of any misuse or unauthorized disclosure of confidential commercial information supplied to a foreign government. In almost all cases, disclosure occurred with the knowledge and consent of the company that submitted the confidential commercial information to FDA. Thus, FDA's experience with the 1993 final rule indicates that confidential commercial information provided to a foreign government official remains confidential and is not used to benefit the foreign government's industry.

Furthermore, FDA emphasizes that the decision to share information with a foreign government is discretionary and that the agency will deny a foreign government's request for confidential commercial information if the foreign government officials are unable to assure FDA of their ability to protect the information. FDA will also deny access where there is a lack of scientific data or regulatory expertise to contribute to a product review or laboratory or clinical investigation, unless the foreign government intends to use the information for law enforcement purposes. (See 58 FR 61598 at 61600.) Similar standards will apply to exchanges with State governments and State government officials.

FDA also disagrees with the assertion that parties often submit false information to the agency. Submitting false information to the government is a Federal crime under 18 U.S.C. 1001. Submission of false or misleading reports with respect to medical devices is prohibited under section 301(q)(2) of the act (21 U.S.C. 331(q)(2)). Submission of false information may also lead to debarment under section 306 of the act (21 U.S.C. 335a) or assessment of civil money penalties under section 303(g) or 307 of the act (21 U.S.C. 333(g) or 335b). FDA has taken legal action against parties that have submitted false information to the agency and emphasizes that it will not tolerate the submission of false information to the agency.

5. Two comments asserted that the proposed rule was contrary to congressional intent, as expressed in the FOIA, to provide information to the public. The comments explained that the FOIA's exceptions to disclosure represented a balance between the public's "right to know" and the government's interest in not disclosing certain types of information. Thus, the comments claimed, only Congress can

alter that balance. Another comment claimed that an executive branch agency cannot withhold information from the public, stating that only Congress could authorize such action.

The agency disagrees with the comments. The preamble to the proposed rule considered this issue and explained why the agency believes that the proposed rule is consistent with the FOIA. FOIA (5 U.S.C. 552) is a disclosure statute and its exemptions are intended to be discretionary. As stated earlier, those exemptions establish several categories of information that can be withheld from public disclosure. The categories relevant to FDA include: (a) Trade secret and confidential commercial information to protect intellectual property rights and research incentives (5 U.S.C. 552(b)(4)); (b) predecisional documents to protect the deliberative process (5 U.S.C. 552(b)(5)); (c) information whose disclosure might invade personal privacy (5 U.S.C. 552(b)(6)); and (d) investigatory files compiled for law enforcement purposes to protect investigations (5 U.S.C. 552(b)(7)).

For disclosures of confidential commercial information under § 20.88(d), the preamble to the proposed rule explained that the FOIA protects two broad categories of information from mandatory public disclosure: Trade secret information and "information that is: (1) Commercial or financial, (2) obtained from a person, and (3) privileged or confidential ('confidential commercial information')." (See 60 FR 5530 at 5535.) The preamble to the proposed rule explained that the proposed rule did not alter agency practice with respect to protecting trade secret information (except to permit disclosure to visiting State scientists) and that disclosures of confidential commercial information to State government officials in accordance with the conditions of the proposed rule would not be a public disclosure and would be "authorized" under the Trade Secrets Act. (See 60 FR 5530 at 5536.)

The preamble to the proposed rule also explained why the provisions regarding predecisional documents and other nonpublic information are consistent with the FOIA. The preamble characterized exchanges of nonpublic, predecisional documents between FDA and State and foreign governments as being of the same character as interagency memoranda and letters that are exempt from disclosure under the FOIA. The preamble to the proposed rule stated that:

*** it is appropriate to assert the deliberative process privilege [to disclosure under the FOIA] in response to requests for public access to certain communications from State and foreign government officials because the same policy reasons that support nondisclosure of deliberative and predecisional memoranda generated by Federal government agencies justify withholding, in many circumstances, the advice and recommendations generated for FDA by State and foreign government counterparts.

The agency's ability to make sound decisions about the development and implementation of public health and harmonization initiatives is enhanced by access to the advice and recommendations of experts in State and foreign governments who are engaged in similar efforts in their own jurisdictions. The agency views this kind of consultation as functionally equivalent to the "intra-" or "interagency" deliberation more commonly protected by exemption 5 of the FOIA. Indeed, it is frequently the case that advice from a State or foreign health official whose responsibilities parallel those of FDA officials concerning the feasibility of a particular technical or harmonization regulation will be as relevant as similar recommendations solicited from employees in other Federal government agencies. (See 60 FR 5530 at 5536 and 5537.) The preamble to the proposed rule noted that courts have applied a "functional" test for assessing the applicability of the exemption for intra- and interagency memoranda and letters and have included "nonagencies" within the exemption. *Id.*

The preamble also noted that in circumstances where advice or information is provided by foreign governments pursuant to international agreements that require confidentiality as a condition of exchange, FDA believes that a record so provided is not necessarily an "agency record" subject to FOIA. *Id.* at 60 FR 5537 through 5538. The agency cited recent court decisions suggesting that FDA could honor requests for confidentiality under these circumstances without contravening public disclosure requirements established by Congress. *Id.*

Thus, the final rule is consistent with the FOIA, and the agency declines to amend the final rule to require public access to documents beyond that required by the FOIA.

6. One comment said that FDA should discuss the proposed rule's potential effects, costs, and implications in a public forum.

FDA believes that notice and comment rulemaking has provided a satisfactory public forum for this issue.

7. Three comments said that FDA cannot ensure that no unauthorized disclosures of confidential commercial information will occur and cannot take

effective action against State or foreign government officials if unauthorized disclosures occur. Two comments added that the agency should describe how it intends to monitor and investigate reports of unauthorized disclosures and take action against those employees making unauthorized disclosures. One comment suggested that FDA establish a mechanism to track such unauthorized disclosures, analyze and report any patterns or trends in unauthorized disclosures, and, if FDA becomes aware of any unauthorized disclosures by State or foreign government officials, notify the company whose confidential commercial information was disclosed and cease information exchanges with the State or foreign government.

FDA cannot guarantee that no unauthorized disclosures of confidential commercial information will ever occur, but it does note that procedures already exist for investigating reports of unauthorized disclosures. In 1994, the agency created the Office of Internal Affairs (OIA). OIA consists of one Special Agent in Charge and a team of Special Agents. These agents are trained criminal investigators and report directly to the Commissioner of Food and Drugs or the Deputy Commissioner/Senior Advisor. FDA described OIA's functions in a notice published in the Federal Register of January 23, 1995 (60 FR 4417 and 4418). In brief, OIA:

- Provides a centralized Agencywide investigative resource for the Commissioner, the Deputy Commissioners, and top Agency management;

- Provides a centralized investigative liaison between FDA and the Office of the Inspector General (OIG);

- Serves as an FDA investigative resource to conduct internal FDA investigations and to support OIG investigations; and

OIA is also responsible for investigating all allegations of misconduct by FDA employees. (See 59 FR 67087, December 28, 1994.) To assist in this task, the office uses a data base to track cases by type of investigation. One investigation type is "Unauthorized Release of Information."

Whenever OIA receives any report of unauthorized disclosures of information, OIA investigates the report and works with the OIG where appropriate. If the investigation suggests that Federal laws were violated, this information is presented to the OIG and may be referred to the Department of Justice for prosecution. These same resources and procedures could be applied, in cooperation with State and

foreign governments, to allegations of inappropriate disclosures by their officials.

Furthermore, when FDA issued the 1993 final rule authorizing disclosure of confidential commercial information to foreign government officials, the agency expressly stated that it would cease cooperative ventures with any government that failed to honor its written commitment to preserve the confidentiality of the information provided by FDA. (See 58 FR 61598 at 61603.) The agency will expand this policy to include State governments. FDA's extensive experience sharing nonpublic investigative records with State government officials indicates that unauthorized disclosures are unlikely to occur and that any State employee misconduct will be expeditiously handled in order to preserve cooperative efforts between FDA and State governments.

Moreover, after issuing the 1993 final rule, FDA established internal procedures and model confidentiality agreements for disclosures to foreign government officials. These procedures will be expanded to apply to State government officials.

The agency also notes that, contrary to the comments' belief that firms and individuals have no recourse if a foreign government official makes an unauthorized disclosure of confidential commercial information, Federal law does provide an avenue for relief. Under section 301 of the Trade Act of 1974 as amended, the United States Trade Representative is authorized to take appropriate action against any act, policy, or practice of a foreign government that "is unjustifiable and burdens or restricts United States commerce." (See 19 U.S.C. 2411.) Such actions can be initiated by a petition to the United States Trade Representative. (See 19 U.S.C. 2412.) Additionally, as previously noted, FDA will not exchange information with any foreign government that does not honor its commitment to protect confidential commercial information. FDA believes that the value foreign governments place on the continuing ability to exchange information will also help assure that foreign government officials respect the confidentiality of information that they receive.

8. Three comments suggested adding additional safeguards to proposed §§ 20.88 and 20.89 to decrease the likelihood that unauthorized disclosures of confidential commercial information would occur. In brief, these comments would require State and foreign governments to provide written assurances that individuals who would

have access to the confidential commercial information: (1) Will not be employees, consultants, or persons who have a professional relationship with a drug manufacturer; and (2) will be subject to a confidentiality agreement and/or appropriate laws and regulations prohibiting them from disclosing any information. These comments also would require both FDA and the firm that had submitted the confidential commercial information to FDA to consent, in writing, to any release or disclosure by the State or foreign government.

Under § 20.88(d)(1)(i), a State government agency must provide a written statement establishing its authority to protect confidential commercial information from public disclosure. FDA will supplement this requirement with guidance to States on conflicts of interest and prohibitions against further disclosure.

FDA declines to amend the final rule to require the agency and the party submitting the confidential commercial information to consent to any release or disclosure by the State or foreign government. This final rule and the 1993 final rule governing disclosures of confidential commercial information to foreign government officials already provide for written consent by the party submitting the confidential commercial information (see § 20.88(d)(1)(i); see also § 20.89(c)(1)(i)) or written permission from FDA before the State or foreign government can make any disclosure. Thus, these rules already would require a State or foreign government to obtain written authorization from the party that submitted the confidential commercial information, or written confirmation from FDA that the information was no longer confidential. The comments' suggested changes, therefore, are unnecessary.

As for disclosures to foreign government officials, since amending § 20.89 in 1993 to allow FDA to disclose confidential commercial information to foreign government officials, the agency has not received any reports of unauthorized disclosures by foreign government officials. The agency acknowledges that, in some cases, firms have requested additional safeguards, similar to those mentioned in the comments, and that the foreign government officials have consented to such additional safeguards. However, FDA's experience under § 20.89 does not indicate that such additional safeguards are necessary.

9. One comment would expand §§ 20.88 and 20.89 so that they applied to State and foreign government officials and "all agents contracted by them for

any part of the review and approval processes involving confidential and trade secret information." The comment would also have State and foreign government officials and agents subject to the same confidentiality restrictions as FDA employees.

The agency agrees with the comment and has amended §§ 20.88(e)(3) and 20.89(d)(3) so that references to State or foreign government officials are understood to include agents contracted by those officials.

10. The agency, on its own initiative, has amended §§ 20.88(e) and 20.89(d) to permit the Deputy Commissioner for Policy to authorize disclosures of nonpublic, predecisional documents to State or foreign government officials. The Deputy Commissioner for Policy is authorized, under 21 CFR 5.20(f), to perform any of the functions of the Commissioner of Food and Drugs with respect to the issuance of notices, proposed rules, and final rules.

11. FDA, on its own initiative, has also amended the authority citation to include a reference to the Pesticide Monitoring Improvements Act of 1988 (21 U.S.C. 1401–1403). FDA has taken this action because that statute provides for cooperative agreements between FDA and foreign governments and exchanges of certain information between FDA and States.

B. Section 20.88—Communications With State and Local Government Officials

12. Proposed § 20.88(d)(1)(i) would require, as a condition of authorizing disclosure of confidential commercial information to a State government official, a written statement from the State government agency "establishing its authority to protect confidential commercial information from public disclosure and a written commitment not to disclose any such information" without the sponsor's written permission or FDA's written confirmation that the information was no longer confidential. One comment would require that State agencies provide written assurance that, notwithstanding their own State laws, the State agency would protect any confidential commercial information that it received "in accordance with Federal law and FDA regulations."

FDA sees no need to amend the final rule as suggested by the comment. FDA would not disclose confidential commercial information to a State government official unless State laws allow adequate protection of that information.

13. One comment would require FDA to notify and to obtain written consent

from a party before disclosing confidential commercial information to State government officials. The comment would have the notice describe the information to be disclosed or provide sufficient detail to permit the party to decide whether to withhold permission for disclosure. The comment would also restrict any permission to disclose confidential commercial information to the specific request.

As stated elsewhere in this document, FDA intends, in most cases, to seek written approval from a party before disclosing confidential commercial information. However, the agency declines to require such written approval in all cases because there are situations, such as enforcement actions, where it would be inappropriate to require written approval prior to disclosure.

The agency does agree, however, that a party's written authorization to disclosure of confidential commercial information is limited to a specific request to disclose information and does not constitute automatic authorization to disclose the information to any subsequent State government official seeking to obtain that information. (See 58 FR 61598 at 61602 (stating that "in general, the sponsor needs to authorize further disclosure of confidential information").)

14. Proposed § 20.88(d)(1)(ii)(A) would authorize disclosure of confidential commercial information if disclosure would be "in the interest of the public health by reason of the State government's possessing information concerning the safety, effectiveness, or quality of a product or information concerning an investigation, or by reason of the State government being able to exercise its regulatory authority more expeditiously" than FDA. One comment objected to this provision, arguing that it provided "no objective criteria for determining when the disclosure of confidential commercial information would be in the interest of public health." The comment claimed that the agency had not shown the State commissioned officials program to be inadequate, that the provision gave no "clear, objective standards outlining the procedure for allowing disclosure," and that the proposed rule would operate in an arbitrary and capricious fashion.

The agency declines to amend the final rule to provide the "objective criteria" requested by the comment. It would be extremely difficult, if not impossible, to draft objective criteria that would encompass all instances where disclosure of confidential commercial information would be in the interest of public health, and any

"objective" regulatory criteria would invite parties to dispute the applicability of a particular criterion instead of examining public health concerns and would prevent the final rule from operating in a flexible manner.

FDA further notes that the phrase "interest of public health" is modified by two criteria. Under § 20.88(d)(1)(ii)(B), disclosure would be in the interest of public health: (1) By reason of the State government's possessing information concerning the safety, effectiveness, or quality of a product or information concerning an investigation; or (2) by reason of the State government being able to exercise its regulatory authority more expeditiously than FDA. Thus, § 20.88(d)(1)(ii)(B) contemplates disclosures in the interest of public health if a State government possesses information about a product or an investigation or can exercise regulatory authority in a particular situation more quickly than FDA; the provision does not permit unconditional or unrestricted exchanges of confidential commercial information. As stated in the preamble to the proposed rule, disclosures to State governments will not be a routine occurrence, but would occur only in limited situations and on a case-by-case basis. (See 60 FR 5530 at 5535.)

As for the comment claiming that the agency had not shown the commissioned officials program to be inadequate, the preamble to the proposed rule described the commissioning process for State government officials and explained why commissioned officials might not always be the best or most appropriate persons to receive the types of confidential commercial information or nonpublic, predecisional documents contemplated by the rule. In brief, section 702(a) of the act (21 U.S.C. 372(a)) authorizes FDA to conduct examinations and investigations through employees of the Department of Health and Human Services (HHS) or through any health, food, or drug officer or employee of any State, territory, or political subdivision commissioned as an officer of HHS. (See 60 FR 5530 at 5531.) State or local government officials commissioned under this program have a status with respect to disclosure of FDA records that permits the commissioned official to review confidential investigative files and proposed policy statements that are normally restricted to Federal employees. Thus, FDA can solicit advice from these commissioned officials without public disclosure.

The commissioning process, however, is too cumbersome to be practical in the

situations that led FDA to issue the proposed rule. A commissioned official is authorized to perform one or more of the following functions: (1) Conduct examinations, inspections, and investigations under the act; (2) collect and obtain samples; (3) copy and verify records; and (4) receive and review official FDA documents. (See Regulatory Procedures Manual, chapter 3 (regarding commissioning State and local officials).) A commissioned official is only authorized to review FDA documents that fall within the scope of his or her commission; the official may not necessarily have authorized access to all the information that the agency may need to convey to the State.

Yet, even if commissioning a State government official would enable an official to review FDA documents, such authority would not eliminate the need for the final rule. Commissioning a State government official does not confer any protection to documents supplied by a State government to FDA, whereas § 20.88(e) authorizes the agency to receive nonpublic, predecisional documents from State government officials and to protect those documents from public disclosure. Similar provisions in documents provided to FDA by foreign government officials are set forth in § 20.89(d). If information exchanges are to be valuable and meaningful, the agency must be able to protect State or foreign government documents that it receives, as well as the documents that it sends, and the final rule provides such protection to information that FDA receives.

Additionally, as stated in the preamble to the proposed rule, the commissioning process cannot be easily adapted for situations requiring rapid exchange of information. (See 60 FR 5530 at 5532.) The process involves identifying suitable candidates (and often requires commissioning the candidates' supervisors or State agency heads as well), reviewing the candidates' qualifications, conducting background checks (if necessary), issuing certificates and credentials, and accounting for credentials on a periodic basis. These procedures, even if they were as streamlined as possible, might be both impractical and unnecessary in situations where rapid information exchanges are necessary. Consequently, the agency believes that the final rule gives FDA needed authority to exchange information both quickly and efficiently in situations when reliance on commissioned officials would prove impractical.

15. Two comments would amend proposed § 20.88(d)(1)(ii)(C) to add new requirements to deter unauthorized

disclosures of information. The comments would require visiting State scientists to confirm that they are not employees, consultants, or persons that have any professional relationship with a drug manufacturer and to provide a written commitment not to release or disclose information without approval from FDA and the party submitting the confidential commercial information. The comments would not permit FDA to authorize disclosures unilaterally.

FDA declines to revise the final rule as suggested by the comments. Section 20.88(d)(1)(ii)(C) already contains sufficient safeguards that accomplish the same purpose as those suggested by the comments. For example, the final rule requires a visiting State government scientist to provide a written assurance that he or she "has no financial interest in the regulated industry of the type that would preclude participation in the review of the matter if the individual were subject to the conflict of interest rules applicable to the Food and Drug Administration advisory committee members under 21 CFR 14.80(b)(1)." Under § 14.80(b)(1), advisory committee members are subject to Federal conflict of interest laws and regulations. A visiting State government scientist, therefore, could not truthfully provide the written assurance required under § 20.88(d)(1)(ii)(C) if he or she were an employee or consultant of a drug manufacturer.

FDA also declines to amend the final rule to prevent FDA from authorizing disclosure of confidential commercial information or trade secrets to a visiting State government scientist. Section 20.88(d)(1)(ii)(C) authorizes disclosure to a visiting State government scientist if, among other things: (1) The visiting State government scientist signs a written commitment to protect the confidentiality of the information; (2) the visiting State government scientist provides written assurance that he or she has no financial interest in the regulated industry of the type that would preclude participation in review of the matter if the visiting State government scientist were subject to FDA's conflict of interest rules; and (3) FDA retains physical control over the information. The agency believes that these safeguards provide sufficient protection to confidential commercial and trade secret information in FDA's possession. The agency further notes that a similar regulation has existed for visiting foreign government scientists since 1993, and the agency has not experienced any difficulties or problems with confidential commercial or trade secret information disclosed to visiting foreign government scientists.

16. One comment said that firms that submitted confidential commercial information should have the opportunity to purge "highly confidential" information before disclosure to State government officials. The comment explained that this would enable firms to discuss why FDA should not release certain information to a State government official.

The agency wishes to reassure regulated firms about its concerns for proprietary information, but declines to accept the comment's suggestion. While FDA intends, in most cases, to seek a firm's approval before disclosing confidential commercial information, there are situations where it would be inappropriate to permit firms to purge information before its release to State government officials. For example, if confidential commercial information in a marketing application indicated that a firm might have engaged in fraud or misrepresentation that violated both State and Federal laws, the agency might want to notify its State government counterparts. Permitting a firm to purge that information before its release to a State government official would defeat any State regulatory action. Consequently, the agency declines to amend the final rule as suggested by the comment.

C. Section 20.89—Communications With Foreign Government Officials

17. One comment from a foreign government official supported proposed § 20.89(d) but asked whether FDA would protect the confidentiality of nonpublic, predecisional documents provided by a foreign government.

Section 20.89(d) authorizes the agency to disclose and to receive nonpublic, predecisional documents to or from foreign government officials. Under § 20.89(d)(2), such documents would not be made available to all members of the public. Thus, FDA would maintain the confidentiality of nonpublic, predecisional documents supplied by a foreign government official. The basis for this position is explained in detail in the preamble to the proposed rule (60 FR 5530 at 5536 and 5538).

18. Four comments suggested that FDA either permit firms that submitted the confidential commercial information to purge those records before their release or to decide whether release should occur, or provide summaries to firms regarding the information disclosed to the foreign government.

The agency addressed similar comments when it issued the 1993 final rule permitting FDA to disclose confidential commercial information to

foreign government officials. The preamble to the 1993 final rule stated that: (1) Any disclosure would be on a case-by-case basis under assurances of continuing confidentiality; (2) the agency will, in most circumstances, seek written authorization from the party submitting the confidential commercial information to permit disclosure; and (3) there are situations where it would be inappropriate to require consent from a party that submitted confidential commercial information. (See 58 FR 61598 at 61601.)

The same rationale applies here. FDA reiterates that the final rule authorizes disclosure only to those governments that have provided written assurances that they have the authority to protect confidential commercial information and nonpublic, predecisional documents from public disclosure and that they will not disclose such documents or information without the written permission of the sponsor or written confirmation from FDA that the information or documents are no longer confidential. Additionally, in most cases, FDA intends to seek written consent from the party that submitted the confidential commercial information before disclosing that information. To permit parties to purge information would lessen the utility of any information provided to a State or foreign government and invite such governments to withhold information themselves.

Requiring FDA to give parties summaries of information disclosed to a State or foreign government would also be inappropriate or unnecessary. For example, if a State or foreign government were considering whether to take action against a particular product, requiring FDA to provide a summary to the product's manufacturer would alert a violative firm of the potential enforcement action. In an action to help a government identify fraudulent goods, the agency might wish to provide confidential commercial information that would help distinguish legitimate products from fraudulent ones; in such a scenario, providing a summary to the product's manufacturer would be worthless because the manufacturer would already know the information that was the basis of the summary. Thus, the agency declines to accept the comments' suggestions.

19. Proposed § 20.89(d)(1)(i) would require, as a condition to authorizing disclosure of confidential commercial information to a foreign government official, a written statement from the foreign government establishing its authority to protect nonpublic documents from public disclosure and a

written commitment not to disclose any such documents without FDA's written confirmation that the information was no longer confidential. One comment would limit disclosures to foreign government officials whose countries "can reasonably be expected to maintain confidentiality and patent protection at the level acceptable under U.S. intellectual property protection agreements with foreign nations." If the agency could not determine whether the foreign country offered "acceptable" protection, the comment said that FDA should be required to consult the firm that submitted the confidential commercial information regarding that firm's prior experience with intellectual property protection in the foreign country.

Although this comment pertains to the rulemaking completed in 1993 rather than the present final rule and is outside the scope of this rulemaking, the agency considered similar comments in 1993 when it issued a final rule authorizing the disclosure of confidential commercial information to foreign government officials. The comments asked FDA to restrict disclosures to countries with similar product approval processes or to list foreign governments "that have been designated as appropriate for the sharing of confidential information." (See 58 FR 61598 at 61602.) The agency declined to accept the comments' recommendations, stating that a list of foreign countries would not be useful, repeating that disclosures were subject to certain safeguards, and stating that, "in every case disclosure is at the discretion of the agency and cannot be automatic for any country." Id. The same rationale applies here. FDA will decide, on a case-by-case basis, whether to disclose confidential commercial information to a foreign government and, in most cases, will seek written permission from the party that submitted the confidential commercial information. Given these safeguards, there is no need to establish a list of countries that would protect intellectual property to an "acceptable" or "appropriate" level. Additionally, because most disclosures would be preceded by written approval from the party submitting the confidential commercial information, there is no need to amend the final rule to require prior consultation with the party that submitted the confidential commercial information.

20. One comment said that proposed § 20.89 would delay public participation in reviewing or commenting on predecisional documents and permit public comment "only after the agency

has more invested in its own viewpoint."

The agency disagrees with the comment. The agency believes that exchanges of nonpublic, predecisional documents with State and foreign government officials will neither significantly delay public review of such documents nor make any public review less meaningful. FDA will be just as interested in hearing what the public thinks about a proposal, whether or not that proposal was previously shared with a regulatory counterpart. Nor will the agency's obligation to consider or respond to public comments in any way diminish because of this rule.

FDA stresses that the purpose behind exchanging nonpublic, predecisional documents is not to diminish the role of any participant in rulemaking, but to enhance Federal-State uniformity and facilitate global harmonization of regulatory requirements. Although FDA often considers State or foreign regulatory requirements when drafting its own predecisional documents, mutual exchanges between FDA and a State or foreign government will enable refinements in the documents to account for new requirements or developments. The agency believes that, in most cases, the changes that would be made would probably be minor technical adjustments or revisions to a document before publication or release, but, in any event, there should be no significant delay in publication for general review and comment.

The final rule also promotes efficiency during any public review period. Mutual exchanges between FDA and State or foreign governments should result in documents that reflect greater consideration of State or foreign requirements and resources, thereby reducing the possibility that the agency would have to substantially revise or even repropose a proposed regulatory approach due to an inconsistent or conflicting State or foreign requirement identified by comments submitted during a comment period. For example, providing a nonpublic, predecisional document to State governments could alert FDA that its proposed enforcement scheme would overly burden State resources; FDA could then revise the enforcement scheme and publish or release a document that contained the revised enforcement scheme. FDA also reiterates that any document that it publishes in the Federal Register will inform the public of any information from State or foreign government officials that affected the document and provide an opportunity for public comment.

In contrast, if FDA cannot exchange a nonpublic, predecisional documents with State governments, the agency may publish a document proposing an enforcement scheme that places unrealistic burdens on State governments, await comments, publish a second document proposing a revised enforcement scheme, await comments again, and then issue a final document. Under this scenario, public participation might occur earlier, but final action on the initiative would occur later, with attendant delays to the program in question and waste of public resources.

III. Description of the Final Rule

Section 20.88(d) of the final rule authorizes FDA to disclose confidential commercial information submitted to FDA or incorporated into FDA-prepared records to State government officials as part of cooperative law enforcement or regulatory efforts, provided that: (1) The State government agency has provided a written statement establishing its authority to protect the information from public disclosure and has provided a written commitment not to disclose such information without the sponsor's written permission or written confirmation from FDA that the information is no longer confidential; and (2) FDA has determined that the sponsor has consented, in writing, to disclosure, disclosure would be in the interest of public health, or disclosure would be to a visiting State scientist, subject to certain additional conditions (such as a written assurance that the visiting State scientist has no financial interest in the regulated industry that would preclude him or her from participating in the matter under review). Information exchanged under § 20.88(d) would not be available to the public.

Sections 20.88(e) and 20.89(d) permit the agency to disclose or to receive nonpublic, predecisional documents to or from State or foreign government officials as part of efforts to improve intergovernmental cooperation and uniformity or to implement intergovernmental agreements. The disclosure or receipt of nonpublic, predecisional documents is subject to two conditions: (1) The State or foreign government agency has provided a written statement establishing its authority to protect nonpublic documents from public disclosure and has provided a written commitment not to disclose such documents without FDA's written confirmation that the information no longer has nonpublic status; and (2) the agency has determined that exchange is reasonably

necessary to cooperative regulatory activities or to improve Federal-State uniformity or to facilitate international harmonization of regulatory requirements. Information exchanged under §§ 20.88(e) or 20.89(d) will not be available to the public.

IV. Environmental Impact

The agency has determined under 21 CFR 25.24(a)(8) that this action is of a type that does not individually or cumulatively have a significant effect on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

V. Analysis of Impacts

FDA has examined the impacts of the final rule under Executive Order 12866 and the Regulatory Flexibility Act (Pub. L. 96-354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). The agency believes that this final rule is consistent with the regulatory philosophy and principles identified in the Executive Order. In addition, the final rule is not a significant regulatory action as defined by the Executive Order and so is not subject to review under the Executive Order.

The Regulatory Flexibility Act requires agencies to analyze regulatory options that would minimize any significant impact of a rule on small entities. Because the final rule promotes harmonized regulatory requirements, nationally and internationally, thereby reducing disparate regulatory requirements, the agency certifies that the final rule will not have a significant economic impact on a substantial number of small entities. Therefore, under the Regulatory Flexibility Act, no further analysis is required.

List of Subjects in 21 CFR Part 20

Confidential business information, Courts, Freedom of information, Government employees.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, 21 CFR part 20 is amended as follows:

PART 20—PUBLIC INFORMATION

1. The authority citation for 21 CFR part 20 is revised to read as follows:

Authority: Secs. 201–903 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321–393); secs. 301, 302, 303, 307, 310, 311, 351, 352, 354–360F, 361, 362, 1701–1706, 2101 of the Public Health Service Act (42 U.S.C. 241, 242, 242a, 242l, 242n, 243, 262, 263, 263b–263n, 264, 265, 300u–300u–5, 300aa–1); 5 U.S.C. 552; 18 U.S.C. 1905; 19 U.S.C. 2531–2582; 21 U.S.C. 1401–1403.

2. Section 20.88 is amended by adding new paragraphs (d) and (e) to read as follows:

§ 20.88 Communications with State and local government officials.

* * * * *

(d)(1) The Commissioner of Food and Drugs, or any other officer or employee of the Food and Drug Administration whom the Commissioner may designate to act on his or her behalf for the purpose, may authorize the disclosure of confidential commercial information submitted to the Food and Drug Administration, or incorporated into agency-prepared records, to State government officials as part of cooperative law enforcement or regulatory efforts, provided that:

(i) The State government agency has provided both a written statement establishing its authority to protect confidential commercial information from public disclosure and a written commitment not to disclose any such information provided without the written permission of the sponsor or written confirmation by the Food and Drug Administration that the information no longer has confidential status; and

(ii) The Commissioner of Food and Drugs or the Commissioner's designee makes one or more of the following determinations:

(A) The sponsor of the product application has provided written authorization for the disclosure;

(B) Disclosure would be in the interest of public health by reason of the State government's possessing information concerning the safety, effectiveness, or quality of a product or information concerning an investigation, or by reason of the State government being able to exercise its regulatory authority more expeditiously than the Food and Drug Administration; or

(C) The disclosure is to a State government scientist visiting the Food and Drug Administration on the agency's premises as part of a joint review or long-term cooperative training effort authorized under section 708 of the Federal Food, Drug, and Cosmetic Act (the act), the review is in the interest of public health, the Food and Drug Administration retains physical control over the information, the Food and Drug

Administration requires the visiting State government scientist to sign a written commitment to protect the confidentiality of the information, and the visiting State government scientist provides a written assurance that he or she has no financial interest in the regulated industry of the type that would preclude participation in the review of the matter if the individual were subject to the conflict of interest rules applicable to the Food and Drug Administration advisory committee members under § 14.80(b)(1) of this chapter. Subject to all the foregoing conditions, a visiting State government scientist may have access to trade secret information, entitled to protection under section 301(j) of the act, in those cases where such disclosures would be a necessary part of the joint review or training.

(2) Except as provided under paragraph (d)(1)(ii)(C) of this section, this provision does not authorize the disclosure to State government officials of trade secret information concerning manufacturing methods and processes prohibited from disclosure by section 301(j) of the act, unless pursuant to an express written authorization provided by the submitter of the information.

(3) Any disclosure under this section of information submitted to the Food and Drug Administration or incorporated into agency-prepared records does not invoke the rule established in § 20.21 that such records shall be made available to all members of the public.

(e)(1) The Deputy Commissioner for Policy, or any other officer or employee of the Food and Drug Administration whom the Deputy Commissioner for Policy may designate to act on his or her behalf for the purpose, may authorize the disclosure to, or receipt from, an official of a State government agency of nonpublic, predecisional documents concerning the Food and Drug Administration's or the other government agency's regulations or other regulatory requirements, or other nonpublic information relevant to either agency's activities, as part of efforts to improve Federal-State uniformity, cooperative regulatory activities, or implementation of Federal-State agreements, provided that:

(i) The State government agency has provided both a written statement establishing its authority to protect such nonpublic documents from public disclosure and a written commitment not to disclose any such documents provided without the written confirmation by the Food and Drug Administration that the documents no longer have nonpublic status; and

(ii) The Deputy Commissioner for Policy or the Deputy Commissioner for Policy's designee makes the determination that the exchange is reasonably necessary to improve Federal-State uniformity, cooperative regulatory activities, or implementation of Federal-State agreements.

(2) Any exchange under this section of nonpublic documents does not invoke the rule established at § 20.21 that such records shall be made available to all members of the public.

(3) For purposes of this paragraph, the term "official of a State government agency" includes, but is not limited to, an agent contracted by the State government, and an employee of an organization of State officials having responsibility to facilitate harmonization of State standards and requirements in FDA's areas of responsibility. For such officials, the statement and commitment required by paragraph (e)(1)(i) of this section shall be provided by both the organization and the individual.

3. Section 20.89 is amended by adding new paragraph (d) to read as follows:

§ 20.89 Communications with foreign government officials.

* * * * *

(d)(1) The Deputy Commissioner for Policy, or any other officer or employee of the Food and Drug Administration whom the Deputy Commissioner for Policy may designate to act on his or her behalf for the purpose, may authorize the disclosure to, or receipt from, an official of a foreign government agency of nonpublic, predecisional documents concerning the Food and Drug Administration's or the other government agency's regulations or other regulatory requirements, or other nonpublic information relevant to either agency's activities, as part of cooperative efforts to facilitate global harmonization of regulatory requirements, cooperative regulatory activities, or implementation of international agreements, provided that:

(i) The foreign government agency has provided both a written statement establishing its authority to protect such nonpublic documents from public disclosure and a written commitment not to disclose any such documents provided without the written confirmation by the Food and Drug Administration that the documents no longer have nonpublic status; and

(ii) The Deputy Commissioner for Policy or the Deputy Commissioner for Policy's designee makes the

determination that the exchange is reasonably necessary to facilitate global harmonization of regulatory requirements, cooperative regulatory activities, or implementation of international agreements.

(2) Any exchange under this section of nonpublic documents does not invoke the rule established in § 20.21 that such records shall be made available to all members of the public.

(3) For purposes of this paragraph, the term "official of a foreign government agency" includes, but is not limited to, an agent contracted by the foreign government, and an employee of an international organization having responsibility to facilitate global harmonization of standards and requirements in FDA's areas of responsibility. For such officials, the statement and commitment required by paragraph (d)(1)(i) of this section shall be provided by both the organization and the individual.

Dated: November 30, 1995.

William B. Schultz,

Deputy Commissioner for Policy.

[FR Doc. 95-29904 Filed 12-7-95; 8:45 am]

BILLING CODE 4160-01-F

Friday
December 8, 1995

Part V

**Department of
Health and Human
Services**

Food and Drug Administration

**Advertising and Promotion; Draft
Guidances; Republication; Notice**

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Food and Drug Administration****[Docket No. 95D-0377]****Advertising and Promotion; Draft Guidances; Republication**

Note: This document was originally published at 60 FR 62471, Wednesday, December 6, 1995. Certain text in the guidances were inadvertently omitted. For the convenience of the reader, the document is being republished in its entirety.

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is publishing two draft guidance documents entitled "Guidance to Industry on Dissemination of Reprints of Certain Published, Original Data" and "Guidance for Industry Funded Dissemination of Reference Texts." These draft guidances are related to the dissemination, by sponsors of human and animal drugs, medical devices, and biological products, of certain reprints of journal articles discussing FDA-approved products, and reference texts (medical textbooks and compendia). The draft guidances describe circumstances under which the agency would exercise its discretion to allow the dissemination of these reprints and reference texts to health care professionals.

DATES: Written comments by January 5, 1996.

ADDRESSES: Submit written comments on the draft guidance documents to the Dockets Management Branch (HFA-305), Food and Drug Administration, 12420 Parklawn Dr., rm. 1-23, Rockville, MD 20857, or FAX at 301-594-3215.

FOR FURTHER INFORMATION CONTACT: Ilisa B. G. Bernstein, Office of Policy (HF-23), Food and Drug Administration, 5600 Fishers Lane, rm. 15-74, Rockville, MD 20857, 301-827-3380, or via internet at lBernste@bangate.fda.gov.

SUPPLEMENTARY INFORMATION: Health care professionals have always been able to obtain, from a number of different sources, journal articles and reference texts (i.e., medical textbooks and compendia), that discuss human and animal drugs, medical devices, and biological products. These journal articles and reference texts are commercially available and may be obtained from publishers, libraries, on-line data bases, colleagues, bookstores, companies upon request, or other sources. Sponsors of human and animal drugs, medical devices, and biological

products frequently have expressed a desire to disseminate reprints of journal articles and reference texts to health care professionals.

FDA traditionally has taken the position that sponsors who wish to distribute articles and reference texts containing information that is inconsistent with the FDA-approved labeling for a product may be in conflict with the Federal Food, Drug, and Cosmetic Act and implementing regulations. The agency's position is based on its mission to help ensure the safety and efficacy of human and animal drugs, medical devices, and biological products. Sponsors seeking approval or clearance to market these products must demonstrate to FDA that the products are safe and effective for their intended use(s). Permitting sponsors to freely disseminate information that is inconsistent with the FDA-approved or cleared use(s) would diminish the incentive for sponsors to perform the clinical studies which are necessary to verify that the product is safe and effective for the unapproved use. Furthermore, information disseminated by a biased source may have a greater potential to mislead the health care professional.

FDA believes that journal articles and reference texts are often useful to health care professionals. Accordingly, the agency has reviewed its policies to determine if modifications can be made without jeopardizing the integrity of the statutorily mandated standard that marketed drugs be safe and effective and have adequate directions for their intended use(s). After careful review, the agency is proposing to modify two of its policies at this time.

First, under one proposed draft guidance, the agency would allow sponsors to disseminate, under certain circumstances, journal articles that report the results of well-controlled studies, provided they represent the peer-reviewed, published version of original efficacy trials used to support approval, licensure, or clearance. Second, under the other proposed draft guidance, the agency would allow sponsors to disseminate, under certain circumstances, reference texts that discuss human or animal drugs, medical devices, or biological products. FDA has prepared two draft guidance documents describing the proposed circumstances under which the agency would exercise its discretion regarding the dissemination of these materials by sponsors.

FDA is particularly interested in receiving comments on whether the reprints discussed in the "Guidance to Industry on Dissemination of Reprints

of Certain Published, Original Data" should be from "peer-reviewed" journals. If so, please comment on what constitutes a "peer-reviewed" journal and what benefits would be afforded if these reprints are from "peer-reviewed" journals.

Interested persons may, on or before January 5, 1996, submit to the Dockets Management Branch (address and FAX number above) written comments on the draft guidance documents. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. The draft guidance documents and received comments are available for public examination in the office above between 9 a.m. and 4 p.m., Monday through Friday.

The texts of the draft guidance documents follow:

Guidance to Industry on Dissemination of Reprints of Certain Published, Original Data¹

I. Purpose of Guidance

Sponsors frequently want to disseminate reprints of articles reporting the results of the effectiveness trials that have been relied on by FDA in its approval or clearance of a drug, device, or biologic product. However, such articles may contain effectiveness rates, data, analyses, uses, regimens, or other information that is different from the approved labeling, and might, if disseminated by the sponsor, be considered violative promotional activities.

Nonetheless, the agency intends to allow the dissemination of reprints of articles that represent the peer-reviewed, published version of original efficacy trials, under the circumstances described in section II. below.

II. Circumstances for Dissemination of Certain Journal Articles Discussing FDA-Approved Products

1. The principal subject of the article should be the use(s) or indication(s) that has been approved by FDA. The article should be published in accordance with the regular peer-review procedure of the journal in which it is published, and the article reports the original study that was represented by the sponsor, submitted to FDA, and accepted by the agency as one of the adequate and well controlled studies providing evidence of effectiveness. In the case of a medical device,

¹This guidance does not apply to reprints of articles that discuss the specific prohibited uses of animal drugs listed in the FDA, Center for Veterinary Medicine Compliance Policy Guide 7125.06 or the Animal Medicinal Drug Use Clarification Act implementing regulations. Although this guidance does not create or confer any rights on any person and does not operate to bind FDA in any way, it does represent the agency's current thinking on the dissemination of reprints of certain published, original data. The agency will consider individual circumstances on a case-by-case basis.

this guidance also applies to studies that were otherwise represented by the sponsor, submitted to the agency, and accepted by the agency as valid and material evidence of safety or effectiveness in lieu of adequate and well controlled studies;

2. The reprint should be from a bona fide peer-reviewed journal. A bona fide peer-reviewed journal is a journal that utilizes experts to review and objectively select, reject, or provide comments about proposed articles. Such experts should have demonstrated expertise in the subject of the article under review, and be independent from the journal;

3. If the article contains effectiveness rates, data, analyses, uses, regimens, or other information that is different from approved labeling, the reprint should prominently state the difference(s), with specificity, on the face of the reprint. One acceptable means of achieving the appropriate prominence for this statement is to permanently affix to the reprint a sticker stating the differences; and

4. The reprint should disclose all material facts and should not be false or misleading.

Guidance for Industry Funded Dissemination of Reference Texts²

I. Purpose of Guidance

Sponsors have also expressed a desire to disseminate reference texts, i.e., medical textbooks and compendia, to health care

professionals. These texts typically discuss a wide range of medical diagnoses and treatments, including drug product utilization, surgical techniques, and other medical topics. FDA recognizes that such texts are often useful to clinicians in the practice of medicine.

Reference texts often contain information about the use of drugs, devices, or biologic products in the treatment, diagnosis, or prevention of disease that may not be consistent with the FDA-approved labeling for the products (e.g., discussion of unapproved uses). FDA recognizes, however, that many textbooks do not necessarily highlight a particular drug or device manufacturers products. In such instances, industry's desire to disseminate these reference texts may be in conflict with the Federal Food, Drug, and Cosmetic Act (the act) and implementing regulations.³

Nonetheless, FDA intends to permit the distribution of sound, authoritative materials that are written, published, and disseminated independent of the commercial interest of a sponsoring company and are not false nor misleading. FDA, therefore, intends to allow the dissemination by sponsors of reference texts that discuss human or animal drug, device, or biologic products, under the circumstances described in section II. below.

II. Circumstances for Dissemination of Reference Textbooks

1. The reference text should not have been written, edited, excerpted, or published specifically for, or at the request of, a drug, device, or biologic firm (see discussion below);

³Printed materials, such as medical textbooks and compendia, which supplement, explain, or are textually related to a regulated product are considered labeling for that product when disseminated by or on behalf of the manufacturer, packer, or distributor of the product. See section 201(m) of the act (21 U.S.C. 321(m)) and *Kordel v. United States*, 338 U.S. 345, 350 (1948).

2. The content of the reference text should not have been reviewed, edited, or significantly influenced by a drug, device, or biologic firm, or agent thereof (see discussion below);

3. The reference text should not be distributed only or primarily through drug, device, or biologic firms (e.g., it should be generally available for sale in bookstores or other distribution channels where similar books are normally available);

4. The reference text should not focus primarily on any particular drug(s), device(s), or biologic(s) of the disseminating company, nor should it have a significant focus on unapproved uses of the drug(s), device(s), or biologic(s) marketed or under investigation by the firm supporting the dissemination of the text; and

5. Specific product information (other than the approved package insert) should not be physically appended to the reference text.

The agency recognizes that there are some useful reference texts that are written, edited, or published by a sponsor or agent of the sponsor. In these instances, FDA intends to allow the distribution of a reference text under the circumstances described in paragraphs 3 through 5 above, when the authorship, editing, and publishing of the reference text results in the presentation of a balanced perspective of the subject matter. Typically, this would be evidenced by an authorship and editorial process that fosters input from a relatively wide spectrum of sources and that allows for information from all sources to be considered.

Dated: December 6, 1995.

William K. Hubbard,

Associate Commissioner for Policy.

[FR Doc. 95-30169 Filed 12-7-95; 10:42 am]

BILLING CODE 4160-01-F

²Although this guidance does not create or confer any rights, on any person, and does not operate to bind FDA in any way, it does represent the agency's current thinking on industry funded dissemination of reference texts. Although FDA believes that this guidance encompasses the vast majority of reference texts, the agency will consider, on a case-by-case basis, reference texts that do not fall within the parameters of this guidance document. This guidance does not apply to textbooks or compendia that discuss the specific prohibited uses or animal drugs listed in the Center for Veterinary Medicine Compliance Policy Guide 7125.06 or the Animal Medicinal Drug Use Clarification Act implementing regulations.

Registered Federal

Friday
December 8, 1995

Part VI

The President

Proclamation 6856—National Pearl Harbor
Remembrance Day, 1995

Memorandum of December 6, 1995

Presidential Documents

Title 3—

Proclamation 6856 of December 6, 1995

The President

National Pearl Harbor Remembrance Day, 1995

By the President of the United States of America

A Proclamation

America's involvement in World War II began 54 years ago as dawn was shattered by a surprise attack on our forces stationed at Pearl Harbor, Hawaii. In the words of President Franklin Delano Roosevelt, "December 7, 1941—a date which will live in infamy" began at 7:55 a.m. when Japan launched an offensive to destroy the United States Pacific Fleet. The losses suffered that day shocked our Nation with the realization that American soil was not immune to the ravages of war—at the end of the attack, more than 3,000 Americans were dead, missing, or wounded. We resolved to boldly defend our shores against further devastation. Just 4 years later, the same fleet that the Japanese had attempted to destroy at Pearl Harbor sailed triumphantly into Tokyo Bay.

The attack of Pearl Harbor marked the beginning of America's total mobilization against a common enemy, and the United States soon became the world's "Arsenal of Democracy." Citizens worked together toward a common goal as the "We Can Do It" attitude spread across the country. The landscape of American business was forever changed as over 19 million women and many minority workers took high-skill jobs to contribute to the war effort.

The courageous veterans who fought selflessly to bring an end to the war in the Pacific deserve our highest respect and our most profound gratitude. Today we honor the sacrifices that led to the ultimate victory—the triumph of freedom over tyranny. We also pay tribute to the families who contributed so much with their support, sacrifices, and prayers from the home front. A grateful Nation will long remember those who came home and those who did not.

In the post-Cold War era, it is vital that we pass along the lessons learned from Pearl Harbor to a new generation of Americans. We must never allow our country to be unprepared, and we must never again isolate ourselves from the problems of the world. This is the legacy we leave to our young people, and it is our responsibility to continue to teach them those lessons. By doing so, we reaffirm the values of democracy, freedom, and leadership that have made America great.

The Congress, by Public Law 103–308, has designated December 7, 1995, as "National Pearl Harbor Remembrance Day."

NOW, THEREFORE, I, WILLIAM J. CLINTON, President of the United States of America, do hereby proclaim December 7, 1995, as National Pearl Harbor Remembrance Day. I urge all Americans to observe this day with appropriate programs, ceremonies, and activities in honor of the Americans who served at Pearl Harbor. I also ask all Federal departments and agencies, organizations, and individuals to fly the flag of the United States at half-staff on this day in honor of those Americans who died as a result of the attack on Pearl Harbor.

IN WITNESS WHEREOF, I have hereunto set my hand this sixth day of December, in the year of our Lord nineteen hundred and ninety-five, and of the Independence of the United States of America the two hundred and twentieth.

William Clinton

[FR Doc. 95-30177

Filed 12-7-95; 10:57 am]

Billing code 3195-01-P

Presidential Documents

Memorandum of December 6, 1995

Delegation of Authority Under Section 321(c) of the North American Free Trade Agreement Implementation Act

Memorandum for the United States Trade Representative

By virtue of the authority vested in me as President by the Constitution and laws of the United States, including section 301 of title 3 of the United States Code, I hereby delegate to the United States Trade Representative (USTR) the powers vested in the President by section 321(c) of the North American Free Trade Agreement Implementation Act (19 U.S.C. 3391(c)) with respect to the tariff rate quotas for tomatoes.

In carrying out this authority, USTR shall consult with interested agencies, as well as the National Economic Council and the National Security Council. You are authorized and directed to publish this memorandum in the Federal Register.



THE WHITE HOUSE,
Washington, December 6, 1995.

Reader Aids

Federal Register

Vol. 60, No. 236

Friday, December 8, 1995

CUSTOMER SERVICE AND INFORMATION

Federal Register/Code of Federal Regulations

General Information, indexes and other finding aids	202-523-5227
Public inspection announcement line	523-5215

Laws

Public Laws Update Services (numbers, dates, etc.)	523-6641
For additional information	523-5227

Presidential Documents

Executive orders and proclamations	523-5227
The United States Government Manual	523-5227

Other Services

Electronic and on-line services (voice)	523-4534
Privacy Act Compilation	523-3187
TDD for the hearing impaired	523-5229

ELECTRONIC BULLETIN BOARD

Free Electronic Bulletin Board service for Public Law numbers, Federal Register finding aids, and list of documents on public inspection. **202-275-0920**

FAX-ON-DEMAND

You may access our Fax-On-Demand service. You only need a fax machine and there is no charge for the service except for long distance telephone charges the user may incur. The list of documents on public inspection and the daily Federal Register's table of contents are available using this service. The document numbers are 7050-Public Inspection list and 7051-Table of Contents list. The public inspection list will be updated immediately for documents filed on an emergency basis.

NOTE: YOU WILL ONLY GET A LISTING OF DOCUMENTS ON FILE AND NOT THE ACTUAL DOCUMENT. Documents on public inspection may be viewed and copied in our office located at 800 North Capitol Street, N.W., Suite 700. The Fax-On-Demand telephone number is: **301-713-6905**

FEDERAL REGISTER PAGES AND DATES, DECEMBER

61645-62016	1
62017-62188	4
62189-62318	5
62319-62700	6
62701-62980	7
62981-63392	8

CFR PARTS AFFECTED DURING DECEMBER

At the end of each month, the Office of the Federal Register publishes separately a List of CFR Sections Affected (LSA), which lists parts and sections affected by documents published since the revision date of each title.

3 CFR

Proclamations:	
6853	62185
6854	62187
6855	62979
6856	63389

Executive Orders:

11533 (see EO 12981)	62981
12002 (continued by EO 12981)	62981
12924 (see EO 12981)	62981
12981	62981

Administrative Orders:

Memorandum of December 6, 1995	63391

5 CFR

Ch. XVI	62319
532	62701
890	62987
1900	62702

7 CFR

17	62702
29	62172, 62974
31	62172
32	62172
51	62172
52	62172, 62708, 62709
53	62172
54	62172
56	62172
58	62172
60	62974
70	62172
81	62974
99	62974
100	62974
101	62974
160	62172
202	62974
319	62319
401	62189, 62321, 62710
443	62710
457	62710
1002	62017, 62018
1260	62019
3200	63368
3305	62974
3411	63368

Proposed Rules:

226	62227
250	62999
985	62229
1280	62298

8 CFR

214	62021

9 CFR

77	62988

10 CFR

475	62316
476	62316
478	62316

Proposed Rules:

475	62318
476	62318
478	62318

12 CFR

Proposed Rules:

Ch. III	62345
213	62349
226	62764
230	62349
250	62050

13 CFR

140	62190

14 CFR

23	62730
39	61645, 61647, 61649, 62192, 62321
71	61652, 61653, 62194, 62323

Proposed Rules:

39	62051, 62772, 62774, 62776, 62799
71	61666, 61667, 61668, 61669, 62053, 62351, 62782, 63007

15 CFR

Proposed Rules:

960	62054

16 CFR

455	62195
1145	62023
1512	62989

Proposed Rules:

303	62352
1203	62662

17 CFR

200	62295
240	62323

18 CFR

375	62326

19 CFR

19	62732
24	62732
146	62732
151	62732

20 CFR

404	62329

Proposed Rules:

404	62354, 62783

416.....	62356
21 CFR	
20.....	63372
176.....	62207
177.....	61654
182.....	62208
186.....	62208
Proposed Rules:	
801.....	61670
803.....	61670
804.....	61670
897.....	61670
23 CFR	
Proposed Rules:	
667.....	62359
24 CFR	
81.....	61846
Proposed Rules:	
3500.....	63008
26 CFR	
1.....	62024, 62026, 62209
53.....	62209
301.....	62209
Proposed rules:	
1.....	62229, 63009
28 CFR	
60.....	62733
29 CFR	
215.....	62964
2606.....	61740
2616.....	61740
2617.....	61740
2629.....	61740
Proposed Rules:	
102.....	61679
1602.....	63010
1910.....	62360
1915.....	62360
1926.....	62360
30 CFR	
917.....	62734
Proposed Rules:	
250.....	63011
251.....	63011
256.....	63011
756.....	62786
906.....	62789
913.....	62229
33 CFR	
165.....	62330
34 CFR	
668.....	61760, 61776, 61796, 61830
674.....	61796
675.....	61796
676.....	61796
682.....	61750, 61796
685.....	61790, 61796, 61820
690.....	61796
36 CFR	
Proposed Rules:	
1.....	62233
13.....	62233
37 CFR	
253.....	61654

255.....	61655
259.....	61657
Proposed Rules:	
202.....	62057
39 CFR	
20.....	61660
40 CFR	
9.....	62930
52.....	62737, 62741, 62748, 62990
63.....	62930, 62991
70.....	62032, 62753, 62758, 62992
180.....	62330
81.....	62741, 62748
185.....	62330
763.....	62332
Proposed Rules:	
52.....	62792, 62793, 63019
61.....	61681
70.....	62793, 62794
81.....	62236, 62792, 62793
122.....	62546
123.....	62546
180.....	62361, 62364, 62366
186.....	62366
261.....	62794
403.....	62546
501.....	62546
41 CFR	
301-11.....	62332
42 CFR	
400.....	63124
405.....	63124
410.....	63124
411.....	63124
412.....	63124
413.....	63124
414.....	63124
415.....	63124
417.....	63124
489.....	63124
Proposed rules:	
413.....	62237
43 CFR	
10.....	62134
44 CFR	
65.....	62213, 62333, 62335
67.....	62337
Proposed Rules:	
67.....	62369
47 CFR	
0.....	61662
73.....	62218, 62219, 62220
80.....	62927
90.....	61662
Proposed Rules:	
73.....	62060, 62061, 62373
48 CFR	
Proposed Rules:	
9.....	62806
15.....	63023
49 CFR	
1.....	62762
219.....	61664
553.....	62221

Proposed Rules:	
571.....	62061
50 CFR	
25.....	62035
32.....	62035
611.....	62339
638.....	62762
649.....	62224
650.....	62224
651.....	62224
652.....	62226
675.....	62339
676.....	62339
677.....	62339
Proposed Rules:	
611.....	62373
642.....	62241
675.....	62373
676.....	62373
677.....	62373

REMINDERS

The rules and proposed rules in this list were editorially compiled as an aid to Federal Register users. Inclusion or exclusion from this list has no legal significance.

Rules Going Into Effect Today

FEDERAL TRADE COMMISSION

Industry guides:

New automobiles; fuel economy advertising guide; published 11-8-95

GENERAL SERVICES ADMINISTRATION

Federal Information Resources Management Regulation: Contracts for multi-agency use; published 11-8-95

HOUSING AND URBAN DEVELOPMENT DEPARTMENT

Mortgage and loan insurance programs:

Mortgages insured under section 235(r) of National Housing Act; refinancing; published 11-8-95

NATIONAL LABOR RELATIONS BOARD

Procedural rules;

Filing and service of documents; facsimile transmission requirements, etc.; published 11-8-95

Comments Due Next Week

AGRICULTURE DEPARTMENT

Consolidated Farm Service Agency

North American Free Trade Agreement (NAFTA):

End-use certificate program; comments due by 12-14-95; published 11-14-95

COMMERCE DEPARTMENT National Oceanic and Atmospheric Administration

Fishery conservation and management:

Pacific Coast groundfish; comments due by 12-13-95; published 11-28-95

EDUCATION DEPARTMENT

Bilingual education:

Graduate fellowship program; comments due by 12-11-95; published 11-9-95

ENVIRONMENTAL PROTECTION AGENCY

Clean Air Act:

State operating permits programs--
Puerto Rico; comments due by 12-14-95; published 11-14-95

Hazardous waste:

Identification and listing--
Dye and pigment production; comments due by 12-15-95; published 11-30-95

Pesticides; tolerances in food, animal feeds, and raw agricultural commodities; exemptions:

1,2-ethanediamine, polymer with oxirane and methyloxirane; comments due by 12-15-95; published 11-15-95

Pesticides; tolerances in food, animal feeds, and raw agricultural commodities:

1-[[2-(2,4-dichlorophenyl)-4-propyl-1,3-dioxolan-2-yl]methyl]-1H-1,2,4-triazole (propiconazole); comments due by 12-15-95; published 11-15-95

FEDERAL COMMUNICATIONS COMMISSION

Common carrier services:

Public mobile services--
Enhanced 911 services compatibility with wireless services; comments due by 12-15-95; published 11-28-95

HEALTH AND HUMAN SERVICES DEPARTMENT Food and Drug Administration

Food additives:

Adhesive coatings and components--
Silver chloride-coated titanium dioxide; comments due by 12-

15-95; published 11-15-95

**INTERIOR DEPARTMENT
Fish and Wildlife Service**

Endangered and threatened species:

Bruneau hot springsnail
Comment period extension; comments due by 12-15-95; published 11-13-95

JUSTICE DEPARTMENT

Executive Office for Immigration Review:
Representation and appearance, nominal fees requirement; and free legal services lists; comments due by 12-14-95; published 11-14-95

LABOR DEPARTMENT

Mine Safety and Health Administration

Metal and nonmetal mine safety and health:

First aid safety standards; comments due by 12-11-95; published 10-27-95

**PENSION BENEFIT
GUARANTY CORPORATION**

Privacy Act; implementation; comments due by 12-15-95; published 11-15-95

**PERSONNEL MANAGEMENT
OFFICE**

Prevailing rate systems; comments due by 12-14-95; published 11-14-95

**SECURITIES AND
EXCHANGE COMMISSION**

Securities:

Ownership reports and trading by officers, directors, and principal security holders (insider trading)

Correction; comments due by 12-15-95; published 10-26-95

STATE DEPARTMENT

Visas; immigrant documentation:

Diversity immigrant visa program; requirements to prevent fraudulent practices; comments due by 12-13-95; published 11-13-95

**TRANSPORTATION
DEPARTMENT**

Federal Aviation Administration

Class C airspace; comments due by 12-15-95; published 11-1-95

Class E airspace; comments due by 12-11-95; published 11-1-95

TREASURY DEPARTMENT

Fiscal Service

Financial management services:

Federal process agents of surety companies; comments due by 12-11-95; published 11-9-95